Received 19 August 2024
Revised 8 October 2024
Accepted 21 November 2024

How ethnic discord impacts the relationship between health service delivery and state legitimacy: lessons from fragile Nepal

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Abstract

Purpose – Despite extensive research on the relationship between service delivery and state legitimacy in fragile settings, we know little about how this relationship is impacted by ethnic discord, particularly when essential health services are delivered to an oppressed ethnic minority by an ethnic majority. This study addresses the research gap in the fragile setting of Nepal, characterized by unresolved ethnic tensions. It examines how Nepal's Madheshi ethnic minority engages with state health services delivered by the Pahadi ethnic majority. The objective is to analyze how Madhesis' perceptions of these services shape their views on state legitimacy.

Design/methodology/approach – Semi-structured interviews were conducted with 18 Madhesi patients and five Pahadi frontline healthcare practitioners at Narayani sub-zonal hospital, a state-run facility in Madhesh, the southern region of Nepal. Additionally, a focus group discussion was held with 11 Madhesi recipients of government health services in Madhesh's Pipra rural municipality.

Findings – Madhesis viewed health service delivery and the Pahadi providers favorably and supported state legitimacy by commending the state's commitment to provide free and equitable health services. In contrast, the Pahadi healthcare providers expressed skepticism and discontentment, perceiving Madhesi patients as ill-behaved and distrustful of their medical decisions. These providers often felt their authority was challenged by the Madhesi patients and their families.

Originality/value – The discrepancies in perspectives are striking. Healthcare workers predominantly viewed clients through an ethnic lens, whereas clients focused more on the professional provider–patient relationship. These findings provide new insights into the nuanced interplay of ethnicity in service delivery in fragile settings characterized by ethnic discord, where governments seek to enhance state legitimacy.

Keywords Health service delivery, State legitimacy, Ethnic discord

Paper type Research paper

Introduction

Recent years have seen widespread recognition of service delivery as a building block of state legitimacy in fragile states (Brinkerhoff *et al.*, 2012; Ficek, 2024; Kubota *et al.*, 2024; Stel and Ndayiragije, 2014; Truppa *et al.*, 2024; Zoellick, 2008).

State legitimacy refers to the widespread acceptance of a government's inherent authority to govern (Brinkmann, 2024; Gilley, 2009). It stands as a central concern in political theory and reflects the capacity of political institutions to maintain public belief in their appropriateness for societal governance (Gilley, 2006; Lipsky, 1980; Pierre, 2020). Policy-makers focus on legitimacy because it is seen as a means to achieve tangible results, such as state stability and compliant behaviors in areas like tax collection and adherence to public health measures (Nixon *et al.*, 2017). In other words, legitimacy is crucial for governance—the greater the legitimacy that the state and associated public actors enjoy, the less they need to rely on

This paper forms part of a special section "Health Governance in Fragile Contexts: Building Trust and Resilience", guest edited by Dr Puspita Hossain.

International Journal of Health Governance
Vol. 30 No. 2, 2025
pp. 222-238
Emerald Publishing Limited
e-ISSN: 2059-464X
p-ISSN: 2059-4631
DOI 10.1108/IJHG-08-2024-0101

coercive measures, such as force and threats, to secure the desired behaviors from the public (Börzel and Risse, 2021; Mcloughlin, 2015). State legitimacy is especially critical in fragile and conflict-affected situations. Building or rebuilding state legitimacy in these settings is considered central to peace and stability (Dagher, 2021; Zaum, 2012).

At the core of the discourse on state legitimacy lies the inquiry into how state actors can enhance legitimacy within fragile contexts. Scholars have asserted that fulfilling core state functions, including effective public service delivery, is foundational for legitimacy (Brinkerhoff *et al.*, 2012; Pierre *et al.*, 2017). The belief in a direct causal link between service delivery and state legitimacy was so prevalent that some scholars dubbed it "received wisdom" (Carpenter *et al.*, 2012; Wolfowitz, 2006). Global organizations used to portray service delivery as a way for the state to reach out to society, demonstrate its commitment to citizens, rebuild confidence in government, and build its legitimacy among populations in crisis (OECD, 2011; The World Bank, 2011).

However, recent scholarship has contested the presumed causal relationship between service delivery and state legitimacy. Researchers have argued that state legitimacy is also influenced by factors like distributive justice, adherence to societal norms, and opportunities for citizen input (Krampe, 2016; Mcloughlin, 2015; Meyerson *et al.*, 2020). Other sources such as political participation, accountability, and inclusiveness are important elements underpinning legitimate governance (Abhayawansa *et al.*, 2021; McCullough *et al.*, 2020). Notably, the impact of ethnic discord on this relationship remains largely underexplored, particularly when services are delivered by an ethnic majority to an oppressed ethnic minority. Understanding the nuances of such interactions is critical for developing effective governance strategies in ethnically diverse societies. Ethnic discord could exacerbate perceptions of inequality and injustice, potentially undermining the legitimacy of the state even when service delivery is efficient. Furthermore, understanding these dynamics is crucial for enhancing social cohesion, managing conflict, and constructing governance frameworks marked by inclusivity and equity. Consequently, investigating how ethnic discord shapes the interplay between service delivery and state legitimacy holds significant implications for theoretical advancements and practical policy development in fragile states. This study seeks to address this critical research gap.

