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# Public Schools, and Health Care: A Strategy to Promote Social Inclusion

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**PUBLIC SCHOOLS, AND HEALTH CARE:  
A STRATEGY TO PROMOTE SOCIAL INCLUSION**

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**Sunset Park Family Support Center brings together adult education and health and social services to provide an integrated one-stop hub for families in southwest Brooklyn.** Sunset Park is a diverse, low income, Middle-Eastern, Latino, Eastern European, and Asian community that serves as home to many of the immigrants who have come to the U.S. in the last two decades. In the Support Center's Adult and Family Education Program, fifty languages can be heard in the classrooms and hallways as each year 700 students enroll in a variety of basic education, literacy, computer, and English-as-a-Second-Language classes. The Center also offers a reading program for preschool children and their parents; a volunteer program that provides outreach, advocacy, and translating services at the sponsoring hospital, Lutheran Medical Center; and many other social services. A new initiative has begun to link adult education with health education.

The Family Support Center illustrates a model of services that can help recent immigrants ease their transition to the U.S., help their children succeed in school, help them find the health services they need, and help them become more fully integrated into their community and political life. Unfortunately, few communities are able to provide recent immigrants with these services, and those that do lack the capacity to meet existing needs. At the Sunset Park Support Center, for example, 600 residents are on a waiting list for services.

Now as in the past, the United States is a country of immigrants. How our nation educates immigrants and their children; provides access to adequate health care, housing, and employment; and includes them in our political system will influence our ability to achieve our society's educational, health, economic, and moral goals. In this essay, we examine how adult education, a service that plays a key role in the lives of many recent immigrants, can act as a bridge for the immigrants and their families into both the educational and health care systems, and thus include them more fully in our society.

We focus on New York City because it, with a handful of other big cities,

serves as the entry point for the majority of recent immigrants and because of our experience working with newcomers as educators, providers, and researchers in NYC's adult education, school, and health care systems. Using our first hand experience and the relevant research, we describe some of the barriers to social inclusion that recent immigrants face; portray the adult education system in New York City and its linkages with schools and health care institutions; and recommend policies and programs that can strengthen these linkages and their capacity to promote recent immigrants' social inclusion. Finally, we provide some suggestions for teachers, adult educators, and health care providers to contribute towards a more integrated system to help recent immigrants and their families.

### **Immigration, Health, and Education**

According to the 2000 Census, more than 28 million people living in the United States are foreign born, and immigrant children make up more than a fifth of the nation's children. These children often face difficult life circumstances: more than half are poor, yet benefit less from public programs than native-born children. In addition, a majority of young immigrant children have one or more parents with limited English proficiency (Capps et al., 2004).

In 2000, most immigrants lived in the gateway metropolitan areas of New York, Los Angeles, San Francisco, Chicago, and Miami. In these cities, the concentration of multi-national, foreign-born populations with different languages and socio-cultural backgrounds makes social inclusion a particularly daunting challenge. Both documented and undocumented immigrants face obstacles; for those who are undocumented, fear of deportation may prevent them from using even services that are available. As post-9/11 restrictions on legal immigration increase, the problems we describe here may become more significant.

Low levels of literacy and formal education present one such barrier. Literacy typically refers to the basic ability to read, write, and compute. According to the National Adult Literacy Survey (Weiss, 2005), more than half the immigrants who enter the United States after childhood have limited literacy in English, which makes it harder to find work at wages that can support a family, to help one's children succeed in school, and to get needed health care.

As most teachers are aware, children of immigrants consistently face obstacles in public schools. They are less likely to attend comprehensive preschool programs, have lower scores on reading and math tests, are more likely to be placed in special education programs, or left back than native born children, rarely have access to bilingual programs, and are more likely to drop out of school (Capps et al., 2004; Takanishi, 2004). These barriers reduce the likelihood that immigrant children will attend college, move up the economic ladder, maintain good health, and become full participants in society.

