Promoting Health and Literacy for Women's Empowerment

Promoting Health and Literacy for Women's Empowerment

UNESCO

United Nations
Educational, Scientific and
Cultural Organization

UNESCO Institute
for Lifelong Learning

CONTENTS

FOREWORD

This publication is the third in a series of research studies focused on literacy and women's empowerment. Its aim is to contribute to the development of cross-sectoral approaches to the provision of adult literacy, education and training, traversing policy on education, family, integration, citizenship, health, social welfare and public finance. The use of such approaches will be necessary in realizing the vision set out in the 2030 Agenda for Sustainable Development and, in particular, in the Education 2030 Framework for Action. Policymakers must move beyond an inward-looking 'silo' mentality and instead bring together health, literacy and gender equality in institutional collaboration and integrated programmes. This paper uses a number of specific examples to show how literacy programmes for young people and adults, with a particular focus on young and adult women, can contribute to the achievement of the Sustainable Development Goals.

The relationship between health, gender equality and education has been extensively investigated. The existing literature sheds particular light on aspects related to literacy for young and adult women. On the one hand, it shows how the acquisition of literacy skills contributes to improving people's health, while also fostering the empowerment of women. It is well documented that those who have had access to literacy and education tend to adopt healthier behaviours and have a greater measure of control over their bodies. On the other hand, progress in health outcomes and gender equality can also be seen to strengthen the literacy skills of both women and men, demonstrating an interdependent cause-and-effect relationship between the three domains: education, health and empowerment. Considering education, health and empowerment as interdependent factors in people's lives also acknowledges the empowering impact literacy has both on individuals and on their families and communities. This is shown by the programmes analysed in this study, all of which feature in the UNESCO's Effective Literacy and Numeracy Practices Database. The 2030 Agenda for Sustainable Development has highlighted how the achievement of each and every Sustainable Development Goal (SDG) is interdependent on the progress towards and achievement of the others. This demonstrates the need for cross-sectoral approaches to 'achieve gender equality and empower all women and girls' (SDG 5), and provides us with an opportunity to rethink some existing conceptions with regard to health. SDG 3 in fact moves away from traditional perspectives to see health not simply in terms of the treatment and prevention of disease, but rather as the ensemble of conditions, including access to quality education, necessary to 'ensure healthy lives and promote well-being for all at all ages'. Health as a state of well-being, women's empowerment and education are again interlinked; something reflected also in the 2015 UNESCO Recommendation on Adult Learning and Education, which states that 'the aim of adult learning and education is to equip people with the necessary capabilities to exercise and realize their rights and take control of their destinies'.

With this publication – a contribution to the 2016 International Literacy Day celebration – it is my hope to share with stakeholders the understanding that while there is still much to do to 'ensure inclusive and equitable quality education and promote lifelong learning opportunities for all' (SDG 4), especially for young and adult women, this can be achieved through new partnerships and effective collaboration between the health, education and social sectors. I am convinced that the intrinsic value of literacy and education, extending far beyond economic development, is to empower people. This means enabling women and men, through education, to take control of their own health and well-being as well as to determine their own futures.

Arne Carlsen, Director,
UNESCO Institute for Lifelong Learning

1. INTRODUCTION

'Learning gardens', 'men's sheds', Our Bodies Ourselves blog and community action against female genital mutilation/cutting (FGM/C) illustrate just a few of the ways in which literacy, learning, gender and health can come together in a process of empowerment. Through a review of programmes linking literacy and health, this paper contributes to a process of reflection on how youth and adult literacy can support health enhancement and women's empowerment.

The recognition of the synergies between health, education and gender equality underpins the Education 2030 Incheon Declaration's commitment (World Education Forum, 2015) to promoting quality lifelong learning opportunities for all: 'Education is one of the most potent ways to improve an individual's health – and to make sure the benefits are passed on to future generations' (p.7). Evidence from the health sector also suggests that healthy and empowered women are 'well positioned for the many roles they have as mothers, caregivers, workers, volunteers and leaders' (Langer et al. 2015, p. 1169). On 1st January 2016, the 2030 Sustainable Development Goals (SDGs) officially came into force and will guide international and national agendas for the next fifteen years. The seventeen SDGs can be seen as either a highly fragmented vision (with 169 targets) or as a holistic agenda promoting inter-sectoral interaction for sustainable development. Taking the latter perspective, this paper sets out to look at the interconnections between three of these goals, specifically in relation to adult literacy:

> **SDG 3:** Ensure healthy lives and promote well-being for all at all ages.
> **SDG 4:** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
> **SDG 5:** Achieve gender equality and empower all women and girls.

All three goals put a strong emphasis on equity, inclusiveness and holistic approaches. As compared to the Millennium Development Goals (MDGs), the SDGs are supported by a stronger understanding that well-being embraces more than health facilities and that education means more than elementary literacy and formal schooling. Gender equality cross-cuts the SDGs and refers here to 'the equal rights, responsibilities and opportunities of women and men and girls and boys...recognizing the diversity of different groups of women and men' (UNESCO, 2014a, p. 3).

The challenge for educators, policy makers and all stakeholders is how to put the 2030 vision into action, given the acknowledged difficulties of working across and between sectors at local, national and international levels. Part of the difficulty undoubtedly lies in institutional financial and governance constraints. Gaps in knowledge and a tendency to work in isolation from each other are significant factors too when it comes to sharing experience and good practice across sectors and between different fields of expertise. The aim of this paper is therefore not only to identify what works in terms of programme intervention and good practice, but also to move towards a common understanding between professionals – health practitioners and educationalists – who share similar goals. For this reason, the paper begins by looking at what is meant by terms such as literacy, health, 'health literacy', learning and empowerment within these different fields.

A student from the Literacy for Women programme (Iraq).

2. LITERACY AND HEALTH

2.1 DEFINING LITERACY

A recent definition by UNESCO (2015a) states that:

> *Literacy is a key component of adult learning and education. It involves a continuum of learning and proficiency levels which allows citizens to engage in lifelong learning and participate fully in community, workplace and wider society. It includes the ability to read and write, to identify, understand, interpret, create, communicate and compute, using printed and written materials, as well as the ability to solve problems in an increasingly technological and information-rich environment.*

This understanding goes beyond earlier definitions of functional literacy as applied reading, writing and numeracy, to recognise literacy as multi-modal and engaging with a complexity of oral, visual and digital practices. Literacy is conceived as a process that takes place both inside and outside educational programmes and settings, involving the use as well as the learning of literacy skills. The notion of literacy as embedded in social and cultural practices and as a continuum rather than a divide between literacy and orality (Street, 1993) shifts attention from literacy skills in classrooms to a consideration of communicative practices in everyday life. In the context of literacy learning, the term 'critical literacy' builds on Freire's pedagogical approach to developing 'critical consciousness': 'a goal to be attained in part through engaging with books and other written materials, but, more profoundly, through 'reading' (i.e. interrogating, theorizing, investigating, questioning...) and 'writing' (i.e. acting on and dialogically transforming) the social world' (UNESCO, 2005, p. 152). By building on academic work about literacy as applied, practised and situated (UIL, 2013a, p. 20), this paper looks at how literacy learning can be connected to or emerge from health beliefs, practices and provision.

2.2 A BROADER CONCEPTUALISATION OF HEALTH

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.* (WHO, 1948)

This definition adopted by the World Health Organization in 1948 has continued to inform policy development, including the recent SDGs, which emphasise this broader understanding of health as well-being not limited to policy in the health sector. The theory of social determinants of health (SDOH)[1] underlines that our health is affected by diverse influences including work, ethnicity, food security, gender, the environment, social relationships and, of course, education. The WHO engages directly with this recognition of how social and economic inequalities affect health through its constitution, which emphasize a rights approach (WHO, 2006). Within this approach, gender equality has been recognized as critical and led to a strong commitment to addressing unequal gender norms and gender stereotypes that influence health policy and services (EWEC, 2015, p. 38).

The recent Global Strategy for Women's, Children's and Adolescent's Health (2016-2030) presents an expanded vision, moving from the earlier narrow focus on Maternal Child Health to a broader framework of sexual and reproductive health (Langer et al., 2015). For the first time, adolescents are included alongside women and children, recognising their 'pivotal role alongside women and children as key drivers of change in the post-2015 era' (EWEC, 2015, p. 11). The Global Strategy takes a life course approach, emphasising that a 'person's health at each stage of life affects health at other stages... and has effects for the next generation' (ibid.). Advocating an integrated and multisectoral approach, the Strategy lists 'health-enhancing factors' which include education along with water, nutrition, clean air etc. Three main objectives are outlined:

---

[1] The social determinants of health are defined by the WHO (n.d) as 'the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems'.

SURVIVE: End preventable deaths
THRIVE: Ensure health and well-being
TRANSFORM: Expand enabling environments
(EWEC, 2015, p. 6)

The focus on enabling environments and related targets – including 'eliminate all harmful practices and discrimination and violence against women and girls' – has particular relevance for this paper.

This conceptualisation of health – as not just about the prevention and treatment of disease but also about supporting and creating the conditions for well-being and equality in communities – has specific implications for the role of health professionals and educators. Over the decades, there has been a shift from health education to the multidisciplinary approach of **health promotion** (signalled first by the use of this term by the WHO in their 1986 Ottawa Charter). Whereas health education was often focused on the individual health client and their needs in relation to health services, health promotion engages with the wider community to raise awareness and directly address the social determinants of health. Describing the limitations of a health education approach, English (2012, p. 16) explains that 'a health promotion approach moves the focus from reliance on health education literature when one is sick, to community engagement in health promotion activities such as community kitchens, faith-based health programs and environmental campaigns, as an everyday occurrence'.

There has been an ideological shift from a medicalised model of health – where citizens were positioned as consumers or clients of expert medicine. But for some commentators, health promotion has not gone far enough in engaging with global inequalities and the larger political/economic structures that influence health. For instance, smoking campaigns have tended to focus more on behaviour at individual and community level, rather than addressing the power of the global tobacco industry. Emphasising the need to develop a more critical and participatory approach to health promotion, English (2012, p. 20) suggests that 'individuals need to be viewed, not as health consumers, as if health services were the source of health, but rather as health creators'.

