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Constitutional Promises and Ground Realities for Equal Access to Health Services in Nepal

Tribhuwon Sharma[1], Bhagwan Aryal[2*], Surendra Giri[3], & Shisir Lamichhane[4]

[1]Graduate School of Education, Tribhuvan University, Kirtipur, Kathmandu, Nepal
ORCID: 0009-0000-9466-5510
[2]Central Department of Education, Tribhuvan University, Kirtipur, Kathmandu, Nepal
ORCID: 0000-0002-9215-3551
[3]Central Department of Education, Tribhuvan University, Kirtipur, Kathmandu, Nepal
ORCID: 0009-0008-5167-4079
[4]Central Department of Rural Development, Tribhuvan University, Kirtipur, Kathmandu, Nepal
ORCID: 0009-0007-2985-7496
*Corresponding Author: bhagwan.aryal@cded.tu.edu.np

Abstract

Nepal's Constitution states that health is a right of citizens, and the National Health Policy 2019 guarantees that health access is universal and accessible to everyone. But it highlights serious inequalities between what was promised in the Constitution and the reality on the ground, especially for Dalits, women and indigenous communities. The systemic dissonance between policy-specific commitments and experiences have been addressed in this paper, with an emphasis on the issues of access to health care in Nepal. Through a rights-based analytical lens in 2023 a policy review of nation's laws, official documents, research reports, and health surveys was carried out over the period 2000–2024. The results demonstrate that Nepal's health system suffers from lasting geographic imbalances, chronic workforce shortages, infrastructural deficiencies, and entrenched social exclusion that hinder equitable access to health services. Specifically, 59% of rural households have health facilities within 30 minutes compared to 85.9% in urban settings, the health worker density is 0.67 per 1,000 population compared to the WHO benchmark of 2.3, and less than 1% of the facilities meet infection control standards. These conditions show a growing chasm between policy ideals and practice. The study suggests equitable allocation of resources, good local governance, community engagement, gender and caste awareness and institutional responsibility are the keys to solving the systemic gaps in health.

Keywords: Constitutional policy framework, equal access, equity vs. equality, health service, universal rights

Introduction

The Constitution of Nepal 2015 is a giant milestone towards making health a human right. There are provisions which establish the right of every citizen to free basic health care under Articles 35(1) and 35(3), and make health care as an equal right for all, all persons are entitled to access (regardless of the regional, gender, ethnic as well as economic groups) it (Government of Nepal, 2015). These are not empty language or

utopian principles, but obligatory legal rights that the State is obligated to respect to the health and dignity of its citizens. In addition, Article 51(h) places a duty on the state to implement policies to further investments in public health and guarantee access to the same through quality healthcare: quality, affordable and accessible. Indeed, these constitutional promises are embedded in national policy documents —most commonly National Health Policy 2019 — which harmonises Nepal's aspirations to UHC and PHC in a rights-based frame. This policy leverages the Astana Declaration (WHO, 2023), which reiterates PHC leadership as necessary for sustainable development, and for the building of strong health systems.

Yet, despite these sophisticated policy and legal tools, lived experiences at the ground level show a longstanding gap between constitutional promise and practical reality. Socialized and excluded groups like Dalits, women, elderly, indigenous, and persons with disabilities still contend with systemic exclusion from accessing health care based on historical, socio-cultural, economic and spatial inequalities (Devkota et al., 2021). Such inequities are not only logistical but are also representative of the pervasive systemic structural imbalances in the health system.

Although specialized and tertiary care is primarily served in major cities, the majority of remote mountainous areas also do not even have health service delivery and PHC facilities. It results in spatial disparity in terms of access with serious obstacles for the majority of its citizens, in fact, in parts of the Karnali and Far-Western Provinces, walking by foot for hours on end, or even days may be necessary for residents who can be both costly and dangerous when accessing health services (Adhikari et al., 2022). Geographic barriers are compounded by financial pressures, cultural insensitivity, language deficits, and bias particularly on behalf of marginalized groupings and ethnic groups. So although the Constitution guarantees a universal health model, ground reality is still affected by continued disparities in healthcare services and no substantial provision of money available. Thus, it is important to look very critically at how Nepal's constitutional and policy promises have been implemented in action and then start seeking to make the right to health more fair, inclusive, in practice.

