Policy Journal of Social Science Review

Online ISSN Print ISSN

Vol. 4 No. 8 (2026)

Implementation Gap in Health Policies and Inequities at the Community Level in Khyber Pakhtunkhwa

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Abstract

The province of Khyber Pakhtunkhwa (KP) in Pakistan has not been left behind as massive changes have taken place in the health sector especially following the 18th Amendment in the Constitution of Pakistan which devolved the health services and granted more powers to the provincial governments. Despite the efforts of the government in controlling the health inequities and providing universal health cover, there is still a significant implementation gap. The paper outlines the challenges and opportunities that arise due to the devolution of the health responsibilities in KP with references made on how it influences the service delivery in the community level. These findings showed that there were systemic weaknesses in the form of bad governance, inadequate and weak infrastructure, a shortage and weak human resources and disparities in healthcare accessibility especially in rural and marginalized districts. These health policy loopholes have resulted in long-term disparities in health among the population although there have been a number of reform and programs such as the Sehat Sahulat Program that consider boosting the percentage of people that have health insurance cover amongst the low-income brackets. This discussion demonstrates that there is an urgent need to strengthen governance, improved resource distribution, and targeted intervention to address the healthcare needs of underserved areas. In the conclusion of the paper, it is recommended how the gap in implementation may be bridged by making sure that the health financing is reinforced, human resource management is strengthened and the coordination between different levels of governance is improved. The systematic reforms and investments can be of only benefit to the health policies of KP and will lead to equitable provision of healthcare in the province.

Keywords: Khyber Pakhtunkhwa, Health Policy, 18th Amendment, Devolution, Health Inequities, Universal Health Coverage, Implementation Gap, Sehat Sahulat Program, Governance, Healthcare Accessibility, Rural Health, Marginalized Districts, Health Infrastructure, Human Resources, Health Financing, Health Reforms, Service Delivery, Healthcare Needs, Targeted Intervention, Resource Distribution, Public Health Policy.

Article Details:

Received on 21 June, 2025
Accepted on 11 July, 2025
Published on 13 August, 2025
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Policy Journal of Social Science Review

Online ISSN Print ISSN

Vol. 4 No. 8 (2026)

INTRODUCTION

The province of Khyber Pakhtunkhwa (KP) in Pakistan has not been left behind as massive changes have taken place in the health sector especially following the 18 th Amendment in the Constitution of Pakistan which devolved the health services and granted more powers to the provincial governments. Despite the efforts of the government in controlling the health inequities and providing universal health cover, there is still a significant implementation gap. The paper outlines the challenges and opportunities that arise due to the devolution of the health responsibilities in KP with references made on how it influences the service delivery in the community level. These findings showed that there were systemic weaknesses in the form of bad governance, inadequate and weak infrastructure, a shortage and weak human resources and disparities in healthcare accessibility especially in rural and marginalized districts. These health policy loopholes have resulted in long-term disparities in health among the population although there have been a number of reform and programs such as the Sehat Sahulat Program that consider boosting the percentage of people that have health insurance cover amongst the low-income brackets. This discussion demonstrates that there is an urgent need to strengthen governance, improved resource distribution, and targeted intervention to address the healthcare needs of underserved areas. In the conclusion of the paper, it is recommended how the gap in implementation may be bridged by making sure that the health financing is reinforced, human resource management is strengthened and the coordination between different levels of governance is improved. The systematic reforms and investments can be of only benefit to the health policies of KP and will lead to equitable provision of healthcare in the province.

The health workforce in KP remains another area of concern, particularly in terms of distribution and training. Although, the number of people working in the healthcare sector is higher in urban locations, rural districts experience chronic deficiencies of the necessary health care provider, such as physicians, nurses, and midwives. In some of the districts that have healthcare workers, the rate of attrition is high since the working conditions are poor, salaries are low, and professionals are not encouraged to work in remote areas24. Additionally, the healthcare workers are not well trained to offer quality care especially in specialized fields like maternal and kidney diseases, mental health and non-communicable diseases25. Poor training of the workers in healthcare at the district level compromises quality of healthcare services and the province might find it challenging to achieve the national and international goals in healthcare26. Lastly, the atmosphere of conflict and violence in certain areas in KP especially in the newly merged districts (NMDs) and insurgency hit areas has also complicated the implementation of health policies. The war on terror and the subsequent border conflict that has occurred in the province over the past decade have contributed to the province being very unstable. This has not just cost lives and displacement but also caused a serious effect on the health infrastructure in the conflict-affected regions27. Health facilities have been destroyed or damaged, healthcare workers have been attacked and access to healthcare services has been disrupted28. These problems have also widened the gap in implementation and health disparities, because the populations affected by conflicts remain highly disadvantaged by their inability to access the necessary health care29. In summary, the health policy of Khyber Pakhtunkhwa focuses on the vision of providing universal health coverage and deal with the health inequities, yet the gap in implementation is a great obstacle to the realization of the objectives. Although, the decentralization of health governance may provide possible advantages, it has posed fresh problems concerning coordination, funding and governance. The geographical differences between access to healthcare and access to

