

## **TITLE PAGE**

### **Women, literacy and health: comparing health and education sectoral approaches in Nepal**

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### **Abstract**

Functional adult literacy interventions have been regarded for many decades by policy makers as an effective way of imparting health knowledge. Supported by research on the statistical relationships between women's literacy rates and health indicators, this dominant policy discourse is based on assumptions that non-literate women lack understanding and confidence, and that formal programmes and institutions constitute the main sites of learning. Proposing a broader conceptualisation of literacy as a social practice and of health as connected with social justice, this article draws on policy analysis and the authors' earlier research in Nepal to re-examine the relationship between gender, literacy and health. By comparing health and literacy approaches used within the education and health sectors and taking account of new and indigenous informal learning practices, the article points to ways of investigating the complex interaction of factors that influence inequalities in gender and health at community level.

### **Key words**

Adult literacy, health education, health literacy, health promotion, gender equality, Nepal, lifelong learning, women's literacy

## **Women, literacy and health: comparing health and education sectoral approaches in Nepal**

### **1. Introduction**

Women's literacy has been a policy focus in Nepal for many decades, reflecting the international discourse on the relationship between adult literacy, development and women's empowerment. In particular, women's literacy has been connected with enhanced health outcomes. UNESCO (2013), for instance, cites evidence that educated mothers are more likely to have their children vaccinated, adopt family planning methods and to seek help from a midwife<sup>1</sup>. In the Nepal context, studies also show that women's health status and their level of education positively correlate: for instance, women with no education are more likely to have a higher birth rate, and less likely to receive the tetanus toxoid injection, to have an institutional delivery and to have children immunised (Nepal Family Health Program II and New ERA, 2010; Thomas et al, 2012; Alejos, 2015).

Influenced by such research findings and a strong international policy discourse that literate women have smaller and healthier families, adult literacy programmes in Nepal have incorporated learning about maternal and child health, family planning, nutrition and sanitation into their curriculum. Both Government and NGO providers have evaluated the impact of such programmes in terms of how many women gained literacy skills and new health knowledge through adult literacy classes. However, these studies tell us little about the processes of social change and informal learning

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<sup>1</sup> It should also be noted that much of the research in this area is based on adult literacy rates – which do not disaggregate between those women who attended school as children and those who learned to read and write as adults. See Robinson-Pant (2004) for a detailed critique.

that influence health and literacy learning practices within the wider community and in everyday life. Providers and researchers have often taken a narrow focus on the individual woman and assume that any behaviour change can be attributed to formal and non-formal learning within an adult literacy programme<sup>2</sup>.

This article sets out to provide a broader perspective on literacy, health and gender equality in Nepal, with the aim of informing future policy and programme directions. Having both researched women's literacy in Nepal since the 1990s<sup>3</sup>, we have experienced firsthand the ways in which cultural, political and economic values are being transformed. Increased mobility, migration and access to digital technologies in Nepal, particularly mobile phones, are influencing not only how people gain access to new knowledge, but also how they view and engage with both literacy and health practices within and outside the classroom. The new more 'gender friendly' constitutional and legal framework signals significant changes related to sexual violence and women's economic rights (Acharya et al 2015: 166).

Our starting point is that the relationship between adult literacy and social change – particularly around health and gender relations – needs to be reconceptualised. We propose a theoretical lens that recognises the social determinants of health and views literacy not just in terms of decoding skills but as a social practice. Moving away from the dominant input-output model often used to analyse the impact of adult literacy programmes, we consider ways of taking greater account of how informal learning processes, indigenous beliefs and practices around health and gender also influence change. This article is based on an analysis of policy and programme documentation,

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<sup>2</sup> An example is Burchfield's 1996 study in Nepal.

<sup>3</sup> We conducted qualitative research on women's literacy and development in Nepal for our doctoral degrees in the 1990s. See Acharya (1999) & Robinson-Pant (1997).

and a review of research conducted in Nepal on women's literacy and health (including our own earlier findings).

## **2. Women's literacy policy and programmes in Nepal: mapping the terrain**

We begin with a historical account of adult literacy policy and programmes in Nepal in order to offer insights into how policy makers and providers have combined health and literacy learning<sup>4</sup>. This is not just around the learning/teaching approaches and curriculum developed, but also about identifying the aims and ideologies underpinning such programmes – particularly in relation to women's empowerment and gender equality.

In 1953, the Government of Nepal invited Frank Laubach to assist in preparing materials for a mass literacy programme, which concentrated solely on reading and writing skills. At this time, literacy was viewed as a means to ensure 'functional' citizens since only 2% of the population were identified as literate (Acharya 2004: 1). By 1961, the literacy rate had risen to 8.9% and the Ministry of Education extended the curriculum to include functional skills on agriculture and health improvement. The aim was to prepare citizens who could support the country's development agenda (ibid). Literacy was viewed narrowly through a functionalist perspective and the programme was designed to enable women 'to better perform their traditional roles as homemakers and childcare takers' (ibid: 2). This emphasis on women's reproductive roles in the household continues to be reflected in present day adult literacy programmes and curricula.

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<sup>4</sup> This account draws on Acharya (2004) and Robinson-Pant (2001a).

