



Summary of the Adult Working Group's
Seaforth Consultations
on Health and Learning with Adults
Living in Rural and Remote Areas

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

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I. Introduction

A. Background Information

[The Health and Learning Knowledge Centre](#) (HLKC) serves as a national network linking expertise about the vital connections between the learning and health of Canadians. In June 2005, the [Canadian Council on Learning](#) (CCL) held a Health and Learning Knowledge Centre consultation in Vancouver, British Columbia. At the consultation, participants agreed to establish various working groups to address the work of the HLKC. These working groups address life stages in health and learning and concentrate on settings, places, and communities where health and learning takes place.

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

These themes are:

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

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

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

The AWG identified priority groups at the outset¹ as follows:

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

Issues of gender and racialization² have been included across this range of priority areas. The AWG's work involved direct discussion with marginalized adults who could benefit from effective knowledge exchange and translation with respect to health and learning.

The Adult Working Group's (AWG) priority groups for 2006–2007 were immigrants and refugees and adults with low literacy skills. The AWG conducted cross-national consultations with community members from these groups along with practitioners and service providers who work with them. In 2007–2008, the AWG conducted cross-national consultations with adults living in rural and remote areas and adults living with HIV/AIDS.

The Seaforth consultation was part of a series of meetings with adults living in rural and remote areas which also took place in Fort Liard, Northwest Territories, and Inverness, Nova Scotia.

B. Purpose of the Consultations

The purpose of the consultations with all four priority groups was to develop a knowledge agenda to advance health and learning in Canada, especially for vulnerable and marginalized adults. From the consultations, the AWG wished to identify themes, gaps, and needs related to health and learning as experienced by these groups. This knowledge agenda will point to research priorities concerning the learning needed to improve the health of these groups and will include a plan to generate, mobilize, disseminate, and translate research-based knowledge into policy and practice change. This, we hope, will also ultimately result in a greater understanding of the relationship between health and learning, and in initiatives to improve the health status of those groups across Canada.

¹ The priority group of Aboriginal adults was removed from the AWG plan because the Aboriginal Learning Knowledge Centre was established by the CCL in 2006. See <http://www.ccl-cca.ca/CCL/AboutCCL/KnowledgeCentres/AboriginalLearning/index.htm>

² In this context, the terms “racialization” and “racialized” refers to a categorization or differentiation made of individuals based on race.

II. Consultation Methodology

A. Consultation Plan

A plan for the national consultations was developed by the AWG as part of its work in 2005–2006. The AWG hired the services of Lindsay Angelow, a health promotion student who worked out of [Access Alliance Multicultural Community Health Centre](#) in Toronto to help develop the consultation plan.

The AWG worked with Harold Flaming, executive director of [The Ontario Rural Council](#) (TORC) to organize and conduct the Seaforth consultations with adults living in rural areas. The tasks included identifying and securing participants for the consultation and making all the logistical arrangements.

B. Consultation Format and Questions

The session was three hours long with lunch served at the completion of the consultation. The format of the session was designed to include both community members and service providers. The session started with introductions of the consultation team—facilitators, note takers and participants. This was followed by a review of the ethics and informed consent practices with participants.³ The group then split into two smaller groups based on whether they were a community member or service provider.

Participants responded to questions⁴ in the following categories:

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

The two groups then came together again to report back on their discussion.

³ Please see Appendix A for Consent Practices.

⁴ Please see Appendix B for Consultation Questions.

Participants were also asked to complete a one-page anonymous background information sheet. Participants indicated particulars such as their gender, age range, employment status, and level of education. An honorarium of \$40 was made available to each participant.

III. Findings

Health care [management] is moving from the provincial government to a community level.

– **Community group**

This section summarizes the findings from the Seaforth consultation. The summary includes an overall profile of participants in the sessions and responses to consultation questions. AWG recommendations have been included in the final report on its 2007–2008 consultations.

A. Participant Profiles

Twenty adults participated in total. They were from rural areas in four Ontario counties—Huron, Perth, Bruce, and Grey.

