State of the Field Report for Health and Adult Learning Updated 2007

Adult Working Group

Health and Learning Knowledge Centre

Canadian Council on Learning

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Introduction

This section includes the purpose of the State of the Field Report, background information on the Health and Adult Learning Working Group (AWG) and its mandate, and an interpretation of health and learning that guided the study.

A. Purpose of the State of the Field Report

The Adult Working Group is a committee of the Health and Learning Knowledge Centre. The purpose of the State of the Field Report on Health and Adult Learning is to make generalizations about the existing literature, both practitioner-based and academic, related to the health and learning of adults. Also, the Report identifies gaps in this literature and makes recommendations with respect to promising lines of inquiry for the future. The Report focuses on the health and learning of adults with particular attention to the five priority areas of the Adult Working Group (AWG), and the themes of the Canadian Council on Learning. It includes the settings (workplace, community, health care, and families) of the AWG. It also includes literature that focuses on issues of gender and race and ethnicity.

The *2007 Updates* of the *State of the Field Report on Health and Adult Learning: 2006* and its companion document the *Environmental Scan on Health and Learning: 2006* were both produced as part of the work of the AWG. With these two major documents, the AWG will seek to help fulfill the mandate of the Health and Learning Knowledge Centre (HLKC) and its own stated mission. The mission of the HLKC is as follows:

> "The Knowledge Centre will become a national reference point and key resource for all knowledge related to the interaction of learning and health…Traditional knowledge development is dominated by the requirements of academia and policy-makers looking for immediate answers. The Knowledge Centre will facilitate the exchange of knowledge across the health and learning sectors and vertically from community to national and international levels. Each working

group will identify knowledge gaps that need to be addressed, and lessons learned that can be shared with the public and with relevant organizations."

B. Background Information

In June 2005, the Canadian Council on Learning (CCL) held a Health and Learning Knowledge Centre consultation in Vancouver, British Columbia. At the consultation, participants agreed to establish six 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 will coordinate and organize its work according to both the life stages and settings. The Adult Working Group[1] is now one of 15 groups addressing learning across the life span.

The mandate of each of the working groups is to define 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 must also 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

[1] See Appendix A for a list of the Adult Working Group members

families and 4) in communities. The AWG identified the priority groups at the outset[2] as follows:

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

Issues of gender and racialisation[3] are included across this range of priority areas.

C. Interpretation of Health and Learning

The AWG seeks to promote an inclusive model of how adult learning fits into the broad arena of health. Adult learning refers to informal, non-formal, and formal ways that adults learn. Health is defined broadly as not just the absence of disease, but as also including all aspects of an individual's health – physical, mental, emotional, and spiritual. Health is affected by social determinants such as literacy, income, housing, racism, social exclusion, and access to health services. Health is seen as a fundamental human right with a vision of equitable, inclusive and just provision of health services to all, with particular attention to marginalized groups.

The AWG examines the links between adult learning and health. One link is how adult learning might improve health, address inequities in health, as well as build and sustain healthy communities. This idea includes how adult learning may help people gain control over the conditions that affect their health through understanding and acting upon these conditions. Adult education has a significant role to play in engaging others in understanding and changing the social and institutional factors that impact health.

[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 "racialisation" and "racialized" refers to a categorization or differentiation made of individuals based on race.

D. Audience for the State of the Field Report

This report is meant to be useful and accessible to a wide range of audiences interested in research on health and adult learning. This includes practitioners, researchers, academics, and policy-makers with an interest in adult learning and health.

II. Methodology

A. Parameters of the Study

The research team's primary goal was to provide a comprehensive picture of the Canadian literature related to the AWG's five priorities. At the same time, it was agreed that there was important international literature particularly from the United States, Great Britain, and Australia that may have a significant influence in Canada and should also be included. The study generally focuses on research literature and includes few practical materials related to teaching and learning.

We chose references that were relevant to the broad Canadian context. Therefore, many references are national; however, significant provincial/territorial or local sources have also been included where they contributed to the national picture, or where there was an absence of information on a topic at the national level. International references that seemed to connect strongly to national work are also in the scan.

In general terms, the research content was selected based on the expertise and judgment of AWG members and the research team. Selection involved searching multiple databases, bibliographies, web sites, and publications, together with continuous consultation with AWG members and other advisors.

The research team did not focus on dissertations and theses on health and learning because of the difficulty in gaining access to the in-house publications. However, there were particular dissertations and theses that were included due to their prominence and reoccurrence in the literature as identified by the experts on the AWG and beyond the committee. In addition, there was a tendency to avoid conference proceedings because

the researchers felt that the material presented at conferences was often duplicated in the published material. The researchers also excluded research that was identified as too location-specific, including most provincial and territorial reports. Because this document is designed to be accessible to a broad audience, research was limited to material that was not extensively technical or medical in nature.

The literature examined was selected from the last 15-20 years; however, there are some important studies and documents that are older than that which have been included. The criteria for selection of the literature were as follows. The literature was considered significant by the members of the Adult Working Group and:

- provided a broad overview of knowledge related to health generally, or was related broadly to health and adult learning
- related to health knowledge broadly, or to health and learning in the AWG's five priorities
- was directly relevant to the health settings that the HLKC is concerned with
- included the themes of interest to the HLKC
- included issues of gender, ethnicity and race

The references for the literature were identified in the following ways:

- by searching the organizational web sites and databases listed in the *Environmental Scan on Health and Learning* (2006) and *Update: 2007*
- by searching Google, Googlescholar and Googlebooks
- by searching ProQuest, Medline, PubMed, SpringerLink and JSTOR
- by searching Canadian documents, contacts, and websites listed currently on the National Adult Literacy Database (NALD), specifically the Canadian Directory of Adult Literacy Research in English and its American counterpart, the National Institute for Literacy: Literacy and Health special collection
- by reviewing the bibliographies of pertinent research reports from web sites and databases searched
- by reviewing the titles of journals related to health and learning on web sites searched
- by consulting with experts on the AWG

The gaps were analyzed by examining the titles and/or content of the literature in each section, categorizing by key themes, and counting the titles in each category for comparative analysis.

B. Limitations of the Study

There are several limitations of the study. The first limitation is that the literature was mainly published in North America and Great Britain. Another limitation is that the literature was mainly limited to studies in the English language.

It should be noted that this list is not exhaustive; the team stopped searching once the evident saturation-point had been attained—that is, once the same references kept re-appearing from the various experts, and no new relevant literature was being added—the team agreed it had attained most of the literature germane to its stated guidelines.

C. Definitions & Common Terms Related to Health and Learning and AWG Priorities[4]

i. Adults and Learning

The definitions and common terms that follow come from the field of adult learning and health and are important for understanding the connections between the two.

Formal learning refers to adult learning programs, courses, etc. typically conducted at an institutional level, for credit or certified recognition (Jarvis, 1990).

Informal learning refers to situations where "adults inform themselves about life and its possibilities" (Courtney, 1989, p. 18). This enormous area of learning is supported by a body of literature that has grown since the 1970s around self-directed learning (Brockett & Hiemstra, 1991; Candy, 1991; Tough, 1971) and incidental learning (Marsick &

[4] Definitions are taken from the *Environmental Scan on Health and Learning* (in press)

Watkins, 1990). The research around self-directed learning asks how and why adults learn *on their own* (Courtney, 1992; Rose, 1989, p. 211).

Nonformal learning "refers to organized adult education outside the established formal system" (Courtney, 1989, p. 19). Typically, *nonformal learning* involves groups of learners in, for instance, many community-based or institutionally-organized programs for general interest, skill development, personal interest, and other non-credit learning events; often, but not necessarily, with some organizing activity, task, or curricula involved.

Adult Basic Education (ABE) "refers to the fundamental areas of reading, writing, listening, speaking, and mathematics" (Taylor, 1989, p. 465). These subjects are taught typically to adult learners in an adult education setting.

Adult Literacy and Basic Education "in the United States and Canada … connotes a field of practice that includes programs of adult basic education (ABE) and, in some communities, English as a Second Language (ESL)" (Taylor, 1989, p. 465).

The terms ABE and Adult Literacy are used differently in every province and territory of the country. This impedes direct comparisons of provision and other related services.

Continuing Professional Education "refers to the education of professionals subsequent to their preparatory or pre-professional education that continues throughout their careers" (Wiesenberg, 2005, p. 152).

English as a Second Language (ESL) refers to "the English of those who are acquiring English in a context where it is the dominant language" (Auerbach, 2005, p. 213).

Higher Education, sometimes referred to as post-secondary education or tertiary education, "refers to formalized and credentialized learning opportunities offered through institutions such as universities and colleges leading to a degree or diploma" (Kreber, 2005, p. 278).