Immigrant families also face economic, language, and socio-cultural obstacles to securing adequate health care. According to the U.S. Census Bureau (DeNavas et al., 2004) in 2003, foreign-born U.S. residents were two-and-a-half times more likely to lack health insurance than the native born. Children of immigrants are at least twice as likely to be uninsured, report fair or poor health, or lack a regular source of care (Capps, 2004). While the number of immigrants in the U.S. has continued to grow, fewer are eligible for health insurance, including Medicaid (Ku & Matani, 2001), due to legal restrictions on public benefits for legal immigrants passed in 1996 (Sherman, 1999; Fix and Tumlin, 1998; Kullgren 2003, Kandula et al., 2004). Undocumented immigrants face even greater obstacles to getting health insurance. As fewer Americans are now covered by employer-based health insurance than in the past, it is likely that un-insurance rates among immigrants will continue to grow.

Immigrants also face problems communicating with their health providers (Viladrich, 2003). Although the number of languages spoken in the US has been steadily growing over the past three decades, most hospitals offer limited or no translation services (Jacobs et al., 2004). Moreover, reductions in funding have reduced the quality and quantity of hospital interpreting services, which were already inadequate to satisfy the increasing demand (Perkins et al., 1998). State and federal laws mandate hospitals and doctors to provide translators and bilingual services, but these policies are rarely enforced and many immigrants are not aware of the laws (Ku & Matani, 2001).

These language barriers adversely affect health care for immigrants (Diaz, 1997; Elderkin-Thompson et al., 2000; Flores et al., 1998; Schur & Albers, 1996;

Valdez 1993). Lack of language skills and insufficient translation services can lead patients to distort or provide incomplete descriptions of symptoms as well as misunderstand doctors' prescriptions, follow-ups, and medical alternatives (Elderkin-Thompson et al., 2001; Gany and Bocanegra, 1996).

Languages barriers may also compound access problems. A study on the association between parents' language of interview and access to health care among their children with special needs found that non-English speaking parents were more likely to belong to disadvantaged groups, and experienced more barriers to health care, than English-speaking parents (Yu et al., 2004).

Finally, immigrants may experience socio-cultural barriers to care. Providers may not be familiar with their health beliefs or cultural practices; may assume that all Hispanics or all Asian immigrants are homogenous and share similar beliefs (Weinick et al, 2004); or may be unfamiliar with their patients' knowledge and resources regarding behaviors that influence health, such as folk healing practices. Ultimately, these communication problems can lead to poorer health outcomes.

Health literacy has been defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Healthy People, 2010). While many people in the U.S. count on few health literacy skills, immigrants, especially those with limited formal education, face unique problems in communicating with health providers or overcoming bureaucratic obstacles due to their lack of familiarity with the U.S. health system and their limited health information. In addition, low-income immigrants often lack basic literacy in any language, making it difficult for them to read and understand health messages, instructions, and prescriptions provided in any written form.

A recent review (Tassi, 2004) concluded that people with lower levels of health literacy had worse overall health status, arrived for treatment at later stages of disease, presented higher rates of hospitalization and less knowledge of health and disease, and had difficulty understanding and using health information.

## **Social Inclusion**

British and European social welfare analysts use the term “social exclusion” to refer to a process that results from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, and bad health (Micklewright, 2002). The antidote to this negative cycle is “social inclusion,” a set of policies and programs that draw excluded populations into the mainstream and seek to mitigate the harmful effects of exclusion.

Immigrants in the U.S. face challenges in protecting their health, helping their children to succeed in school, and becoming involved in the social and political life in this society. Each problem can amplify others. For example, poor health and school failure make it more difficult to earn a decent income; illiteracy often limits participation in community politics, which can lead to loneliness, ostracism, and social exclusion. Anti-immigrant prejudice and orchestrated campaigns to limit immigrants’ access to education and health care can exacerbate this negative cycle. Ultimately, immigrants’ social exclusion can harm society as a whole, contributing to racial and ethnic conflict; community health problems, such as epidemic disease or low immunization rates; and finally, to a lack of an educated, informed citizenry and workforce. On another level, excluding immigrants from mainstream society undermines a core American value rooted in the principle that we are members of a nation that welcomes citizens from any nationality who arrive here in search of a better life for themselves and their families. In the next section, we examine whether adult education can play a role in successfully including immigrants in the United States.

### **Adult Education in the United States**

Adult education includes such components as: basic education (BE), which focuses on literacy skills; basic education in a native language; programs preparing adults for the General Education Diploma exam (a high school graduation equivalency diploma); English for Speakers of Other Languages (ESOL); citizenship preparation; and computer literacy. ESOL programs for immigrants have been the fastest growing components of state-administered adult education programs, increasing from 33% of participants in 1993 to 48% in 1999 (NIFL, 2002).