In total, 13 community members participated. There were five women and eight men. Ten participants were 51 years of age or older and three participants were over 60. Participants had a range of educational backgrounds. One person had less than a high school diploma, four people had a high school diploma, two had community college diplomas and five had university degrees. Three people were retired, and ten were employed. Those employed worked in farming, carpentry, small businesses, banking, teaching, real estate and social services.

There were seven participants representing providers. Six participants were women and there was one man. The majority were between 41 and 60 years of age. They worked in social services, public health, community health, and health policy. They indicated they were nurses, nurse practitioners, administrators and one university lecturer.

Service providers indicated that they worked with a wide range of people from prenatal to elderly, including palliative care. The populations they work with include culturally diverse groups, high-risk families, those with low social economic status, those with mental health issues, people with drug issues and addiction problems, and stroke victims (See Table 1).

Community Member Participant Characteristics (20 Participants: 13 community members, 7 service providers)	
<i>Community Members</i>	
• Employment Status	
Employed	10
Retired	3
• Education	
Less than high school	1
High school diploma	4
College diploma	2
University degree	5
• Age	
51 years or older	10
More than 60	3
• Gender	
Female	5
Male	8

Table 1: Community member participant characteristics

B. Summary of Responses to Consultation Questions

i. Concepts of Health and Being Healthy

If you live on a farm during the winter, you are unlikely to exercise [because you are] trapped in the home by weather conditions.

– **Service provider**

Concepts of health

A key theme coming from the community members' session was that health is the ability to do what one wants as well as preventing illnesses. Some participants discussed the spiritual, mental, and environmental dimensions of health, and the fact that health is affected by a wide spectrum

of factors. One idea raised was that health is moving from a focus on disease to more of a wellness attitude with a focus on healthy living.

Some providers felt that there was a shift in health where clients are seeing that they can change their health and that there is more of a focus on wellness. For example, some patients realize that doctors do not have time for wellness and have taken this on themselves. Another example of this shift was from a long-term care perspective where seniors are no longer waiting to die but want to live. As a result, they want activities and have high expectations. The idea that long-term care providers are there to serve rather than care for clients was emphasized.

Others disagreed and felt the focus of their clients was still the absence of disease. They indicated there was still a lot of work to be done. Comments indicated that if people do not feel sick they are not sick, and they want a quick fix through drugs when they are sick. Some providers felt that even if they give their clients all the information about being healthy and they understand it, they may not want to change their attitudes.

Keeping in good health

Community members reported that keeping in good health means paying attention to both mental and physical health. Many people said they are involved in a lot of physical activities such as walking, working out, sports, and yoga to keep healthy. They suggested strategies to improve physical health such as using community trails, walking, and taking stairs instead of elevators. However, other comments suggested that if one has a disability, the situation is very different. In addition, some people mentioned the difficulty in finding balance and in finding time or motivation to exercise. Healthy food was addressed as going hand-in-hand with physical activity. The issue of processed foods was raised along with the need to stop buying these products so manufacturers will change their products.

Others emphasized the need for spiritual and mental health as well. The family was mentioned as key to mental health—facilities where families can do things together, have meals together, and attend regular family get-togethers. Other ways to keep in good health include social relationships, church, and reading about health issues.

Factors that make being healthy difficult in rural areas

Poverty

Providers identified poverty as another factor affecting a hierarchy of needs in rural areas. The large population that are in poverty, the working poor, will be more concerned with putting food on the table and having a place to live than their health. Therefore, health and wellness fall to the bottom of priorities. In addition, people may be more concerned with the short term when they make health decisions because the long term does not matter or may never come. For example, some people may find smoking acceptable because it helps them get through the day.

Transportation

One factor that makes it difficult to be healthy according to both community members and service providers is access to transportation. Transportation was identified as a significant issue in terms of staying healthy and accessing health services. The issue of transportation is interconnected with age, socioeconomic status, and weather. For example, getting to a fitness facility becomes more difficult with age and distance, especially with weather complications. In fact, there may be a lack of public facilities and cost of some facilities will be a barrier. In other cases, there may be no transportation such as taxis to get to services. Lack of transportation is connected with affordability and disability access.

