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POPULAR EDUCATION for ADULT LITERACY and HEALTH DEVELOPMENT in INDIGENOUS AUSTRALIA

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Abstract

The focus of this paper is adult literacy, and the impact this has on Aboriginal and Torres Strait Islander individual and community health. It directs attention to those Aboriginal and Torres Strait Islander young people and adults who have not benefited from the formal school education system, and who, as a consequence, have very low levels of basic English language literacy. Analysing data from a range of sources, I suggest that these people comprise as much as 35% of the Aboriginal and Torres Strait Islander adult population nationally, and a much bigger proportion in some communities and regions. Moreover, they are key to improving overall health outcomes in the population as a whole, because they are among the people most at risk. Drawing on research in countries of the global South over recent decades, the paper then suggests that one of the most effective ways to improve health outcomes and foster health development is through a popular mass adult literacy campaign. Popular education is not formal education, of the kind provided by schools, TAFEs and universities. It is "non-formal" education, provided on a mass scale, to people in marginalised and disadvantaged communities, as part of wider social and political movements for equality. The paper concludes that this is the most appropriate form of education to deal with the massive social and economic inequality at the heart of the social determinants of Indigenous health.

Introduction

The paper is about the education of the Aboriginal and Torres Strait Islander *adult population*. Its focus is adult literacy and the impact this has on individual and community health. It uses the most common international definition of "literacy" – the capacity of young people and adults aged 15 and over to read and write, with understanding, a simple sentence about their own life (UNESCO, 2005). That said, it is important to acknowledge that definitions of literacy are vigorously debated, and the main advantage of the one chosen here is its simplicity and directness. In fact, literacy is relative, depending on the context, and there is no clear dividing line between "literate" and "illiterate". More importantly, while in Australia we often use the term "literacy" in discussing school outcomes, in international circles literacy almost always means adult literacy. Some people use the term "functional literacy", to describe the level of literacy competence required in specific contexts or settings, but this debate, which is dealt with comprehensively in other places (e.g., Lind, 2008, pp. 41-56), is not pursued further in this paper. Suffice it to say that this is not a paper about school education, which has been the focus of most attention in discussions in Australia of education-health links. Rather, the paper aims to focus attention on those Aboriginal and Torres Strait Islander young people and adults who have not benefited from the formal school education system, and who, as a consequence, have very low levels of basic English language literacy.

The paper argues that these people, who are estimated to comprise as much as 35% of the Aboriginal and Torres Strait Islander adult population nationally, and a much bigger proportion in some communities and regions, are the key to improving overall health outcomes in the population as a whole. This is because:

a) These people and their children are at the biggest risk in terms of their health; and
b) They are also the people most likely to be disengaged from processes of health development already underway in their communities.

It argues further that an effective way to improve health outcomes and foster health development is through a mass literacy campaign – one which sets out to raise literacy levels significantly over a relatively short period of time. English literacy acquisition on a mass scale, it argues, is a key to better health.

This is a controversial position, which many will want to challenge. This is because mass adult education – often called popular education – has historically been linked to social and political struggles around knowledge and power. Popular education is not formal education, of the kind provided by schools, TAFEs and universities. It is "non-formal" education, provided on a mass scale, to people in marginalised and disadvantaged communities, as part of wider social and political movements for equality. Popular education is not familiar to most Australian policy-makers in either education or health, but it is very common in countries of the global South (Kane, 2001). It was also well-known in Europe in the eighteenth and nineteenth centuries, in the period before formal education was extended via compulsory education Acts. There it was associated with movements for democratic change, such as the British Chartists, and with nationalist movements in countries such as Denmark which were dominated by the great powers (Steele, 2007). Popular education, this paper argues, is the appropriate form of education to deal with the massive social and economic inequality which most authors agree is at the heart of the social determinants of Indigenous health (Saggers & Gray, 2007).

The literacy-health link: What do we know?