Nepal's constitutional and policy frameworks ensure the right to health; however, most people still have unequal access to health services. Most studies either have examined health inequalities in a general sense or documented policy deficits, yet few have directly examined how these issues intersect with a constitutional guarantee of health as a right. This study attempts to fill this gap by connecting the constitutional framework to empirical evidence on health outcomes. Through exploration of how Nepal's Constitution and National Health Policy 2019 have enacted their promises, such a paper draws attention to the structural and systemic impediments to attaining health equity. In so doing, it adds to the literature by demonstrating how rights-based reform could help

narrow the gap between constitutional obligations and practical realities within Nepal's health system.

Accordingly, the study critically evaluates the extent to which Nepal's constitutional- and policy- commitments—most notably Article 35 in the Constitution, the National Health Policy 2019 and the PHC system—have been translated into tangible UHC measures. It specifically focuses on systemic and policy-level gaps in health care, describing how those which inhibit equal access to health care at the national and local levels and suggests rights-based reform for an equity, inclusion and accountability-oriented reform of Nepal's health system.

Methods

This study employed a policy review–based qualitative analytical framework to examine how Nepal's constitutional and policy commitments related to the right to health have been translated into practice. The review covered national constitutional provisions, health policies, government reports, and empirical research published between 2000 and 2024. Relevant literature was retrieved from databases including Google Scholar, JSTOR, and PubMed, using key search terms such as *Constitution of Nepal*, *right to health*, *health equity*, *universal health coverage*, *primary health care*, *social inclusion*, and *policy implementation*. Boolean operators were applied to improve search precision, and reference lists of key policy documents and reports were manually reviewed to identify additional relevant sources.

The inclusion criteria comprised peer-reviewed studies, national policy documents, constitutional provisions, and institutional reports focusing on health rights, access to health services, equity, and primary health care in Nepal. Sources published in Nepali or English by credible institutions—such as the Ministry of Health and Population, the World Health Organization, and recognized academic journals—were included. Opinion pieces, non-research commentaries, duplicated sources, and publications outside the defined time frame were excluded.

The reviewed literature was thematically analyzed across five dimensions: the constitutional and policy foundations; ground-level implementation challenges; issues of access, equity, and social inclusion; social justice and inclusive primary health care practices; and policy and practice implications. Together, these themes provided an integrated analytical framework for interpreting how constitutional assurances of health are realized—or constrained—within the country's health system. These thematic dimensions guided both the organization of findings and their interpretation in relation to Nepal's health governance and service delivery system.

Results and Discussion

This section aims to report and discuss the key findings of the analysis with regards to a number of themes derived from policy documents and literatures that were reviewed in this study. These themes comprise constitutional and policy contexts in which the right to health is framed, on the ground difficulties in realizing it, issues of equity and social inclusion and policy and implementation related to enhance Nepal's PHC system. Each sub-segment summarizes the progress and the ongoing disparities that impact on equal access to health care across the country.

Constitutional and Policy Frameworks

These findings further demonstrate that Nepal's constitutional and policy framework has laid a very progressive foundation for health governance and the right to health have been promoted as a fundamental element of social justice and human dignity. The Constitution of Nepal (2015) sets health as an inherent right under Article 35 and the state must ensure free basic health services so that all citizens have universal access to basic health services. Articles 40, 41, and 42 further guarantee these individuals; among other things, the protections for vulnerable groups: Dalits, aged citizens, persons with disabilities, etc. For example, Article 40(5) guarantees free medical facilities to persons with disabilities; Article 41 guarantees social security and special medical facilities for the aged citizens. This intersectional approach is a major advance in embedding inclusion and equity at the heart of Nepal's public service provision.