Isolation

In the community member group, participants identified isolation as a serious issue. One participant explained isolation with an example of farmers who spend a lot of time alone and take work personally. This can lead to mental health issues. Connected with isolation was the loss of places for the community to come together. Examples given were church and other building closures, leading to loss of community meeting places and spiritual leaders.

Health seen as a local community responsibility

Community members indicated that there is a shift to health as a responsibility of the individual and that there is choice in terms of making informed decisions about health. However, some participants indicated that they do not take enough responsibility for their own health—that it is difficult to do so.

Responses indicated that there is also a shift from government to looking after people to communities and their members looking after themselves. Health is being quietly off-loaded to communities. The off-loading is taking place as a preventative measure because government cannot pay for it. Several comments focused on the need to lobby politicians for funding for health care.

The general thrust of the group was that communities need to take ownership of health, healthcare, and health policy. Grassroots organizations need to be involved and local people, not elected officials, should run health in their communities. One positive aspect of the aging population is that people have time to look after themselves and to lobby politicians. One comment indicated that it is hard for Torontonians to understand local problems because people have never been to a farm.

ii. Learning about Health and Getting Information about Health

Getting information about health

Participants made it clear that there are a variety of ways that people in rural areas get information about health that fits their comfort level. People usually get their information from what they consider a trusted source.

While some community members get the majority of their information from the Internet, others, including seniors, may not be computer literate. In addition, many people may not have computers and the Internet may not always be reliable. Service providers indicated that there is a lack of access to the Internet in rural areas which technologically lag behind urban centres. Libraries may be a source of information for some, but others who do not like reading will not use this source. Other sources where community members get information about health include word-of-mouth, clubs, television, magazines, and Family Health Teams (FHTs)⁵. It was noted that male farmers would not likely get their information from print materials.

⁵ According to the Ontario Ministry of Long Term Care, a Family Health Team (FHT) is an approach to primary health care that brings together different health care providers to co-ordinate the highest possible quality of care for the patient. FHTs are designed to give doctors support from other complementary professionals such as nurses, nurse practitioners and other health care professionals who work collaboratively. FHTs are intended to bring better health care services to Ontarians. There are 150 teams altogether.

Barriers to getting information about health

Participants identified a number of barriers to accessing information.

Lack of relevant and accessible information

Service providers reported the information needs to be targeted to different groups, especially those that are marginalized. Information also needs to be relevant and based on the most up-to-date research. Practitioners need access to library services to increase their research knowledge so they can provide the most up-to-date information to the populations they serve. Currently there is no central place to access thorough information. Patients also need more information about FHTs and how they work.

Lack of knowledge about where to go or what to ask

Some community members and service providers reported that some people do not know where to get information. Information may not be consistent or people may feel stupid asking questions. Some people will need help in getting information. A handout with sources of information in the community would be helpful.

Literacy

Service providers identified literacy as a barrier to getting information about health from print. In one example, patients “pretended” to read the information they were given. For many years, one doctor did not know some of his patients could not read. As a result, they did not understand the information the clinic was giving them and what they needed to do to be well. Service providers discussed the fact that knowing how to be healthy is very much related to being able to read.

Some participants said that low literacy may be an issue with respect to the Amish population. One participant, in explaining the impact of low literacy, gave the example that some people with low literacy in this specific population may not be able to apply for an Ontario health card.

Providers discussed that medicine is becoming more complicated. Therefore, print materials may not be the best way to get information across to people. In addition to understanding the material, it may be difficult for people to take next steps or know where to go next.

Information about medication

Service providers noted that there is a lot of information about medications and it is difficult for clients to process this information. This includes what happens if they do not finish their medications or they stop taking them altogether. For example, a patient may stop a medication like high cholesterol or diabetes medication because they were not feeling bad in the first place. Follow-up from a health care professional would be helpful.

iii. Experiences with Health and Health Services

[There have been] *deaths due to poor doctor service.*

– **Community member**

Barriers to health care services

Lack of health care services

Service providers and community members identified the lack of health care providers—family doctors, specialists, psychiatrists, nurses, geriatricians, dieticians, and personal service workers—as a serious challenge in rural areas. Many of those practitioners who do come to rural areas need training on working in rural areas. In addition, there are a lot of people who do not have a family physician even though they may have lived in the region a long time. People cannot access a doctor or other services in FHTs unless they have a family doctor.