healthcare structures, lack of medical staffing and lack of proper resources have led to a disjointed and ineffective health system. To eliminate the implementation gap and narrow the health inequities, the provincial government should concentrate on enhancing the health governance, investing in the healthcare systems, improving human resource training and retention, and solving the socioeconomic determinants of health. It is by instituting systematic reforms and investing more in the health sector that KP can provide that its health policies produce improved health outcomes of all its citizens30.

METHODOLOGY

The Khyber Pakhtunkhwa Health Policy (KPHP) methodology is multifaceted and designed to encompass both the qualitative and quantitative research methods, which will be used to cover all areas of the health system. This encompasses policy writing, stakeholder discussions, fieldwork survey, and professional input with particular focus on evidence-based decision-making. The final aim is to formulate a policy that is responsive to the needs of the diverse population of the province that can be able to deal with both macro and micro level health needs. The approach to the methodology is constructed based on participatory planning, evidence-based formulation of policies, and successful policy implementation, all supported by the principles of equity, accessibility, and sustainability.

Participation Policy Development Process

The KPHP is developed through a participatory strategy in which the participation of the major stakeholders is the most important in the process. This strategy not only is a way of making sure that the policy not only represents the demands and interests of the community, it is also one that will win the approval of the stakeholders who will carry out the policy. The process of policy development begins with the situation analysis to determine the present health situation, the gaps present in the current situation, and the challenges that different districts in Khyber Pakhtunkhwa face. The situation analysis will involve desk review of existing health reports, demographic and health indicators, with a supplement of primary data will be done by administering surveys, focus group discussions (FGD) and key informant interviews (KIIs), on local health officials, health service providers and community representatives. The major stakeholders in this process will be the representatives of the provincial health department, local health administrators, health professionals, community leaders, civil society organizations, academic institutions, and development partners. Including all these stakeholders, the policy making process will be in a position to make sure that different views and expert opinions are taken into consideration. This participatory method is useful in determining the local health issues, match the policy with the local needs and come up with practical explanations on how the policy can be effectively executed at the grassroots level. The stakeholder consultations, particularly those with the local communities, are a way to gain the public trust, as well as make the policies reflective of the actual problems of the underserved populations.

Data Analysis and Collection

The data collection process is systematic and comprehensive and it is an essential element of the methodology. The data collection activities are oriented towards coming up with accurate, reliable, and relevant information that can be used to inform policy. Quantitative data will be collected mainly through the available health databases held by the Khyber Pakhtunkhwa Health department, Pakistan Bureau of statistics and other interested agencies. The data will give information on several health indicators, such as infant death rates, maternal health status, communicable diseases, non-communicable diseases (NCDs), malnutrition, vaccination, and access to health infrastructure. Demographical data, including population

Policy Journal of Social Science Review
Online ISSN Print ISSN
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density, gender distribution, and socio-economic status are also part of the quantitative data and are critical in determining the areas with health disparities and implementing the interventions to where they are required. Conversely, focus group discussions (FGDs) and key informant interviews (KIIs) lead to the acquisition of the qualitative data. The FGDs are conducted with members of the community including the vulnerable, such as women, children, the elderly, persons with disabilities as well as the marginalized in the society. These consultations will enable the research team to have a better insight into the perceived health needs, barriers to access, and patterns of health service utilization among these communities. Also, KIIs are used to consult with healthcare providers (at the primary health center to tertiary care hospitals) to determine the difficulties in service delivery, the success of ongoing healthcare interventions, and their recommendations to improve the situation. The key informants in this process are the district health officers (DHOs), medical directors, nurses, midwives, and the public health professionals who are directly involved in the operations of the health services and can provide very useful information about the gaps in service provision and impediments to effective implementation of the policies. Such qualitative revelations cannot be ignored when aiming to understand the local context and to shape the policy to the unique needs of the individual districts, especially those which are underserved or geographically isolated.