The constitution also includes directive provisions in Article 51(h) of the Constitution that state must spend more on public health, make safe drinking water access, improve the quality of quality health services, accessible health services, and inclusive health services. Together, these guidelines establish the ideal of high level of health governance in Nepal, one that aims to disrupt the long-standing tradition of exclusion and disparity.

Although these constitutional guarantees make a normative case, significant gaps remain in their execution. A significant limitation has been a lack of clear mechanisms for translating these high-level rights into actionable responsibilities at subnational levels. And while access and quality in health care are required by Constitution, it does not adequately point out coordination as well as execution between the provinces and local governments within the federal framework. Moreover, researchers have observed that the progressive nature of the Constitution remains unclear when it comes to defining UHC and PHC leaving a range of interpretations and weakening of accountability (Simkhada et al., 2015; Dahal, 2024).

The definitional lack of clarity is especially worrying among Nepal who is ever-decentralizing its health system, leaning on local authorities to coordinate planning, budgeting, and servicing. The need for constitutional promises to be put into practice within the pragmatic framework of the National Health Policy 2019, in the interest of

overcoming this shortcoming. This policy is reaffirmed as part of Nepal's Health Sector Strategy 2015–2020 with its commitments to equity, inclusion, and a strong PHC system (MoHP, 2015), which included human resource development and building referral systems and embedding digital health solutions (MoHP, 2019). It is in line with Sustainable Development Goal 3, which aims to "Ensure healthy lives and promote well-being for all at all ages."

But where there is no legally binding mechanism that compels provincial and local actors to take equity-oriented approaches and measurable accountability frameworks, implementation often remains patchy. Although some of Nepal's constitutional and policy underpinnings are noble in intention, the continuing challenge has been establishing stronger institutions to guarantee that these promises translate into concrete advancements for the country's most vulnerable members.

Ground-Level Challenges

Ground-Level Challenges are associated with the sub-themes including the disparities of geographic location, workforce and infrastructure deficits, and social exclusion. Taken together, these dimensions describe how structural, social and spatial components interact to limit healthcare for all in Nepal.

Geographic Disparities

The findings point to a wide-ranging range of social, economic, and environmental inequalities created by Nepal's geographical diversity, particularly for those in remote places. The geographic diversity of Nepal — from the Terai plains to the mid-hills and mountain ranges — yields significant disparities in people's access to health care. In many hard-to-reach regions, health centers are several hours away and individuals often have to walk up to 7 to 8 kilometers through hills, forests and rivers to get even basic treatment. These long, tiring hikes are particularly challenging for women, seniors and patients who are gravely ill. The small, scattered population, on a land of steep terrain and with underdeveloped living conditions, together with poor infrastructure makes it even harder for people to reach health centers, so too with an over-stretched urban population (Marahatta et al., 2020). These realities highlight the urgent need to overcome geographic barriers and more easily access health services in Nepal.

Only 59% of rural households live within a 30-minute walking distance of health facilities according to Nepal Demographic and Health Survey data compared with 85.9% of urban households (Ministry of Health and Population et al., 2023; Ministry of Health and Population et al., 2022), reflecting a continuing rural–urban disparity. Insufficient infrastructure for transportation, temporary road closures such as those caused by landslides or flooding, lack of medical and emergency services all help to isolate rural populations. Furthermore, infrastructure in these areas frequently lacks basic necessities and resources and is inadequately staffed, supplies of life-saving drugs and infrastructure,

that will decrease the quality of care being administered, threaten the health outcomes of workers and patients (Acharya et al., 2017). Staffing shortages in these remote posts are also exacerbated by the move of health workers to urban areas and countries to seek greener pastures (Baral et al., 2013).

