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Rural-Urban Disparities in the Condition of Health and Education Facilities across Provinces of Nepal

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Abstract

This paper examines rural-urban disparities and provincial variations in public perceptions of government and private health and education facilities across Nepal, revealing significant disparities in accessibility and quality. This paper utilizes the national level survey data of Nepal Living Standard Survey (NLSS) IV (2022/23) which includes 9,600 households and 46,870 individuals. The method was bivariate analysis including Chi-square test of independence. The findings show that private facilities generally receive higher satisfaction ratings than government services, though their availability is unevenly distributed. Urbanized provinces such as Bagmati and Koshi report greater satisfaction and engagement with private services, while remote regions like Karnali and Sudurpaschim show lower satisfaction and higher non-response rates, reflecting limited access. Karnali stands out with relatively better perceptions of public facilities but weaker private sector presence. Provinces including Madhesh & Sudurpaschim consistently exhibit low satisfaction across sectors, underscoring the need for focused interventions. Overall, there is significant rural-urban disparities in access to both government and private health and education services across all provinces including Bagmati province which is capital city of Nepal. The findings highlight the importance of province-specific strategies that leverage successful models from higher-performing areas to enhance equity and quality in Nepal's health and education systems.

Keywords

Province, rural-urban, disparity, basic services, health, education, Nepal.

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1. Introduction

Individuals' income, health (and that of their children), and capacity are important determinants to interact and communicate with others. However, these determinants differ from one individual to another and the consequences of access to health and education also differ from individual to individual. Inequalities in education, thus, contribute to inequalities in other important dimensions of well-being (WDR, 2006: 34 as cited in Gautam, 2013). Therefore, measurement of education-related capabilities is important to explain inequalities between individuals and groups. However, measuring inequality in education is not easy. Census and survey data in most countries can generally yield statistics on, for example, years of schooling. But such information does not capture adequately the quality of education and how that might vary across individuals. Nor is it easy to compare years of schooling across countries or social groups, because those years might mean something quite different across countries and societies (WDR, 2006 cited in Gautam, 2013). But comparison is required to examine inter- and intra-group inequalities in terms of education. It is also necessary to make standard criteria to explain the current educational system in any country including Nepal as it is connected to other variables as well.

While talking about health, for sociologists, the experience of sickness and disease is an outcome of the organization of society. For example, poor living and working conditions make people sicker, and the poorer people die earlier, than do the richer people at the top of the social system. Even when there are improved living conditions and medical practices, if inequalities based on class, gender and ethnicity are not tackled, the differences between the rich and the poor persist and widen. Disease and inequality are intimately linked. The outcome of the unequal distribution of political, economic and social resources necessary for healthy life is the social gradient of health. Those at the top of the social system are healthier and live

longer while those at the bottom are sick, do not live as long, and die more from preventable disease and accidents (White, 2002: 1 as cited in Gautam, 2013).

Ensuring equitable access to quality health and education services is essential for sustainable development and improving well-being. In Nepal, however, significant geographic, economic, and social diversity across provinces has created disparities in the distribution and quality of these services. Understanding how citizens perceive health and education facilities is vital for identifying shortcomings, improving service delivery, and shaping effective policies. This study examines provincial differences in accessibility and satisfaction with both public and private health and education services in Nepal, with the goal of highlighting inequalities and informing strategies for more equitable service provision nationwide.

The current Nepal Health Sector Strategic Plan (NHSSP) for the period of 2023 to 2030 AD was developed in alignment with Nepal's federal structure, considering the health-related constitutional mandates and provisions outlined in the Public Health Service Act 2075 BS, National Health Policy, periodic plans, and other related policy documents. The NHSSP is envisioned as an instrument to achieve universal health coverage, especially as Nepal transitions from a Least Developed Country (LDC) to a developing country. The NHSSP aims to continue and strengthen the SWAp, as outlined in the development cooperation policy, to address the major unfinished health agendas. The primary focus of the strategic plan is to improve the health status of all citizens by creating an environment that enables every individual to access optimal health services (DoHS, 2025).

The Department of Health Services (DoHS) is responsible for delivering promotive, preventive, curative, rehabilitative and palliative care services throughout Nepal. DoHS plays an important role in ensuring health service delivery by developing and facilitating the implementation of the service delivery standards from the service delivery outlets throughout the country. Furthermore, it functions as an intermediary between the Ministry of Health and Population (MoHP) (federal) and other tiers of government (provincial and local level) by providing logistical, financial, supervisory and technical support from the center to the periphery. The DoHS is responsible for maintaining functional viability and

coordination of all health systems building blocks, with the primary objective of guaranteeing the delivery of high-quality services to the public (DoHS, 2025). As mentioned by DoHS (2025), currently, DoHS comprises five divisions¹. These health institutions work to improve the accessibility and quality of health services in Nepal. The efforts made by these institutions contribute in increasing access to health facilities in Nepal. However, there is disparities among individuals of different social categories.

2. Inequality in Access to Health and Education

Health is generally regarded as an individual and biological phenomenon—a person is ill because of an infection, accident or perhaps because he/she has inherited some problem. If this were the case, one would expect that illness would be randomly distributed across population virtually with everyone having a similar chance of being ill. But this is not the case when we look at social class, for lower the social class, greater the chance of illness (or morbidity, as it should be known) and lower the age of death (permanent mortality) (Moore, 1995: 284 as cited in Gautam, 2013). Moore (1995: 279) further writes that illness is claimed not to be an individual, random occurrence, but something that is distributed among people relative to the distribution of power and wealth—the poorest and the least powerful comprise the sick and disabled, and these states of poverty and disability are actually caused by poverty, they are not its result. However, power and wealth may not be the only causes that influence individual's health status. They may be social and cultural causes as well (Gautam, 2013).

In the context of India, Arora (2012) notes that India is often described as a “high globalizer” and a showcase for globalization (Rato, 2007). Following the 1991 economic reforms, which sought to liberalize policies and integrate India more closely with the global economy, the country experienced significant changes. Yet, the effects of globalization have not been uniform—different social groups, including the rich, poor, women, disabled, marginalized castes, and rural populations, have experienced its impact differently. Although research has widely discussed regional disparities since the reforms, issues such as gender inequality at the sub-national level and its implications for economic growth remain underexplored. Some localized studies have examined gendered dimensions of globalization, but they cover only a limited number of states.

