ABSTRACT

Background: Adult Basic Education (ABE) is the national system that offers adults with low literacy and/or limited English with educational services in reading, writing, math, technology, and communications from basic levels to high school equivalency, with specialty programs in transition to community colleges and family literacy. Brief description of activity: To show the role of ABE in increasing health literacy in low literate and/or limited English populations through partnership with community health organizations (CHO). Implementation: This article was developed through a collaborative thought process over a period of 8 months with experts from the field of ABE in development of health literacy within low literate and/or limited English populations. It describes the research that links low literacy and/or limited English with poor health, and introduces how ABE and CHOs have addressed these issues together. It also introduces research on the impact on learners of integrating health into ABE. Results: ABE learners have consistently shown a strong interest in learning about health for themselves and their families, and health content energizes ABE instruction. Learners report improvements of basic health knowledge, their confidence communicating with health care professionals, enhanced self-efficacy, and intention to make changes in such health behaviors as diet and tracking blood pressure. Partnerships between ABE programs and their local CHOs strengthen the teaching/learning process and can be mutually beneficial. ABE provides access to hard-to-reach populations, a safe learning environment, and teaching expertise. CHOs provide health expertise, preventive health screenings, and access to treatments. Lessons learned: The link between low literacy and poor health is no longer disputed. ABE programs and many CHOs share a common mission and commitment to serving vulnerable populations. Stronger partnerships between these organizations should be viewed as a viable strategy for addressing health disparities. A coordinated effort of community health centers across the nation is required to meaningfully respond to health disparities as a national social issue. [HLRP: Health Literacy Research and Practice. 2019;3(Suppl.):S1-S7.]

Plain Language Summary: This article introduces ABE and the role this system plays in improving health literacy within populations with low health literacy and/or limited English populations. It details the educational services the system provides, how health content has been integrated into instruction, the impact on learners, and how partnerships between ABE programs and community health services strengthen the work.

Low literacy and poor health are directly linked (Berkman, Sheridan, Donahue, Halpern & Crotty, 2011) In the early 1990s, research began emerging that established a direct connection between low literacy and poor health (Davis et al., 1996). The term “health literacy” was introduced to define the array of skills needed to obtain, process, and understand basic health information to take care of one’s health. Berkman et al., (2011) synthesized the research. They found that low health literacy was consistently associated with more hospitalizations, greater use of emergency care, lower receipt of mammography screening and influenza vaccine, poorer ability to demonstrate taking medications appropriately, poorer ability to interpret labels and health messages, and, among elderly persons, poorer overall health status and
higher mortality rates. In addition, the research found that poor health literacy partially explains racial disparities in education, housing, and income. This emerging research was coupled with literacy assessments in 2003 and 2013 (U.S. Department of Education, 2014) that uncovered alarming rates of low literacy in the United States, finding that the population with low health literacy simply did not have the health literacy skills to navigate an ever-changing health care system.

HISTORY OF ADULT BASIC EDUCATION AND HEALTH CARE EFFORTS TO ADDRESS LITERACY AND HEALTH

Adult Basic Education (ABE) and health care organization practitioners began meeting to address this national social justice issue, culminating in the 2010 Health and Human Services National Action Plan to Improve Health Literacy (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2010) and Healthy People 2020 (Office of Disease Prevention and Health Promotion 2010) in 2011, which emphasize integrated systems to improve health literacy (Koh & Rudd, 2015). The ABE field began its own programming to integrate health literacy education into its curricula and classrooms. Research studies about the impact and outcomes of integrating health found that ABE programs are a good place to learn about health, and are particularly effective when coordinated with local health services. Learners have been highly receptive to learning about health in ABE classrooms (Hohn, 1998; Levy et al., 2008; Rivera & Hohn, 2010).

