

# Health and Learning Data Strategy Framework: Monitoring Healthy Communities of Learning

## Human Early Learning Partnership

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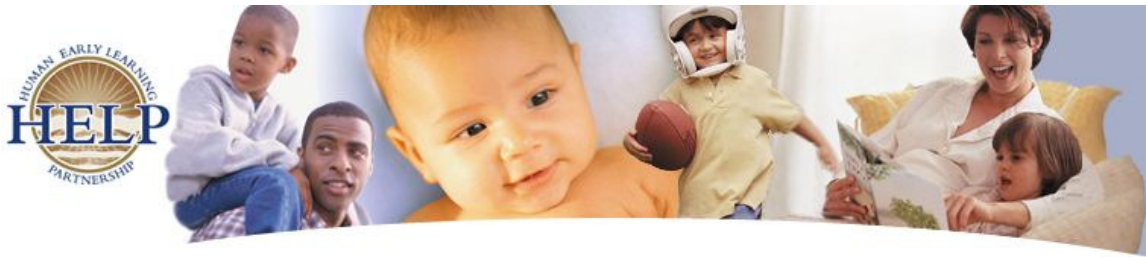
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## HEALTH AND LEARNING

Knowledge Centre

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## **HUMAN EARLY LEARNING PARTNERSHIP**

The Human Early Learning Partnership (HELP) is an interdisciplinary collaborative research institute that is directing a world-leading contribution to new understandings of and approaches to early child development.

Directed by Dr Clyde Hertzman, HELP is a partnership of over 200 faculty, researchers and graduate students from six BC Universities

- The University of British Columbia
- University of Victoria
- Simon Fraser University
- University of Northern British Columbia
- University of British Columbia Okanagan
- Thompson Rivers University

HELP's mission is to create, promote and apply knowledge through interdisciplinary research to help children thrive.

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## TABLE OF CONTENTS

<b>PART 1: BUILDING A COMMON FRAMEWORK .....</b>	<b>4</b>
INTRODUCTION .....	4
BACKGROUND.....	5
<i>Figure 1: Building Capacity for Healthy Communities of Learning</i> .....	6
<i>Table 1 : Health and Learning Knowledge Centre Working Groups</i> .....	7
MOVING FROM RESEARCH TO POLICY .....	8
<i>The Right Information</i> .....	8
<i>To the Right People</i> .....	9
<i>At the Right Time</i> .....	9
DATA STRATEGY ISSUES.....	9
<i>Identifying policy and research questions</i> .....	9
<i>Meeting Goals and Objectives with a Data Strategy</i> .....	10
TYPES OF DATA .....	11
MEASUREMENT ISSUES .....	13
<i>Psychometric Properties of Measures</i> .....	13
<i>Collection and Access Issues</i> .....	16
<i>Feasibility, cost (including sustainability of financing), and     timeliness of data collection</i> .....	19
<i>Identifying and Prioritizing Data Gaps</i> .....	19
<i>Troubleshooting</i> .....	20
<b>PART 2: IMPLEMENTING THE HLKC MISSION .....</b>	<b>22</b>
THE EARLY CHILDHOOD WORKING GROUP (ECWG).....	22
<b>GOALS/PURPOSE</b> .....	22
<b>POLICY ISSUES</b> .....	23
<i>Tables of Data Sources and Data Gaps for Early Childhood Education</i> .	24
SCHOOL AGE CHILDREN WORKING GROUP .....	27
<b>GOAL/PURPOSE</b> .....	27
<b>POLICY ISSUES</b> .....	28
<i>Tables of Data Sources and Data Gaps for School Age Health</i> .....	29
YOUTH ENGAGEMENT WORKING GROUP.....	31

<b>GOALS/PURPOSE</b> .....	31
<b>POLICY ISSUES</b> .....	31
<i>Tables of Data Sources and Data Gaps for Youth Engagement</i> .....	32
YOUNG ADULTS WORKING GROUP.....	34
<b>GOALS/PURPOSE</b> .....	34
<b>POLICY ISSUES</b> .....	34
<i>Tables of Data Sources and Data Gaps for Young Adults</i> .....	36
ADULT WORKING GROUP .....	39
<b>GOALS/PURPOSE</b> .....	39
<b>POLICY ISSUES</b> .....	39
<i>Tables of Data Sources and Data Gaps for Adults</i> .....	42
OLDER ADULT WORKING GROUP .....	45
<b>GOALS/PURPOSE</b> .....	45
<b>POLICY ISSUES</b> .....	45
<i>Tables of Data Sources and Data Gaps for Older Adults</i> .....	47
OTHER VOICES WORKING GROUP.....	50
<b>GOALS/PURPOSE</b> .....	50
<b>POLICY ISSUES</b> .....	50
<i>Tables of Data Sources and Data Gaps for Other Voices</i> .....	52
HEALTH HUMAN RESOURCE CAPACITY BUILDING FOR HEALTH LITERACY – EDUCATION STRATEGIES FOR HEALTH PROFESSIONALS .....	54
<b>GOALS/PURPOSE</b> .....	54
<b>POLICY ISSUES</b> .....	54
<i>Table of Data Source and Data Gaps for Health Human Resource Capacity Building</i> .....	56
COMMUNITY BASED PRACTICE DRIVEN RESEARCH.....	59
<b>GOALS/PURPOSE</b> .....	59
<b>POLICY ISSUES</b> .....	59
<i>Tables of Data Sources and Data Gaps for Community Based Research</i> ...	61
REFERENCES .....	63

# Part 1: Building a Common Framework

## *Introduction*

A healthy population depends on many interrelated societal factors. Crucial to the health and well being of individuals is the community context in which people live, work, study and play. A **healthy community of learning** provides a physical and social environment that is rich in the resources that allow individuals to engage, connect, and participate in order to maximize their potential for health and learning across the life span. “Healthy communities of learning build on common interests, understandings, skills, and knowledge for shared purposes, and are integrated into the routine life of organizations, formal and informal settings, and social systems.” (Health and Learning Knowledge Centre Workshop)<sup>1</sup>

The health of communities rests on a community **capacity** to meet and develop the health and learning needs of its citizens and on the **health literacy** of its citizens; their ability “... to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course.”(Rootman, 2007)

Health literacy is mediated by the communication skills and settings of health professionals, by the printed health materials and media health messages available, and by the education, culture and language of those involved. What capacitating factors underlie or produce healthy communities of learning? And, how do healthy communities of learning produce health literate citizens? In order to approach answering these important questions we first must identify markers that can be used to index the capacity and status of the health and learning of communities and their citizens. This document provides a data strategy framework for identifying and assessing key indicators of the health and learning of communities and individuals.

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<sup>1</sup> In this document, the terms 'healthy communities of learning' and 'settings' are used interchangeably to reflect the importance of a physical place and/or social context where multiple environmental, organizational and personal factors come together to affect health and learning.

## ***Background***

The Canadian Council on Learning (CCL), an independent corporation funded by Human Resources and Skills Development Canada, was given the mandate to report on the life-long learning of Canadians. The intersection of Health and Learning of Canadians was deemed an important component of this responsibility. CCL created the **Health and Learning Knowledge Centre (HLKC)** as a national centre of reference for this issue. Noting that traditional knowledge development is dominated by the requirements of academia and policy-makers looking for immediate answers, HLKC was planned to facilitate horizontal exchange of knowledge across organizations that address health and learning and vertical interchange of knowledge from community to national and international levels. The stated mission of the HLKC is to become "... a national reference centre and knowledge broker on the critical interactions and interdependence of the learning and health of Canadians by engaging a pan-Canadian network of partners in identifying a national research agenda and a variety of activities in knowledge exchange, and monitoring and reporting." (pg. 4, HLKC Business plan, 2006)

The HLKC is chaired by the Faculty of Education at the University of Victoria and governed by a steering committee of member organization. It was formed as a consortium that included 17 organizations from across the country. A group of more than 30 members representing Canada's health and learning communities functions as a national advisory committee for the HLKC. Currently the activities of the HLKC are led and conducted by 11 working groups, addressing different populations or ages/stages of human life, and the three overarching themes that guide the activities of the HLKC. The three themes are (see Figure 1):

- ◆ **health literacy**, prioritizing access, equity, and the achievement of basic health literacy for all
- ◆ developing and **sustaining healthy communities** of life-long and life-wide learning
- ◆ strengthening the **capacity** of communities, practitioners and public agencies/systems to implement intertwined health and learning strategies in comprehensive, sustainable, effective ways (HLKC, 2005).



**Figure 1: Building Capacity for Healthy Communities of Learning**

The mandate given to the working groups was to define a knowledge agenda around each of the three themes related to their associated life stage or special focal population; the working groups are identified by the following life stages: early childhood, defined as 0-6 years of age; school-age children in schools; school-age children in out of school settings (disbanded in 2007); young adults, defined as 18 to 34 years of age; adults; and older adults. Two additional working groups address populations that are more difficult to access and engage: other voices, which focuses on marginalized adult populations, and youth engagement, which links to model programs for adolescents. The focus of the ninth working group, Community and Practice Based Research, is on engaging communities in research aimed at issues generated by local concerns. Two final working groups address the themes of the knowledge center directly, Health Literacy and Capacity Building<sup>2</sup>.

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<sup>2</sup> The Expert Panel on Health Literacy completed their mandate in 2008. The final report for Health Literacy can be obtained from the on-line document at the CCL website: A Vision for a Health Literate Canada. The Health Human Resource Capacity Building for Health Literacy panel functions largely as a networking group. These two groups are not covered in detail in this document.

Each working group is mandated to address the four primary functions of CCL in the activities it recommends and undertakes: 1) research, 2) data/monitoring/reporting, 3) knowledge transfer, and 4) dissemination/communications. Additionally, two expert panels were set up to focus more specifically on the themes of the knowledge centre; Health Literacy, Developing Capacity, and Community and Practice Based Research.

**Table 1 : Health and Learning Knowledge Centre Working Groups**

<b>Working Group Area</b>	<b>Settings / Communities to be Addressed</b>
#1 Early Childhood Education	Family Support & Resource Centres; Parenting Centres Early Childhood Education, Development Centres and Child Care programs Health-care Services – Prenatal & Home visiting programs, Infant Development and screening programs Kindergarten, preschools and nursery schools
#2 School-age Children in Schools Settings	Schools Families Workplace Health-care services
#3 School-age Children in Community Settings – This working group was disbanded in 2007.	Families Schools Recreation centres Health-care services Workplace
#4 Youth Engagement	Model youth programs for adolescent girls
#5 Young Adults	Post-Secondary Education and Training institutions Workplace Health-care services
#6 Adults	Workplace Family Community Health-care services
#7 Older Adults	Workplace Recreation Health-care services
#8: Expert Panel on Health Literacy (completed mandate in 2008)	Researchers in health literacy FTP policy makers Practitioners in literacy and in health Learners
# 9 Other Voices	Marginalized adult communities: Homeless people Sex workers

	Mental health consumers People with addiction history and/or criminal justice system experience Lesbian, gay men, transsexuals or Trans-gender individuals. Low literacy individuals
#10: Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals	Health authorities Health professional organizations Post-secondary educational institutions
#11 Community based and practice driven research – Canadian Consortium for Community Health Promotion Research	Community based and practice driven research organizations (e.g., CCHRC)

This document addresses the data monitoring and reporting function of the HLKC. It brings together the diverse interests of the working group areas to tackle issues of data quality, data types, and data sources available to monitor progress in communities and individuals related to health and learning in the varied settings represented by the work groups. Policy issues and gaps in available data as they relate to policy issues are also discussed.

## ***Moving from Research to Policy***

There are many goals of developing a health and learning data strategy, one of which is to identify indicators of effective practice which can influence policy- and decision-making. Moving from research into policy and practice requires getting the right information to the right people at the right time.

### **The Right Information**

Research and data need to be presented in a way that is easy for stakeholders to use and understand what (is the issue?), so what (why does it matter?) and now what (what does the research indicate will solve the problem?). The Canadian Health Services Research Foundation (CHSRF) has a number of resources to help create, use and share research information: [http://www.chsrf.ca/knowledge\\_transfer/tools\\_e.php](http://www.chsrf.ca/knowledge_transfer/tools_e.php).

## **To the Right People**

Health and learning intersect in a number of important and dynamic ways and therefore touch on almost every aspect of our lives. Within the policy environment, issues in health and learning cut across multiple ministries and government departments including health, public health, education, immigration, and social services. Building relationships with policy- and decision-makers within relevant ministries and departments early in the research and indicator development process can help facilitate the knowledge exchange.

## **At the Right Time**

One of the biggest challenges moving from research to policy and practice is timing. Research, especially within health and learning, is often longitudinal and can't deliver the information needed for evidence-based informed decision making within a typical two to four year government mandate. Scanning the environment for potential policy windows of opportunity can help identify what research information might be needed and when: are there key issues capturing media attention that can be linked to your research? Are there initiatives, reports, or commissions underway that are relevant to your work?