Providers indicated that there was a lack of providers in rural areas because younger people have a negative perception of the health care system and may not want to come into it. In addition, doctors want to have more time off for their own mental health. Furthermore, not enough people are accepted into medical school, and attracting students back to rural areas is also a challenge.

Providers also indicated that doctors are overburdened and do not have time to focus on wellness.

Long wait lists for specialized services

Service providers noted that there are long waiting lists to see specialists, including psychiatrists. The lack of adequate mental health services means that there are long waiting lists of families in distress and, as a result, children and families in crisis have to be referred to the emergency departments in the city.

Mental health stigma and expertise

Service providers reported that there is stigma with mental health care. People feel a lot of shame. Everyone knows everyone and people do not want others to know they are mentally ill. In one example, a woman told her husband not to go for an appointment during certain hours because he would be seen.

Another issue is that staff may not know how to approach chronic mental illness and need more training themselves.

Costs associated with health care

There are costs associated with health care such as the cost of prescriptions and dental care. According to providers, most rural clients do not have drug benefits, so when doctors want to start them on drugs, they do not have the money to follow through. Dental care was also identified as a cost issue. An example was given of a client who had to have all her teeth removed, but could not afford dentures. Transportation to get to health care facilities was also identified as a serious cost issue by providers.

Cultural barriers

Providers said there were cultural barriers to accessing health services particularly for Mennonite and Amish communities. Older order Amish or Mennonite communities may have unique health issues, no health card, and may believe that things happen because it is God's will.

Services for seniors

Community members indicated that access to health and other services for seniors is problematic especially if people do not have a support network or family. There should be more options that focus on services in the home.

Miscellaneous barriers

Other barriers were identified by providers in terms of accessing health care. One barrier identified by providers concerned what treatment people would get—for example if they were poor or looked different. Another barrier centred on a patient's view of doctors in terms of seeing them as god-like or part of a patriarchal system. This may influence people to filter what they tell their doctor or not question what their doctor tells them. They may also not reveal important information or ask questions because of lack of time.

What is working well

Nurse practitioners

Providers indicated that services provided by nurse practitioners work well even though there was an initial reluctance towards them, especially from physicians. After a few months of working together, there have been very positive outcomes.

Better partnerships

There has been a growing trend to more and better collaboration between and within agencies in terms of service provision and information sharing. This collaboration has been in response to the lack of funding and resources in rural areas.

FHTs

Community members noted that FHTs are the way of the future and can provide access to information as well as integrated health services that can help compensate for the lack of doctors.

Community gatherings

Community members spoke about the importance of community places for spiritual and mental health such as churches, schools and special programs such as Tuesday Toons, which is a music program to help with mental health and mobility issues.

C. Recommendations from Participants

Participants suggested strategies and recommendations for addressing the barriers they identified. These are listed below.

1. Social factors affecting health

Providers would like to see social factors such as poverty, housing, and food security be better addressed. They would like to see improved, affordable housing, better welfare rates, and more resources for organizations, such as poverty coalitions that address these issues.

2. Promotion of health careers in rural areas

One major recommendation of participants was to find ways to promote careers in health services with youth so they will come back to rural communities. One way is to have medical students come out to rural areas for internships. Another way is through camps like MedQuest that help young people consider careers in Grade 10 and 11 when they have to start making decisions. The community could also pay for a person's education on the stipulation that they come back to the local area for a required amount of time. In addition, there needs to be greater access to the University Fair to explore options in different locations. Participants also thought that more spots need to be opened up for medical students.

3. Researching the needs of rural areas

Providers indicated that more qualitative research is necessary in rural areas. They recommend conducting a needs assessment on the health care needs of the community so these needs can be addressed in a relevant way.

They also recommend that more research money be put towards local issues as opposed to just clinical issues at universities. They would like to see a research agenda on rural

issues and health. This would include prevention research as opposed to the primary research conducted by drug companies.

