

LLN teachers and health workers: Partnership programs in action

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Abstract

This paper will examine several case studies of partnerships between language, literacy and numeracy (LLN) teachers and health professionals undertaken as part of two research studies: an NCVER funded project entitled *Literacy and numeracy development in partnership: Social capital perspectives*, and a DEEWR funded project entitled *Diabetes Literacy*.

The research is ongoing and the projects will be due for completion by mid 2008. The three case studies involve: an LLN teacher working in an inner city medical centre for sex workers and intravenous drug users; an LLN teacher working with a women's health coordinator at a Muslim women's centre in western Sydney; and an LLN teacher working with a nutritionist at a local neighbourhood centre with mainly Chinese students. All three case studies represent LLN teachers and health professionals working together for largely health and social capital outcomes for their respective client groups. Action research was undertaken to document the pedagogical processes involved in each of these programs. The data collected mainly comprised taped, semi-structured interviews with both teachers and health professionals at the conclusion of each session.

Within the context of the call for greater integrated literacy programs involving cross-sectoral partnerships between LLN providers and different public sectors (Wickert & McGuirk 2005), these case studies represent early attempts to document how LLN teachers and health professionals can work together effectively. In particular, they examine the influence of an adult literacy pedagogy and how this results in social capital outcomes.

Introduction

There has long been an affinity between the adult language, literacy and numeracy field and the health sector. Health, for example, often features as a topic of interest and focus in adult LLN classrooms. Significantly, also, many Commonwealth-funded workplace English language and literacy (WELL) programs are conducted in health organisations. Rarely, however, is there a close examination of how professionals from the two areas of adult LLN and health manage to work together.

This paper features several case studies of adult LLN teachers and health professionals working together in partnership. These case studies are drawn from two current national research projects. The first is a project entitled *Literacy and numeracy development in partnership: Social capital perspectives* (Black, Balatti & Falk forthcoming) and funded by the National Centre for Vocational Education Research (NCVER). This project is looking at partnerships between adult LLN providers and several different sectors, of which health is one. One of the main aims of this study is to analyse the pedagogy involved in these partnerships and how this pedagogy results in social capital outcomes. The second project is entitled *Diabetes literacy: A partnership approach to educating culturally and linguistically diverse*

people about the risks of types 2 diabetes (Black forthcoming) and is funded by the Department of Education, Employment and Workplace Relations (DEEWR formerly DEST). This project is about trialling a partnership in which adult LLN teachers and health professionals team teach on diabetes prevention programs in culturally and linguistically diverse community settings.

There are several key drivers behind the need to focus more closely on adult LLN teachers and health professionals working together and these will be examined in more detail in the literature review in the next section. First, there is the growing field of health literacy in which the health of individuals and communities is seen to be determined to some degree by people's literacy skills and there would appear to be considerable potential for developing health literacy Australia. Second, one of the current policy imperatives for the adult LLN field is to work in local community contexts in partnership with a range of different sectors (of which health is a key one), and thus contribute to community capacity building (Wickert & McGuirk 2005). Third, there is the continuing need for partnerships involving workplace programs in the health sector, especially in light of the training implications of new accreditation standards in aged care. For each of these driving forces it would be useful to have some models of how adult LLN teachers and health professionals can work together effectively. This paper outlines the beginning process of examining the issues and developing these models.

Literature review

Literacy, health and 'health literacy'

It seems almost self-evident that LLN provision should be linked closely with the health sector given the long held view that people with low LLN skills suffer greater health disadvantages in the general community, a view consistent with low LLN skills being related to increased poverty, unemployment and crime (e.g. Hartley 1989). Recently, health has been flagged as one of the key sectors which derive social and economic benefits from improved LLN skills and where there is considerable scope for partnerships between LLN providers and the health sector (Figgis 2004, Hartley & Horne 2006).