Making sure the right information gets into the right hands at the right time is even more challenging when dealing with the cross cutting issues relating to health and learning, but for all of the challenges, there are also opportunities to move the important work in this area forward. There is a broad potential group of partners and stakeholder to work with and the HLKC has all of the ingredients of strong evidence: data + research + personal experiences of health and learning. The working groups of the HLKC give voice to the stories that make the data real, creating the foundation for the development of this data strategy framework.

## ***Data Strategy Issues***

### **Identifying policy and research questions**

The HLKC represents a consortium of diverse member organizations all with the common goal of working together to create a national research agenda that considers the intersection of health and learning throughout the life span of all Canadians. The intent is to act as a national repository and knowledge broker for information about health and learning and to influence key stakeholders and decision makers who set and implement policy in the areas of health and learning by promoting best practices.

**Users of health and learning data:** Data about health and learning has a very broad audience that extends from the individual citizenry to the federal government. As **parents**, we want to know about the health of our children, the schools they attend, and the communities in which we as families live. As **school administrators** and **educators** of children and adults we need to know how our programs and curricula are influencing our young and older pupils and what we can do to make the school environment a healthy community of learning. **Health, recreation and social service professionals** use data to inform planning of community health promotion programs and policies. **School and**

**public health agencies** also have a strong stake in understanding how to improve the health of Canada's children, youth, and adults. **Provincial and Territorial health and education ministries** need reliable and valid data on which to base policy. At the National level, the **Canadian government** needs to be able to assess how the country is faring as a result of established policy and to make informed decisions when implementing policy changes. **Researchers** in the fields of health and education who seek to understand the evolving trajectories of individuals, communities, and systems are both generators and consumers of health and learning data.

**What do stakeholders, policy makers and researchers need to know?** Healthy communities of learning have as their foundation a literate citizenry and as their strong point, the capacity to meet and improve the health and learning skills of all its citizens. Identifying the key characteristics, system conditions, and outcomes that can serve as indicators of healthy communities is an important starting point for those invested in maintaining and creating healthy communities of learning. Beyond arriving at meaningful indices of healthy communities, consumers need to understand how these characteristics and system conditions contribute to healthy community outcomes; those causal questions which can be answered in part by examining the relationships among good indicators and by inclusion of contextual measures that help elucidate the factors that mediate these relationships and those through which outcomes are effected.

At the 2007 HLKC workshop, *Building Data Systems for Health and Learning*, policy and research questions relevant for each of the working groups were voiced. The examples provided here are from a much larger list, but they serve to articulate the types of questions relevant to the working group areas for which data could provide answers.

Selected Policy Research Questions Raised at the HLKC Vancouver Workshop

- ◆ What are the entry points into the health system for individuals and how do these relate to educational attainment?
- ◆ What is the perception of, as compared to the actual, validity of health information communicated through media and internet sources?
- ◆ What is the impact of technology (cell phones; internet etc) on children's health (e.g., obesity, mental health) and learning (e.g., literacy)?
- ◆ What compositional (e.g., service capacity) and contextual (e.g., learning conditions) factors support healthy communities?
- ◆ Are measures of social capital also measures of health communities as measured by health literacy?

## Meeting Goals and Objectives with a Data Strategy

**Identifying Goals:** The diverse age groups and populations represented by the HLKC make the process of defining common goals and objectives challenging. This paper uses the knowledge centre's central themes, that of developing and sustaining healthy

communities of life-long and life-wide learning, health literacy and the capacity of communities, practitioners and public agencies/systems to put into practice effective, comprehensive and sustainable health and learning strategies as the scaffold around which goals and objectives can be individually framed in separate sections for each of the working groups.

**Choosing and understanding data:** Data choices always need to be specific to the questions and goals they purport to address. A distinction can be made between: data that measures outcome, for example, the presence or absence of disease; data that describes the process by which systems achieve different outcomes, for example, the relationship between school health curricula and academic curricula and the health curricula itself; and the inputs or initiating factors that contribute to both process and outcome, for example, the presence of an environmental toxin in a school playground.

Outcomes, processes, and inputs can be measured through the use of key indicators that, if well chosen, represent the measured phenomena with simplicity and precision and allow stable assessment across time and place. As an example, the number of treated cases of sexually-transmitted diseases (STD) in a community health clinic per month can be an index of the STD incidence in the community. Communities, agencies, local, provincial and federal governments can set performance benchmarks, representing an average value of a key indicator that can be compared across time and regions, for example, adult literacy levels have been used as provincial, national (ALLS, Adult Literacy and Skills Survey) and international (IALLS) comparative benchmarks to index how regions or nations compare. Similar values can also be expressed as targets, or values which communities, provinces or nations wish to achieve, for example the eradication (0 cases) of smallpox. In this case, careful consideration of political and economic costs, and the feasibility of the requirements of implementation arise.

Indicators, benchmarks and targets

- ◆ Key indicators: a statistic or set of statistics that provide a concise description of the condition or performance of a system - simplicity; accuracy; stability.
- ◆ Benchmark: an average value of the performance or condition of a system. Allows meaningful comparisons and communicates effectively.
- ◆ Target: a numerical expression of what communities, institutions, provinces or nations consciously choose as their future aspiration.

### ***Types of Data***

The sectors of health and learning have a wealth of data that pertain to their respective domains. The actuality of data that addresses the interrelationship of these two interdependent sectors is less apparent. Nevertheless, one can turn to the same types of data that abound in the respective fields of health and learning with the aim of constructing meaningful indicators that cut across the two domains.

These types of data can be distinguished by the categories of their source. Most available is administrative data is routinely collected in the course of managing or administering programs and systems, for example, hospitals collect data upon admission, treatment, and discharge of all patients; and school records contain demographic data, grades and achievement test scores of all students. Survey data comes from questionnaires devised to address specific issues or needs can be used by stakeholders, institutions, and policy makers to obtain information useful in planning and conducting their respective responsibilities. For example, the Canadian Community Health Survey (CCHS) was designed to provide reliable cross-sectional estimates of health determinants, health status, and health system utilization for 132 health regions across Canada. In addition, researchers collect a plethora of research study data on a broad variety of issues that are typically focused on testing a particular hypothesis or answering an individual set of questions. Qualitative studies, often aimed at generating rather than testing hypothesis, also yield useful data. Such studies frequently focus on local problems and involve community participants who have a stake in problem solving. Answers to research problems are characteristically derived either from *cross-sectional data* that assess different population subgroups or different age groups at one point in time, or from *longitudinal data* that track the same individuals developmentally or the same set of indicators over time. Finally, all data need context for comprehensive interpretation. Contextual statistics/data can provide the framework for a more thorough reading of results obtained from examination of administrative, survey or research data. Understanding the availability of community assets such as libraries, for example, clarifies an interpretation of related IALSS scores.

#### Data Types

- ◆ Management statistics/administrative data: routine descriptive data from foundational information sources.
- ◆ Specially structured survey data: used to provide institutions and policy makers with specific information (e.g., IALSS, CCHS).
- ◆ Research study data on target issues: focused and time-limited. Address specific policy questions or locally identified problems, identify and track trends, illuminate associations and causal links, and/or support or challenge specific theory.
  - cross-sectional data, taken as a snapshot at one point in time across different age groups or subgroups.
  - longitudinal data, track indicators over time or in the same cohort over time, e.g., NLSCY.
- ◆ Contextual data/statistics: used to provide the context for interpreting core data, e.g., census demographic data, economic data, quality of life surveys, community assets mapping, environmental scans, labour force statistics, qualitative data.

## ***Measurement issues***

One of the critical questions data users must ask is what is the quality of data on which decisions will be made? The ability of data to assemble an accurate portrait of a given state of affairs depends on several key psychometric properties of the indicators or measures producing the data.

### **Psychometric Properties of Measures**

One of the most important of these is the *validity* of a measure to either directly and accurately assess the phenomena of interest (e.g., standardized reading achievement scores as an assessment of child language skills) or to serve as a highly acceptable proxy (e.g., number of library books checked out in the course of a year as an assessment of literacy). There are a number of methods accepted by psychometricians for establishing the validity of an assessed construct. Qualitative researchers also have identified methods for assessing the validity of research that relies on qualitative paradigms and analytic techniques. A brief description of the key types of validity follows.

**Validity:** Content Validity is a procedure in which experts in a field are asked to judge whether the content of a measurement device is representative of the domain/construct(s) that it is designed to measure. Concurrent Validity is established when indicators or measures that purport to assess the same construct show a high level of agreement with each other. Criterion-related or Predictive Validity addresses the ability of an indicator or measure to predict with a high level of certainty an outside criterion, for example Grade 7 math achievement scores as predictive of performance in school math classes. Convergent Validity is established when two or more *different methods* of measurement converge on the same construct and are in good agreement, such as clinical self-report scales and clinician ratings of depression. Discriminant/Divergent Validity indicates the specific nature of an assessment to measure only the construct it purports to measure, thus the pattern of results obtained with the measure relates to the intended construct and not to other measurable constructs.

**Multilevel construct validation:** Zumbo (2008) identifies this type of validation as increasingly meaningful to educators and policy makers. Zumbo defines a multilevel construct as “a phenomenon” that has meaning at more than one level, for example at the level of the individual student and at the level of the aggregate such as the classroom, school or school district. A problem arises when validity has been established at the level of the individual but the construct is primarily “interpreted and used only at the aggregate level...” Zumbo notes that such multi-level measures are often employed for tracking the performance at the aggregate level, for example tracking school district performance on standardized achievement tests. “At the very least, systematic and coherent evidence (validation evidence) needs to be assembled to support the inferences at the various levels. Furthermore, the level of validation evidence needs to be in line with the level of inferences.”(Zumbo, 2008).

**Transgressive Validity:**<sup>3</sup> The criteria for evaluating the properties of measures discussed so far apply to those generated from quantitative or conventional research studies. There is also a significant presence of information or data derivable from qualitative studies that can be particularly useful for policy purposes. The criteria for considering indicators based on qualitative or naturalistic studies differ from those applied to quantitative research studies, reflecting the differing assumptions underlying qualitative research. To cite some examples of differences in foundational assumptions: The nature of truth is assumed to be bound by both time and context in qualitative research, rather than enduring and context free; the relationship between researcher and subject is collaborative and constructed by mutual interaction and influence in qualitative research rather than one that invests authority in the researcher and maintained by independence and distance; and the goal of inquiry is to develop idiographic knowledge bound by hypotheses developed in context in qualitative research rather than to generate nomothetic knowledge that can be generalized independent of context (Guba and Lincoln, 1982; Lincoln and Guba, 1985).

The way in which we know is most assuredly tied up with both *what* we know and *our relationships with our research participants*. (Guba and Lincoln, 2005, p. 209).

Qualitative studies have shown their merit over the past several decades as the dust from the paradigm wars has settled.<sup>4</sup> Such merits include, but are not limited to, providing base-line descriptions of changing phenomena, uncovering basic structural elements of organizations, giving voice to marginalized people, developing new concepts and theory as well as elaborating existing ones, uncovering new problems – problem finding, providing contextual relevance and richness to data, and offering a sensitivity to process absent from experimental paradigms that seek to control “extraneous” variables (Guba and Lincoln, 1982; Peshkin, 1993).

Validity (internal) as credibility: This form of validity as first discussed by Guba and Lincoln (1986) was proposed as an analog of the standard concept of validity used in quantitative research. Credibility can be established: by extended engagement with the phenomena and/or participants and in-depth pursuit of salient features of the research problem; by *triangulation* or cross-checking data through use of different sources, methods, and/or researchers; by *peer debriefing* with disinterested colleagues who can offer outside perspective; by analysis of negative or contradictory cases, e.g., an active search for negative instances; by *member checks*, a continuous informal testing of information with participants followed by a terminal formal testing with representative samples of stakeholders.

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<sup>3</sup> Transgressive validity is taken from Lather (1993) and used here because it reinforces the non standard meaning of validity in the context of qualitative research.

<sup>4</sup> Political conservatism in the US since 2000 has resulted in a “backlash” against research that does not conform to a “gold standard” of quantitative experimental methods. As a result, qualitative research, with its emphasis on context-situated studies, has taken a back seat to clinical models of research both in terms of federal funding and of standing in the academic community (Lincoln and Cannella, 2004).

Validity (external) as transferability. Typically thought of as the generalizability or applicability of research results to other populations or contexts, Guba and Lincoln (1986) treat this as an analog of external validity. Establishing this form of validity in qualitative research relies on developing *thick descriptions* of the research context so that the degree of fit across potentially applicable contexts can be assessed.

Validity as authenticity. Authenticity criteria were originally offered by Guba and Lincoln (1986) as validity criteria more directly tied to the types of assumptions under which qualitative or naturalistic researcher is carried out, i.e., a research paradigm that is inherently value-bound, relativistic and interactive.<sup>5</sup> Criteria of authenticity can be established by assuring the following: *Fairness*, that is that the research represents the views, perspectives, claims, concerns and voices of all stakeholders; *Ontological and educative authenticity*, reflected by a raised level of awareness in the research participants and also in those in the community with whom participants come into contact. This criteria is similar to that proposed by others as the capacity of the research to stimulate participants' engagement in moral critique (e.g., Schwandt, 1996); *Catalytic and tactical authenticity* is established when the research a) prompts action on the part of participants and b) involvement of the researcher in training participants in specific forms of social and political action. This criteria resembles that proposed by action researchers who deem research valid when the co-generated knowledge results in action by local stakeholders (Greenwood and Levin, 2005). Lather (1993) goes a step further in proposing that catalytic validity is established by the degree to which research moves the understanding and stance of participants so that participants gain self-understanding and self-direction as well as manifesting the *reality altering* impact of the research process.

