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MIRA Channel

Case study by UNESCO-Pearson Initiative for Literacy



Name

MIRA Channel



Location

India, Afghanistan and Uganda



Implementing organization

ZMQ Development



Year launched

2012



Focus of intervention

Improve maternal and child mortality rates through a mobile health-care extension service for women and adolescents with low literacy levels in rural communities



Reach

850,000 women, children and adolescent girls across three countries

Summary

India has the world's second highest maternal mortality rate (MMR), with 15 per cent of cases globally, amounting to 45,000 pregnancy and childbirth-related deaths in 2015 (Graham et al., 2016). While the country almost achieved the Millennium Development Goals target to reduce this number by three-quarters from 1990 to 2015 (WHO, 2015), socio-economic disparities continue to be leading determinants of the drastic within-country variance (UNICEF, n.d.a).

India also has the world's worst under-5 mortality rate, accounting for one in five cases globally (IVAC, 2015). While institutional births and births assisted by a skilled professional have increased to almost 80 per cent of all births, rural children still have a 60 per cent higher mortality rate than their urban peers (IIPS, 2016). Other major determinants of child mortality across India are mothers with low literacy levels and limited schooling, and younger mothers under the age of 20 (NIMS et al., 2012). These groups are typically associated with lower adherence to a full cycle of antenatal care (ANC) and post-partum child care (PPC). Despite expanded coverage of health services and institutions, many families have little access to comprehensive information about the services to promote improved pregnancy and childbirth practices (UNICEF, n.d.b).

MIRA Channel was launched in 2012 as an integrated mobile phone service providing communication and information tools for maternal and child health care to rural women in low-resource settings. The solution offers app-based modules referred to as 'Channels' related to a variety of topics, including ANC and PPC, child immunization, family planning and adolescent health. The channels are intended to emulate television programming through audio recordings and multimedia content, to improve awareness and build knowledge on health issues, with a particular focus on mothers with low levels of literacy.

MIRA Channel has been deployed across hundreds of villages and schools in India, covering almost 850,000 women, adolescent girls and children. Some MIRA Channel villages have experienced a 50 per cent increase in ANC consultations and institutional deliveries, while immunization rates have increased by over 40 per cent. The solution comprises the MIRA Channel App for individual use, the MIRA Channel Worker Toolkit for home visits by community health workers (CHWs), and an analytics dashboard called MIRA-PHC Connect for generating reports from MIRA Channel data. This allows service providers to take timely action for reducing maternal and child mortality.

ABOUT THIS CASE STUDY

Through the UNESCO-Pearson Initiative for Literacy: Improved Livelihoods in a Digital World, this case study is part of a series highlighting how inclusive digital solutions can help people with low skills or low literacy levels use technology in ways that support skills development and, ultimately, improve livelihoods – in contribution to achieving the Sustainable Development Goal on education. For more information go to en.unesco.org/themes/literacy-all/pearson-initiative.

Why selected

MIRA Channel was born out of direct experience working with low-literate women in a microfinance programme. The women indicated a need for maternal and child health (MCH) information. MIRA Channel is thus user-driven and deeply cognisant of the skills of the women and adolescents it serves. By using games and interactive storytelling, MCH content is made more engaging.

Key takeaways

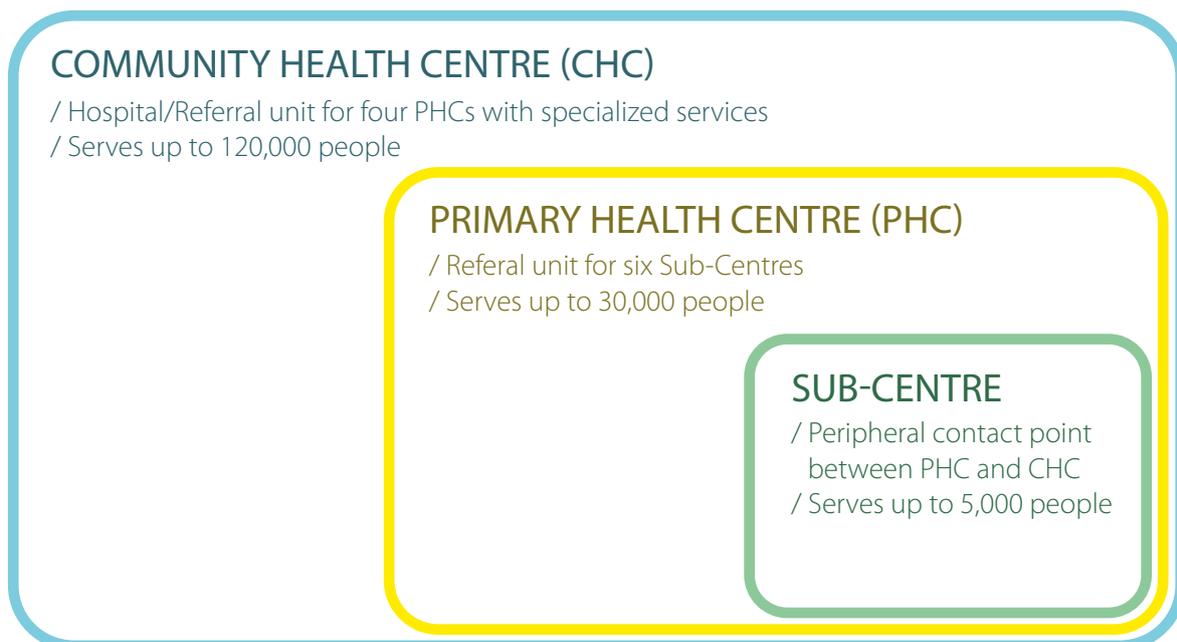
- 1 / MIRA Channel is a comprehensive MCH digital platform for providing vital health information to expectant mothers and adolescent women while connecting rural communities in under-resourced settings to health providers.
- 2 / The user-friendly interface, which relies on culturally appropriate animations and locally adapted audio content, delivers an inclusive digital solution for mothers with low levels of literacy.
- 3 / ZMQ has adapted MIRA Channel to multiple country contexts while maintaining substantial community stakeholder engagement to ensure contextualized content delivery.