Bambra (2019) highlights that research into health inequalities in the UK has a long history, stretching back more than 300 years (Macintyre, 2003; Smith *et al.*, 2016). For example, in the 1840s, men of higher social status in Bath lived more than twice as long as laborers in the same city (Chadwick, 1842). Similar class-based disparities existed in Liverpool, though overall life expectancy there was lower. Despite improvements in life expectancy across all groups over the past two centuries, significant inequalities remain. Currently, men in the most deprived neighborhoods of England live on average nine years less than those in the least deprived areas, while for women the gap is seven years (ONS, 2015). Regional divides also persist, with poorer health outcomes in the North compared to the South (Bambra *et al.*, 2014). Moreover, gender and ethnicity contribute to health inequalities in intersecting ways (Gkiouleka *et al.*, 2018 as cited in Bambra, 2019).

Chapman (2010) argues that international frameworks, such as the Committee on Economic, Social and Cultural Rights' general comment on the right to health, have often been under-emphasized in global health reports. For instance, the Commission on Social Determinants of Health (CSDH) devoted little attention to the Special Rapporteur on the right to health and only briefly cited the Committee's influential interpretations. Chapman further stresses that human rights approaches prioritize equality of dignity, legal recognition, and protection under the law, rather than economic or social parity. Central principles include non-discrimination and equality before the law. States that ratify human rights treaties are therefore obligated to uphold these rights without distinction based on race, gender, religion, political views, or social origin.

Curran and Mahutga (2018) review evidence suggesting a causal link between income inequality and health outcomes (Pickett & Wilkinson, 2015). Mechanisms include psychosocial stress from low social status (Wilkinson, 1999), under-investment in public goods (Lynch & Kaplan, 1997), and declining social trust (Kawachi *et al.*, 1997). These explanations fall into two main categories: integrationist and neo-materialist. Integrationist theories emphasize psychosocial effects, where status comparisons create anxiety, shame, and depression that negatively influence health behaviors. Neo-materialist perspectives focus on reduced investment in public goods and growing individualism, which weakens social cohesion. Both approaches highlight how inequality not only harms

individual well-being but also undermines overall population health (Curran and Mahutga, 2018).

Davis (1991) notes that inequality in health outcomes and access to care has been a central focus of U.S. public health debates for decades. Recognition of disparities by income, race, and geography in the 1960s and 1970s fueled efforts to expand healthcare for vulnerable groups, including proposals for national health insurance. However, these initiatives lacked sufficient political support. By the 1980s, rising healthcare costs shifted policy priorities away from access, resulting in funding cuts and a push for competition in healthcare delivery. Despite these challenges, continued academic attention to vulnerable groups supported modest expansions of programs like Medicaid and community health initiatives (Davis, 1991).

Grimm (2011) emphasizes the complex relationship between health and economic growth. While better health can enhance productivity, skills, and capital accumulation, higher income can also improve health through better services and technology. Although earlier studies questioned whether health significantly drives growth (Acemoglu & Johnson, 2007), more recent analyses (Bloom *et al.*, 2004; Weil, 2007; Cervelatti & Sunde, 2009) suggest that health improvements may have a stronger effect on growth than income does on health. Nonetheless, debates continue, as measurement issues and endogeneity complicate the evidence (Deaton, 2006).

Obuaku-Igwe (2015) emphasizes that population health depends partly on access to healthcare, which in turn is shaped by service availability, professional quality, and financial resources. Despite government interventions, health disparities persist, especially in low- and middle-income countries. Such inequalities are driven by social factors like race, gender, education, income, and geography. In South Africa, for example, life expectancy remains low, and both health and income inequalities have widened since the mid-1990s, with stark differences across regions such as the Western Cape (Obuaku-Igwe, 2015).

Mellor and Milyo (2002) note that many studies find correlations between income inequality and poor health outcomes, often summarized as the “income inequality hypothesis” (IIH). However, they caution that much of the evidence relies on aggregate data without sufficient controls. Some studies show that results vary

depending on time, mortality causes, and statistical models, suggesting that observed associations may not reflect causal relationships at the individual level. Instead, income inequality may act as a proxy for the proportion of low-income individuals, rather than being a direct cause of poor health.

Raphael (2000) explains that health should be understood not only as the absence of illness but also as the presence of resources that enable individuals and communities to thrive. Health promotion, as framed by the WHO's Ottawa Charter, emphasizes empowerment, supportive environments, and policy advocacy. He further highlights the importance of social determinants of health, such as income distribution, education, and community structures. Growing economic inequality, particularly in the U.S., Canada, and the UK, has become a major concern because of its role in shaping health outcomes.

Rasanathan *et al.* (2011) note that interest in primary health care (PHC) has revived after being sidelined in the 1990s. The Alma Ata Declaration (1978) envisioned PHC as central to achieving "health for all" through equity, community participation, and intersectoral action. Recent reforms in countries such as Brazil, Thailand, Chile, and New Zealand reflect this vision, while India and China are also strengthening primary care in their pursuit of universal health coverage. Civil society movements, including the People's Health Movement, have also played a critical role in restoring PHC to the global health agenda. Various efforts made in health and education sector improves the status of health and education all over the world including Nepal.

Ilie and Rose (2016) observe that the global expansion of higher education raises questions about who benefits most. Equity, following McCowan (2007), requires that all individuals with sufficient preparation have access to higher education and that opportunities are not limited to lower-quality institutions. While more places in higher education exist, achieving genuine fairness remains difficult, especially when considering access to elite institutions.

Jacobs (1996) highlights that educational inequality research has long focused on social class, often sidelining gender issues. When gender is considered, it is frequently treated as secondary to class. Some scholars argue that education systematically disadvantages

women, but Jacobs contends that women have gained significant access advantages, even though disparities remain in college experiences and post-graduation outcomes. He stresses the need to differentiate between areas where women have achieved parity and those where inequalities persist.

Li (2002) examines gender inequality in Chinese education, noting that most studies have concentrated on access to formal schooling. This research instead looks at whether male and female students have equal access to knowledge within the school system. Since the 1985 reforms, secondary school curricula and tracking systems have created barriers to female students, limiting their knowledge acquisition, opportunities for higher education, and career prospects, thereby reinforcing broader gender inequalities. However, there are various aspects of health and education including rural-urban disparities in accessibility and quality of health and education services which are still less explored in the context of Nepal.

Mishra (2010; 2070 VS), Pandey (2010), Gautam (2013) and Nakarmi (2021) have emphasized on the structural dimension of inequality in the context of Nepal. The macro structure at state level and micro level at individual and household level play an important role in shaping access to health and education opportunities. Nakarmi (2021) discusses the Newar community, where socio-economic background significantly affects their access to opportunities and resources. At micro level, access to educational opportunity differs by the ethnic background of individual as well (Gautam, 2017) which is one of the reasons of inequality in the context of Nepal. Thus, the background of individuals including socioeconomic status, place of residence, region and so on of individuals and households have some kind of role in shaping access to and perception on health and education facilities in Nepal. It is therefore important to look for the status of government and private-non-government services on health and education in the rural-urban setting of Nepal.