In 1970, the National Education System Plan (NESP) was developed, with a vision of adult education becoming more ‘functional’ and relevant to local conditions, combining vocational training and literacy learning. Shortly afterwards, the UN Declaration of Women’s Year in 1975 emphasised the need for women to be integrated into development and the national five-year plans began to address women’s conditions (ibid). A major development at this time was the launch of the Government’s *Naya Goreto* (meaning ‘A New Trail’) adult literacy course, which is still the basis of many Government and NGO programmes today.

The *Naya Goreto* primers used the key word approach of Paulo Freire (Freire 1970), which appeared to be a move away from a functional literacy approach<sup>5</sup>. However, rather than using key words and pictures to raise political awareness (‘conscientisation’), the key word approach was used to teach the letters and words (Adhikari, 2059 BS<sup>6</sup>) and did not challenge the existing political system. Described as having a ‘multi message’ approach, the course was ‘touching on a variety of life-related subjects, such as health, agriculture or family planning, in combination with literacy instruction’ (Shrestha, 1993: 11), characteristic of a functional literacy approach. Through the influence of WAD (Women and Development) discourses in the international context, women’s literacy programmes in Nepal began to include income generation activities, awareness building and access to health care facilities.

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<sup>5</sup> For an historical analysis of the conceptualisation and meanings of ‘functional literacy’ within international literacy policy, see Verhoeven 1994. UNESCO first highlighted this concept in 1965, stating that ‘Rather than an end in itself, literacy should be regarded as a way of preparing man for a social, civic and economic role that goes beyond the limits of rudimentary literacy training consisting merely in the teaching of reading and writing’ (cited in Verhoeven 1994: 297).

<sup>6</sup> The Nepali calendar (Bikram Sambat, BS) is 56 years ahead of the Gregorian calendar (AD).

Following the overthrow of the party-less Panchayat system and restoration of democracy in 1990, there was a huge mushrooming of national and international NGOs, with many working in the field of adult literacy. In a study of 50 NGOs implementing literacy programmes (Shrestha 1993), all described literacy as ‘an entry point’ to other development activities. Literacy was seen to serve various functions, including facilitating an awareness-raising process, contributing to group building and strengthening connections with an NGO (ibid). This ‘literacy first’ approach (Rogers 2000) where literacy skills are considered a foundation for other skill and awareness building, including health, has been a strong feature of Government programmes in Nepal.

Women made up the majority of class participants, not just because more women than men were ‘illiterate’, but also because providers considered ‘women a more reliable and secure investment’ (Shrestha, 1993: 18)<sup>7</sup>. The curriculum reinforced rather than challenged existing gender relations and stereotypes, depicting women in household chores and men as active in the external world, and did not engage with indigenous values and practices around gender roles (Acharya 2004). Rather than recognising that divorce, marriage by widows and selecting one’s own partner were acceptable in some ethnic and caste groups, literacy programmes tried ‘to inject the value of the mainstream or power holding people, i.e. Brahman and Chettri in the case of Nepal’ (ibid: 8). This meant that certain ethnic groups were under-represented in the literacy textbooks, which failed to acknowledge a diversity of practices related to women’s access to and control over resources and reproductive health.

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<sup>7</sup> A review of the impact of women’s literacy at this time noted that: ‘Female functional literacy can play a key role in nurturing and harnessing this tremendous potential of resources and productivity... the most visible impacts are in the areas of income generation, increased awareness of personal hygiene and sanitation, aspiration for education and confidence building’ (Development Alternatives Nepal, 1991: 10).

Turning to the NGO sector, a significant programme linking women's literacy and health was set up by World Education in the 1990s, funded by USAID. HEAL (Health Education and Adult Literacy) was developed to support the work of Community Health Volunteers (CHVs), who were trained and supported by the Ministry of Health to provide health education, distribute Oral Rehydration Therapy packets, keep simple statistics on deaths and births, and arrange immunisations (Shrestha 2000).

Recognising the difficulties faced by non-literate women in undertaking these tasks, World Education developed a three-month post-literacy course (called *Diyalo*, meaning 'Light') which included health topics such as sanitation, family planning methods, HIV/Aids, vitamin A and good nutrition. The CHV supported the literacy facilitator through encouraging local women to attend the classes, running oral discussion sessions based on health posters and arranging facilities.

Evaluation of the HEAL programme revealed that on the ground facilitators and participants tended to focus more on the literacy instruction – than on health education – often preferring to chant the letters rather than to discuss the health issues introduced (Robinson-Pant 2001b). This was partly because many participants were learning literacy in a second language (since Nepali was not their mother tongue<sup>8</sup>), so they were able to decode but not necessarily understand the stories. Health education proved more effective when the topics were directly relevant to women participants (like midwifery, breastfeeding and cleanliness) as compared to topics like AIDS and first aid, which needed 'technical knowledge' (Shrestha 2000). However the primer presented simplistic messages such as a woman simply persuading her husband to

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<sup>8</sup>The Population Census (2011) identified 123 languages in Nepal and that Nepali was spoken by 44.64% of the population.



adopt family planning. The situation was often more complex in real life, with pressures from in-laws and economic concerns about the effect of contraceptive pills on women's productivity at work (Robinson-Pant 2001b). There were also structural issues around how to organise a programme working across sectors. Most district education office staff saw HEAL as a health project and therefore not part of their responsibility, whereas health providers saw HEAL as a literacy programme (Smith 1994).