Although definitions of health literacy vary, and there are many of them, they are usually presented within a 'functional' sense involving an individual's capacity to read and comprehend medical information and instructions (see Shohot 2004: 67). Much of the interest in health literacy has been generated in the United States (e.g. Nielsen-Bohlman *et al.* 2004) and in particular by large pharmaceutical companies such as Pfizer (2006) with their obvious interest in how people access health products. Canada (see Rootman & Ronson 2005) has been very active with health literacy initiatives and there is considerable interest in the United Kingdom and Europe generally (Kickbusch *et al.* 2006).

To a large extent, theoretical approaches to health literacy mirror those relating to literacy generally. There are narrow 'functional' approaches which focus on improving basic skills and making material easier to read, and there are broader 'empowerment' or 'critical' approaches (see Shohot 2004: 78) drawing largely on the work of researchers such as Nutbeam (1999), Freebody and Freiberg (1997) and Hohn (1998). In this latter approach individuals and communities, through their ability to

read health-related information critically, demonstrate increased power and autonomy over their own health needs as a challenge to the medical orthodoxy in which clients are expected to remain largely compliant and passive (Cuban 2006). Some recent health literacy research draws on the theoretical approach of the 'New Literacy Studies' in which literacy, or more accurately, literacies, are seen as social practices and therefore 'situated' contextually (e.g. Barton & Hamilton 1998, Barton, Hamilton & Ivanic 2000). Within this approach the focus is on how people in their everyday lives access health information and services within their local community networks (Green 2007).

To date, LLN providers and health organisations have essentially operated independently of each other in relation to health literacy. At a local level, when LLN providers focus on health topics they invite to class the occasional health expert, but little beyond this. The health sector has been more active than the LLN field in getting health literacy on the agenda, in fact, it was identified in the early 1990s in Australia as a national health target (Nutbeam 1993) and it continues to be pushed in major international forums on health promotion (Nutbeam 2005, World Health Organisation 2005). The main focus from within the health sector has been on improving ease of access to health information (for example, rewriting pamphlets) and the concept of health literacy has become more specialised in recent years with, for example, concepts such as mental health literacy (Jorm *et al.* 2006) and maternal health literacy (Renkert & Nutbeam 2001). While there have been calls from within the health sector for more research into health literacy (Keleher & Hagggar 2007) and while at least one state health system (Department of Human Services 2006) is providing some research funding, there are currently no "formal alliances, shared agenda, unifying framework or national approach" to take forward a broader policy framework linking the LLN field with the health sector (Green *et al.* 2007:30).

Cross-sectoral partnerships

The adult LLN field has been alerted to the potential for collaborative work in the health sector (Hartley & Horne 2006), but the problem has been described largely as one of gaining the interest of a poorly resourced health sector (Figgis 2004). The adult LLN field has also been provided with the elements of an effective model for this type of collaborative work. Wickert and McGuirk (2005) indicate that the future for LLN will involve a shift away from stand-alone institutional provision to community capacity models involving cross-sectoral partnerships with sectors such as health. They base their ideas largely on the success of overseas 'joined-up' models in Birmingham in the UK (Bateson 2003) and New Orleans (Cowan 2004). As in many workplace literacy programs, LLN provision within these partnerships needs to be 'integrated' with the issues and problems involved in these sectors (McKenna & Fitzpatrick 2005). Cross-sectoral partnerships have been promoted heavily in VET research in recent years (Allison *et al.* 2006, Billett *et al.* 2005, Guenther *et al.* 2006) and the most prominent characteristics of successful partnerships include trust and strong network relationships.