Consequently, high percentages of the general population —especially Dalits, Janajatis, and women— rely on unofficial or traditional caregivers owing to cost-effectiveness, access, and closeness, not safety as a guarantee of regulated access (Kafle et al., 2021). These disparities run directly counter to Nepal's constitutional guarantee of equal access to health services. To address geographic disadvantages, few new technologies have been established, with applications of mobile health camps and telemedicine being limited. Nepal, for example, established its first teleconsultation center at Bir Hospital in 2021 to provide free telephone-based medical consultations for people in remote areas (WHO, 2021).

Workforce and Infrastructure Deficits

There is a severe lack of health workers and infrastructure in Nepal, the results demonstrate. Consequently, the percentage of doctors and nurses per 1,000 population is 0.67, far below the minimum of Human Resources for Health Country Profile Nepal (WHO, 2024: 2.3 per 1,000). For example, in hill districts the highest percentage of health worker vacancies occur that is up to a maximum 16%, making it hard for all these areas to get decent enough health workers. Furthermore, just 43 percent of the hospitals and 18 percent of PHCCs have the appropriate skill mix to provide quality health care, showing significant quality disparities (Baral et al., 2013). Consequently, people living in areas that lack resources are forced to buy high-priced private services, compounding disparities and the costs attached to them (Saito et al., 2016).

Healthcare systems face limitations from infrastructure as well. The Nepal Health Facility Survey 2021 reports that fewer than 1% of health facilities have adequate infection prevention and control and very few have adequate resources such as disinfectants, gloves or waste management facilities. Moreover, just 6% of facilities have outbreak control plans and only 36% completed a financial audit in the last 12 months as both indicators of poor institutional readiness and accountability (MoHP, 2022). These scenarios not only threaten patient safety but also dent public confidence in the health care system. These gaps do call for a multi-sectoral action to enhance people deployment, infrastructure upgrading, and institutional governance to bring good healthcare to Nepal.

Social Exclusion

The findings indicate that the marginalized populations in Nepal -- in particular Dalits, indigenous communities, and women -- are facing deepening patterns of exclusion and inequality. Thapa et al. (2018) found no evident pro-poor usage of public health facilities in the urban context, where wealthier populations heavily rely on private as well as public

sectors. Disparities are exacerbated by cultural insensitivity and discrimination in the health system, as members of marginalised groups receive biased service practices from health professionals. In the Indian context, similar patterns of discrimination, language, and even culturally insensitive care among Dalit and indigenous populations have also been reported. In both instances, access to quality care is determined to a considerable extent by one's socio-economic status, perpetuating a vicious cycle of exclusion and adverse health outcomes. Inequality between women, especially in rural communities, is aggravated by the intersection of gender and social exclusion.

From the perspective of gender-based violence, exclusion from decision-making, and limited autonomy, these conditions limit women's access to timely and adequate medical care (McNamara & Harris-Coble, 2018). Due to geographical, economic, and socio-cultural barriers, health services are often underfunded and/or nonexistent. In patriarchal environments, traditional gender norms limit mobility and decision-making at the expense of women's reproductive and general health needs. Structural-based obstetric barriers like these serve to inhibit women from pursuing appropriate health care when required (Namasivayam et al., 2012). Special policies need to be implemented in order to address the above-mentioned problems, in view of multilayered social structures leading to exacerbation of health disparities and the provision of differential health care interventions that is inclusive and equitable and respectful to marginal groups.

Equity vs. Equality in Health

The results show that despite Nepal's Constitution's dedication to equality, its health care delivery violates principles of equality, leading to disparities in health among its population groups based on demographic classification and socio-economic status. Health care equality is the sharing of treatment of the very same rights, regardless of needs or difficulties experienced by different sections of the population (Wagstaff, 2018). While this seems fair, it fails to account for the differences of social, geographic, and economic status with respect to the various groups. This can be seen in the case of some rural and mountainous areas of Nepal that are hard to access and are deprived of health facilities and basic resources (Simkhada et al., 2015). Those inequities are exacerbated by poor transportation networks that require people to move a very long distance to receive even the most basic health services.