Context and project origins

Health care in rural India operates as a three-tier system: sub-centres feed into primary health centres (PHCs) and PHCs feed into community health centres (CHCs), each with increasing population coverage capacity. Sub-centres comprise the greatest number of health facilities in the health care system, and act as a first point of contact with rural communities. A primary role of the rural sub-centres is to provide localized services and information related to MCH, family welfare, nutrition, immunization, and control of diarrhoea and communicable diseases. According to a report on rural health statistics released by the government in 2015, these sub-centres do not sufficiently meet the demands of the populations they were designed to serve. The study reveals an average of one female health worker to a rural population of almost 4,000, and one male health worker per 15,000 people at functioning sub-centres (India, 2015).

ZMQ developed MIRA Channel as a strategy to offset the shortfall in CHWs across rural India. A pilot was launched in Mewat district in the state of Haryana in 2012. Mewat is a primarily rural northern district with a female literacy rate of 36 per cent (IIPS, 2016). Fewer than 13 per cent of women from Mewat have over nine years of schooling, while the under-20 fertility rate is 14 per cent, almost double the national average (IIPS, 2016). Mewat also has more than double the average maternal and infant mortality rates for India as a whole (Manav, 2015). Institutional births account for 38 per cent of registered cases, while fewer than half of all childbirths are assisted by skilled health personnel (IIPS, 2016).

Figure 1. The rural health care system in India



Digital skills of MIRA Channel users

Mothers. The majority of the mothers using MIRA Channel had little to no prior experience using mobile phones. Therefore, ZMQ reached out to their adolescent children or siblings who generally had more experience in using mobile phones to assist in training them to use MIRA Channel. Including end-users beyond pregnant mothers laid the groundwork for building a programme directed at adolescent girls.

CHWs. Community health workers had more experience with mobile phone use. Their common exposure involved using feature phones to search contact lists and initiate calls, and send messages over SMS. The MIRA Channel programme was first introduced on the types of feature phone CHWs were familiar with. When the programme migrated to smartphone delivery, CHWs generally experienced little difficulty in using the more advanced keyboard feature of the smartphone devices instead of the keypad display of the feature phones.

In 2016, only 14 per cent of households in India had access to personal computers (ITU, 2016). These devices are most commonly found in internet cafes, where they are used for word processing or web browsing. The high cost of personal computers is prohibitive for many rural Indians, and their disinclination to obtain computers is compounded by the need to be trained and acquire technical literacy in order to use them effectively, and the problems caused by an often sporadic power supply.

Despite the low level of access to the internet via computer, subscriptions to mobile phone services have reached the level of 88 for every 100 inhabitants, with smartphone subscriptions expected to make up 30 per cent of India's mobile coverage and over 90 per cent of its mobile data traffic (Ericsson, 2017). These insights led ZMQ to produce a smartphone platform for MIRA Channel while keeping the feature phone version largely unchanged.



MIRA Channel operates as a mobile-based app for MCH using interactive graphics and voice-overs adapted to both feature phones and smartphones. Content is delivered across five sub-channels: prenatal care, neonatal care, child immunization, adolescent health (for girls) and family planning. MIRA Channel uses icons with audio support, making the service an interactive ‘talking toolkit’ designed for women and young people with low literacy skills. MIRA Channel also provides digital content by way of stories and mobile games to adolescent girls on issues related to water, sanitation and hygiene (WASH), menstrual hygiene, and dowries and early child marriage.



Figure 2. MIRA's suite of channel offerings includes (left to right): prenatal care, neonatal care, immunization, adolescent health (for girls) and family planning

INSIGHT

Leveraging human networks for programme expansion

Prior to MIRA Channel, ZMQ and its partners developed a financial lending module providing mobile-based solutions to micro-finance institutions (MFIs) in Uttar Pradesh, Rajasthan and Haryana. The objective of this micro-finance programme was to assist the MFIs and their loan officers in collecting and distributing loans. ZMQ discovered that most of the borrowers were women with low literacy levels who needed information on MCH. Therefore, ZMQ decided to build another module which would provide both loan information and health-care information to expectant and new mothers, as well as child immunization and family planning content. Expectant mothers registered the date of their last menstrual period, and received information during the subsequent weeks of their pregnancy. The messages came in the form of audio-visual content conveyed through icons, graphics and illustrations, embedded with local language audio. The child immunization module operated similarly: a woman entered the date of her baby's birth and received regular alerts about scheduled vaccinations. After adding more MCH content ZMQ developed MIRA Channel. ZMQ worked with the MFIs to expand the service to other areas served by CHWs across rural India.