Prior Learning Assessment and Recognition has been defined as "the process of identifying, assessing and recognizing skills, knowledge, or competencies that have been acquired through work experience, unrecognized training, independent study, volunteer activities, and hobbies. PLA may be applied toward academic credit, toward requirement

of a training program, or for occupational certification" (Human Resource Development, Canada, 1995).

ii. Health and Learning

Access in this context refers to "having the right, opportunity or ability to reach, enter or use a facility, program, service or materials, visit a person or people and/or receive, understand and use information, knowledge or skills" (Ontario Healthy Communities Coalition, 2004, p. 124).

Community capacity-building, regardless of definition (Stirling, 2000), typically includes a focus on sharing information and knowledge, using local resources, and focusing on future possibilities. Mattesich and Monsey (1997) suggest that community capacity-building has to do with using community skills, resources, and strengths to address community problems. Furthermore, they state that community capacity is the extent to which a community can work together effectively to achieve goals.

Cultural competence of health care providers refers to the ability to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care setting. Cultural competence has been defined as "the level of knowledge based skills required to provide effective clinical care to patients from a particular ethnic or racial group" (U.S. Dept of Health and Human Services, Bureau of Health Professions. Retrieved May 1, 2006, from http://www.bhpr.hrsa.gov/diversity/definitions.htm).

An alternate definition is that "cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural settings" (U.S. Dept of Health and Human Services, Health Resources and Services Administration, Retrieved May 1, 2006, from www.omhrc.gov/clas/po.htm).

Determinants of health refer to "the range of personal, social, economic, and environmental factors which determine the health status of individuals and populations" (World Health Organization, 1998, p. 6). The 1986 Ottawa Charter for Health Promotion stresses that the fundamental conditions or determinants of health are peace, shelter, food, education, income, a stable eco-system, sustainable resources, and access and equity. The Public Health Agency of Canada (2002a) specifically identifies that the "key factors

which influence population health are: income and social status; social support networks; education; employment/ working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture" (Retrieved May 1, 2006, from http://www.phac-aspc.gc.ca/ph-sp/phdd/resources/subject_determinants.html).

Health is usually defined broadly as not just the absence of disease but as including all aspects of an individual's health – physical, mental, emotional, and spiritual. In this way, health is defined as a human right. Health is affected by many determinants. Health is seen as a resource that we need for everyday living and is a concept that emphasizes social as well as physical capacities. (Retrieved May 1, 2006, from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)

Health literacy is an emerging concept linking health and literacy and is defined in many ways. Gillis (2005) describes health literacy as a concept that links literacy ability and ability to act upon health information and control health. Similarly, health literacy is defined as the ability to access, understand, appraise, and communicate information to engage with the demands of health contexts to promote health across the life-course (BC Health Literacy Research Group, working document). The Institutes of Medicine of the National Academy of Sciences (2004) defines it as, "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health literacy is not just about the individual processing information but also about how health providers relay the information.

Health promotion refers to "the process of enabling people to increase control over and to improve their health." (Retrieved May 1, 2006, from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)

Health services "particularly those designed to maintain and promote health, prevent disease, and restore health" are among the determinants of population health identified by Health Canada (2004).

Healthy communities are ones in which all sectors of the community work together to develop a healthy setting. They ensure access and participation of all members including those who face barriers. A healthy community process involves wide community

participation involving all community sectors, healthy public policies, and the involvement of municipal government (Ontario Healthy Communities Coalition, 2003).

Population health "is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. The population health approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one's goals, to acquire skills and education, and to grow. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health." (Public Health Agency of Canada, 2002b)

Primary health care "refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury." (Health Canada, 2004)

Public health refers to the supports that individuals get in their daily lives to promote and protect their health. According to the Canadian Public Health Association, public health works with people to make sure they have the necessary information and skills needed to make decisions and act appropriately to protect their health. Public health initiatives have advanced life expectancy, overall health and quality of life through public health initiatives such as providing vaccinations, clean water, pasteurization and better living conditions. (Retrieved May 1, 2006, from http://www.cpha.ca/chd/images/chd_2006_psa.pdf)

Social determinants of health consider "the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment." (Retrieved May 1, 2006, from http://www.cspi.org/books/s/socialdeter.htm)

III. Generalizations, Gaps, and Promising Lines of Inquiry

A. Introduction to the Section

This section provides an analysis of the literature in terms of trends, generalizations, research gaps and promising lines of inquiry. The section is divided into sub-sections that reflect general overview literature related mostly to a social approach to health, and then specific categories that are related to the priorities, settings, and themes of interest to the AWG.

The literature included in this report does not include medically-oriented research or research that takes an epidemiological approach or that provides genetic explanations. However, work by social epidemiologists has been included.

B. Concerning the Overview of Canadian Social Literature on Health

This section deals with Canadian overview literature on a social approach to health that does not fall into specific AWG priorities in this report. In the Canadian literature, including government reports, there are only two references that explicitly link health and learning in their titles. One title focuses on learning, health and environmental factors and the other questions the connection between health and literacy. (However, there are many explicit and implicit references to health and learning under each sub-category that reflects AWG priorities).

Out of all the references in this category, about 37% are government reports.

The major topics that come out of the academic and non-academic literature are 1) disparities and inequalities in health, 2) the determinants of health, and 3) health care. Other notable topics include health policy, population health, public health, healthy cities/communities, and health promotion. There are also a few overview documents that relate to Aboriginal health and HIV/AIDS and to homelessness and health.

The major topics that come out of the mostly federal government reports focus on an overview of the health of Canadians and on improving health. Other topics include the

determinants of health, the health of Aboriginal and homeless people, population health, health care, women, rural health, health and literacy, and health promotion. It is notable that only three citations deal directly with disparities and inequalities. There is one government report that explicitly questions the link between health and literacy, dated 1998.

i. Overview of Canadian social literature on health (excluding government reports)

In this category, the literature on determinants of health and inequalities represents approximately 27% of all the titles. This literature focuses generally on social determinants and inequalities, and specifically on inequalities such as socio-economic status, access to health care, and housing. It also examines the impact of inequalities and the need to address them. The literature tends to be quite recent, being mostly from the last six years.

Ten percent of the literature addresses the issue of health care. The focus within health care is on sustainability, financing, as well as transforming, restructuring and solutions.

Eleven percent of the literature looks at policy. This literature includes a spotlight on policy and health promotion, new perspectives on health policy, a federal policy overview, addressing the research-policy gaps, addressing poverty, and government policy as a threat to health.

About 12% of the literature reflects citations on healthy cities/communities. This literature reflects on healthy community initiatives, their history and evolution, relations to the environment, and sustainability.

The literature also includes references on population health and public health. The population health literature tends to focus on an overview of population health in Canada, an approach to housing, relations to health promotion, and uses of a population health approach for research. The public health literature reflects a Canadian overview and comparisons within Canada, the future of public health, interventions, investments and how public health fits into an integrated system.

ii. Canadian government and government-related reports

About 22% of the government documents cited report on the status of the health of Canadians and improving, investing in, and optimizing their health. Other reports focus

on the health care system. For example, there are a number of citations for large-scale reports on the health of Canadians and the public health care system. Reports include the Lalonde report of 1974, the Kirby report of 2002, Romanow report of 2002, and more recently, the Canadian Council on Learning's 2006 *Survey of Canadian Attitudes towards Learning*. There are others from the mid to late 1990s. National and provincial reports focus on strategies for health, including strategies for population health. Additional reports focus on consultations with the public on health. In the last eight years, Statistics Canada has produced a number of reports that address the health of Canadians quantitatively. Some reports focus specifically on women and communities and draw comparative analyses.

Approximately 20% of government reports reflect the determinants of health. More specifically, they tend to focus on describing the issue of poverty and health, income inequality, place as a determinant of health, social determinants of health for the immigrant population, and consumers' perspectives on determinants of health.

Another theme in the government reports is Aboriginal health. Sixteen percent of the reports directly and indirectly reflect issues related to Aboriginal health, including heath status, population health and healing, health transfer, Aboriginal realities, and health action plans.

Other citations reflect issues such as health and literacy, rural health, visible minority women and health, inequities and health, HIV/AIDS, and health promotion. Notably, there is one Health Canada report published in 2005 that focuses on health disparities and discusses reducing them through policy directions. Also, in 2005, Statistics Canada released their survey on community health.

iii. Analysis

In the academic and non-academic literature (excluding government reports), the major focus is on the social determinants of health and health inequalities. By contrast, the major focus of the government reports is on the overall health of Canadians, improving and investing in health, and the health care system. Notably too, the academic literature has more of an emphasis on policy, healthy communities and public health than the government reports. The government reports also have a heavy focus on Aboriginal health. There has been a slight increase in the number of reports on the links between homelessness and health and ethnicity.