Madhesis, indigenous to Nepal's southern Madhesh region, have historically encountered systematic marginalization in political, economic, and social spheres (Deysarkar, 2015; Hachhethu, 2023). These grievances were instrumental in catalyzing a decade-long civil conflict (1996–2006), precipitated by demands from the Maoist party of Nepal for a new constitution recognizing minority rights, including those of Madhesis, against a backdrop of Pahadi dominance in the Nepali central government for centuries (Boquérat, 2006; Einsiedel *et al.*, 2012). Following the cessation of hostilities in 2006 and the interim constitution, Madhesis' demands for recognition in the reconfigured state framework were largely unmet, leading to significant unrest and Madhesi uprisings in 2007 and 2008, and resulting in casualties among Madhesis at the hands of state forces (Jha, 2017; Pherali, 2021). Despite subsequent constitutional revisions, including the 2015 promulgation, Madhesi concerns persisted, contributing to ongoing ethnic tensions between Pahadis and Madhesis.

This research seeks to explore how these ethnic tensions manifest in the delivery of public services and influence Madhesis' perceptions of state legitimacy. Focusing on health service delivery—a critical state function—the study explores the daily interactions between Madhesis and predominantly Pahadi healthcare providers. Specifically, it addresses the following research objectives: (1) to examine the experiences of Madhesis in accessing state health services that are delivered largely by the ethnic majority Pahadis, (2) to assess how these experiences influence their perceptions of state legitimacy, and (3) to analyze the role of ethnic dynamics in shaping healthcare interactions and outcomes. Madhesis' experiences of health service delivery play a pivotal role in shaping their perceptions of state legitimacy, illustrating the intricate intersection of policy implementation with broader ethnic dynamics. Understanding these dynamics is essential for informing policies that enhance state legitimacy and promote social cohesion in Nepal's diverse and fragile socio-political landscape.

Methods

To address the research objectives, qualitative data collection was conducted with 23 semi-structured interviews and one focus group discussion with 11 participants, conducted in April 2016.

The COREQ (COnsolidated criteria for REporting Qualitative research) guideline was employed for reporting this research (Tong *et al.*, 2007). Data was collected solely by the male author, who held a Bachelor of Arts at the time and was pursuing a Master's program. The author did not have access to research funding for this Master's thesis, which made it difficult to engage additional help from other researchers to help strengthen the objectivity and reliability of findings. Additionally, the Master's program expected that the research be conducted independently. Regardless, the author was able to recruit an interpreter fluent in both Bhojpuri and Nepali, who assisted the author in ensuring and accuracy and clarity of participant feedback. Also, the translator belonged to the Madhesi community, so he helped reduce responder bias, specifically social desirability bias, given that the author belonged to the Pahadi community. The author had prior experience with qualitative research from his undergraduate training and a public health fellowship. Four individuals declined participation due to time constraints. The author did not establish relationships with participants before the study but communicated the research objectives before requesting interviews. Interviews and focus groups were audio recorded with participants' consent, and notes were taken afterward. Data saturation was achieved with 18 Madhesis and five health service providers. Because of time constraints, transcripts were not returned to participants for feedback, and participants also did not have the opportunity to review the findings. Data management was conducted manually due to financial constraints, as this study lacked external funding for new software. However, meticulous manual organization and regular checks for data accuracy were implemented throughout the analysis process.

The semi-structured interviews were central to the research design, enabling one-on-one conversations with 18 Madhesi health service recipients and five health service providers. The semi-structured format allowed informants to express their views freely, uncovering the underlying reasons behind their opinions, attitudes, and beliefs. Additionally, interviews with health service providers were conducted to gain a balanced perspective on their relationship with the service recipients.

The interviews were conducted in the Parsa district of the Madhesh region of southern Nepal, for several reasons. First, it aligned with the research focus on Madhesi recipients of health services delivered by Pahadis in a state-run health facility or community health program. Second, Parsa was a key site during the 2015 Madhesi revolution, offering valuable insights from citizens involved in or affected by the protests, particularly regarding their views on the national government and state legitimacy. Third, Birgunj city within Parsa district hosts the Narayani Sub-Regional Hospital, the region's largest government hospital, attracting residents from across Parsa. This hospital served as the primary research site for these interviews, allowing access to a diverse patient population and healthcare professionals, including doctors, nurses, and health educators employed by the state.

Interview preparation included formulating a plan of action and creating a flexible questionnaire as a frame of reference, rather than a rigid structure. Before starting the interviews, the author visited Narayani Hospital for unstructured participant observations to familiarize with the hospital environment and patient behavior. Using purposive sampling, Madhesis who had visited the hospital at least once and received care in one of three departments: gynecology, surgery, and outpatient were selected. This selection minimized variation within the hospital, ensuring that differences in perspectives were not due to the nature of the services received. Frontline healthcare workers in these departments were also interviewed to understand discrepancies between their narratives and those of their Madhesi clients. Interviews lasted between 20 to 90 min, depending on the level of detail shared by the interviewees. Open-ended follow-up questions were employed to explore participants' key experiences and interactions with service providers in greater depth. All interviews and the focus group were conducted face-to-face.

To explore how Madhesis conceptualize the legitimacy of the state in a group setting, a focus group discussion was conducted in the Pipra rural municipality of Parsa district. The aim was to uncover discrepancies and similarities in their perceptions regarding state health delivery in the Parsa district of Nepal. The focus group consisted of members of a community organization that received government training and funding for public health initiatives. All participants belonged to the Madhesi ethnic group.

Conducted in Bhojpuri with the assistance of a Madhesi translator, the discussion was structured into three phases: engagement, exploration, and exit, following established guidelines for focus group facilitation (Denzin and Lincoln, 2017). During the engagement phase, participants were introduced to the research project, and they introduced themselves, providing context for their involvement. The exploration phase, central to the discussion, employed a series of leading and follow-up questions. Participants discussed their interactions with government officials and their experiences receiving state funds for community health programs, providing insights into their perceptions of government accountability, representation, and trustworthiness in service delivery. The exit phase allowed participants to reflect on the discussion and share any final thoughts or additional comments. It also provided an opportunity to clarify any points raised during the exploration phase and to summarize the key themes that emerged from the discussion. The discussion spanned approximately one hour.