3. Objectives

The primary objective of this study was to investigate rural-urban disparities in public perceptions of health and education facilities across the provinces of Nepal. The study aimed to identify differences in satisfaction and accessibility between government and private services and to explain how these variations correlate with

geographic and socioeconomic factors. Additionally, the research sought to highlight provinces with unique service profiles and those requiring targeted interventions to improve equity and quality in health and education sectors.

4. Methods

This paper utilized large-scale survey data of Nepal Living Standard Survey IV (2022/23) collected from 9600 households and 46870 individuals across all provinces of Nepal, capturing their ratings of health and education facilities in both the public and private sectors. Statistical analyses were conducted to assess the significance of differences in satisfaction levels, non-response rates, and patterns of service access among provinces. Comparisons were made between urbanized and remote regions to identify gaps and unique regional characteristics. The robust sample sizes allowed for confident interpretation of provincial-level variations, informing recommendations for province-specific policy interventions.

5. Study Area

As mentioned earlier this study utilized large-scale survey data collected from respondents across all seven provinces of Nepal, encompassing both urbanized and remote regions to capture a comprehensive national perspective. The survey gathered public perceptions and satisfaction ratings of health and education facilities in both the public and private sectors. Statistical analyses were conducted to assess the significance of differences in satisfaction levels, non-response rates, and access patterns among provinces. This provincial-level approach allowed for detailed comparisons between more developed areas such as Bagmati and Koshi and less developed, remote provinces like Karnali and Sudurpaschim. The robust sample sizes enabled confident interpretation of regional disparities, providing a foundation for tailored policy recommendations.

6. Rural-Urban Disparities in access to Health and Education across Provinces of Nepal

Rural-urban disparities in health and education are of critical importance because they directly influence social equity, human development, and long-term prosperity. In many developing contexts, including Nepal, rural areas often face limited access to healthcare facilities, trained medical personnel, quality schools, and

educational resources compared to urban centers. These gaps contribute to higher rates of preventable diseases, malnutrition, and maternal and child mortality in rural regions, while also restricting educational attainment and employment opportunities. As a result, rural populations are caught in a cycle of poverty and social exclusion, widening inequalities within the nation. Addressing these disparities is essential not only for improving individual well-being but also for achieving inclusive economic growth, reducing migration pressures, and fostering balanced national development. In this regard, the experiences of people on health facility are presented in the following Table-1:

Table-1: Rural-Urban Disparities in the Condition of Government Health Facility across Provinces of Nepal

Province	Rural-Urban	Test values	Condition of Government Health Facility (%)				
			Good	Fair	Bad	N/A	Total
Koshi	Other urban	$\chi^2=21068.10$	15.7	68.3	8.8	7.2	100.0
	Rural	df=3	11.7	75.1	11.3	1.8	100.0
	Total	p=0.00	14.3	70.6	9.7	5.4	100.0
Madhesh	Other urban	$\chi^2=21068.10$	9.0	74.6	11.7	4.7	100.0
	Rural	df=3	6.1	75.3	13.7	4.9	100.0
	Total	=0.00	8.3	74.8	12.2	4.8	100.0
Bagmati	Kathm- andu	$\chi^2=11376.32$	26.1	61.1	6.4	6.5	100.0
	Other urban	df=3	27.6	62.6	5.5	4.3	100.0
	Rural	p=0.00	22.4	66.3	8.3	3.0	100.0
	Total		25.9	62.5	6.4	5.2	100.0
Gandaki	Other urban	$\chi^2=11978.90$	25.1	64.1	4.9	5.8	100.0
	Rural	df=3	15.1	77.0	3.1	4.8	100.0
	Total	p=0.00	21.9	68.2	4.3	5.5	100.0
Lumbini	Other urban	$\chi^2=16044.17$	20.4	69.4	6.2	4.0	100.0
	Rural	df=3	17.4	77.7	2.8	2.1	100.0
	Total	p=0.00	19.2	72.7	4.9	3.2	100.0

Karnali	Other urban	$\chi^2=3960.23$	36.5	52.8	9.9	0.8	100.0
	Rural	df=3	27.0	60.9	11.5	0.5	100.0
	Total	p=0.00	32.4	56.3	10.6	0.7	100.0
Sudur-paschim	Other urban	$\chi^2=6077.43$	18.0	66.9	12.3	2.8	100.0
	Rural	df=3	13.7	72.5	13.4	0.4	100.0
	Total	p=0.00	16.5	68.9	12.7	1.9	100.0
	Kathm-andu	$\chi^2=82156.61$	26.1	61.1	6.4	6.5	100.0
	Other urban	df=3	18.7	68.0	8.5	4.7	100.0
	Rural	p=0.00	15.4	73.5	8.5	2.6	100.0
Nepal			18.6	68.8	8.3	4.3	100.0

Source: Computed from NLSS IV (2022/23) Data Set (The results in the table are weighted)

The perception of health facility quality varies noticeably across Nepal’s provinces, revealing both areas of concern and examples of relative satisfaction. Overall, the majority of respondents in all provinces rated services as “Fair”, with provincial figures ranging from 56.3% in Karnali to 74.8% in Madhesh, suggesting that while facilities generally meet basic expectations, they often fall short of being considered “Good”. Notably, Karnali stands out with the highest proportion of respondents (32.4%) expressing satisfaction, more than 13 percentage points above the national average of 18.6%, indicating a comparatively positive public perception. Bagmati (25.9%) and Gandaki (21.9%) also record above-average satisfaction levels. In contrast, Madhesh, with only 8.3% rating facilities as “Good” and 12.2% as “Bad”, reflects the lowest satisfaction and one of the highest dissatisfaction rates, pointing to possible gaps in infrastructure, accessibility, or service quality. Similarly, Sudurpaschim shows elevated dissatisfaction (12.7%), despite a moderate “Good” rating (16.5%). The relatively low “N/A” responses across most provinces suggest that people are engaged and willing to share their views, making these findings a valuable reflection of lived experiences. These patterns highlight the need for targeted improvements in provinces such as Madhesh and Sudurpaschim, while also encouraging policymakers to draw lessons from better-performing regions like Karnali and Bagmati.