These citations of Canadian literature, while by no means exhaustive, indicate that that there is a great deal of literature related to information and knowledge about health, the health care system, and other health-related topics. The main general themes are status and strategies for the health of Canadians, determinants of health, and inequalities, health care, health policy, population health, and public health.

What is notably absent from this overview literature are explicit connections that there might exist between health and adult learning as they relate to any of these key topics. This lack of connection in the broad arena of Canadian health is an obvious gap in the research literature.

C. Concerning an Overview of International Social Literature on Health

Although only small (6%), there is emergent literature reviewed in the international category which makes explicit connections between adult education and health. Notably, only one government citation links literacy and health.

Approximately 80 percent of all the citations in this category are academic and non-academic literature (excluding government reports). The major themes in this literature are social determinants of health and health inequities, especially economics; health promotion; public health; and health policy.

American government reports emphasize the role of research in improving health and also focus on identifying and confronting health care disparities generally, and specifically with respect to race, ethnicity, and economics. There are also a few recent government reports linking community-based participatory research to improved health and other than focus on health and literacy. International government-related reports tend to focus on HIV/AIDS and the general state of global health.

i. International overview of social literature on health (excluding government reports)

Five percent of the literature reviewed in this category explicitly makes connections between adult education and health. All the references in this area are recent, no earlier than 2000. The literature focuses on the impact of adult learning on health, the contributions of adult learning to health, the role of adult education with respect to health,

and the relationship of training and adult education with respect to preventative health care.

The major themes in the international literature reviewed are 1) health promotion 2) social determinants of health and health inequities 3) public health, and 4) policy. Other notable topics focus on health overview issues, healthy communities and cities, health and adult learning, and partnerships.

Nearly one quarter of the citations focus on the social determinants of health and health inequalities. These titles reflect general works on the social determinants of health and also, a more specific focus related to privilege, safety nets, housing, race, class, poverty, population health, health behaviour and mortality. Most of the literature was published in the United States and Great Britain, and spans the early to late 1990s. One notable exception is a more recent 2005 citation in a book on the social determinants of health published by Oxford University Press. Another 2007 citation comes from China. Other literature emphasizes connections between health inequalities and globalization, neo-liberalism and poverty. The literature also focuses on naming and analyzing these inequalities, and challenging them. Specific disparities referred to include income, place of residence, and the distribution of disease. The strongest critiques of the reasons and context for these inequalities are within the last few years, and pertain to the United States.

About 11% of the citations in this section focus on health promotion overviews that relate to working with the community, different disciplines and concepts in health promotion, state of the art examples, health promotion throughout life, national strategies, country comparisons, and critiques. The health promotion literature was generally published in the United States and Great Britain. These influential overview pieces tend to be from the early 1990s.

Over 8% of the literature reviewed addresses the issue of policy and health. This literature emphasizes health policy for the 21st century, the education of policy makers, local public policy intended to promote health, social policy, policy tools for effective health services, the role of research in effective policymaking, and community driven policy-making. This literature spans the early 1990s up until the early 2000s. Some is internationally-based, published by organizations like the World Health Organization. Other references have emerged from the United States.

Public health is another notable theme with approximately 16% of citations falling into this category. Sub-themes includes the collapse of global public health, the link between academic research and public health practice, community-based public health focusing on competencies and partnerships, trends in practice, and the connection between public health and social capital and theory.

The literature also reflects on different contexts and concepts of health and well-being. This includes attitudes towards health, health realities, healthy lifestyles, health and well-being, research and change in urban community health, and how to build healthier societies.

Other topics with lesser emphases include healthy cities/communities, partnerships between community-based organizations and academia, consultations with the public, and health care. Of note in this literature is a focus on how to make collaborative partnerships work, on how to reform health care, and on health care ethics.

ii. International organizations and foreign government reports

Government and government-related reports from the international sector have a different emphasis than the Canadian government reports. The literature identified for this report is mostly from the United States federal government and from international organizations like the World Health Organization.

Approximately 44% of the government reports in this category are from the United States. The most recent American federal government and government-related reports from the last three years focus on the role of research, particularly community-based participatory research in improving health. They also focus on identifying and confronting health care disparities generally and especially with respect to race and ethnicity. Still other recent reports focus on health and literacy. Other earlier reports focus on improving minority statistics, multicultural health capacity, connections between research and public health practice, health promotion and disease prevention

The rest of the literature is from international organizations such as WHO and UNAIDS. These reports reflect on the status of AIDS globally, peer education, AIDS and the workplace, and impact of AIDS on families. Much of this literature is from the last two years. Other reports in this category focus on world reports on health, and also on climate change and human health.

iii. Analysis

The literature contained in this report by no means represents all the international literature available on heath-related topics of interest in terms of implications for adult learning. As in the Canadian literature, this analysis indicates that that there is a great deal of research and information related to knowledge about health and health related topics. The main themes in the academic and non-academic literature are social determinants of health, health promotion, public health, and healthy policy. The government reports focus on health promotion, health care disparities, health and literacy, the role of research in improving health as well as global reports on health in general, environment and AIDS in particular.

There are some important developments in this literature that relate directly to the purpose of this study. The first is the emerging literature that begins to make explicit connections between adult education and the role it has to play in relation to health. At the same time, several recent government reports coming out of the United States make links between community-based participatory research and improved health. These connections become more visible in the capacity-building section. They make good starting points with respect to clear links connecting health and adult learning in the literature. This emerging literature that makes explicit connections between adult learning and health can serve as a starting point for addressing this research gap in the Canadian context.

D. Concerning Theory and Health and Learning

This section reviews the theories of 1) health promotion and 2) motivation and participation in adult education. This section is not meant to be an exhaustive list of all theories related to health promotion or adult learning related to participation and motivation. The purpose is to bring to light theories that would specifically relate to, and be helpful with respect to the health and learning of adults.

i. Health promotion theory

Rimer and Glantz (2005) stress that health promotion includes multiples strategies. This includes not just a focus on individuals but also a focus on changing organizations and the physical and environmental factors in communities. The authors call this the

ecological perspective. While there are many specific theories related to health promotion, it appears that the significant models fall into three categories[5]. These models include 1) ones that focus on the individual for health behaviour change; 2) ones that focus on self-empowerment, and 3) others that focus on community action and community development. All models aim to promote good health but have different goals and different approaches.

Poole (2003) has developed a chart of health promotion theories which outline the focus (group or individual), key concepts, pros and cons and major theorists associated with each particular theory. These theories include a focus on individuals and/or groups, community capacity building and ecological models of health behaviour. Similarly to Rimer and Glantz's (2005) categorization, these theories include a focus on individuals and/or groups, community capacity building and ecological models of health behaviour.

Theory (social cognition models) that addresses the individual level focuses on the individual's readiness to change and the person's understanding of the threat of a health problem and recommended behaviours to deal with the problem. Rimer and Glantz (2005) describe social cognition theories as those that examine the connection between personal and environmental factors on human behaviour. They add that these theories focus on individuals as they relate to influence in groups and organizations. They emphasize that social cognition theories of health promotion are the most frequently used theories of health behaviour.

These models tend not to consider the social world or material or social factors. They do not target the socio-economic causes of ill health (Marks, n.d.). Poole (2003) notes that these kinds of models can help to understand how individuals change to healthier behaviours, and that they are relatively easy to implement. Cons are that it is difficult to measure the impact of these models over time, keep them going, and reduce all barriers to participation.

Theory that addresses self-empowerment focuses on empowerment of groups and individuals through participatory learning in order to control one's social and internal environments. There is a focus on examination of social structure and resources. This theory does not take into consideration inequalities in power distribution. It assumes that

[5] Marks, D. (n. d.) *Theories and approaches in health communication.* Retrieved April 21, 2006 from http://www.city.ac.uk/psychology/dps/teaching/David%20Marks/Lecture%203%20-%20theories%20and%20approaches.pdf

power can be mobilized by individuals. The advantages of this type of model are that it can enable sustainable change and create greater community capacity when used with other methods. Some negatives are that it may be dominated by professionals and not favoured by government funders who prefer an individual approach.