The data collected from interviews and the focus group were analyzed by the author using thematic analysis, a widely used method in qualitative research. Thematic analysis was used to identify, analyze, and report patterns (themes) within the data, facilitating a rich understanding of participants' experiences and perspectives. The analysis process followed six steps (Braun and Clarke, 2006; Naeem *et al.*, 2023). First, the data was familiarized by engaging in the transcripts, noting initial impressions and insights. This step was crucial for developing a contextual understanding of the participants' narratives. For instance, during initial readings, patients' frequent emphasis on "trust in the government" stood out as a significant recurring sentiment. Second, initial codes were generated by systematically organizing the data into meaningful units. Codes were created based on significant statements that reflected participants' experiences with health service delivery and their perceptions of state legitimacy. For example, one patient noted, "The behavior of nurses is good. Based on their qualifications and skills, they are trying their best," which was coded under "trust in healthcare services." This step allowed for a granular examination of the data and highlighted recurring topics and sentiments.

Third, following coding, themes were searched for among the codes, grouping similar codes together to form broader categories. For instance, codes related to "improved access," "better staffing," and "visible improvements in facilities" were grouped under the broader theme of "enhanced healthcare service delivery." This thematic mapping helped in identifying overarching themes that captured the essence of participants' experiences. Fourth, the identified themes were reviewed, ensuring these themes accurately represented the data and were distinct from one another. This involved revisiting the original data to verify the validity of the themes and refining them as necessary. Fifth, the themes were defined and named, capturing the core meaning of each theme and its relevance to the research questions. One prominent theme, "trust in ongoing government efforts," emerged from participants' comments on how they perceived the government's commitment to continuing improvements in healthcare. Finally, the final manuscript was produced, integrating participant quotations to illustrate the themes and provide a voice to the participants' narratives. For instance, one patient remarked, "The state wants to provide good services". That is why it is investing here. They established this huge building. They are offering a lot of facilities," illustrating the theme of "positive perceptions of the reforms." This approach ensured a transparent and comprehensive analysis, contributing to a nuanced understanding of how ethnic discord impacts health service delivery and state legitimacy in the context of fragile Nepal.

Findings

Using the robust methods outlined above, this research was able to identify a complex, multifaceted relationship between Madhesis service recipients and the Pahadi service providers, characterized by both satisfaction and underlying tensions.

A majority of Madhesis held favorable views about the health services received and the health service providers. All research participants related their experiences with tangible aspects of the hospital, which helped them conceptualize the health service delivery they were experiencing at large. Some participants discussed the availability of beds, while others focused on the access to doctors and nurses during critical times, the complimentary food and medicine, and the absence of treatment costs. In a resource-constrained environment, these tangible aspects can help shape positive perceptions of the state's health service provision.

One Madhesi service recipient noted that the hospital's provision of food for all admitted patients helped him manage his illness. They were referring to the free-of-charge food services offered two times a day by the hospital to all patients. This emphasis on the provision of free meals points to how tangible benefits can shape perceptions of service quality, particularly in resource-constrained environments. Another respondent who had been coming to the hospital for their illnesses for the past few years also shared their enthusiasm about improving services:

> Service provision has increased quite a bit compared to the past. Everything is free. If you go upstairs, then you will find that a lot of beds are free of cost. In the gynecology ward, it is free of charge. The delivery, operation, all the services are free of cost. Those who go through the procedure receive free medicine. When a woman leaves after giving birth, the hospital provides them 500 rupees. Everything is good. Everyone is getting excellent services.

The respondent was referring to the hospital program that provided 500 rupees, approximately four US dollars, to mothers to help them buy nutritious food and clothes for their newborns (Bhattarai, 2008). This support not only reflects the state's focus on addressing citizens' immediate needs but also reinforces broader perceptions of state accountability in health service provision. Another respondent receiving services from the outpatient department of the hospital mentioned that his reasons for choosing this hospital over the other ones were the availability of the doctors and the range of services he had access to:

> The doctor stays here, and gets work done here. I am a businessman and I have a brick factory. I knew that the doctor visited the hospital from 8 a.m. to 12 a.m. So, I knew that I had to meet the doctor then so that I am not late for my business. If I went to the private clinic, then I would have waited till 2 p.m. So, I came here expecting that my work will be done early. I have confidence that I will get the right kinds of services, based on my past experiences. That is why I am here.

These narratives highlight the importance of state-funded health services in meeting the needs of marginalized communities, framing the state as a provider that is actively invested in the welfare of its citizens. However, satisfaction, while important, masks deeper complexities. The respondents' emphasis on material benefits suggests that the state's legitimacy in health service provision can be largely transactional, dependent on the continued availability of free services. One could argue that this transactional relationship while fostering short-term satisfaction, may not guarantee long-term legitimacy if state investments wane or if services degrade in quality over time. Though celebrated, the notion of "free" services risks becoming a fragile foundation for state legitimacy, where the public's confidence could erode if resources diminish.

Many service recipients extended their satisfaction with the service provision to health workers. The majority trusted the health providers, the street-level bureaucrats, to afford them high-quality service. The majority of the Madhesis spoke favorably of the health service providers and demonstrated confidence in the providers' qualifications. A service recipient who chose the hospital for its free services praised the nurses for their care:

> The behavior of nurses is good. Based on their qualifications and skills, they are trying their best.

Another recipient, when asked about why they chose this hospital to receive the services, talked about their faith in the doctors of the hospital. They said:

> Doctors and nurses have a pretty good response. No matter where you go, they look after the patients. Their response to our needs is quite good.