Adult education has a long tradition in the United States (Sticht, 2002);

one of its principal goals has always been to bring recent immigrants into mainstream society. During the Progressive Era, wealthy reformers, foundations such as Ford and Carnegie, and various professional organizations of educators joined forces to create a national network of adult educators and programs. During the Great Depression, many of these programs lost support; however, in the 1960s' War on Poverty, adult literacy again became a federal focus and several new national programs were created.

By the last decade of the twentieth century, nearly forty million people were enrolled in the U.S. Adult Education and Literacy System programs (AELS), (Sticht, 1998) and almost a quarter of them were estimated to be foreign-born (U.S. Department of Education, 1998). Between 1965 and 1999, federal funding for adult education increased almost twenty fold (Sticht, 1998). However, in the last two decades, the proportion of federal support for adult education has declined while local and state support has increased.

While these programs and their funding sources are distributed throughout the United States, the delivery and quality of services and the approaches to teaching and learning vary tremendously. Only since the 1990s have government-funded programs been mandated to report their outcomes under the National Reporting System for Adult Education (NRS).<sup>1</sup> Many recent adult immigrants, in an effort to improve their English and to advance their formal education, participate in one or more of these programs, including ESL, GED, and citizenship.

In New York City, more than half the children under the age of seven are growing up in immigrant families; in many of these families, no one over the age of thirteen speaks English well (Bernstein, 2004). Between 1990 and 2000, the number of adults who had a problem speaking English increased by more than 30%, to more than 1.5 million. According to one city official, this growth in non-English speaking adults is now affecting the education of the next generation

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<sup>1</sup> The NRS is a "project to develop an accountability system for the federally funded adult education program. This system includes a set of student measures to allow assessment of the impact of adult education instruction, methodologies for collecting the measures, reporting forms and procedures, and training and technical assistance activities to assist states in collecting the measures." (Division of Adult Education and Literacy, 2001).

(Bernstein, 2005). Almost half the adults without proficiency in English in NYC have not graduated from high school, compared to 27% of all New Yorkers who are eighteen years of age or older (Bernstein, 2005).

New York City has one of the nation's largest and most developed adult education systems. Since 1984, the New York City Adult Literacy Initiative (NYCALI), a unique urban system of adult education, has brought together a wide variety of adult education providers, including 13 campuses of the City University of New York (CUNY), about 40 Community Based Organizations (CBOs), 175 NYC Department of Education (DOE) sites, and 23 branches of the public library systems in Manhattan, Brooklyn, and Queens.

These literacy agencies are supported by a common stream of funding administered jointly by the NYC's Department of Youth and Community Development (DYCD) and by the New York State Department of Education. According to the latest available report (LAC, 2002), NYCALI has served nearly 500,000 adult students in the last ten years. Classes are offered during the day, evening, and on weekends to accommodate the complex lives of adult students. While in 1985, the majority of students in these programs were enrolled in BE classes and two-fifths in ESOL classes, by 2001, more than half were in ESOL programs, reflecting recent immigrants' growing participation. While students of all ages over 16 attend, the majority of the students enrolled in these programs are between 25 and 44 years old and two-thirds are female. Ethnically, NYC's adult education programs represent the diversity of the city's population. In some programs, students speak more than 20 native languages. Still, the majority of students are Latino, except in the BE programs, where most are of African descent.

Participants rate these programs highly. A recent survey of 400 students in the CBO programs revealed that over 90% rated their program as excellent or very good. Students liked their teachers: their main complaint was that the classes met for too few hours per week. A formal longitudinal study conducted across the NYCALI programs provided "strong evidence that participation in BE and ESOL programs has a positive impact on many aspects of adult learners' lives. The effects of improved skills are felt at work and in the search for employment; they are recognized when reading and writing to children and interacting with children's



schools; and they have positive social implications through the increased use of literacy skills and English speaking ability in a variety of group and community activities” (Albert & D’Amico, 1991).