Theory that relates to community development or collective action seeks to address the socio-economic and environmental factors that cause ill health. Communities that have shared interests and assets come together to collectively address these issues rather than changing individual behaviour. The self-empowerment approach may be a first step in the community development approach or self-empowerment may be a consequence of the community development approach. This approach is influenced by Freire's concept of critical consciousness. Participatory action research is seen as a vehicle for community development. Advantages include the idea that this approach is in line with a social determinants of health approach that takes power into account. This approach has been popular in provinces like Ontario with many local Canadian leaders in the field such as the Wellesley Institute, the Ontario Prevention Clearinghouse, and Hershfield (Poole, 2003). Negatively, it is seen as time-consuming, and there are debates about concepts like capacity. Poole notes that recent work shows how moving from the individual to the community can be problematic.

ii. Adult learning theory

The theory discussed in this section relates to what motivates adults to participate or not in learning. One prevalent model of motivation to participate is that of Boshier (Beder, 1991). Boshier focuses on the needs of the individual. He sees motivation to participate related to two underlying factors. He argues that individuals are motivated by internal or external factors. Those motivated by external factors tend to be motivated to meet lower order needs (Maslow's hierarchy) while those focusing on internal factors are growth oriented or "self actualizing." Growth oriented learners are likely to participate, be open to new experiences and persist in their learning. Adults motivated by external factors are less likely to participate in adult education. This theory assumes that adults such has those with literacy challenges have deficits that can be treated. The theory separates individuals from their social context.

The Expectancy-Valence associated with Rubenson (1977) is a model that also focuses on the individual. However, in this model, motivation to participate is based on the expectation that adults will be successful and the outcomes of learning will be positive

and beneficial. Motivation is also based on the consequences of participation against other aspects of the adult's life: that is, that other aspects of life will get in the way. Adults may decide that there is not enough reward for participating in adult learning. Large-scale research studies also shed some light on why adults may or may not participate in adult learning. One such study conducted by Carp, Peterson, and Roelfs in 1963 found the most common reason for participation or would-be participation in learning was "to become better informed" (as cited in Beder, 1991). The results of the study showed that would-be participants wanted to learn in relation to their roles as family members and citizens. Those already learning had motivations related to their jobs as well as an overall desire to become better informed.

Courtney (1992) notes that most of the research on adult learning focuses on the psychological and does not do justice to the social context and environment where the activity takes place. He also makes the distinction between formal organized, more visible adult education and the other kinds of learning that adults do. Moreover, he notes that organized adult education is predominantly the domain of the white, middle class, educated, urban adult. He emphasizes that participation or non-participation is related to the formality and context in which the activity takes place.

Miller's (1967) Force Field Analysis model was one of the first major theories on motivation and participation. Miller postulates that adult learners participate in education to satisfy needs, which are organized according to social class differences and Maslow's hierarchy of needs. This model is unique in its attempt to superimpose social class on motivation. At the same time, Miller acknowledges the clash between working class values and adult education.

Brookfield (1986) notes that education attainment correlates most significantly to future participation in mainstream adult education. However, using resistance theory to explain non-participation of adults with low literacy skills, Quigley (1990) found that low participation rates among this group are linked to previous negative experiences with the public school system. Past school experiences, he argues, contribute to low participation rates of adults with low literacy skills in mainstream adult education programs as well (Quigley, 1997).

Brookfield (1986) moves beyond the individual to emphasize social conditions. He stresses how labelling adults who did not participate in formal education as deficient or disadvantaged as in Boshier's model is both false and flawed. He emphasizes that both

disadvantage and non-participation are social products rather than individual deficiencies. He stresses that once adults see their individual troubles are related to broader social conditions they are more likely to come together for collective action to change these structures. He also makes the point that formal adult education is only one way that adults learn and that adults are continually learning in many different ways.

Courtney picks up on the social thread introduced by Brookfield. The social participation theory developed by Courtney (1991) focuses on learning in organizational settings and argues that motivation for participation in learning is similar to why adults are motivated to join organizations. Courtney also suggests that one needs to look at the totality of adults' life activities to understand why people participate or not.

Cross's (1981) model encompasses elements of all the other models discussed. Cross developed a seven-stage process called "the chain of response" model to explain participation in learning. All the chains in the model are linked to the ultimate goal of participation. The model starts with individual self-evaluation and ends with external factors. Although more complex than other theories, it tends to be linear and culture bound (Retrieved May 1, from www.infed.org/biblio/b-partln.htm)

Critical pedagogy which is associated with Paulo Freire, Stephen Brookfield, Henry Giroux, and Stanley Aronowitz does not theorize motivation to participate but critiques it (Beder, 1991). If adults do not participate in adult education, it is not because of individual deficits, but because they are unmotivated and disempowered due to inequalities in society and its structures. Freire (1970) notes that because of these unequal structures, the oppressed believe they are deficient and thus are disempowered to challenge these inequities. According to critical pedagogy, motivation is a class trait and suppressing motivation in others maintains the class order. For example Giroux (1983) says: "the culture transmitted by the school is related to the various cultures that make up the wider society in that it confirms the culture of the ruling class while simultaneously disconfirming the cultures of other groups" (p. 268).

Livingston and Sawchuck (2004) identify the characteristics of working class learning. In a study involving unionized workers, they found that working class learning is largely informal and grounded in the collective. They also found that there are constraints like time, energy, and space that work against any kind of learning for working class people.

Brookfield (1986) also notes that the literature on participation and motivation tends to focus on institutional adult education through continuing education in colleges, schools boards and universities. He identifies gaps in the literature in that adult learning such as training, community action, labour education, self-directed learning and other forms of learning are not included.

iii. Analysis

Upon examination of the major theoretical approaches to health promotion and motivation to participate in adult learning, there are many parallels. First and foremost, there are theories in both fields that focus on individuals and individual change. There are other theories that consider both social context and the individual and still others that include an analysis of power and focus on collective action and community capacity building.

Perhaps the most useful theories for the purposes of making the links between health and learning and pointing to promising areas of research are those which address the issue of community capacity building and self-empowerment found in the health promotion literature and the critical pedagogy and other theories that take social factors into account found in the adult education literature.

E. Concerning Capacity-Building and Health and Learning

The literature included in this section represents various aspects of community involvement, including community participation and collaboration, and expands to community development and capacity-building. Included in these sections are citations that reflect 1) community participation, collaboration and partnerships, 2) community-based participatory and participatory action research, 3) community action, participatory education and empowerment, and 4) community capacity-building. The majority of the literature appears to be out of the United States.

The Canadian literature represents approximately 11% of all the literature in the community capacity-building section. This literature starts in the early 1990s and goes to the present. The trends in the Canadian literature are a focus on the need for greater

community capacity-building, and on community collaboration. There are also a few references that point to projects in community-based participatory and participatory action research. The community capacity-building references focus on projects that were aimed at strengthening communities, community action, influencing policy, reflective practice, conceptual models, tools, literacy, health promotion, and public health. Community collaboration focuses on integrated research, health promotion, and participation through the eyes of participants. The citations that examine research reflect whether community participation in participatory research can work and whether or not power can be shared. The literature also highlights participatory research as it related to health promotion practice and building research capacity. There are no longitudinal studies of note.

The literature in this section spans the last fifteen years or so. However, it is interesting to note that a little over two thirds of the literature has been published in the last five years. The more recent literature reflects governmental and organizational interests in community based, participatory research, more emphasis on community capacity-building and community involvement, and more emphasis on participatory research to address health-related disparities and the social determinants of health.

Overall, over two thirds of the literature in this section reflects community participation, collaboration, and partnerships. The literature emphasizes collaborative research, community partnerships, empowerment, community involvement, and community coalitions. The most common reasons reflected for this involvement or partnership is to improve health and health care practices related to health promotion, public health and prevention. Some citations emphasize the challenges and the gaps in the partnership, power relationships between researcher and the community, and ways to improve the partnership.

About 24% of the literature emphasizes community-based participatory and participatory action research. The major focus is on community-based participatory research. Within this category, the emphasis is on its role in improving health, community interventions, addressing social determinants of health, reducing disparities, and social transformation. The literature also highlights issues, methods, models, experiences, getting the community involved, descriptions of partnerships, funding this research, and its relation to health promotion. Ethical challenges, opportunities, power sharing, and lessons learned are also highlighted, as is the relationship of research to practice.

Approximately 12% of the literature refers to community capacity-building, community development and community building. This literature examines capacity-building as a way to influence policy, promote and improve health, to intervene, use community assets, and to meet goals. It also highlights process for capacity-building, models of capacity-building, and the use of community members as health advisors. It also introduces ties between community capacity-building and research and highlights the importance of those ties for bringing research into action.