This trust extended by many Madhesi service recipients toward healthcare workers highlights an important but often overlooked aspect of service delivery in fragile states: the role of street-level bureaucrats in mediating state-citizen relationships. While state legitimacy is typically assessed at the institutional level, the positive interactions between service recipients and frontline health workers suggest that trust in individuals can partially substitute for trust in the state, at least in the short term. This trust in individual health workers can be seen as a reflection of the broader trust in the state's ability to deliver quality services, suggesting that positive interactions at the micro-level of service delivery contribute to macro-level perceptions of state legitimacy.

The confidence expressed by Madhesi participants toward the health service providers translated extended to their views of the state as well. The majority considered the state—interchangeably referred to as the government—accountable to health service delivery and praised the facilities it provided. Most of the research participants did not question the state's legitimacy within the domain of health service delivery. They instead argued the state was ready to pay for their healthcare through this large institution—the Narayani sub-zonal hospital, which demonstrated that the state was accountable for its citizens' health. A research participant suggested that the reason the state was investing in health services was because it was responsible for improving the health of its people:

> The state wants to provide good services. That is why it is investing here. They established this huge building. They are offering a lot of facilities. Why is that? The government is about serving people. The government has thought about how to provide the best services possible, and on that line of reasoning has invested in providing these services.

Another service recipient indicated the cost-effectiveness of coming to a state hospital, compared to the private ones. They also questioned why anyone would choose to go to a different hospital when there is one run by the state:

> The services are pretty good. The doctors here are very good, knowledgeable. The private hospitals have the same doctors we interact with here. It costs a lot of money there. It is the hospital of the Nepal government. Then why go to a different hospital?

Despite some frustrations regarding the state's inefficiencies, most respondents praised it for "taking care of them." The majority of Madhesi interviewees voiced their satisfaction with the state's health system delivery mechanism. Few pointed to some room for improvement, and even fewer questioned the state's legitimacy in its mandate to provide health service for all.

This strong endorsement of health service delivery can significantly bolster the state's legitimacy among marginalized groups. When citizens perceive the state as an active participant in improving their health, it creates a sense of trust and reliance on the state's institutions. Thus, the experiences within the health sector not only reflect individual satisfaction but also contribute to a larger narrative of state legitimacy, suggesting that effective service delivery can bridge gaps in citizen-state relations.

The focus group discussion also yielded similar attitudes of the Madhesi community towards the Nepalese state. Participants reported varying levels of interaction with street-level bureaucrats. The majority indicated satisfaction with governmental programs aimed at improving their community's health conditions. The discussion also uncovered some opinions within the group regarding the overall functioning of the state and, consequently, their perceptions of the state's legitimacy. A few particularly vocal participants expressed strong disagreements with the government's health service delivery strategies but also conveyed hope that these issues would be addressed, highlighting the community's ongoing challenges. This

blend of satisfaction with certain aspects of health service delivery and critical engagement with its shortcomings illustrates a dynamic perspective on state legitimacy, wherein the community both acknowledges progress and calls for continued accountability.

A high level of satisfaction and trust from the Madhesi service recipients represents only one aspect of the dynamic. The perspectives of Pahadi health service providers reveal a more complex and nuanced outlook on their relationship with Madhesi health service recipients. Conversations with Pahadi health service providers indicate a significant level of distrust, originating from the Pahadi side towards the Madhesi patients. Many health service providers reported encountering unruly behavior from their clients, raising numerous complaints that reflect an underlying wariness towards the patients' behaviors and broader cultural practices. One health service provider specifically highlighted the issue of visitor control as a major challenge in maintaining law and order within the hospital:

> We made so many rules, regulations, and then there was a pass system. But, that was not successful. In the morning, there is a guard for two to three hours, and he would close the gate when the doctor is on a ward round. But, then just for that five to 10 minutes, there would be an enormous number of visitors. It felt as if they were going to kill.

Another provider shared the concern:

> They do not agree, you know. So, when the gate closes during rounds, we have a fight. 'Why are you closing the gate? Open the gate', they say. 'We are closing the gates because we have rounds going on', we tell them. Then, they say 'I am going to hit you.' Sometimes, they threaten to kill you. When we start arguing a lot, police come.

These comments revealed an underlying fear and distrust from the side of the health service providers towards the clients. A nurse manager tried to make sense of these instances by crediting these behaviors to the culture of Madhesis:

> Let's just say it is the ill-behaved system of Madhesh. When you control, the guard gets beaten up.

Some healthcare providers credited the behaviors to illiteracy on the part of the Madhesis. One credited it to the difference in language:

> There are a lot of people who do not understand the rules and regulations. They do not follow what we ask them to do. I think there is a difference of language.

One healthcare provider shared yet another reason for explaining the unruly behavior. They said that the revolution—alluding to the 2015 Madhesi uprising—was creating more problems for the hospitals:

> They ask – 'do you know who I am?' Similar to that. No one is apprehended for that. Right now, the revolution is creating more problems. (pauses) There is a situation right now where you cannot say anything.

Health service providers' attribution of unruly behavior to the Madhesis' language, illiteracy, culture, and the 2015 revolution may reflect their attempts to make sense of their experiences with Madhesi patients. Within these reasons, hid a more substantial fear and contrast with the Madhesis. One Pahadi health provider shared their frustrations of being associated with an outsider by the Madhesi service recipients:

> Well, you know, we are locals here. We are not people from outside. There are issues like this. We have lived here for so long; we have adjusted here. If they scold us, we tell them 'We are also local here. If you have people in the authority, then we do too.'

These concerns illuminate a profound distrust and cultural misunderstanding that complicates the interactions between Pahadi health service providers and Madhesi service recipients. Providers frequently perceive their authority as challenged, which engenders significant frustration and apprehension. This sense of alienation is exacerbated by the providers'

perception of themselves as outsiders within the very community they are tasked with serving, despite their local status. Such dynamics underscore the urgent necessity for enhanced communication strategies and cultural sensitivity within the healthcare environment, which are essential for fostering more constructive relationships between healthcare providers and patients.