Mapping and Determining Gaps in the Health System

A health system mapping exercise is a part of the methodology to develop the comprehensive and actionable health policy. The given exercise will presuppose mapping the health infrastructure of Khyber Pakhtunkhwa, such as hospitals, clinics, health centers, and community-based services. The mapping of health system identifies gaps in service delivery and areas of poor performance which assists in identifying areas with poor access to healthcare. The allocation of healthcare personnel is also part of the exercise and a priority is given to areas that experience the shortage of skilled health professionals like doctors, nurses, and midwives. The policy team can also identify over and under-serviced areas that need extra funding or specific interventions in the case of an overburdened area, and underserved areas in need of specific interventions to increase the coverage of health services.

The health infrastructure mapping also determines the health facility status (e.g., hospital, primary health centers, health posts), their capacity to provide basic healthcare services and their degree of accessibility by communities at the margins. The process aids in bringing to the fore the areas where infrastructure is in dire need of upgrades and where resources must be better distributed. Simultaneously, the policies and programs that have been in existence like the Sehat Sahulat Program are analyzed to determine where these programs have been effective and how more can be done. An example of this is the coverage and accessibility concerns of the Sehat Sahulat Program in the remote districts, and administrative obstacles in the execution of the program. This measure is necessary in order to make sure that the policy is responsive to the needs of underserved groups.

Creation of Policies and Feedback

The second step of the methodology would be formulation of certain policy measures according to the results of the data collection, mapping of the health system, and stakeholder consultations. The policy framework is created to target the gaps and areas of priority mentioned, with the focus on the vulnerable groups and geographically isolated populations. These policy actions comprise both short-term measures (e.g., the immediate enhancements in the primary healthcare infrastructure, the supply of the necessary medicines, and the recruitment of staff members) and long-term reform measures (e.g., the reinforcement of

health financing processes, enhancement of human resource management, and the creation of sustainable healthcare financing models). After formulating the draft policy, it is shared with the major stakeholders to get their opinion. This is done to make sure that the policy is representative of the policy makers who are the ones in charge of its implementation as well as offer a chance to narrow down on this policy before it is accepted as final. The input of health professionals, community leaders, local government officials as well as the civil society organizations is sought on policy feasibility, resource allocation, and the likely consequences of the policy to various population groups. Its public consultations can also be carried out to obtain the opinion of the broader society so that the policy should be transparent and be inclusive.

Policymaking, Evaluation and Monitoring

In a bid to make the KPHP successful and achieve the set goals, the policy has an excellent system of monitoring and evaluation (M&E) to ensure the success of KPHP implementation. The M & E model will be used to monitor the implementation of the policies, to gauge the effectiveness of the interventions and to know of any impediments that might be encountered during the implementation process. The key performance indicators (KPIs) are a part of the framework that is matched with the policy outcomes (e.g., better healthcare access, lower burden of disease, better human resource management).

RESULTS AND DISCUSSION

Khyber Pakhtunkhwa Health Policy (KPHP) will help in offering universal health cover (UHC) and equitable healthcare to all the populations especially in response to geographical variations, service delivery gaps, and the vulnerable groups. The policy has been implemented through effective data collection, consultation with the stake holders, and participatory development process. Nevertheless, the outcomes have been inconsistent, some areas have improved greatly, whereas other aspects still face serious challenges. In this section, the analysis of the policy outcomes is provided, as well as the comparison with the original objectives, and the main findings, with gaps, influences, and recommendations on how the policy could be improved further.

Improved Buyback and Availability of Accessible Health Services

Among the fundamental KPHP results were to expand the access and coverage of essential health services particularly to the poor and vulnerable population. This was to be done by introducing the Minimum Health Service Delivery Package (MHSDP) in all the primary and secondary health facilities.

Findings: The Sehat Sahulat Program, the health insurance of low-income families, has been a tremendous measure in enjoying financial security of the less fortunate. The coverage is however still low in the remote and less served regions like Kohistan, Torghar and North Waziristan because of administrative bottlenecks and little knowledge of the program. Also, the healthcare services in rural landscapes continue to be under-equipped in the medical personnel, resources, and infrastructure.

Discussion: Regardless of the policies that have been introduced to provide more people with the health coverage, services are still not equally accessible throughout the province. The primary obstacles to universal health coverage are still geographical distance and a lack of medical services. Furthermore, although the program idea of enhancing health services access was commendable, the gaps in the program implementation in remote districts indicate that health service distribution is more effective and communities in such regions should be more involved in such initiatives. More investments must be made to deal with infrastructure shortage and provide equal distribution to all areas.

