

Original Article

Evaluating the Effectiveness of Health Policy Implementation Within Pakistan's Public Health System.

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ABSTRACT

Background: Despite extensive policy development, Pakistan's public health system continues to face challenges in translating policy into effective implementation. Limited empirical evidence exists on how policies are operationalized across different levels of the system, particularly from the perspective of key stakeholders. **Objective:** To explore stakeholder perceptions of health policy implementation effectiveness in Pakistan, identify key barriers and facilitators, and examine how policy intentions are translated into practice. **Methods:** A qualitative, interpretative study was conducted using semi-structured interviews with stakeholders including policymakers, district health managers, frontline healthcare providers, and development partners. Data were analyzed thematically following an inductive approach, with dual coding and iterative refinement of themes. **Results:** Four major themes emerged: governance and coordination deficits, resource constraints and fiscal decentralization, bureaucratic rigidity and administrative culture, and the role of external actors. Implementation was perceived as a fragmented and non-linear process influenced by institutional ambiguity, delayed and rigid financial systems, risk-averse administrative practices, and parallel donor-driven structures. Key mechanisms shaping implementation included coordination breakdown, limited adaptability, and misalignment between policy intent and operational realities. **Conclusion:** Health policy implementation in Pakistan is constrained by systemic and institutional factors that extend beyond policy design. Strengthening implementation requires improved governance alignment, financial flexibility, administrative reform, and integration of external support within national systems. **Keywords:** Health policy, implementation science, Pakistan, governance, qualitative research

INTRODUCTION

Health policy is fundamentally concerned with translating political commitment and strategic intent into coordinated action that improves population health. In Pakistan, the past two decades have seen the development of numerous national and provincial policies, strategies, and action plans addressing maternal and child health, communicable and non-communicable diseases, health financing, and universal health coverage. Despite this policy activity, progress in service delivery and health outcomes has remained uneven, and the distance between formal policy commitments and implementation realities continues to be a persistent concern. The 18th Constitutional Amendment, enacted in 2010, marked a major restructuring of the governance of health by devolving substantial authority to the provinces, with the expectation that decision-making would become more responsive to local needs and implementation would become more contextually grounded. In practice, however, Pakistan's public health system continues to face fragmentation, inequitable access, weak coordination, and variable institutional capacity, suggesting that the central challenge lies not only in policy formulation but in the

conditions under which policies are interpreted, operationalized, funded, and monitored across different tiers of the system (1–5).

Implementation science has consistently shown that the success of public policy depends on more than the technical quality of the policy document itself. Implementation is shaped by the interaction of governance arrangements, institutional roles, resource allocation, administrative culture, stakeholder ownership, accountability mechanisms, and the broader political environment in which a policy is introduced and sustained. In low- and middle-income countries, implementation is often treated as an assumed downstream stage rather than an empirical object of inquiry, leaving a limited understanding of how policy intent is translated, reinterpreted, delayed, diluted, or resisted in routine practice. Pakistan reflects this pattern. Although several policy documents and reform frameworks exist, there remains limited empirical evidence describing how implementation actually unfolds at federal, provincial, district, and frontline levels, and how actors positioned within these levels understand the barriers and enabling conditions that shape execution (6–11).

Existing literature on Pakistan's health system has highlighted several structural barriers to effective implementation, including governance fragmentation after devolution, chronic underinvestment in health, weak district-level capacity, political discontinuity, and the distortive effects of donor-supported vertical programming. However, much of this work has focused on specific programs or disease areas rather than examining policy implementation as a broader systemic phenomenon that cuts across administrative and service domains. A cross-cutting qualitative inquiry is therefore needed to move beyond formal policy rhetoric and capture how implementation is experienced by those who formulate, manage, support, and deliver policy in practice. A qualitative approach is especially appropriate in this context because it allows exploration of ambiguity, institutional norms, administrative behavior, competing accountabilities, and the lived realities of execution that are not adequately captured through quantitative indicators alone. Such an approach is well suited to examining how power, coordination, discretion, and organizational culture influence whether policies become actionable road maps or remain symbolic commitments (3,10–15).

Using a qualitative, interpretive approach, this study examined health policy implementation within Pakistan's public health system from the perspective of key stakeholders directly involved in policy development, management, delivery, and external support. The study was designed to explore how these stakeholders perceive the effectiveness of implementation, what barriers and facilitating factors they identify across federal, provincial, and district settings, and how policy intentions are translated, adapted, or constrained in operational practice. By focusing on the experiences of policymakers, district health managers, frontline healthcare providers, and development partners, the study sought to generate contextually grounded insights that can inform more realistic and execution-oriented health system strengthening efforts in Pakistan.