An Australian demographer, Professor Jack Caldwell from the Australian National University (ANU), was one of the first health researchers to draw international attention to the links between education levels and population health. In the late 1970s, he traced the link between rising education levels and mortality decline in Nigeria (Caldwell, 1979). In the 1980s, he established a major research centre, the Health Transitions Centre, within ANU's National Centre for Epidemiology and Public Health (NCEPH), which produced numerous studies throughout the 1980s and 1990s of the education-health link. International agencies took this work very seriously. For example, in 1993, the World Development Report published by UNDP suggested that a 10% increase in literacy rates globally could lead to a 10% decrease in child mortality (cited in Weeramanthri, 1995). In the last ten years, the education-health link has proved a fertile ground for further research, including more recent studies of "health literacy" in first-world countries. This ongoing work has helped develop Caldwell's original explanatory models into more complex and nuanced accounts (Robinson-Pant, 2001).

In 1995, Caldwell presented his work to the first Aboriginal Health Transitions Workshop in Darwin (Caldwell & Caldwell, 1995). Caldwell's paper, along with several others (Gray & Smith, 1995; Tsey, 1997), helped shape the Education and Health Research Program of the Cooperative Research Centre for Aboriginal Health (CRCAH) in the period 1998-2001. This initial research program undertook several studies which explored the education-health connection in an Indigenous context. Boughton (2000) reviewed the international research, and linked it to recent work on the social determinants of health, before suggesting a more complex and historically-grounded agenda for more detailed research in Australia. Ewald and Boughton (2002) and Gray and Boughton (2001) trialled quantitative studies of the connection, using previously-collected data. Lowell et al. (2003) explored the attitudes of Aboriginal informants to the suggested links, and Malin (2003) problematised the transfer of Caldwell's model to schooling in an colonial context. Since this early work, the Australian Bureau of Statistics/Australian Institute of Health and Wellfare's annual publication, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, has included a chapter on education and health. The most recent begins:

> Higher levels of educational attainment are thought to directly impact on health by improving a person's health-related knowledge and their ability to efficiently use this information. Educational attainment is also associated with better employment prospects and higher income which, in turn, may serve to increase access to health-related services and products (Pink & Allbon, 2008, p. 15).

Reviewing this history, Dunbar and Scrimgeor (2007) concluded that the Australian research on the impact of education on health outcomes "remains speculative and inconclusive". They suggested that a key issue determining the health impact of education was whether or not the education provided was "culturally and locally relevant" (2007, p. 147). If not, they said, it might have negative rather than positive impacts on health. While educational ethnographers regularly make this point, it begs the question as to what constitutes an education which is "culturally and locally relevant", and how communities become empowered to decide this, when faced with large scale modern education bureaucracies staffed by tertiary-educated professionals. Community-controlled education, like community-controlled health, cannot function effectively without a literate local leadership able to negotiate with the colonial state.

Because most health transition studies used "years of schooling" as a proxy for education levels, discussions in Australia on links between education

and health have tended to equate education with formal schooling. If rising education levels produce better health outcomes, it is argued, then we need to discuss whether, and/or how, to improve retention and outcomes (including literacy outcomes) among children and young people who are still in formal education. Most Aboriginal young people and adults, however, ***have already left school***, and improving school retention rates and outcomes does nothing for their education level. Moreover, unless attention is shifted to these out-of-school young people and adults, further investment in improving school outcomes will tend to benefit only the children of those adults who already have higher levels of formal schooling. This will exacerbate inequalities within and between communities. For this reason, the focus needs to shift to adult literacy, defined broadly, both as an indicator of people's education level; but also as the focus of programs designed to address the problem of educational inequality. This point was made by Bell et al. (2007) in the CRCAH's *Beyond Bandaids* collection. The authors advocated using a popular education approach with people with low levels of literacy to develop a renewed community-based health leadership.

The focus on schooling also ignores another important finding of Caldwell and his colleagues which is that the countries of the global South in which education was extended to a much wider section of the population with resulting improved health outcomes tended to be countries with strong mass social movements for equality; particularly, but not only, equality for women. Examples included Sri Lanka, Costa Rica, Cuba and China; and the state of Kerala in India (Caldwell, 1986). In the same vein, Nag (1990) reported a study which compared rural Kerala and West Bengal in India, and argued that ***attitudes towards fighting for one's rights***, which were stronger in Kerala, were an important explanation for decisively lower mortality. One study which is of direct relevance to this paper was done by Sandiford et al. (1995). This ten-year follow up study of participants in the the 1980-1985 Sandinista popular education and literacy campaign in Nicaragua found that the children of women who had participated in the campaign had significantly lower mortality and better health outcomes (measured by nutritional status), compared with the children of those who had not, after controlling for other socio-economic factors.