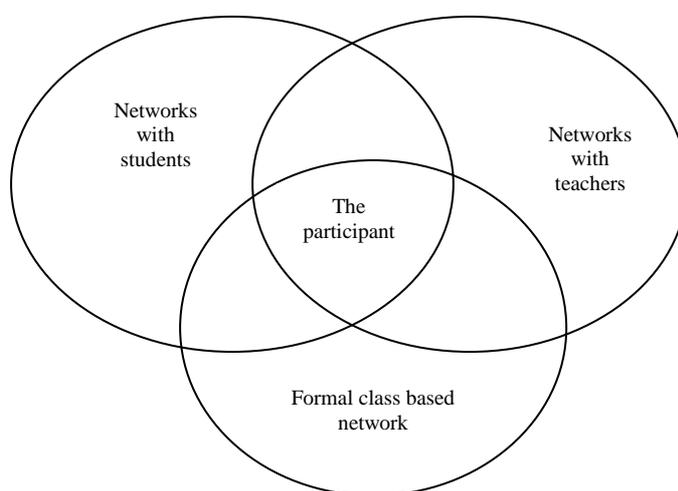
Social capital outcomes

Social capital is usually a strong feature in the above community capacity models, and a recent NCVER-funded project by Balatti, Black and Falk (2006) suggests that social capital outcomes can result from adult literacy and numeracy course participation and that they affect the socioeconomic wellbeing of the students and/or community.

Hence social capital outcomes are useful and not merely a benign by-product of participation (p.39).

Social capital in these discussions is understood to mean “networks, together with shared norms, values and understandings which facilitate cooperation within or amongst groups” (Australian Bureau of Statistics 2004: 5). This focus on social capital outcomes is new in the adult LLN field (Black, Balatti & Falk 2006) and offers an alternative and potentially valuable means of considering the outcomes of adult LLN courses. Social capital outcomes are realised as a result of specific teaching strategies, such as promoting interaction with peers, and through the new networks and relationships experienced in the course. Balatti, Black and Falk (2007) indicate the need to reframe adult literacy and numeracy teaching/learning to include the idea of the student as a member of networks, a perspective which would make the social capital-building function of the courses more explicit (see Figure 1).

Figure 1: Participant membership of course-related networks



To date this form of analysis has not extended beyond formal VET provision to promoting well-informed integrated literacy and numeracy provision in community-based programs – a research gap which this current paper hopes to start to fill.

Health sector workers

In looking at partnership between LLN and health we need to move beyond the concept of health literacy and also consider LLN provision for those who work in the health sector. In particular, the lower skilled/AQF level workers in the health sector; the care workers, cleaning and catering staff for example, are often in need of improved LLN skills, especially in light of the training involved with new accreditation and compliance requirements in the health sector (Wyse & Casarotto 2004). This aspect of workplace LLN has been addressed to some degree with Commonwealth-funded WELL (Workplace English Language and Literacy) programs. However, there has been no national approach comparable to the United Kingdom where ‘life skills’ (which include LLN) have been embedded within the workforce structures of the health and social care sectors (Weston 2006).

The three case studies reported in this paper concern LLN provision for clients of the health system rather than to workers within the health sector.

Research methods

As part of the NCVER project on which this paper is partly based, there were two main phases to the research: an environmental ‘scan’ of partnerships involving LLN providers and the health sector in New South Wales, followed by an action research component focusing on a small number of case studies of LLN teachers and health people working together. Action research was also used in the other DEEWR project on *diabetes literacy*. In this paper the focus will be primarily on these action research case studies.

Denscombe (1998: 57-67) explains that action research involves four main characteristics. It is based on *practical*, hands-on issues; it relates to *changing* matters; it involves a *cycle of research*; and teachers are encouraged to *participate* as collaborators in the research. In particular, as part of the cycle of research, teachers and researchers *plan* a strategy of action, *act and observe* what is happening in the classroom, and then *reflect* on the effectiveness of the strategy. On the basis of these reflections, the plan is revised accordingly and the cyclical process continues (Kemmis & McTaggart 1988). In the cases outlined in this paper, LLN teachers and health workers introduced team teaching and strategies designed to promote not only the learning of new skills and knowledge (human capital), but social capital outcomes as well. In each case study the researcher met with the teachers following each class in an informal interview of up to one hour and tape recorded their reflections on their teaching approaches and methods and likely outcomes. All interviews were later transcribed in full and these transcriptions formed the primary data for the research.