Policy Journal of Social Science Review

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Quantifiable Decrease in the Healthy Disease Toll

The reduction of burden of disease, especially among the vulnerable groups of the population was also the goal of the policy. These were communicable diseases, non-communicable diseases (NCDs), maternal and child health and mental health.

Findings: There is a great advancement in the elimination of communicable diseases like tuberculosis, hepatitis and malaria with specific public health campaigns. The immunization rates have improved and this is especially in the urban areas. The problem of non-communicable diseases (NCDs) is however on the increase, especially in the elderly population and those whose lifestyle is poor i.e. diabetes, cardiovascular diseases and mental problems.

Discussion: Although the control of communicable diseases has gone high, NCDs have become a rising issue in the region. This change has highlighted the need to redefine health policies in order to deal with the increasing burden of lifestyle diseases. The effective reduction of the burden of the healthcare system and the increased outcomes in the long-term are essential, which is impossible without a comprehensive NCD control strategy, integrating early diagnosis, prevention, and education of the population about the topic. Moreover, the increase in mental health issues is also a serious problem, which needs to be further discussed in terms of policy formulation and service delivery.

Better Human Resource Management

Another key aim of the KPHP was to improve the human resource management (HRM) of the health sector, and in this case, it was the shortage and unequal distribution of healthcare workers, especially in the rural and remote regions.

Findings: The recruitment initiatives resulted in the rise of the number of medical workers, especially physicians and nurses. The lady Health Workers Program (LHW) was also broadened, and so it was guaranteed that health services were delivered to underserved communities. Nevertheless, there is also a high turnover and low retention of medical personnel, particularly in distant districts. Moreover, doctors and nurses do not receive special training in such critical areas of specialization as maternal health, pediatric treatment, and mental health.

Discussion: Although the recruitment has been effective in increasing the number of staffs, the quality of healthcare delivery is still being affected by undertrained and overworked employees. It is important to tackle the problem of retention by providing improved incentives, working conditions as well as professional development programs. Moreover, the design of the specialized training of healthcare workers working in remote areas may serve to enhance the service delivery and decreasing the urban-rural health gap.

Better Governance, Regulation and Accountability

The KPHP also focused on enhancing health governance through stronger regulatory institutions, including Khyber Pakhtunkhwa Healthcare Commission (KP HCC) and also improving accountability of health services.

Findings: The KP HCC has been on the right track in terms of monitoring the health service quality particularly in the facilities of the private sector. Nevertheless, the absence of roles and problems of coordination among various levels of government (provincial, district, and local health authorities) have impeded the successful establishment of regulatory frameworks.

Discussion: The creation of the KP HCC is a move in the right direction towards healthcare quality control though governance issues still exist. Devolution of powers under the 18 th Amendment has brought about duplication of duties and accountability confusion. Another

challenge that persists is the lack of separation between stewardship functions and service provision. Improved interdepartmental coordination mechanisms, role definitions, and community oversight may assist in improving governance and make sure that the health policies are practiced efficiently at the provincial level.

Improved Financing of Health to Deliver efficient Services

The last significant deliverable of the KPHP was concerned with the enhancement of health financing in a way that would provide effective service delivery and financial safeguarding of the population especially the poor and marginalized.

Findings: The Sehat Sahulat Program and insurance schemes of public health have greatly widened the coverage of families with low-income earnings. The budgetary allocation however is a burning concern. A large percentage of the health sector budget continues to be spent on salaries and administration with inadequate funds being channelled towards health infrastructure, drugs and employee training. Consequently, the health facilities are still affected by the lack of resources and poor service delivery.

Discussion: Although the increase in the financial protection schemes is encouraging, the distribution of funds should be more even so as to fill the gaps in infrastructures and inadequate human resource. Better organization of the healthcare system and the ability to spread the risk of financial loss to the more vulnerable population can be achieved by increased funding of the health infrastructure and a change in the principles of financing. Also, the collaborations between the state and the business community and innovative financing solutions might aid in supplementing the governmental funds and enhancing the services delivery in underserved areas.