Designing with the user

As a part of the content development and user-design process, ZMQ staff made almost a dozen field visits to Mewat to meet with local stakeholders including non-governmental organizations, community-based organizations and health ministry representatives. The process included over 300 individual interviews with CHWs, auxiliary nurse midwives (ANMs: see below), expectant mothers, telecom providers and department officials. During this preliminary fieldwork, ZMQ identified three major challenges: low literacy levels among their target group, low female mobile phone ownership and poor mobile connectivity.

Environmental challenges

Preliminary field surveys among 381 women revealed that over 70 per cent of respondents reported less than eight years of schooling. To address the challenge created by the low literacy level and support the female target group, ZMQ developed audio-visual content for MIRA Channel. It uses prominent and contextualized icons, and provides weekly audio information for expectant mothers with a special focus on nutrition, medication and frequently asked questions.

The country has a relatively high gender gap in mobile phone ownership, with 36 per cent more coverage among men than among women (GSMA, 2015). Most women who own mobile phones have basic models that do not provide access to the internet or the ability to download apps (Figure 4). Therefore, ZMQ created a multi-strategy approach for distributing MIRA Channel content. Women can access it on a shared feature phone (Figure 5), or their CHWs can show it on their smartphones during their routine house calls. An additional component of the platform uses an online portal to connect ANMs and other health workers to user or CHW-generated data. The aim is to flag high-risk pregnancies. ANMs are village-level female health workers who are often a woman's first point of contact with government health services. They act as supervisors to the CHWs.



Figure 3. Interface of MIRA Channel India

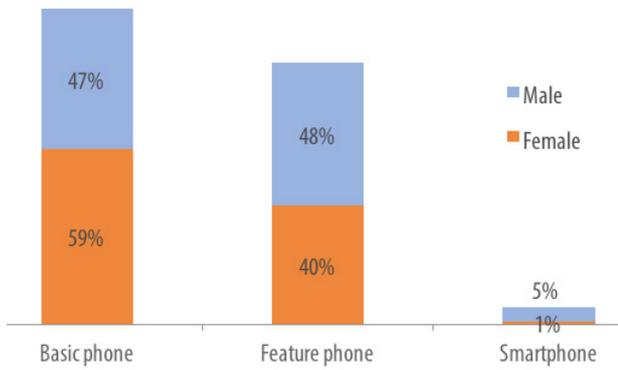


Figure 4. Type of handset owned by gender in India, 2015

Note: A basic phone has no alphabet keypad, touchscreen, internet access or ability to download apps. Feature phones have at least one of these features, while smartphones have all of these features. Authors' adaptation from GSMA (2015).



Figure 5. Feature phone versions of MIRA Channel (India and Uganda)

To address the connectivity challenge, ZMQ created an offline mode which enables CHWs to use the MIRA Channel Toolkit to perform their daily maternal and neonatal health-care activities when they are offline. The data is uploaded as soon as their handset re-establishes a connection.

Content development

As part of the visual content design process, ZMQ began by testing multiple images for each message, with graphics contextualized for the region. The images were discussed in focus group sessions along with the intended messaging. During the focus groups, the MIRA Channel team also invited the community representatives to draw additional icons that they felt best represented the messaging content. ZMQ then used the feedback and community images to develop a new set of graphics. Individuals from the communities recorded the spoken messages associated with the graphics so they would preserve the essence of the local dialect.

LESSON

Cultural variations in graphic design

As part of the design approach for the graphics associated with each of the messages, ZMQ learned about important cultural variations between the implementing countries. For instance, bananas in India are longer than bananas in Uganda. When presented with images of both kinds of banana, Ugandan communities preferred the smaller variety that they were used to seeing in their own markets. In Afghanistan, local women were concerned about how images of husbands appeared in the content. They preferred charming facial features and images of the husband smiling. In Uganda, focus groups revealed that stakeholders wanted the CHWs and ANMs to look well dressed, with the images showing their headgear and medical equipment. ZMQ learned from these community design sessions to develop visual content culturally adapted to each of the implementation contexts.

Early female users of the MIRA Channel platform were unfamiliar with the use of feature phones. Those who owned mobile devices used them primarily for voice calls, and less frequently for messaging through SMS. Therefore, creating a user-friendly, animation-rich interface became a priority for ZMQ. Some sub-channels provide content over weekly segments, such as the prenatal channel in the weeks leading up to delivery, for example. To improve content navigation between weeks, ZMQ used big, bold arrows on either side of the main

icon for the week (Figure 6). Field-testing revealed that this simple design feature worked better than the previous approach of using a sliding bar to toggle between weeks. An additional feature was incorporated for improving the way workers using MIRA Channel delivered information to women at high risk. Green (not-high-risk) and red (high-risk) dots next to the answers to questions allowed the CHWs to distinguish easily between high-risk and less at-risk patients, and select the appropriate information to provide.