About 18% of all the citations address participatory education, community empowerment, and community action and change. This literature reflects increasing community participation, creating community change, improving community quality of life, meeting goals, creating critical consciousness, achieving health equity, and advocacy. The literature raises issues such as power and powerlessness, and working with oppressed groups.

i. Analysis

The literature reflects various aspects of community involvement that includes community participation and moves to community-based participatory research, participatory education and action, and community capacity-building. There is no shortage of this research overall. However, there is little Canadian literature in this area. Moreover, many of the sources show evidence for the need for more collaboration among researchers and community-based organizations as there has been little collaboration in health and learning. Community capacity-building is a critical area that relates to health and learning and needs to be further explored as a vehicle for community empowerment, whether it is through participatory research, or through research related to other community capacity-related interventions.

F. Concerning Health Promotion, Learning, Teaching and Health, and Research-in-Practice

The literature in this section reflects 1) an overall discussion of health promotion and health education, 2) a specific focus on program planning and practice, and 3) an emphasis on changing health behaviour, 4) educational of health professionals, and 5) research-in practice related to adult literacy.

The Canadian literature represents less than 15% of all the literature in the health promotion, learning and teaching, and research-in-practice section. Most of the Canadian literature on health promotion overview and practice is from the mid-1990s. The research-in-practice literature is emerging and tends to span the last six years, particularly the last three or four. The trends in the Canadian literature show and emphasize a wider discussion on health promotion, and an emerging focus on research-in-practice. There are also growing number of references (about 37%) on health promotion planning and practice. The health promotion literature emphasizes practice and research connections between health promotion and population health, information technology and health promotion, and the dissemination of knowledge. The references on practice reflect the need for a constructivist paradigm, empowerment, and the challenges for the past decade and into the 2000s. The research-in-practice references, while focusing on practitioner research with adult learners with literacy challenges, indirectly address issues of health.

Overall, except for the research-in-practice literature, the references in this section are concentrated in the 1990s, particularly the mid-nineties. Over one third of the references are from the 2000s and emphasise health communication, integrating healthy community concepts into professional training, an empowerment approach to health promotion, unifying research and practice in health education,

The first major emphasis in the literature is an overview of health promotion and health education. For example, there are a number of citations that broadly refer to health promotion and education. These references provide an introduction to health promotion and perspectives for the 21st century. They also focus on health promotion as a movement, models, values, philosophy, empowerment, and challenges. There are also references that include a focus on health promotion in relation to psychology, health care, and health care reform, new technologies, population health, dissemination methods, and building health communities.

A second major emphasis of the health promotion literature is on program planning and practice. Over one third of all the citations pertain to health promotion and education practice and research. The references tend to come mainly from the United States with a few from Canada and Great Britain. The literature on planning and practice focuses broadly on program planning and design, approaches, and models. Also, it focuses more specifically on how to assure quality, standards of good practice, good communication practices, and community collaboration.

A third emphasis is on behaviour change. Almost 13% percent of the literature reflects this theme and it spans the early to mid-1990s to the present day. This includes literature on health behaviour research and research strategies, motivating and changing health behaviour, and a values approach.

A few references focus on the education of health professionals. Some of the emphasis is on educating professionals for the communities they serve in terms of literacy levels, race, and class.

i. Analysis

The earlier research in this section appears to focus more on traditional models of health education and promotion including a focus on individual and behaviour change. The more recent literature examines links between research and practice with a focus on community and community involvement. This ties in closely with the findings under the last section on community capacity-building where there has been much more of an emphasis on participatory research to improve health and community capacity-building.

The obvious research gap in Canada is the limited amount of Canadian literature in this emerging area. As noted previously, community capacity-building is a critical area that relates to health and learning and needs to be further explored in research. Moreover, there is a gap in the emerging research-in practice literature in terms of more explicit links between health and learning that would be valuable to explore. The area of research-in practice with adult literacy learners shows much promise for informing and reforming health practice and policy.

G. Concerning Women and Health and Learning

Almost three-quarters of the citations in this section are Canadian. Over 65% of the literature is from the last six years. The major themes are 1) the state of women's health, what impacts it and what health care is needed; 2) women's empowerment in planning and acting for health-related issues; and 3) women's poverty and health.

Seventy-six percent of the literature reflects the present state of women's health, health care access, and factors that impact on their health. The literature reflects more specific themes such as impact of social support, poverty, globalization, and lack of housing on

women's health. It also reflects gender differences in health and in access to health care as well as the need for holistic health care. The literature includes a focus on lesbian and bisexual women's health, the health of women with disabilities, and women's mental health.

Twenty-two percent of the literature is related to women's empowerment and involvement as a community in their own health. The literature focuses on use of support groups, current models of women-centred care, advocacy for women's health, participatory action for health, partnerships, and participatory action research to influence policy.

The literature also focuses on women and violence including an emphasis on health care for women who have experienced sexual abuse.

i. Analysis

In relation to health and learning, the emerging literature reflects a growing community-centred approach to addressing and influencing women's health and health-related issues. Even though this is the case, research related to women and community capacity-building is still lacking. It represents a promising area for further research, especially in the areas of literacy, health, and positive parenting.

H. Concerning Race and Ethnicity and Health and Learning

The literature in this section highlights the following major themes: 1) racism, discrimination, and inequities as they relate to health, health related issues, and health care, 2) health status, health issues and health care issues related to race and ethnicity, 3) a cultural diversity model of health care, and 4) community building and partnership initiatives. Fifty-six percent of the references are from the last five years; this increase indicates a growing focus of the links of race and ethnicity with health and learning. The literature tends to be published in the United States and, to a lesser extent, Great Britain.

Less than 15% of the literature related to ethnicity and race is Canadian. The majority of works appear in the last six years. The remainder of the literature is from the mid to late 1990s. The thrust of this literature is on racism and discrimination, and disparities mostly related to health care for ethnic and racial minority groups. The sub-themes reflected in

this literature are racism in Canada, health care access and socio economic inequalities, and the social marginalization of racialized groups.

Also included is a focus on women of colour and health. These references address health issues, social exclusion, and Black women's health. There are also a few references relating to cultural competence.

The first major theme in the literature focuses on racism, discrimination, and inequities as they relate to health, health-related issues, and health care. This represents approximately 41% of the literature. First, there are general citations on inequities related to race and ethnicity. One sub-theme addresses the relationship between racial discrimination and health status. Another sub-theme relates to income disparities, poverty, and racism in employment. Other issues raised include race, culture, and mental health including the struggle against racism. Some titles also reflect issues of social exclusion and marginalization. Another sub-theme reflects addressing these disparities and the connection of this action to improving health outcomes.

The second theme in the literature examines health status, health issues, and health care. This theme is gaining momentum and now reflects about 40% of the literature. One focus is the profile of health for ethnic and racial minorities and improving statistics. Another sub-theme includes health issues for the Black population generally, and women of colour specifically. Another focus is related to care including, race-related community care, differences in care, creating a climate for care, access to care, and quality in care.

The third major theme in the overall literature is the idea of working with diversity or cultural competence in health care. Over 14% of the literature reflects this idea. This literature is mainly published in the United States and Canada. The references reflect topics that include models of care, managing diversity, strategies, relation of cultural competency to health promotion, principles and elements, and standards of cultural competence. One title questions whether this model of care can reduce disparities for racial and ethnic minorities.

A fourth theme relates to community building and community partnerships. This accounts for 14% of the literature. There are references to public health capacity-building projects, exploring empowerment, community experiences, education, and participation. There is also a focus on community-academic partnerships. For example, the

Community-Campus Partnerships for Health (CCPH) encourages and disseminates research done in partnerships for reducing health disparities.

Finally, there are a few citations that focus on race and ethnicity in research. These include how to describe ethnicity in research, and perspectives on ethnicity and race-related research outcomes.

i. Analysis

There is a great deal of literature documenting the issue of racism, discrimination, inequities in health and health care, and large-scale studies that illustrate these inequities. There is a little research that shows how any of the strategies—building capacity, forming partnerships, or identifying diversity approaches that have actually made a difference in making change or reducing disparities. This is particularly true of the Canadian context. This is an important research gap that needs to be addressed.

I. Concerning the Health and Learning of Adults with Low Levels of Literacy[6]

There has been a growing body of literature on health and literacy in North America, starting in the late 1990s and building exponentially to the present. More than twice as many references appear in the last five years as compared with the last five years of the nineties. The majority of the current literature tends to be published in an assortment of health care and health related journals and is being published by health-related and medical organizations, as opposed to adult education organizations and in adult education journals.

The bulk of the health literacy literature focuses on connections and intersections between health, health care, and literacy. The literature mainly focuses on 1) overview reports and studies, and bibliographies, 2) individuals with low literacy skills and health, 3) health information and communication, and 4) projects and research that link the two.