The perception of health facility quality varies noticeably across Nepal's provinces, and the differences are not just descriptive—they are statistically significant. The majority of respondents in all provinces rated services as “Fair”, with figures ranging from 56.3% in Karnali to 74.8% in Madhesh, suggesting that while facilities often meet basic expectations, they frequently fall short of being considered “Good”. Karnali stands out with the highest satisfaction level (32.4%), well above the national average of 18.6%, followed by Bagmati (25.9%) and Gandaki (21.9%). In contrast, Madhesh records the lowest satisfaction (8.3%) alongside one of the highest dissatisfaction rates (12.2%), indicating notable service gaps, while Sudurpaschim also shows elevated dissatisfaction (12.7%).

The findings indicate that perceptions of government health facilities in Nepal vary significantly across provinces and between rural and urban areas. Overall, most respondents rated facilities as Fair (68.8%), followed by Good (18.6%) and Bad (8.3%), with only a small proportion (4.3%) indicating N/A. Urban residents consistently reported higher Good ratings compared to rural residents, who tended to rate facilities more as Fair. Bagmati and Karnali provinces showed the highest proportion of Good ratings, reflecting relatively better perceived service quality, while Madhesh and Sudurpaschim reported lower satisfaction levels. Across all provinces, the differences between rural and urban perceptions were statistically significant ($p < 0.001$), highlighting notable disparities in health service quality and accessibility between urban and rural areas.

The Chi-square test results ($\chi^2 = 322,122.678$, $df = 18$, $p < .001$) confirm that these differences are highly significant and unlikely to have occurred by chance. The large sample size ($n = 7,185,103$) further reinforces the robustness of this finding, with zero cells having expected counts below the statistical threshold. This suggests that the observed provincial disparities in perceived health facility quality reflect real and substantial differences in public experience, underscoring the need for targeted policy interventions in low-performing provinces like Madhesh and Sudurpaschim, while drawing lessons from higher-performing regions such as Karnali and Bagmati.

Across all provinces of Nepal, there are statistically significant rural-urban disparities in the perceived quality of government health facilities ($p < 0.001$). Urban residents consistently report a

higher proportion of “Good” ratings compared to their rural counterparts, while rural areas tend to have more “Fair” or “Bad” assessments. For instance, in Gandaki, 25.1% of urban respondents rate facilities as good versus only 15.1% in rural areas, and in Koshi the gap is 15.7% versus 11.7%. Karnali’s urban areas stand out with the highest “Good” rating nationally (36.5%), while Madhesh records the lowest across both urban (9.0%) and rural (6.1%) populations. In most provinces, “Fair” dominates as the most common rating, often exceeding 70%, especially in rural Madhesh, Gandaki, and Lumbini. These patterns indicate a consistent urban advantage in perceived quality of government health facilities, with substantial and significant gaps persisting across all regions. There is also private/non-government facility available in Nepal. The perception of people on the condition of private/non-government facility on health is shown in the following table-2.

Table-2: Rural-Urban Disparities in the Condition of Private/Non-Government Health Facility across Provinces of Nepal

Province	Rural-Urban	Test values	Health Facility (Private/Non-Government) (%)				
			Good	Fair	Bad	N/A	Total
Koshi	Other urban	$\chi^2=4961.40$	34.7	57.3	2.7	5.2	100.0
	Rural	df=3	33.2	55.0	4.3	7.5	100.0
	Total	p=0.00	34.2	56.6	3.3	6.0	100.0
Madhesh	Other urban	$\chi^2=9534.27$	34.6	57.7	2.2	5.5	100.0
	Rural	df=3	38.9	51.0	1.1	8.9	100.0
	Total	p=0.00	35.7	56.0	1.9	6.4	100.0
Bagmati	Kathm- andu	$\chi^2=42298.19$	47.3	47.8	1.9	3.0	100.0
	Other urban	df=3	38.6	54.5	2.0	4.8	100.0
	Rural	p=0.00	33.8	52.3	3.2	10.6	100.0
	Total		42.3	50.6	2.2	4.9	100.0
Gandaki	Other urban	$\chi^2=7836.59$	30.8	61.3	1.4	6.5	100.0
	Rural	df=3	21.1	71.5	0.9	6.5	100.0
	Total	p=0.00	27.7	64.6	1.3	6.5	100.0

Lumbini	Other urban	$\chi^2=8105.37$	41.2	54.5	1.2	3.0	100.0
	Rural	df=3	33.8	61.4	1.1	3.8	100.0
	Total	p=0.00	38.3	57.2	1.2	3.3	100.0
Karnali	Other urban	$\chi^2=3837.30$	18.9	70.5	7.3	3.4	100.0
	Rural	df=3	14.8	69.8	8.1	7.4	100.0
	Total	p=0.00	17.1	70.2	7.6	5.1	100.0
Sudur-paschim	Other urban	$\chi^2=9779.42$	25.4	60.2	8.7	5.7	100.0
	Rural	df=3	17.0	59.9	14.1	9.1	100.0
	Total	p=0.00	22.5	60.1	10.6	6.9	100.0
	Kathmandu	$\chi^2=98454.07$	47.3	47.8	1.9	3.0	100.0
	Other urban	df=3	34.3	57.9	2.8	4.9	100.0
	Rural	p=0.00	30.2	58.9	3.7	7.3	100.0
Nepal			34.6	57.0	3.0	5.4	100.0

Source: Computed from NLSS IV (2022/23) Data Set (The results in the table are weighted)

The perceptions of private health facilities show marked variation across Nepal's provinces, with overall satisfaction levels notably higher than in the earlier public facility dataset. Nationally, 34.6% of respondents rated private facilities as "Good", while 57.0% considered them "Fair" and only 3.0% rated them as "Bad", suggesting a generally favorable impression of private sector health services. Bagmati leads with the highest proportion of "Good" ratings (42.3%), followed by Lumbini (38.3%), Madhesh (35.7%), and Koshi (34.2%), indicating stronger perceived service quality in these provinces. Gandaki (27.7%) and Sudurpaschim (22.5%) fall below the national average, while Karnali records the lowest satisfaction (17.1%) and one of the highest dissatisfaction rates (7.6%), pointing to regional inequities in access or quality of private care. Sudurpaschim stands out with the highest "Bad" rating (10.6%), over three times the national average, highlighting a localized gap in performance. The consistently low proportion of "N/A" responses across provinces suggests respondents felt confident in evaluating these facilities. Taken together, these findings indicate that while private health facilities are generally perceived more positively than public ones, significant disparities persist, with provinces such as

Karnali and Sudurpaschim requiring targeted policy attention, and high-performing provinces like Bagmati and Lumbini offering potential models for improvement.