IMPACT OF INTEGRATING HEALTH LITERACY EDUCATION

Long before health literacy became a field in its own right, adult educators had been teaching adults to read, write, communicate, and do math while customizing these skills to address learners’ real-life needs and purposes. Across program contexts, learners frequently identify health information, communication with health care providers, and health care navigation skills as high priority topics in their learning. They value the classroom for the opportunities to ask questions and to clarify their understanding of health information in a safe and trusted environment, which is a luxury rarely afforded to them in clinics or hospital settings (MAGI Educational Services, 2005).

Many ABE teachers have found health to be a motivating and engaging content area that can successfully improve both health literacy skills and the core literacy or language skills they are charged with teaching. Successful health literacy projects in ABE reveal the range of relevant and meaningful markers of change that matter to basic education programs, and most importantly, to adult learners themselves. In many cases, these projects have been shown to improve not just learners’ knowledge of basic health, but their confidence communicating with health care professionals, enhanced self-efficacy, and intention to make changes in health behavior such as getting blood pressure or blood glucose checks or improving their nutrition (Santos, Handley, Omok & Schillinger, 2014).

This has not been at the expense of the development of transferable literacy and language skills. For example, a health literacy curriculum based in El Paso, Texas found that English language learners improved their document literacy skills (e.g., filling out a health form, reading a prescription label) (Soto Mas, Mein, Fuentes, Thatcher & Schillinger, 2013). Moreover, learners reported increased intrinsic motivation for seeking out online health information, as reflected in this learner’s comment:

I [used to] look at the computer and I did not even turn it on….[but] with this program with the worksheets that they gave us, with the suggestions that the teacher gave us, it’s that now I’m getting the sweet taste of investigating….it was good because now I am interested.

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OPPORTUNITIES, CHALLENGES, AND RESOURCES FOR TEACHING HEALTH IN ADULT BASIC EDUCATION

The success of health literacy and basic education integration has created a growing interest among ABE practitioners and program directors, but there are some challenges. Two of the barriers that teachers often voice are their lack of health knowledge and a lack of health-related curricula materials. Teachers often worry that they will not be able to answer health-related questions. There are two easy fixes for this concern. One is to focus more on the skills needed to find and understand health information, and less on teaching health facts. Another is to partner with a community center (CHC) program and invite an expert into the classroom to share health information and to answer questions.

Both of these fixes, however, require some curriculum resources to help guide teachers through the process. To incorporate health units and health literacy skills into curricula, teachers need specialized instructional materials and also guidance on how to address health in the classroom. In some cases, ABE programs have had success with mini-grants that allow them to create their own instructional materials, but short of that there is a need for ready-to-use materials. There are now many resources available, which include comprehensive curricula, lesson plans, easy-to-read health books (authentic materials), and guidance on how to incorporate health into basic instruction such as “Health Literacy in Adult Basic Education” (LINCS, 2018), which guides adult educators in creating health literacy curricula, lessons, and evaluation plans. There are also guides to help build partnerships between ABE programs and CHCs. These resources would be useful to both teachers and program administrators who want to build a mutually beneficial relationship with local health organizations.

ADULT BASIC EDUCATION AND COMMUNITY HEALTH PARTNERSHIPS

One promising avenue emerging from the work over the past two decades is partnerships between the ABE and CHC systems, which have overlapping and intertwined responsibilities for the same population. Local program partnerships have shown great potential benefits for partners and the communities they serve. CHCs are of particular importance. They are providers of primary and preventive care for those with low health literacy, low-income, and other underserved populations; however, they struggle to connect with those most in need of their services. ABE programs are in direct contact with members of these underserved communities, and the teaching environments provide much greater learning time than health care settings. Moreover, basic instruction educators are skilled and trusted teachers in diverse populations. Working together in their local communities, the ABE and CHC systems can provide ABE learners with opportunities to improve their health and, as a result, enhance their productivity as workers, parents, and community members. In addition to improving health literacy skills, ABE students can learn to trust and use their local primary care health services. This not only improves their health, but also reduces costs for them and the health care system by reducing emergency department use and unnecessary doctor visits (Herman & Mayer, 2004). Partnership work is relatively new, but promising models are emerging. There is a critical need, however, for future partnerships to conduct robust collection and analysis of student outcome data and to document promising partnership practices.