Figure 6.
On-screen illustration of weekly progress through pregnancy cycle (weeks 19 and 35) with large navigation icons, India



The digital solution

The MIRA Channel programme provides digital communication and health management tools while expanding the coverage of the public health service system among rural women and adolescent girls. The platform consists of three components: a mobile app, a health worker toolkit, and an analytics dashboard.



Figure 7.
MIRA Midwife Toolkit, Uganda

- 1 The MIRA Channel Individual App** can be downloaded to mobile phones for individual use and self-management of maternal and neonatal health (MNH). The app also features a multiple registration function allowing groups of women to access their individual profiles from a single handset. Telecom recharge kiosks and community radio stations also serve as download stations to improve distribution. When users download the app for personal use, they are not networked into the broader public health-care and tracking system linked to the MIRA Channel Worker Toolkit.
- 2 The MIRA Channel Worker Toolkit** is designed for the network of MIRA Channel CHWs who make regular house calls to register pregnant women, and children under 5 for routine immunization. MIRA Channel workers visit the registered women weekly to deliver the programme content from their smartphone devices. Registered data associated with either the health status of the mother or the immunization progress of the infant is then sent from the mobile to the central server and is shared with local PHCs.
- 3 MIRA-PHC Connect** is a communication and service delivery platform that is connected to the Haryana State Rural Health Mission. The online platform communicates with two distinct apps customized for CHWs and their supervisors, the ANMs. During weekly visits, the CHW uses the MIRA Worker Toolkit (item 2 above) to ask expectant mothers a set of five symptomatic questions related to high-risk pregnancies. On the other app, the ANM Toolkit, nurses can view all of the pregnancy records registered by the CHW (Figure 9, right). Weekly checkup records are uploaded to the state health servers and redistributed to the CHWs. This integrated online platform allows state health workers to take timely action for supporting high-risk pregnancies. The platform also generates reports to inform policy decisions made by district health representatives.

INSIGHT

Profile of a MIRA CHW

MIRA Channel CHWs are female community health-care workers who receive a basic stipend for their efforts. They work from 8 a.m. to 1 p.m. daily, conducting house visits throughout their assigned communities. Generally, they have completed a full cycle of primary education (eight years of schooling) and live in the villages they serve.

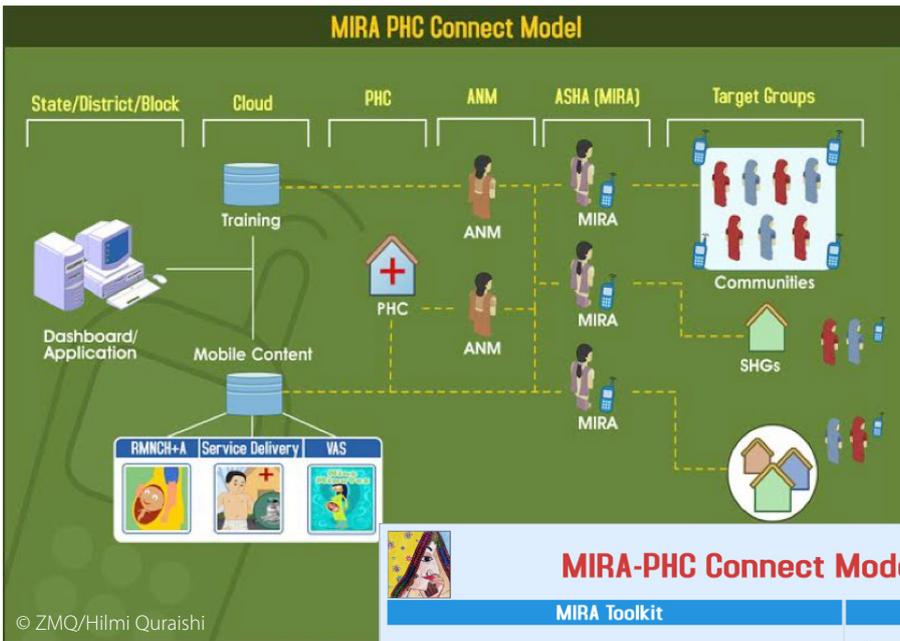


Figure 8. Architecture of the MIRA Channel-PhC Connect model

The screenshot displays the MIRA-PhC Connect Model (Live-Data) interface, divided into two main sections: the MIRA Toolkit and the ANM Toolkit.

- MIRA Toolkit:** Shows a mobile interface for CHWs with a 'MIRA Channel' header and a 'Question 5' screen. The question asks: 'क्या आपके पेट के निचले हिस्से में चर्द होवे हुए 12 घंटे से अधिक समय हो गया है?' (Is there a hard lump in the lower part of your abdomen for more than 12 hours?). The interface shows 'Yes' and 'No' options with corresponding colored circles (red for Yes, green for No, yellow for missing).
- ANM Toolkit:** Shows a 'High Risk Pregnancy' status table and a list of patients. The status table has columns for Name, Q1, Q2, Q3, Q4, Q5, and Wk. The patient list includes Anita, Manisa, and Bismil. A dropdown menu is visible with options: 'Refer to hospital', 'Call to sub center', and 'ASHA to follow up'.