Action research is particularly suited to researching language and literacy classrooms and is usually associated with qualitative research methods (Burns 1999). It can be considered ‘grounded’ research in so far as it “enables the researcher to adopt interpretations that are motivated by data derived from actual social situations ... rather than theoretical constructs alone” (Burns 1999: 25).

Findings and discussion

In this paper just three case studies of partnerships from the two research projects will be considered. As the research projects are current, data have yet to be fully documented and analysed and therefore the findings and discussion outlined here need to be considered preliminary only. The aim is to identify some of the main issues involved in LLN/health partnerships at the practitioner level.

One way of classifying partnerships between LLN providers and the health sector is the extent to which the partnerships involve LLN as ‘stand alone’ or ‘integrated’. By ‘stand alone’ I refer to a primary focus on teaching LLN as separate skills. By ‘integrated’ LLN in this context (sometimes referred to as ‘embedded’ LLN, see Wickert & McGuirk 2005), I refer to a primary focus on teaching about health-related aspects, and LLN skills are taught not as separate skills but in the process of teaching about health (i.e. they are ‘built in’, see McKenna & Fitzpatrick 2005).

Case Study 1 - 'Stand alone' LLN within a health organisational context

This case study features an inner Sydney medical centre, established twenty years ago to provide health care for sex workers in the local area. Its client group now includes other 'marginalised' people in the area as well, such as intravenous drug users and youth at risk. Centre personnel include a doctor, nursing and administrative staff, and counsellors. One of the functions of the centre is to provide a methadone program for clients. One afternoon every week an Aboriginal 'health and healing' group meets at the centre, and it was members from this group who requested a literacy program. Since the beginning of 2007 an Aboriginal education college in Sydney has provided a fortnightly literacy class at the centre, thus becoming the LLN 'partner'.

The LLN class is 'stand-alone' in so far as the teacher teaches 'literacy'. In a room with a central table and few teaching facilities (no whiteboard for example), the teacher provides discussion and work sheet exercises based on a range of different topics of interest to the students, but all with the main focus on improving reading and writing skills. 'Literacy' therefore is the reason for this small group of students/clients meeting together in a classroom network. However, it could be argued that the class is 'integrated' with health in that the students in the class are at the same time members of at least two other health social networks: the Aboriginal 'health and healing' group and the medical centre generally. In relation to the latter, for example, the teacher commented that sometimes the doctor will pop his head around the door and say to a client, "I can see you now". Furthermore, present during every lesson are two counsellors from the medical centre, one of whom is Aboriginal, and both of them participate in the lesson. So, while literacy skills are taught as 'stand alone', and health topics do not feature necessarily, the class itself is very much an 'integrated' part of the medical centre.

While the focus is on 'literacy' learning, the teacher acknowledges that it's not grammatical rules she is concerned with, rather, her priority is what she terms individual 'empowerment', which, as she explains, involves the students realising they still have skills despite not using them for many years. The teacher refers to herself as a 'facilitator', seeing her role as providing the literacy setting but not dictating content. The classroom environment is necessarily respectful and non-judgemental. It is also highly interactive involving lots of discussion, flexible and informal with the latter two factors being reflected in one student feeling relaxed enough to bring her dog along to the class each week. This overall learning environment (the pedagogy) would appear to result in social capital outcomes. There is evidence, for example, of increased bonding between students and changes in the ways they support each other in class. Some students have also visited the Aboriginal education college in a neighbouring suburb and there are signs they may undertake courses there next year (i.e. linking social capital).

The relationship between the LLN teacher and the health staff is close and based largely on trust built up previously. The LLN teacher was contacted in the first place by one of the centre's counsellors because they knew each other from having both taught at the Aboriginal education college a decade or so previously. At the end of each lesson they reflect together on issues to do with how the course is going. However, in relation to the health-related aspects of the clients' lives, there is a sharp distinction in roles. The LLN teacher is not informed, and neither does she ask, about the life and health aspects of the students/clients. To a large degree there appears to be

congruence in the philosophical assumptions and beliefs of both the LLN teacher and the health workers and in particular the counsellor who first set up the literacy class. Neither of them is Aboriginal, but both hold similarly strong social justice beliefs and notions of empowerment that help to enable them to work together productively. In this case study, therefore, the discourses of health and LLN overlap to produce an effective and trusting partnership.