The Florida Health Literacy Initiative

The Florida Health Literacy Initiative (FHLI) is a statewide grant program administered by the Florida Literacy Coalition and funded by the Florida Blue Foundation. It provides training, resources, and financial support to assist the Florida Literacy, English Language, and Family Literacy programs to integrate health education into their instruction. The objective is to teach students English language, literacy, and math skills while sharing information and resources to help them navigate the health care system and make informed choices regarding their health and nutrition.

The FHLI seeks to help local literacy providers build successful and robust health literacy projects. This includes providing (1) grants of up to $5,000; (2) regular professional development and technical support opportunities; (3) access to free, high-quality instructional materials, including the initiative curricula “Staying Healthy, An English Learner’s Guide to Health Care and Healthy Living” (Florida Adult Literacy Coalition, 2017); and (4) opportunities to network and share promising practices, partnership opportunities, and resources across programs.

Working with health centers and other community partners is a key component of the FHLI. Activities have included providing health care screenings, courses in cardiopulmonary resuscitation, health provider presentations, exercise classes, health fairs, and field trips to hospitals, health centers, grocery stores, and fire stations.

Gregory Smith, Director of the Florida Adult Literacy Coalition since 2002 and coauthor of this article, provided some summary statistics garnered from a variety evaluations and assessments since 2009. From that date, the the FHLI has served more than 15,000 students in partner-
ship with adult education and literacy programs throughout Florida. Evaluation at the program level through uniform pre- and post-health literacy assessments found that approximately 76% of students who were assessed experienced measurable improvement in their health literacy. Moreover, there was a 26% average increase in literacy performance as measured through pre- and post-literacy assessments. Students reported through program surveys that they are exercising more, eating healthier, and better able to communicate with their doctor.

**The Literacy Assistance Center of New York City**

The Literacy Assistance Center of New York City implemented a robust program between 2003 and 2010 to increase the health knowledge of ABE and intermediate English language students to increase their involvement with health issues and to connect them to health services. Partnerships were developed between approximately 75 programs and 35 health facilities that involved more than 3,000 adults and 175 teachers during the 7-year period. (MAGI Educational Services, 2005).

The program was conducted using an empowerment approach in which ABE students identified and named health topics and issues important to them. Teachers contextualized these topics with oral communication lessons for English as a second language students and math, science, and written lessons for other students. For example, students used data from the health care industry to explore math concepts and practices such as percentages, decimals, fractions, and data analysis related to daily living. Data sources included the cost of insurance, medications, and doctor visits, and charts and tables were used that contained health-related data. For science, students learned medical and scientific terminology, and they explored content learning on the human body’s structure, vital systems, diseases, and conditions. Students also read medical articles and wrote opinion pieces on health topics and issues, developing an understanding of the language of health care and debating health care quality.

Initially, partnerships were funded primarily through private foundations. Later in the initiative by the Literacy Assistance Center of New York City, there was some indirect funding from the New York State Education Department. One stream of funding was awarded to the Literacy Assistance Center, an adult education professional development agency, for general leadership development and training of teachers as part of the federal Workforce Innovation and Opportunity Act (U.S. Department of Labor, 2013). Another funding opportunity came to the state-funded programs that were part of a New York state adult education program initiative called Literacy Zones. Some of the money was allocated primarily for case managers to develop partnerships with social service agencies in the community, including health agencies, to ensure that students were able to access services while pursuing their education and training.

Outcomes for students included (1) increased health-related knowledge; (2) increased understanding of the medical system; (3) increased ability to identify the causes, symptoms, or conditions of various diseases; (4) increased healthy practices in dietary habits; and (5) increased participation in blood pressure and other preventive screenings. Students also showed greater educational gains on standardized literacy tests in pre- and post-testing than students in other classes. Additionally, programs developed relationships with community and health organizations that recognized the role of ABE in promoting health equity and reducing health disparities.