 At the bottom, there is a detailed data table with columns for Name of Women, Home No., Date of Registration, LMP, Current Week, and 21 weekly status indicators (Week 1 to Week 21). The table shows data for Anita, Manisa, and Bismil. The interface is credited to © ZMQ/Hilmi Quraishi.

Figure 9. The MIRA Channel-PhC Connect online platform displaying a screenshot of the MIRA Channel Toolkit for CHWs (left) and the MIRA Channel ANM Toolkit (right)

Figure 9 displays screenshots of the dashboard report. The bottom of the report displays the names of each MIRA Channel CHW, the contact information of her assigned patients (pregnant women) and their current week of pregnancy. The dots and circles to the left of the ANM Toolkit shot represent the status of the mother in each week of her cycle. Every week the MIRA Channel CHW asks her patients five questions related to high-risk pregnancies. This patient’s yes/no responses are indicated by coloured circles, with ‘Yes’ corresponding to the red dot and ‘No’ corresponding to the green dot. Yellow dots represent responses that are missing for

the given week, because either the CHW did not visit the home, or the patient was not present at the time of the visit. This data is then pushed from the CHW phone to the dashboard where it becomes available to the ANM through the ANM Toolkit. The ANM uses this information to track high-risk trends and plan health care follow-up needs. ANM action plans may include a community-level follow-up, calling the woman in for an ANC checkup, or referring the woman to the nearest hospital. Each action planned by the ANM is also registered in the toolkit, and the dot changes colour once the prescribed action has been fulfilled.

The MIRA Channel model of delivery has two parts. The central focus is on communication and MNH service delivery. MNH services are provided to communities free of charge. The other part of the model is VAS (value added services), which consist of digital stories and social games.

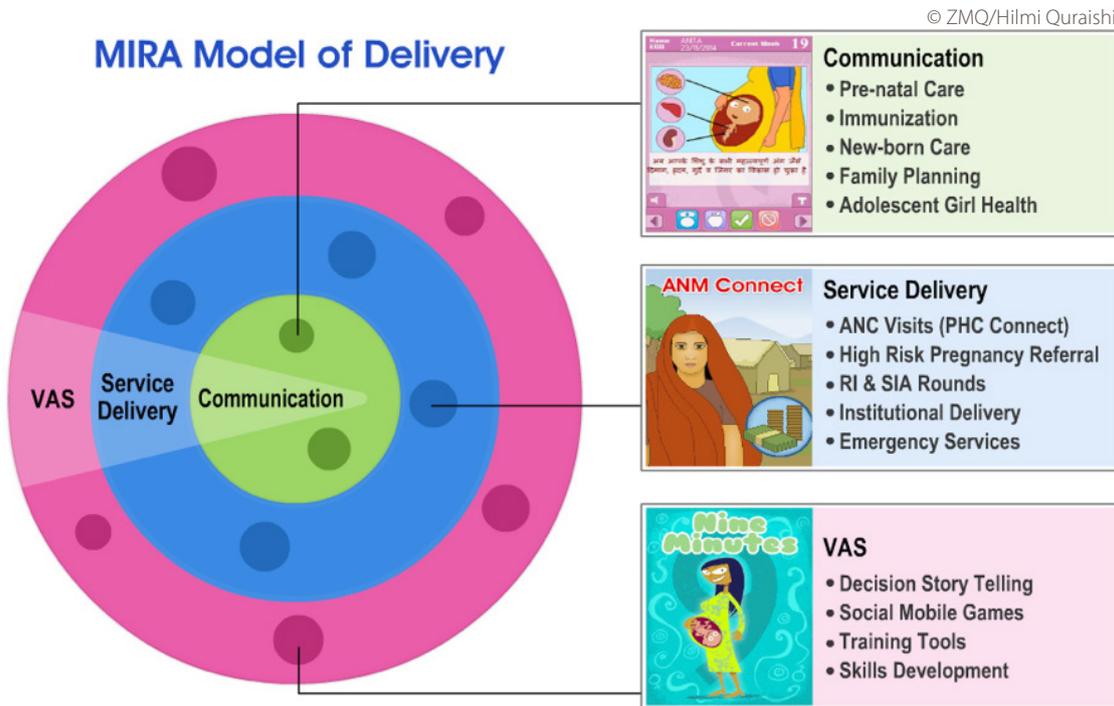


Figure 10. The MIRA model of delivery, expanding from core to value-added services

INSIGHT

Integrating unintended stakeholders can lead to new opportunities

Most women accessing the MIRA Channel platform have little to no experience working with mobile phones and thus need training. During the training sessions, ZMQ invited children or adolescents with better digital literacy skills to work with their mothers or aunts to learn how to use the channel. This unintentionally created a network of younger stakeholders, which motivated ZMQ to develop content specifically catering to the needs and style of adolescent women. Therefore, the team began developing a new model of content delivery through digital storytelling and social mobile games. The success of the new content has created new opportunities to reach a larger audience as well as expand the original MIRA Channel delivery model.