The perceptions of private health facilities vary significantly across Nepal's provinces, and these differences are confirmed to be statistically meaningful. Nationally, 34.6% of respondents rated private facilities as "Good", 57.0% as "Fair", and only 3.0% as "Bad", reflecting an overall favorable view of private sector services compared to public facilities. Bagmati leads with the highest satisfaction (42.3%), followed by Lumbini (38.3%), Madhesh (35.7%), and Koshi (34.2%), suggesting stronger perceived service quality in these regions. In contrast, Gandaki (27.7%) and Sudurpaschim (22.5%) fall below the national average, while Karnali records the lowest "Good" rating (17.1%) and a relatively high "Bad" rating (7.6%), highlighting regional inequalities in access or service quality. Sudurpaschim's dissatisfaction rate (10.6%)-over three times the national average-signals a concentrated challenge in that province.

The findings for private or non-government health facilities show that overall perceptions are more positive compared to government facilities, with the majority of respondents rating them as Good (34.6%) or Fair (57.0%), and only 3.0% as Bad. Urban residents generally reported higher Good ratings than rural residents, although in some provinces, such as Madhesh, rural areas rated facilities slightly higher in Good. Bagmati province, particularly Kathmandu, had the highest proportion of Good ratings (47.3%), indicating strong satisfaction with private health services, while Karnali and Sudurpaschim recorded lower Good ratings and higher Bad ratings, reflecting regional disparities. Across all provinces, the rural-urban differences were statistically significant ($p < 0.001$), highlighting that private health facilities are perceived more favorably overall, but access and quality perceptions still vary considerably between regions and settlement types.

The Chi-square test results ($\chi^2=317,576.167$, $df=18$, $p<.001$) indicate that these provincial differences are highly significant and unlikely due to chance, supported by a very large sample size ($n=7,185,102$) and no cells with small expected counts. These findings underscore that while private facilities are generally perceived more positively than public ones, significant disparities remain, warranting targeted health sector interventions in provinces like Karnali and Sudurpaschim, and drawing on best practices from high-performing provinces such as Bagmati and Lumbini.

Across all provinces, there are statistically significant rural-urban disparities in perceptions of private or non-government health facilities ($p < 0.001$). Urban residents generally rate such facilities more positively, with a higher share of “Good” responses compared to rural areas, though the gap is narrower than for government health facilities. For example, in Bagmati’s Kathmandu, 47.3% rate private facilities as good versus 33.8% in rural areas, while in Lumbini, the figures are 41.2% and 33.8%, respectively. However, in Madhesh, rural respondents actually report slightly higher “Good” ratings (38.9%) than urban residents (34.6%), and in several provinces, rural areas also have higher “Fair” ratings, suggesting relatively less dissatisfaction with private services. Negative (“Bad”) ratings remain low across the board, typically below 4% except in Karnali and Sudurpaschim, where they exceed 7%-particularly in rural Sudurpaschim (14.1%). Overall, while urban residents tend to have more favorable perceptions, private/non-government health facilities are rated relatively well in both rural and urban areas, with smaller but still significant disparities compared to the government sector. There is also disparities in the condition of government education facility across rural-urban location and provinces of Nepal (Table-3).

Table-3: Rural-Urban Disparities in the Condition of Government Education Facility across Provinces of Nepal

Province	Rural-Urban	Test values	Education Facility (Government) (%)				
			Good	Fair	Bad	N/A	Total
Koshi	Other urban	$\chi^2=29039.96$	10.9	50.4	4.5	34.2	100.0
	Rural	df=3	8.1	63.5	7.0	21.4	100.0
	Total	p=0.00	10.0	54.8	5.3	29.9	100.0
Madhesh	Other urban	$\chi^2=12272.38$	9.4	47.4	5.7	37.4	100.0
	Rural	df=3	3.7	47.2	6.6	42.5	100.0
	Total	=0.00	8.0	47.4	6.0	38.7	100.0
Bagmati	Kathm- andu	$\chi^2=4821.47$	18.1	55.3	3.1	23.4	100.0
	Other urban	df=3	19.9	52.6	4.3	23.2	100.0
	Rural	p=0.00	18.6	52.2	5.6	23.6	100.0
	Total		18.8	54.0	3.9	23.4	100.0

Gandaki	Other urban	$\chi^2=9817.90$	21.8	41.2	1.1	35.9	100.0
	Rural	df=3	14.3	52.9	1.1	31.7	100.0
	Total	p=0.00	19.4	44.9	1.1	34.6	100.0
Lumbini	Other urban	$\chi^2=3805.43$	17.1	50.6	1.7	30.6	100.0
	Rural	df=3	15.4	47.5	1.5	35.6	100.0
	Total	p=0.00	16.4	49.4	1.6	32.6	100.0
Karnali	Other urban	$\chi^2=3509.93$	28.5	37.9	5.2	28.3	100.0
	Rural	df=3	21.3	44.0	7.5	27.3	100.0
	Total	p=0.00	25.3	40.6	6.2	27.9	100.0
Sudur-paschim	Other urban	$\chi^2=5122.02$	15.8	46.5	4.0	33.7	100.0
	Rural	df=3	13.3	55.0	5.2	26.4	100.0
	Total	p=0.00	15.0	49.4	4.4	31.2	100.0
	Kathmandu	$\chi^2=48206.35$	18.1	55.3	3.1	23.4	100.0
	Other urban	df=3	15.4	48.0	3.8	32.9	100.0
	Rural	p=0.00	12.7	52.1	4.6	30.5	100.0
Nepal			14.9	50.1	4.0	31.0	100.0

Source: Computed from NLSS IV (2022/23) Data Set (The results in the table are weighted)

Perceptions of government education facilities in Nepal reveal substantial provincial variation, with generally lower satisfaction levels than those seen for health facilities. Nationally, only 14.9% of respondents rated government education facilities as “Good”, while half (50.1%) considered them “Fair”, 4.0% viewed them as “Bad”, and a notably high 31.0% either did not respond or felt the question was not applicable. Karnali stands out with the highest “Good” rating (25.3%), suggesting relatively better perceived performance in the government education sector there, followed by Gandaki (19.4%) and Bagmati (18.8%). In contrast, Madhesh records the lowest satisfaction (8.0%) and one of the highest dissatisfaction rates (6.0%), along with the largest proportion of “N/A” responses (38.7%), potentially reflecting disengagement or weaker connection with government education services. High “N/A” levels across most provinces, particularly Gandaki (34.6%) and Lumbini (32.6%), suggest either limited experience with these facilities or a lack of willingness to evaluate

them, possibly due to the presence of alternative education options, such as private institutions. These results point to both performance gaps and participation challenges, with provinces like Madhesh requiring urgent policy attention, while lessons could be drawn from relatively better-performing Karnali and Gandaki to inform targeted improvements in public education provision.