Despite the diversity and breadth of its adult education programs, New York City lacks the capacity to meet the educational needs of recent immigrants and other populations, such as adults with low literacy skills or those who could not finish regular high school. This is reflected by the fact that most adult literacy and ESOL programs have long waiting lists. Even the additional family literacy programs, which offer about 45,000 seats to both adults and their children, are not enough to cover the increasing demand. Most of these programs are located outside of immigrant neighborhoods. For example, in NYC, more than 40% are located in Manhattan and less than 10% in Queens, the borough with the highest proportion of recent immigrants (Bernstein, 2005). In addition to limited seats, many potential learners fear that programs will check their immigration status or ask for social security numbers, a policy increasingly demanded by funding sources attempting to track down how many students are served (Bernstein, 2005).

### **Adult Education Programs as Bridges: Innovative Approaches**

Integrating health education into adult basic education and ESOL classes is not a novel idea, as it has been shown that health-related lessons increase students’ interest in learning and in remaining within the educational system. In fact, many of the first health education programs in the United States had recent immigrants as their focus and teaching American health and hygiene standards as their aim. Public schools, settlement houses, and municipal health centers were among the settings for these early efforts (Markel and Golden, 2004).

Health educators and adult educators began to develop renewed links in the early 1990s (Rudd, 2002). Local initiatives led to “development of adult education curricula on specific topic areas such as breast and cervical cancer or smoking prevention. The idea of integrating health topics into adult learning centers was based on the assumption that health curricula would enhance the goals of the health field while also supporting the goals of adult education.” (Rudd, 2002: 5) Educational programs can be unique venues for reaching immigrant students and

their families, particularly if they aim at improving immigrants' language and cognitive skills, while also promoting social solidarity and social justice among immigrant groups (Blewett, et al., 2004; Blake, et al., 2001).

The increased importance of health literacy has been reflected in the creation of health literacy initiatives, as well as in the integration of health education into BE and ESOL curricula in diverse programs across the country. To illustrate diversity of these programs, we provide brief overviews of two programs in Massachusetts and California, and a more detailed description of one in New York City.

### **The Massachusetts and California Health Literacy Programs**

Since 1994, the Massachusetts Adult Health Literacy Effort has created more than fifty adult basic education programs with comprehensive health projects. These are based on a peer-leadership model and a participatory framework inspired by the work of Brazilian educator Paulo Freire (Freire, 1983). According to this approach, learners critically analyze life experiences in order to learn new skills and prepare for social action that will lead them to improve their life circumstances. Freirian methods have been used in both adult literacy and health education in the developed and the developing world (Hohn, 2004).

In the Massachusetts model, teams of five to ten students, along with a facilitator, carry out health-related projects. The teams, whose members get paid for participating, work with teachers, community health organizations, and health practitioners to engage other students in health-related activities through peer teaching. After identifying learners' common interests, the teams conduct research and teach other students about diet and exercise, cancer and smoking, and HIV/AIDS. This approach both enhances knowledge about health and supports more traditional literacy skills.

Preliminary evaluations of the Massachusetts program show that participants were enthusiastic about their learning experiences. Students expanded their health vocabulary and increased their ability to communicate about health issues, leading to increased skills and confidence. Students reported that finding out about community health services and learning about concepts such as prevention

and early detection of disease made them feel they had more control over their own and their families' health. (Hohn, 2004:18).

The California Health Literacy Initiative, launched by California Literacy, a non-profit organization, demonstrates a different approach to integrating health into adult education. To make health literacy a higher priority, California Literacy organized a task force of health care providers, health educators, public health directors, language access advocates, adult education directors and practitioners, and representatives from community-based organizations (Rothchild, 2004). The overall aim was to prepare adult literacy tutors and professionals to present health information to adults with limited literacy skills, to develop quality standards for low health and low literacy populations that are accepted by the medical community; and to organize work groups on various health issues. To achieve this goal, they created an online health literacy center for adult educators, health care professionals, adult learners, and policymakers; and conducted an awareness campaign directed at health care professionals and low literate adults (Rothchild & Bergstrom, 2004).

### **New York City Health Literacy Initiative**

In 2004, the Literacy Assistance Center (LAC) of New York City, the Mayor's Office and New York City Adult Literacy Initiative (NYCALI) launched the Health Literacy Initiative (HLI). The HLI seeks to improve family health by encouraging partnerships between literacy and healthcare providers; and by creating a professional development model for adult educators to infuse health literacy into their teaching curricula (MAGI Educational Services, Inc., 2004).

