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Women Literacy and Social Change

K.Santhi Sri — Associate Professor, Department of MCA, Vignan's University, Vadlamudi-522213

PRSM Lakshmi — Assistant Professor, Department of MCA, Vignan's University, Vadlamudi-522213

ABSTRACT

Education is important for everyone, but it is especially significant for girls and women. This is true not only because education is an entry point to other opportunities, but also because the educational achievements of women can have ripple effects within the family and across generations. Investing in girls' education is one of the most effective ways to reduce poverty. Investments in secondary school education for girls yields especially high dividends. Educated women can recognize the importance of health care and know how to seek it for themselves and their children. Education helps girls and women to know their rights and to gain confidence to claim them..By acquiring literacy, women become more economically self-reliant and more actively engaged in their country's social, political and cultural life. All evidence shows that investment in literacy for women yields high development dividends.Education also brings a reduction in inequalities and functions as a means of improving their status withinthe family

KEYWORDS : Education, Female literacy rate, Women empowerment, Investment,Dividend,Enrolment rate.

1.Introduction:

Literacy, in its most direct definition, is the ability to read, write, listen, comprehend, and speak a language. Historically it has been a collection ofcultural and communicative practices shared among members of particular groups.

1. But society inevitably changes and so does literacy. In more recenttimes the term has evolved to refer specifically to the ability to read and write at a level adequate for communication or at a level that lets one understand and communicate abstract ideas.
2. To function well in the 21st century a person must possess a wide range of abilities and competencies, in essence many 'literacy's'. These 'literacy's'—from being able to read a newspaper to understanding information provided by a health care provider—are multiple, dynamic, and malleable.
3. The UnitedNations Educational, Scientific and Cultural Organization (UNESCO) also acknowledges the multi-dimensionality of literacy, defining it as the "...ability to identify, understand, interpret, create, communicate, compute and use printed and written materials associated with varying contexts. Literacy involves a continuum of learning in enabling individuals to achieve their goals, to develop their knowledge and potential, and to participate fully in their community and wider society."
4. Using the definition of literacy as the ability to read and write a simplesentence in any language, the United Nations reported that 80% of theworld's population was literate in 1998.
5. Other estimates, using thedefinition "age 15 and over can read and write", placedthe overall world literacy rate in 2008 at 82% (87% males and 77% females).
6. Literacyrates vary widely from country to country and even from region toregion, a variation that often coincides with the region's wealth orurbanization. However, many factors can play a role; for example, certain social customs limit the education of females in some countries

2. Literacy and Health

The statistical correlation between women's literacy and health indicators, particularly decreased fertility, child mortality and increased life expectancy, was the focus of much research in the '70s and '80s. Cochrane (1979) demonstrated that there was an inverse relationship between women's literacy and fertility. Caldwell (1979) analysed the impact of women's education on child health, concluding that each extra year of maternal education was associated with a 9% decrease in under-five mortality.Eloundou-Enyegue (1999) observed that the relationship between female education and health often varied greatly from one context to another.In the '90s, research has thus looked particularly at the 'why' surrounding the relationship between women's education (using literacy as a proxy indicator) and health, in terms of the educational process and other (non-school) factors.

There is now a growing body of research evaluating the health benefits of literacy programmes, as opposed to schooling. Comings et al (1994) developed a model in the context of schooling and health linkages to analyse the impact of a women's literacy programme. Defining 'four main mechanisms that mediate between education and health and family planning', they analysed the case study in terms of 'time, dispositions, literacy and knowledge', revealing that the programme had a particular impact on 'dispositions' through women meeting regularly as a group. Since then, several major longitudinal studies of literacy programmes have been conducted. The Bolivia study revealed that 'improvements in health-related knowledge and behaviour were greater for women who attended literacy and basic education programs' (p xi). Positive changes included: seeking medical health for themselves and a sick child, adopting preventive health measures, such as immunisation, and greater knowledge of family planning methods.