This paper is framed by the holistic conceptualisation of health outlined above and draws on a social justice approach to health as integral to and emerging from social, political and economic inequalities. The distinction between health education and health promotion (as a more collective and politicised approach) offers a way of analysing different kinds of learning and the roles of educators in relation to literacy and health.

2.3 INVESTIGATING THE RELATIONSHIP BETWEEN LITERACY AND HEALTH

The relationship between literacy and health has been the focus of much research and policy debate. In the US, for instance, people with low literacy competency were found to be 1.5 to 3 times more likely to have an adverse health outcome as compared with those who read at higher levels (DeWalt et al., 2004). In low-income countries, particular attention has been given to women's literacy, as linked to positive health outcomes, including the adoption of family planning, improved nutrition and sanitation. 50% of child deaths avoided between 1970 and 2009 were attributed to women's increased levels of education (Langer et al., 2015). UNESCO (2014b, p. 3) stated that a literate woman is on average 23% more likely to seek support from a midwife and educated mothers are more likely to ensure their children are vaccinated. Based on such assertions, literacy policy and programmes have generally taken an instrumental and limited approach to women's empowerment, focusing on literacy in relation to their reproductive role as mothers. Conversely, looking at the impact of health on literacy and education, research has shown that the healthy adults are less likely to rely on daughters' labour, freeing them to attend school (Langer et al., 2015).

The majority of studies in this area have adopted a quantitative research approach. An example is the 2011 study by Ali et al. which compared the health of children born to literate and non-literate women at a hospital in Pakistan and found a significant difference with regard to vaccination (with more educated mothers being more likely to vaccinate their children). Though often demonstrating a significant statistical correlation, such studies have raised questions about how other variables – particularly poverty – might influence the relationship between women's literacy and health outcomes. The conceptualisation of health

within such studies could be related to the earlier discussion about the need to recognise the wider influences on health. More significantly (for this paper on adult literacy), the women's literacy rates on which such research is based, tend to measure years of schooling and rarely distinguish between women who have learned to read and write through school in their childhood or as adults (Robinson-Pant 2005). Defining literacy – and measuring literacy – seems a harder task than assessing health outcomes through child mortality or fertility rates. So adult literacy levels are often estimated by using completion of school grades as a proxy indicator, self-reporting (whether a woman declares her level of literacy or lack of it) or seeking information from the head of household. In the case of the Pakistan study above, women were asked to read newspaper headlines to see if they were 'literate' (Ali et al., 2011). The assumed divide between literacy and illiteracy underpinning this body of research contrasts with the definition of literacy given earlier, as a continuum of skills and proficiency levels.

Going back to the Belém Framework For Action (UIL, 2010a, p. 6), this paper argues that 'the right to literacy (is)... a prerequisite for the development of personal, social, economic and political empowerment.' This notion of literacy as an 'empowering tool' (UIL, 2013a, p. 20) is important for exploring how women engage critically with multiple inequalities in their lives, including the factors influencing health. 'An enriched literate environment' (ibid.) is also identified as a key element for understanding literacy and turns attention to the producers of written and visual texts as well as those who use them. The term 'literate environment' puts the emphasis not only on what is already there (the 'literacy environment'), but 'the condition we are trying to achieve' and 'contexts that are particularly supportive of the acquisition and use of literate skills' (Easton, 2014, p. 36).

The definition of literacy as a continuum, involving a wide range of skills, knowledges, communication practices (some related to health outcomes), and the literate environment has emerged from policy makers and researchers in the education sector. This paper turns now to compare ideas about literacy and learning, common in the health sector and used by health professionals, particularly the term 'health literacy'.

3. 'HEALTH LITERACY': THE ALTERNATIVE PERSPECTIVE OF HEALTH PROFESSIONALS

Does 'health literacy' mean the same as 'literacy and health'? First used at a health education conference in 1974, the term has evolved, as Frisch et al. (2011, p. 119) point out, to mean more than 'functional literacy in the health domain'. This section looks at how the meaning of 'health literacy' has evolved over time and in different contexts.

The definition of health literacy emerged in the health sector with a narrow focus on reading and writing health materials, but has broadened to include the use of such knowledge, reflecting the more holistic health promotion approach outlined earlier. This is illustrated by the WHO's (1998) definition of health literacy:

The cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health (WHO, 2013).

Since 1998, various types of 'health literacy' have been defined, often in terms of the different kinds of skills developed in relation to health knowledge/citizenship. Nutbeam's (2000) distinction between three types of health literacy have been particularly influential, consisting of:

- functional health literacy (basic reading and writing skills which enable the understanding and use of health information);
- communicative or interactive health literacy (more advanced cognitive and literacy skills to interact with healthcare providers and the ability to interpret and apply information to changing circumstances);
- critical health literacy (more advanced cognitive skills to critically analyse information in order to exert greater control over one's life)
  (From Frisch et al., 2011, p. 118)

The assumption in Nutbeam's model is that the advanced skills associated with 'critical health literacy' lead to greater empowerment and involvement in health-related decision making. Health literacy

has also been conceptualised in terms of the kinds of knowledge acquired (Schulz and Nakamoto, 2005). The various models of 'health literacy' presented here are all multi-dimensional, going beyond literacy as the skill to simply decode health messages or information in print. Yet they differ in terms of how far they narrow their focus to the health sector and providers and in how much they acknowledge the importance of the context in which health literacy is practised. Significantly, the research on health literacy cited above has been conducted in Canada, the US and Europe. In these 'literate rich' environments, there has been strong recognition that 'health literacy' is a two-way process involving interaction with producers as well as the readers of print and digital texts. The 'plain language' initiative (CDC, 2016), for instance, set out to improve communication between health providers and the public through enhancing the readability of medicine instructions and health promotion material. There is also the importance of supporting writing skills – for instance, when patients with diabetes are requested to keep daily records of their symptoms.

A major difference between approaches is the extent to which 'health literacy' is conceptualised in terms of empowerment, as in this definition by Kickbusch et al. (2005): 'It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility'. The WHO (2013) built on these ideas of personal and individual empowerment, to examine the institutional dimension of 'health literacy', particularly the need to develop linkages between multiple stakeholders and to share political power.

'Health literacy' clearly overlaps in meaning with the definitions of 'literacy and health' provided earlier, which focus on reading and writing in relation to critical reflection and empowerment. There is a strong focus on 'health citizenship' (see Zarcadoolas et al., 2005) and the skills needed for people to assert their rights to access good health facilities and information. The idea that 'health literacy' is a lifelong and life-wide learning process underpins much of the research in this field and resonates with the recent UNESCO (2015a) definition of literacy cited earlier (see section 2i). Although 'health literacy' has sometimes been criticised for promoting a medical model where the focus

is on providers and clients (English, 2012), there is some evidence of the multiple literacy domains (outside formal health programmes and facilities) where people also engage with health information.

Looking at what is different in the health sector, health educators often start from an **'asset model'** (Pakaari and Pakaari, 2012), which positions health and literacy as resources which people bring to the encounter. Ostrouch-Kaminska and Viera (2015, p. 183) illustrate in their examples of informal health education, such as men with breast cancer searching for information about the disease (Seltrecht, 2015) that 'life experience is an important concept that can both initiate a learning process and be a resource of educational activity'. This starting point contrasts with the deficit approach often taken by literacy policy makers and programmers towards 'illiterate' women' (see Robinson-Pant, 2004 and Chopra, 2004). Here the focus has been on the skills and knowledge that women lack in terms of literacy and health. Within the literature on 'health literacy', there is also stronger recognition of people's informal learning approaches and knowledge that health educators can both build on and facilitate in new directions. Informed by a social justice approach, Hill (2016, p. 46) outlines the responsibilities of adult health educators both within and outside the classroom, including: work in communities, influencing health professionals, promoting healthcare access, influencing legislation/policy, working internationally, promoting and conducting integrated research and providing education to individuals.

The different types of knowledge and skills identified in relation to 'health literacy' – exemplified by Nutbeam's model of functional, communicative and critical literacy skills – suggest greater attention to the **kind of learning** that might facilitate health outcomes. This analysis of learning processes and various factors influencing health behaviour can help to open up the 'black box' of literacy in quantitative studies cited earlier on the links between literacy and health. All too often there is an assumption of a straightforward linear cause-effect relationship between adult literacy and health improvement. An illustration comes from a women's literacy and health project in Nepal where the US implementing agency set out to evaluate through a survey whether acquiring literacy

skills had led to changed health practices. Although family planning uptake was to be directly correlated with literacy rates, the agency soon realised that the equation '(women's) literacy = changed reproductive health behaviour' would not capture the complexity of change. The process was then broken down to explore whether the literacy programme led to increased health knowledge and whether this in turn had led to changed health behaviour, asking: 'does literacy programme = increased health knowledge = greater family planning uptake?' (Robinson-Pant, 2001). A multidimensional model of 'critical literacy' and health could help, in programmes like this, to provide a more nuanced account of **why** women's literacy might have an impact on health outcomes.

So how relevant are the definitions, approaches and models of 'health literacy' in the health sector to literacy practitioners in low-income countries? Assumptions about universal access to quality health care underpin much of the 'health literacy' work that has originated in Canada and the USA and need to be mediated in situations in low-income countries where such facilities might be an aspiration rather than a reality. More significant is the focus on the formal health sector, with little acknowledgement of the strength and importance of indigenous institutions, knowledges and practices that are often dominant in communities in low-income countries. These alternative ways of 'doing health' sometimes have an influence on the formal health sector too. For instance, there may be less dependence on written record keeping within clinics and health practitioners may prioritise informal oral communication over written agreements and instructions.