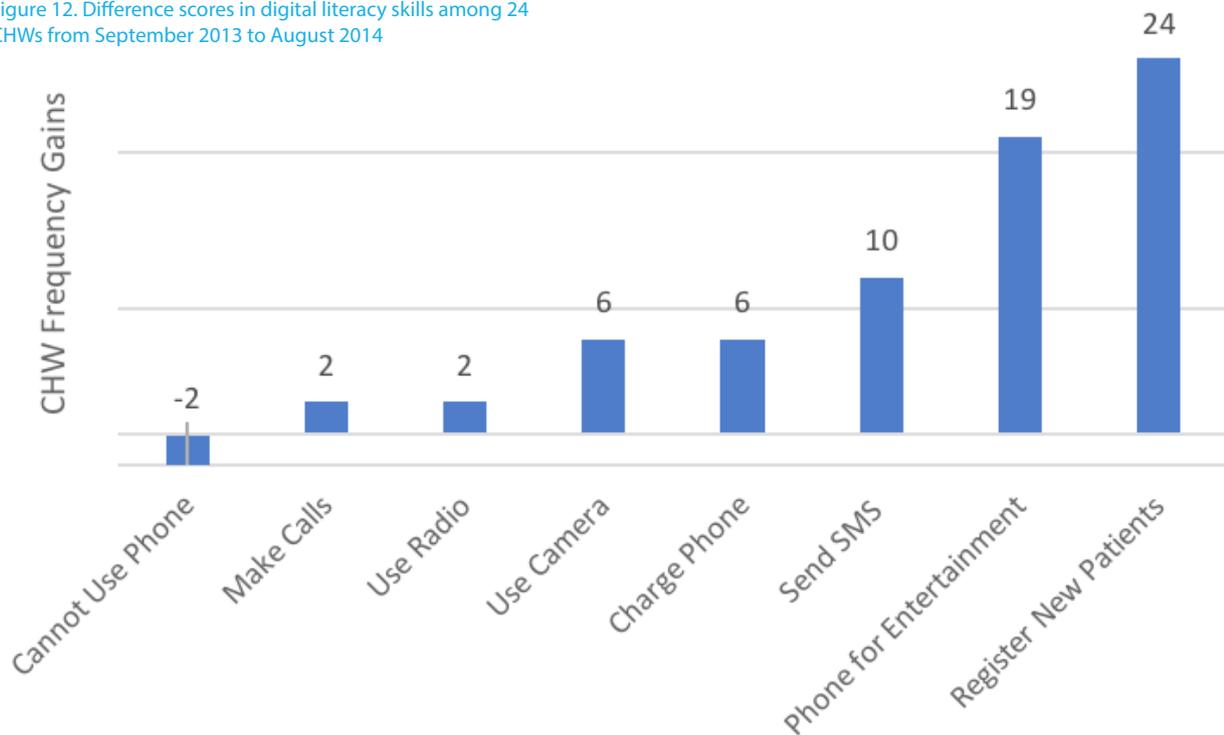
Figure 11. *Worm Attack*, *Nine Minutes* and *Family Choices* are examples of VAS games and stories developed by ZMQ. The company runs a programme called 'Game Lab' which involves game design workshops with communities to help them develop their own gaming storyboards on paper. The programme helps empower communities to identify local issues and arrive at unique solutions through gamification. Promising storyboards are then converted into digital games and used as a part of the MIRA Channel VAS model.



The MIRA Channel CHW training approach began with working with motivated CHWs and developing them into master trainers. After developing a substantive base of master trainers, ZMQ began to deploy a cascade training approach in the target communities. Basic digital literacy training precedes the health-care service delivery approach with MIRA Channel, to make sure all workers have sufficient technical skills to operate the platform (Figure 12).

The CHW training begins with the mobile device most comfortable for the volunteers. As they become comfortable with the phone functions, the training advances to operating the MIRA Channel Toolkit. The toolkit training is separated into three components. First volunteers learn to browse through the basic communication material. Next, they practise registering mothers and recording data. The third component involves analysing the patient data. Training materials include large posters, live presentations and training manuals for volunteers to take home.

Figure 12. Difference scores in digital literacy skills among 24 CHWs from September 2013 to August 2014



RECOMMENDATION

Benchmark
the digital
competences
of users

DigComp2.1: The Digital Competence Framework for Citizens (Carretero et al., 2017), developed by the European Commission, provides a common reference on how to describe key areas of digital competence and proficiency levels among individuals. UNESCO has applied this framework to understand the minimum skills needed to use MIRA Channel and thirty-one other digital solutions. Benchmarking digital competences is recommended, because it provides a knowledge base which can then be used to design appropriate solutions and to track progress of skill development. Please refer to the forthcoming UNESCO landscape review *Digital Inclusion for Low-skilled and Low-literate People* for the DigComp2.1 mapping and more information.