The Canadian literature makes up approximately 16% of the literature found that links health and literacy with the majority of citations are from the last three or four years. The literature tends to focus on overview reports and studies linking health and literacy. It

[6] Adapted from *State of the field report: Adult literacy. Final report* (in press).

also focuses on projects and research that emphasizes the health and literacy fields working together and the connections between the two to address the issue of literacy and health. The 2005 International Adult Literacy and Life Skills Survey shows connections between health and literacy that need further exploration.

Overall, the majority of the literature tends to focus on overview reports and studies linking health and literacy and the patient or individual with low literacy skills as the target for screening and remediation rather than the complexities of health as understood and lived by the population with lower literacy skills. There is a tendency to use a deficit approach to talk about lower literacy skills and frame issues around "choices" and individualism. At the same time, there is a focus on accessibility of health information and communication for people with literacy challenges as well a growing focus on projects and research that emphasize action, and the two fields of health and adult education working together. Notably in the U.S. literature, there are a number of recent federal government reports that focus literacy and health. These reports specifically focus on literacy and health outcomes, health communication, and strategies to improve health.

i. Analysis

It is noted that while the main body of literature research on literacy has moved away from a deficit approach, terms such as deficient knowledge, low literacy, poor literacy, treating literacy, illiteracy, shame, and inadequacy still appear with frequency in even recent citations and research frameworks related to health and literacy in the health related journals. By contrast, the few adult education references found that focus on learning, participatory education, and integration of health and literacy show promise of addressing these evident gaps.

As a further observation, in the last few years the health literacy literature has begun to reflect more crossover research and increasing collaboration between the health care and adult education fields, particularly in the Canadian context. Overall, in this area of the literature there is also a move to focus on a broader approach to health literacy, on wider literacy and health outcomes, on new directions for a research agenda for health literacy, and on literacy as a social determinant of health, with implications for policy and practice. However, the focus and application of this rapidly growing body of literature tend to be on the health field rather than on the literacy field of practice. There is even limited literature on educating health professions students about health literacy as part of their professional preparation. The noted gap in this area is the need to strengthen literacy

practice and policy through health literacy, not only to inform, but possibly to reform health practice and policy.

With several Canadian federal government reports published in the late 1990s and early 2000s that examine literacy and health, and the 2005 International Adult Literacy and Life Skills Survey, literacy and health is a clear area of growth in the research landscape that shows promise, especially in view of the recent collaborations between health care and adult education the research.

J. Concerning the Health and Learning of Adults Affected by HIV/AIDS

The research on adults affected by HIV/AIDS reflects a great diversity of topics. Topics include the results of large status reports, issues around social exclusion for those with HIV/AIDS, HIV/AIDS and poverty, as well as a focus on people with HIV/AIDS returning to work. Most of the literature on people with HIV/AIDS returning to work is only five years old. Other literature focuses on HIV/AIDS and gay men, women, Aboriginal people, and ethno-cultural groups. Some literature addresses the impact of HIV/AIDS on families.

The major trend in the literature highlights community capacity-building, peer support, participatory research and collaborative partnerships. The other trends include a focus on AIDS prevention, promotion and education, and research in general.

Over 45% of the literature is Canadian. Much of it originates in Vancouver, Toronto and Ottawa where there are strong networks for HIV/AIDS. The Canadian literature reflects the overall trends in the literature as outlined above. About 37% of the Canadian literature is from the last six years. The Canadian literature includes a spotlight on trends in HIV/AIDS, HIV/AIDS and poverty, HIV/AIDS and specific groups, and the impact of HIV/AIDS on families. Also, the *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research* was launched in 2006.

It also focuses on community collaboration and capacity-building, capacity-building for research for prevention, prevention initiatives, and HIV/AIDS education and training. In addition, there are several retrospectives that look back a decade from the 1990s to the 1980s. Words like review, retrospective, and rethink come up. These reports look at

HIV/AIDS research in general, HIV/AIDS research and families, and rethinking approaches to prevention education.

One important document of note in this section is the Paris Declaration of 1994. In 1994, 42 heads or representatives of state signed the Paris Declaration to make the fight against HIV/AIDS a priority. The Declaration acknowledges that AIDS is a pandemic and a threat to all humanity and that national policies that protect and promote the rights of individuals are needed. Further, it includes a focus on prevention strategies, comprehensive care and international cooperation.

Overall, more than a quarter of all the literature identified focuses on community-based strategies for supporting for people with HIV/AIDS, for education and prevention, and for research. This is reflected in topics such as community-based HIV prevention research, community planning, and capacity for creating prevention tools. In the research arena, there is an emphasis on building partnerships to improve prevention research, the need for prevention research, the need to involve stakeholders, research as a way to empower communities, and communities creating their own knowledge. Challenges and sustainability issues also are acknowledged. Community planning topics focus on involving those with HIV, and improving the planning process for HIV prevention. Peer group literature highlights "taking care of each other," using peer support groups, future direction for peer education, support group themes, and challenges of this approach.

Over one quarter of the literature also relates to prevention, promotion, and education initiatives. Topics reflect cultural sensitivity, the effectiveness on interventions on behaviour, lessons learned, responding to changes, new findings, strategic approaches, and challenges.

In some of the recent literature, there is language that gives the sense of a current wave of change with respect to HIV/AIDS. This wave of change is reflected in language such as remobilizing, reflections on lessons learned, responding to changing environments, and "back to the future" (going back to work).The literature on returning to work reflects the idea that HIV/AIDS is no longer an automatic death sentence.

Research is another notable theme. In this case, research is not necessarily connected to community capacity-building. Some of the sub-themes that arise around the theme of research are the importance of research in HIV prevention strategies, the importance of needs assessments and evaluations, bridging research to practice, and methodological

issues. The need for a national research strategy is also reflected within the research theme. Other notable less visible reflections in the literature centre around women's issues, Aboriginal issues, and AIDS global updates.

There is almost no research literature that focuses on how people living with HIV/AIDS learn about different treatments, especially the side effects, and make informed decisions about their health. Another area missing from the research is the link between learning, drug use, and HIV/AIDS.

i. Analysis

The connection between health and learning for people affected by HIV/AIDS or prevention of HIV can be a matter of life and death or wellness and health. The literature reflects this urgency along with the capacity this community has built for its own strategies, solutions and process. The importance of all kinds of research is clear in linking adult education with not only prevention strategies but also treatment and harm reduction strategies.

The literature suggests that it would be important to continue to build this community capacity and the community-based research and efforts that exist. These areas show promise for continued research and combined effort.

K. Concerning the Health and Learning of Immigrants and Refugees

The most prevalent themes in the literature relate to 1) health overview and status related to immigrants and refugees, 2) experiences with health care, 3) social determinants of health, 4) immigrant and refugee women and health, 5) mental health, and 6) policy.

Almost half of the literature reviewed concerning the health and learning of refugees and immigrants is Canadian. The focus of the Canadian literature is mainly on the health status of immigrants and refugees in Canada, connections and relationships between immigration and health, social determinants of health, mental health issues, and how to assess and work with immigrants and refugees in relation to health.

Approximately 28% of the literature focuses on the health status and a health overview related to immigrants and refugees. This literature includes statistics and information on

immigrant and refugee health generally, health and life expectancy by immigrant status, and the relationship between immigration and health. Another issue raised in the literature is the relationship between immigration and hospitalization.

Approximately 26% of all the literature identified focuses on the social determinants of health for immigrants and refugees. Topics reflected in this literature include class, housing, discrimination, and access to health care.

Other literature examines the experiences of immigrants and refugees with health care. Some of the literature focuses on the experiences of different ethno-cultural groups with health care. Almost 18% of the literature looks at how language barriers prevent access to health care, how responsive the health care system is to newcomers, and unmet health care needs.

One sixth of the literature focuses on immigrant and refugee women. Issues raised include their health and health practices, mental health, and health promotion strategies.

Mental health is also raised in the literature as a notable issue. Mental health concerns reflected are post-traumatic stress disorder and other mental health issues, mental health education, and mental health and wellbeing.

The remaining scant literature looks at policy issues, working with immigrants and refugees, HIV/AIDS and immigrants and refugees, and community-based research and community building.

i. Analysis

The literature tends to focus on information about the health of immigrants and refugees, the factors that affect their health, and their experiences with health care. There are plenty of works that focus on these areas. What is clearly missing from the literature is the connection between health and learning for immigrants and refugees. The other gap is a lack of research on immigrants and refugees and the social determinants of health especially with respect to racism, housing discrimination, poverty and their impact on health.