Though HEAL went some way in developing an integrated approach to literacy and health instruction, the programme did not challenge traditional gendered roles and, like *Naya Goreto*, promoted a functional literacy approach. However, some small-scale NGO projects used rights-based approaches to mobilise women for social action and to tackle gender violence (see Parajuli and Enslin's (1990) account of a women's centre in Gunjanagar village). The REFLECT approach similarly supported marginalised groups to tackle inequalities – unusually, the literacy circles included awareness-raising around gender equality for men too and sometimes built on indigenous structures (Cottingham, Metcalf, and Phnuyal, 1998).

A Roundtable Discussion in 1997 on 'The linkages of adult literacy to improved health and family planning in Nepal' (Llewellyn 1997) highlighted a number of issues that had arisen by then. The participants questioned how to integrate the sectors, including decisions about personnel and whether 'literacy people' should teach health or 'health people' teach literacy. They noted the dominance of a 'literacy first' approach, pointing out that: 'literacy programme outputs become another programme's inputs' (ibid), since health interventions tended to follow on from an

initial basic literacy course. Programmes were seen to emphasise content and knowledge, rather than ‘critical skills’ and there was discussion about the ‘trade-off’ between health and literacy content. Discussants recognised that literacy was not necessarily the best way to gain health knowledge, and that listening and talking played an important part too. Even if women were gaining new knowledge, this was no guarantee that they would change their behaviour. Often disregarding indigenous health knowledge, programmes had tended instead to promote Western health practices through literacy, such as Save US’s ‘baby books’ which encouraged mothers to record their child’s milestones (Robinson-Pant, 2001a). Above all, though programmes focused on a group, the aim was not to facilitate collective action for enhanced health provision, but to influence individual knowledge and behaviour change.

Many of these observations from 1997 are still relevant in Nepal today: the dominance of formal instruction in health and literacy characterised by a ‘literacy first’ approach, health curricula (focused on women’s reproductive roles) determined by policy makers and planners rather than communities, assumptions of a dichotomised relationship between literacy/illiteracy and literacy/orality, and promotion of functional rather than transformative literacy learning. Recognising the need to revisit the relationship between literacy, health and women’s empowerment, we began by investigating an alternative ideological stance.

### **3. Literacy, women and health: towards an alternative theoretical framework**

Capturing the complexity of the processes involved in social change is a major challenge facing researchers in the field of literacy, health and gender. In this section, we explore ideas around literacy as a social practice, which foregrounds power, identity and voice, connecting with the conceptualisation of health from a social justice perspective. We suggest that this starting point could help researchers and policy makers to develop a more holistic and dynamic understanding of the relationship between women's literacy and health.

### **i) Understandings of literacy**

Much research on the links between women's literacy and health has adopted a quantitative methodology and set out to compare literate women with those who are not literate in relation to various health indicators such as fertility, child mortality, and nutritional status<sup>9</sup>. This body of research is underpinned by what has been termed an 'autonomous' model of literacy (Street 1984), which assumes a 'great divide' (Goody 1968) between orality and literacy, and between literate and illiterate people.

By contrast, an 'ideological' model of literacy (Street 1984) draws attention to relationships of power, identity and inequality that are constructed around and through literacy. Recognising the dominance of 'schooled' literacy (i.e. that associated with formal educational institutions and programmes, often in official languages or English), the ideological model proposes the concept of multiple literacies with differing values according to context, and a continuum rather than a divide between orality and literacy. These assumptions have led researchers and policy makers to

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<sup>9</sup>See for instance, LeVine et al's (2004) study on maternal literacy and health in Nepal.

develop a ‘social practice’ or ‘situated’ (Barton et al 2000) approach to literacy which recognises that throughout our lives we are all learning new literacy and oral practices, whether inside or outside a classroom. The notion of ‘multiple literacies’ draws attention to multilingualism and multimodality, providing a way of analysing diverse literacy practices, including indigenous and digital communicative practices.

Central to this understanding of literacy are ideas about informal and intergenerational learning – which challenge assumptions within both the health and education sectors that formally acquired knowledge and skills can alone transform behaviour and attitudes. Rather than simply polarising formal and informal learning, Rogers (2013: 5) proposes ways to analyse a wide range of informal learning practices: purposeful, planned and ‘learning-conscious learning’ (‘measured by learning’) as compared to informal, accidental/incidental learning (‘measured by task’). Polanyi’s (1967) writing on ‘tacit knowledge’ - defined as ‘that which we know but cannot tell’ - points to the challenge of identifying this kind of knowledge (including literacy) and how we learned it.

Our earlier historical account of the development of women’s literacy programmes in Nepal can be analysed through these lenses. The majority of programmes were informed by an autonomous model of literacy, designed around the assumption that non-literate women needed to read and write standard Nepali before they could understand and practise new health knowledge. Indigenous values, practices, literacies and knowledge (in relation to health, literacy or gender relations) were rarely acknowledged. By contrast, taking a social practice approach to literacy, gender and health implies looking not only at formal learning within a development programme,

but also investigating informal learning and indigenous values in everyday life.

Although many providers were concerned that literacy learning should be relevant to women's lives (as in the case of HEAL's work with Community Health Volunteers), they did not take account of how women were currently engaging in everyday literacy practices and informal learning within their communities.