Although 'health literacy' is discussed as social and cultural capital in the WHO (2013) report and elsewhere, surprisingly there is little mention of women or gender equality in relation to empowerment, nor are measures of health literacy levels disaggregated by gender. For instance, a systematic review of literacy and health in the USA by DeWalt et al. (2004), analysed health outcomes according to ethnicity, culture and age, but not gender. This seems to contrast most greatly with the educational research in low-income countries, which has focused almost exclusively on women's literacy as the key to enhanced individual,

family and community health. There is also evidence that the development of reading, writing and numeracy skills has not been such a priority within 'health literacy' approaches. The above account points to the importance of developing adult learning programmes that aim at health promotion through facilitating critical literacy and empowerment. The next section explores the concept of women's empowerment in order to broaden our understanding of how literacy and health programmes can support processes of change in gender relations.

4. EXPLORING WOMEN'S EMPOWERMENT, LITERACY AND HEALTH

Women's empowerment is all too often taken as a quantifiable outcome of development programmes – particularly within educational contexts. Conceptualising empowerment as a 'journey' rather than a destination, Cornwall and Edwards (2014, p. 7) argue that 'empowerment is a process, not a fixed state, status or endpoint, let alone a measurable outcome to which targets can be attached'. This notion of empowerment as fluid, taking different forms in different contexts, challenges the kind of research approach discussed earlier on the links between women's literacy and health. For instance, the research by Burchfield et al. (2002) into the impact of literacy on women's empowerment in Bolivia was based on surveys asking women about their behaviour and attitudes before and after attending a literacy programme in relation to various indicators of empowerment (such as whether they learned about the importance of cleanliness). The design of the research – with a control group of women who had not attended the literacy programme – implied that any indicators of empowerment could be directly associated with literacy development through the classes.

By contrast, the concept of 'hidden pathways to empowerment' (Cornwall and Edwards, 2014) conveys the unplanned and unpredictable ways in which women learn new knowledge that helps them to reflect on their situations – for instance, by watching television, chatting with neighbours, through social media and through religious practice. This involves stepping outside formal development programmes and institutions and taking a broader lens on gender issues

that influence health too. For instance, in Bangladesh, Nazneen and Sultan (2014) explore the strategies used by a women's organisation to mobilise support and to campaign against acid attacks through examining the cultural representation of women. Moving away from a focus on the individual woman becoming empowered to take into account broader social, political and cultural practices, we can then recognise that:

Empowerment is a complex process of negotiation rather than a linear sequence of inputs and outcomes (Cornwall and Edwards, 2014, p. 27).

This broader multidimensional perspective on women's empowerment and gender equality can help us to look outside planned development interventions to consider what changes may already be taking place at a global and local level that challenge gender roles and relationships. The relational dimension of empowerment has particular significance for gender equality as sometimes empowerment for one woman can mean disempowerment for another. For example, a younger sister or daughter-in-law may have to 'cover' domestic duties so that her senior female relative can attend a literacy class.

Ethnographic research on gender and literacy has revealed that not only the functional aspects, but also the symbolic value of literacy is particularly important within processes of empowerment. In disadvantaged Latino communities in Los Angeles, Rockhill observed that some husbands perceived women's literacy as a threat to men's identities in terms of perceived 'status': 'Literacy is women's work but not women's right... most do not have the right to change – to be 'somebody' – their husbands object, sometimes forcefully' (1993, p. 171). Within the health sector, the impact of women's literacy on decision-making has been of particular interest to see whether literate women have more say than their husbands in key decisions such as family planning or accessing health facilities. Ethnographic research on the family planning programme in Nepal, described earlier, illuminated that processes of decision-making were more complex than a woman simply gaining the confidence to persuade her husband. In the Nepal study, other factors such as pressure from in-laws and a woman's financial concerns about the effect of contraceptives on their productivity at work

influenced these decisions (Robinson-Pant, 2001). Literacy programmes are often evaluated in terms of women's increased decision-making power. Seeing women's empowerment as a complex process of negotiation raises important methodological issues about how decision-making (particularly around reproductive health) can be researched and evaluated.

This conceptualisation of empowerment as something which goes beyond planned development intervention and as a lens for looking at the complex processes of social change connects with the ideological shifts noted earlier in relation to health. The holistic rights approach to health promotion takes account of the diverse factors influencing health and well-being – including gender inequality. Looking at adult health learning through a feminist lens, English and Irving (2015) discuss how transformative learning has often been narrowly concentrated on individual transformation for women, rather than on challenging larger issues. They suggest that 'transformative learning… has been largely constrained to talking about health as a series of individual choices and local conditions, rather than as a venue for social transformation' (ibid., p. 34). They draw on Gorman's (2007) identification of three types of 'non school-based learning' for health in the community:

■ survival learning (such as learning to feed a family, manage low income)
■ resistance learning (such as neighbours fighting the loss of a local park)
■ struggle learning (collective action to find out why a forest is being cut with no regard to where residents collect water)
(Based on English and Irving, 2015, p. 38)

This distinction between different kinds of transformative learning suggests a way of facilitating understanding and action to address the global and local gender inequalities influencing health. In contrast to many literacy and development programmes with a 'literacy first' approach (Rogers, 1999), transformative learning can start from a gendered understanding of health inequalities and may later move towards literacy learning activities. For instance, the Boston Women's Health Book Collective in the 1960s in the USA grew out of women's concerns to take own-

ership over issues affecting their health, especially reproductive health (English and Irving, 2015). Through this movement, women came together to engage in learning, sharing experiences and in 1973 published a book called *Our Bodies, Ourselves*, demonstrating that 'women as informed health consumers are catalysts for social change' (OBOS, 2016). The book has now been published in multiple languages in different countries around the world, with women's groups adapting it to their own cultural situations and interacting through a blog on the website. This example illustrates how literacy activities and health texts can emerge from transformative learning about health and women's collective action.

So where and how do adult literacy and development programmes fit into these ideas about women's empowerment as an unplanned, unpredictable journey? The above examples of informal learning around gender equality and health suggest that **literacy may also follow, rather than initiate, transformative learning.** The focus on an individual's health needs and literacy can be combined with a more holistic and politicised approach, in order to facilitate collective action to tackle the larger inequalities that impact on women's health. Viewed from a policy and planning perspective, these ideas about connecting immediate practical health concerns ('survival learning') with longer term legal, social and economic changes (associated with 'struggle learning') could be linked with Moser's (1993) concepts of practical and strategic gender needs.[2] Practical gender needs are identified in relation to women's 'socially accepted roles in society' and 'do not challenge the gender divisions of labour or women's subordinate position in society, although arising out of them' (ibid., 40). Strategic gender needs are those 'women identify because of their subordinate position to men in their society' (ibid., p. 39) and can include women's control over their bodies, legal rights and gender violence.

Currently, literacy interventions that respond to women's (or men's) strategic gender needs through starting with a practical gender need can help tackle broader issues around empowerment and health. The wide range

of actions proposed within SDG 5 (including legislative change, supporting women's leadership, tackling gender violence and harmful practices) could be addressed through this broader approach to women's empowerment in the framework of literacy programmes.

5. TOWARDS SOME PRINCIPLES FOR INVESTIGATING ADULT LITERACY AND HEALTH LEARNING FOR WOMEN'S EMPOWERMENT

The above review of research and policy in the fields of health, literacy and women's empowerment has illuminated some key principles for investigating literacy programmes from a health and gender equality perspective:

i.   **The concept of health as a state of well-being goes beyond disease and health provision to embrace a social justice agenda.**

The shift from health education to health promotion and adopting a holistic perspective on health as connected with global inequalities has important implications for literacy programmes. This ideological stance on health raises a challenge to traditional approaches to pedagogy, curriculum and planning through advocating participatory learning and critical reflection. Positioning the individual as an active citizen rather than a passive client interacting with 'expert' health professionals has implications for the roles (and training) of all those involved in health promotion and literacy programmes.

ii. **The relationship between women's literacy and health can be investigated through looking at what kind of literacy learning and what kind of health learning supports empowerment processes.**

The research literature on women's literacy and health has focused on statistical analysis of the health outcomes associated with becoming literate. The multidimensional model of 'health promotion' and critical literacy point to the importance of researchers looking beyond reading, writing and numeracy to investigate

---

[2] It should be noted that Moser's distinction between practical and strategic gender needs was first conceptualized in the 1980s when more 'top-down' approaches to gender policy and planning were dominant.

a complex range of communicative practices around health issues in everyday life. Rather than considering literacy only in functional terms, critical approaches to literacy and health promotion, and the broader view of literacy as embedded in socio-cultural practices, highlight issues of power, identity and voice in relation to health and women's empowerment.

iii. Women's empowerment also involves informal learning about relationships, communication, social action and change beyond (as well as within) adult literacy and health education programmes.

The concept of women's empowerment, as a journey (with 'hidden pathways' to empowerment) rather than a destination, challenges educators to consider the diversity of knowledge and learning that can support social transformation. This might involve drawing on the experiences of social movements, exploring alternative learning structures and curricula, and forming groups concerned with specific social and political concerns. Literacy may emerge from or be embedded within these social processes – rather than be the starting point for women's empowerment. Informal learning is recognised as integral to such processes and intimately connected with formal and non-formal literacy and health learning too.

Underpinning these principles is the recognition that literacy and health activities need to respond to specific contexts in terms of their aims, structures and pedagogy. Rather than targeting women as a homogeneous group, this involves taking account of their differing identities, needs, linguistic and cultural practices in relation to health and empowerment. Health promotion has been conceptualised as a life-long and life-wide process of learning, suggesting the need to reconsider the many short-term women's literacy programmes in this light. Classes might, for instance, include people with literacy abilities at various levels. The issue about how to connect short-term courses with future learning opportunities raises questions about the staffing and resourcing of literacy programmes as part of a wider endeavour to facilitate health and gender equality. The envisaged collective activity on health, gender and literacy requires a stronger attention to cross-sectoral collaboration, partnership and programming. These issues will be addressed in the second part of this paper, which focuses on literacy policy, planning and programmes.