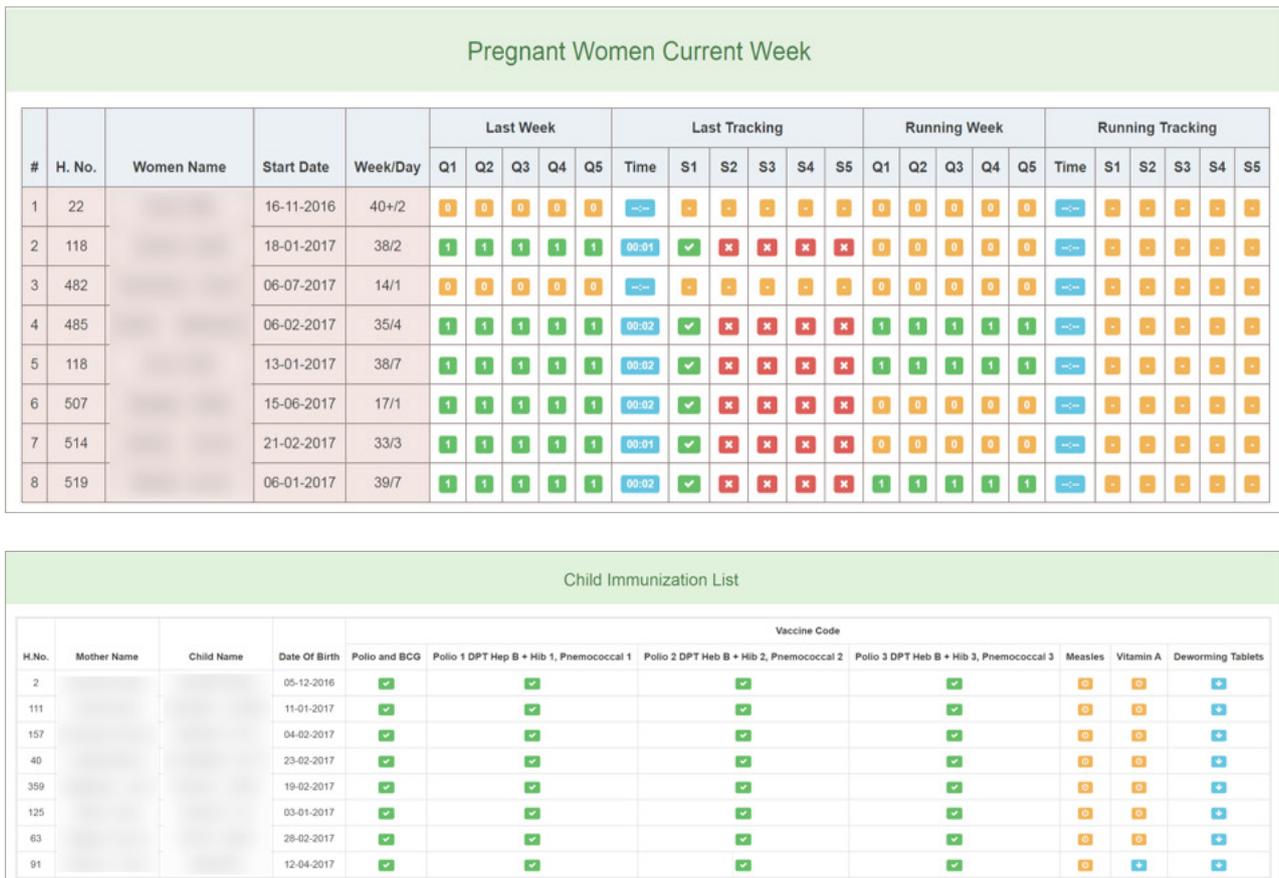
Monitoring and evaluation strategy

ZMQ believes that by creating a comprehensive digital health platform for new and expectant mothers and training CHWs on its implementation, it will enable the use of MCH services to increase in rural communities, leading to improved health practices among rural women.

The MIRA Channel platform produces real-time data through the MIRA-PHC Connect platform for timely decisions and action by community and state health workers. Information related

to consultation schedules, immunization records and ANC health is all part of the monitoring and evaluation strategy. Usage statistics such as user access frequency and time spent viewing each message are all tracked and sent to the MIRA Channel dashboard, providing an up-to-the-minute snapshot of each registered mother. The toolkit not only aids the health workers in providing consistent information to patients, but improves transparency among CHWs and facilitates improved care for women with high-risk pregnancies.

Figure 13. Screenshots of the MIRA Channel dashboard displaying the pregnant women tracker with ANC status and delivery status (top) and child immunization tracker (bottom)



Results to date

MIRA Channel has a current reach of over 850,000 women, children and adolescent girls, including a roll-out with the Haryana Livelihood Mission involving 511,000 women.

ZMQ expanded its distribution through a productive collaboration with telecom recharge kiosks and community radio stations. It partnered with recharge centres to help community women download the MIRA Channel app, games and digital stories to their phones. Similarly, ZMQ partnered with local radio stations to help promote the service and the recharge kiosks in the communities.