This alternative understanding of literacy as practised in specific contexts and embedded in social, cultural and economic relationships – not just a set of skills learned in a classroom – has implications for looking at health and literacy policy. In particular, rather than starting with evaluation of the impact of programmes, we can first investigate everyday informal literacy and health practices and see how programmes support these. Exploring the specific context can also involve understanding and working with those who influence the 'literacy environment' (Easton 2014) – including producers of literacy texts, such as health educators, clinicians and medicine companies, in the case of health.

Within the field of women's education, feminist researchers and women's movements have drawn on Freire's (1970) concepts of conscientisation and praxis as key to promoting women's empowerment through literacy. Thus Stromquist (2015: 308) defines empowerment 'as a set of knowledge, skills and conditions that women must possess in order to understand their world and act upon it' and identified four dimensions of empowerment (psychological, cognitive, political and economic) (Stromquist 2009). Arguing the importance of empowerment at 'both the individual and collective levels' through learning knowledge and skills (ibid), she highlights that the 'acquisition and transmission of systematic knowledge operate through two main

modalities: formal education or schooling and non-formal education’ (Stromquist 2015: 313). Stromquist’s attention to planned educational interventions contrasts with proponents of a social practice approach to literacy who focus on informal learning and literacy practices embedded in everyday life. With regard to the kind of literacy instruction provided through development programmes, Stromquist argued in 2015 that ‘the emancipatory elements of literacy continues to receive limited governmental attention’ (p 316). This suggests that the trends we have observed in Nepal - with regard to depoliticising so-called ‘Freirean’ approaches to women’s literacy - are far more wide-spread. The distinction between individual and collective action, and the ‘critical literacy’ lens adopted by Stromquist and other feminist educational researchers will be re-visited below in relation to health promotion and health education.

## ii) **Health and social justice**

Many women’s literacy programmes have continued to be informed by a narrow understanding of health, focused on technical inputs and disseminating messages around family planning, immunisation and disease prevention, usually related to women’s reproductive role as mothers and carers. However, a broader conceptualisation of health as connected with social inequalities has long been dominant in the international health policy arena. In 1948, the World Health Organisation adopted a definition which has continued to inform policy development, including the 2030 Sustainable Development Agenda: ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO 1948). Within the rights-based approach developed by the WHO,

gender equality has been recognised as central (WHO 2006). The recent Global Strategy for Women's, Children's and Adolescents' Health (EWEC 2015) emphasises a commitment to address unequal gender norms and gender stereotypes that influence health policy and services. This politicised and holistic view of health, informed by theory on the social determinants of health<sup>10</sup>, lies behind a movement over the decades from health education to the multidisciplinary approach of health promotion (WHO 2013).

Whilst health **education** focuses on the individual client and their health needs, health **promotion** engages the whole community in a politicised process of awareness-raising and mobilisation to directly address the social determinants of health. There has also been an ideological shift from a medicalised model of health, with hierarchical positioning of citizens in relation to 'expert' medical staff. English (2012: 20) comments that 'individuals need to be viewed, not as health consumers, as if health services were the source of health, but rather as health creators'. Taking a feminist lens on health promotion, English and Irving (2015: 34) suggest that learning has often been focused more on individual change for women, than on challenging larger issues: 'constrained to talking about health as a series of individual choices and local conditions, rather than as a venue for social transformation'. This stance can be seen in most of the literacy programmes reviewed earlier – the emphasis was on educating individual women about their health rather than facilitating community action to address health inequalities. By contrast within health promotion, women are viewed as having skills and resources that they contribute to their communities – what

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<sup>10</sup> Defined by WHO (2016) 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'.

has been termed an ‘asset-based’ approach (Pakaari and Pakaari 2012) focused on ‘adults as participants, critical thinkers and agents of change’ (Hill 2016: 45)<sup>11</sup>. This approach also differs greatly from many literacy programmes which take the deficit starting point of analysing the skills and knowledge that women are thought to lack.

### iii) **Literacy and health**

Adult literacy is commonly viewed as a means for disseminating health-related messages about the benefits of smaller families or information about child nutrition through stories in primers<sup>12</sup>. By contrast, in the health sector there has been greater emphasis on literacy and citizenship, with attention to how health educators can support literacy practices in a broader range of contexts. The concept of ‘health literacy’ thus differs from meaning simply ‘literacy and health’ and has evolved, reflecting the ideological changes in the health model outlined above. Whereas the first use of the term (in 1974) referred to functional literacy in the health domain (Frisch et al 2011) with a narrow focus on reading and writing health materials (as evident in many adult literacy programmes in Nepal), now there is more attention to people’s use and ability to engage critically with such knowledge.

Health literacy has been conceptualised in terms of the kind of knowledge acquired (Schulz and Nakamoto 2005) and the kinds of skills promoted. Nutbeam (in Frisch et al 2011: 118) distinguishes between ‘functional health literacy’ (basic reading and writing skills to be able to read and use health information), ‘communicative health literacy’ (skills to interact with healthcare providers) and ‘critical health literacy’

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<sup>11</sup> For a more detailed account of this literature, see Robinson-Pant, 2016.

<sup>12</sup> Referred to as ‘schooled literacy’, see Street 2005.



(more advanced cognitive skills to critically analyse information to exert greater control over one's life). Zarcadoolas et al (2005: 197) added 'cultural literacy' (recognise collective beliefs, custom, world view and social identity). Taking these ideas into the context of women's literacy programmes, we can see greater recognition of diverse cultural beliefs around health, as well as different kinds of literacy practices.