In summary, the international research suggests that poor health in disadvantaged and impoverished communities may well be caused in part by lack of schooling and low levels of literacy and educational attainment; but the relationship in Aboriginal communities is unlikely to be straightforward. We can also conclude that actions which aim to raise adult literacy and education levels may well produce better health, but again, this will depend on the context in which this occurs, including the extent to which the education strategy is embedded within a wider movement for social and political change.

How widespread is the problem of illiteracy in Aboriginal communities?

In the absence of a national literacy survey of the Aboriginal population, which has never been done in Australia, the extent of illiteracy has to be inferred from other data. The discussion below draws on the following six sources: 2006 Census data, the 2006 Australian Bureau of Statistics Adult Literacy and Lifeskills Survey (ABS ALLS), the annual National Schools Collection, studies of vocational education and training participants, small scale community studies of literacy, and anecdotal evidence from education and health practitioners working in communities.

At the 2006 Census, approximately 266,000 people aged 15 and over identified as Aboriginal or Torres Strait Islanders. A third had left school at Year 9 or below. In remote communities, the figure was closer to 50% (Pink & Allbon, 2008). While some of these people may well have attained a good education up to that point, we know from school literacy and numeracy test scores reported in the annual National Report to Parliament on Indigenous Education that most have not (Australian Commonwealth, 2007). Moreover, even if people have acquired some literacy by the time they leave school, it is unlikely to be retained unless it is used regularly in daily life (Lind, 2008). On this basis we could expect perhaps a third of the adult population, and a larger proportion in remote communities, to have insufficient English language literacy for basic living skills, employment and citizen participation.

However, the situation may actually be worse than this. The 2006 Adult Literacy and Lifeskills Survey (ABS, 2008) assessed literacy and numeracy levels across the whole Australian population, and found between 17 and 22%, depending on the type of literacy/numeracy tested, to be at only the most basic level (level 1 of 5). The sample size was too small to extract data by Aboriginality, but the percentage of the population in this lowest level was much higher for people with 10 years or less of schooling, around 40%. On this basis, we can expect there to be over 100,000 Aboriginal and Torres Strait Islander adults to have literacy and numeracy levels well below what is required to cope with day-to day realities.

This figure can be expected to reduce over time, as more people stay on at school longer. But while 90% now stay on at school until at least Year 10, the figure 10 years ago was significantly lower (83%); and before that, much lower again. Moreover, there is a lot of evidence to suggest that even among those who do stay on, literacy levels remain fairly low for those whose families and communities do not have

a literate culture. Schooling is compulsory to Year 10; and once the magic age is passed, drop out rates among this group rise sharply. These are the people who go on to become young and not so young adults who lack basic literacy. In the Northern Territory in 1999, an independent inquiry heard evidence that most secondary-aged Aboriginal school students in remote communities left school with a literacy level equivalent to primary school year three (Northern Territory Department of Education, 1999). Ten years later, it is most unlikely that these young adults would have retained any basic literacy. Their children are also likely to be those having least success at school now.

Studies of Aboriginal adult participation levels in post-school courses in the Vocational Education and Training (VET) system provide a further source of evidence. Firstly, VET participation levels by Indigenous students are high, but they tend to concentrate on low level qualifications, at Certificate I and II, where literacy requirements are very low. Many of these courses are providing enabling skills such as literacy, numeracy and study skills, and becoming the basis on which students can move to higher levels courses (Miller, 2005, p. 18). The high level of enrolments in these courses is therefore indirect evidence of low literacy levels among adults, even among those who are engaged in formal post-school education. Secondly, several recent studies have found that many Aboriginal adults, especially in remote communities, have insufficient English language literacy to succeed in even these basic VET courses (Schwab, 2006; Young et al., 2007). Low levels of literacy are thus operating as a barrier to further study and training and this impacts directly back on community health and wellbeing, because people are unable to get the qualifications they need to take up employment in their communities, including as health workers, but also in numerous other roles that contribute to health development.