Small scale qualitative studies have provided evidence about how literacy affects cultural beliefs which impact on health: for instance, in interviews with 36 women in two districts of Nigeria, Egbo found that literate women who had circumcised their daughters 'would not do so in future since further reading on the subject had sensitised them to the potential health hazards involved in the practice' (Egbo, 2000: 113). Recent research has looked at the impact of literacy programmes on knowledge and attitudes towards HIV/Aids in particular. Burchfield's Nepal study (2002b: 57) showed 'a clear pattern of increasing knowledge of both STIs and HIV/AIDs among literacy participants during the three years' (covered by the survey). Reports on PACT's Women's Empowerment Program (WEP) in Nepal demonstrate the importance of integrating literacy with economic and community action approaches to tackle health problems. Women in this program mobilised groups to organise awareness discussion about HIV/AIDs, arrange treatment for people (80% of participants) suffering from STD-related illnesses and create emergency health funds through saving initiatives. The benefits reported from this program included increased individual self-confidence in talking about AIDs, as well as greater awareness of social action as a way to tackle the spread of the disease and provide economic support.

The relationship between Knowledge, Attitudes and Practice has been identified as key in the analysis of how literacy affects development practices, including the uptake of family planning, immunisation and preventive health care. Although literacy programmes often focus on providing knowledge about family health care, research

has brought into question whether literacy classes are the best way to convey such information. An evaluation of the impact of literacy on family planning uptake in Nepal found that non-class participants had similar knowledge to class participants, due to information from other sources such as the media, friends and relations (Robinson-Pant 2001b). Carr Hill et al's (2001: 76) evaluation of two literacy programmes in Uganda found that people were less sure about health-related questions than current affairs, such as who the president was, but that non-literates 'scored substantially lower on nearly all these questions'. They also found that there was less difference between literates and non-literates in relation to questions about modern versus traditional attitudes. As discussed in my introduction to this paper, evidence on increased health knowledge is limited: the majority of studies are based on assessments of participants' recall of health messages and information conveyed in the course textbook (see for example, Carr Hill et al's (2002) findings from Uganda). Ethnographic research has however given insight into how women who have 'learnt' these messages may also dispute the new health knowledge in their everyday lives and during interaction with the facilitator in literacy classes (Fiedrich, 2004, Robinson-Pant 2001a).

Research on the relationship between women's education and health outcomes has suggested that behaviour change is more dependent on changing attitudes and values, than on learning new knowledge. For instance, Le Vine et al (1991: 492) found in Mexico that schooling had an effect on mother-infant relationships through introducing women to a new 'model of social interaction between an adult and children'.

Though literacy programmes may affect knowledge and attitudes, health practice is also influenced by other development inputs, not least, access to health facilities. In an evaluation of family planning uptake in Nepal, both participants and non-class participants had knowledge of family planning but had no access to contraceptives, other than permanent methods, in the local area (Robinson-Pant 2001b). This relates to Burchfield's findings in Bolivia (2002b:xi) that although women's knowledge and practices in health care had improved through participation in literacy programmes, there was a need to improve medical services and facilities to support these changes.

3. Adult literacy and children's education

As well as taking better care of their children's health, educated mothers have been shown to be more likely to send their children to school.Cathedra's (1997) study in Bangladesh noted increased school attendance when children's parents attended literacy classes. Burchfield (1997) reported similar findings regarding school attendance and enrolment in Nepal. Within the adult literacy context, research evidence suggests that though both literate and non-literate parents believe strongly in education for their children, literate parents were more likely to be able to support children in practical ways, such as meeting teachers and discussing progress with children. Carr Hill et al's (2001: 90) evaluation in Uganda reported that literacy class graduates 'were nearly twice as likely to discuss schoolwork and check homework as were the nonliterates'. There has been particular interest in evaluating the impact of family literacy programmes in relation to parents supporting children's education: when literacy courses introduce parents to ways of helping children in school and the school curriculum, the social benefits have been shown to be greater.