Significantly, health literacy is often discussed in terms of citizenship and social justice: 'a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility' (Kickbusch et al, 2005). This emphasis on community mobilisation and social action has led to discussion about the multiple roles of health educators, who may be helping individuals to negotiate the literacy demands of treatment instructions, promoting community learning and educating people about their rights to healthcare (Hill 2016). There is strong acknowledgement of the need to build on informal learning to address gender inequalities in health, including 'the ability of women to both learn to engage in and ultimately learn through collective struggles against oppression' (English and Irving 2015: 37). This focus on informal learning contrasts with adult literacy policy, which - as we have seen in the case of Nepal - often assumes a formalised classroom-based approach. Concerns about the roles and capabilities of health educators link with similar findings in the adult literacy sector, where facilitators are seen as catalysts of change, but have often had little training or support<sup>13</sup>.

#### **iv) Implications for investigating health and women's literacy**

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<sup>13</sup> See Stromquist's (1997: 223) case study of the MOVA literacy programme in Sao Paulo, Brazil where she concludes that 'the pedagogical, emotional and cultural challenges encountered by literacy teachers are seldom investigated'.

The above review has indicated how a social practice model of literacy can help to analyse the relationships between different literacy practices, languages and modes of communication. The concepts of health promotion and critical health literacy bring these ideas into the health domain – emphasising that social justice involves not only awareness raising and new knowledge, but also processes of collective action.

In the second part of this article, we take these theoretical ideas to look at health and literacy in Nepal today from a gendered perspective. This approach can help us to ask different questions about health and literacy – rather than simply evaluating the impact of classes on women’s health or literacy skills:

- Taking the starting point that health literacy is more than functional literacy in the health domain and a recognition of multiple literacies/knowledges, we can ask what kind of literacy is being promoted and how?
- Building on ideas about health promotion involving women as ‘co-constructors of knowledge’ and adult educators as having diverse roles, we can look at who is involved (and targeted) in programmes and how?
- Recognising that learning takes place outside educational programmes and institutions, we can question what kind of informal learning about literacy, health and gender are people engaged in?
- Understanding that learning may emerge from - rather than only facilitate social transformation - we can ask what changes are already taking place outside development programmes that may influence health, gender relations and learning?

#### **4. Taking a gendered perspective on health and literacy: the case of Nepal**

We turn here to investigate recent developments in health and literacy policy and programmes in Nepal. We draw on a review of relevant documents primarily produced by the health and education sectors (including learning/teaching materials) and research literature on current prospects and challenges in women's literacy in Nepal. The review adapted the direct content analysis approach described by Hsieh and Shannon (2005) through generating themes and categories around our questions outlined in section 3iv. For policy documents and educational materials, we used a discourse analysis approach similar to that discussed by Aphorpe and Gasper (1996), noting how problems and issues were framed and what was unsaid/excluded from consideration, as well as what was said.

##### **i) Adult literacy: what kind of literacies, learning and knowledges?**

Analysing the kind of learning promoted in adult literacy programmes, there continues to be an emphasis on functional literacy – rather than the critical skills for empowerment pioneered by Freire (1970) that informs health and social justice approaches. The national adult literacy programme described earlier has been continuously revised over the past few years. In 2008 the government launched the National Literacy Campaign, which continued under the name of 'Literate Nepal Mission' from 2012 to 2015 (Ministry of Education, 2016). The purpose of both initiatives was to increase the literate population – reflecting the dominant 'autonomous' model of literacy discussed in section 3i.

Women's literacy programmes, which had previously been separately implemented, were then incorporated into the new versions of the literacy programme, i.e. National 'Literacy Campaign', 'Literate Nepal Mission' and at present 'Continuing Education' (NFEC, 2016). From 2015, Continuing Education has been introduced, with the seventh area of each level being devoted to health, hygiene and nutrition. However, the Level One primer does not include any related content, except yoga and physical exercise. The Level Two primer includes content related to safe motherhood and childcare, nutritious food, communicable and non-communicable diseases and first aid. In both levels, under the learning competencies dedicated to 'civic education', learners are expected to gain knowledge about women's and children's rights, social security, and act accordingly. This connects with a broader conceptualisation of health literacy in terms of citizenship outlined in 3iii above. They are also intended to learn about services provided by local government such as birth, death and marriage registration, and be able to share this information. Yet there is no actual content related to these topics in the primer or facilitator's instruction manual. The Preface states that adult literacy facilitators should seek materials from local sources like Community Learning Centres to teach these topics. So, whilst there is an apparent recognition that enhanced health is related to empowerment in other spheres, such as understanding civic rights, the lack of curriculum guidelines or specific content in these areas suggests that this approach might not be prioritised in practice. Rather, the emphasis is on imparting health messages such as 'Balanced diet is necessary for us to remain healthy. There must be minimum three types of food in our diet' (NFEC BS2073/2016: 94).