6. IDENTIFYING GOOD PRACTICE IN LITERACY PROGRAMMES FOCUSING ON HEALTH AND GENDER EQUALITY

This section uses the lens developed above to review adult literacy programmes that engage with health and gender equality which could be summarised as: health being broader than disease; development of literacy more so than just elementary levels of reading; inclusion of writing and numeracy; and empowerment as a process not an output. Adopting a holistic approach to health as embracing social, cultural, economic and political change implies that it would be possible to include almost every adult literacy programme within this definition! For this reason, this paper largely considers programmes that have explicit aims in relation to health promotion and gender equality. Their approach will be analysed under health-related sub-themes connected with specific SDG3 targets (including maternal health and child mortality, nutrition and mental health) in order to identify good practice.

6.1 MATERNAL AND CHILD HEALTH (MCH)

The majority of adult literacy programmes which incorporate a health education component focus on women's reproductive role – particularly as mother and carer for the family. This is based on what has been termed an instrumental approach to women's empowerment and the rationale that educated/literate women will have a greater positive impact on their children's health. Aubel et al. (2004) challenge this narrow focus on individual behaviour change in women of reproductive age, arguing that the role of older women in household maternal and child health issues has been largely ignored. This could also be argued for the role of young girls. An action research nutrition education project in Senegal illustrates an alternative approach. Formative research had revealed that older women were an important source of ongoing advice when women were pregnant. Men generally sought advice from their own mothers, commenting, 'The grandmothers advise us what our women and children should and should not eat. They know best' (ibid., p. 950). During the project, grandmothers were

introduced to new ideas and encouraged to reflect on common beliefs about pregnancy – for instance, that pregnant women should work hard and not eat much so that the foetus would be small and easy to deliver. As a result, 91% of women in the project villages reported that they had decreased their workload during their last pregnancy. This research pointed to the need to avoid a 'reductionist' focus in Maternal and Child Health (ibid., p. 947) and to take into account the multiple agents involved in decision making, for instance around family planning.

Looking at what kind of literacy and health approach is promoted in literacy programmes, many adult literacy primers include stories and information related to maternal and child health, which could be seen in terms of the conventional individualised 'health education' approach (as opposed to 'health promotion') discussed earlier. Teaching literacy tasks associated with accessing health care – such as learning to read directions on medical bottles, calculating doses or keeping records – could also be related to Nutbeam's model of 'functional health literacy'. A number of programmes have adopted a broader view of literacy and health, underpinned by a social justice agenda, and these will be the focus of this review.

The *Tostan Community Empowerment Programme* (UIL, 2012a) illustrates a participatory rights-based approach to literacy, gender and health, which connects with a broader life course approach to maternal, child and adolescent health (EWEC, 2015). Set up in 1991 in Senegal, the NGO Tostan International (Tostan) developed a learner-centered methodology drawing on local knowledge and beliefs to encourage participants to reflect on their own experiences. In response to women's views that 'they wanted to understand their own bodies first and then learn about child development' (Gillespie and Melching, 2010, p. 485), a curriculum was developed looking at women's health from a rights perspective and lasting for over two years. Starting with largely oral discussion, the first phase includes hygiene and health sessions on understanding the body, common illnesses and nutrition. The second phase focuses on literacy learning, including writing letters, simple project proposals and text messages on mobile phones. Through collective action on harmful practices like FGM/C and involving

a wide range of community members (including religious leaders), the programme has both built on and challenged indigenous health beliefs. Initially, some men were resentful of Tostan's focus on women's rights, leading some classes to be closed down. The NGO responded by rewriting modules to include men's rights too. Tostan's programme is underpinned by the broader understanding of literacy, outlined earlier in this paper, as multimodal, involving oral, print and digital communication and lifelong/life-wide learning.

The *Literacy for Women* project implemented by Iraqi Al-Firdaws Society (UIL, 2014) has a similar starting point to the Tostan programme in terms of women's rights and health. However, rather than promoting a participatory approach to knowledge construction and learning, Al-Firdaws has designed a curriculum to teach women more formal knowledge about systems of governance and their rights in order to enhance their role in society, the political process and democracy. The course covers topics such as 'Voting Education', 'Islam and Democracy', as well as health education. The entry point to this programme could be identified as women's strategic gender need for greater voice and representation in political and legal structures, as well as access to formal education. The approach follows the literacy curricula of the Ministry of Education and certificates are awarded to show equivalence to fourth and sixth grade of primary education. Given the strong opposition to women's education by some tribe leaders (Shekhs), Al-Firdaws implemented awareness campaigns to gain the support of all the community. By embedding health topics within their overall approach, this initiative differs from many women's literacy programmes which use MCH as the starting point. The focus on legal rights and formal educational certificates presents an alternative route to women's empowerment.

Within the field of reproductive and sexual health, indigenous knowledge and social structures have provided a valuable starting point with the potential to integrate new knowledge. In Uganda, Glanz (2009) explored the role of the *senga*, a family member (paternal aunt) who traditionally counselled her niece in sexual matters. Due to urbanisation and changing literacy practices, the *senga* institution has now evolved (from letters written by young people

A picture from the Tostan Community Empowerment Programme (Senegal)

seeking advice on sexual matters from the *senga* and 'books of secrets' in Luganda language about sexuality) to include mass media (radio) where male *sengas* also give advice. Recognising the effectiveness of this indigenous approach to sex education, the Ministry of Health planned to integrate the *senga* model into health and sexuality communication strategies.

Aiming to introduce new methods of family planning to communities in Afghanistan, the USAID-funded *REACH (Rural Expansion of Afghanistan's Community Healthcare)* programme (Sato, 2007) engaged with Islamic teaching about contraception. The programme used Quranic verses that justified spacing of pregnancies to communicate with both women and men, and produced a sheet of 'common myths about birth spac-

ing'. Mullahs in the communities played a key role in advocating contraceptive use through discussion with men. A literacy programme called *Learning for Life* (LfL) was developed to build women's confidence and self-esteem so that they could take a greater part in family decision-making (UIL, 2013b). With a curriculum covering language, health, maths and religion, the programme set out to support the education of a pool of women who could later be trained as Community Health Workers. This helped to fill a major gap: previously it had been difficult to find educated mature women for this role, only young girls who were unmarried and unable to advise on family planning. Incorporating role play and dialogue based on real-life events, LfL classes offered opportunities for women to enhance their communication skills, which they could

then use within the family and in their community health work. The REACH programme moved beyond health education to consider the democratisation of health services – noting, for instance, that some medical professionals tended to take 'an authoritarian attitude towards clients' and gave contraceptives without counselling. Like the earlier examples, REACH demonstrates the value of building on traditional beliefs and practices, as well as working holistically with the whole community and enhancing peer learning. Literacy is seen as one resource, along with health knowledge and family planning facilities, which can support women's empowerment.

Maternal and child health has been critiqued as 'uni-directional', based on message-based methods and focused on individual behaviour change (Aubel et al., 2004). By contrast, the *Bilingual Literacy and Reproductive Health* (Bi-Alfa) programme in Bolivia recognised the complexity and influence of other family members and community values on health decision-making (UIL, 2010b). Their curriculum combined awareness of women's reproductive health rights with developing women's skills of negotiation. Based on a Freirean approach, the literacy courses encouraged women and men to discuss topics from a gender perspective, such as self-esteem, violence-free relationships and decision making in families. As the programme focused on disadvantaged indigenous communities, literacy learning was conducted in both indigenous languages and Spanish, and integrated indigenous knowledge systems into the process. As a result, many rural women gained the confidence to interact with health care professionals and sought primary health care services, including screening for breast and cervical cancer. Through contextualising the contents (health, literacy and language), the programme was able to respond to the specific situation, needs and interests of participants.

The Family Literacy Programmes implemented by the ACEV Mother-Child Education Foundation in Turkey demonstrate a similar attention to enhancing the interaction between spouses as a means to addressing gender inequalities in decision-making and voice (UIL, 2011a). Their Mother Support programme focuses on positive child rearing and sexual reproductive health for mothers. At the request of the women participants,

a Father Support Programme was set up to improve the parenting skills of fathers and create a more supportive home environment. Women later reported that patterns of interaction with their husbands had changed and they were more likely to make joint decisions on matters such as birth control and child discipline. Through a functional adult literacy programme, women also gained literacy skills that gave them the confidence to access health care facilities. In targeting the whole family, these programmes recognise that health decision-making is often collective, and that women's role within this process can be strengthened through enhancing self-esteem and confidence in negotiation and literacy skills. This approach clearly engages with the ideas of health citizenship and empowerment signalled earlier.

The idea of literacy learning as involving oral skills as well as reading, writing and numeracy lies at the heart of the *Adult Literacy Programme* run by the *National Women's Council* (NWC) in Mauritius (UIL, 2016a). The programme focuses on enhancing women's self-confidence and autonomy through literacy and practical conversational skills to help them to stand up for their rights within the family. Women are also encouraged to seek support from trained counsellors or government services when faced with violence from their husbands. The literacy element of the programme – learning to fill out forms or budgeting – is directly related to their lives, aiming to increase self-esteem while reducing dependence on men. As well as using the NWC literacy course books, the class facilitators use a 'real literacies' approach (see Rogers, 1999), using brochures available locally on healthy eating, AIDS, hypertension and other health issues. At first

From the programme Bilingual Literacy and Reproductive Health (Bolivia).

glance, this programme might appear to be adopting a health education approach through functional literacy, focusing on dissemination of health information through the classes (modules include information on diseases and balanced diets). However, the overarching aim of promoting the social and economic empowerment of disadvantaged women through addressing gender relations within the household points to the social justice agenda which informs the pedagogy and curriculum.

All these programmes engage with women's health and empowerment from a rights perspective, though as the Al-Firdaws programme in Iraq illustrates, this does not necessarily involve participatory pedagogy or a curriculum which focuses on local knowledge and health needs. The programmes differ in terms of how far they put health or literacy first as the entry point and what kind of health knowledge or what kind of literacy practices they prioritise. In the NWC programme in Mauritius, functional literacy fulfils a dual purpose, enabling women to become more independent, and also to access new health knowledge through published materials. Whilst the ACEV programme in Turkey sees women mainly in their role as mothers, others like Tostan in Senegal recognise women in their many different roles, aiming to enhance their economic status and mobilise them as community activists to tackle harmful practices. Reproductive health and family planning is a particular focus of many women's literacy programmes which aim to target individual women with information or messages. By contrast, the REACH, Tostan and Bi-Alfa programmes show the importance of recognising decision-making as a collective/community practice and engage with religious and indigenous beliefs and languages to enhance communication.

