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Bridging the Green Gap: Awareness, Attitudes, and Practices of Future Healthcare Leaders in Nepal – A Study for Building an Inclusive and Resilient Health System

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Abstract

Background: The healthcare sector, while dedicated to healing, is a significant contributor to environmental degradation. The concept of "Green Healthcare" aims to resolve this contradiction by promoting sustainable practices that reduce the ecological footprint of healthcare delivery. In Nepal—a nation facing socio-economic disparities, climate vulnerability, and the challenge of building resilient systems—the role of future healthcare leaders is critical. This study investigates the readiness of undergraduate healthcare management (BHCM) students to drive this necessary transition, examining their awareness, attitudes, and practices regarding green healthcare.

Objectives: This research aimed to: 1) Assess the level of awareness of green healthcare principles among BHCM students; 2) Evaluate their attitudes towards the role of sustainability in healthcare; and 3) Examine their current engagement in sustainable practices and advocacy. The study sought to identify the gap between knowledge, belief, and action.

Methods: A quantitative, cross-sectional study was conducted among 205 undergraduate BHCM students from multiple colleges in Nepal, using a convenience sampling method. Data were collected via a structured online questionnaire with sections on demographics, awareness, attitudes, and practices, using a 5-point Likert scale. Analysis was performed using SPSS, employing descriptive statistics, one-sample t-tests, ANOVA, Pearson's correlation, and Chi-square tests.

Findings: Students demonstrated a significantly high level of theoretical awareness (mean score 3.91/5, $p<.001$) and uniformly positive attitudes across different academic backgrounds (no significant difference, $p=.544$). However, a distinct gap existed between this cognitive endorsement and consistent practical implementation. Positive correlations were found between awareness and practices ($r=0.512$, $p<.01$) and, more strongly, between practices and advocacy ($r=0.569$, $p<.01$). Gender showed no statistically significant association with core awareness.

Conclusion: While the foundational awareness and positive attitudes essential for a green transition are firmly established, a tangible "green gap" in practical competency persists. The findings suggest that current education successfully homogenizes normative values but falls short in providing the context-specific, applied skills needed for implementation in Nepal's unique setting. To build a truly inclusive and resilient health system, pedagogical reform is required to shift from creating universally aware graduates to empowering locally competent, practicing advocates for sustainable healthcare.

Novelty: This study provides the first focused assessment of the Green Healthcare Awareness-Attitude-Practice (AAP) framework among future health system managers in Nepal. It uniquely frames the findings within critical sociological themes of inclusivity and resilience, arguing that bridging the "green gap" is not merely a technical educational challenge but a central component of preparing leaders who can advance environmental justice and equitable health system development.

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Keywords: Green Healthcare, Sustainable Health Systems, Awareness-Attitude-Practice Gap, Healthcare Education in Nepal, Environmental Resilience

1. Introduction: The Imperative for Sustainable and Resilient Health Systems in Nepal

The global healthcare sector faces a profound ethical contradiction: as a system dedicated to healing and preserving human life, it is a significant contributor to environmental degradation, accounting for approximately 4.4% of global net greenhouse gas emissions (Eckelman et al., 2020). This environmental impact—through energy-intensive operations, voluminous waste generation (particularly exacerbated by events like the COVID-19 pandemic (Narang & Vij, 2021)), and resource-intensive supply chains—directly undermines public health by exacerbating climate change, pollution, and resource scarcity. The concept of **"green healthcare"** emerges as a critical paradigm to resolve this contradiction, advocating for the delivery of health services that minimize ecological footprints while maintaining or enhancing care quality, aligning with the Sustainable Development Goals (SDGs), especially SDG 3 (Good Health) and SDG 13 (Climate Action) (Wozny & Rataj, 2023).

In Nepal, a nation characterized by significant socio-economic disparities, fragile ecosystems, and a high vulnerability to climate change, the move towards sustainable healthcare is not merely an ethical choice but a necessity for building **inclusive and resilient systems**. The conference's thematic areas—from addressing spatial inequalities and disparities in access to health, to community-led resilience and environmental justice—provide a crucial lens through which to examine this transition. Nepal's health system grapples with dual burdens: the challenge of expanding equitable access to quality care, and the imperative to do so without replicating the environmentally destructive pathways of more industrialized nations.