There is scant reference to or research on health education or community capacity-building. These are clear gaps in the research that need to be addressed, especially in the

area of access to health literacy information in plain language or in languages other than English or French.

L. Concerning the Health and Learning within Regions that Fall Below Health Norms

There is scant literature on health and place of residence. This priority has one of the least amount of literature of any of the categories in this report, accounting for less than 4% of the total citations. In the literature, health and place predominantly refers to rural or northern health. Sometimes it refers to neighbourhood.

The major trends in the literature include an overview of rural health, access to health care in remote areas, women and health in remote areas, and community collaboration and capacity-building. This literature spans the last 18 years.

Thirty-nine percent of the citations refer specifically to Canada. Many others are from Australia and some are from the United States.

Seventy-eight percent of the literature provides on overview of rural or remote health. This literature focuses on rural settings, research and rural health care, rural public health, area variations in health behaviours, rural community health and quality of life, sustainability, and determinants of rural health such as poverty.

About 22% of the literature also focuses on access to, and disparities in remote health care. Specifically the literature focuses on improving access, the character of rural health care, comparisons of access in urban and rural populations, and who reports lack of access. The literature also reflects on rural community needs for health care.

Another trend is to focus on women and rural health with 22% of the literature having this focus. Key themes in this literature are women's health in remote areas, lack of access, women's leadership in rural organizations, their health programs, and their experiences.

Community collaboration and capacity-building is another theme that is not nearly as prevalent as the other three. The literature focuses on community organizing, community

entry to conduct research, participatory research, building capacity for rural research to influence policy, and building capacity for heart health promotion.

i. Analysis

There is scant literature in this category. There are few references to research on health and learning in remote areas. Most of the literature describes the situation of remote health or the challenges. There is a great gap in the literature with respect to research on learning initiatives and health, and the community building for health that is effective in remote areas.

M. Concerning the Health and Learning of Aboriginal Adults

All but six citations of the literature on health and learning and Aboriginal adults is Canadian-centred or published in Canada. The major trends highlighted in the literature are overall health status, issues, and concepts, collaboration and community capacity-building, access to health care, research, and women and health. Other themes include general policy issues, and HIV/AIDS. Throughout the literature, health and healing are often linked. There is an emphasis on indigenous knowledge, and indigenous control of their own health strategies. There is also a focus on indigenous approaches to research, and codes of ethics for conducting research with Aboriginal people. The references to ethics are mostly from the last five years or less.

More than a quarter of the literature reflects overall health, health concepts and issues of Aboriginal and Inuit people. The literature focuses on the health of indigenous people, and a history of their health and health patterns. It also highlights the marginalization of indigenous knowledge and communities, the meaning of respect, mental health, regional health, literacy, and family violence. It also includes comparisons of the health of Aboriginal people and others. Other literature focuses on the problems and inequities related to Aboriginal health and improving health. One citation addresses the issue of environment al damage and Aboriginal health.

About 62% of the literature reflects the idea of community partnerships, capacity-building and empowerment. This literature spans the last decade. The sub-themes

reflected in this literature include integrating participatory research into Aboriginal organizations and community-based research as an empowerment tool. There are specific descriptions of community-based research projects. Other literature refers to building capacity using indigenous knowledge, building a leading-edge organization, and university-Aboriginal community partnerships for research. Conflicts in community-based research partnerships between Whites and Aboriginal people are also discussed. There are particular references to community-based research and women. These include a focus on women's health needs, and women's stories about health promotion and community healing.

Research is an important theme in the literature that is connected to community capacity-building and collaborative relationships. There are a numbers of references that address the development of a code of ethics for conducting indigenous research. Other sub-themes that come under research refer to women's research and healing groups. Indigenous approaches to research are highlighted in terms of protecting and working with indigenous knowledge, aboriginal research as a ritual practice, and the development of a holistic framework for Aboriginal research. Opportunities for Aboriginal research, models, networks and research excellence are also sub-themes along with what indigenous research really is. There is one longitudinal study that focuses on healing and wellness strategies.

Health care is another trend in the literature for indigenous people. The focus includes the following sub-themes: health systems and their renewal, evaluations of health care systems, as well as improving and financing health care programs and systems for Aboriginal people. Other themes are First Nations women's experience with mainstream health care, control issues in health care and critical issues in traditional medical practice. Another focus is indigenous-designed and delivered health care systems that have worked in Canada, Australia, and the United States.

Policy is another area of lesser focus in the literature. It comes up in terms of both research and health. One policy focus is on developing a strategy for Aboriginal research and policy that is different from what it is now. In particular, this includes a research policy focus on Aboriginal women. There is also reference to national, provincial and international work that could influence Aboriginal health policy, and reference to Inuit health policy. One citation makes connections between Aboriginal involvement in policy development and adult education.

Aboriginal women is another main theme in the literature of this section and its sub-themes have been integrated into other sections. Other themes related to Aboriginal women include places of healing, healing resources, story telling, and wellness and cultural identity.

The theme of HIV/AIDS and Aboriginal people is also discussed in the literature. The literature includes the impact on Aboriginal women, living with HIV/AIDS, and Aboriginal strategies for HIV/AIDS.

i. Analysis

There is an important thread that runs through the majority of the recent literature on Aboriginal people and learning and health. This thread emphasises respect for indigenous knowledge and practices in both health interventions and research related to health. The emphasis is on indigenous people leading their own solutions for health that reflect their own culture and history. This is also true for health and health-related research.

A great deal of the literature documents the state of Aboriginal health and the way health care systems and policies should work. There is emerging research that documents experiences with health and successful health strategies, and how people learn about health from an empowerment perspective in through their own culture.

There is a clear need for more community-based, participatory research that utilizes and respects indigenous ethics and knowledge in research approaches. This research must link the connections between Aboriginal health and learning from the cultural perspective of Aboriginal people in their own voices.

N. Concerning Health and Learning and Work

Almost 40% of the research literature on work and health examined is based in Canada or published in Canada. The major trends in this literature are 1) connections between work and health, 2) workplace and workforce trends and issues, 3) health promotion and wellness programs, and 4) work life balance and conflicts and 5) the impact of low pay and different types of work on health.

About 41% of the literature reflects the connections between work and health. A third of this literature is Canadian with the rest having been published mostly in the United States, Great Britain, and Australia. The literature identifies many connections between work and health. These connections to health include the nature of work organization, restructuring, social relations and job hierarchy, working conditions, overwork, work-life balance, gender, class, income, and job insecurity. The major aspect of health affected by work is stress and stress-related illness according to the number of citations that include a reference to stress. Other literature reflects new understandings of the connections between work and health and the development of a research framework to study this issue.

About a sixth of the literature provides an overview of workplace and workforce trends and issues. Almost three quarters of this literature is Canadian. These trends and issues focus on globalization, the future of work, the quality of work, changing work, the changing workforce, worker representation by unions in the new economy, and labour market inequities. The literature also reflects families and the economy, and gender and generation issues. Worker control and the rights of workers to participate in work reorganization and the politics of this participation are discussed. Labour issues such as falling Employment Insurance protection, labour standards, legal and policy issues and low paid vulnerable workers are highlighted as well.

About ten percent of the literature also focuses on health promotion and wellness programs at the workplace. Much of this literature is from the late 1980s and the 1990s with few recent citations. Less than a third of this literature is Canadian. There are several key sub-themes in this literature. There are a number of citations that reflect an overview of health promotion in the workplace. Another sub-theme is the experience that different workplaces have had with health promotion and wellness initiatives. This includes getting worksites involved, designing and implementing programs, working with small businesses and the impact of these programs. There is also literature on workplace health promotion concepts and principles, how to set these programs up, and why workers do not participate.

About 10% of the literature reflects work-life balance and conflict. The focus is on the interface between the two, balancing the two, and the effects of work-life conflict on health and quality of life, especially for women. Recent Canadian literature looks at work-life conflict in the present day in terms where Canada is at and future directions.

About 15% of the literature focuses on income and type of work as social determinants of health. Nearly 60% of the literature is Canadian. The literature highlights non-standard work and economic vulnerability; gender, inequality and precarious work; and contingent work: the myth of flexibility and its connection with ill health. Other topics include Canada's working poor, and the relation between income inequality and unemployment to mortality. Other titles reflect the overall health impacts of low pay. Questions are raised about how many low-paid workers are part of low-income families and how this situation might be improved.

It is interesting to note the literature includes two action research references. One project was about the impact of a worker health study on working conditions. The other reference cites an action research approach to workplace health.

i. Analysis

There is abundant literature that provides a description of the impact of work and other work-related social factors on health. Health and learning in this literature is reflected through health wellness and promotion programs at the workplace. This seems to present a very narrow interpretation of health and learning. It would be interesting to know what other ways the workforce engages in, especially collectively, to improve their health and the conditions that affect their health. This is an obvious gap in the research. In this literature there is only one study found that actually looks at worker-conducted research that was used to improve working conditions and thus health.