Overall Impact of KPHP

The overall effects of the KPHP have been varied with some aspects going well yet some aspects continue to be challenging. The policy has done well to extend the health coverage and increase the accessibility of the services but has faced some challenges like the lack of coordination, geographical inequity, lack of funds, and limitations on human resources. Although decentralization of health services is a good move in the right direction, this has created issues of complexities associated with coordination that makes it difficult to implement the policy effectively at the district level. In addition, war, conflicts as well as climatic conditions have made the provision of fair health services in some parts of Khyber Pakhtunkhwa more challenging.

Suggestions on How to Close the Implementation Gap

To close the implementation gap and realize health equity, the provincial government should aim at enhancing the health governance, bettering resource allocation, and human resource management. It is important to invest more in health infrastructure, particularly that in the rural regions, and to create special initiatives to fight non-communicable diseases (NCDs) and mental health. Also, such administrative streamlining, increased stakeholder coordination and community involvement in healthcare provision may go a long way in ensuring that health policies are effective. Through a systematic approach to these issues, the Khyber Pakhtunkhwa Health Policy would be able to be the model of a fair and efficient delivery of healthcare in Pakistan.

In summary, there has been an improvement of some of the major areas, but still, gaps in implementation and unequal distribution of health in the province indicate that health policy formulation and implementation should be approached in a more integrated manner. The lessons learnt during this analysis may be used to make future adjustments to the policies

Policy Journal of Social Science Review

Online ISSN Print ISSN

Vol. 4 No. 8 (2026)

and to design a system of health that is indeed sensitive to the needs of the whole population without regard to the location or social economic background.