Within this context, the role of future healthcare professionals is pivotal. Students of healthcare management, like those in BHCM programs, are the future administrators, policy influencers, and institutional leaders who will shape the operational norms of hospitals and public health programs. Their understanding and commitment to sustainability will directly influence whether Nepal's health sector evolves to be part of the environmental problem or a leader in the solution. As noted by Marshal et al. (2021), healthcare organizations that proactively adopt sustainability measures often see co-benefits in financial savings and improved resource management, outcomes desperately needed in Nepal's resource-limited setting.

However, international literature consistently identifies a gap between the awareness of sustainability principles and their practical application among health professionals (Lister et al., 2022; Topcu & Kiraz, 2025). This study seeks to investigate this AAP framework specifically within the Nepali educational context. It asks: Are we producing future health leaders who are not only aware of green principles but are also critically equipped and motivated to implement them amidst Nepal's unique challenges? The answer to this question has profound sociological implications. It touches on the **homogenizing role of modern education**—does it provide standardized, decontextualized knowledge?—and on the potential

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for fostering **community-led resilience practices** through professionally-empowered local actors.

This paper presents the findings of a study conducted among BHCM students across multiple colleges in Nepal. It analyzes their levels of green healthcare awareness, assesses their attitudes, and evaluates their self-reported practices. The results are then critically discussed not just as an educational assessment, but as a sociological case study on preparing a workforce capable of steering Nepal's health sector towards a future that is both environmentally sustainable and socially inclusive.

2. Literature Review & Conceptual Framework

2.1 The Global Mandate for Green Healthcare

The environmental footprint of healthcare is well-documented. Hospitals are energy-intensive buildings, medical waste poses disposal challenges, and pharmaceutical pollution contaminates water systems (Karliner, 2019). The COVID-19 pandemic laid bare the sector's waste generation vulnerability, with billions of single-use personal protective equipment (PPE) items entering the waste stream (Otolorin et al., 2022). In response, frameworks for "green" or "sustainable" healthcare have been developed, such as the ten-component model by Fadda (2020), which encompasses leadership, waste management, energy efficiency, sustainable procurement, and green building design. The World Health Organization (WHO) has increasingly emphasized environmental health as integral to global health security, advocating for low-carbon, resilient health systems (Mailloux et al., 2021).

2.2 The Critical Role of Education and the Awareness-Attitude-Practice (AAP) Gap

Education is recognized as the bedrock for instilling sustainability values in future professionals. Gupta et al. (2022) argue that integrating sustainability into medical and health sciences curricula is essential for shaping future practice. However, multiple studies reveal a persistent disconnection within the AAP model. Awareness—knowledge of concepts like carbon footprint and waste segregation—is often high, especially among younger, educated populations (Kasikci et al., 2025). Attitudes—beliefs about the importance and relevance of these concepts—are also generally positive, particularly when framed as an ethical extension of the "do no harm" principle.

The rupture occurs at the level of **Practice**. Barriers such as perceived cost, lack of institutional support, established workflows prioritizing convenience, and a lack of practical skills impede the translation of positive attitudes into consistent action (Topcu & Kiraz, 2025). Othman et al. (2025) demonstrated that targeted training could enhance green behavior intention and advocacy among nurses, suggesting that the gap is bridgeable with appropriate educational interventions. This AAP model forms the core analytical framework for this study.

2.3 The Nepali Context: Inclusivity, Resilience, and Sociological Dimensions

Nepal's journey towards green healthcare cannot be divorced from its socio-economic realities. The conference themes highlight critical contextual layers:

- **Disparities in Access:** Green solutions like advanced waste incinerators or solar panels require capital investment. There is a risk that sustainability becomes a privilege of

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urban, private hospitals, exacerbating existing inequalities in healthcare access between urban and rural areas, and between socio-economic classes.