**Reliability:** The *reliability* of a measure is another psychometric property of an assessment that should be determined prior to acceptance of an indicator as a credible measure of a given construct. Reliability refers to the precision of a measuring device; it addresses a measures stability or consistency to produce the same or similar results over repeated measurements with a relative absence of measurement error. Reliability can be established in several different ways depending on the measure and type of research paradigm. If the measure is a self-report questionnaire or direct test, reliability can be indexed by the agreement between two repeated administrations carried out in relatively close time – close enough to measure an equivalent state of affairs in an individual or system, but not so close as to allow the assessed person or system to reproduce from memory the prior results. Cronbach's Alpha, a statistical procedure whereby a questionnaire or test is split into two parts and the results from each half are compared, can also be used to assess the consistency of a measure. If a measure is intended as an objective assessment by an external judge, reliability is established by having two or more external judges make judgments on the identical events, with the aim of producing results that are in very close agreement. Reliability for research paradigms that are qualitative can be established through procedures that guarantee the *dependability* and

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<sup>5</sup> Schwandt (2007), however, views the criteria of *authenticity* as complementary to the validity criteria of credibility and transferability, collectively labeled criteria of *trustworthiness*.

*confirmability* of the results. The procedure proposed by Guba and Lincoln (1986) involves an external audit by disinterested auditors of the research process that led to the results (dependability) and the final research product or findings (confirmability). An audit trail must be available, involving careful documentation of every step in the process that led to the research conclusions.

**Sensitivity and specificity** are statistical indices of the performance of a measure to make binary classifications such as presence or absence of disease or pass, fail on a screening measure. *Sensitivity* measures the proportion of true positives (taking into account the false positives) which are correctly identified (i.e. the percentage of sick people who are identified as having an illness, or the percentage of children identified at risk for developmental delays) while *specificity* measures the proportion of correctly identified true negatives (i.e. the percentage of well people who are identified as not having the condition or children not at risk).

**Responsiveness to change:** The psychometric properties of measures that are intended to capture change, for example those that identify intra-individual differences over time or the change in systems for example, are distinct from measures designed to assess static states/events. Evidence of construct validity for change measures needs to begin with a clear theory about *the change* for measurement of a dynamic variable; a theory that will be different from that which applies to static states/events. Validity for this type of research relies on the ability of a measure to accurately reflect change in people or systems. Null results on a measure of expected change can easily result from measures that have ceiling effects, that is, those that do not measure above a certain level. Measures that only tap a restricted range also will give a distorted view of the developmental progression in a domain or evolution of a system.

#### Quality and Credibility of Measurement

- ◆ Validity of measure as an accurate representation of construct being measured.
- ◆ Reliability of measure – stability of measure over assessments with little or no measurement error.
- ◆ Sensitivity of measure to capture *all instances* of measured construct.
- ◆ Specificity of measure to index *only* the measured construct.
- ◆ Responsive to change – ability of measure to capture change in phenomena across time.

### Collection and Access Issues

**How is the data produced or accessed?** A key issue in evaluating data quality is the methods under which data collection occurred. The foundation of data collection is the method used to sample from the population of interest. The population itself can be individuals, systems, or even existing data for secondary analyses. Below is a brief description of the types of sampling methodologies and issues that arise in data collection methods.

**Samples and populations:** When educators, stakeholders, and policy makers use data to make decisions, the procedures for selecting individuals or systems on which the data are based should be carefully considered. In most cases data are based on a sample, some finite number of individuals or systems that are used to epitomize all such individuals or systems. The degree to which a sample accurately represents the larger population rests on the manner in which the sample is selected. *Probability samples or random samples* are the gold standard in efficacy trials when the internal validity of research evidence is of paramount concern.<sup>6</sup> Random sampling is variously defined: as a method of selecting from a population so that every member of the population has an equal chance of being chosen; and as a method of selection such that *all possible samples of the same size* have an equal probability of being selected. Although the first definition is easily communicated, the second is more general. Inferences made from random samples have the greatest legitimacy for the subgroup or population as a whole. Random samples can be accomplished by choosing randomly from a total population, from different strata of a population, or by successive random samples of units or subgroups as for example, randomly selecting schools within a school district, then classrooms within the selected schools and finally pupils from the selected classes.

In some cases, a sample is chosen as a *non-probability sample*: either as a purposive sample, to deliberately be “representative” of specific attributes in a population. In qualitative research this might involve including all stakeholders as participants in the research; or as quota sampling, to deliberately include a fixed number of individuals from different strata of the population (i.e., gender, ethnicity, geographical, etc.). Purposive or quota sampling is frequently used in effectiveness or dissemination research when the focus is on implementation or the uptake of healthy living or learning initiatives, in order to understand the most effective means to support the transition from evidence into policy and practice. Samples can also intentionally include a proportional over representation of a subgroup because the group is under-represented in the population at large. Typically these are instances when the under-represented subgroup is at greater risk than others in the population and it is important to include sufficient numbers for well-founded conclusions. Non-probability sampling techniques can be combined with probability sampling techniques, for example when individuals of an over-sampled subgroup are chosen randomly from within the subgroup or when the fixed quota of individuals is randomly selected from the different strata of interest.

**Population-based data:** The capacity and value of having data based on entire populations is increasingly a part of monitoring and reporting in wealthy nations, that can afford to do so. Administrative data often includes all individuals in a given population, for example Canada’s health care system issues personal health numbers to all eligible individuals living in Canada and administratively tracks their use in order to pay doctors for services. Population census also can be achieved with survey data, for example in British Columbia all kindergarten children are assessed by teachers with the Early Development Instrument. Most nations who can afford to do so periodically gather

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<sup>6</sup> See Sussman et al. (2006) for a discussion of the distinction between different phases of research that prioritize internal or external validity.

census demographic data on all its citizens through survey. In Canada a population census is carried out every 5 years.

**The Manitoba experience:** Ideally population-based data systems from a wide variety of sources can be linked to create a person specific data base. For example, the Manitoba Centre for Health Policy (MCHP) maintains The Population Health Research Data Repository in Manitoba. The repository contains anonymized records of individuals' contacts with the provincial health care system, individuals' records from provincial primary and secondary education systems, individuals' teacher assessments on the Early Development Instrument (maintained by Healthy Child Manitoba Office), contacts with the provincial social services systems, and use of child day care services. In addition to the datasets mentioned above, numerous other population-based records have been deposited in the Repository, including data from the Office of Vital Statistics (birth, death and cause of death information), data from provincial surveys (e.g., the Manitoba Longitudinal Study on Aging), and data from national surveys (e.g., the Canadian Community Health Survey). In all, over 90 administrative, survey and clinical databases are currently contained in the Repository that can be linked at the level of the individual. Strict guidelines and privacy regulations are in place for the use of the linked data bases and decisions are made on a project-by-project basis subject to approval by all parties involved as data sources.

Such a data repository is a very powerful research resource for studying the health and well being of children and families. One example is a study done by the MCHP to examine educational outcomes by socioeconomic status (SES) linked data on educational performance, area-level SES, and residency in Manitoba (Brownell et al., 2004; 2006; Roos et al., 2006). Among a number of findings, the use of these linked data revealed that gradients across socioeconomic status on students performance on Grade 12 language arts standards test were much steeper than previously found. Instead of including only the high school outcomes of students still in Grade 12, the study also was able to add outcomes for all those who had fallen behind (repeated a grade) or who had dropped out of school. When these students were included, the previously hidden but dramatic effect of low SES on school achievement was demonstrated. By linking datasets across time, children can be followed from birth through adolescence and into adulthood, allowing study of which factors (e.g., birth weight, region of residence) are the best predictors of various outcomes (e.g., high school completion, health conditions such as asthma and diabetes).

If possible, the system created in Manitoba could be a model for provincial systems across Canada. But right now, Canada has a provincial patchwork of administrative data linkage systems for health, education, and development. In Ontario and Québec linkable health services data systems exist, but function according to specific jurisdictional rules of access. Saskatchewan and Nova Scotia have linkable data for specialized areas like pharmaceuticals and child health. British Columbia is the only other province to be successful in providing access to linked data collected province-wide for health, education, and development. British Columbia recently created a new resource for the research community housed at the University of British Columbia, that functions similar

to the MCHP in Manitoba. Known as Population Data BC, it allows BC's research community access to anonymized inter-sectoral linked data on a secure analysis platform. The data are population-based, person-specific and longitudinal, giving researchers the potential for tracking the health and welfare of BC's children from birth throughout their years in school.

**Comparability of data:** The issues of comparability of data arise when: data, such as benchmarks, are compared across geographical regions or time; and different types of data are linked. Different regions may use different reporting formats, different standards or different measures to form an index that is being compared across regions, for example quality of child care may be indexed by child-minder child ratio or by absolute size of child group. The foundational measures or methodologies that form benchmarks tracked across time and/or the meaning of the scales on which the benchmarks rest may also change. For example, over the years, the methodologies underlying the individual measures that make-up the Human Development Index, reported by the United Nations as best used for national comparisons across time, have varied considerably. Evaluators must carefully consider the nature of these differences and how they influence the comparability of indices. These issues of comparability also arise when different types of data are linked. In addition, caution must be applied in interpreting results when data collected at different levels are linked, for example, postal code census estimates of SES linked with individual child or family data.

### **Feasibility, cost (including sustainability of financing), and timeliness of data collection**

To fully enable population health, education, and related research scientists to reach the most informed conclusions and for stakeholders and policy makers to effect the best decisions, access to current cross-sectoral, linked, population-wide data is needed. Access to such data creates the capacity for fundamental advances in our understanding of the complex interplay of influences on human health and development and can serve to better inform future social policy and investment decisions for the continuing improvement of all Canadians. Facilitating access to such data for bona fide, public-interest research purposes, while at the same time ensuring protection of privacy and confidentiality of individuals is a complicated but achievable end (Hertzman & Williams, 2008). It requires the creation and maintenance of repositories such as The Population Health Research Data Repository in Manitoba or Population Data BC, housed at The University of British Columbia. Financial sustainability will always be a challenge but rewards are promising to be substantial.

### **Identifying and Prioritizing Data Gaps**

Identifying data gaps requires careful consideration of what we know in areas of interest and concern, and honest acknowledgement of what we do not know. Resource commitment, both financial and time, is required to fill needed gaps. The cost and benefits of addressing data gaps must be carefully weighed before embarking on procedures to remedy the information void.

The intersection of health and learning represents vast and largely uncharted territory with islands of data, such as health literacy, that are richly informative but which for the most part, remain unexplored. Data linkages between health and education provides a promising direction that can prove insightful in identifying and prioritizing existing data gaps.

Collection/Access issues

- ◆ How are the data and indicators accessed or produced?
- ◆ Are the data derived in a way that is comparable with other relevant data standards and collections?
- ◆ What is the feasibility, cost (including sustainability of financing) and timeliness of collecting the data?
- ◆ What are the major data gaps in the existing data and what is the feasibility of addressing them?

## Troubleshooting

When data are desired and/or accessed that appears to answer pressing research, evaluation, or policy questions, care should be taken to assess their quality and fit. This is particularly true when data are combined over time or pooled from diverse sources. Methodologies or reporting formats may vary widely and in order to be combined meaningfully, such differences must be understood and resolved. Comparing data to benchmarks that differ in methodology and/or reporting format also can pose interpretation problems. Lack of common standards for data collection, analysis, and reporting present significant challenges for comparing or combining diverse data sources, as do omissions of data on specific population subgroups. Judicious review of data collection and analysis methodologies can resolve such uncertainties.

Additional issues can arise when data collection is planned unaided by public or stakeholder input and then used to inform the public or make policy. Data that are meant to inform or educate the public or that form the basis for policy decisions should be relevant to public and policy needs and not distorted or shoehorned to fit those needs. Providing fora for stakeholders to weigh in on the type of data needed and carefully assessing the relevance of acquired data are key to minimizing these types of obstacles. Other difficulties can occur around the ease of accessing data, for example data held by separate ministries have different rules of access. Related to data access is the timeliness of the data when access is granted. Too often delays and barriers to data access make the data irrelevant or obsolete to the questions and needs of stakeholders. Costs also pose significant barriers. Funds may be available to collect and/or access and analyze data for only limited periods making long-term and consistent monitoring problematic.

Troubleshooting

- ◆ Diverse approaches to and formats for reporting.

- ◆ Lack of comparability with existing benchmarks.
- ◆ Lack of a common set of data standards.
- ◆ Data gaps on specific subgroups.
- ◆ Poor public or stakeholder input & accessibility.
- ◆ Timeliness: time frame in which outcomes can be accessed is a poor match for time frame of data.
- ◆ Finances are not available or are time limited.