Case study 2 – “Integrated” LLN within a health context

This second case study features a three-way partnership involving a Muslim women’s centre in western Sydney, a TAFE adult literacy section and an area health service. The Muslim women’s centre is a community organisation providing mainly advice, support and advocacy services. For several years a TAFE College has provided a weekly literacy class as an off-campus program. The informal three-way partnership for a health course arose as the result of a deliberate exercise to promote cross-sectoral LLN programs in local communities (Wickert & McGuirk 2005). The aim was to conduct a weekly two-hour health course for Muslim women with a women’s health coordinator team teaching with the regular LLN teacher. Previously the centre had conducted one-off health workshops with guest speakers from various health organisations and it was clear that health issues were both popular and needed.

This was primarily a health course and LLN skills were integrated within it. The participants were all local Muslim women from often different demographic (age, marital status) and cultural backgrounds, though Arabic was the most common language. They were recruited to the course primarily through the networks of the Muslim women’s centre.

The content of the course was dictated by what the students wanted. Students in the existing LLN class (who also wanted to attend the health course) nominated the topics of healthy eating, exercise and stress relief, but then each session took on, in the words of the health coordinator, “a life of its own”. The health expert, the women’s health coordinator, explained her teaching approach as follows: “... the whole idea is for them to take control, it’s about empowering them ... to be healthy themselves”. She later explained further that she wanted to enable the women “to make informed choices” about their health. Interestingly, her fellow team teacher, the LLN teacher, also promoted empowerment but with a slightly different meaning. She saw it more about helping people to “positively engage with the ‘new’ community/culture/way of life – it’s about breaking that sense of isolation and ‘otherness’ ...”

The sessions themselves were extraordinarily interactive with avid discussions interspersed with informal interpreting as students grappled with health issues and the language. The LLN teacher described the interaction within this classroom network as “more like the conversation around the dinner table” as one topic led to another with lots of cross threads. So interactive and informal were the discussions that at times individual students ‘disclosed’ deeply personal information about their lives, events that caused the health coordinator some concern because she felt they belonged more in the domain of one-on-one counselling. Certainly the pedagogy resulted in social capital outcomes for the women in the form of increased trust, self efficacy, bonding, and changes in the way women supported one another.

LLN issues were dealt with when or if they arose in the lesson. Participants were learning LLN skills but almost incidentally in the course of learning about health. As the LLN teacher explained after one session, “the vocabulary you use is just

extraordinary, ‘anti-inflammatory’ and ‘anti-‘ whatever ... and if anyone hadn’t realized what ‘anti’ meant, well, they will certainly realize now, after today.”

The women’s health coordinator and the LLN teacher planned lessons by email before the sessions and reflected together after sessions. They had similar ideas and approaches to how and what they should teach. They had a close and complementary working relationship in which there was no clear distinction between their respective roles. The women’s health coordinator was the health ‘expert’ but with teaching experience; the LLN teacher was an expert in her field (LLN) but also had knowledge and experience on health matters. As the LLN teacher said, “we sort of cross-fertilise ... seeing other ways of looking at things”

Case study 3 – “Integrated and equal” LLN within a health context

This third case study also features integrated LLN but in a slightly different specialized way. A ‘diabetes literacy’ course was team taught by a dietitian and a LLN teacher to a group of ten Chinese residents in a neighbourhood centre. This innovative course resulted from a partnership project between a TAFE college and an area health service funded by DEEWR (formerly DEST). The course aimed to educate for the prevention of type 2 diabetes, and Chinese populations were a target given their higher risk category. The course ran for seven weeks and was structured around the themes of: what is diabetes, food and healthy eating, and exercise. The students were all local Chinese residents, with ages ranging from the mid 50s to late 80s. Many of the students spoke only limited English and therefore a translator (the Chinese community worker from the neighbourhood centre) was actively present during all sessions.