6.2 COMMUNITY HEALTH AND NUTRITION

The broader approach to women and health signalled by the WHO's Global Strategy (EWEC, 2015) identifies nutrition as an important 'health-enhancing factor' across the life course. Recognising women's strong role as care-givers, some programmes have promoted women's literacy in order to enhance health and nutrition in the wider community. The *Alternative Community Education Programme* (ACEP) in the Philippines works with indigenous Ubo and T'boli peo-

ple in Mindanao who have limited access to health and education services (UIL, 2010c). The programme brings together women in literacy classes to reflect critically on T'boli knowledge and cultural systems, whilst also learning about modern knowledge systems. Through combining traditional medicine and food patterns with modern nutritional practices, community elders are invited to share stories and discuss cultural beliefs. This led to the development of 'learning gardens' to support literacy and gardening skills and raise awareness of affordable and nutritious food crops. The development of literacy skills in two languages was supported through labelling the crops in T'boli and Filipino terms and indicating the nutritional or medicinal value. The use of traditional herbal medicines and cooking of indigenous foods has become more widespread as women set up their own learning gardens at home. As well as building on indigenous knowledge, ACEP demonstrates a holistic and empowering approach to community learning and health – using their numeracy skills, women have greater confidence to deal with traders more effectively.

In Brazil, the *Alfabetizando com Saúde* programme provides adult literacy classes that promote health awareness (UIL, 2011b). Funded by the Curitiba City Council health and education departments, the programme trained a network of qualified community volunteer educators through the local Municipal Health Unit. A curriculum was developed around local health issues. An example is the first booklet produced which focused on diseases caused by a poisonous brown spider that was common in the city. Participatory methods are used, including drama, debates and role play. Literacy education is linked to health through using the alphabet to raise awareness: for instance, for the letter 'C' learners learn about cholesterol and how to lower it. Volunteer educators noted that gaining confidence and self-esteem also helped some women cope with depression. There was also an impact on eating habits due to growing awareness about foods that reduce cholesterol. The programme is unusual in being funded by local government (for teaching materials and transport allowances) but is dependent (like many of the programmes reviewed in this paper) on the commitment of unpaid volunteer educators for its success. This has implications for sustainability in the long run.

Alfabetizando com Saúde (Brazil)

Whilst the ACEP programme in the Philippines adopts what they term a 'learning by doing' approach to nutrition knowledge, the *Alfabetizando com Saúde* programme in Brazil focuses on gaining health-related information through reading published materials. Food security and issues around poverty are central to improving nutrition and suggest that literacy programmes may need to incorporate agricultural and economic training and support alongside such health awareness. Nutrition also needs to be seen from a gendered perspective as Verburg (2016) reflected: 'Not surprisingly, higher levels of gender discrimination are associated with higher levels of both acute and chronic undernutrition'. A broader approach to women's empowerment through literacy may therefore have a stronger impact than a narrow focus on nutrition education for women.

6.3 HIV/AIDS PREVENTION

Reducing the transmission of HIV can be seen as a medical rather than an educational challenge. In the early days of the AIDS epidemic however, education was proposed as a 'social vaccine' to prevent spread of the HIV virus (Aikman et al., 2008, p. 3) as if dissemination of information about the disease through schools could in itself solve the problem. There is now greater acknowledgement that shifts towards more equal gender relations are in fact key and that education can provide a way for women and men to challenge gendered attitudes. At the Dakar Forum of Education For All (EFA), the WHO called for a goal centred on life skills, which would help youth to 'make informed decisions, communicate effectively and manage their lives in a healthy way' (UNESCO, 2015b, p. 122). The greater emphasis on sexuality education has been accompanied by a shift in approach from seeing learners as passive recipients of information about the risks associated with sex, to a focus on healthy sexual behaviour and addressing gendered power relations.

The links between adult literacy and HIV/AIDS were earlier seen in terms of functional literacy – that people did not have the skills to read information or verify verbal messages (UIL, 2007). The majority of literacy programmes continue to focus on incorporating HIV/AIDS messages and information into course materials. However, those adopting Freirean critical and participatory approaches to literacy have now expanded this area through wider discussion on power, gender and sexuality. Critical approaches to literacy can provide a means for challenging beliefs and practices that influence sexual behaviour, and mobilise people to advocate for better health facilities.

Peer learning has been a key element of literacy programmes aiming to support communities living with HIV/AIDS. In the early 1990s, a participatory methodology called *Stepping Stones* was developed to help young people learn about sexuality, reproductive health and decision-making within sexual relationships using visual methods such as 'body mapping' (Welbourn, 1995). Stepping Stones went on to embrace multi-media approaches, including participatory film training in Malawi run by the Salamander Trust. Members of the Coalition of Women Living with HIV

attended workshops with their male partners to learn basic filming and editing techniques to develop stories about their lives (Stepping Stones, 2016). The groups were able to use the films to engage local audiences in discussion about the issues raised, including HIV and gender-based violence.

By fusing this health education methodology with REFLECT (a Freirean adult literacy methodology pioneered by ActionAid), the *STAR (Societies Tackling AIDS Through Rights)* approach emerged as a way of combining HIV prevention communication/advocacy with adult literacy education. Pioneered in Uganda, groups of around 25 people – mostly those living with HIV and women's groups – met regularly in REFLECT circles to discuss issues such as conflict, livelihoods and gender relations in the context of HIV and AIDS. Through discussing, for instance, power dynamics in their families and decision-making in relation to family planning and marriage, participants began to analyse these influences on the spread of HIV/AIDS. Literacy skills were strengthened through encouraging people to read and write related information, as well as learning to make a will and memory book (Nakiboneka, 2007).

In the *Jeunesse et Développement (Youth and Development) programme in Mali,* the STAR approach formed part of a holistic and community-wide strategy to address HIV/AIDS in the context of poverty (UIL, 2009a). The Civic Education Committee built citizen capacity and awareness of rights through REFLECT circles, while the Women's Group Steering Committee planned and implemented income-generating projects, including market gardening and loan/credit schemes. Peer educators were identified from the village to facilitate reproductive health education as well as distributing Sexually Transmitted Disease (STD)/HIV/AIDS prevention items. Community-based literacy education was sustained through establishing Civic Action Centres. The materials made available were not only around HIV/AIDS and health information, but also concerned decentralisation and issues around people's rights. This example illustrates the importance of adopting a health promotion approach, which uses participatory learning (including literacy, health and political awareness) to set in motion a process of empowerment and capacity building. In the Mali programme, women's participation in local projects and

Jeunesse et Développement (Mali)

community organisations increased considerably, as well as access to health care services and facilities.

Responding to existing unequal gender relations, some programmes have targeted young men in an attempt to transform risky sexual attitudes and behaviour. The *Yari Dosti* (meaning 'bonding among men') programme was developed in India in 2003 (Khandekar et al., 2008). The aim was to address behaviour that was putting young men at risk of HIV/AIDS and reduce violence against women in poor urban communities in Mumbai, India. Building on participatory action research with young men exploring 'what does it mean to be a "real man"?', the programme adopted two main strategies. Firstly, discussion groups with young men were set up, using storylines about decision-making and attitudes within sex for reflection and debate. These were deliberately open-ended rather than didactic, so that participants could change their positions if convinced by others' arguments – covering issues including consent, respect in relationships, socialisation of boys and girls and peer pressures. The second strategy was a 'social marketing campaign' developed in response to participants' concerns about a lack of supportive environment outside the discussion groups. Activities included street plays on issues of sexuality and gender, as well as posters designed by the participants with tex-

tual messages. Working with young men from a similar background (urban Dalit[3] poor communities) was a key factor in the programme's success in challenging ideas around masculinity and opening up a new space for talking about sex. Whilst communication and gender awareness was the starting point, literacy played an important role in disseminating the approach to a wider community.

These programmes all engage with the idea that the educational response to the HIV/AIDS pandemic is not just about disseminating information. Rather, their approach includes empowering women and men to address issues of poverty, power imbalance and gendered identities that contribute to the spread and impact of the virus. Promoting participatory literacy activities, these programmes show the value of a critical approach to health promotion, including looking at how young men can transform attitudes towards women and sexual behaviour.

6.4 MENTAL HEALTH AND WELL-BEING

Several of the literacy programmes reviewed so far have noted an impact on community and individual well-being, including mental illness, even though this was not their primary focus. Particularly in middle- and high-income countries, literacy has been associated with enhancing social connectedness and providing an escape from depression or stress. A survey in the UK on reading for pleasure (Billington, 2015, p. 7) found that a fifth of respondents felt less lonely as a result and that: 'regular readers reported fewer feelings of stress and depression and stronger feelings of relaxation from reading than watching television. Reading creates a parallel world in which personal anxieties can recede'. Writing has also proven itself a way of dealing with stress, particularly for those who have experienced violence and abusive relationships.

Describing their experiences of facilitating participatory action research to encourage women to reflect on their lives and feelings, Duckworth and Ade-Ojo (2016) observe that 'violence is silenced in shame'. As a facilitator, Duckworth (2013) used poetry to engage

---

[3] Dalit are historically considered 'outcastes' from the Hindu four-fold caste system.