**The Chicago Citywide Literacy Coalition**

Alexandra Ziskind, former Program Manager of the Chicago Citywide Literacy Coalition (CCLC) and coauthor of this article, provided important background on the origins of their health literacy initiative. The Chicago Citywide Literacy Coalition (CCLC) has gained first-hand knowledge about the valuable benefits that a partnership can bring to learners as well as to the ABE programs and CHCs. The CCLC received funding from the Chicago Community Trust to focus on preventive health and create deeper engagement between ABE providers and federally qualified CHCs. This initiative, the Empowerment-based Health Literacy Project, consists of eight community-based adult literacy organizations across Chicago that are paired with a nearby CHC to create and implement a preventive health care curriculum for their learners (Open Door Collective, 2017). Some organizations choose their CHC partner based on a pre-existing relationship with a nearby CHC, but others needed help being matched with a CHC. In those cases, the funder made recommendations about a potential partner and the CCLC helped broker that relationship. The CCLC distributes a stipend to the providers for implementing this work, which gave them the latitude to forge and develop their ABE-CHC partnership. The CCLC created a detailed list of roles and responsibilities for the CHCs so they could better understand their involvement (Table 1).

The CHC and the literacy provider are required to create five modules in their curriculum: (1) how to navigate the health care system (which includes a tour of a CHC), (2) how to talk to your doctor, (3) diabetes, (4) heart disease, and (5) mental health. Both teachers and CHC partners are
Trained in the participatory-centered approach, which emphasizes that learning is a result of participant action. It focuses on using a wide variety of techniques to facilitate learning and aid in retention.

In the initial phase of the CCLC’s project, some teachers were concerned they could not deliver the health content effectively because they were not medical professionals. With the support and content knowledge from the CHCs, teachers felt more confident in delivering the modules. Also, the partnership with a CHC allows providers to offer more robust health services to their students. For example, one organization in the CCLC’s project noted that they plan to continue their relationship with the CHC by offering stress management classes to their students.

After launching the health literacy project, several CHCs approached the CCLC to see if there were more adult educa-

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**TABLE 1**

| Health Literacy Initiative | Description | Partnership Goals | Funded Activities |
|----------------------------|-------------|-------------------|------------------|
| **The Florida Health Literacy Initiative** | A partnership between the Florida Literacy Coalition and Florida Literacy, English Language, and Family Literacy programs Funded by the Florida Blue Foundation, 2009 to present | To teach students English language and literacy while sharing information and resources to help them to navigate the health care system and make informed choices about their health and nutrition To help local literacy providers build successful and robust health literacy projects | Teacher professional development Health literacy grants Improving access to free, high-quality instructional materials Project-based learning Network-building and resource-sharing across organizations |
| **The Literacy Assistance Center of New York City** | A partnership between 75 ABE programs and 35 community health centers Funded by private foundations and the New York Department of Education, 2003-2010 | To increase the health knowledge of ABE/ESOL students, promote learner involvement with health issues, and connect them to health services | Health literacy curriculum development Network-building and resource-sharing across organizations Program evaluation research Student tours of health centers |
| **The Chicago Citywide Literacy Coalition** | A partnership between 8 adult literacy organizations and local FQHCs Funded by The Chicago Community Trust, 2016-2018 | To promote adult learners’ access to the health care system and strengthen their preventive health knowledge To create partnerships between adult education providers and community outreach staff at FQHCs | Student tours of FQHCs Collaborative; ABE curriculum development on topics such as type 2 diabetes, heart disease, mental health, communication with doctors, and navigation of health care system Program stipends provided to adult education teachers |
| **Quincy Asian Resources** | A partnership between Boston-area nonprofit organizations, local English language programs supported by the Boston Medical Center Health Net Plan | To lay the foundation for formal integration of health literacy into the English language curriculum | Funding-supported English language programming Delivery of two workshops on doctor-patient relationships and health insurance Health literacy curriculum development for English language classrooms |

Note. ABE = adult basic education; ESOL = English as a second language; FQHCs = federally qualified health centers.
tion providers interested in partnering. This emphasizes the CHC’s desire to engage patients earlier and in a more preventive way. A project of this nature, which emphasizes strong partnership, allows CHCs and community-based organizations to continue engaging with each other beyond the scope of the current initiative.