## **Part 2: Implementing the HLKC Mission**

The stated mission of the HLKC “is to become a national reference centre and knowledge broker on the critical interactions and interdependence of the learning and health of Canadian by engaging a Pan-Canadian network of partners in identifying a national research agenda and a variety of activities in knowledge exchange, and monitoring and reporting.”(HLKC, 2005) This mission was delegated to the leadership of the eight core working groups that concentrate on different life stages and populations. The working groups were charged with addressing the three themes (health literacy, healthy communities of learning, and capacity development) of the HLKC as they related to the different ages and populations of focus. In this section, each working group is addressed separately, identifying the goals and purposes set forth by each working group and the central policy issues singled out by the working group. Potential data sources to address these policy issues and data gaps in each of the three HLKC theme areas are found in tables specific for each working group.

### ***The Early Childhood Working Group (ECWG)***

#### **GOALS/PURPOSE**

The initial task set by this working group was “... to investigate how minimal and optimal health literacy and health knowledge/skill levels can be promoted through early childhood networks/services...” Recognizing that optimal growth and development of young children relies on the understanding policy makers, educators, practitioners, and parents have of the health, social development and learning requirements of young children, the initial undertaking of the ECWG was a Pan-Canadian consultation with these groups. Five themes emerged from this year long consultation as fundamental “for supportive health information to families:

1. Relationships between parents and professionals are ‘key’ for health information.
2. Income security is a determinant of health. Poverty impacts all levels of health and learning.
3. Mixed messages about health abound: on the internet, media and agencies/departments.
4. Understanding health literacy with a sensitivity to cultural practices is essential.
5. Communities and context matter.

The parent consultation indicated that parents were relying primarily on their health care professionals, the internet, and articles about health topics to inform themselves about the health needs of their young children and family. The consultation emphasized the significance of the relationships parents have with early childhood educators and health practitioners as actual and potential sources of health and early child development knowledge. Personal contact appeared to be the preferred and most trusted source of health information, underscoring the crucial role educators and health professionals have in providing reliable and comprehensible health and early child development information to the community. The consultation also suggested that early childhood educators and

health professionals are serving as models for families both with respect to the environmental, health, and nutrition practices they provide in child care settings and their own personal health practices. Building capacity through enhanced training and professional development of practitioners (e.g., public health nurses, community health nurses, health promotion workers) and educators (e.g., post secondary faculty involved in ECE training) surfaces as an appropriate and straightforward route to increasing a community's ability to promote the healthy development of young children.

## **POLICY ISSUES**

The ECWG identified several key policy issues that came out of their community consultations.

**Early child care policy:** The most pressing issues are reliable and affordable child care for preschool children. “[T]he long-term absence of adequate public policy and funding have resulted in the low wages and poor working conditions that plague the sector. This makes it very difficult to attract a potential workforce and retain the existing one. With a large number of child care workers moving out of the field for higher wages and improved working conditions, Canada faces a critical child care labour shortage.” (Doherty & Forer, 2004) Job burnout, low wages and poor compensation-related benefits, lack of on-the-job benefits that improve daily working conditions, perceived low job status, and poor ECCE training of centre staff all contribute to high turnover and instability in the child care labour force (Doherty and Forer, 2004). From the parents’ perspective, there is little staff stability in child care programs and personal plans for children are often shelved or dropped. In addition, access is often limited by available space, affordability, and the capacity of the program to meet the child’s and family’s needs, for example a child with disability or parent’s work schedule (CCRU, 2004).

**Parental leave policies and family friendly work policies:** Since the year 2000, over 65% of mother’s with children age 0 to 3 years and over 70% of mothers’ with children age 3 to 5 years are working in the paid labour force (CCRU, 2004). Working parents express concern that the needs of families in the work place are not adequately addressed. Leave policies to take care of ill children, and job sharing among working mothers were salient in the ECWG consultations with parents.

**Access to Health Professionals:** According to Statistics Canada (Yearbook, 2006), “[a]lthough access to health care is guaranteed under the Canada Health Act, some Canadians have difficulty finding a physician—13.6% of the adult population, or 3.5 million Canadians, did not have a regular family doctor in 2005....” The ECWG consultation revealed that the family doctor is one of the primary individuals that parents rely on for child development information, yet a significant proportion of parents lack access to these health professionals. In addition, cultural sensitivity remains a significant issue for Canadian immigrants. For example, cultural practices that prohibit females from being attended by a male physician or health professional further limits the access of newcomers to Canada.

## Tables of Data Sources and Data Gaps for Early Childhood Education

Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data <b>(bolded items indicate surveys)</b>	Source
<b>ECEs AND CHILD CARE:</b> Level of education and training levels of ECEs Level of access to high quality child care. Policy analysis about ECE	ECE education and training	Child Care Human Resources Sector Council	<a href="http://www.ccsc-cssge.ca">www.ccsc-cssge.ca</a>
	School readiness measures	<b>Early Development Instrument (EDI – used in BC, MB &amp; ON)</b>	<a href="http://www.earlylearning.ubc.ca">www.earlylearning.ubc.ca</a> (BC) <a href="http://www.gov.mb.ca">www.gov.mb.ca</a> (MB) <a href="http://www.torontodacs.net">www.torontodacs.net</a> (ON) <a href="http://www.offordcentre.com/index.html">www.offordcentre.com/index.html</a> (National repository)
		<b>Early Years Evaluation (EYE – KSI research international)</b>	<a href="http://www.ksiresearch.com">www.ksiresearch.com</a> (NB)
		Understanding the Early Years (UEY)	<a href="http://www.successby6ottawa.ca/uey/">www.successby6ottawa.ca/uey/</a> (ON)
		Child and Youth Data Laboratory	<a href="http://www.research4children.com">www.research4children.com</a> (AB)
<b>HEALTH</b> Level of access to health practitioners Degree of culturally sensitive health care practices	Health surveys	<b>National Population Health Survey (NPSH – Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>Aboriginal Children’s Survey (ACS – Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		Participation and Activity Limitation Survey (PALS)	<a href="http://www.statcan.gc.ca">www.statcan.gc.ca</a>
	Longitudinal studies	<b>Quebec Longitudinal Study of Child Development</b>	<a href="http://www.jesuisjeserai.stat.gouv.qc.ca">www.jesuisjeserai.stat.gouv.qc.ca</a>
		<b>National Longitudinal Survey of Children and Youth (NLSCY)</b>	<a href="http://www.statcan.gc.ca">www.statcan.gc.ca</a>
<b>WORK POLICIES</b> Degree of parental and family-friendly work policies	Access to health care	<b>Health Services Access Survey</b> (Part of the Canadian Community Health Survey – Statistics Canada)	<a href="http://www.statcan.ca">www.statcan.ca</a>

	Health data collection (various early childhood dimensions related to health)	Public Health Agency of Canada	<a href="http://www.phac-aspc.gc.ca">www.phac-aspc.gc.ca</a>
		Provincial Databases	<a href="http://www.chspr.ubc.ca">www.chspr.ubc.ca</a> (BC) <a href="http://www.umanitoba.ca">www.umanitoba.ca</a> (MB)
	Parental and family friendly work policies	Statistics Canada (Child and Youth section)	<a href="http://www.statcan.ca">www.statcan.ca</a>
		Institute for Health and Social Policy (McGill University)	<a href="http://www.mcgill.ca">www.mcgill.ca</a>

<b>Healthy Communities</b>	<ul style="list-style-type: none"> <li>● Data specific to meeting the community learning needs of children with special needs</li> <li>● Level of access to and usage of community resources (including child care) for children from all SES groups.</li> <li>● Quality of child care settings</li> <li>● Degree of health, social services and education services for children in the early years</li> </ul>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>● Data for children living on reserves</li> <li>● Data for children with special needs</li> <li>● Data for children who have English as their second language</li> <li>● Data for children in foster care</li> <li>● Degree of culturally sensitive health care practices</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>● Data for reserve communities</li> <li>● Inventory of all community-based programs, range of program foci, level of integration among community programs and number of children served in these programs</li> <li>● Level of investment in capacity building for children in the early years</li> </ul>

<b>Organization</b>	<b>Information Area</b>	<b>Website</b>
Child Care Resource and Research Unit	Child care Early child development	<a href="http://www.childcarecanada.org">http://www.childcarecanada.org</a>
Public Health Agency of Canada – Community Action Program for Children (CAPC)	Child Care	<a href="http://www.phac-aspc.gc.ca">http://www.phac-aspc.gc.ca</a>
Justice Canada - National Crime Prevention Strategy	Community Capacity Building	<a href="http://www.prevention.gc.ca">www.prevention.gc.ca</a>
Health Canada	Community Capacity Building (e.g, The Canada Prenatal Nutrition Program; First Nations Head Start)	<a href="http://www.hc-sc.gc.ca">http://www.hc-sc.gc.ca</a>
Ontario Child Health Study	Child Health	<a href="http://www.offordcentre.com">http://www.offordcentre.com</a>
(Human Resources and Social Development Canada) Understanding the Early Year	Community Capacity to support ECD	<a href="http://www.hrsdc.gc.ca">www.hrsdc.gc.ca</a>
Child Care Canada	Child Care	<a href="http://www.childcarecanada.org">www.childcarecanada.org</a>

## ***School Age Children Working Group***

The structure of this working group is more complex than that of the other working groups. It has three subunits with different functions: a) to study and influence the health and learning of school-age children and youth in the school setting. It is the point of reference for school-health promotion in Canada; b) to disseminate health knowledge to school-age children and through the Youth Sector School Health Bulletin (Canadian Teachers Federation); c) and to build and provide a network of information exchange and serve as a support through outreach to all those organizations and individuals who are part of the network. The working group is coordinated by the Canadian Association of School Health (CASH) which has direct access to school settings and provides one of the two conduits through which health literacy and health knowledge/skills can be promoted within the schools. The other affiliated conduit for dissemination of health knowledge is the Canadian Teachers' Federation. CASH also provides outreach and networking through the schools to link and consult with provincial, territorial, and national organization related to school health.

### **GOAL/PURPOSE**

Although several goals are apparent in the tasks undertaken by the subunits of the working group, the goal set by the group for health promotion within the schools aligns most directly with the development of a health and learning data strategy. This goal is the development of a logic model or framework that will identify meaningful indicators for monitoring and reporting on school health, safety, and community development programs. Developing a system for regular monitoring and reporting on key indicators of school health is an essential aspect of effective school health promotion. Canada has made progress towards building national systems for monitoring and reporting on child/youth health, learning, and program capacities that respect local, provincial-territorial and federal roles. These include: a task force on monitoring of chronic and infectious diseases through the PHAC; consolidation of provincial/territorial surveys on health topics such as substance abuse (CCSA); intergovernmental and inter-ministry cooperation in sharing and analyzing data in some provinces (i.e., Manitoba); the use by some local school boards and health authorities of data from national surveys such as the Canadian Community Health Survey that offers modules covering most of the health challenges facing youth; the inclusion of health and social development issues in the mandatory school improvement/reporting programs of some jurisdiction (NF, QC); and increased attention from the media to school health programs (e.g., Globe and Mail cited in McCall, 2007). Nevertheless, these are at best, piecemeal attempts rather than a comprehensive approach that takes a holistic view of the educational system and the child to address the myriad of health and social issues in a planned and sequential manner.

Coordinating interventions for specific concerns such as bullying and sexual health that combine instruction, preventive health services, parent and youth involvement, and changes to the physical environment within school settings have proved effective in changing health behaviors and increasing student achievement (McCall, 2006).

## **POLICY ISSUES**

**Expand areas of monitoring and reporting on school health:** Currently the areas of monitoring and reporting on school health and social development are limited to specific health programs and fail to include areas such as basic health literacy/essential social responsibility among all students, as well as optimal health and social development for most graduates, and vocational preparation/exploration for health careers despite the fact that such curricula and learning are defined as mandatory for most grades. Current monitoring and reporting systems often lack cultural relevancy and utility for aboriginal communities and do not adequately reflect, nor are they useful, to rural, geographically isolated communities (McCall, 2007).

**Sharing of data across systems:** The delivery of school health programs typically falls to different health sectors. Many of these agencies believe that monitoring and reporting can, or is being done adequately by developing self-assessment tools that busy, pre-occupied schools can administer and use in their yearly planning. Data that are collected by an agency often remain singular and results in narrowly focused reports to the schools or educators rather than being shared across the different health systems to report on overall functioning of the health system. When studies and surveys are administered to assess urgent health issues, they frequently are one-off studies that remain disconnected from on-going research and evaluation programs and are not brought to the attention of policy-makers and decision-makers who have the authority to modify programs (McCall, 2007).