Moreover, a culturally insensitive form healthcare system is a common experience for many marginalized groups such as the Dalits and indigenous communities (Joshi et al., 2023), who face discrimination and limited communication in primary care. The evidence shows that treating everyone equally may serve to reinforce existing inequalities rather than correct them. Therefore, Nepal's health system needs to be equity focused where the needs and challenges of different groups are recognized to provide an appropriate intervention (Adhikari, 2023). Health equity considers the need for individualised care

based on one another's needs and circumstances; thus, creating an equal (as well as inclusive and accessible) health landscape for everybody (Braveman et al., 2011).

Such a concept of equity lays the basis to address the plight of marginalized society in Nepal. Rural areas are another example that experience acute shortages of health professionals and a doctor-to-population ratio that is well below the World Health Organization's minimum level of 2.3 doctors per 1,000 population (Adhikari et al., 2022). In addition, the shortage of trained health providers in rural communities directly compromises care quality and deepens health disparities (Wasti et al., 2023). This has meant that many patients in these communities are forced to rely on informal and traditional health professionals because of their scarcity of access to organised health services (Thapa, 2022).

Closing these gaps necessitates equity-oriented policies to design strategies to deploy health resources to those regions and populations who need them most: mobile health clinics and telemedicine initiatives (Aker et al., 2010). Enhancing access to health services within the framework of financial and infrastructural support is critical to narrowing disparities and improving general health outcomes. Adopting such equity-based approaches would serve to increase the access to disadvantaged communities and decrease health care costs as well (Thapa, 2022). This ensures equitable access to care needed to reach the highest attainable standard of health possible, regardless of one's location or socio-economic status (Vaidya & Pradhan, 2008).

Importance of Social Justice and Inclusive PHC

This study reveals that Nepal's Primary Health Care (PHC) system is structured around the principles of social justice focused on the eradication of structural inequities and the expanding of health services to underserved communities. But one of the key barriers to this, of course, is the top-down policy approach that has often been prevalent at health policy level. Often such a method excludes local community voices, resulting in a development of health care models that do not adequately represent the needs of the target populations in the model. According to Sapkota et al. (2024), exclusion of community voices not only undermines the successes of health policy, but also keeps social and economic inequalities alive. Insufficient community involvement in health service planning and delivery ensures that interventions are oblivious to the distinctive cultural, geographical, and socio-economic considerations of marginalized groups – particularly those living in rural and disaster-affected communities (Gholipour et al., 2023). Consequently, participation from communities in PHC planning and practice is a key to the design of full and inclusive health care systems that are in the best interests of individuals and communities, particularly those from marginalized groups.

This view is consistent with the results from Dahal et al. (2023), community-based health interventions improve health outcomes by addressing the local problems and accessing

local knowledge and resources. Sharma (2024) also argues that health services provided by the authorities tend to ignore community opinion and in so doing generate ineffective and non-expanding outreach programs, mainly in relation to poor and marginalised individuals. In this sense, Female Community Health Volunteers (FCHVs)—who make up the front-line workforce of rural PHC in Nepal—face significant barriers to maintaining the health system's reach and trust. Apart from delivering maternal and child health services, FCHVs assume a heavy workload, sometimes in non-pay job and without adequate financial provision (Panday et al., 2017). The absence of remuneration not only affects their initiatives but also diminishes their intrinsic motivation leading to burnout and turnover. The formal health system of Nepal also has a history of dismissing indigenous cultural health knowledge as superstition, failing to view this knowledge as a significant member of the community (Tikkanen et al., 2024). This exclusion serves to further marginalize at-risk populations and deny them access to culturally sensitive services.