The focus of the course was clearly on diabetes, what it is, and how best to prevent it. The dietitian was the knowledge expert with an essentially content role. The LLN teacher’s role was essentially pedagogical, to structure the learning environment to ensure the students maximized their learning opportunities. The LLN teacher, with little prior knowledge of diabetes, was more than a support person to the dietitian, she had an equal role. In planning for a session, for example, the dietitian would outline the topics she would like to teach in an email to the LLN teacher, who would then:

... think about it from a literacy point of view, how can we do that, and structure the lesson plan ... maybe think of some exercise we can do together, to clarify things ... C (dietitian) does the content bit in the middle and I sort of clarify it, what they know, eliciting stuff from them.

Despite the complexities of dealing with the technical language of diabetes with a group of non-English speaking background students, the partnership worked very well and the students were engaged and enthusiastic throughout the course. In the classroom in fact it was an effective three-way partnership as the dietitian explained:

If it’s a little more complex ... I’ll look at S (translator) and say, “Do you want to translate that?” and give her a moment to translate ... and when I’ve finished a bit of content, B (LLN teacher), would go through it and revise

The success of this partnership was based on good communication and planning among the presenters and respect for one another’s skills. It was also founded on an openness in the classroom that accommodated respect for the students, their culture and their knowledge. For example, when it came to exercise, the Chinese participants

had their own version of Tai Chi that the presenters were happily (though clumsily) prepared to learn and participate in.

The outcomes of the course are still being evaluated, but as with the other two case studies, there were social capital outcomes in addition to improved knowledge and skills. There was evidence the participants had changed in terms of taking greater responsibility for their health (self efficacy) and in the ways they sought support from others and shared their knowledge. There were also important links to other health organizations for support.

Conclusions

As indicated earlier in this paper, these three case studies of LLN/health partnerships form parts of projects that are ongoing and findings and discussion are necessarily preliminary. The case studies in this paper, therefore, are more descriptive than analytical. Over the coming months more in-depth analytical reports on the case studies will be forthcoming. It also needs to be pointed out that while this paper is about LLN/health partnerships, inevitably it is the LLN perspective that is foregrounded because all the case studies are based on Commonwealth government 'adult literacy' research funding.

The three case studies, whilst not yet properly evaluated, can be considered successful partnerships. In two of the cases there were strong knowledge and skills outcomes in relation to students learning about healthy living generally and diabetes prevention in particular. In each case study, however, it has also been indicated there were social capital outcomes which have recently been highlighted as significant outcomes from adult LLN courses (Balatti, Black & Falk 2006). Social capital outcomes, as indicated in the literature review, are increasingly important as they relate strongly to community capacity building projects which are promoted in the adult LLN field (Wickert & McGuirk 2005) and at the highest levels of health promotion (Nutbeam 2005, World Health Organisation 2005).

An important aspect of these discussions involves the concept of 'empowerment', which featured strongly in two case studies and was alluded to in the third. The adult LLN field has long embraced the term empowerment drawing largely on the Freirean concept of conscientisation (Freire 1972) which formed the basis of the critical literacy tradition. But empowerment is clearly a central tenet of health promotion discourses also with notions of individuals and communities taking control of their own health (World Health Organisation 1986, 2005). The case studies demonstrated that while empowerment is a key concept in these partnership contexts, there are differing interpretations over its meaning, and this needs to be explored further in other research forums.

Analysing the elements of pedagogy which can be seen to result in social capital outcomes is a key focus of the NCVET project which features case studies 1 and 2. These will be reported on in the near future and should contribute to providing models for LLN partnerships with the health sector and other sectors. What is clear at this stage, based on the case studies outlined in this paper, is that a successful partnership at the practitioner level depends on a number of key factors. These include mutual trust and respect for each other's professional skills. When these factors are present,

LLN teachers and health professionals feel comfortable working with each other, and in this situation, as one presenter said, “we just jump up and interchange”. Other key factors include cooperation and joint planning as considerable time was spent in at least two of the case studies planning sessions ahead by email and phone. The action research element also demonstrated the value of joint reflection at the conclusion of sessions. Often this was a means of validating what was happening in the classroom, but it was also useful for adapting future lessons to better meet the needs of the students.