MATERIALS AND METHODS

This study employed an interpretative qualitative design to examine the effectiveness of health policy implementation within Pakistan's public health system. An interpretive approach was selected because policy implementation is a socially and institutionally mediated process shaped by organizational norms, power relations, administrative discretion, and contextual constraints, all of which require in-depth exploration rather than measurement alone. The study was conceived as an inquiry into how policy is experienced and enacted across different levels of the health system, with particular attention to the ways in which governance, financing, coordination, and institutional culture influence the translation of policy intent into routine practice.

Data were collected through semi-structured interviews with purposively selected participants who had direct experience in health policy formulation, implementation, oversight, or service delivery. Purposive sampling was used to capture variation across institutional roles and levels of the health system and to

ensure that participants could speak from practical engagement with policy processes rather than from indirect observation. The stakeholder groups included federal and provincial policymakers, district health managers, frontline healthcare providers such as doctors, nurses, and lady health workers, and representatives of development partners involved in supporting public health programming. This sampling strategy was intended to enable triangulation across policy, managerial, service-delivery, and partner perspectives and to generate a broader account of implementation dynamics across the system.

The interview guide was developed through engagement with implementation science literature and was structured around domains relevant to policy execution in health systems. These domains included the clarity and feasibility of policy goals, governance and coordination arrangements, financial allocation and budget flows, leadership and administrative decision-making, stakeholder engagement and ownership, monitoring and accountability systems, and contextual influences on implementation. The guide was piloted with two individuals from the target stakeholder groups to improve clarity, sequencing, and flow, after which minor refinements were made before formal data collection commenced. This iterative approach was intended to ensure that the guide was conceptually grounded while remaining flexible enough to capture unanticipated implementation experiences raised by participants.

Interviews were conducted in either English or Urdu according to participant preference and took place in person at participants' offices or through secure video conferencing platforms. Each interview lasted approximately 45 to 75 minutes. With participants' informed consent, interviews were audio-recorded, and contemporaneous field notes were maintained to document contextual observations, non-verbal cues where possible, and early analytical reflections. Attention was given to conducting interviews in settings that supported privacy and open discussion, particularly because the topic involved reflections on institutional performance, coordination failures, and administrative constraints. All identifying information was removed during transcription, and de-identified participant labels were used in the dataset and reporting to protect confidentiality.

Audio recordings were transcribed verbatim. Urdu-language material was translated into English for analysis, and a process of back-translation was undertaken for a subset of transcripts to improve accuracy and preserve meaning across languages. The transcripts were reviewed repeatedly to achieve immersion in the data before coding began. Data were then analyzed thematically following the Braun and Clarke framework. Initial coding was conducted inductively, allowing codes to arise from participants' accounts rather than imposing a rigid a priori structure. Two researchers independently coded the transcripts, compared their coding decisions, discussed discrepancies, and consolidated their interpretations into an agreed analytical framework. Related codes were subsequently grouped into candidate themes, which were reviewed, refined, and organized into a final thematic map capturing the principal patterns across stakeholder groups. Reflexive memos were maintained throughout the process to document analytical decisions, emerging interpretations, and the researchers' responses to the data, thereby strengthening transparency and confirmability.

The study incorporated several measures to enhance trustworthiness. Credibility was supported through triangulation across multiple stakeholder categories and through the use of direct quotations to anchor interpretation in participant accounts. Dependability was strengthened by maintaining an audit trail of coding decisions, theme development, and analytic memos. Confirmability was supported by dual coding, peer discussion of interpretive differences, and reflexive documentation of analytical assumptions. Transferability was addressed by providing sufficient contextual description of participants, roles, and the policy environment to allow readers to judge the applicability of the findings to comparable health system settings. Although the original study design emphasized depth and diversity of perspectives, future reporting would be strengthened by explicitly stating how sampling sufficiency and thematic saturation were assessed during data collection and analysis.

Reflexivity was considered important because the research team's backgrounds in public health and health policy could shape both data collection and interpretation. A reflexive stance was therefore maintained throughout the study, with the researchers acknowledging that prior familiarity with policy discourse, implementation challenges, and health systems reform could influence the framing of questions, attention to certain themes, and interpretation of stakeholder narratives. Maintaining reflexive memos and conducting coding discussions between researchers served as practical strategies to reduce the risk of a single unexamined perspective dominating the analysis.