Looking at the question of who is targeted within literacy programmes, there is an even greater diversity of learners in literacy classes now. Women - who are still the major clients of literacy programmes - come with varied interests and literacy levels. But, so far adult literacy programmes have not been able to diversify approaches and content to respond to their differing needs and experiences. Though previously some programmes have developed curriculum using indigenous languages and representing different ethnic groups (Robinson-Pant 2010), this is still the exception rather than the norm. One attempt to respond to women's learning needs has been the Non Formal Adult School programme (NFEC, 2016), initiated in 2008 and also known as 'women's school' or 'housewives' school'. Women who are interested to gain a school examination certificate (and some have been to school as children) join these schools. Those who need basic literacy skills start from the 'flexible school programme' and gradually move up the levels as in the formal school system. A major challenge facing these programmes relates to the curricula and textbooks that are intended for children who study in flexible alternative school programmes or the formal regular school system – rather than for adult women (Gyanwali, BS2073/2016, ERDC, 2016). Adult women studying in the Non Formal Adult School grade nine are expected to learn topics such as 'Statistics' in Mathematics and 'Carbon and its Compounds' in Science (Luitel et al, BS2073/2016: 179; Basnet et al, BS2073/2016: 145)

Analysing these developments in adult literacy programmes/policy from the perspective of what kind of literacies/health knowledge and for whom, we can see that there has been a policy shift to seeing literacy as a form of continuing education (with a range of abilities in the classes) and a stated broader approach to health education in terms of citizenship. However, on the ground, the curriculum looks remarkably

similar, focusing on functional literacy and a more conventional approach to health literacy as functional skills and knowledge. An example is material advising women, 'Do not hide the disease and believe in superstition' (NFEC BS2073/2016: 56) - rather than creating a space for discussion about why women might hide disease. Though there has been a move away from women-only programmes in the recent literacy campaign policy, women still make up the majority of participants and there is a dominant 'one-size-fits-all' approach to curriculum development which rarely acknowledges indigenous health practices, identities and values. The continued emphasis on imparting knowledge, rather than developing practices of critical analysis in large-scale literacy programmes, has made it difficult to facilitate reflection on gender inequality in discussions of women's reproductive health issues.

## **ii) Health education and health policy: who is involved and how?**

Taking the starting point discussed in 3(iv) of health promotion as involving women as 'health creators' (English 2012) and the importance of informal learning, we look at how far health policy and practice in Nepal has responded to these ideas. Within the health sector, women's reproductive health has been a major priority, connecting with WHO's prioritisation of a rights-based approach to gender equality (see section 3ii). Since the formulation of the National Safe Motherhood policy in 1998, the focus has been on maternal and child health, reproductive rights of women, and improving women's access to and utilisation of health services. The National Safe Motherhood Plan (2002-2017), revised in 2005, paved the way to the Safe Motherhood and the Newborn Health Long Term Plan (2006-2017). Additionally, the then Ministry of Health and Population introduced Operational Guidelines for Gender Equality and

Social Inclusion Mainstreaming in the Health Sector in 2013. In the same year, the government of Nepal implemented the Multi-sector Nutritional Plan 2013-2017, which targeted teenage girls, pregnant women and breastfeeding mothers from low-income groups.

As mentioned earlier, ‘gender-friendly’ legal frameworks have been introduced and the Constitution of Nepal 2015 has validated the above initiatives by supporting women's right to safe motherhood and reproductive health through legal recognition (Clause 38/2). The strategies advocated by the Three Year Development Plan 2013-2016 to address gender disparities in health include: extension of basic health services (including safe motherhood and maternal health services for women); building capacities of Female Community Health Volunteers (FCHVs<sup>14</sup>); making health services more socially inclusive and equitable; incentives for effective delivery of services to rural women, women of disadvantaged and marginalised groups; and sensitisation and counselling services for better sexual and reproductive health. These initiatives<sup>15</sup> indicate a stronger attention to gender inequality and gender justice within the health sector as compared to the adult literacy programmes reviewed earlier – though the approach is similar in terms of top-down delivery of information and services at community level through the FCHVs.

The Government has adopted Information, Education and Communication (IEC) and Behaviour Change Communication (BCC) as the major strategies for effective

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<sup>14</sup> Similar to the CHVs discussed in our earlier account of the HEAL programme, FCHVs are women from the same community who facilitate discussion in mothers’ group (formed by the health sector) meetings.

<sup>15</sup> Documented in the Interpersonal Communication and Counselling Skill Development Manual for FCHVs, BS 2072/2015; Operational guidelines for gender equality and social inclusion mainstreaming in the health sector 2013 and [Health sector gender equality and social inclusion strategy, 2009](#)

implementation of all these activities (Ministry of Health and Population, 2013 and Ministry of Health and Population, n.d.). Development and dissemination of audio, audio-visual and printed educational materials campaigns and one-to-one health education by Female Community Health Volunteers (FCHVs) have been implemented to inform, communicate and educate women, particularly about safe motherhood and reproductive health. By contrast with the health education elements of adult learning programmes delivered through the Ministry of Education, the Ministry of Health initiatives rely on oral communication rather than reading materials, through organised discussion forums, group meetings and training courses. As community members, FCHVs can choose to facilitate discussion using local languages and use examples that women recognise. The emphasis is however on imparting modern knowledge and skills related to reproductive health and childcare – ‘preaching’ what to do or what should be done, and offering no space to discuss indigenous health practices or knowledges. For instance, the following extract from a training manual for FCHVs (written in very formal Sanskritised Nepali and with clear Western influences) implies that the FCHVs and mothers are completely unfamiliar with breastfeeding:

*Stages of breastfeeding position*

- *Keep infant’s neck and head straight*
- *Infant should be attached to the mother*
- *Infant should be turned towards the mother*
- *Infant’s body should be fully supported*

*Stages of breastfeeding latching*

- *Infant’s chin should touch the mother’s breast*
- *Infant’s mouth should be fully open*



- *Infant's lower lip should turn out*
- *The dark part of the breast should be visible (upper rather than lower)*

[Translated from Nepali version, NHEICC BS2073/2015: 71]

FCHVs are thus trained through formalised written instruction to disseminate new information about improved health practices, rather than being positioned as critical thinkers and co-creators of knowledge (see Hill 2016).