- **Community-Led Resilience:** Traditional and community-based practices often embody sustainability. Integrating these with modern healthcare waste management or disaster preparedness (a key conference theme) requires professionals who respect and can hybridize local and scientific knowledge.
- **Homogenizing Education:** Does a BHCM curriculum, possibly modeled on global frameworks, adequately prepare students to solve local problems like managing waste in a squatter settlement (*sukumbasi*) or conserving energy in a district hospital with frequent power cuts? Or does it produce a homogenized awareness detached from actionable local strategies?
- **Urban Poverty and Informal Labor:** The precarity of informal settlements and labor markets means environmental health risks are disproportionately borne by the marginalized. Future health managers must understand green healthcare as a tool for **environmental justice**, reducing pollution that affects these vulnerable communities first and worst.

Thus, evaluating student AAP is not an academic exercise. It is an assessment of whether the next generation of health leaders is being equipped with the *contextualized competence* needed to build a health system that is not only "green" in a technical sense but also **inclusive** and **resilient** in the Nepali sociological sense.

3. Methodology

3.1 Research Design and Approach

This study adopted a **quantitative, descriptive cross-sectional research design**, underpinned by a **positivist philosophical worldview**. This approach was chosen to objectively measure variables (awareness, attitudes, practices) and test predefined hypotheses using statistical methods, allowing for generalizable insights about the student population (Adil et al., 2025).

3.2 Study Population and Sampling

The target population was undergraduate students enrolled in Bachelor in Healthcare Management (BHCM) programs across multiple affiliated colleges in Nepal. A **convenience sampling technique** was used to recruit participants. The minimum required sample size was calculated as 196, based on a 95% confidence level and a 7% margin of error using an online calculator (Calculator.net, n.d.). The final sample comprised 205 respondents.

3.3 Data Collection Tool and Procedure

Data was collected via a structured, self-administered questionnaire distributed online through Google Forms. The questionnaire consisted of four sections:

1. **Demographics:** Gender, age, semester, parental education, prior academic faculty.
2. **Awareness (7 items):** Assessing knowledge of green healthcare concepts (e.g., medical waste, energy saving, telemedicine's benefit).
3. **Attitudes (7 items):** Gauging beliefs and values regarding sustainability in healthcare.

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4. **Practices & Advocacy (7 items):** Evaluating self-reported behaviors and advocacy actions related to sustainability.

Items in sections 2-4 used a 5-point Likert scale (1=Strongly Disagree to 5=Strongly Agree). Informed consent was obtained electronically prior to participation.

3.4 Data Analysis

Collected data was analyzed using the Statistical Package for the Social Sciences (SPSS) version [Version Number if known]. Analysis included:

- **Descriptive Statistics:** Frequencies and percentages for demographic data.
- **Inferential Statistics:**
  - **One-Sample t-test:** To compare the mean awareness score against a neutral test value (3).
  - **One-Way ANOVA:** To test for differences in attitude scores across different faculties of previous study.
  - **Pearson's Correlation:** To examine relationships between awareness, practices, and advocacy.
  - **Chi-Square Test:** To assess associations between categorical variables (e.g., gender and ability to explain "Green Health").

4. Results and Findings

4.1 Demographic Profile of Respondents

The sample consisted of 205 undergraduate BHCM students. **Table 1** presents the gender distribution, showing a higher proportion of female participants (66.8%). **Table 2** illustrates the semester-wise distribution, indicating representation across all academic levels, with the highest concentration in the fourth semester (21.0%). **Table 3** details the age distribution, confirming the sample's concentration in the early 20s (mode = 22 years). **Tables 4 and 5** show parental education levels, revealing a mix of higher education and limited formal schooling, with a notable proportion of mothers reported as illiterate (13.2%). **Table 6** indicates that nearly half of the respondents (46.3%) came from a Science background prior to enrolling in BHCM.