A moment from the Literacy for Women programme (Iraq)

participants in a City and Guilds government-funded adult literacy programme in the North of England in discussion about identity, gender and race. This opened up a 'space to use poetry as a means for emotional expression'. Women who had suffered abuse and traumatic events began to explore their creativity, often through writing but also using images and art. Carol, a participant who had experienced severe depression now found release through writing poetry, as she explained: 'If I could have used poetry, well, words even, to make sense of how I felt, my life would have been different. Now I don't get as low, when I'm overwhelmed and starting to feel down, I write it all down in verses and it empties onto the page.' (ibid.). Writing their life stories helped not only the individuals, but also other women in similar situations. The local media followed the trajectories of some of these class participants and the press coverage inspired single mothers to come together and offer support to each other. It was important to these women not only to share experiences with each other, but also to gain a voice in the public domain through their writing and 'construct identities that challenge negative representations in the media' (ibid.). The creative process of writing helped women to reflect on their feelings of depression or anger, and also became a source of constructing new identities and pathways.

In Yemen, the *Literacy Through Poetry* project developed an adult literacy pedagogy based on community story-telling and poetic creative practices (UIL, 2009b). Women came together to learn reading and writing skills through using their own stories, poetry and proverbs. Through writing out these stories initially in the local dialect with the help of the teacher, they were gradually introduced to standard Arabic. Finally the texts were typed and compiled as a book so that women

could learn to read their own stories and poems in print. In many rural Yemeni communities, people over the age of 35 can compose short poems which they sing while they work in the fields or at home. However, imported conservative interpretations of Islam were denouncing women's oral traditions as un-Islamic and television was taking the place of women's poetry and stories within the household. Rather like the UK example above, the project helped to enhance women's voices in the public domain. Through publishing their poetry, women developed new identities and transformed the low status of oral poetry associated with rural women. Through this empowering process, women presented their poems in national events and gained the confidence to initiate health interventions in two of the villages. From a well-being perspective, the creative process of writing poetry to express their emotions and ideas helped women to adapt to their changing environment, as well as becoming change agents themselves.

The reluctance of some men to approach health services and professionals or to admit to illness, particularly depression, has been the focus of much discussion in middle- and high-income countries. An approach to enhancing male health and well-being has emerged through the men's shed movement. 'Shedagogy', described as 'the way some men prefer to learn informally in shed-like spaces mainly with other men' (Golding and Carragher, 2015) has rapidly grown in popularity. There are now over a thousand men's sheds in the world, primarily in Australia where the bottom-up movement began in the 1980s (and has been compared with the 1970s 'neighbourhood house movements' for women). As a traditional space where men spend time learning and working informally, the shed could be compared with literacy programmes in low-income countries that build on indigenous structures and practices. Golding (2011, p. 76) points to 'the irony that if community men's sheds were to describe or name themselves as learning centres (or literacy, employment preparation, health and well-being centres), they would likely cease to be as attractive to and as effective for men who participate'.

Though literacy learning and support is not central or the starting point within this approach, literacy can play a part in shed activities, particularly when men are seeking to move into employment. The sheds pro-

vide a space for specific groups of men, usually organised through an existing community organisation, to meet and share experiences and skills with other men. In Ireland, an evaluation revealed that the sheds had helped older men with depression and anxiety, and offered a place where men felt comfortable accessing male health information. The shed movement has however been critiqued as reinforcing rather than challenging traditional gender roles and stereotypes – though some sheds have included women. This informal grassroots learning initiative illustrates the value of same gender learning groups for enhancing wellbeing. Similar findings have emerged from research with women's literacy classes in low-income countries where women have welcomed the opportunity to share their feelings and develop their knowledge/skills in a safe space.

The *Free Minds Book Club* and Writing Workshop was set up for 16 and 17 year olds in prisons in the USA, and is also largely a male-only programme (UIL, 2016b). Girls make up only 1% of Free Minds beneficiaries as incarceration rates are so much lower than for boys. This programme began as a fortnightly book club and poetry workshop, aiming to use books, creative writing and peer support to empower young people to envisage a different future for themselves. Members often had a negative experience of literacy at school, so the programme attempts to introduce them to authors and characters from similar backgrounds with similar obstacles in their lives. After release, the re-entry book club provides writing workshops on vocational skills such as writing CVs and encourages members to express themselves through creative writing as a way to deal with trauma. Free Minds members have also been involved in a violence prevention initiative, which involves being 'poet ambassadors' and sharing their poetry and life experiences in community spaces. Though reading helped participants to 'open their minds' and share their personal stories of change with the wider public, there might be a similar criticism to that of men's sheds – that the books chosen reinforced existing gender stereotypes, and skills were in traditional male areas of employment.

These very different examples of programmes that have combined learning, literacy and mental wellbeing point to the therapeutic benefits of reading and writing. The UK and Yemen projects build on the notion that literacy can be a collaborative as well as individual practice. Once women's poetry and autobiography enter the public domain through presentations (Yemen) and the media (UK), their writing becomes a source of inspiration and support for women in similar situations. All these programmes show the value of single sex approaches in providing an informal and safe space for creative expression and tackling loneliness. The challenge, as indicated by the men's sheds movement and the Free Minds Book Club, is how to integrate a gender empowerment dimension, to counter prevailing gender stereotypes - such as women as abused victims or men being associated only with traditional male occupational activities.

7. WHAT MAKES GOOD PRACTICE?

This review has revealed how women's empowerment, new gendered identities and more equal gender relations can emerge through adult literacy learning. Recognising the diversity of aims, institutions and pedagogical approaches explored above, this section identifies some key aspects that informed their success.

i. **Understanding and identifying appropriate target groups: literacy and health for women, for men – or everyone.**

Free Minds Club and Writing Workshop (USA)

Whilst a majority of programmes identified women as their major beneficiary group (and within this group, a particular focus on women of reproductive age), there was strong recognition of the need to involve men and the wider community. This reflects the shift noted earlier from health education focusing on individual women, to the concept of health promotion as targeting the whole community and going beyond dissemination of health information in order to support political action. The review also highlighted the value of single sex programmes – in terms of providing a safe space for experiences shared between those with similar backgrounds or to discuss gendered attitudes that influence health. The challenge is how to ensure that gender stereotypes are not perpetuated through single-sex programmes and how to connect transformative learning about health and gender relations within the group with change in the wider society/community.

ii. Promoting critical approaches to health and literacy for women's empowerment.

Underpinned by a human rights approach to literacy and health, most programmes reviewed here adopted a participatory pedagogy, drawing particularly on a Freirean critical literacy approach, involving awareness-raising (conscientisation) and action. Though functional literacy certainly played a part in women's empowerment (such as enhancing economic roles through learning to keep records and budgets), there was also evidence of the symbolic value of literacy in enhancing women's identities and roles in the public space. This kind of empowerment had an indirect impact on health and well-being – whether giving women the skills and confidence to advocate for or set up new health facilities or become more assertive within sexual relationships and within the household. The emphasis on critical approaches to health and literacy as connected to relationships of power challenged the common practice within many women's literacy programmes of incorporating didactic health messages into a literacy primer. Although current literature (UNESCO, 2015c) suggests that mobile phones and other technologies can be used to critically engage learners with digital ways of communicating, there is surprisingly little evidence of digital practices within adult literacy and health programmes. Where mobile

phones and other ICTs have been used, this has largely been to send health messages (via SMS texting), rather than to develop critical digital literacy skills to access and evaluate health-related information in everyday life. A review of mobile learning projects in relation to women's empowerment revealed that there was 'a predominant reliance on information transfer' and that 'the learning process remained weak in depth, with little learner-content interaction' (UNESCO, 2015c, p. 7). Literacy and health have been discussed as competing priorities in terms of the curriculum (see Rudd et al., 1988, on whether there should be 'more' literacy or 'more' health content). By taking an embedded and holistic approach, the review demonstrated that it was not a question of either/or trade-offs, but of approaching both literacy and health as part of a wider process of empowerment.

iii. Responding to specific contexts.

All the programmes highlight the importance of understanding cultural practices, relationships between local and official languages, indigenous knowledges and structures. Taking a gendered perspective on indigenous practices around literacy and health may mean analysing, challenging and attempting to transform practices that threaten women's health (like FGM/C) or introducing and mediating different sources of health knowledge (like indigenous and Western ideas about nutrition). Respecting and building on established social structures and networks was a starting point for several programmes, providing a way for outside organisers to build up trust with local communities and help embed new practices in existing institutions. Above all, exploring and responding to women's and men's traditional gendered roles and relations proved an important starting point for addressing health issues. In the case of reproductive health and family planning literacy initiatives, decision making was conceptualised not just in terms of the individual woman (as might be expected in a Western context) – but as a collective act, often involving many other people, communities and institutions. Different meanings and values were attached to literacy in differing contexts and this influenced approaches adopted, whether this was creative writing to deal with difficult emotions or reading about legal rights.

A health poster from the Community Empowerment Programme (Gambia).

iv. Recognising that empowerment is not dependent on a particular starting point or literacy approach.

There can be a tendency to assume that only critical literacy approaches and a participatory bottom-up curriculum can facilitate women's empowerment. However, this review suggests that a top-down centrally designed literacy programme implemented through formal classrooms might also be empowering for specific groups of women – who, for instance, wanted to catch up on schooling that they missed out on as children. What many of the programmes have in common is a social justice agenda on literacy, health and empowerment, which encourages a view of women as active citizens. This contrasts with literacy programmes adopting a deficit view of women as passive recipients of health information or literacy skills. The latter are likely to be informed by an instrumental objective of promoting women as agents of development, focusing narrowly on their reproductive role to enhance the health of their communities and households. Rather than advocating that literacy classes or health education initiatives are necessarily the most effective starting point for initiating change, several programmes documented the unexpected journey of empowerment. They noted a 'ripple effect' as planned educational interventions sometimes led to take-up and adaptation of ideas beyond the programme. Such informal learning is key to facilitating wide-spread social change, particularly with regard to gender equality. Literacy is one resource amongst many others (including health knowledge and facilities) that can support this process of empowerment.

v. Building sustainability for long-term provision.

The institutional structures developed for the literacy and health initiatives reviewed above varied from grassroots community-owned projects to large-scale government-run programmes. The majority of programmes developed new organisational structures – whether committees, community learning centres, libraries or health education centres. They worked in partnership with the community to take forward the activities once the externally funded initiative had ended. Developing a literacy and health initiative through a municipal health department showed an alternative strategy in terms of building on the existing infrastructure to establish stronger linkages between the health providers and literacy programmes. However, the challenge for most programmes reviewed was that community educators worked on a voluntary basis. By contrast, providers offering payment and career structure to facilitators demonstrated a commitment to raising the status and sustainability of adult literacy and community health programmes in the long term.