**Inter-sectoral linkage of administrative data:** The education and public health systems in Canada's culturally diverse and geographically dispersed bilingual nation, are "governed by local governments and agencies (approximately 500 local school boards, 300 local health authorities, 750 municipalities), thirteen provincial/territorial governments and a federal government that has two health departments and several other departments ..." that promote the health, social development, and learning of children and youth (McCall, 2006). Currently, there is a provincial patchwork of administrative data linkage systems for health and education. Ontario and Quebec have data systems with the potential for linkages but each functions by a different set of rules. In Saskatchewan and Nova Scotia data are linked in specialized areas like pharmaceuticals and child health. Manitoba and British Columbia have been successful in achieving inter-sectoral data linkages between health and education but only Manitoba has legislated the linkage and the rules under which these linkages operate (Hertzman, 2008). Achieving a Pan-Canadian system of linkages between health and education requires a long-term and large scale public investment if it is to achieve the potential for identifying programmatic and systemic factors that affect child and youth developmental outcomes. Hertzman (2008) recommends the creation of "...a coordinated system of ... child development statistics that is population-based, person-specific, and longitudinal in character. This system would need to be linkable at the level of both the individual and the group, (e.g. community) to data on the social environments and programs experienced by children in the course of their daily lives."

## Tables of Data Sources and Data Gaps for School Age Health

Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data <b>(bolded items indicate surveys)</b>	Source
Degree of development of linked school-health monitoring system	Health and Education linked data	Early Development Instrument (EDI) BCLHD	<a href="http://www.edudata.educ.ubc.ca">www.edudata.educ.ubc.ca</a> (BC)
		Population Health Research Data	<a href="http://www.umanitoba.ca/medicine">www.umanitoba.ca/medicine</a> (MB)
	Longitudinal surveys	<b>National Longitudinal study of Children and Youth (NLSCY – Human Resources and Social Development Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Literacy surveys	<b>Foundational Skills Assessment</b>	<a href="http://www.bced.gov.ca">www.bced.gov.ca</a> (BC) <a href="http://www.education.alberta.ca">www.education.alberta.ca</a> (AB) <a href="http://www.edu.gov.mb.ca">www.edu.gov.mb.ca</a> (MB)
	General Health surveys	<b>National Population Health Survey (NPHS – Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>Health Behaviour in School-aged Children (HSBC-World Health Organization)</b>	<a href="http://www.phac.aspc.gc.ca">www.phac.aspc.gc.ca</a>
		<b>Canadian Community Health Survey (CCHS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Overall Child Well-being (incl. health, community)	Canadian Council on Social Development	<a href="http://www.ccsd.ca">www.ccsd.ca</a>
	Housing conditions and parental health	<b>Aboriginal Peoples Survey (APS – Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>

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<b>Healthy Communities</b>	<ul style="list-style-type: none"> <li>• Data for children living on reserves</li> <li>• Data specific to meeting the community learning needs of children with special needs</li> <li>• Level of access to community resources for children from all SES groups</li> <li>• Degree of variety of out-of-school resources available in communities</li> <li>• Activity engagement of children during their out-of-school time</li> </ul>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>• Data for children living on reserves</li> <li>• Data for children with special needs</li> <li>• Data for children who have English as their second language</li> <li>• Data for children in foster care</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>• Data for reserve communities</li> <li>• Inventory of all community-based programs, range of program foci, level of integration among community programs and number of children served in these programs</li> <li>• Level of investment in capacity building for school-aged children</li> </ul>

<b>Organization</b>	<b>Information Area</b>	<b>Website</b>
Canadian Children's Rights Council	Child abuse and neglect	<a href="http://www.canadiancrc.com">http://www.canadiancrc.com</a>
Canadian Council on Social Development	Poverty rates	<a href="http://www.ccsd.ca">http://www.ccsd.ca</a>
Human Resources Development Canada	Poverty	<a href="http://www.hrsdc.gc.ca">http://www.hrsdc.gc.ca</a>
United Way of the Lower Mainland	Children's Out-of-School Time	<a href="http://www.uwlm.ca">http://www.uwlm.ca</a>
Centre for Population Health Promotion Research, UBC	Health Literacy: Is developing measure of health literacy for high school students	<a href="http://www.ihpr.ubc.ca">www.ihpr.ubc.ca</a>

## **Youth Engagement Working Group**

### **GOALS/PURPOSE**

Initiatives and projects that engage children and youth even when successful, often go undocumented. This workgroup headed up by the Department of Curriculum and Instruction at the University of Victoria undertook to gather research and information available on youth engagement in health and wellness programs and projects, and used the information to identify and provide support to strengthen those that promote a healthy lifestyle for youth. In the future the workgroup will analyze the successful strategies used by youth engagement programs, and then disseminate the information on these programs as a resource for others. The particular focus has been on programs that incorporate the arts and/or technology as means for engaging youth around health and well being. In particular, the workgroup identified and supported a project called ANTIDOTE, as a model of sustained engagement that is working, organic in origin, and powerful. ANTIDOTE is a racialized group of girls between the ages of 9-15. They meet in heterogeneous age groups. What makes this group exemplary is the manner in which the group is structured. Younger girls are partnered with supportive older girls who have been in the project before – these young women are called *Sistahs* and form a supportive ring around the core group of younger girls. Around the *Sistahs* are a ring of *Aunties*, young professors and professional women in their 30s and 40s who directly support group activities by their own engagement. Around the ring of *Aunties* are the *Grannies*, a group of older supportive adults who have been successful in leveraging funds for ANTIDOTE.

### **POLICY ISSUES**

**Mine or Yours.** A number of policy issues which pose particular challenges for the success of such programs have stood out. Chief among these is the tension between *adult structured* and *youth owned*. Often adults who initiate youth programs are uncomfortable allowing youth too much autonomy. On the other hand, youth do not respond well to programs that give them little voice. The workgroup leaders emphasize that the issue can best be framed as a continuum, with the purpose and context of the program determining where on the continuum the program's organization structure is placed.

**Space and Funding.** A second crucial issue is the barriers youth engagement programs face when trying to organize in communities. These often have to do with allocation/availability of space and funding, and the degree of youth autonomy allowed such programs.

**Multicultural Issues.** Finally, a call for greater inclusion and expansion of multicultural issues as focal points for youth engagement programs. ANTIDOTE has been successfully spun off as a separate group for First Nations girls in Victoria.

Monitoring and reporting areas of focus identified by the working group	Description	Organization	Source
Repository of successful programs that aim to foster a healthy lifestyle for youth.	Organizations that monitor and gather program evaluations for children and youth	Collaborative for Academic, Social and Emotional Learning	<a href="http://www.casel.org">www.casel.org</a>
	Organizations that fund programs that are evaluated	National Crime Prevention Council	<a href="http://www.ncpc.org">http://www.ncpc.org</a>
		Citizenship and Immigration Canada	<a href="http://www.cic.gc.ca">http://www.cic.gc.ca</a>
	Specific Programs that have undergone evaluation	Windows to Youth Health	<a href="http://www.phac-aspc.gc.ca">http://www.phac-aspc.gc.ca</a>
		Big Brothers Big Sisters of Canada (Teen mentoring, Go Girls program)	<a href="http://www.bbbsc.ca">http://www.bbbsc.ca</a>
		Youth Educating About Health (YEAH)	<a href="http://goliath.ecnext.com">http://goliath.ecnext.com</a>
	Provincial organizations that receive funding to conduct surveys of youth	The McCreary Centre Society	<a href="http://www.mcs.bc.ca">http://www.mcs.bc.ca</a>
	Websites that list programs and evaluation results	School-based violence prevention programs: a resource manual	<a href="http://www.ucalgary.ca/resolve/violenceprevention">http://www.ucalgary.ca/resolve/violenceprevention</a>
		Programs related to gang prevention	<a href="http://www.ucalgary.ca/~crilf/">http://www.ucalgary.ca/~crilf/</a>
	Aboriginal Youth Focused Programs	Centro de Investigación de Enfermedades Tropicales (CIET)	<a href="http://www.ciet.org">http://www.ciet.org</a>

**Tables of Data Sources and Data Gaps for Youth Engagement**

<b>Healthy Settings</b>	
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>Youth at risk</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>National repository of evaluated youth-focused programs</li> </ul>

<b>Organization</b>	<b>Information Area</b>	<b>Website</b>
Centre for Population Health Promotion Research, UBC	Health literacy: Has been doing studies focused on youth at risk and health literacy	<a href="http://www.ihpr.ubc.ca">www.ihpr.ubc.ca</a>
Statistics Canada	Health Literacy: International Adult Literacy and Skills Survey (2003). The survey may be repeated in 2013 or 2014	<a href="http://www.statcan.ca">www.statcan.ca</a>
CCL	Health Literacy; CCL has produced reports on health literacy that has youth data from 2003 IALSS	<a href="http://www.ccl-cca.ca">www.ccl-cca.ca</a>

## ***Young Adults Working Group***

### **GOALS/PURPOSE**

Led by the Association of Canadian Community Colleges (ACCC), the purpose of this working group is to provide leadership and support in areas of health and learning to young adults, working primarily through the institutions and settings in which these young people can be accessed. Their approach to date has been to study access and health issues of young adults at Health services in post- secondary education (PSE) institutions; in particular health promotion services offered, including health literacy concerns that impact on learning. The working group notes that although, tobacco smoking is disproportionately started in young adulthood with long range consequences, few health promotion activities target this age group. They have also looked at the capacity of PSE Institutions to deal with young adult health challenges through their health services. They have conducted focus groups at 11 PSE Institutions with 80 young adults and interviewed and surveyed college administrators. The most ubiquitous response to challenges these young adults face was the stress of balancing their time between school, social, and work obligations.

The working group plan is to move to study young adults in the workplace and particularly toward identifying the challenges in health and safety which impact this age group more than any other in the workplace. Young adults have the highest rate of workplace accidents. Some improvements have been achieved in different regions of Canada but there is no coordinated pan-Canadian practice. The working group plans to compile *Best Practices* in the workplace, working in consultation with the Work and Learning Knowledge Centre.

### **POLICY ISSUES**

The working group cites a number of policy priorities in relation to PSE institutions.

**Health Promotion Activities:** Campaigns against tobacco and drugs have been largely targeted toward adolescents younger than the young adult age group of 18-34 years. Such campaigns need to happen for young adults. One priority is getting Health Canada to recognize that this age group is at high risk for these types of damaging health behaviors. Postsecondary institutions are important vehicles for reaching young adults. Governments are providing support for health promotion activities aimed at increasing adolescents' health literacy. But again such programs largely target youth in secondary schools. Programs for young adults are less prevalent even though research confirms that youth are particularly vulnerable during the transition from adolescence to adulthood. The Quebec experience (Fédération des cégeps, 2005) affirms the need for policy makers in provincial ministries of health and education to collaborate to ensure that PSE institutions have sufficient resources to provide adequate health services for young adults.

Another policy priority is to further an approach to health promotion at PSE institutions that is holistic because of the *domino effect* cited by young people, that is when young

adults become stressed (e.g., time management ) a cascading effect of behaviors is initiated that often ends in harmful health behaviors (e.g., drinking). In addition, the working group aims to get PSE institutions to realize their role in promoting healthy eating by providing healthy choices in cafeterias and vending machines, restricting smoking and drinking on campus and at campus activities, and communicating strong messages about the health benefits of participating in sports.

**Accessibility of Health Information:** Gaining awareness within PSE institutions of accessibility of health information is also a priority policy issue. Health information should not simply be restricted to health services locations. Young people do not necessarily want to be seen as consuming health information so they may not get information by going to the Health Services. In addition, the working group found many young people in the focus groups who did not know health information on many topics was even available. The working group plans to conduct a policy roundtable around health and learning with representatives from colleges, universities, students and the federal government. The group is hoping that the policy round table will help to get these issues of access to health information on the radar screen.

**Students with disabilities** at PSE institutions are already provided with funding for computer or adaptive technologies. Government departments and PSE Institutions need to better utilize these opportunities to reach disabled young adults with health information. Changes to Canada's copyright legislation are required to accommodate the needs of those who cannot read regular print. There also is a need to establish professional standards of quality production of alternate format texts and other learning materials in Canada. Disability service centres and libraries on college and university campuses should have sufficient resources, staff, and technology to produce materials in a variety of formats and of different types – as required by individual students – in-house.

**Increasing the capacity of health services:** Increasing the capacity of health services at PSE Institutions to work with and target young adults' needs is a policy priority as well. This requires making these services a greater funding priority at the PSE level. Development and implementation of anti-smoking policies on campuses which include supporting programs to assist young adults with smoking cessation strategies, should be included as a major concern when capacity building.

**Safety in the work place:** Policy priorities in the workplace put safety issues as the foremost concern. The Canadian Labour Congress 2005 report entitled *Better Educated, Badly Paid and Underemployed: A Statistical Picture of Young Workers in Canada* identifies key policy perspectives regarding young workers. These include improving access to training for already-employed younger needing a second chance after leaving the education system relatively early and with limited credentials. This would include an expansion of apprenticeship programs, school-to-apprenticeship programs, and promotion of jobs in the skilled trades. More attention needs to be paid to the plight of younger workers, including planning for more successful transitions from school to work.