There are very few detailed studies of adult literacy levels in specific communities, but the ones there are confirm the level of illiteracy described above. Kral and Falk (2004, p. 29) report a case-study in a remote community in the NT, in which "80% stated that they could read and write in English yet when assessed it was found that 50% of males and 40% of females were not yet competent at National Reporting System Level 1". The National Reporting System levels are comparable to but not the same as the levels used in the ABS ALLS described above. It should be noted, however, that the community studied was reported in *The Medical Journal of Australia* last year to have mortality and morbidity levels below the NT average:

> Mortality in the cohort was 964/100 000 person-years, significantly lower than that of the NT Indigenous population ... Hospitalisation with CVD as a primary cause was 13/1000 person-years for the cohort, compared with 33/1000 person-years for the NT Indigenous population (Rowley et al., 2008).

This once again reveals the complexity of simply trying to read off health outcomes from literacy levels.

There is little point in collecting more detailed data on literacy levels, unless this is done as part of a strategy to raise literacy competence among people at the lowest levels. In this respect, measuring illiteracy can be compared with public health screening, which is considered unethical if nothing is going to be done about the problems uncovered. In fact, one of the best ways to get a better idea of literacy levels is to deliver a mass intervention which targets those who have least literacy with specific learning activities, and involves a pre-assessment of people as they enter the program.

Overcoming illiteracy: International experiences

In Australia, the predominant view is that Australia does not have a problem with illiteracy, because most people complete at least ten years of compulsory schooling. Internationally, and especially in the global South, the situation is somewhat different. In Asia, Southern Africa, and Latin America, adult literacy has been a significant policy issue for at least the last fifty years. International development agencies and national governments have engaged in vigorous debates over several decades about what kinds of strategies are required to reduce illiteracy, and many countries have embarked on major efforts to lower illiteracy rates. Some, but by no means all, have had significant successes. The Education for All Global Monitoring Report 2006 (UNESCO, 2005) reviews some of this history.

Partly as a result of their marginalisation from mainstream education policy debates, most efforts to address adult literacy in Aboriginal communities are small scale, one-off programs working with very limited numbers of people. These include TAFE literacy/enabling courses, and courses aimed to improve "functional" literacy in a specific field or sector, such as the Commonwealth Workplace English Language Literacy (WELL) program. In the absence of any comprehensive mapping of these programs nationally, it is impossible to say how many people are involved, and with what effect. However, the international research literature would suggest that such an uncoordinated approach is unlikely to have any significant impact on the overall rate of literacy in a population:

> Many methods of promoting adult literacy have been adopted by international organizations, governments, social or political movements, faith-based organizations and NGOs. Despite the fact

> that some are of outstanding quality and deliver such desirable outcomes as improved learners' empowerment, few have made a significant contribution to increasing national literacy rates (Lind, 2008, p. 5).

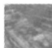
Where there is a significant rate of illiteracy in a specific population, the most successful approach to reduce it is via a national campaign, rather than by a series of discrete, inconsistently staffed and uncoordinated programs.

In the second half of the twentieth century, many newly independent countries, faced with mass illiteracy resulting from a combination of colonial neglect and war, opted to undertake national literacy campaigns. Cuba, Nicaragua, Tanzania, Mozambique and the Indian state of Kerala are among the best-known and best-documented examples, but there are many more. For the countries which adopted this strategy, which amounted to a mass adult education campaign, the eradication of illiteracy was seen as an essential first step towards producing a more educated population, one which could take an active role in consolidating independence. Overall, and despite many problems, there were substantial successes. Illiteracy rates fell by more than twenty percentage points in several countries, while many of the participants, both "graduates" and teachers, went on to play a significant role in their country's subsequent development (Arnove & Gaff, 1987; Lind, 1988). Today, many campaigns are underway again, in South Africa, Brazil, Ecuador, and Bolivia, to name a few. There is currently one underway in Timor-Leste, Australia's nearest neighbour, where nearly 50% of the adult population is illiterate. After 18 months, the campaign in Timor-Leste has achieved significant success, reaching over 18000 people; and is on track to eradicate illiteracy altogether within the next five to seven years (Boughton & Durnan, 2008).