**Quincy Asian Resources**

Rob Sheppard, Director of Quincy Asian Resources (QARI) and a coauthor of this article, provided information about the beginning efforts of QARI. QARI is a mid-sized nonprofit near Boston, Massachusetts, with various English-language programs serving about 350 students per year. Health literacy had not been a formal, fixed component in the English-language curriculum, and one of the barriers to doing so was limited funding. As a step toward the formal incorporation of health literacy, QARI partnered with the Boston Medical Center Health Net Plan. Boston Medical sponsored the English language program, and delivered two workshops on topics of interest to students in the program: (1) the doctor–patient relationship in the U.S. and (2) health insurance in the U.S. The workshops were integrated into the health units in the curriculum and designed in collaboration with the teachers in the program.

**PARTNERSHIP DEVELOPMENT**

In addition to the programs discussed previously, health literacy initiatives in other states have garnered additional expertise for developing and maintaining partnerships. Michele Erickson, Director of Wisconsin Health Literacy, described critical milestones in their development. Wisconsin Health Literacy, which has been in working on the integration of ABE and health literacy education for more than a decade, has developed a collaborative guide for literacy organizations on how to create a successful partnership between a hospital and an ABE program to engage the community in their local health care options. Wisconsin Health Literacy also has an annual health literacy summit that brings leaders and practitioners from the health literacy, health care, and ABE fields together to learn about broadening and deepening the integration of ABE and health literacy development. Information, resources, and summit information can be found on the Wisconsin Health Literacy website (http://www.wisconsinliteracy.org/health-literacy/index.html).

In the state of Virginia’s Literacy for Life program, a two-pronged approach is used that couples health literacy education for ABE learners with training for medical staff. This coupling is described in detail on their website (http://www.literacyforlife.org). The health literacy education provides an 8-week program covering such topics as describing symptoms to a doctor, reading and understanding medication instruction, knowing when to use urgent care instead of the emergency department, and identifying lifestyle changes to improve health. The medical staff training includes the issue of low health literacy, identifying low literate patients, communicating clearly and effectively, creating easy-to-read materials, checking for comprehension, and being culturally sensitive. Information and resources can be found on Virginia’s Literacy for Life website under Health Education in Adult Literacy (https://literacyforlife.org/programs/).

**DISCUSSION**

Partnerships between local ABE programs and CHCs can be mutually beneficial. ABE provides access to hard-to-reach populations and a safe learning environment. CHCs can provide health expertise, preventive health screening, and treatments. ABE learners have consistently shown strong interest in learning about health for themselves and their families, and health content energizes basic education curriculum and instruction. Teachers do not have to be health experts and can draw on a wealth of resources for contextualizing instruction in health content. Robust examples of long-term partnerships show how they operate and benefit ABE programs, teachers, and students. They also provide guidance in setting up partnerships and securing funding. These partnerships are especially timely as U.S. policymakers continue to debate the future of the Affordable Care Act, a program that directly affects large numbers of ABE learners; particularly those living in poverty, with limited education, or with limited English proficiency.

The links between low literacy and poor health are no longer disputed. ABE programs and CHCs, as well as many other CHC providers, share a common mission and commitment to serving vulnerable populations. Thus, stronger partnerships between these systems should be viewed as a viable strategy for addressing health disparities. A coordinated effort is required to meaningfully respond to health literacy disparities as a national social issue.

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