Perceptions of government education facilities in Nepal vary markedly across provinces, and these differences are statistically significant. Nationally, only 14.9% of respondents rated government schools as “Good”, while 50.1% considered them “Fair”, 4.0% viewed them as “Bad”, and a substantial 31.0% gave “N/A” responses, indicating either limited personal engagement with the public education system or reliance on non-government alternatives. Karnali leads with the highest satisfaction level (25.3%), followed by Gandaki (19.4%) and Bagmati (18.8%), suggesting comparatively stronger public education services in these regions. In contrast, Madhesh records the lowest satisfaction (8.0%) and one of the highest dissatisfaction rates (6.0%), alongside the highest proportion of “N/A” responses (38.7%), pointing to both quality concerns and possible disconnect between communities and public schools.

The findings for government education facilities in Nepal indicate that overall perceptions are moderate, with the majority of respondents rating them as Fair (50.1%) and a smaller proportion rating them as Good (14.9%) or Bad (4.0%), while a significant share (31.0%) reported N/A, suggesting either non-availability or inability to assess. Urban respondents generally rated facilities slightly higher in Good compared to rural respondents, although rural areas often reported higher Fair ratings, reflecting a perception of adequacy rather than excellence. Bagmati and Karnali provinces exhibited relatively higher Good ratings, particularly in urban areas, while Madhesh showed the lowest Good ratings and the highest N/A responses, highlighting challenges in accessibility or quality perception. Across all provinces, differences between rural and urban ratings were statistically significant ($p < 0.001$), indicating notable disparities in perceived quality and availability of government education facilities across regions and settlement types.

The Chi-square results ($\chi^2 = 260,746.726$, $df = 18$, $p < .001$) confirm that these provincial differences are highly significant and unlikely to have arisen by chance, supported by a large sample size ($n = 7,185,104$) and robust expected counts. The high proportion of “N/A” responses-particularly in Gandaki (34.6%) and Lumbini

(32.6%)-highlights a potential structural challenge, as accessibility or perceived relevance of public education may be uneven across regions. These findings underline the need for targeted interventions in provinces like Madhesh, while drawing on the experiences of better-performing regions such as Karnali and Gandaki to enhance equity and quality in government education services.

Across all provinces, rural-urban differences in perceptions of government education facilities are statistically significant ($p < 0.001$). Urban residents generally report a higher share of “Good” ratings, while rural areas more often select “Fair” or “Bad”, though the “N/A” category is notably high in both settings, often exceeding 25%. For example, in Koshi, 10.9% of urban respondents rate government education facilities as good compared to 8.1% in rural areas, while rural residents more frequently choose “Fair” (63.5% vs 50.4%) and “Bad” (7.0% vs 4.5%). Gandaki and Karnali show some of the largest urban advantages, with urban “Good” ratings of 21.8% and 28.5%, respectively, compared to rural ratings of 14.3% and 21.3%. In contrast, Madhesh records low “Good” ratings overall, particularly in rural areas (3.7%), where the majority responses are “Fair” or “N/A”. While positive ratings are generally higher in urban areas, the high proportions of “Fair” and “N/A” responses suggest that many respondents-especially in rural areas-perceive government education facilities as average or have limited experience with them. This kind of disparities can be observed in the condition of private/non-government education facility too (Table-4).

Table-4: Rural-Urban Disparities in the Condition of Private/Non-Government Education Facility across Provinces of Nepal

Province	Rural-Urban	Test values	Education Facility (Private/Non-Government) (%)				
			Good	Fair	Bad	N/A	Total
Koshi	Other urban	$\chi^2=13348.62$	29.8	39.8	1.4	28.9	100.0
	Rural	df=3	24.7	36.7	3.9	34.8	100.0
	Total	p=0.00	28.1	38.7	2.3	30.9	100.0
Madhesh	Other urban	$\chi^2=30645.37$	16.7	32.2	0.7	50.4	100.0
	Rural	df=3	17.5	17.0	1.1	64.3	100.0
	Total	p=0.00	16.9	28.4	0.8	53.9	100.0

Bagmati	Kathm- andu	$\chi^2=109885.34$	43.2	41.2	1.3	14.3	100.0
	Other urban	df=3	33.4	38.1	1.6	26.9	100.0
	Rural	$p=0.00$	22.1	33.6	2.4	41.9	100.0
	Total		36.5	38.9	1.6	23.0	100.0
Gandaki	Other urban	$\chi^2=29521.41$	25.9	35.0	1.4	37.8	100.0
	Rural	df=3	8.7	40.0	0.7	50.6	100.0
	Total	$p=0.00$	20.4	36.6	1.2	41.9	100.0
Lumbini	Other urban	$\chi^2=57555.83$	26.3	38.0	1.1	34.5	100.0
	Rural	df=3	16.5	27.6	0.7	55.3	100.0
	Total	$p=0.00$	22.4	33.9	0.9	42.8	100.0
Karnali	Other urban	$\chi^2=13552.03$	17.4	15.5	5.3	61.8	100.0
	Rural	df=3	5.9	11.9	5.7	76.5	100.0
	Total	$p=0.00$	12.4	13.9	5.5	68.2	100.0
Sudur- paschim	Other urban	$\chi^2=27140.29$	21.3	25.1	1.3	52.3	100.0
	Rural	df=3	9.0	16.0	3.3	71.7	100.0
	Total	$p=0.00$	17.1	22.0	2.0	59.0	100.0
	Kathm- andu	$\chi^2=454196.72$	43.2	41.2	1.3	14.3	100.0
	Other urban	df=3	24.5	34.3	1.4	39.7	100.0
	Rural	$p=0.00$	16.7	27.5	2.2	53.6	100.0
Nepal			24.4	33.1	1.6	40.9	100.0

Source: Computed from NLSS IV (2022/23) Data Set (The results in the table are weighted)

Perceptions of private education facilities in Nepal show notable differences across provinces, with a generally higher share of “Good” ratings compared to government schools, but also a much larger proportion of “N/A” responses, indicating uneven access or engagement. Nationally, 24.4% of respondents rated private education facilities as “Good”, 33.1% as “Fair”, and only 1.6% as “Bad”, while a substantial 40.9% either did not respond or indicated non-applicability-possibly reflecting the high cost or limited

availability of private schooling in some areas. Bagmati stands out with the highest satisfaction (36.5%) and one of the lowest “N/A” rates (23.0%), suggesting broader accessibility and perceived quality. Koshi also performs well (28.1% “Good”), while Karnali (12.4% “Good”) and Sudurpaschim (17.1% “Good”) record both low satisfaction and very high “N/A” levels (68.2% and 59.0%, respectively), indicating that private education is either less common or less valued in these provinces. Madhesh presents an interesting case: its “Good” rating (16.9%) is below the national average, but its “Bad” rating is the lowest in the country (0.8%), suggesting that those who do use private schools generally rate them positively, even though over half (53.9%) report no direct engagement. Overall, these findings suggest that private education is perceived as higher quality than government education where it is available, but its reach is highly uneven, with rural and less developed provinces lagging far behind more urbanized regions like Bagmati and Koshi.