Incentives to recognise and support the role of FCHVs and integrate indigenous health knowledge into the national health system are required in order for PHC to be genuinely inclusive. Integrating traditional healing and cultural practice at the local level not only improves health care provision but could also contribute as well to a broader cultural respect, preservation and partnership, leading to a more equitable and inclusive health care situation for all Nepali citizens (Aryal et al., 2016).

Based on the above discussion, a clear and visual presentation of Nepal's constitutional promises and the actual situation of equal access to health services in Nepal. Figure 1.

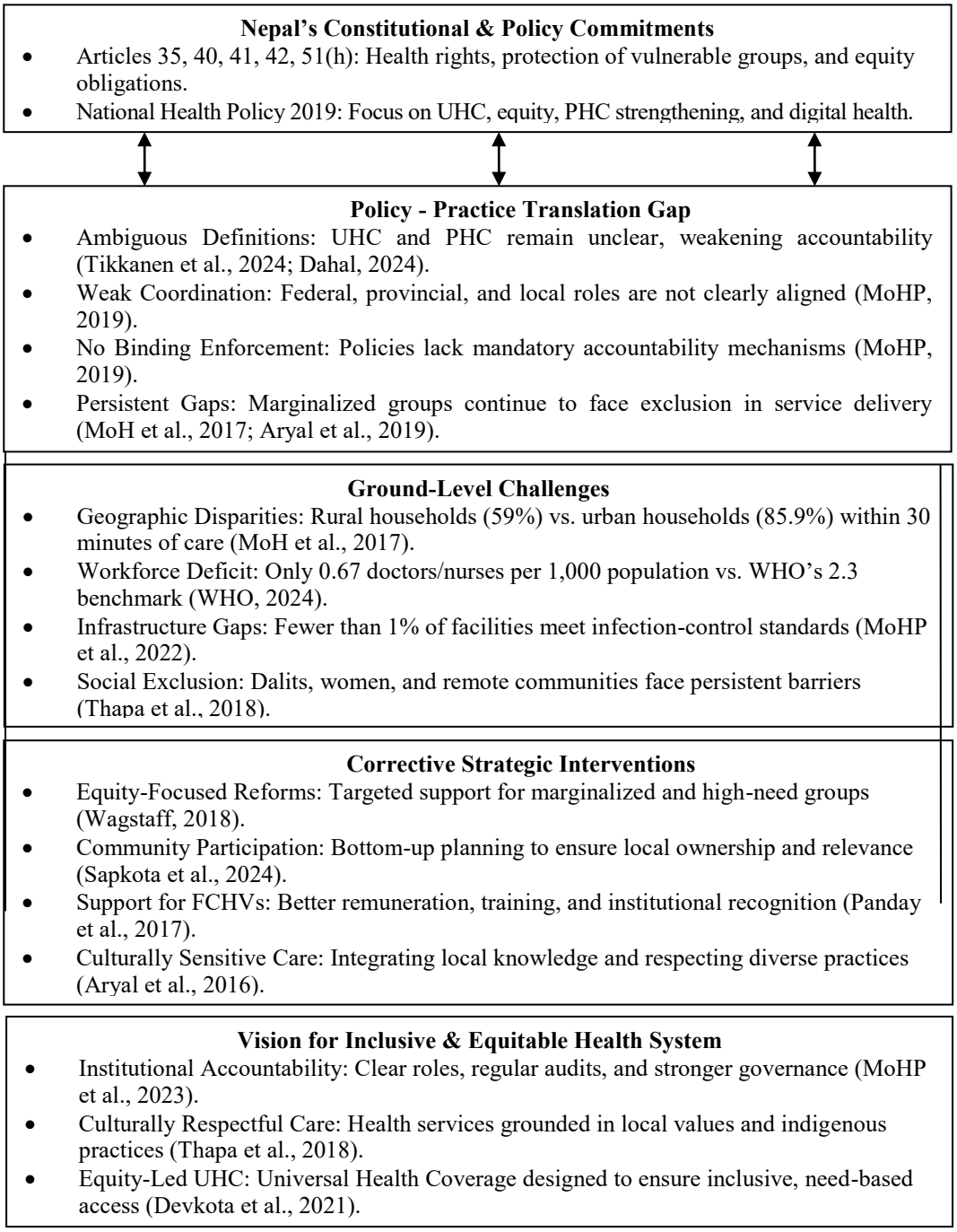

Figure 1: Constitutional Promises and Ground Realities for Equal Access to Health Services in Nepal

Though Nepal is committed to its constitutional and policy documents (Articles 35, 40, 41, 42, and 51(h) of the Constitution and expressed in National Health Policy 2019 which is a vision for Universal health coverage (UHC), equity and digital health), there is still a large gap between it and the delivered service. This policy—practice gap results from unclear definitions of UHC and PHC, ambiguous federal roles, non-binding accountability mechanisms, and significant difference in service provision across rural and marginalized groups.

These challenges are reflected by geography, chronic shortages of health professionals, inadequate infrastructure and systematic societal stigma against marginalized individuals. While some progress has been made (equity-led reforms, greater engagement of communities, FCHV empowerment, outreach via digital) efforts to address this, there is still a long way to go. It is only through institutionalizing accountability, ensuring culturally appropriate care, and integrating UHC efforts through an equity lens that Nepal can move toward realizing the constitutional vision in an equitable health system that embodies both democratic aspiration and reality.

Implications for Policy and Practice

The results indicate that improving access and quality of PHC in Nepal will need a multi-faceted approach to strengthen infrastructure-driven and inclusive elements. Among them has been a consistent provision of staffing, a sufficient supply of essential medicines and a favourable infrastructure for facilities with growing demand from excluded communities (Wasti et al., 2023). Telemedicine (Banu et al., 2024) and mobile health facilities are equally important to reach rural populations, using the possibilities of digital technology to break through geographical barriers (Siddiquee et al., 2020). In addition to this, Gender Equality and Social Inclusion (GESI) budgeting is important and guarantees that the relevant public allocations go where they are most needed and that people from excluded communities like women, Dalits and indigenous people receive the greatest financial allocations.