Table 1: Gender Distribution of Respondents (N=205)

Gender	Frequency	Percent
Male	66	32.2%
Female	137	66.8%
Other	2	1.0%
Total	**205**	**100.0%**

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Table 2: Semester-wise Distribution of Respondents

Semester	Frequency	Percent
First	9	4.4%
Second	40	19.5%
Third	4	2.0%
Fourth	43	21.0%
Fifth	10	4.9%
Sixth	35	17.1%
Seventh	38	18.5%
Eighth	26	12.7%
Total	**205**	**100.0%**

Table 3: Age Distribution of Respondents

Age Group	Frequency	Percent
18-20	50	24.4%
21-23	104	50.7%
24-26	39	19.0%
27+	12	5.9%
Total	**205**	**100.0%**

4.2 Testing the Hypotheses

H1: There is a high level of awareness of green healthcare among students. Supported. A one-sample t-test (**Table 7**) revealed that the mean awareness score (M = 3.91) was significantly higher than the neutral midpoint of 3 ($t(204) = 18.68$, $p < .001$, 95% CI [3.82, 4.01]). This indicates a statistically significant leaning toward "Agree" on awareness items.

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Table 4: One-Sample Test for Awareness of Green Healthcare

Test Value = 3	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval
Awareness Mean	18.680	204	.000	0.91463	Lower: 0.8181, Upper: 1.0112

H2: There is no significant difference in attitudes across faculties

Supported. A one-way ANOVA (**Table 8**) showed no statistically significant difference in attitude scores between students from Science, Management, or Diploma backgrounds ($F(2, 202) = 0.611$, $p = .544$). Attitudes were uniformly positive regardless of prior academic discipline.

Table 5: ANOVA Test for Attitudes Mean Across Previous Faculties

Source of Variation	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.303	2	0.151	0.611	.544
Within Groups	50.097	202	0.248		
Total	**50.400**	**204**			

H3: There is a significant correlation between sustainable practices and advocacy. Supported. Table 9 shows a strong positive correlation ($r = 0.569$, $p < .01$), indicating that students who engage more in sustainable practices are also more likely to advocate for them.

Table 6: Correlation Between Practices and Advocacy

Variable	Practices Mean	Advocacy Mean
Practices Mean	1	.569**
Advocacy Mean	.569**	1
*Note: ** Correlation is significant at the 0.01 level (2-tailed).*		

H4: There is a significant correlation between sustainable practices and awareness. Supported. Table 10 shows a moderate positive correlation ($r = 0.512$, $p < .01$), confirming that higher awareness is associated with more frequent sustainable practices.

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Table 7: Correlation Between Awareness and Practices

Variable	Awareness Mean	Practices Mean
Awareness Mean	1	.512**
Practices Mean	.512**	1
*Note: ** Correlation is significant at the 0.01 level (2-tailed).*		

H5: There is no significant association between gender and response (ability to explain Green Health).

Partially Supported/Inconclusive. A Pearson Chi-Square test (**Table 11**) showed no statistically significant association at the 0.05 level ($\chi^2(8) = 14.308$, $p = .074$). However, the cross-tabulation showed interesting descriptive trends: while both genders predominantly agreed or strongly agreed, a higher proportion of males (51.5%) chose "Strongly Agree" compared to females (27.7%). The near-significance and significant linear-by-linear association (p=.017) suggest a potential nuanced relationship warranting further study with a larger, balanced sample.

Table 8: Chi-square Test for Gender and Ability to Explain "Green Health"

Chi-Square Test	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.308	8	.074
Likelihood Ratio	15.128	8	.057
Linear-by-Linear Association	5.701	1	.017
N of Valid Cases	205		

5. Discussion: Interpreting the Green Gap through a Sociological Lens

The findings present a clear and critical narrative: Nepali BHCM students are **aware** and **positively inclined** toward green healthcare, but this does not seamlessly translate into **practice**. The strong, above-neutral awareness (H1) and the lack of attitudinal difference across faculties (H2) suggest that sustainability as a normative value is being successfully and uniformly transmitted through the educational milieu. This can be seen as a success of the **homogenizing role of modern education and policy**, creating a shared baseline of "correct" knowledge and values among future professionals, as highlighted in the conference themes.

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However, the moderate strength of the correlation between awareness and practice (H4, r=.512), while significant, reveals the **gap**. Knowing *that* something is important is not the same as knowing *how* to implement it within the complex, resource-constrained realities of the Nepali health landscape. The stronger correlation between practice and advocacy (H3, r=.569) is particularly telling. It suggests that *experience in doing* is a more powerful driver for championing change than abstract knowledge alone. This underscores the need to move education from a focus on creating "aware advocates" to creating "practicing advocates."