Several adult literacy programs, including the Sunset Park program described earlier, have taken part in HLI by providing additional professional development for their staffs, by partnering with health care providers in their communities, and by devoting a portion of their classes to health. LAC developed three modules for its community participants: navigating the American health care system, chronic disease management, and illness prevention. Then they offered teachers professional development in these topics. This key component of HLI utilized Study Circle Plus, a participatory approach to teaching and

learning, in which educators rely on health-related information and materials for the purpose of satisfying their students' particular needs (MAGI, 2004).

At Sunset Park, the health care providers from Lutheran Medical Center were eager to participate in this initiative so they could better communicate with patients, better inform the community of the health and health care options the Center offers, and become a more informed community institution. Administrators, teachers, and counselors of the adult literacy program and the health center met to plan the program. As part of the program's curriculum, students discussed health issues relevant to them and their families, practiced making appointments over the phone, and planned for an actual visit to the health center in class. Prior to the visit, students chose illnesses or injuries they would describe to a provider, learned relevant vocabulary, discussed health insurance issues, and practiced conversations. During the actual visit, which took place when the health center was closed to the public, students completed an entire mock patient visit and had the opportunity to interact with all the center's staff, including its nurses, doctors, health assistants, and administrators.

Six months after it started, MAGI Educational Services conducted an independent evaluation of the first phase of HLI. Evaluators reported that adult learners said that the health literacy classes had helped them to better their own and their families' lives, and that their language and literacy skills had been strengthened as a result of their participation. Teachers found that the health care partnerships enhanced students' and their own health literacy (MAGI, 2004).

In summary, the New York City and the Massachusetts and California State programs demonstrate that adult educators and health providers can work together, identify and reduce system barriers, engage recent immigrants in a variety of services, and contribute to improved literacy and more confident use of health services.

## **Recommendations**

Our review of the barriers experienced by recent immigrants, and the impact of adult education programs aimed at addressing these problems, provides both bad and good news. On the negative side, many immigrants face serious

problems getting the health care they need, educating their children, and becoming fully included in our society. Moreover, newcomers' needs for adult education, health care, and education seem to be increasing faster than the supply of these services. Recent and proposed cuts at the local, state, and federal levels suggest that in coming years the problems may get worse, not better.

The good news is that innovative models for adult education programs that can serve as a bridge into the educational and health care system are available; that dedicated workforces in adult education and health care provide valuable resources for policy change; and that immigrants bring a determination, resilience, and energy into their goal of inclusion.

So where do we go from here? From our perspectives as practitioners and researchers in New York City communities, we believe both bottom up and top down changes are needed. From the bottom up, local partnerships can develop, implement, and evaluate model programs that bring together key players, prepare immigrants to participate in the political arena, and advocate for additional educational and health care resources—particularly in communities with high numbers of immigrants. In addition, teachers, adult educators, and health professionals can learn about the resources in these domains and help families find the services they need. Local networks of teachers, adult educators, and health workers can play an important role in advocating for more coordinated services, opposing discriminatory policies or practices, and promoting social inclusion. Neighborhood health centers, adult education programs, immigrants' rights groups, or educational advocacy groups can serve as conveners of such grassroots efforts.

From the top down, K-12 and higher education, adult education, and health care officials can bring the right people together to address system barriers so they can begin to design seamless and comprehensive programs. In NYC, as we have described, some of these efforts have already begun, and show the promise of this approach. Nevertheless, additional resources will be needed to make such collaborative efforts meaningful. In addition, elected officials should advocate for additional resources and fight cutbacks and discriminatory policies at higher levels of government. Universities can also play a more proactive role. In most universities, those enrolled in community health education, adult education, and primary

and secondary education professional programs rarely meet or learn about how to collaborate across systems to improve services for their students. By developing more interdisciplinary courses and internships, universities can better prepare their graduates to meet the needs of recent immigrants.

On the political front, proposals to limit immigrants' access to health care, public education, or civil liberties risk further excluding newcomers from the mainstream; they also violate basic American principles. When professional organizations of teachers and health providers oppose these measures, they add political clout to those advocating inclusion and they demonstrate to immigrant communities that they can be trusted to act on behalf of their students and patients.

Through these and other efforts we hope to promote a dialogue on what our nation stands for in regard to immigration; and we can combat social exclusion and identify new strategies to improve the health and education of all Americans.

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## CROSSING BORDERS / SHAPING TALES