4. Improved access to quality health care in rural areas

Incentives for health care providers

Community members indicated that incentives are needed to encourage health care providers of all kinds to come and work in rural areas. For example, nurses need to have full-time work as opposed to part-time work and the attitude in the health care environment must be more welcoming. Although the group had not found examples of strategies that had worked to bring providers to rural areas, they felt that this would be a good topic to explore.

Improved transportation

Community members suggested having a mobility bus so people can access health and other services, especially given that the population is aging in rural areas.

Community responsibility for health care

Community members emphasized the need for community innovation for community solutions in health care. They indicated that over time, FHTs could compensate for the lack of doctors. They reported on the importance of multi-professional health care teams when developing programs and policies, along with community ownership. These teams would share resources and responsibilities to help off-load work.

More prevention

Providers indicated that there needs to be more primary prevention and a focus on wellness in rural areas. Prevention needs to be primary rather than secondary as sometimes secondary prevention is too late.

Best practices and new models

Participants emphasized the need for sharing of best practices and new models for communities.

More options from health care providers

Community members would like to see health care providers providing more alternatives and options for health care as opposed to the way they have always done it. This includes more at options for home care strategies and second opinions.

5. Improved access to health-related information

All participants recommended new ways of getting health-related information out to the community to address different learning styles.

In particular, providers recommended a multi-media approach where current, consistent information is available to people in a number of different ways including Web site, phone-in, hard copy, and television. They recommended that triage be conducted over the phone by a nurse practitioner. They also suggested that a central place to access information would be important. Another suggestion was to have an FHT staff member follow up with patients to see that they are taking their medication properly. Proximity is also important when accessing information. Providers recommended that people be able to access important health-related information close to home.

Community members felt that FHTs would be able to provide health-related information in collaboration with others.

IV. Summary Statement

Participants indicated that health in their rural communities is very much related to community involvement, gatherings, and support from others in the community.

Participants' feedback also shows living in a rural area has a large impact on health and access to health and other services. One of the most serious issues identified by participants was the lack of health care professionals of all kinds, especially doctors. The need for mental health professionals and other specialists was identified as a particular area of concern. There may also be few facilities to help people keep healthy such as public fitness facilities. Associated barriers include few options for care, lack of transportation, and costs of services: available transportation, medication, and dental care. Another important issue is that responsibility for health has been off-loaded to local communities. All these barriers are compounded by poverty, lack of affordable housing, low literacy, and cultural factors related to beliefs about health. While there has been a push to focus on wellness in rural areas, there is still a long way to go.

Participants see FHTs as a promising multi-professional approach to health and health care that can compensate for the lack of doctors and provide better quality and access to information and services to rural communities in the future. There is a belief in community ownership of health,

community innovation, and the need to advocate and lobby politicians for better resources in rural areas. They would also like to see more qualitative research on community health and health care needs, along with a research agenda for rural health.

Learning has a place in participants' recommendations. For example, they advocate for a multi-media approach to providing information about health that will create access to this information in a way that fits a wide range of learning styles. In addition, they believe that providers who work in rural areas need to learn about the particular issues and concerns of rural areas. Learning is also related to attracting youth to engage in careers in health care and come back to practice in rural communities. FHTs are also seen as a place of learning where practitioners can share resources, learn from each other, and learn best practices and new options for care.

Along with these recommendations, participants also see that larger social factors such as poverty, affordable housing and food security need to be addressed.

Appendix A: Consent Practices

Community Consultation on Health and Learning in Rural Areas

**Sponsored by the Adult Working Group of the Health and Learning
Knowledge Centre, Canadian Council on Learning**

What are the community consultations about?

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

What will I do at the consultation?

Community members and service providers will attend the consultation for a total of about 20-25 people. We will ask questions about health, getting information about health, and your ability to access health care services. Community members and providers will work in two separate groups. Everyone will come together at the end to share highlights of their discussion.

How much time will it take?

The consultation will take about 4 hours. Lunch will be provided.

What if I want to stop my participation?

Participation is voluntary. You can leave the meeting at any time.

Will anyone know what I said?

We will not use your name or anything that can identify you in the report on the consultations.

What are the possible outcomes if I participate in the consultation?