In the MIRA Channel intervention area in the Mewat district, there has been a 55 per cent increase in ANC consultations and 49 per cent increase in institutional deliveries, while child immunization rates have increased by 41 per cent (Net Hope, 2017). The MIRA Channel PHC-Connect model is being scaled to 180 government-sponsored CHWs and 25 ANMs reaching 69,000 women. Positive outcomes from India have led to an adaptation of the MIRA Channel for implementation in Uganda and Afghanistan, where 66,000 and 43,000 women, children and girls are using the solution. Results have shown that almost 3,000 Ugandan and 1,700 Afghani women have successfully completed their pregnancies using MIRA Channel. Another 10,200 Ugandan children and young women have received immunizations, with an additional 5,200 immunizations in Afghanistan.



Sustainability and future plans

The total operating budget across the three sites in India, Uganda and Afghanistan is US\$600,000. Funds have come in the form of a grant from bilateral agencies including the Federation of Indian Chambers of Commerce and Industry (FICCI), USAID and the UK Department for International Development (DfID). In addition to grant funding, ZMQ has generated US\$125,000 in revenue through the VAS model by selling digital stories and social mobile games to registered users.

MIRA Channel has been adapted for Uganda and Afghanistan with contextualized content including graphics and messages in the local languages. ZMQ is planning to reach out to more countries in Africa and expand to cover all of Afghanistan by adaptation to more languages and contexts. Beyond geographic expansion, ZMQ will soon expand its content delivery to include a skills development channel with a variety of livelihood development training courses and capacity-building tools for women and girls.

In addition to providing health-care information and edutainment content using social games and digital stories, ZMQ is working on two categories of skills development and training content. The first category is educational content for children and young people. This will primarily be basic literacy content for learning to read and write in Hindi and English as well as basic numeracy content.

The second category is training content. Another ZMQ project called Ajeevika Connect provides basic content for learning how to code. This model has already been tested through a rural entrepreneurship programme working in self-help groups in the Mewat area. Ajeevika Connect is now being integrated into the suite of MIRA Channel offerings. Other mobile-based training content includes soft-skills training, financial literacy, entrepreneurship training, and promotion and marketing training.

Figure 14. MIRA Channel Uganda



Figure 15. MIRA Channel Afghanistan



Lessons learned and recommendations

Be patient. When working with rural communities, ZMQ has found that it is important to work at a reasonable pace and not to rush through the implementation process. Adapting to local contexts is critical and takes time.

Be inclusive. ZMQ has tried to develop a culture of collaboration and inclusion where local groups are viewed as stakeholders and not just beneficiaries. Trust and buy-in about the design and implementation approach are necessary at the beginning of the process.

Be adaptive. Developing a functioning business model for lifeline services like MCH is not easy. The strategy will take time and is still evolving even after initial success. It is important to be flexible and view development work as a continuous process.

Plan for skills development. Developing digital skills will allow for more advanced multimedia and diversified topical content beyond health, such as skills development, literacy, livelihood training and entrepreneurship development. ZMQ hopes to build on the strong user base already accessing the health content to provide more services to meet the requirements of women, children and adolescent girls in need.

Design for populations with low literacy levels. ZMQ's use of icon-based images, localized audio and video, and one-click interfaces enabled uptake among individuals with low levels of literacy. Preliminary design workshops with low-literate communities improved the final content and digital products.



Contact information

ZMQ Development identifies critical social problems of under-resourced communities and designs digital solutions for them. ZMQ's methodology for addressing social problems is based on a 'system-changing' approach across interdisciplinary domains such as health care, education, livelihood development and climate change.



www.zmqdev.org and www.mirachannel.org



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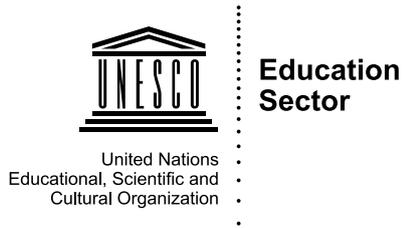
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UNESCO Education Sector

Education is UNESCO's top priority because it is a basic human right and the foundation on which to build peace and drive sustainable development. UNESCO is the United Nations' specialized agency for education and the Education Sector provides global and regional leadership in education, strengthens national education systems and responds to contemporary global challenges through education with a special focus on gender equality and Africa.



The Global Education 2030 Agenda

UNESCO, as the United Nations' specialized agency for education, is entrusted to lead and coordinate the Education 2030 Agenda, which is part of a global movement to eradicate poverty through 17 Sustainable Development Goals by 2030. Education, essential to achieve all of these goals, has its own dedicated Goal 4, which aims to *"ensure inclusive and equitable quality education and promote lifelong learning opportunities for all."* The Education 2030 Framework for Action provides guidance for the implementation of this ambitious goal and commitments.



About Pearson

Pearson is a digital education company, with expertise in educational courseware and assessment, and a range of teaching and learning services powered by technology. Our mission is to help people make progress through access to better learning. We believe that learning opens up opportunities, creating fulfilling careers and better lives.



About Project Literacy

Project Literacy is a global campaign founded and convened by Pearson to make significant and sustainable advances in the fight against illiteracy so that all people - regardless of geography, language, race, class, or gender - have the opportunity to fulfill their potential through the power of words.



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