Perceptions of private education facilities in Nepal differ sharply across provinces, and these differences are highly statistically significant. Nationally, 24.4% of respondents rated private education as “Good”, 33.1% as “Fair”, and only 1.6% as “Bad”, while a large share (40.9%) gave “N/A” responses, indicating no direct engagement—likely due to cost barriers or limited availability in certain areas. Bagmati emerges as the top performer, with 36.5% “Good” ratings and a relatively low “N/A” rate (23.0%), suggesting both broader access and stronger perceived quality. Koshi follows with 28.1% satisfaction, while provinces like Karnali (12.4% “Good”) and Sudurpaschim (17.1% “Good”) show low satisfaction and extremely high “N/A” rates (68.2% and 59.0%, respectively), pointing to limited private school penetration. Madhesh presents an interesting profile: its satisfaction level (16.9%) is below average, but it has the lowest “Bad” rating (0.8%), suggesting that while private schooling is less common (with 53.9% “N/A”), those who access it tend to view it favorably.

The findings for private or non-government education facilities in Nepal show that overall perceptions are more positive than government schools, with 24.4% of respondents rating them as Good and 33.1% as Fair, while only 1.6% rated them as Bad. However, a substantial proportion (40.9%) reported N/A, indicating either limited access or inability to assess these facilities. Urban respondents generally rated private schools higher in Good compared to rural respondents, who often had higher N/A responses. Bagmati province,

particularly Kathmandu, had the highest Good ratings (43.2%), reflecting stronger satisfaction with private education, whereas Karnali and Madhesh showed low Good ratings and high N/A responses, pointing to limited availability and access. Across all provinces, rural-urban differences were statistically significant ($p < 0.001$), highlighting disparities in access, perceived quality, and availability of private education facilities across regions and settlement types.

The Chi-square results ($\chi^2 = 654,550.302$, $df = 18$, $p < .001$) confirm that these differences are highly significant and unlikely due to chance, bolstered by a very large sample size ($n = 7,185,104$) and strong expected counts. Overall, the findings indicate that while private education is generally rated more positively than government education, its benefits are unevenly distributed, with urbanized provinces like Bagmati and Koshi enjoying far better access and perceptions than rural and remote provinces such as Karnali and Sudurpaschim.

Across all provinces, perceptions of private or non-government education facilities show significant rural-urban disparities ($p < 0.001$), with urban residents generally giving higher “Good” ratings and rural residents more often selecting “N/A”, indicating lower access or familiarity. The gap is most striking in provinces like Bagmati, where 43.2% of respondents in Kathmandu rate facilities as good compared to only 22.1% in rural areas, and in Gandaki, where urban “Good” ratings reach 25.9% versus just 8.7% in rural areas. Rural areas in Karnali (5.9% Good) and Sudurpaschim (9.0% Good) have some of the lowest positive ratings, paired with very high “N/A” responses (over 70%), suggesting limited presence or accessibility of private education institutions. In contrast, urban areas tend to have both higher “Good” and “Fair” ratings and much lower “N/A” percentages, indicating greater availability and use. While “Bad” ratings are generally low in both settings, slightly higher values appear in rural areas of Karnali and Sudurpaschim. Overall, private education facilities are perceived more positively in urban areas, with rural-urban differences driven less by dissatisfaction and more by differences in access and exposure.

7. Findings

The analysis reveals significant provincial disparities in perceptions of both health and education facilities across Nepal, with

these differences being statistically robust given the large sample sizes. Generally, private facilities are rated higher than government ones, reflecting better perceived quality where available. However, access to private services is uneven, with urbanized provinces like Bagmati and Koshi showing higher satisfaction and lower rates of non-response, while more remote regions such as Karnali and Sudurpaschim exhibit lower satisfaction and substantial proportions of respondents indicating “N/A”, highlighting gaps in availability or engagement. Notably, Karnali presents a unique profile with relatively higher satisfaction in public education and health services but lower ratings for private facilities, suggesting reliance on government provisions in the absence of strong private alternatives. Provinces like Madhesh and Sudurpaschim consistently show lower satisfaction across both sectors, underscoring the need for targeted interventions to address service quality and accessibility challenges. These findings emphasize the importance of province-specific strategies, drawing lessons from higher-performing regions to improve equity and quality in Nepal’s health and education systems.

The comprehensive analysis across all aspects of health and education facilities in Nepal highlights pronounced provincial disparities in public perceptions of service quality. Private facilities-both health and education-tend to receive higher satisfaction ratings compared to government counterparts, reflecting a general preference where private options are accessible. However, availability and engagement with private services vary widely, with more urbanized provinces such as Bagmati and Koshi reporting higher satisfaction and lower non-response rates, while remote and less developed regions like Karnali and Sudurpaschim exhibit lower satisfaction and notably higher proportions of “N/A” responses, indicating limited access or familiarity. Karnali uniquely shows relatively better perceptions of government services but weaker private sector engagement, suggesting reliance on public provision in the absence of robust private alternatives. Provinces including Madhesh and Sudurpaschim consistently register lower satisfaction and higher dissatisfaction across health and education sectors, signaling urgent needs for targeted improvements. These statistically significant differences underscore the importance of tailored, province-specific policies that address both quality and accessibility, leveraging lessons from better-performing regions to promote more equitable and effective health and education services nationwide.

Across Nepal, there are consistent and statistically significant rural-urban disparities ($p < 0.001$) in perceptions of both health and education facilities, whether government or private. Urban areas generally report higher proportions of “Good” ratings for government health facilities, private health facilities, and both government and private education institutions, while rural areas more often select “Fair” or “Bad” for government services and show notably higher “N/A” responses for private education, indicating limited access. The rural-urban gap is most pronounced for government health facilities, where positive ratings are consistently lower in rural areas, and for private education facilities, where “N/A” exceeds 70% in some rural provinces such as Karnali and Sudurpaschim. Provinces like Bagmati, Gandaki, and Karnali show relatively higher urban satisfaction across sectors, while Madhesh often records the lowest “Good” ratings for government services. Negative ratings for private services remain generally low, suggesting that disparities are driven more by access and service quality gaps in government facilities than by outright dissatisfaction with private providers. Overall, the data point to an entrenched urban advantage in both quality perception and service availability across sectors, with rural populations facing both lower satisfaction and more limited exposure to non-government options.