An event organised by communities that are participating to the Tostan's Community Empowerment Programme (Senegal).

8. RECOMMENDATIONS FOR FUTURE ACTION

The 2030 Agenda for Sustainable Development declares a strong commitment to gender equality and the empowerment of women and girls as cross-cutting the multiple dimensions of sustainable development addressed within the SDGs. Gender inequalities in health and education are highlighted within SDGs 3 and 4, as well as within many related goals such as SDG 2 (End Hunger). In addition, SDG 5 on gender equality and women's empowerment emphasises the need to eliminate all harmful practices including female genital mutilation (target 5.3) and ensure universal access to sexual and reproductive health and rights (target 5.6). The evidence in this paper points to the value of adult education and literacy in addressing these goals and targets, particularly through influencing dominant gendered values and attitudes in society. However, experience suggests that national and international educational policy is often likely to translate into a focus on formal schooling, rather than giving priority to adult learning and education. The Second Global Report on Adult Learning and Education reported in 2013 that only half of the countries surveyed were actively working to improve gender equality in adult education (UIL, 2013a, p. 118). So the major challenge remains – to ensure greater commitment to resourcing high quality adult literacy and education programmes.

Within the adult literacy sector, it is difficult to find a programme that does not include health within their curriculum. However, the majority adopt a traditional functional literacy approach in order to convey health messages to women through literacy primers, and focus almost exclusively on their reproductive roles. This paper has pointed to the importance of promoting a broader view of health as encompassing well-being and addressing interconnected issues such as gender violence, as signalled in SDG 3. The shift in the health sector towards health promotion and a life course approach challenges the narrow focus on maternal and child health. Above all, rather than taking an instrumental approach to women's empowerment, the most effective literacy programmes are underpinned by transformative aims, participatory pedagogy and a longer duration. Looking ahead, the rapid growth of digital technologies, increasing mobil-

ity of women and men across the world, environmental change, conflict and war and longer living populations, are all factors that will shape the future health and literacy agenda.

Building on the best practice highlighted in this paper and formulated in the context of the 2030 Sustainable Development Agenda and the changing global landscape, the following recommendations are proposed:

i.   **A broader, holistic understanding of health as well-being is needed within the education sector so that literacy programmes can support SDG 3.**

Health has been narrowly addressed within many women's literacy programmes that set out to disseminate information related to Maternal and Child Health. Literacy programmes can however adopt a broader perspective, aiming to empower women and men to become active citizens who can take control of and advocate for better health services and community well-being. Such literacy programmes are more likely to lead to positive changes in health practices, challenge issues of inequality and ensure greater accountability by health providers to the communities they serve.

ii. **Adult education and literacy policy and programmes should urgently respond through the use of flexible, creative and innovative pedagogy and use of technologies to wide-spread changes taking place in the literate environment.**

The growing accessibility to digital technology in most areas of the world presents an important opportunity for adult educators (in both health and literacy) to look at how people are currently engaging with information related to their well-being in the rapidly changing literate environment. Adult literacy programmes are still, however, largely focused on print materials, adopting a functional literacy approach. Though many now incorporate ICT, this has usually been to convey messages about literacy and health in a similarly didactic way to primers, rather than to develop creative, critical and participatory approaches to literacy learning. Whether recognising the ways that people can share health-related experiences and support civic action through social media, or use Internet sites to assess symptoms, literacy programmes need also to build on local digital practices

A moment from a Tostan's event (Senegal).

and resources, particularly mobile phones. Such pedagogy can also be seen as supporting women's strategic gender need for equal access to digital technologies. Acknowledging the existence of a digital gap, providers need to respond to and take account of the availability of resources in specific contexts. This might involve developing flexible, creative and innovative pedagogies in addition to ICT-based approaches, such as poetry (as illustrated in this paper) to enhance learners' literacy and health skills.

iii. Building on learners' prior experience and valuing local knowledge, culture and language, a diversity of approaches to literacy, health and empowerment should be used.

Principles for good practice – particularly building on learner experience, valuing indigenous knowledge and local languages – have been shown to have a stronger influence on women's engagement in literacy and health programmes than on men's. This is because in many contexts, women may have less access to dominant languages and cultures. Even more significant is the need to explore how existing institutional or informal structures (like women's groups or men's sheds) can form the basis for health and literacy learning. In partnership with communities, literacy programmes can then build on indigenous forms of organisation, informal learning approaches and knowledge, and recognise that empowerment takes different forms in different contexts.

iv. Organizational and personnel structures need to be given particular attention when developing literacy and health programmes for women's empowerment.

Working across sectors raises questions about how to select and train staff – whether this is about health workers understanding and learning to teach literacy development for adults or, as is more usually the case, literacy facilitators gaining some health knowledge. These practical issues around mandates, organisation, resourcing and training of literacy and health programmes often influence how far policy can be translated into practice. Many literacy and health programmes are dependent on volunteer or low paid female facilitators and short-term training/career opportunities, thereby undermining overarching gender equality aims. Existing organisational, institutional and personnel structures should be catalysed for health and literacy programmes, as well as creating new structures through collaboration, partnership and capacity building across sectors.

v. Health and literacy policy and programmes should shift from an instrumental to a transformative approach to women's empowerment and gender equality.

Many literacy programmes have been characterised by an instrumental approach to women's empowerment and health, influenced by a narrow research focus on the links between women's literacy and various maternal/child health indicators. A transformative gender approach could ensure that adult literacy programmes move beyond stereotypes of women as mothers and carers and men as the breadwinners, and promote greater diversity in programme aims, methods and evidence of impact.

LIST OF REFERENCES

Aikman, S., Unterhalter, E. and Boler, T. (eds). 2008. *Gender Equality, HIV and AIDS: A challenge for the Education Sector.* Oxford, OXFAM.

Ali, S., Chaudry, T. and Naqvi, Q. 2011. Effect of maternal literacy on child health: myth or reality. *Ann. Pak. Inst. Med. Sci.*, Vol. 7, No. 2, pp. 100–03.

Aubel, J. Toure, I. and Diagne, M. 2004. Senegalese grandmothers promote improved maternal and child nutrition practices: the guardians of tradition are not averse to change. *Social Science and Medicine,* Vol. 59, pp. 945–59.

Billington, J. 2015. *Reading Between the Lines: the Benefits of Reading for Pleasure.* Quick Reads. Centre for Research into Reading, University of Liverpool.

Burchfield, S., Hua, H., Iturry, T., Rocha, V. 2002. A longitudinal study of the effect of integrated literacy and basic education programs on the participation of women in social and economic development in Bolivia, USAID/World Education Inc. http://datatopics.worldbank.org/hnp/files/edstats/BOLdprep02.pdf (Accessed 25 July 2016.)

CDC (Centers for Disease Control and Prevention). 2016. Health Literacy and Plain Language. http://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html (Accessed 25 July 2016.)

Chopra, P. 2004. Distorted mirrors: (de)centring images of the 'illiterate Indian village woman' through ethnographic research narratives. A. Robinson-Pant (ed.), *Women, Literacy and Development: Alternative Perspectives.* London, Routledge.

Cornwall, A. and Edwards, J. 2014. Negotiating empowerment. A. Cornwall and J. Edwards (eds), *Feminisms, Empowerment and Development: Changing Women's Lives.* London/New York, Zed Books.

DeWalt, D., Berkman, N., Sheridan, S., Lohr, K. and Pignone, M. 2004. Literacy and health outcomes: a systematic review of the literature. *J. Gen. Intern. Med.*, Vol. 19, pp. 1228–239.

Duckworth, V. 2013. *Learning Trajectories, Violence and Empowerment Amongst Adult Basic Skills Learners.* London, Routledge.

Duckworth, V. and Ade-Ojo, G. 2016. Journey through transformation: a case study of two literacy learners. *Journal of Transformative Education,* pp. 1–20.

Easton, P. 2014. *Sustaining Literacy in Africa: Developing a Literate Environment.* Paris, UNESCO.

English, L. 2012. A critical theory of adult health learning. L. English (ed.), *Adult Education and Health.* Toronto, University of Toronto Press.

English, L. and Irving, C. 2015. Adult health learning: for women, with women. L. English and C. Irving (eds), *Feminism in Community: Adult Education for Transformation.* International Issues in Adult Education.

EWEC (Every Woman Every Child). 2015. The global strategy for women's, children's and adolescents' health (2016–2030). *Survive, Thrive, Transform.* Geneva, WHO. http://www.who.int/life-course/publications/global-strategy-2016-2030/en/ (Accessed 26 July 2016.)

Frisch, A., Camerini, L., Diviani, N. and Schulz, P. 2011. Defining and measuring health literacy: how can we profit from other literacy domains? *Health Promotion International,* Vol. 27, No.1, 117–25.

Gillespie, D. and Melching, M. 2010. The transformative power of democracy and human rights in non-formal education: the case of Tostan. *Adult Education Quarterly,* Vol. 60, No. 5, pp. 477–98.

Glanz, C. 2009. Locally developed literacy practices: the field of Senga in Uganda. K. Parry (ed.), *Reading in Africa, Beyond the School.* Kampala, Fountain Publishers.

Golding, M. 2011. Men's informal learning and wellbeing beyond the workplace. S. Jackson (ed.), Innovations in Lifelong Learning: *Critical Perspectives on Diversity, Participation and Vocational Learning.* London, Routledge.

Golding, B. and Carragher, L. 2015. Community men's shed and informal learning: an exploration of their gendered roles. J. Ostrouch-Kaminska and C. Vieira (eds), *Private World(s): Gender and Informal Learning of Adults.* Rotterdam, ESREA Sense Publishers.

Hill, L. 2016. Interactive influences on health and adult education. *New Directions for Adult and Continuing Education,* No. 149, Spring 2016.