Many workers were quick to acknowledge the limitations that bound their day-to-day practice and tried to reveal that patients' often negative responses were unfair. The healthcare workers pointed to the limited resources and many clients as hindrances to delivering the best care that they were committed to providing. A healthcare provider discussed an instance where patients questioned the delay in delivering medication to them:

> When there is just one health staff, and you have to serve 50 people. You have to take the vital; you have to give the medicine. People then get mad at us. When we start providing medicine at five pm, they ask why we delivered services only at six pm. Some come with sticks to beat us.

Another healthcare worker shared the previous provider's concern by pointing to the constraints and limitations of working as a healthcare professional in the hospital. The healthcare worker then discussed the limited resources that they are bound to work with. They described how patients question the judgment of the healthcare workers on issues like the availability of bed sheets. There was a sense of resignation in many of the healthcare providers' responses. They were upset that despite having done so much hard work the patients were not giving healthcare workers the credit they deserved.

Some health workers acknowledged that there might be room for improvement on their part to improve the services for the patients. They recognized that there might be failures on their side and reasoned that the government could take action to fill the loopholes in care. A health service provider mentioned that despite Narayani Hospital being a sub-regional hospital, the facilities were not up to par. They pointed out that because of a high patient-to-nurse ratio, the services the patients deserve were compromised. They also hinted at the lack of cooperation between different departments of the hospital. So, while healthcare workers expressed frustration over resource limitations and patient dissatisfaction, they also recognized the broader systemic challenges within the hospital's organizational structure, highlighting areas where state intervention could strengthen service delivery.

> I think there is a lack of coordination. For example, the emergency department sends us patients. They should least once should ask how many beds are open. That would make things really easy. They send patients, but we do not have a bed. Where are we supposed to put the patients? That is difficult.

The narratives shared by healthcare workers provide critical insight into the multifaceted challenges faced within the healthcare system, reflecting deeper systemic issues that extend beyond individual interactions. The providers' frustrations highlight a disconnect between patient expectations and the realities of healthcare delivery, exacerbated by inadequate staffing and resource constraints. This gap reveals a troubling dynamic where healthcare workers feel undervalued despite their commitment to patient care.

Discussion

The findings of this research provided opportunities to reflect on Madhesis' perception of health service delivery, their perception of health service providers as well as state legitimacy, and also Pahadi healthcare providers' perception of their Madhesi patients.

Madhesis' perception of state health service delivery

The majority of Madhesi interviewees in the semi-structured interviews expressed satisfaction with the health services delivered by the state hospital. Many pointed to the free healthcare they were receiving as an essential reason for their frequent visits to the hospital. In fact, the cost might have constrained participants' choices in visiting other hospitals. While healthcare

services in Nepal are provided by both the state and private hospitals, most Nepalese cannot afford to seek services in the latter because of the high costs associated with these services (Adhikari *et al.*, 2022; Subedi, 2022). So, many obtain services that are provided by the state, which are either free of charge or require a minimal payment. Narayani sub-regional hospital, where the interviews were conducted, is one state-run hospital that directs health services toward the poor and marginalized. As a result, many impoverished people, including many Madhesis visit Narayani Hospital for health services. Madhesi focus group participants also expressed their approval of public health services.

Madhesis' perception of state health service providers

In the context of this research, Madhesis' acceptance of the legitimacy of health service providers and their trust in these professionals to deliver high-quality care can be understood through the lens of their client-professional relationship with street-level bureaucrats, rather than being primarily defined by ethnic differences. In Nepal, healthcare professionals such as doctors and nurses hold esteemed social status (Adhikari *et al.*, 2021; Askvik *et al.*, 2011). Thus, Madhesis' perceptions of Pahadi healthcare workers may have been shaped less by inter-ethnic dynamics and more by the professional authority and expertise these providers represent.

Although Pahadis, who historically dominate national bureaucratic and military spheres, make up the majority of health service providers, this study reveals unexpectedly high levels of trust from Madhesis towards Pahadi healthcare workers. This trust contrasts with the broader socio-political context marked by historical inequalities and the 2015 Madhesi movement, which articulated grievances against Pahadi dominance. Lipsky's conceptualization of unequal power dynamics inherent in client-bureaucrat relationships helps explain this paradoxical trust. Lipsky argues that street-level bureaucrats wield significant power by monopolizing essential services, compelling clients to rely on state institutions despite their grievances (Lipsky, 1980). This coercive relationship often limits clients' alternatives, reinforcing their dependence on bureaucratic authority.

Furthermore, instances cited by healthcare workers where deviant client behavior led to punitive measures, such as police involvement, illustrate the discretionary power bureaucrats exercise in defining and enforcing behavioral norms (Lipsky, 1980). This power dynamic underscores Madhesis' limited agency in healthcare settings, where dissent often results in legal repercussions. Thus, while Madhesis express frustrations with broader socio-political inequalities, their compliance with and trust in Pahadi healthcare workers suggest a nuanced negotiation of power dynamics in the healthcare service delivery context.

Madhesis' perception of state legitimacy

Members of the Madhesi ethnic group, who historically questioned state legitimacy through revolutions in 2007 and 2015, generally held favorable views toward the state. One plausible explanation for this phenomenon is that the Madhesis perceive the state's health service delivery as equitable and just, creating a spillover effect that fosters their recognition of state legitimacy. This aligns with the belief that service delivery, especially in healthcare, can influence perceptions of legitimacy (Kruk *et al.*, 2010; Saulnier *et al.*, 2024). However, previous research emphasizes the complex, non-causal relationship between service delivery and state legitimacy, cautioning against assuming a linear connection (Brinkerhoff *et al.*, 2012; Rinne-Koski and Lähdesmäki, 2024). Future studies exploring other variables, such as access to education and employment opportunities, may reveal a more nuanced interplay between service delivery and state legitimacy. This study could be a precursor to a more extensive investigation.