4. Literacy and gender equality

Many attempts have been made to develop a measure of 'women's empowerment' within literacy programmes. The policy move away from an instrumental approach to women's literacy and the growing emphasis on a 'rights perspective' (UNESCO 2002), has led to a wider definition of 'empowerment' and increasing recognition of the limitations of quantitative measures. The links between literacy and empowerment will be explored in other papers in this series in relation to economic, political, cultural and human benefits.

From many parts of the world, there is evidence of women gaining access to and challenging 'male' domains through participation in adult literacy programmes. Many women report that learning literacy and attending a class is in itself a threat to existing gender relations (Horsman 1990, Rockhill 1987). Literacy participants can gain more voice in household discussions through having experience of speaking in the 'public' space of the class: Diagne and Oxenham (2001:11) report from Burkina Faso that 'the majority of participants [in a literacy programme evaluation] felt that they had indeed learned how to persuade their husbands to listen to them more and had gained confidence in steering family affairs'.

Literacy can provide a bridge to formal education and vocational training for women who have been excluded from school as children – offering practical skills, confidence in the classroom and occasionally, accredited qualifications. Of particular benefit to adolescent girls are literacy programmes that offer an equivalence to a certain level of school education. However, in practice, many literacy class graduates wanting to pursue formal education encounter the same barriers that prevented them from attending school in the first place: there is social opposition and they cannot afford the costs in terms of time and fees for secondary education (Akhter's analysis (2004) of why literacy participants had dropped out of school in Bangladesh: poverty, 38%, early marriage, 18.7%, working 10%, religion 9%). Basic education courses are also the first step for women to acquire the literacy skills necessary to enter higher status 'male' areas of vocational training (such as computer maintenance and graphic design) and can form part of workplace training programmes. As with health benefits, such as family planning or AIDS prevention, evidence suggests that though women may have gained awareness about domestic violence or access to further education, it is more difficult for them to actually make changes at the household level. There are many instances of social mobilisation due to literacy programmes tackling gender issues at a community level (Dighe's (1995b) account of the campaign against alcohol in Nellore, India and Khandekar's (2004) research with Dalit women who took collective action against alcohol abuse by men – in Farah's paper, p. 8). Similarly, with the development of 'legal literacy' programmes, there is increasing evidence of literacy participants learning about and tackling gender inequality through legal means.

The research evidence reviewed in relation to gender equality and health suggests that this kind of social change does not come about through curricula that focuses directly on giving information about alternative beliefs and practices. However, the social space and certain skills introduced by the class (including reading and writing, and also work-oriented skills and speaking in a new language) can enable people to reflect on and improve their situations in small ways. The fact that most literacy programmes have targeted women, rather than including men, has limited the ways in which gender inequality has been tackled through education – the emphasis being on raising awareness of legal rights and mobilising women to take action against abuse (see Monga (2000) on the MARG legal literacy programme in India), or 'catching up' on both technical skills (including literacy and languages of power) and soft skills, such as enhanced self-esteem and confidence. This focus on women's inequality, rather than gender equality, is also reflected in the research evidence available which inevitably analyses the impact of literacy interventions on women's attitudes and practices, rather than men's. Though research on literacy and health change has occasionally taken account of changes in men's behaviour too – this is usually considered as a secondary effect of women's literacy (see Leve et al 1997), rather than analysing directly the impact of men's participation in literacy programmes on gender equality.

5. Conclusion:

The social benefits of literacy have been shown to be enhanced when literacy programmes are accompanied by supportive interventions, such as credit facilities, skills training, and in the health context, access to family planning facilities or maternal child health centres. This relates also to the kind of approach promoted in literacy programmes that integrated health and literacy programmes had a greater effect on women's health, than literacy alone or health alone. The literacy/health curriculum encouraged women to seek advice from local health professionals. Similarly, in family literacy programmes, parents are offered practical ways of supporting their children's education, alongside their own literacy learning.The difficulties faced by women who try to adopt the new social practices they have learnt about, particularly around sexual health and family planning, suggest the need for a holistic approach to adult education which takes into account that other family members – particularly men – should be included in educational programmes, even if they are already literate.

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