Khandekar, S., Rokade, M., Sarmalkar, V., Verma, R., Mahendra, V. and Pulerwitz, J. 2008. Engaging the

community to promote gender equity among young men: experiences from 'Yari Dosti', Mumbai. S. Aikman, E. Unterhalter and T. Boler (eds), *Gender Equality, HIV, and AIDS: A Challenge for the Education Sector.* Oxford, OXFAM Publications, pp. 184–201.

Kickbusch, I., Wait, S., and Maag, D. 2005. *Navigating Health: the Role of Health Literacy.* London, Alliance for Health and the Future.

Langer, A., Meleis, A., Knaul, F.M., Atun, R., Aran, M., Arreola-Ornelas, H., Bhutta, Z., Binagwaho, A., Bonita, R., Caglia, J., Claeson, M., Davies, J., Donnay, F., Gausman, J., Glickman, C., Kearns, A., Kendall, T., Lozano, R., Seboni, N., Sen, G., Sindhu, S., Temin, M., and Frenk, J. 2015. Women and health: the key for sustainable development. *The Lancet Commissions,* Vol. 386 September 19, pp. 1165–210.

Moser, C. 1993. *Gender Planning and Development: Theory, Practice and Training.* London, Routledge.

Nakiboneka, E. 2007. Mobilizing community members to reflect and act on HIV and AIDS: Experiences with using the STAR methodology in Uganda, Article produced as part of the KIC Project, OXFAM. http://www.bibalex.org/Search4Dev/ files/292417/122941.pdf (Accessed 26 July 2016.)

Nazneen, S. and Sultan, M. 2014. Reciprocity, distancing and opportunistic overtures: women's organizations negotiating legitimacy and space in Bangladesh. A. Cornwall and J. Edwards (eds), *Feminisms, Empowerment and Development: Changing Women's Lives.* London/New York, Zed Books.

Nutbeam, D. 2000. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International,* Vol. 15, pp. 259–67.

OBOS. 2016. Our Bodies Ourselves. http://www.our-bodiesourselves.org/ (Accessed 26 July 2016.)

Ostrouch-Kaminska, J. and Vieira, C. 2015. Informal learning and gender: a revision for the future. J. Ostrouch-Kaminska and C. Vieira (eds), *Private World(s): Gender and Informal Learning of Adults.* Rotterdam, ESREA Sense Publishers, pp. 183–90.

Pakaari, L. and Pakaari, O. 2012. Health literacy as a learning outcome in schools. *Health Education,* Vol. 112, No. 2, pp. 133–52.

Robinson-Pant, A. 2001. *Women's literacy and health: can an ethnographic researcher find the links? B.V.* Street (ed.), *Literacy and development: ethnographic perspectives.* London, Routledge.

Robinson-Pant, A. 2004. 'The illiterate woman': changing approaches to researching women's literacy. A. Robinson-Pant (ed.), *Women, Literacy and Development: Alternative Perspectives.* London, Routledge.

Robinson-Pant, A. 2005. The social benefits of literacy. Background paper for EFA Global Monitoring Report 2006. Literacy for Life. Paris, UNESCO. http://unesdoc. unesco.org/images/0014/001461/146105e.pdf (Accessed 26 July 2016.)

Rockhill, K. 1993. Gender, literacy and the politics of literacy. B.V. Street (ed.), *Cross-Cultural Approaches to Literacy.* Cambridge, Cambridge University Press.

Rogers, A. 1999. Improving the quality of adult literacy programmes in developing countries: the 'real literacies' approach. *International Journal of Educational Development,* Vol. 19, pp. 219–34.

Rudd, R., Zacharia, C. and Daube, K. 1998. Integrating health and literacy: adult educators' experiences. *NCSALL Reports No. 5, August 1998.* Harvard School of Public Health.

Sato, M. 2007. Challenges and successes in family planning in Afghanistan. *Management Sciences for Health (MSH) Occasional Paper,* No. 6. https://www. msh.org/sites/msh.org/files/Challenges-and-Successes-in-Family-Planning-in-Afghanistan.pdf (Accessed 26 July 2016.)

Schultz, P.J. and Nakamoto, K. 2005. Emerging themes in health literacy. *Studies in Communication Sciences,* Vol. 5, pp. 1–10.

Seltrecht, A. 2015. Not just for women: breast cancer, gender and informal learning in an exceptional situation. J. Ostrouch-Kaminska and C. Vieira (eds), *Private World(s): Gender and Informal Learning of Adults.* Rotterdam, ESREA Sense Publishers, pp. 41–58.

Stepping Stones. 2016. Participatory Video Training. http://www.steppingstonesfeedback.org/index. php/page/Resources/gb?resourceid=74 (Accessed 26 July 2016.)

Street, B.V. 1993. Introduction: the new literacy studies. B.V. Street (ed.) *Cross-Cultural Approaches to Literacy. Cambridge,* Cambridge University Press, pp. 1–23.

UN. 2015. *Transforming Our World: The 2030 Agenda for Sustainable Development, Resolution Adopted*

by the General Assembly on 25th. September 2015. http://www.un.org/ga/search/view_doc. asp?symbol=A/RES/70/1&Lang=E (Accessed 26 July 2016.)

UNESCO. 2005. *Literacy for Life, EFA Global Monitoring Report 2006*. Paris, UNESCO.

UNESCO. 2014a. UNESCO's *Promise: Gender Equality – a Global Priority*. The Division for Gender Equality. Paris, UNESCO.
http://www.unesco.org/new/fileadmin/ MULTIMEDIA/HQ/BSP/GENDER/PDF/GEAPweb.pdf (Accessed 26 July 2016.)

UNESCO. 2014b. *Sustainable Development Begins with Education: How Education Can Contribute to the Proposed Post-2015 Goals*. Paris, UNESCO.
http://en.unesco.org/gem-report/sustainable- development-begins-education#sthash.Rr6865al. dpbs (Accessed 26 July 2016.)

UNESCO. 2015a. *Recommendation on Adult Learning and Education*. http://unesdoc.unesco.org/ images/0023/002325/232596e.pdf (Accessed 26 July 2016.)

UNESCO. 2015b. *EFA Global Monitoring Report 2015, Education for All 2000-2015 Achievements and Challenges*. Paris, UNESCO.

UNESCO. 2015c. *Mobile Phones and Literacy: Empowerment in Women's Hands. A Cross-Case Analysis of Nine Experiences*. Paris, UNESCO.

UIL. (UNESCO Institute for Lifelong Learning). 2007. *Making the connections: why literacy matters for HIV prevention*. Hamburg, UIL (written by C. Medel-Anonuevo and D. Mahamadou Cheick)

UIL (UNESCO Institute for Lifelong Learning). 2009a. Community Development Programme. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?me nu=13&country=MU&programme=227 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2009b. Literacy through poetry (LTPP). *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?menu=12&cou ntry=YE&programme=25 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2010a. *Confintea VI Belem Framework for Action: Harnessing the Power and Potential for Adult Learning and Education for a Viable Future*. Hamburg, UIL.

UIL (UNESCO Institute for Lifelong Learning). 2010b. Bilingual Literacy and Reproductive Health. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/lit base/?menu=16&country=BO&programme=38 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2010c. Alternative Community Education Programme (ACEP). *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco. org/uil/litbase/?menu=14&country=PH&program me=64 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2011a. The Family Literacy Programme. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?menu=15&cou ntry=TR&programme=141 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2011b. Alfabetizando com Saúde (Learning to Read and Write in Good Health). *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?menu=16&co untry=BR&programme=2 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2012a. The Tostan Community Empowerment Program. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/lit base/?menu=13&country=SN&programme=86 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2013a. *Global Report on Adult Learning and Education (GRALE 2), Rethinking Literacy*. Hamburg, UIL.

UIL (UNESCO Institute for Lifelong Learning). 2013b. Learning for Life. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http:// www.unesco.org/uil/litbase/?menu=14&country= AF&programme=76 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2014. Literacy for Women. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?menu=12&co untry=IQ&programme=160 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2016a. Adult Literacy Programme. *Effective Literacy and Numeracy Practices Database (LitBase)*. Hamburg. http://www.unesco.org/uil/litbase/?menu=13&co untry=MU&programme=227 (Accessed 26 July 2016.)

UIL (UNESCO Institute for Lifelong Learning). 2016b. Free Minds Book Club and Writing Workshop. *Effective Literacy and Numeracy Practices Database (LitBase).* Hamburg. http://www.unesco.org/uil/litbase/?menu=15&country=US&programme=232 (Accessed 26 July 2016.)

Verburg, G. 2016. Good nutrition: our bets are on the girls. *ELDIS Blog.* 23 May, 2016. http://www.eldis.org/go/blog/posts/good-nutrition--our-bets-are-on-the-girls (Accessed 26 July 2016.)

Welbourn, A. 1995. *Stepping Stones: A Training Package in HIV/AIDS, Communication and Relationship Skills.* London. Strategies for Hope. http://www.steppingstonesfeedback.org/index.php/About/Stepping_Stones_training_package/gb (Accessed 26 July 2016.)

World Education Forum. 2015. *Incheon Declaration, Education 2030: Towards Inclusive and Equitable Quality Education and Lifelong Learning for All.* http://www.waam2015.org/sites/default/files/incheon_declaration_en.pdf (Accessed 26 July 2016.)

World Health Organization. 1948. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, No. 2, p. 100) and entered into force on 7 April 1948.

World Health Organization. 2006. *Constitution of the World Health Organization.* http://www.who.int/governance/eb/who_constitution_en.pdf (Accessed 26 July 2016.)

World Health Organization. 2013. *Health Literacy: the Solid Facts.* Copenhagen, WHO Regional Office for Europe.

World Health Organization. No Data. *Social Determinant of Health.* http://www.who.int/social_determinants/en/ (Accessed 27 July 2016.)

Zarcadoolas, C., Pleasant, A. and Greer, D. 2005. Understanding health literacy: an expanded model. *Health Promotion International,* Vol. 20, No. 2, pp. 195–203.