## Tables of Data Sources and Data Gaps for Young Adults

Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data <b>(bolded items indicate surveys)</b>	Source
<p><u>Health services at the post-secondary level</u> Level of access to health practitioners at the post-secondary level.</p> <p>Degree of health promotion activities at the post-secondary level.</p> <p>Degree of services for health promotion for young adults with disabilities.</p> <p><u>Workplace issues</u> Degree of services for young adults who require retraining due to limited credentials.</p> <p>Young adult health and safety in the workplace.</p>	Health surveys	<b>Canadian Community Health Survey (CCHS – Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>National Population Health Survey (NPHS-Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
	Access to Education and Training	<b>Composite Learning Index (CCL)</b>	<a href="http://www.ccl-cca.ca">http://www.ccl-cca.ca</a>
		<b>Adult Education and Training Survey (AETS – Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>Access and Support to Education and Training Survey (ASETS – Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>National Apprenticeship Survey (NAS-Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>Post-secondary student information system (PSIS- Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>Participation in Activity Limitation Survey (PALS)</b>	<a href="http://www.hrsdc.gov.ca/">http://www.hrsdc.gov.ca/</a>
	Health Literacy	<b>International Adult Literacy Survey (IALS)</b> <b>International Adult Literacy Survey and Skills Survey (IALSS)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
	Labour and Workplace-related surveys	<b>Survey of Income and Labour Dynamics (SLID – Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
	<b>Survey of Income and Labour Dynamics (SLID – Statistics</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>	

		<b>Canada)Workplace and Employee Survey (WES – Statistics Canada)</b>	
		<b>Workplace and Employee Survey (WES – Statistics Canada)</b> Association of Workers Compensation Boards of Canada	<a href="http://awcbc.org">http://awcbc.org</a>
	Youth transition to work and/or school	Association of Workers Compensation Boards of Canada <b>Youth in Transition Survey (YITS – Statistics Canada)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>

<b>Healthy Settings</b>	<ul style="list-style-type: none"> <li>• Degree of Health Promotion activities at the post-secondary level.</li> <li>• Level of access to health care professionals at the post-secondary level.</li> <li>• Degree of health promotion services for people with disabilities.</li> </ul>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>• IALSS health literacy analysis for the young adult age group (18 to 34 year olds, or compare 18 to 24 year olds to 25 to 34 year olds)</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>• Degree of coordination of efforts in the area of health promotion on Canadian post-secondary campuses.</li> </ul>

<b>Monitoring and Reporting Area</b>	<b>Organization</b>	<b>Website</b>
Access to education for people with disabilities; general access to post-secondary education and training	Educational Policy Institute HRSDC – A profile of Disability in Canada	<a href="http://heqco.ca/assets">http://heqco.ca/assets</a> <a href="http://www.hrsdc.gc.ca/">http://www.hrsdc.gc.ca/</a>
Health Promotion at the Post-	Centre for Community Health Promotion Research (University of	<a href="http://web.uvic.ca">http://web.uvic.ca</a>

Secondary Level	Victoria)	
Labour Market Involvement	OECD Programme for International Assessment of Adult Competencies (PIAAC)	<a href="http://www.oecd.org">http://www.oecd.org</a>
Health Literacy	<p>Statistics Canada: International Adult Literacy and Skills Survey (IALSS) provides health literacy data on young adults for 2003. Survey may be repeated in 2013 or 2014. Examine health literacy via IALSS using indicators identified by CCL</p> <p>CCL has published reports on health literacy with information about young adults from 2003 survey</p>	<p><a href="http://www.statcan.gc.ca">http://www.statcan.gc.ca</a></p> <p><a href="http://ccl-cca.ca">http://ccl-cca.ca</a></p> <p><a href="http://ccl-cca.ca">http://ccl-cca.ca</a></p>

## ***Adult Working Group***

### **GOALS/PURPOSE**

The Adult Working Group (AWG) seeks to promote an inclusive model of how adult learning fits into the broad arena of health and has worked toward developing a knowledge agenda for promoting the health and learning of adults in: 1) the workplace, 2) health care settings, 3) among families and 4) in communities. Specific target populations have included: a) adults with literacy challenges b) immigrants and refugees, c) adults affected by HIV/AIDS and d) adults living in remote/rural areas. The AWG's work has involved face-to-face, pan-Canadian consultations with marginalized adults in the identified groups who could directly benefit from effective knowledge exchange and translation with respect to health and learning, and with providers and practitioners who work with community members in the priority areas. The outcome of these discussions points to research priorities concerning the learning needed to improve the health of these groups and recommendations to generate, mobilize, disseminate, and translate research-based knowledge into policy and practice change.

Across the consultations with the different groups there are some consistent themes. Participants' responses and recommendations reveal that it is not simply a matter of providing more or clearer information or education about health, although much can be done in these areas. Instead, the consultations suggested that it is crucial to address the "...social determinants of health such as poverty, racism and discrimination, lack of employment opportunities, substandard housing, lack of recognition of foreign credentials, different cultural assumptions, and access to health services, including mental health services."(Adult Working Group, 2008). These factors prevent people from pursuing their own and their family's health, even when they do know what it takes to be healthy. Nevertheless, health literacy remains an important consideration, particularly for adults with low literacy levels and immigrants who face additional language barriers. Learning and obtaining health information rests on having adequate literacy skills and/or access to language training to obtain these skills and on health care providers who are willing to take the time to ensure that their clients understand written and oral communications. Many of the consulted groups were obtaining health information directly from health professionals as well as from their peers.

### **POLICY ISSUES**

**Access to Jobs and Recognition of Foreign Credentials for Immigrants:** The Adult Working Group focused on immigrants and refugees as one priority group. Immigrants face several issues that relate to current Canadian immigration and labour policy. Chief among them is the lack of recognition of foreign credentials particularly in the case of doctors who cannot practice in Canada. The consultation participants identified the lack of doctors who speak immigrants' languages and can provide culturally appropriate health care as a serious problem. They suggested that recognizing the credential of foreign trained doctors could present a solution to the shortage of doctors and could provide a pool of health providers who understand the needs of immigrants and refugees.

Immigrants face discrimination both at work and in obtaining employment. Many jobs require Canadian experience or only recognize Canadian job experience as valid. This means that immigrants qualified in their home country, are unable to work in their profession or field of training. The result is that they must take low paying jobs in which they are not always treated with respect. Mental health issues appear for many immigrants as a result of lowered self-esteem when their worth in the job market has little value. Language is also a barrier to obtaining good jobs. Often lack of English or French language skills means that an immigrant is shut out of many skilled jobs. One recommendation is to offer far more affordable, accessible language classes. The consultation participants would also like to see free higher education and training programs where they could upgrade their skills (Folinsbee et al., 2007).

**Affordable, Accessible and Appropriate Health Care Services:** The lack of availability of doctors generally and more particularly of doctors who understand the language and/or culture of different immigrant groups, as well as long wait times to see doctors discourage newcomers from using the health care system. In addition, little or no access to interpreters in the health care system further affects access and treatment of immigrants. Employing interpreters from the immigrant's own community is not always seen as a viable solution because privacy rights can be violated. One conclusion from the consultations was that physicians should receive sensitivity training to recognize and learn to work with adults who face literacy challenges as well as with immigrants and refugees and with people affected by HIV/AIDS. This should be part of the required training for health providers (Folinsbee et al. 2007; 2008a;2008b). This issue of access to health care is also a concern for people living with HIV/AIDS and for those in remote/rural areas. It is recommended that health-care services to people with HIV/AIDS be increased (Folinsbee et al., 2008b). Key recommendations for rural areas center around having more health care workers and incentives to keep them; more options from health care providers; more local services and coordination of these services; and improved transportation (Folinsbee et al., 2008a).

**Housing:** The need for the government to provide affordable and secure housing was identified by all four priority groups consulted by the working group. It was noted that people cannot learn or study in sub-standard housing conditions. Some providers noted that some people's addresses are changing constantly and that their rooms/accommodations are not secure. One recommendation was to have co-op housing where people could share food and childcare (Folinsbee et al., 2007).

**Poverty Reduction:** The need for poverty reduction has been identified by all four priority groups consulted (Folinsbee et al., 2007; 2008a) Recommendations included increasing social assistance and employment insurance rates, more resources for poverty coalitions, more support for food banks and greater accessibility of public agencies to those living with HIV/AIDS.

**Increase Public Awareness:** Conduct public awareness campaigns in order to educate the public and key stakeholders about HIV/AIDS, and target specific audiences such as young people at risk, schools, churches and hospitals (Folinsbee et al., 2008b).



## Tables of Data Sources and Data Gaps for Adults

Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data ( <b>bolded items indicate surveys</b> )	Source
<p><b>Focusing in four areas:</b> 1) workplace, 2) health care settings, 3) families, 4) communities</p> <p>Four monitoring areas are identified</p> <ul style="list-style-type: none"> <li>-the health and learning of adults with low levels of literacy skills</li> <li>-the health and learning of adults affected by HIV/AIDS</li> <li>-the health and learning of adult immigrants and refugees</li> <li>-the health and learning of adults in remote/rural areas.</li> </ul>	Health	<b>Canadian Community Health Survey (CCHS- Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>National Population Health Survey (NPHS – Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		BC Linked Health Database (BCLHD)	<a href="http://www.chspr.ubc.ca">www.chspr.ubc.ca</a>
		<b>Aboriginal Peoples Survey (APS- Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>First Nations Regional Longitudinal Health Survey (RHS – AFN)</b>	<a href="http://www.rhs-ers.ca">www.rhs-ers.ca</a>
		<b>Physical Activity Monitor</b>	<a href="http://www.cflri.ca">www.cflri.ca</a>
		<b>I-Track Survey (Public Health Agency of Canada)</b>	<a href="http://www.phac-aspc.gc.ca">www.phac-aspc.gc.ca</a>
	Overall well-being	<b>General Social Survey (GSS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Literacy surveys	<b>International Adult Literacy Survey (IALS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>International Adult Literacy Survey and Skills Survey (IALSS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Workplace and labour-related surveys	<b>Survey of Income and Labour Dynamics (SLID)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>Workplace and Employee Survey (WES)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		Association of Workers Compensation Boards of Canada	<a href="http://awcbc.org">http://awcbc.org</a>
Immigrant-focused	<b>Longitudinal Survey of Immigrants to Canada (LSIC - Statistics Canada)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>	
Community resource	Composite Learning Index	<a href="http://www.ccl-cca.ca">www.ccl-cca.ca</a>	

### Adults: Data Gaps

<b>Healthy Settings</b>	<ul style="list-style-type: none"> <li>• Data on smaller Northern communities and other specific areas (e.g., PEI rather than the “Atlantic provinces”)</li> <li>• Qualitative research on the health care needs of specific communities.</li> <li>• Data that demonstrate the systemic discrimination faced by immigrants and refugees and by people living with HIV/AIDS.</li> </ul>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>• Data that examines the link between low income families, immigrant and refugee families and health</li> <li>• First Nations health and literacy data</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>• Examples of promising practices for community wellness.</li> <li>• Data on the effectiveness of particular policy interventions for addressing social determinants of health (e.g., poverty reduction, housing, health literacy, etc.)</li> <li>• Longitudinal data that tracks the outcomes of community capacity-building efforts related to learning and health over a period of several years</li> </ul>

Monitoring and Reporting Area	Organization	Website
Health and learning issues related to AIDS	Canadian AIDS Society	<a href="http://www.cdnaids.ca">www.cdnaids.ca</a>
Mental Health among refugees	Canadian Mental Health Association	<a href="http://www.ontario.cmha.ca">www.ontario.cmha.ca</a>
Support to refugees in Canada	UNHCR (UN Refugee Agency) Canadian Council for Refugees	<a href="http://www.unhcr.org">www.unhcr.org</a> <a href="http://www.ccrweb.ca">www.ccrweb.ca</a>

Health Literacy	Statistics Canada: 2003 IALSS provides data on health literacy of adults. Statistics Canada may repeat survey in 2013 or 2014 CCL has published data on adults from 2003 survey	<a href="http://www.statcan.gc.ca">www.statcan.gc.ca</a> <a href="http://www.ccl-cca.ca">www.ccl-cca.ca</a>
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## ***Older Adult Working Group***

### **GOALS/PURPOSE**

The Older Adults working group is led by The Canadian Network for Third Age Learning (CATALIST). The objectives developed by CATALIST to guide this work are: the identification of the primary health challenges faced by older adults with an eye towards how learning could assist them to overcome these challenges; the promotion of promising practices and strategies for disseminating knowledge relevant for both healthy older adults and those who must learn to cope with health challenges; and the encouragement of researchers and health professionals to work together with older adult learning organizations and seniors groups to enhance the well being of older adults across Canada. The Older Adult group uses a network approach, working through approximately 50 senior centers affiliated with colleges and universities around the country. The working group also targets health care professionals who work with older adults, to raise awareness around health literacy.

The working group cites significant knowledge transfer and knowledge translation challenges in the senior sector. Much of the research about the health and ageing of older adults is found only in academic articles and presentations, written at a level appropriate for researchers and scholars, not lay persons. The research topics focus largely on illness, ignoring the large number of seniors who live independently in relatively good health. It is important to have this vital information about ageing and health accessible to all seniors. Involving seniors in the research as participant researchers, repackaging useful information found in academic sources using a multi-media approach in recognition of diverse learning styles, and using senior organizations to disseminate health and learning information to their members, are strategies suggested by the working group to meet these challenges.