In order to ensure women's access and utilization of health services and to promote gender equality in the health sector, Gender Equality and Social Inclusion (GESI) related concepts and skills are also integrated in regular training courses provided to health workers, including the FCHVs. Where integration is not possible, GESI modules are delivered separately. A GESI 'training of trainers' manual has also been developed and a separate training package for other agencies working in the field of health education. The main purpose is to educate pregnant women and mothers and other community members primarily about reproductive health and family health and thereby increase access and utilization of health services by women. The package also includes topics such as male roles and responsibilities in family planning, communication between spouses and mainstreaming gender and social inclusion in health services. An example in the guidelines for Health Education and Promotion is a session on 'Vibeki Logne' (meaning 'Thoughtful Husband') with the purpose of inspiring 'spouses to discuss when and if they want another child and to go for counselling' (National Health Education, Information and Communication Centre [NHEICC], 2013: 18). Sessions on gender-based violence are included in all the relevant training manuals. However the reliance of most health education initiatives

on female health workers (FCHVs) may make it difficult in practice to involve male participants in these sessions.

Compared to the adult literacy programmes reviewed earlier, there appears to be a greater emphasis on raising awareness and critically challenging gender inequalities in society through these health sector initiatives – adopting a more holistic ‘health promotion’ rather than health education approach (see section 3ii). Despite these efforts, gender barriers can prevent Nepali women from making decisions about their health-related issues, and accessing health services. Women's health-related behaviour is influenced not only by their educational status and is far more complex than presented in many health education and literacy materials. Irrespective of literacy attainment or women’s educational experience, decisions regarding their access to health services are commonly still made by either their husbands or parents-in-law and the permission is not granted all the time (Population Division, Ministry of Health and Population, 2012). Similarly the Nepal Demographic Health Survey (2011) reports that 13% of men aged 15-49 believe that contraception is a woman’s business, and 20% believe that use of contraception may make women promiscuous. This research suggests that gendered attitudes are still likely to affect different aspects of women's health.

Young married women were found to be doubly disadvantaged, due to the culture of gender and age-related hierarchical power relations (Population Division, Ministry of Health and Population, 2012). Older women - based on their own experience of not using health services yet having had healthy babies - often consider the use of health services unnecessary and dissuade younger women in their family (ibid.). While

Sushan Acharya was visiting a rural health facility for a Ministry of Health GESI training assessment, a senior health worker shared similar observations. Mothers below the age of 20 years had told him that their mother-in-law said that they had also given birth when they were young so it would not harm their daughter-in-law getting pregnant early (Acharya: field notes from Panchthar 2015). This illustrates how gender barriers compounded by intergenerational power relations often leave women's health-related decisions in the hands of other family members.

Health education is still largely focused around teaching women about modern (Western) knowledge and skills related to safe motherhood and reproductive health. Although the Ministry of Health materials and programmes include recognition of some gender barriers and social structural issues, research has not shown positive changes in these areas (Population Division, Ministry of Health and Population, 2012 and Shrestha, 2012). Moreover, there is no room in any of the health education programmes to discuss and recognise positive indigenous practices related to women and children's health. Whilst the health policy initiatives reviewed above build on informal approaches to learning (including oral discussion) and challenge gender inequalities to some degree through establishing the key role of the FCHVs as facilitators, the kind of knowledge prioritised is still determined by 'experts' rather than positioning FCHVs as 'health creators'. This top-down approach to curriculum development could be considered to undermine the gender equality aims by reinforcing women's existing low status in these communities, as unpaid health workers at the bottom of the hierarchy.

### **iii) Literacy and social change: what changes in learning and livelihoods are taking place outside development programmes?**

Looking beyond planned development programmes in Nepal, it is clear that people's lives and literacy learning opportunities are rapidly changing due to new technologies, increased mobility and globalised markets. The boundary of literacy learning has expanded with the development of technologies and can no longer be confined to formal or non-formal education programmes. Access to mobile phones and computers has expanded people's choices and use of communication media, even in remote mountain areas. Communication choices and cultures have become more personalised and covert, offering new spaces for women and men to develop relationships and transforming indigenous social structures. For example, the Gurung community has a specific community cultural practice (known as 'Rodhighar'<sup>16</sup>) particularly organised to facilitate socialisation among young men and women. Today, access to mobile phones offers young people the opportunity for virtual socialisation, replacing indigenous social practices like the Rodhighar. Through virtual socialisation and/or communication, women and men are informally learning the use of technology and engaging in new literacy practices which also influence gender relations. For instance, mobile phones have become a tool for some boys to lure girls for relationships, which may otherwise not have been possible due to family and community cultures. There is some evidence that mobile phones are having a negative impact on gender equality and health enhancement: recent research on the

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<sup>16</sup> Rodhighar (Rodhi house) is traditionally a dormitory for teenage girls and boys, and young men and women. It is a temporary establishment in villages for entertainment and socialisation. Under the supervision of adult women and men, singing, dancing and other fun activities take place in Rodhighar.

misuse of mobile phones by young boys and adult men has shown serious implications for women's mental and physical health (Gautam, 2017).