Campaigns of this nature have to be coordinated nationally, and lead by governments. Above all, they only succeed where there is significant political will:

> The success or failure of a literacy activity does not ultimately derive from economic or technical issues, but rather from the existence or not of *a firm political will* with the capacity to organize and mobilize the people around a literacy project (Torres, cited in Lind, 1988, p. 21)

In the case of Indigenous Australia, the required political will would need to come, not just from governments at all levels, but also, most critically, from the national Indigenous leadership. The need arises from the nature of the campaign approach, which is very different from anything that has been tried previously in Australia.



What are the features of successful national literacy campaigns?

A literacy campaign can be mounted in a community, or a region, or a country as a whole, but because such campaigns are usually associated with large scale movements for social change, most of the research has been done on national campaigns. First, a distinguishing feature is that a campaign has very explicit objectives, expressed in terms of a reduction in the illiteracy rate to be achieved in a specific time frame. For example, if the national illiteracy rate is 30%, the campaign sets out to reduce it to, say, 10%, within a period of five years (Arnove & Graff, 1987; Lind, 2008; UNESCO, 2005).

Second, the approach is that responsibility for it is not left to the education system. Campaigns are "whole-of-government, whole of population" affairs, involving mobilisation of resources across many different sectors. In countries where campaigns have been run out of the Ministry of Education, they soon falter, because education officials and their systems tend to be geared to the requirements of formal education. The most successful campaigns are led by political leaders; and they engage leaders from across a range of different functional areas of government. They also exhibit a "top-to-bottom" model of political leadership, where national-level leadership is matched and complemented by leadership at regional and local level, right down to the level of villages and communities (Boughton, 2008).

Third, successful campaigns have a "three-phase" approach. The first phase, which can be called "socialisation and mobilisation", involves building the political leadership and commitment, among leaders, those who will work in the campaign, and the participants. The second phase, the literacy "class", is a short sharp period of instruction, usually no more than three months, in which groups of participants acquire the very basics of literacy – perhaps only learning to write their own names and a simple sentence. The third phase, called "post-literacy", provides ongoing activities which encourage the participants to utilise their new-found skills and develop them further. This can be through further "education-style" classes, but it can just as easily mean engagement in community and personal activities in which there is a specific objective to build on the newly-acquired skills (Lind, 2008). These phases are continuous and integrated. They have been likened to three spokes in a wheel. Each one must remain strong for the wheel to keep rolling.

Fourth, campaigns are tightly coordinated and controlled, with good records kept of progress through each stage of the campaign, and regular reviews of progress against the goals that have been set. Local "sites" must regularly report to the "centre", and action taken if progress starts to flag.

Fifth, the participants in a campaign are honoured and respected, for the efforts they are making, not

just to assist themselves, but to become more active participants in the processes of community and national development. This applies to the "illiterates" who join the classes, but also to all the local workers and volunteers who are brought into activity around the campaign. Campaigns are self-consciously egalitarian and democratic, encouraging even the poorest and most disadvantaged people to see themselves as active citizens with a contribution to make to the development of a viable future (Arnove & Graff, 1987).

Sixth, the people who teach the classes are not professionally-qualified educators. Campaigns mobilise local people, who may only have basic high school literacy themselves, as the people who deliver the program. The "professional" workforce in a campaign tend to be concentrated in the tasks of training the community based "tutors", and in the overall organisation and coordination. There is consequently a requirement for good preparation and training of the tutors, and of ongoing support.

Conclusion

Low levels of English-language literacy significantly reduce the capacity of Aboriginal communities to take action themselves to improve their health and well-being. A large number of people in communities are daily being marginalised by the ever-growing apparatus of administration and services which are staffed by tertiary-educated professionals. This goes to the heart of the so-called "control factor", which we know to be a major cause of ill-health (Bell et al., 2007). The formal education system will be unable to impact on this growing inequality unless urgent attention is also paid to the needs of the poorest and most disadvantaged, the non-literate adults. This paper has proposed a way out of this situation, informed by the experiences and struggles of disadvantaged peoples in many other countries of the world, who share many aspects of the situation of Indigenous people. While these experiences are not directly transferable, few will argue that underneath all the complex writing about the social determinants of health, there is one fundamental fact, which is widespread and growing social and economic inequality. Such inequality is unlikely to change, unless those who are its "victims" become active agents in social and political processes which are currently dominated by others. A popular mass adult literacy campaign, properly researched and piloted, may provide a proven "road-tested" model for seeding such a process.

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