8. Discussion

The analysis reveals significant provincial disparities in perceptions of both health and education facilities across Nepal, highlighting the uneven geography of service quality and access. Provinces such as Bagmati and Koshi, which are more urbanized and better resourced, consistently report higher satisfaction with both government and private services. By contrast, more remote provinces such as Karnali and Sudurpaschim show markedly lower satisfaction, accompanied by higher proportions of “N/A” responses, reflecting limited access or engagement with available services. These differences are statistically robust, underscoring how geography, infrastructure, and economic development intersect to shape citizens’ evaluations of basic services. Similar patterns of regional variation in health outcomes have been observed elsewhere, such as in South Africa, where Obuaku-Igwe (2015) notes persistent health disparities across provinces despite state interventions, driven largely by uneven service distribution and broader socioeconomic inequalities.

A consistent finding across the analysis is the preference for private over government facilities in both health and education. Where private options are accessible, they are generally rated higher, with low negative responses suggesting greater satisfaction with their quality. However, the rural-urban divide amplifies access inequalities, with rural areas-particularly in Karnali and Sudurpaschim-reporting high levels of “N/A” for private education facilities, in some cases exceeding 70%. This pattern suggests that dissatisfaction is not rooted in poor private services but in their absence or limited penetration in rural contexts. Such disparities resonate with Mellor and Milyo’s (2002) caution regarding the broader income inequality-health debate: perceived inequities often reflect structural barriers in access rather than intrinsic differences in service quality. For Nepal, this indicates that service gaps are as much a matter of availability and affordability as they are of quality.

Interestingly, Karnali emerges as a unique case where satisfaction with government services is relatively stronger compared to private alternatives. This suggests a reliance on government provision in contexts where private services remain weakly developed. The finding illustrates how reliance on public services is not necessarily a matter of preference but of necessity, shaped by structural constraints. This aligns with Obuaku-Igwe’s (2015) argument that health outcomes are contingent not only on quality but also on service availability and financial resources, with marginalized regions forced to depend disproportionately on state services. In this sense, improving government service quality in lagging provinces may have greater immediate impact than promoting private alternatives, which are less likely to reach remote populations without targeted policies.

The analysis also reveals consistent disadvantages for Madhesh and Sudurpaschim, where satisfaction levels remain low across both health and education sectors. These patterns echo Jacobs’ (1996) observation in the education domain that structural inequalities persist even as some groups make progress. While Jacobs emphasizes gender inequalities in educational outcomes, the parallel here is regional inequality: despite national improvements, specific provinces remain structurally disadvantaged in service access and quality. Likewise, Li’s (2002) findings on gendered barriers in Chinese education highlight how systemic structures-curriculum, tracking, and institutional access-can reinforce broader inequalities.

For Nepal, structural provincial disparities in service provision may be reinforcing cycles of disadvantage in health and education, leaving already marginalized regions further behind.

Taken together, the findings point to entrenched provincial and rural-urban disparities in Nepal's health and education systems, with statistically significant gaps that demand province-specific strategies. Drawing from better-performing regions such as Bagmati and Koshi, policies could focus on strengthening government service quality in underserved provinces, while also gradually expanding private sector engagement where feasible. However, as the literature reminds us, inequality is multidimensional-shaped by geography, income, gender, and social structures. Thus, tackling disparities in Nepal requires more than replicating urban or provincial "best practices"; it requires a holistic strategy that accounts for accessibility, affordability, and equity across all regions.

9. Conclusions

The findings show significant rural-urban and provincial disparities in public perceptions of health and education services across Nepal, highlighting underlying inequalities in both quality and access. Private facilities consistently receive higher satisfaction ratings than government ones, indicating a preference for private options where available. However, access to private services is uneven, with more urbanized provinces such as Bagmati and Koshi reporting greater satisfaction and lower non-response rates, while remote regions like Karnali and Sudurpaschim experience lower satisfaction and higher proportions of "N/A" responses, reflecting limited availability and engagement. Notably, Karnali stands out with relatively higher satisfaction in public facilities but weaker private sector presence, suggesting dependence on government services. Provinces such as Madhesh and Sudurpaschim exhibit persistent dissatisfaction across sectors, underscoring urgent needs for targeted interventions to improve service quality and accessibility. These findings emphasize the importance of tailored, province-specific policies that leverage successful practices from higher-performing regions to promote equitable and effective health and education systems throughout Nepal.

The finding further shows a clear and persistent rural-urban divide in the perceived quality and accessibility of health and education facilities across Nepal. Urban residents consistently report

higher satisfaction with both government and private services, reflecting better service quality, infrastructure, and availability, while rural populations face lower satisfaction with government facilities and significantly reduced access to private education and, to a lesser extent, private health care. The high proportion of “N/A” responses in rural areas, particularly for private education, underscores the role of service absence rather than mere dissatisfaction. These disparities suggest that improving rural service quality, expanding access to private sector options, and addressing infrastructure gaps in government facilities are critical for reducing inequalities and ensuring equitable development across provinces.

Overall, the analysis indicates that both health and education facilities in Nepal exhibit significant rural-urban and provincial disparities. Government facilities are generally perceived as adequate but not excellent, with most respondents rating them as Fair, while private facilities tend to receive higher Good ratings, reflecting better satisfaction and perceived quality. Urban areas consistently report more positive assessments than rural areas, highlighting gaps in access and service quality. Provinces such as Bagmati and Kathmandu show relatively higher satisfaction for both private and government services, whereas regions like Madhesh, Karnali, and Sudurpaschim report lower ratings and higher N/A responses, indicating limited availability or engagement. These patterns underscore the need for targeted interventions to improve accessibility, quality, and equity in both health and education services across Nepal.

Footnotes

1. Family Welfare Division (FWD), Epidemiology and Disease Control Division (EDCD), Curative Service Division (CSD), Nursing and Social Security Division (NSSD), and Management Division (MD), Additionally, it includes five centres: National Tuberculosis Control Center (NTCC), National Health Training Center (NHTC), National Health Education Information and Communication Center (NHEICC), National Center for AIDS and STD Control (NCASC), and National Public Health Laboratory (NPHL), along with two sections: Personnel Administration Section (PAS) and Financial Administration Section (FAS).

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