### **POLICY ISSUES**

**National resource sharing of information and dissemination:** Networks of older adult organizations and seniors centres across Canada should be encouraged to share resources they have developed to encourage healthy ageing. They should also be encouraged to work closely with gerontology research centres and others who conduct research on older adult health concerns to ensure that it is relevant and accessible to older adults. These networks could also be used to effectively disseminate knowledge about healthy living to older adults across Canada since many of them have newsletters, websites and other means of communication with seniors groups.

**Planning for Healthy Seniors:** The majority of government agencies that are responsible for seniors are located within Ministries or Departments of Health. This is somewhat surprising since 80% or more of those over the age of 65 are living independently and are considered to be seniors who are quite well. More recognition of and appropriate planning for the majority of seniors who are and will remain healthy.

**Funding Seniors' Programs:** Training people to enter and compete in the labour force is a government funding priority. Seniors fall outside of this group yet learning remains a strong value, especially for seniors living independently. Research shows that being active in learning activities has positive health benefits, including extending a person's life, with the potential of keeping seniors from having to go into costly residential care. Too often, however, seniors' programs that allow for continued education are underfunded or lack funding altogether. Most are run on a cost recovery basis and often, although not always, are not charged overhead costs by Universities. Provincial or Federal funding to enhance the life of seniors through learning activities and continuing education programs should be a policy priority. In the past, Canada provided a tax credit for older learners. This has been replaced with the Healthy Living strategy – which allows for deductions of sports for children but nothing comparable for seniors.

**Ageism:** Some older adults appear to face discrimination when it comes to inclusion in health promotion programs and health services. Elder abuse and neglect is an issue for some older adults since society does not always recognize their human rights

## Tables of Data Sources and Data Gaps for Older Adults

Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data <b>(bolded items indicate surveys)</b>	Source
Degree of knowledge transfer and translation	General well being	<b>National Population Health Survey (HPS)</b> <b>Aboriginal Peoples Survey (APS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Literacy	<b>International Adult Literacy Survey (IALS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
		<b>International Adult Literacy Survey and Skills Survey (IALSS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Learning, social support and aging	<b>General Social Survey (GSS)</b>	<a href="http://www.statcan.ca">www.statcan.ca</a>
	Aging Specific	CIHR Institute of Aging	<a href="http://www.cihr-irsc.gc.ca">www.cihr-irsc.gc.ca</a>
	Composite measures	Composite Learning Index	<a href="http://www.ccl-cca.ca">www.ccl-cca.ca</a>
	Health Promotion	Provincial Websites for Seniors	<a href="http://www.seniors.cimnet.ca">www.seniors.cimnet.ca</a> (MB) <a href="http://www.health.gov.bc.ca">www.health.gov.bc.ca</a> (BC) <a href="http://www.gov.ns.ca/scs/publications.asp">www.gov.ns.ca/scs/publications.asp</a> (NS) <a href="http://www.fadoq.ca">www.fadoq.ca</a> (QC)
		National Websites for Seniors	<a href="http://www.culture.gov.on.ca/seniors/">www.culture.gov.on.ca/seniors/</a> (ON) <a href="http://www.seniors.gc.ca">www.seniors.gc.ca</a> (Seniors Canada Online)

## Older Adults: Data Gaps

<b>Healthy Settings</b>	<ul style="list-style-type: none"> <li>• Access to Seniors Centres, programs and organizations</li> <li>• Health promotion activities available at Seniors Centres, Long Term Care Facilities, etc.</li> <li>• Access to health care professionals and treatments - ageism</li> <li>• Data for seniors living on reserves</li> <li>• Data re Aboriginal and immigrant/refugee seniors access to seniors centres and programs</li> </ul>
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>• Degree of Knowledge transfer and translation among seniors</li> <li>• Level of health promotion activities in Canada</li> <li>• Data for older ESL adults</li> <li>• Data for older adults living on reserves</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>• Number and SES of older adults participating in seniors centres, seniors programs or seniors organizations</li> <li>• inventory of seniors programs by location and type – i.e. physical activity, learning, etc.</li> <li>• involvement of Aboriginal seniors in seniors programs</li> <li>• Involvement of visible minority seniors in programs</li> <li>• Involvement of francophone seniors out side QC in seniors programs</li> <li>• coordination of seniors programs to extend reach</li> </ul>

<b>Monitoring and Reporting Area</b>	<b>Organization</b>	<b>Website</b>
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Health	Health Canada: Division of Aging and Seniors	<a href="http://www.phac-aspc.gc.ca">http://www.phac-aspc.gc.ca</a>
Health Promotion among seniors	Veterans Affairs Canada	<a href="http://www.vac-acc.gc.ca">http://www.vac-acc.gc.ca</a>
Mental Health	Canada Mental Health Association	<a href="http://www.ontario.cmha.ca">http://www.ontario.cmha.ca</a>
Funded Community Project to Engage Seniors	New Horizons Grant Funded projects (Human Resources and Social Development Canada)	<a href="http://www.hrsdc.gc.ca">http://www.hrsdc.gc.ca</a>
Health Literacy	Statistics Canada: IALSS (2003) has be used to measure health literacy among older adults. The survey may be repeated in 2013 or 2014 CCL has published reports based on 2003 survey data on health literacy among older adults	<a href="http://www.statcan.gc.ca">http://www.statcan.gc.ca</a>  <a href="http://www.ccl-cca.ca">http://www.ccl-cca.ca</a>

## ***Other Voices Working Group***

### **GOALS/PURPOSE**

This working group, based at the University of Victoria, is intended to provide meaningful involvement and give voice to those traditionally excluded from major provincial and national initiatives. The population of interest includes people who are homeless, drug addicted, sex workers, those with mental health problems, and/or experience with the criminal justice system, those with non traditional sexual orientations, and those with very low literacy levels. The working group seeks to actively engage these marginalized groups in learning about and advocating for their health with the recognition of the value of lived experience and the important role insider knowledge plays in the development and exchange of knowledge. These groups are at considerable risk for significant health problems. The working group is committed to giving these marginalized groups a public voice through forums for dialogue with policy makers, academics, community organizations, and adult learning organization representatives. The working group also provides policy and resource support for capacity building among marginalized individuals and group organizations, seeking as well to increase the education of policy makers and research institutions as to the value of inclusive processes, and to increase the access of marginalized groups to collaborative research. The working group advocates the development of materials written especially for marginalized groups as well as training materials that will support meaningful involvement of these groups in community based research activities. CCL has sponsored roundtables with demonstration pilot projects and addiction models that focus on inclusion of these marginalized voices in the policy planning and solution process.

### **POLICY ISSUES**

**Hearing other voices:** Despite awareness in policy circles that policies determined in the abstract often have little practical value on the ground, marginalized groups are still left out of the process. Strategies should be developed for including those voices that are not heard, particularly when setting policies that affect them.

**Examples of narrow and abstract policy:** Currently policy around addiction requires that an addict remain clean for 30 days in order to qualify for entrance into a treatment facility. The policy effectively eliminates treatment for many addicts who want treatment but need it much more immediately. Many treatment facilities also will not allow a parent to enter with his or her children, requiring removal of the children which stands as a further barrier to seeking treatment. In addition, there is little focus on aftercare, once an individual successfully completes treatment. There is a real and pressing need for long-term aftercare to prevent recidivism.

Policy in many communities around sex workers also fails to take the practical realities of this group into account. Prostitution is legal in Canada, however, it is criminal to negotiate price, work with other sex workers and work on the street, making it impossible to work in the sex industry without punitive consequences. In Victoria, sex workers and

agencies must purchase business licenses, however, often they do not receive the same services other businesses receive. The laws and policies surrounding sex work are confusing and contradictory. In Victoria sex workers are often "red zoned" or prevented from going into certain areas of the city; in this case, the areas where they would go to access the social services they need. Such policies remain a major barrier for bettering the life of these marginalized groups and indicate that there is a very real need to include them in the planning process.

## Tables of Data Sources and Data Gaps for Other Voices

Other Voices			
Monitoring and reporting areas of focus identified by the working group	Global areas of indicator measures	Examples of measures and organizations that track data (bolded items indicate surveys)	Source
<p>Degree of health and learning promotion activities among marginalized groups.</p> <p>Degree of voice that marginalized population have in steering policies.</p> <p>Degree of supports that promote health (as opposed to hindering).</p>	Specific Populations	<b>First Nations Regional Longitudinal Health Survey (RHS – AFN)</b>	<a href="http://www.rhs-ers.ca">http://www.rhs-ers.ca</a>
		<b>Longitudinal Survey of Immigrants to Canada (LSIC)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>Aboriginal Peoples Survey (APS)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>
		<b>Ethnic Diversity Survey (EDS)</b>	<a href="http://www.statcan.ca">http://www.statcan.ca</a>

<b>Healthy Settings</b>	
<b>Health Literacy</b>	<ul style="list-style-type: none"> <li>• Very little data on health literacy in any marginalized group</li> </ul>
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>• Degree of involvement in policy-making among marginalized populations</li> </ul>

<b>Monitoring and Reporting Area</b>	<b>Organization</b>	<b>Website</b>
Health and learning issues related to AIDS	Canadian AIDS Society	<a href="http://www.cdnaids.ca">http://www.cdnaids.ca</a>
Mental Health among refugees	Canadian Mental Health Association	<a href="http://www.ontario.cmha.ca">http://www.ontario.cmha.ca</a>
Support to refugees in Canada	UNHCR (UN Refugee Agency)	<a href="http://www.unhcr.org">http://www.unhcr.org</a>
Health Literacy	The Centre for Population Health Promotion Research at UBC conducts studies related to health literacy in vulnerable populations	<a href="http://www.ihpr.ubc.ca">http://www.ihpr.ubc.ca</a>

## ***Health Human Resource Capacity Building for Health Literacy – Education Strategies for Health Professionals***

### **GOALS/PURPOSE**

Led by the British Columbia Academic Health Council, the aim of this working group was to build capacity in education and learning systems and health authorities and agencies around awareness and skills of health professionals for dealing with health literacy issues and those of patient self-management support.

Success for this work was measured in the recognition for health literacy and its importance in patient self-management support in health professional conferences/continuing education and in formal academic health professional education programs both in British Columbia and across Canada. Ultimately the goal was to improve supportive patient care with better health outcomes.

The BC Academic Health Council worked on several different fronts to build capacity in this area:

- Research on patient self-management support and health literacy and capacity building in health professionals for this work.
- Development of an education resource list on health literacy.
- Consultations with accreditation bodies, professional colleges, educators, practitioner leads, health professional associations, and Ministries of Health and Education nationally about how to move health literacy and patient self-management support onto agendas and into health education programs.
- Development of a national workshop in British Columbia in conjunction with the Adult Working Group, and the Early Childhood Working Group, also part of HLKC. The purpose of the workshop was to offer an opportunity for health and learning exchanges, discuss barriers and approaches to surmount them and develop a regional action plan which addresses recommendations that arise from consultations with various stakeholders.
- Development of the beginnings of a British Columbia Health Literacy Strategy with a number of stakeholders in order to develop a model that could be relevant and utilized in other parts of the Canada.

### **POLICY ISSUES**

**National Resource Sharing and Dissemination of Information:** There are continuing education programs and resources/health literacy materials in the country and elsewhere but very little public awareness of these activities or where to get information exists.

**Increased Awareness of Health Professionals, and Health and Education Systems about the Importance of Health Literacy in Achieving Good Health Outcomes:** The importance of health literacy in achieving good health outcomes needs to be accorded a more prominent role with health professionals and in health educational programs that promote better health.

**Recognizing Culture and Language Issues within Health Literacy:** Issues arise about different understandings of health based on culture and/or language that need to be addressed as part of health literacy.