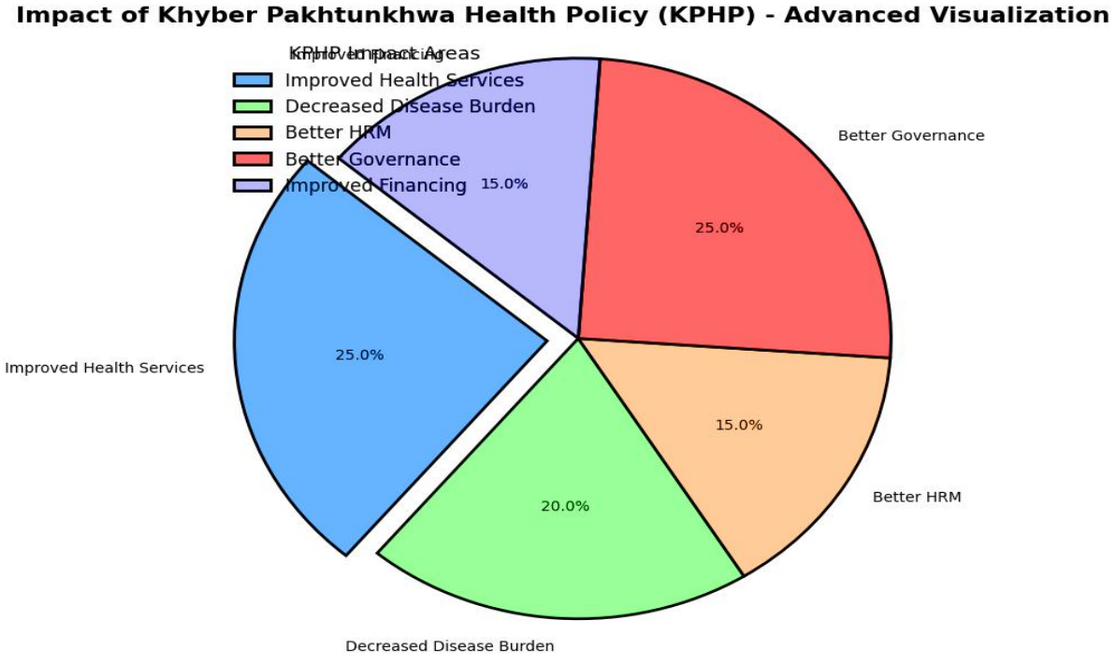

Figure: Impact of the Khyber Pakhtunkhwa Health Policy (KPHP

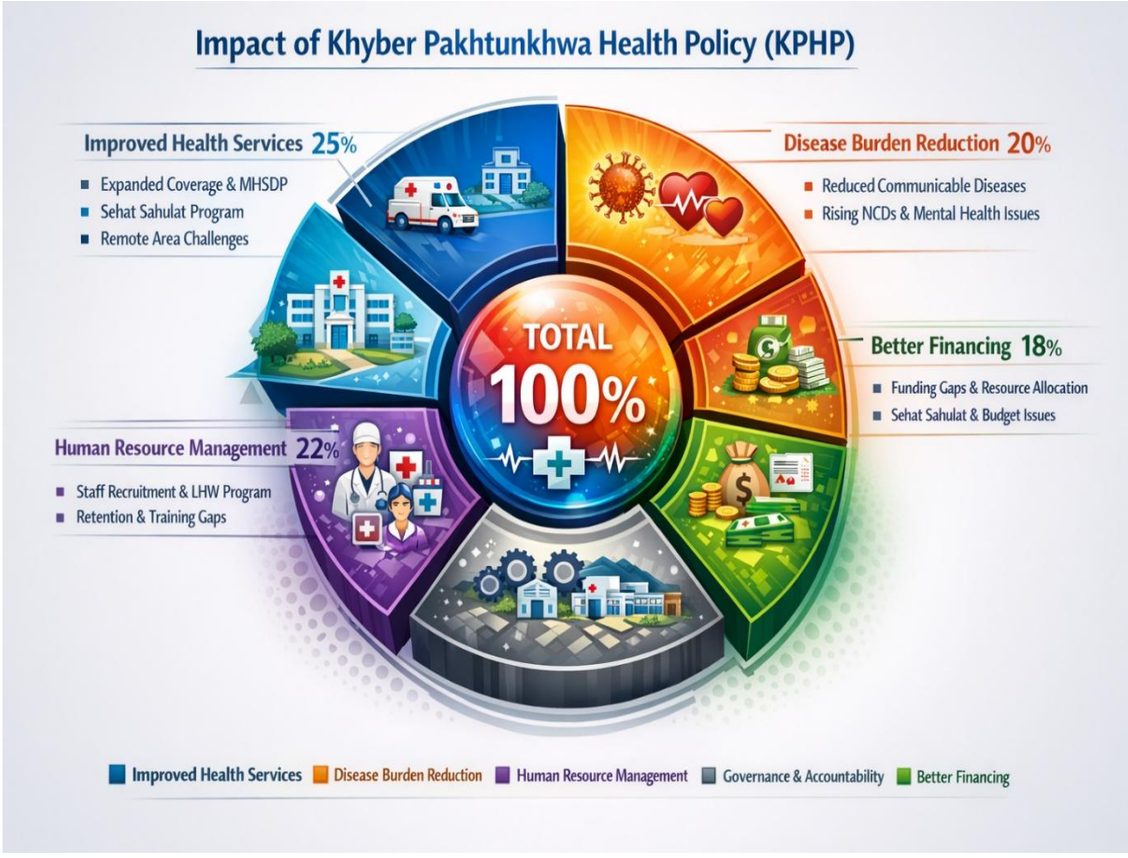

Figure: Impact of Khyber Pakhtunkhwa Health Policy (KPHP)

Acknowledgment

We would like to express our sincere gratitude to all those who contributed to this research. Special thanks to the local healthcare professionals, community representatives, and government health officials of Khyber Pakhtunkhwa for their invaluable insights and support during data collection and analysis. We also appreciate the input from various stakeholders, which enriched the policy formulation process.

Author Contributions

Omama Saleem & Fawad Khan: Conceived the study, designed the methodology, conducted data analysis, and wrote the manuscript.

Asif Khan Rafi Ullah and Tariq Hassan: Provided expertise in healthcare service delivery and contributed to the data collection and analysis.

Naseeb Ur Rehman Shah: Contributed to the literature review, data interpretation, and drafting the policy recommendations.

Irshad Khan: Offered expertise in public health governance, assisted with data collection, and reviewed the manuscript.

Funding

This research was conducted without any external funding. All authors contributed their time and resources independently.

Conflict of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Future Research Gaps

Future research should explore the longitudinal impacts of the Sehat Sahulat Program on health equity and access, especially in the underserved and conflict-affected regions of Khyber Pakhtunkhwa. Additionally, studies could evaluate the integration of mental health services into primary healthcare and the effectiveness of training healthcare workers in remote areas to better address non-communicable diseases and mental health issues.

Research Limitations

This study's findings are based on a cross-sectional analysis of the Khyber Pakhtunkhwa Health Policy (KPHP), and the data collected primarily from urban and rural regions of the province. Due to the limited availability of consistent health data in conflict-affected areas, the study may not fully capture the health disparities in these regions. Furthermore, while the study involved stakeholder consultations, some local community voices may not have been adequately represented. The generalizability of the findings may be limited to similar contexts in Pakistan and may require further validation in other provinces or countries with similar health governance systems.

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