All participants provided informed consent prior to participation. Confidentiality and anonymity were emphasized throughout the study, and only de-identified transcript materials were used in analysis and reporting. The manuscript would benefit from the addition of the formal ethics approval body and approval number in the final submission version to align more fully with COREQ and SRQR expectations for qualitative reporting.

RESULTS

The analysis showed that the perceived effectiveness of health policy implementation in Pakistan was shaped not by a single operational weakness but by the interaction of governance fragmentation, financial constraints, bureaucratic culture, and external influence. Across stakeholder groups, implementation was described as uneven, politically mediated, and frequently disconnected from the formal logic of policy design. Although participants recognized that policy documents were often technically sound and aligned with national or global priorities, they repeatedly emphasized that execution was weakened once responsibility shifted across administrative levels. Four interrelated themes were identified: governance and coordination deficits; resource constraints and fiscal decentralization; bureaucratic rigidity and administrative culture; and the role of external actors. These themes were not experienced in isolation. Rather, participants described them as mutually reinforcing, such that weak coordination intensified funding inefficiencies, rigid administrative systems limited local adaptation, and donor-supported interventions sometimes further fragmented already complex implementation arrangements.

Theme 1: Governance and Coordination Deficits

Governance and coordination deficits emerged as one of the most consistently described barriers to implementation. Participants across federal, provincial, district, and development-partner levels described the post-devolution health system as structurally ambiguous, particularly in relation to the division of authority between the federal and provincial tiers. National policies were often viewed as carrying symbolic and strategic importance, yet participants emphasized that the mechanisms needed to ensure coherent execution across provinces were weak or absent. This produced uncertainty around responsibility, duplication of effort, and limited accountability for implementation failure. Federal participants most often framed the problem in terms of policy drift after devolved transfer, whereas district participants described the problem more concretely as receiving multiple directives from different units without a workable mechanism for harmonization.

Poor coordination was described both horizontally and vertically. Horizontally, participants referred to weak alignment between health, finance, and planning authorities, resulting in policies that existed on paper without corresponding fiscal or operational commitment. Vertically, participants described inconsistent communication between provincial authorities and district managers, leaving frontline implementation dependent on local improvisation rather than structured execution. District managers in particular portrayed themselves as absorbing the contradictions of the system: they were expected to meet policy targets, comply with separate program demands, and resolve operational tensions despite limited formal authority. Compared with frontline providers, policymakers focused more on structural ambiguity, while providers experienced the consequences of that ambiguity through shifting priorities, inconsistent support, and unclear operational expectations.

Theme 2: Resource Constraints and Fiscal Decentralization

A second dominant theme concerned the mismatch between policy ambition and the financial realities of implementation. Participants across groups described chronic underfunding as a persistent problem, but the qualitative accounts suggested that the issue extended beyond the absolute amount of money available. Participants repeatedly emphasized the timing, rigidity, and administrative handling of funds as equally important constraints. Delayed release of budgets, limited flexibility in reallocation, and compressed spending periods undermined implementation quality and prevented local managers from sequencing activities in a rational manner. This theme was especially prominent among district managers and provincial officials, who described a recurring cycle in which policy expectations were annual and continuous, whereas financial access was delayed and operationally restrictive.

Frontline participants linked these financial problems to practical service consequences, including interrupted training, weak logistical support, and reduced implementation continuity. Provincial respondents, by contrast, emphasized the structural limitations of public financial management, particularly the inability to adapt spending categories when local conditions changed. The findings therefore suggest that fiscal decentralization did not automatically translate into functional implementation autonomy. Instead, participants portrayed a system in which decentralized responsibility was not matched by sufficient technical capacity, timely fund flow, or flexible budget governance. Development-partner respondents acknowledged these constraints but were generally less likely than district or provincial actors to frame financing as the core problem alone, often viewing it as entangled with governance and management weaknesses.

Theme 3: Bureaucratic Rigidity and Administrative Culture

The third theme highlighted the role of administrative culture in shaping implementation. Participants described the public health system as heavily process-driven, with institutional norms oriented more toward procedural compliance than toward adaptive problem-solving or results. This theme was especially visible in descriptions of delayed approvals, file-based decision-making, and a pervasive fear of audit scrutiny. Development partners and district managers most explicitly described a culture of risk avoidance, in which officials were rewarded for avoiding procedural error rather than for achieving implementation outcomes. In this context, policy execution was slowed not only by formal rules but by an organizational ethos that discouraged initiative, local discretion, and timely decision-making.