Some development agencies have explored the possibility of building interventions on mobile phone communication and informal learning. E-interaction, initiated by UNICEF Nepal between children affected by the 2015 earthquake and those in Western Nepal who might be affected by earthquakes in the future, has provided young girls and boys with a way of sharing information and knowledge more widely (UNICEF, 2016). In the health sector, UNICEF initiated interactive games for children to develop skills and learn healthy habits through a program called Gameathon (UNICEF, 2015). A mobile phone intervention for mid-level health workers has already been piloted and scaled up in Nepal, after positive responses from health workers and patients (Morrison et al 2013). Similarly, mobile phone applications have been developed and used in prenatal care for pregnant women to receive necessary information and notices regarding health check-ups and vaccinations (National News Agency, 2073 BS and Read Global, 2015). Access and use of mobile phones has also been credited for improved antenatal and postnatal care, making it easier for women to seek help quickly when problems arise (Ministry of Health and Population, 2010).

Changes in political and legislative structures, particularly the new Constitution have begun to influence gender relations and attitudes, including recognising diverse cultural identities. As well as leading to new strategies to address gender inequality in the health and education sectors, legal reform has helped to open up new economic and political opportunities for women and men. Looking at 'social transformation

from the bottom up’, Yadav (2016: 163) has explored the ways in which new spaces opened up for women’s political and economic engagement as a result of the ‘changing discourse of post-conflict Nepal’. This growing body of feminist research in Nepal (see Gururani and Berry, 2015) engages with women’s experiences of political transformation and how gender relations are being reconfigured.

The complex picture of social, political and environmental change that emerges from looking outside planned health and education interventions suggests that social transformation – particularly in gender relations and roles – comes about when people become ‘co-creators’ of knowledge, learning informally with and from their peers, and choosing when and how to engage with new literacy and health practices.

## **5. Conclusion: What can we learn from comparing health and education sectoral approaches to adult literacy and learning?**

The 2030 Sustainable Development Agenda presents an important opportunity to give more critical attention to the interconnection between sectors, including education and health. There is recognition of the potential synergies between the seventeen Sustainable Development Goals (SDGs), particularly the significance of learning and the cross-cutting goal of gender equality and empowerment (SDG 5). The SDGs are underpinned by a broader understanding of education and health than the earlier MDGs, embracing ‘well-being’ rather than just the absence of disease (SDG 3) and ‘inclusive, lifelong learning opportunities for all’ rather than focusing only on schooling (SDG 4). By reflecting on Nepal’s experience in women’s literacy and health through an alternative lens based on the concepts of literacy as a social

practice, health promotion and critical health literacy, this article offers new insights into the relationship between the SDGs 3, 4 and 5. As Stromquist (2015: 319) earlier commented, ‘implementation of empowerment has tended to be unidimensional’ and requires ‘simultaneous multisectoral action’.

Our analysis has revealed the different ways in which health and literacy learning have been combined and promoted within the health and education sectors in Nepal. With regard to communicative practices, health education programmes relied strongly on oral facilitation in contrast to the dominant ‘literacy first’ approach in adult literacy programmes, which mainly prioritised functional literacy. By comparing these sectoral initiatives, important policy implications can be drawn: for instance, supporting grassroots female health workers (FCHVs) with their literacy practices could contribute to enhancing their professional status and thereby address gender inequalities. Lifelong learning is now a strong policy priority in Nepal, meaning that schooled adults are also encouraged to continue their education. Adult literacy programmes thus face the challenge of responding to the more diverse needs and abilities of women in classes and could learn from health programmes that use multimodal approaches and a greater emphasis on oral discussion. Neither health nor literacy programmes reviewed above incorporated or engaged with indigenous beliefs except in a negative way, starting from a deficit perspective that women lacked modern health knowledge. Above all, though both sectors have made a policy shift from ‘women-only’ initiatives to ‘gender equality’, programmes do not appear to have changed their pedagogical approach – tending to disseminate health and gender messages rather than to facilitate critical dialogue. This is perhaps not surprising,

given the limited training and resources available to support facilitators based in rural areas of Nepal.

By looking outside planned development interventions in health and education, we have provided a glimpse into the complex factors influencing social change, relating to new technologies and globalised economies. Significantly, in this analysis from Nepal, both health and education sectoral policies and programmes foregrounded formal knowledge and skills as the basis for changing health practices. In particular, little account was taken of people's tacit knowledge and social factors (such as peer group pressure) that strongly influence health behaviour. Such informal learning processes are rapidly changing, for instance through new forms of digital communication and through experiences of migration. Whilst there is an increasing body of research on the impact of formal and non formal learning on health and literacy attainment, there is an urgent need for research on informal learning in relation to processes of social transformation, particularly gendered roles and relations. The conceptualisation of health education and literacy that we have explored in this article points to new research questions around the relationship between literacy, learning, gender and health. Understanding more about the kind of learning, knowledge, literacy and health practices in which women and men already engage is an essential first step towards developing policy and programmes informed by a social justice approach.

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