Finally, a philosophical congruence over the rationale for the course and the way the course is taught is helpful in these partnerships. Currently we know little of the commonalities and differences in the discourses of health and adult LLN. Understanding where professionals from both sectors are coming from and examining and comparing their respective ideological assumptions would go a long way to assisting future partnerships and providing models of how best to work together.

References

- Australian Bureau of Statistics. (2004), *Measuring social capital: An Australian framework and indicators*, Information paper (Catalogue No. 1378.0), ABS, Canberra
- Allison, J., Gorringer, S. & Lacey, J. (2006). *Building learning communities: Partnerships, social capital and VET performance*. National Centre for Vocational Education Research, Adelaide.
- Balatti, J., Black, S. & Falk, I.(2006), *Reframing adult literacy and numeracy course outcomes: A social capital perspective*. National Centre for Vocational Education Research, Adelaide.
- Balatti, J., Black, S. & Falk, I (2007), Teaching for social capital outcomes: The case of adult literacy and numeracy courses, *Australian Journal of Adult Learning*, 47:2, 245-263.
- Barton, D. & Hamilton, M. (1998), *Local literacies: Reading and writing in one community*, Routledge, London.
- Barton, D., Hamilton, M. & Ivanic, R. (eds) (2000), *Situated literacies: Reading and writing in context*, Routledge, London.
- Bateson, G. (2003), *Moving the mountain: Halfway there? A whole city approach to basic skills development*. Viewed 29 September 2007
www.coreskills.co.uk/index.html
- Billett, S., Clemens, A. & Seddon, T. (2005), *Forming, developing and sustaining social partnerships*, National Centre for Vocational Education Research, Adelaide.
- Black, S. (forthcoming), *Diabetes literacy: A partnership approach to educating culturally and linguistically diverse people about the risks and prevention of type 2 diabetes*, DEEWR Innovative Projects 2007, Canberra.
- Black, S., Balatti, J. & Falk, I. (2006). Social capital outcomes: The new focus for adult literacy and numeracy courses, *Australian Journal of Adult Learning*, 46:3, 318-336.
- Black, S, Balatti, J & Falk, I (forthcoming), *Literacy and numeracy development in partnership: Social capital approaches*, National Centre for Vocational Education Research, Adelaide.
- Burns, A. (1999), *Collaborative action research for English language teachers*. Cambridge University Press, Melbourne.