Frontline providers articulated this issue in relational terms, describing a disconnect between policies designed at higher administrative levels and the realities of community-level delivery. They reported being assigned targets and responsibilities without meaningful consultation about feasibility, local context, or community resistance. This produced a sense of distance between planners and implementers and contributed to low morale when frontline staff were blamed for failures that they perceived as structurally produced. Compared with policymakers, who tended to discuss governance in institutional language, providers highlighted lived implementation strain: rigid targets, limited voice, and weak recognition of local knowledge. The pattern across accounts suggests that bureaucratic rigidity was not merely a background administrative feature but an active mechanism through which implementation became slowed, depersonalized, and poorly adapted to context.

Theme 4: The Role of External Actors

The final major theme concerned the role of development partners and other external actors in supporting, shaping, and at times distorting implementation. Participants generally acknowledged that external actors provided essential funding, technical input, and momentum for innovation. At the same time, they described this support as creating parallel systems of reporting, staffing, priority-setting, and operational management. Federal and provincial participants were particularly likely to frame this as a tension between short-term program support and long-term system ownership. While external assistance

filled immediate capacity and financing gaps, it also introduced additional fragmentation and sometimes shifted attention toward donor priorities rather than nationally integrated planning.

District respondents drew attention to the practical consequences of these arrangements, including staff movement toward better-remunerated donor-supported roles and the coexistence of government and externally supported structures that were not fully integrated. Sustainability emerged as a central concern across these accounts. Participants described successful externally supported initiatives that weakened or collapsed once project funding ended because recurrent costs, supervision systems, or institutional ownership were not absorbed into the government structure. Development-partner respondents themselves recognized this tension, often positioning their role as necessary but imperfect within a system already marked by limited state capacity. Taken together, these findings suggest that external actors were viewed not simply as facilitators or obstacles, but as embedded participants in an implementation environment where immediate support could coexist with longer-term dependency and fragmentation.

Across all four themes, participants portrayed policy implementation as a negotiated and uneven process rather than a straightforward administrative sequence. Governance ambiguity reduced coherence, financial rigidity disrupted execution, bureaucratic culture weakened adaptation, and external actors complicated ownership. Importantly, the data suggest that implementation breakdown was most often experienced at the interfaces between actors and levels of the system rather than within a single organizational unit alone. Policymakers emphasized system design and jurisdictional uncertainty; district managers emphasized operational contradiction; frontline providers emphasized feasibility and voice; and development partners emphasized both support gaps and the unintended effects of externally driven programming. This pattern indicates that the central problem was not simply the presence of barriers, but the absence of a coherent execution architecture linking policy intent, fiscal practice, managerial authority, and frontline realities.

Table 1. Theme Matrix Across Participant Groups and Contexts

Theme	Policymakers (Fed/Prov)	District Managers	Frontline Providers	Development Partners	Overall Intensity	Illustrative Quote IDs
Governance and Coordination Deficits	Frequent	Frequent	Moderate	Frequent	Frequent	Policy-Fed-2, District-Mgr-4
Resource Constraints and Fiscal Decentralization	Frequent	Frequent	Frequent	Moderate	Frequent	District-Mgr-2, Policy-Prov-1
Bureaucratic Rigidity and Administrative Culture	Moderate	Frequent	Frequent	Frequent	Frequent	DevPart-2, Provider-3
The Role of External Actors	Frequent	Moderate	Rare to Moderate	Frequent	Moderate to Frequent	Policy-Fed-3, DevPart-1

Footnote: Rare = mentioned by a small number of participants; Moderate = raised repeatedly across more than one stakeholder group; Frequent = raised across most interviews and/or by multiple stakeholder categories. These descriptors indicate qualitative intensity and recurrence, not statistical frequency.