Madhesis' interactions with the state often occurred through health service providers, representing instances of policy delivery. The Nepalese government implements its health policies through public sector providers, who are integral parts of the health bureaucracy.

Madhesis' positive experiences with these healthcare workers likely shape their perceptions of state legitimacy within the health service domain. Additionally, limited exposure to private healthcare facilities, due to prohibitive costs, means that many Madhesis have no basis for comparison. Consequently, their approval of state-provided health services may reflect a spillover effect of their satisfaction with the accessible public health services they routinely encounter. Nevertheless, Madhesis experience the state partly through the mechanisms of the health service providers they interact with. In fact, most citizens encounter the state (if they encounter it at all) not through letters to congressmen or by attendance at school board meetings but through their children's public teachers, the policeman on the corner or in the patrol car, or while receiving driver's license. Each encounter of this kind represents an instance of policy delivery (Lipsky, 1980). Nepal's government implements its health policy through the public sector health service providers, who are the appendages of the overall health bureaucracy. Madhesis' experience towards the healthcare workers is primarily positive, and such knowledge could be attributable to their positively influenced perceptions about the state's legitimacy within the health service delivery domain.

Another plausible explanation for Madhesis' positive impression could be their limited experiences with alternative forms of health delivery, particularly private hospitals and clinics. Many Madhesis interviewed for this study had never interacted with these private facilities due to the high costs of care, limiting their frame of reference for judging the quality of the government facilities. Their perceptions of state legitimacy may stem from this narrow purview; from their perspective, the state was making significant efforts to ensure quality health services for all. However, it is essential to consider how the experiences of Madhesis who have accessed private healthcare facilities might offer a different perspective on state legitimacy. Those who could afford private care might hold more critical views of state-run facilities. Comparisons between public and private healthcare services—particularly in terms of quality, accessibility, and patient satisfaction—could reveal disparities that influence perceptions of the state's role in delivering equitable care. This divergence in experiences might suggest that while state healthcare services may be viewed favorably by those without alternatives, individuals with access to private care might question the state's effectiveness in providing universally high-quality services. Exploring these potential differences could enhance understanding of how healthcare service delivery shapes perceptions of state legitimacy.

Researchers have pointed out that certain services such as healthcare might be more salient in the negotiations of legitimacy in fragile countries (Jawad *et al.*, 2021; McCullough and Hennessey, 2020). This might also help explain the high degree of legitimacy that Madhesis bestowed on the state—through their interactions with the healthcare providers. Healthcare might be afforded special status because it is usually considered a universal value, prized irrespective of ideologies or identities (Hordern, 2021; Kruk *et al.*, 2010). However, other researchers have noted that while sector characteristics are important, state legitimacy is multi-layered and multifaceted (Brinkerhoff *et al.*, 2012; Hickey *et al.*, 2014; Murphy, 2023). There might be an overlap and interaction of these sectors, and the hierarchy might be context-dependent given the normative value of different services (Gül, 2023; Mcloughlin, 2017). In the Nepali context, health is considered a human right and enshrined in the constitution, which might influence the normative value of the people about service delivery in this sector.

Pahadis' perception of Madhesi service recipients

The study revealed that Pahadi healthcare providers harbored significant distrust towards Madhesi service recipients, a sentiment likely influenced by the broader socio-political dynamics between Pahadis and Madhesis during the study period. Historically, the Madhesis have experienced considerable socio-political marginalization, often being perceived as outsiders due to their closer ties with India, with many questioning their nationality as true Nepalese (Gautam, 2021; Gellner, 2007; Hachhethu, 2023). The presence of fringe political

movements in Madhesh advocating for regional autonomy or a separate Madhesh state further fueled these suspicions, as Pahadi elites utilized these movements to frame Madhesis as aligned more closely with Indian interests rather than national unity. This pervasive suspicion and antagonism likely permeated the interactions between Pahadi street-level bureaucrats and their Madhesi clients. Despite possessing significant advantages in social, political, and bureaucratic spheres, Pahadi healthcare providers exhibited notable skepticism towards Madhesi health recipients. This identity-based conflict thus significantly shaped the relationship between healthcare workers and clients, providing a framework to understand the underlying distrust.

Additionally, the frame of reference for these healthcare workers—where they predominantly view clients through an ethnic lens while clients prioritize the professional provider-patient relationship—offers a unique perspective for understanding state legitimacy. This dichotomy suggests that while Pahadi providers' skepticism is rooted in ethnic identity, Madhesi clients focus on the expected professional conduct and care provision. In several interviews, Pahadi healthcare workers mentioned perceiving Madhesi clients as ungrateful or demanding, sentiments that seem to stem from a broader ethnic understanding of Madhesi behavior. For instance, one Pahadi doctor reported that Madhesi families desired to visit their loved ones even when the gates to the hospital were closed while doctors were on rounds. They credited the misunderstanding to the culture of Madhesi people. It revealed an implicit bias where ethnic identity influences the interpretation of client demands. These examples from the findings illuminate the complex dynamics where healthcare workers' perceptions are shaped by ethnicity, creating an additional barrier to equitable service delivery.

However, the Madhesi clients themselves frequently described their interaction with healthcare workers as being primarily about their health needs, downplaying any ethnic framing. They reported that the doctors and nurses were well educated and professional, and took good care of them. This gap in perception illustrates how ethnic discord does not always manifest as a central issue for clients, who prioritize professional relationships over ethnic identity. These contrasting views reflect broader issues in health service delivery, where the structural imbalances created by ethnic biases are often invisible to those receiving services but are palpable to those delivering them. This suggests that while ethnic dynamics undeniably shape the delivery of care, Madhesi clients are less focused on ethnicity and more on the professional obligations of healthcare providers.