- Cowan, M. (2004), 'Beyond single interests: Broad-based organising as a vehicle for promoting adult literacy' in J. Comings, B. Garner & C. Smith (eds) *Review of Adult Learning and Literacy, Volume 6, Connecting research, policy and practice*. Jossey Bass, San Francisco.
- Cuban, S. (2006), "Following the physician's recommendations faithfully and accurately": Functional health literacy, compliance, and the knowledge-based economy, *Journal for Critical Education Policy Studies*, 4:2 Viewed 29 September 2007 www.jceps.com/
- Denscombe, M. (1998), *The good research guide: For small-scale social research projects*. Open University, Buckingham.
- Department of Human Services (2006), *Research programs*. Victorian Government Health Information, Viewed 29 September 2007 www.health.vic.gov.au/researchprograms/
- Figgis, J. (2004), *Literate Australia: A whole life approach. Report No.1: taking literacy to fresh fields*, Viewed 29 September 2007, www.acal.edu.au/publications_papers.shtml
- Freebody, P. & Freiberg, J. (1997), *Adult literacy and health: Reading and writing as keeping-well practices*. Language Australia, Melbourne.
- Freire, P. (1972), *Pedagogy of the oppressed*. Penguin, Harmondsworth.
- Green, J. (2007), Health literacy: socially situating community-based research, *Fine Print*, 30:1, 3-7.
- Green, J., Lo Bianco, J. & Wyn, J. (2007), Discourses in interaction: The intersection of literacy and health research internationally, *Literacy & Numeracy Studies*, 15:2 19-37.
- Guenther, J., Falk, I., Arnott, A., Lucardie, D. & Spears, H. (2006), *How can VET/ACE partnerships improve industry, community and individual socio-economic well-being?*, National Centre for Vocational Education Research, Adelaide.
- Hartley, R. (1989), *The social costs of inadequate literacy*, DEET, Canberra.
- Hartley, R. & Horne, J. (2006), *Social and economic benefits of improved adult literacy: Towards a better understanding*, National Centre for Vocational Education Research, Adelaide.
- Hohn, M. (1998), *Empowerment health education in adult literacy: A guide for public health and adult literacy practitioners, policy makers and funders*, National Institute for Literacy, Lawrence, Mass.
- Jorm, A., Barney, L., Christensen, H., Highet, N., Kelly, C. & Kitchener, B. (2006), Research on mental health literacy: What we know and what we still need to know, *Australian and New Zealand Journal of Psychiatry*, 40:1, 305.
- Keleher, H. & Haggart, V. (2007), Health literacy in primary health care, *Australian Journal of Primary Health*, 13:2, 24-30.
- Kemmis, S. & McTaggart, R. (198), *The action research planner*, Deakin University, Geelong.
- Kickbusch, I., Wait, S. & Maag, D. (2006), *Navigating health: The role of health literacy*, London: International Longevity Centre – UK. Viewed 29 September 2007, www.ilcuk.org.uk/files/pdf_pdf_3.pdf
- McKenna, R. & Fitzpatrick, L. (2005), *Integrated approaches to teaching adult literacy in Australia: A snapshot of practices in community services*. National Centre for Vocational Education Research, Adelaide.
- Nielsen_Bohlman, L., Panzar, A. & Kindig, D. (eds) (2004), *Health literacy: A prescription to end confusion*, Institute of Medicine, Washington DC.

- Nutbeam, D., Wise, M., Bauman, A., Harris, E. & Leeder, S. (1993), *Goals and targets for Australia's health in the year 2000 and beyond*, AGPS, Canberra.
- Nutbeam, D. (1999), Literacies across the lifespan: Health literacy, *Literacy and Numeracy Studies*, 9:2, 47-55.
- Nutbeam, D. (2005), What would the Ottawa Charter look like if it were written today? Viewed 18 March 2008 at www.rhpeo.org/reviews/2005/19/index.htm
- Pfizer. (2006), *Pfizer clear health communication initiative*, Viewed 29 September 2007, www.pfizerhealthliteracy.com/
- Renkert, S. & Nutbeam, D. (2001), Opportunities to improve maternal health literacy through antenatal education: An exploratory study, *Health Promotional International*, 16:4.
- Rootman, I & Ronson, B (2005), Literacy and health research in Canada: Where have we been and where should we go? *Canadian Journal of Public Health*, 96:2, 62-76.
- Shohot, L. (2004), Health and literacy: Perspectives, *Literacy and Numeracy Studies*, 13:1, 65-83.
- Weston, B (2007), *Stepping forward: The main steps to embedding Skills for Life in health & social care – what, why and how*, UNISON, London
- Wickert, R & McGuirk, J (2005), *Integrating literacies: using partnerships to build literacy capabilities in communities*, National Centre for Vocational Education Research, Adelaide.
- World Health Organisation (1986), Ottawa Charter for Health. First International conference on health promotion. Viewed 18 March 2008 at www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
- World Health Organisation (2005), The Bangkok Charter for health promotion in a globalised world. Viewed 18 March 2008 at www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/print.html
- Wyse, L. & Casarotto, N. (2004), Literacy in the world of the aged care worker, *Literacy and Numeracy Studies*, 13:1, 19-30.