Table 2. Quote Table Mapping Subthemes to Representative Verbatim Quotes

Theme	Subtheme	Representative Quote	Participant Label
Governance and Coordination Deficits	Federal-Provincial Ambiguity	“The 18th Amendment was great in theory, but in practice, we are still figuring out who does what. This ambiguity is exploited by both sides to avoid responsibility.”	Policy-Fed-2
Governance and Coordination Deficits	Poor Inter-Ministerial Coordination	“Our policy requires funding from the Ministry of Finance and the Ministry of Planning. But they don’t see it as their priority. So we have a policy with no budget.”	Policy-Prov-3
Resource Constraints and Fiscal Decentralization	Chronic Underfunding	“We are expected to deliver first-world health services with a Policy-Fed-1 budget that is less than 1% of GDP. The policy says one thing, but the budget says another.”	Policy-Fed-1
Resource Constraints and Fiscal Decentralization	Rigid Budgeting and Delayed Releases	“We get the funds in the last quarter. The policy requires a year-long process, but we have to compress it into three months. Quality suffers, and we often have to return the money.”	District-Mgr-5

Theme	Subtheme	Representative Quote	Participant Label
Bureaucratic Rigidity and Administrative Culture	Fear of Accountability	“Our entire culture is about avoiding audit paras. People are promoted for not making mistakes, not for achieving results. This is the biggest barrier to implementation.”	DevPart-3
Bureaucratic Rigidity and Administrative Culture	Disconnect Between Policy and Frontline	“The policy is made in Islamabad or Lahore. They don’t know the ground realities. They make a plan, and we are just supposed to execute it like robots.”	Provider-1
Role of External Actors	Creation of Parallel Systems	“We have a government system and a donor system. The donor system offers better salaries, better cars. So all the good people are sucked out of the government system.”	District-Mgr-1
Role of External Actors	Unsustainable Projects	“A donor will fund a program for five years. We build it up, it works well, then they leave. The government doesn’t take it over, and it collapses. We haven’t built capacity; we’ve created dependency.”	Policy-Prov-2

Table 1 shows that governance deficits and fiscal constraints were perceived across nearly all participant groups with frequent intensity, suggesting that these were system-wide concerns rather than role-specific complaints. Bureaucratic rigidity was especially prominent in district, frontline, and development-partner accounts, indicating that the effects of administrative culture were most strongly experienced where policy had to be translated into operational action. By contrast, the role of external actors was discussed most strongly by policymakers and development partners, while frontline providers referred to it less directly, implying that external influence may be felt more through institutional arrangements than through everyday service language. Table 2 further illustrates that each major theme was supported by concrete accounts of ambiguity, delayed resource flow, risk-averse administration, and sustainability concerns, with the quotes showing how similar implementation problems were interpreted differently depending on participants’ position within the system.

Policy Framework Thematic Network Graph – Teal Spectrum Layout

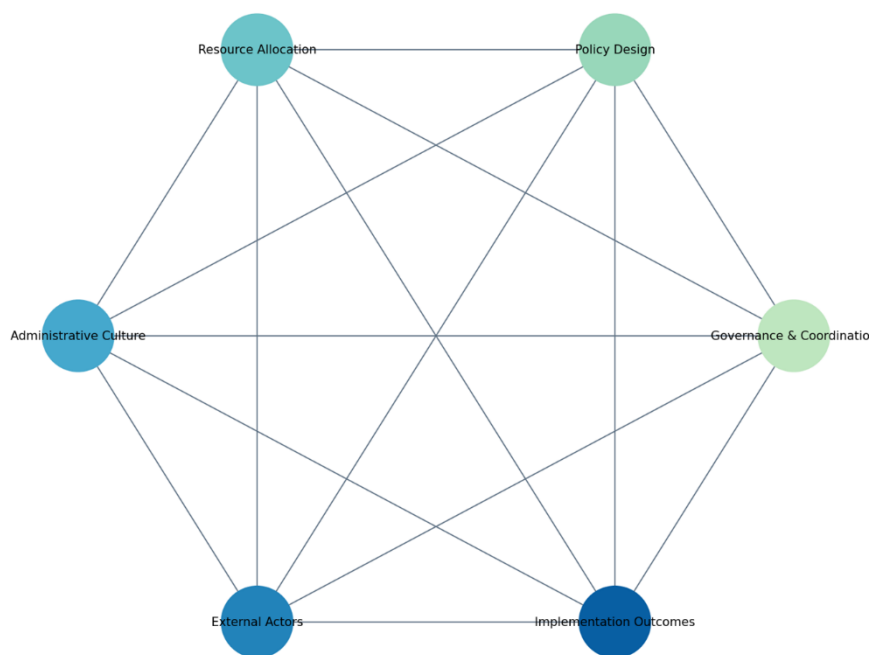


Figure 1 Policy framework thematic network graph illustrating the interrelationships between key components influencing health policy implementation in Pakistan’s public health system. The diagram demonstrates how policy design interacts with governance and coordination, resource allocation, administrative culture, and external actors within a highly interconnected system, collectively shaping implementation outcomes. The dense network structure highlights that implementation is not a linear process but a dynamic and reciprocal interaction of institutional, financial, and organizational factors, where changes in one domain can influence multiple others simultaneously, ultimately determining the effectiveness and coherence of policy execution.