Additionally, the healthcare providers characterized the relationship as marked by a perceived inability of the Madhesis to appreciate the challenges faced by the healthcare workers. Lipsky's framework on street-level bureaucracy elucidates this perspective, suggesting that street-level bureaucrats, who often provide essential services where citizens have no alternatives, expect deference from clients due to the nonvoluntary nature of their interactions (Lipsky, 1980). Lipsky argues that compliance in these bureaucracies typically stems from the workers' superior position, control over benefits, and their ability to withhold or complicate access to these benefits (Lipsky, 1980). When their authority is questioned, bureaucrats are likely to reprimand or penalize deviations from expected client behavior (Lipsky, 1980). The frustrations and anger expressed by healthcare workers may thus reflect their perceived challenge to authority by the Madhesi clients.

This imbalance of power is starkly evident in how healthcare workers recall instances of patient behavior deemed inappropriate. For example, one healthcare worker recounted how many of the patients' demands led to altercations that resulted in the hospital calling security, highlighting how deviations from expected patient behavior were swiftly reprimanded in this environment. From the healthcare workers' perspective, their authority is grounded in the limited options Madhesi patients have for seeking alternative care, reinforcing their power within the healthcare setting. These types of interactions point to a deeper structural issue, where Madhesi patients' distrust of state institutions collides with healthcare workers' expectations of compliance, thus perpetuating a cycle of misunderstanding and ethnic tension.

Contributions to the literature

Confirms dynamic and non-causal relationship between service delivery and state legitimacy. This study advances the understanding of the relationship between service delivery and state legitimacy by demonstrating that it is neither linear nor causal, but dynamic and context-dependent. Specifically, it reveals that Madhesis' perceptions of state legitimacy are shaped by repeated interactions with the health service providers, where they continuously negotiate their service delivery needs. This iterative process suggests that state legitimacy evolves through continuous engagement rather than being a static phenomenon. While the non-linear nature of the relationship between service delivery and state legitimacy has been documented in some fragile state contexts such as Sri Lanka and Pakistan, this study contributes novel empirical evidence from the health sector, highlighting the critical role of co-construction in shaping state legitimacy (Fisk and Cherney, 2017; Godamunne, 2015; McCullough *et al.*, 2020).

Highlights sector-specific dynamics between service delivery and state legitimacy. This study contributes to the growing body of literature examining the relationship between service delivery and state legitimacy within the healthcare sector. The findings suggest that this relationship may be domain specific. Unlike other sectors such as water delivery and social services, healthcare possesses unique characteristics, including information asymmetry, where health service providers hold specialized knowledge that patients lack. The asymmetry results in a high level of deference, significantly influencing recipients' perceptions of legitimacy (Kruk *et al.*, 2010). Previous research has highlighted the non-causal nature of the relationship between service delivery and state legitimacy; yet, this study underscores the importance of considering such relationships within specific domains rather than generalizing them across sectors (Brinkerhoff *et al.*, 2012).

Detects the impact, or lack thereof, of ethnic discord in shaping the service delivery-state legitimacy relationship. The study contributes novel insights to the academic literature by suggesting that ethnic discord may not significantly influence how individuals perceive the legitimacy of state healthcare services. This finding is particularly valuable because it highlights that other factors, such as accessibility of health of healthcare, its cost, and professional authority of healthcare providers, may be more influential than ethnic divisions in shaping perception of state legitimacy. These insight emphasize the need for more nuanced examinations of how socio-political and institutional dynamics, beyond ethnic identity, shape citizens' perceptions of state legitimacy (Brinkerhoff *et al.*, 2012). This study also encourages further exploration of diverse, context-specific factors—such as service accessibility and institutional efficiency—that can influence public trust, providing a deeper understanding of interplay between ethnicity, service delivery, and state legitimacy.

Contributes to the street-level bureaucracy research literature. This study advances the street-level bureaucracy literature by providing a novel focus on the perception of care recipients, particularly from marginalized groups like the Madhesis, rather than primarily examining the perspective of bureaucrats. By foregrounding how healthcare recipients interpret and navigate their interactions with state health services, the study offers critical insights into the power dynamics between service providers and clients. It highlights how citizens' engagement with bureaucratic systems shapes their perception of service delivery, and consequently, their view of state legitimacy. This contribution underscores the need for street-level bureaucracy research to incorporate recipient perspectives as a key factor in understanding service delivery outcomes, especially in diverse and politically fragile settings.

Limitations

A limitation of this study was the sampling bias, as the research was limited to one government hospital and only included Madhesi participants who visited the hospital. This research did not account for Madhesis attending private hospitals, due to the limited scope of the study. Additionally, there were security concerns, which prevented the author from reaching the rural parts of Parsa that were primarily removed from the security apparatus. Selection criteria

further contributed to potential bias, as participants were selected based on their access to the government hospital, which may not fully reflect the broader Madhesi population. The limited inclusion of only five healthcare providers may also affect the comprehensiveness of the findings.

Another limitation was the absence of data management software, which may raise concerns about data organization, consistency, and reliability during the analysis. Due to financial constraints, manual data management was the most feasible option for this study, though the author acknowledges the benefits of using such software and plans to implement it in future research.

The data collection and analysis conducted solely by the author is another limitation that could introduce bias. Financial constraints and the expectations of the Master's program meant that the research had to be conducted independently. An interpreter, fluent in Bhojpuri and Nepali, helped ensure accuracy in participant feedback. However, the author recognizes that involving additional researchers would have helped mitigate potential biases and hopes to collaborate in future studies.