**Table of Data Source and Data Gaps for Health Human Resource Capacity Building**

<b>Health Human Resource Capacity Building</b>			
<b>Monitoring and reporting areas of focus identified by the working group</b>	<b>Global areas of indicator measures</b>	<b>Examples of measures and organizations that track data (bolded items indicate surveys)</b>	<b>Source</b>
Health Professionals Awareness of Health Literacy	Health professionals addressing health literacy needs	BC Rural and Remote Research Network (BC Cancer Agency)	<a href="http://www.bcurrhn.ca">www.bcurrhn.ca</a>
		BC Mental Health & Addictions Services, Provincial Health Services Authority (PHSA) – BC Mental Health Literacy Strategy	<a href="http://www.bcmhs.bc.ca">www.bcmhs.bc.ca</a>
		BC Centre of Excellence for Women’s health, PHSA – health literacy resources for diverse groups of women with substance abuse and mental health problems	<a href="http://www.bccewh.bc.ca/knowledge-generation/addictions-research-projects.htm">www.bccewh.bc.ca/knowledge-generation/addictions-research-projects.htm</a>
		Collaborative of primary care physician practices and literacy coordinators – Impact BC and BC Ministry of Health Services	<a href="http://www.impactbc.ca">www.impactbc.ca</a>
		Canadian Public Health Association – Health literacy programs	<a href="http://www.cpha.ca">www.cpha.ca</a>
		Public Health Agency of Canada	King J. Environmental Scan of Interventions to Improve Health Literacy. Final Report, March 2007 <a href="http://www.nccdh.stfx.ca">www.nccdh.stfx.ca</a>
		Government of Nova Scotia – Health literacy as part of primary	<a href="http://www.gov.ns.ca/health/pri">www.gov.ns.ca/health/pri</a>

		Guysborough Antigonish Strait Health Authority, Nova Scotia – Awareness building sessions	Carpenter CA, Sears SA, Gillis DE. Building Capacity Among Primary Health Care Providers to Address Literacy and Health Awareness Building Session Evaluation <a href="http://www.erhb.ns.ca/literacy/HLAE_Apr2005.pdf">http://www.erhb.ns.ca/literacy/HLAE_Apr2005.pdf</a>
		St. Francis Xavier University, Nova Scotia	McNeil_Mulak S. Literacy and Health: Environmental Scan Summary: Examining the Level of Awareness, Programs and Policies in Nova Scotia's Health Care Sector. Health Literacy in Nova Scotia Research Project, 2004.
		Manitoba – Literacy Partners	Report – Moody C & Rose M. Literacy and Health: Defining Links and Developing Partnerships. A Final Report to Population Health <a href="http://www.health.mb.literacy.ca/projects/defining/defining.pdf">http://www.health.mb.literacy.ca/projects/defining/defining.pdf</a>
	Health Professional Groups	Canadian Association of Occupational Therapists – Position Statement Health and Literacy (2006)	<a href="http://www.caot.ca/default.asp?nameid=273">http://www.caot.ca/default.asp?nameid=273</a>

	Health Literacy Curricula	Collection of Curricula by Andrew Pleasant	<a href="http://www.advancinghealthliteracy.com/curricula.html">http://www.advancinghealthliteracy.com/curricula.html</a>
	Framework and Indicators for Capacity Building	BC Academic Health Council Developed dimensions and indicators to measure capacity building around health literacy in formal health professional programs	Lesson in Learning: Framework and Indicators for Capacity Building Around Health Literacy in Formal Health Professional Education Programs <a href="http://www.bcahc.ca/index.php?option=com_docm">http://www.bcahc.ca/index.php?option=com_docm</a>

Healthy Settings	<ul style="list-style-type: none"> <li>▪ Data on health professionals' role across settings with regard to health literacy</li> </ul>
Health Literacy	<ul style="list-style-type: none"> <li>▪ Data on number of continuing education and formal programs which include health literacy in training of health professionals in Canada</li> </ul>
Capacity Building	<ul style="list-style-type: none"> <li>● Data on what works and what doesn't in capacity building in this area</li> </ul>

Monitoring and Reporting Area	Organization	Website
Awareness of health literacy issues by health professionals	Health professional associations	See above for possible data sources
	Universities – health professional programs	

## ***Community Based Practice Driven Research***

### **GOALS/PURPOSE**

The purpose of this working group, led by Douglas College, is to bring community based research (CBR) researchers together, explore and identify roles for higher education institutions, and develop professional resources for CBR, practice driven research in the area of health and learning. The mandate of this group has not been limited to any specific population or particular setting. Unlike other working groups, the focus of this group has been on process, more specifically an approach to research, rather than a focus on a particular age group or target population.

Community-based research (CBR) takes place in community settings and involves community members as active participants in the design and/or in the implementation of research projects. Typically CBR involves a partnership between communities or community organizations and academic researchers. CBR initiatives are action-oriented and intent on effecting real change through the policies and practices at local and regional levels. These principles shape the nature of the collaborative relationship, and ultimately guide the research design and choice of research methodologies.

(<http://wellesleyinstitute.com/issues/community-based-research/overview>).

The group has consisted of members from a number of academic institutions, both colleges and university as well as wide range of not-for-profit agencies such as Planned Parenthood in Ontario and the HIV/AIDS CBR Capacity Building Program in BC. To date, the panel completed an environmental scan in 2007 of Community Based Research in Health and Learning, a national survey in 2008 of Community Based Research in Canadian Colleges and Institutes and mounted a symposium, *Conversations on Community Based Research (CBR): Engaging college faculty and students*. The group is currently involved in strengthening networks among CBR researchers and is creating web-based professional development modules for the CBR community.

### **POLICY ISSUES**

The policy issues defined for this working group reflect a desire to increase the visibility and utilization of CBR. Largely based on qualitative methods (see discussion of validity for naturalistic inquiries), the focus of CBR is grounded in the problems and questions generated by local stakeholders. The methodological conservatism that has weighed down funding agencies and academic communities in the last decade (Lincoln and Cannella, 2004) have had a significant impact on the esteem with which CBR is held in those circles. This means that when careful and methodologically sound CBR research is done, the results are often discounted. The discourse, initiated over 30 years ago, that opened the doors of institutions and university departments to qualitative methods, should be re-introduced given the more recent methodological fundamentalism. This type of research has an important

role to play in setting inclusive public agendas and policy, and in developing the awareness and capacity for action of communities, in light of concerns and issues that are brought to light by community involvement and ownership of the research process.

## Tables of Data Sources and Data Gaps for Community Based Research

Community Based Practice Driven Research		
Areas of focus identified by the working group	Examples of reports and organizations that document data	Source
<p>Degree of involvement of marginalized groups in the different stages of research about health and learning.</p> <p>Impact of Community Based Research on health and learning practices and policies.</p> <p>Higher Education policies and tenure requirements: Degree of support and recognition within academic organizations of Community Based Research</p> <p>Involvement of specific groups in CBR about Health and Learning</p>	<p><b>A Snapshot of CBR in Canada</b></p> <p><b>Survey of CBR in Colleges</b> (to be posted on the Health and Learning Knowledge Centre website).</p> <p>Wellesley Institute:</p> <p>Loka Institute:</p> <p>Community-Campus Partnerships for Health (CCPH)</p> <p>Canadian Aboriginal AIDS Network</p>	<p><a href="http://depts.washington.edu/ccph/pdf_files/CDR%20snapshot%20report%20final.pdf">http://depts.washington.edu/ccph/pdf_files/CDR%20snapshot%20report%20final.pdf</a></p> <p><a href="http://wellesleyinstitute.com/research/cbr-practice">http://wellesleyinstitute.com/research/cbr-practice</a></p> <p><a href="http://wellesleyinstitute.com/issues/community-based-research/cbr-policy-impact">http://wellesleyinstitute.com/issues/community-based-research/cbr-policy-impact</a></p> <p><a href="http://www.loka.org/index.html">http://www.loka.org/index.html</a></p> <p><a href="http://www.ccpnh.info/">http://www.ccpnh.info/</a></p>

Community Based Practice Driven Research	
Healthy Settings	<ul style="list-style-type: none"> <li>CBR as a beneficial approach to research to involve a variety of non traditional actors in research about their experiences with healthy settings</li> </ul>
Health Literacy	<ul style="list-style-type: none"> <li>Measurement and monitoring of impacts and outcomes of CBR projects on the Health Literacy of groups meaningfully involved in research project</li> <li>CBR as a research approach that can bring different voices to the values and different dimensions of health literacy</li> </ul>

<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>● Documentation, monitoring and evaluation of individual, group and community learning and capacity outcomes by CBR projects</li> <li>● Impact of CBR involvement on capacity in marginalized groups and underprivileged communities</li> <li>● Benefits of involvement of academic researchers in CBR on their teaching, research skills and community understanding</li> </ul>
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<b>Community Based Practice Driven Research</b>		
<b>Monitoring and Reporting Area</b>	<b>Organization</b>	<b>Website</b>

## **References**

- Adult Working Group (2008) *Adult Working Group's Cross-National Consultations on Health and Learning, Final Report*. Unpublished report to the HLCK.
- Brownell M. D., Roos, N., Fransoo, R., Guevremont, A., MacWilliam, L., Derksen, S., Dik N., Bogdanovic, B., & Sirski, M. (2004). How do educational outcomes vary with socioeconomic status? *Key findings from the Manitoba Child Health Atlas 2004*. Winnipeg, Manitoba: Manitoba Centre for Healthy Policy.
- Brownell M. D., Roos, N. P., Fransoo, R., Roos, L. L., Guèvremont, A., MacWilliam, L., Yallop, L., & Levin, B. (2006). Is the class half-empty? A population-based perspective on socio-economic status and educational outcomes. *IRPP Choices*, 12(5),1-30.
- Canada Yearbook, (2006). Statistics Canada.
- CCRU (2004). *Trend and Analysis: Early Childhood Education and Care in Canada 2004*. Childcare Resource and Research Unit at the University of Toronto.
- Doherty, Gillian & Forer, Barry (2004). *Shedding new light on staff recruitment and retention challenges in child care*. Report prepared for the Child Care Human Resources Sector Council.
- Fédération des cégeps, (2005). *Rapport de recherché sur les services psychosociaux et les services de santé dans les collèges en 2002-2003*. <http://www.fedecegeps.gc.ca>.
- Folinsbee, S, Kraglund-Gauthier, W., Grégoire, H. & Quigley, A. (2007). *State of the Field Report for Health and Adult Learning*. Report prepared for the Health and Learning Knowledge Center, Canadian Council on Learning.
- Folinsbee, S, Kraglund-Gauthier, W., Grégoire, H. & Quigley, A. (2008a). *Adult Working Group's Cross-National Consultations on Health and Learning Final Report on Adults Living in Rural and Remote Areas*. Report prepared for the Health and Learning Knowledge Center, Canadian Council on Learning.
- Folinsbee, S, Kraglund-Gauthier, W., Grégoire, H. & Quigley, A. (2008b). *Report on consultations with adults living with HIV/AIDS*. Report prepared for the Health and Learning Knowledge Center, Canadian Council on Learning.
- Greenwood, D. J. & Levin, M. (2005). Reform of the social sciences, and of universities through action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage Handbook of Qualitative Research*, (3<sup>rd</sup> edition, pp. 43-64). Thousand Oaks, CA: Sage.

- Guba, E. G. & Lincoln, Y. S. (1982). Epistemological and methodological bases of naturalistic inquiry. *Educational Communications and Technology Journal*, 31(4), 233-252.
- Guba, E. G. & Lincoln, Y. S. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. Williams (Ed.), *Naturalistic evaluations*. New Directions for Evaluation, no 30. San Francisco: Jossey-Bass.
- Guba, E. G. & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage Handbook of Qualitative Research*, (3<sup>rd</sup> edition, pp. 191-216). Thousand Oaks, CA: Sage.
- Gulli, Cathy & Lunau, Kate (2008) *Adding fuel to the doctor crisis*. Macleans.ca: /science/health/article.jsp?content=20080102\_122329\_6200.
- Health and Learning Business Plan* (2005/2006), Unpublished document, Canadian Council on Learning.
- Hertzman, Clyde (2008). *The world's best system of child development statistics for Canada: Strategies for Federal-Provincial-Territorial collaboration*. Unpublished document prepared by the Monitoring Committee of the Early Child Learning Knowledge Center.
- Hertzman, C. & Williams, R. (to be published 2008) Commentary, Making Early Childhood Count: Monitoring Early Child Development in Canadian Children. *Canadian Medical Association Journal*.
- Lather, P. (1993). Fertile obsession: Validity after poststructurealism. *Sociological Quarterly*, 34(4), 673-693.
- Lincoln Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lincoln Y. S. & Cannella, G. S. (2004). Dangerous discourses: Methodological conservatism and governmental regimes of truth. *Qualitative Inquiry*, 10(1), 5-14.
- McCall, Doug (2007). *Monitoring and Reporting on Key Health, Learning and Program Indicators in School Health Promotion*. Unpublished HLKC School Age working group document .
- McCall, Doug (2006). School health working group progress report. Progress report to HLCK, September 30.
- Peshkin, A. (1993). The goodness of qualitative research. *Educational Researcher*, 22(2), 24-30.

- Roos, N. P., Brownell, M., Guevremont, A., Fransoo, R., Levin, B., MacWilliam, L., & Roos, L. (2006). The true story: A population-based perspective on school performance and educational testing. *Canadian Journal of Education*, 29(3), 1-22.
- Rootman, Irv (2007) Presentation on Expert Panel on Literacy. *Building Data Systems for Health and Learning: Identifying Indicators and Issues*. Health and Learning Knowledge Centre Workshop, February 28-29, 2007.
- Schwandt, T. A. (1996). Farewell to criteriology. *Qualitative Inquiry*, 2, 58-72,
- Schwandt, T. A. (2007). Judging interpretations. *New directions for evaluation*, 114, 11-14.
- Sussman, S., Valente, T., Rohrbach, L., Skara, S., & Pentz, M. (2006). Translation in the health professions. *Evaluation & the Health Professions*, 29(1),7.
- Zumbo, Bruno (2008). Testing and measurement from a multi-level view: Psychometrics and validation. Paper presented in invited session, *The big challenges and research opportunities in testing and measurement*. AERA, NY, New York.