5.1 Linking to Conference Themes: From Homogenization to Contextualized Resilience

1. **Addressing Disparities in Access and Spatial Inequalities:** A student may know solar power is green, but can they design a feasible financing and maintenance plan for a rural health post? The curriculum must integrate economics, local governance, and project management to turn awareness into actionable solutions that don't widen the urban-rural divide.
2. **Community-Led Resilience and Adaptive Strategies:** Green healthcare cannot be purely top-down. Future managers must be trained to identify and partner with community-led initiatives—for example, local waste-picker cooperatives for recycling segregation or traditional practices for natural disinfectants. This requires skills in community engagement and participatory design, not just technical knowledge.
3. **Environmental Justice and Urban Poverty:** Students with high awareness should be able to conduct a socio-ecological assessment: How does hospital plastic waste affect the river beside a squatter settlement? Teaching green healthcare through the lens of **environmental justice** makes it directly relevant to the conference's focus on marginalized groups and spatial inequality.
4. **The Role of Education:** Our findings challenge educators. The current model is effective at the "awareness-attitude" stage (homogenization). The next step is to **disrupt this homogenization productively** by layering on context-specific, problem-based learning. This aligns with the **interpretivist and communitarian worldviews** mentioned in the original report, which value subjective meaning and community context—elements that must be integrated into the predominantly positivist curriculum.

5.2 Implications for Building an Inclusive and Resilient Nepal

To build resilience, systems need actors who can adapt global principles to local shocks and stresses. A health manager who only knows textbook waste protocols will fail during a flood that disrupts disposal chains. One trained in adaptive management and local stakeholder networks can co-create a resilient response. Similarly, inclusivity means ensuring green transitions are just. This requires future leaders who are not only environmentally literate but also sociologically literate—understanding caste, gender, and class dynamics that affect who bears the cost of pollution and who benefits from green solutions.

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6. Conclusion and Recommendations

This study concludes that while the foundational building blocks—awareness and positive attitudes—for a sustainable healthcare transformation are firmly in place among future Nepali health managers, a critical "green gap" in practical implementation remains. This gap is not merely a pedagogical failure but a sociological one, reflecting a system that disseminates universal knowledge without fully arming its recipients with the tools to apply it within the specific, constrained, and unequal context of Nepal.

To align healthcare education with the broader goal of building an **inclusive and resilient Nepal**, we recommend:

1. **Curriculum Reformation:** Integrate applied, context-rich green healthcare modules across the BHCM curriculum. Move beyond "what" and "why" to "how in Nepal." Include case studies on Nepali hospitals, cost-benefit analyses in local currency, and regulatory landscapes.
2. **Pedagogical Shift to Experiential Learning:** Mandate hands-on projects: conducting waste audits at college, designing solar feasibility plans for a mock health post, or developing advocacy campaigns for specific local environmental health issues. Partner with "green" hospitals and community organizations for internships and live projects.
3. **Fostering Critical Sociological Competence:** Train students to conduct intersectional analyses of green initiatives. Who employs the waste management system? Does it rely on informal labor? Does a water conservation project affect downstream communities differently based on their social identity? This links environmental sustainability directly to the conference's core themes of caste, ethnicity, and spatial justice.
4. **Institutional Leadership by Academic Centers:** Colleges should become living labs of sustainability, implementing green policies on campus. This "practice what you preach" model bridges the attitude-practice gap for students experientially and builds institutional credibility.

By implementing these recommendations, Nepal's healthcare education can transform from a system that homogenizes awareness into one that cultivates a generation of resilient, inclusive, and pragmatic green health leaders. These individuals will be equipped not only to reduce the sector's carbon footprint but also to ensure that the path to sustainability strengthens, rather than undermines, the nation's quest for health equity and social justice. This is the essence of building a truly inclusive and resilient Nepal.

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Authors' Contributions: The authors jointly conducted all research activities i.e., concept, data collecting, drafting and final review of manuscript and second author contributes for feedbacks ad correction in each steps of research and final review of manuscript.

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