Interview bias also represents a limitation, as participants may have provided socially desirable responses or modified their feedback based on their perceptions of the interviewer. Additionally, the methodology of relying on in-person interviews may have inadvertently influenced participant responses, as participants may feel compelled to respond differently in face-to-face settings.

Finally, sample size is a significant limitation. The small sample size, particularly among healthcare providers, limits the generalizability of the study. While key themes were identified in line with the research objectives, the author acknowledges that a larger and more diverse sample would likely enhance both the credibility and the generalizability of the findings. Future research should aim to include a broader sample to better capture the complexity of the topic.

Future research and policy recommendations

This study lays the groundwork for several targeted research inquiries. First, researchers should explore how social factors beyond health services—such as employment opportunities, education quality, and social mobility—shape Madhesis' perceptions of state legitimacy. Investigating the relative influence and interaction of these domains will provide a more nuanced understanding of how state legitimacy is formed across multiple areas of governance. Since Madhesis engage with the state through various sectors, exploring whether perceptions of legitimacy in one domain spill over into others will be crucial. This insight could guide policymakers in deciding between sector-specific reforms or broader government-wide initiatives to improve service delivery.

Second, cross-setting studies are needed to examine how local socio-political, historical, and cultural contexts influence perceptions of legitimacy. For example, ethnic tensions between Pahadis and Madhesis in Nepal may not mirror the dynamics between Kurds and Arabs in Iraq, where different historical and cultural factors shape ethnic relations. Identifying both commonalities and distinctions will enable a more culturally sensitive understanding of ethnic discord across various regions.

Third, future research should incorporate mixed-methods and longitudinal designs. Mixed-methods approaches would provide a richer, more comprehensive view by combining quantitative and qualitative data, capturing both the breadth and depth of experiences. Longitudinal studies, on the other hand, would track changes in perceptions over time, offering insights into how ethnic dynamics and state legitimacy evolve with changing political or social conditions.

Fourth, while Lipsky's street-level bureaucracy theory contextualized the interethnic dynamics between Madhesis and Pahadis, it left some questions unanswered—such as why some Madhesis are dissatisfied despite generally positive feedback and why some healthcare

workers acknowledge service quality issues self-critically. Future research should address these gaps with a larger sample size, presenting an opportunity to expand the theory of street-level bureaucracy within ethnically discordant contexts.

Additionally, future research should investigate how perceptions of state legitimacy differ between Madhesis who utilize private healthcare facilities and those who rely on public hospitals. Understanding these comparisons could reveal insights into the quality and accessibility of health services and their impact on perceptions of state legitimacy. Exploring these potential differences will add depth to the understanding of how healthcare service delivery shapes perceptions of state legitimacy.

This study offers Nepali health policymakers the opportunity to better understand the perspectives of health service recipients in Madhesh. Madhesi voices have largely been excluded from public policy debates in Nepal. Thus, providing policymakers with stories that reflect anger, frustrations, and even admiration provides empirical evidence to develop policies that address challenges and build on successes. It may also influence international development and health service delivery organizations to emphasize strengthening health governance, particularly in fragile countries like Nepal.

Several policies can be implemented. First, given that many Madhesis rely on state hospitals due to cost constraints, it is crucial for policymakers to ensure that state health services remain accessible and adequately funded. Specifically, efforts should be made to increase funding for public health initiatives, ensuring that essential services continue to be provided without direct costs to patients, thus preventing service disruptions that could affect Madhesis' perceptions of state legitimacy.

Second, while Madhesis generally expressed satisfaction with healthcare services, there remains a need to address the underlying ethnic tensions that influence provider-recipient relationships. Specifically, healthcare providers, particularly Pahadis, should undergo mandatory cultural competency training that focuses on understanding the socio-political context of Madhesis. This training should particularly emphasize effective communication strategies and methods to build trust with Madhesi patients, considering the historical background of distrust towards Madhesis.

Third, while the study underscores a generally positive perception of state health services among Madhesis, it also reveals the enduring impact of socio-political inequalities that disproportionately affect marginalized groups. To promote health equity, policymakers must center the voices and lived experiences of these communities in policy development. This includes crafting and implementing health policies that not only address the distinct needs of marginalized ethnic groups but also dismantle systemic barriers to equitable care. Ensuring authentic representation of Madhesis and other marginalized communities in decision-making spaces, both at the state and national levels, is essential. By amplifying their agency, these groups can advocate for transformative policies that foster inclusivity, accountability, and justice in health service delivery.

Conclusion

To conclude, this research aimed to explore the relationship between service delivery and state legitimacy through the perspective of Madhesis, an ethnic minority in southern Nepal. The study examined how Madhesis experience state-delivered healthcare services and analyzed the influence of such experience on their perceptions of the state's legitimacy.

The findings were surprising and challenged the assumption that Madhesis' anger and frustration against the state would extend into the healthcare domain. Instead, this research found out that the majority of Madhesis held favorable views not only of the health services they received but also the health service providers, many of whom belong to the Pahadi ethnicity. Madhesis did not question the state's legitimacy; in fact, they praised the state's commitment to providing them with free and equitable health services. The skepticism and discontent came from the healthcare providers, the street-level bureaucrats, who viewed their

Madhesi clients as ill-behaved and distrustful. They perceived Madhesis as frequently questioning their medical decisions and challenge their authority. This research thus reveals the discrepancies in perspectives on the relationship between the ethnic majority and minority viewed through the angles of these two groups. Their differing frames of reference may explain the variation in understanding the relationship. While the street-level bureaucrats viewed their clients primarily through the lens of ethnicity, the clients saw the workers in a professional light, where the provider-patient relationship overshadowed ethnic divisions. The Madhesis' positive evaluation of the state's legitimacy may be attributed to the spillover effect of their approval of the workers, who are after all, extensions of the state.

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