Female Community Health Volunteers (FCHVs), are essential to the sustainability of rural health systems. By offering them financial rewards, institutional credit, and building their capacity, the effectiveness of service delivery will increase while reducing burnout and turnover (Panday et al., 2017). Finally, PHC planning must ensure that community engagement is at its core. As outlined by Dhungana et al. (2023), engagement of local leaders, traditional healers, and community organisation would help to mediate the current disconnection between modern health care and health care system at the traditional level (Dhungana et al., 2023).

By integrating these ideas— strengthened infrastructure, digital expansion, inclusive budgeting, FCHV empowerment and community participation—Nepal can reach a

healthier, equitable and sustainable health care system that meets the needs of all of the people in Nepal.

Conclusion

This study examined the extent to which Nepal's constitutional and policy assurances of the right to health—particularly Article 35 of the Constitution and the National Health Policy 2019—have been translated into practice. The findings indicate that, despite Nepal's strong legal and policy foundations, a considerable gap persists between constitutional commitments and ground realities. Persistent challenges such as inadequate health infrastructure, shortages of human resources, social exclusion, weak coordination, and unclear accountability mechanisms continue to limit equitable access to health care.

Although policies emphasize equity, community participation, and technological innovation, their implementation remains uneven and under-resourced. The study underscores the need for effective health reforms that empower local governments, ensure equitable deployment of health personnel and resources, and promote culturally sensitive and inclusive care. Bridging the gap between constitutional promise and lived experience is crucial to realizing Nepal's vision of "health for all." Only through sustained, inclusive, and accountable reform can health rights become effective and sustainable for every citizen.

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