DISCUSSION

The findings of this study demonstrate that health policy implementation in Pakistan is not a linear administrative process but a complex, multi-layered phenomenon shaped by governance structures, institutional norms, financial systems, and external influences. The results indicate that implementation challenges emerge not from a single point of failure but from the interaction of structural and operational constraints across different levels of the health system. Governance fragmentation, particularly following the 18th Constitutional Amendment, remains a central issue, with unclear delineation of roles between federal and provincial authorities contributing to coordination gaps and accountability vacuums. This aligns with existing evidence from decentralized health systems in low- and middle-income countries, where devolution without clear operational frameworks can weaken coherence and policy execution (16,17).

The study further highlights that financial constraints are not limited to insufficient funding but are deeply embedded in the structure and functioning of public financial management systems. Participants described delayed fund disbursement, rigid budgetary categories, and limited reallocation flexibility as critical barriers that disrupt implementation timelines and reduce program quality. These findings are consistent with broader literature suggesting that fiscal decentralization without parallel strengthening of financial governance capacity can exacerbate inefficiencies and underutilization of resources (19,20). Importantly, the qualitative accounts suggest that implementation failure is often produced through temporal mismatches between policy expectations and financial availability rather than absolute scarcity alone.

A key contribution of this study is the identification of bureaucratic culture as an active mediator of implementation outcomes. The findings suggest that administrative systems prioritize procedural compliance and risk avoidance over performance and adaptive decision-making. This process-oriented culture, reinforced by audit-driven accountability mechanisms, discourages initiative and slows execution. Similar patterns have been documented in South Asian public sector systems, where institutional legacies have shaped administrative behavior toward rule adherence rather than outcome optimization (21). The accounts of frontline providers further reveal how this culture creates a disconnect between policy design and service delivery realities, undermining morale and limiting the incorporation of contextual knowledge into implementation processes.

The role of external actors emerges as both enabling and constraining. While development partners provide essential financial and technical support, their involvement often introduces parallel structures and reporting systems that can fragment national efforts and weaken long-term sustainability. This duality reflects global critiques of donor-driven programming, where short-term project success may coexist with limited system strengthening and weak institutional ownership (22–24). The findings suggest that external support is most effective when aligned with national systems and when it contributes to building endogenous capacity rather than creating dependency.

From an implementation perspective, the study underscores that policy success depends on the alignment between design, governance, financing, and execution capacity. The conceptual framework developed in this study illustrates how policy outcomes are mediated by system-level mechanisms rather than directly determined by policy content. Strengthening implementation therefore requires interventions that go beyond policy formulation to address coordination mechanisms, financial flexibility, administrative reform, and integration of external support within government-led structures.

The study also reflects on issues of trustworthiness. The use of multiple stakeholder groups enhanced credibility through triangulation of perspectives, while the thematic analysis process and audit trail contributed to dependability and confirmability. However, the findings should be interpreted in light of certain limitations. Social desirability bias may have influenced participants' responses, particularly given the institutional sensitivity of discussing governance and administrative weaknesses. The

recruitment of participants with direct system involvement may also have introduced perspective bias toward managerial and institutional viewpoints, potentially underrepresenting community-level experiences. Additionally, the process of translation from Urdu to English may have led to subtle loss of meaning despite back-translation efforts. Finally, as an endline qualitative assessment, the study captures perceptions at a specific point in time and does not track how implementation dynamics evolve longitudinally.

CONCLUSION

This study demonstrates that the effectiveness of health policy implementation in Pakistan is shaped less by policy design and more by the conditions under which policies are operationalized. Implementation is mediated by governance clarity, financial functionality, administrative culture, and the nature of external engagement, all of which influence whether policies translate into coordinated action or remain fragmented in practice. The findings suggest that improving implementation requires strengthening institutional capacity for execution, enhancing coordination across levels of the health system, introducing greater flexibility and timeliness in financial processes, and fostering an administrative culture that supports adaptive decision-making. Sustainable progress will depend on aligning external support with national priorities and ensuring that implementation systems are responsive to contextual realities at provincial and district levels. These insights emphasize that policy success is ultimately determined not by formulation alone but by the system's ability to execute under real-world conditions.

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