O. Concerning Indicators of Change

This section is concerned with indicators of change as they relate to health and learning in practice and in the larger context of programs and policy. In the practice-based section, terms like evaluation, impact and measurement to a lesser extent prevail.

In the section on programs and policies, there is a different set of terms. These include indicators, measurement, and "evidenced-based." Evidence based may need some explanation. Singh, Nirbhay, and Oswald (2004) note that the concept of "evidence-based" originated at McMaster University in Canada in 1981 as a way to teach physicians how to critically review medical research literature and developed into a way of using research evidence in routine patient care. According to researchers Rose, Thornicroft, and

Slade (2006), the last decade reflects a growing trend for practitioners, clinicians and policy makers to believe that clinical practice should be based on information that show that interventions are effective and cost-effective. However, they add that what is not clear is who determines what is evidence.

i. Practice-based

There are scant references in this category with 21 citations. Trends in the literature reflect evaluation, impacts, and measurement to a lesser extent. About a quarter of the references are Canadian.

The literature that reflects evaluation tends to focus on health promotion and education. Sub-themes include references to qualitative evaluation of community work, evaluation of health programs, finding out whether a program works, and evaluating how well community collaboration is working. Other themes around evaluation highlight more appropriate forms of evaluation for community health, women-centred evaluation, and principles and perspectives for health promotion evaluation. The literature that focuses on impacts refers mainly to the impact of workplace wellness and health promotion programs. It also refers to tools for community health impact assessment and participation in health impact assessment. The references to measurement sometimes go hand in hand with the evaluation of health education. Other references to measurement include measuring community health and measurement tools.

ii. Policy and program based

In this category, the emphasis is on indicators, measurement and evidence. Thirty-three percent of the literature refers to indicators. This literature covers the last decade. More specifically indicators refer to the measurement of health or quality of life for specific groups or situations. This includes indicators for Métis women, Aboriginal people, immigrants, vulnerable communities, neighbourhoods, population health, rural health, environmental health, and general access to health care. Indicators also come up in the context of definitions and interpretations, decision-making, policy-making, health strategies, issues in deciding funding, and sustainable development. Indicators also arise in the development of a participatory evaluation model.

About a sixth of the references refer to measurement. The literature on measurement includes references to the impact of prevention research on health practice, Aboriginal

well-being, and women's health. It also refers to health promotion capacity, community capacity, qualitative measures, and the climate for health.

Nearly 12% of the references address the question of "evidence-based." This literature is very recent, spanning the last six years and the majority of it is Canadian. In the literature, evidence-based approaches are connected to public health, decision making for strategic directions, action in health care, and population health. The literature also reflects developing a culture of evidence-based decision-making.

Some of the issues raised in this section based on citations include: the appropriateness of the measurement tools for community action success, measurement, indicator development, and decision-making challenges. Other issues include barriers to producing and disseminating data, and providing evidence.

iii. Analysis

In the practice section, the focus is on evaluating and measuring the results of health promotion and health education programs. There is little reference to the evaluation of community-based participatory research initiatives and community capacity-building efforts that relate to learning and health. There is an absence of the results of longitudinal studies that tracks outcomes over a period of several years.

In the policy and program-related section, the emphasis appears to be on large-scale amounts and counts through indicators and measures of health for different populations and situations. It is this kind of measurement that is largely being used to make health policy, funding, and health strategy decisions. Also growing is the emphasis on evidence-based approaches. At the same time, the literature suggests that there are challenges with some of these approaches.

These approaches as a unitary method of determining evidence and making important decisions about health policy and strategy seems out-of-step with the emerging and growing tendency in the overall literature that reflects more community control, community-based participatory research, and other community capacity-building strategies for improving health.

It seems that a critical gap in the research is to examine more compatible forms of measurement and evaluation that are complementary to the kinds of initiatives to improve

health that are being developed in different communities. There is also a gap in terms of longitudinal studies that measure outcomes over the long term.

P. Conclusions

Overall, there are several trends in the literature. First, there is no shortage of literature and government reports that focus on knowledge or provide information about health, health care and health-related issues generally and for specific communities in particular. There is an abundance of literature that describes the health of Canadians or the health status of communities or regions of Canada. There is also a wealth of literature that describes and reports on the social determinants of health, inequalities, and how to address these inequalities and improve health. At the same time, there is also an abundance of indicators for all kinds of health-related topics, and other measurement tools that measure health and access to health care.

Another notable trend is that, overall, there is an explicit lack of connection between adult learning, and education as a field and what role it might play in improving the health of Canadians. However, there are a few very recent citations in the international literature that make these connections and may be helpful to the Canadian context.

Another trend in the literature is the reflection of a variety of forms of community involvement that includes community participation and moves to community-based participatory research, participatory education and action, and community capacity-building. However, there is scant Canadian literature in this area. Community capacity-building is a critical area connecting health and learning and needs to be further explored as a vehicle for community empowerment whether it be through participatory research, research-in-practice or research related to other community capacity related interventions. This approach, to different degrees, is reflected as a growing trend in the literature with respect to all of the AWG's priority groups.

Based on a review of the literature, the profitable lines of inquiry related to health and learning include areas where:

1) overall connections can be made around the role of adult learning and education to improve health,
2) there are clear connections between adult learning and health

3) little research has been done
4) emerging and developing themes require more research
5) themes are strong and leading the way

An important link between health and adult learning is how adult learning might improve health, address inequities in health, build and sustain healthy communities, and help people gain control over the conditions that affect their health. Adult learning has a significant role to play in improving the health of communities and individuals in these areas.

Given the role that adult learning might have in improving health, the emerging areas in the literature that currently show the most strength and promise as approaches are ones that are collective such as community-based participatory education and community capacity-building. Community-based participatory research including research-in-practice shows promise as an approach to researching health and learning. This would apply to all of the AWG priority groups, especially regions that fall below health norms, and immigrants and refugees. In these two areas, there is less literature that connects health and learning than the other priority areas. These recommendations would also apply to work and workplace settings.

In conclusion, more attention to the connections between health and learning through community-based participatory research strategies that examine community capacity building and participatory forms of education would provide a necessary complement to the wealth of health-related knowledge that already exists.

IV. Literature Related to Social Health and Learning

This section includes general works, overview reports, books and articles associated with social research on health generally, including health and learning. The literature reflects a broad definition of health as reflected earlier in this report. There are two sub-sections. The first section focuses on Canadian literature, both academic and practitioner-based, and government and government related reports. The second section includes international literature, both academic and practitioner based, as well as government and government-related reports.

Government reports or other overview reports that address specific priorities or settings of the AWG are also included under these other heading as well.

A. Concerning Canadian literature

i. Journal articles, reports and books

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V. Literature on Theory Related to Health and Learning

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VI. Literature Related to Capacity-building and Health and Learning

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VII. Literature Related to Health Promotion and Learning, Teaching, and Research-in-Practice

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VIII. Literature Related to Health and Learning and Women

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IX. Literature Related to Health and Learning, and Race and Ethnicity

In this section, the literature included focuses on race and ethnicity as it relates to health and learning. This includes issues of racism and social determinants of health related to racism as well as culturally appropriate health care.

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XI. Literature Related to the Health and Learning of Adults Affected by HIV/AIDS

This section includes literature related to the health and learning of adults affected by HIV/AIDS. The section includes references to HIV/AIDS in general, as well as specific groups and settings that relate to AWG priorities. These references are also included under the AWG priorities they apply, for example, to literacy or the health and learning

of Aboriginal adults. This section does not include technical or medical research such as HIV/AIDS treatment research.

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XII. Literature Related to the Health and Learning of Immigrants and Refugees

This section includes references on health and learning related to immigrants and refugees. It includes literature on general issues of health related to these priority groups as well as particular issues related to women and racialized groups who are immigrants and refugees. Literature referring to language barriers in the context of health is included in this section.

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XIV. Literature Related to the Health and Learning of Aboriginal Adults

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XV. Literature Related to Health and Work

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XVI. Literature Related to Health and Learning and Indicators of Change

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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.**

Name	Institution/ Affiliation	Location	Area of Work or Interest
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
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

Name	Institution/ Affiliation	Location	Area of Work or Interest
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
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**

Name	Institution/ Affiliation	Location	Area of Work or Interest
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
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

Name	Institution/ Affiliation	Location	Area of Work or Interest
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