The long-term benefits are that there may be some improvements in accessing information about health and health care services for you, your families and other people who have had similar experiences to yours.

Where do I get questions answered?

You can contact XX at XX.

Appendix B: Consultation Questions

Questions for Consultations on Health and Learning in Rural Areas

Community Members	Providers, Practitioners
<p>1. What does health mean to you?</p> <ul style="list-style-type: none"> • <i>Can you describe what it is like to be healthy?</i> • <i>What does it mean to be in poor health?</i> • <i>Why does this happen?</i> <p>2. What do you do to get or keep in good health?</p> <ul style="list-style-type: none"> • <i>What do you need to get or keep good health?</i> • <i>Where do you get it?</i> • <i>What makes it difficult?</i> • <i>How does where you live affect your health?</i> <p>3. How do you learn about health in for you and your family? How do you get the information you need to be healthy?</p> <ul style="list-style-type: none"> • <i>Where do you find this information?</i> • <i>How do you get it?</i> • <i>Do you talk to people or do you read information or do you use the Internet?</i> • <i>If you use the Internet, where do you get access to a computer?</i> • <i>What problems do you have using this and how do you overcome them?</i> • <i>What health information have you found so far?</i> • <i>Would you use a HELP Web site to find the health –related information you need?</i> • <i>What works well for you to get the information you need?</i> 	<p>1. From your experience, what does health mean to your students/clients?</p> <p>2. What do they do to get or keep in good health?</p> <ul style="list-style-type: none"> • <i>What do they need to get or keep good health?</i> • <i>Where do they get it?</i> • <i>What makes it difficult?</i> • <i>How does where you live affect your clients' health?</i> <p>3. What are your clients' experiences with health and health services?</p> <ul style="list-style-type: none"> • <i>What makes it difficult to have the kind of health your clients and their families want?</i> • <i>What's it like when your clients have to go to the doctor, the hospital, or a community health centre.</i> • <i>What works well?</i> • <i>What was difficult?</i> • <i>How does where you live affect what kind of health services you get?</i> • <i>What are some of the different cultural assumptions?</i> • <i>What could these organizations do differently to make it easier for their clients?</i> • <i>What could your clients do?</i> • <i>What else would help them access health services better?</i>

Community Members	Providers, Practitioners
<ul style="list-style-type: none"> • <i>What kind of information or health topics is most important for you to get?</i> • <i>What's hard?</i> • <i>What would make it easier to get the health information you need?</i> • <i>What suggestions do you have for the health field?</i> • <i>How does where you live affect what kind of information you get about health?</i> <p>4. What are your experiences with health and health services</p> <ul style="list-style-type: none"> • <i>What makes it difficult to have the kind of health you want for you and your family?</i> • <i>What's it like when you have to go to the doctor, the hospital, or a community health centre?</i> • <i>How does where you live affect what kind of health services you get?</i> • <i>What works well?</i> • <i>What was difficult?</i> • <i>What could these organizations do differently to make it easier for you?</i> • <i>What can you and others do?</i> • <i>What else would help you get health services easier?</i> 	<p>4. How do you get information for your clients so they can learn about health for themselves and their family? How do they get information they need to be healthy?</p> <ul style="list-style-type: none"> • <i>Where do you find this information?</i> • <i>Do you use the Internet to get health-related information?</i> • <i>What information have you found that is useful? Please give examples.</i> • <i>Would you use a HELP web site to find the health-related information you need?</i> • <i>What works well for your clients to get the information they need?</i> • <i>What's hard?</i> • <i>How does where you live affect what kind of information clients get about health?</i> • <i>What kind of information or health topics is the most important for your clients?</i> • <i>What would make it easier for you to get the health information they need?</i> • <i>What suggestions do you have for the health field to do to improve the situation?</i> • <i>What kind of informal or formal learning would help? Who needs to learn?</i> • <i>How could this learning happen?</i>
<p>5. What types of learning can help address these barriers?</p> <p>6. Who should do the learning?</p> <p>7. What else needs to be done?</p>	<p>5. What types of learning can help address these barriers?</p> <p>6. Who should do the learning?</p> <p>7. What else needs to be done?</p>