



Designing a Model for Health System Policy Implementation in Afghanistan

Mutiullah Sharq¹, Vahid Araei^{2*} Mohammad Reza Rabiee Mandejin¹ Hasan Givarian¹

¹ Department of Public Administration, CT.C., Islamic Azad University, Tehran, Iran

² Department of Public Administration and Public Policy, CT.C., Islamic Azad University, Tehran, Iran

* Corresponding author email address: vah.arai@iauctb.ac.ir

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Abstract

Afghanistan's health system, due to its specific political, security, economic, and social conditions, faces serious challenges in the implementation of health policies. The gap between policy formulation and realization at the operational level, weaknesses in managerial structures, shortage of financial resources, inadequacy of infrastructure, and limited human resource capacity highlight the need to design an indigenous model for the effective implementation of health policies. The present study was conducted with the aim of designing and explaining a model for health system policy implementation in Afghanistan. In terms of approach, this research was qualitative, and in terms of purpose, it was applied. The statistical population of the study consisted of experts, policymakers, executive managers of the health system, service providers, and scholars familiar with the issues of Afghanistan's health system, who were selected using purposive sampling. The research data were collected through semi-structured interviews and continued until theoretical saturation was reached. The coding process and MAXQDA software were used to analyze the data. The findings showed that barriers to health policy implementation in Afghanistan can be classified into three main categories: structural-managerial challenges, economic-infrastructure challenges, and educational-content-related challenges. The results indicate that the successful implementation of health policies in Afghanistan requires smart decentralization, strengthening of governance and accountability systems, human resource empowerment, sustainable financing, improvement of health service infrastructure, localization of training programs, and establishment of a data-driven monitoring and evaluation system. Accordingly, the proposed model of the study can be used as an applied framework for reducing the gap between the formulation and implementation of health policies in Afghanistan.

Keywords: *policy implementation, health system, Afghanistan, health governance.*

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1. Introduction

Health policy implementation is one of the most critical yet difficult stages of the public policy process, because it is at this stage that formal decisions, strategic documents, and governmental commitments are translated into institutional action, service delivery, resource allocation, and measurable public outcomes. Public policy theories have long emphasized that policy success cannot be assessed merely by the quality of formulation, because implementation is shaped by administrative capacity, actor networks, political incentives, legal structures, organizational routines, street-level discretion, financial resources, and the degree of

alignment between policy goals and contextual realities [1-4]. In the health sector, this issue becomes even more complex because policy implementation directly affects population health, equity in access to services, the distribution of scarce resources, and the legitimacy of public institutions. Therefore, the implementation of health system policies requires more than formal approval of policy documents; it requires coherent governance, evidence-based decision-making, accountable institutions, competent human resources, sustainable financing, and implementation mechanisms that are sufficiently adaptive to social, economic, political, and geographical conditions.



The health system is a multidimensional policy domain in which decisions are implemented through multiple levels of governance and across various institutions, professions, and service delivery environments. Contemporary implementation scholarship has shown that effective implementation depends on the balance between top-down direction and bottom-up adaptation, because national policy goals must be translated into feasible actions at provincial, district, facility, and community levels [5, 6]. Top-down approaches are important for standard setting, resource mobilization, legal authority, and national coordination, while bottom-up approaches are necessary for responsiveness to local needs, practical problem solving, and incorporation of the knowledge of frontline actors. In health systems, the role of frontline workers and local managers is especially important, because policies are frequently interpreted and operationalized through discretionary decisions in real service environments [7]. Accordingly, the implementation gap often emerges when central policy assumptions do not correspond to local capacity, field-level constraints, or the lived realities of service providers and users.

Afghanistan provides a particularly important context for examining health policy implementation because its health system has operated under prolonged political instability, conflict, institutional fragility, donor dependence, economic vulnerability, and repeated governance transitions. The country's political and social history has created a policy environment in which public institutions have often faced weak continuity, limited administrative capacity, and competing pressures from national authorities, international donors, humanitarian organizations, and local communities [8, 9]. Studies on Afghanistan's health sector indicate that the system has experienced major disruptions after socio-political changes, including challenges in primary healthcare governance, service continuity, workforce retention, community trust, and coordination among health actors [10–13]. These conditions make health policy implementation in Afghanistan not only a technical administrative issue but also a governance challenge embedded in political economy, social legitimacy, institutional resilience, and humanitarian need.

The importance of health policy implementation in Afghanistan is further intensified by persistent service delivery challenges and inequities in access to care. Evidence indicates that access to healthcare in Afghanistan remains constrained by geographical barriers, poverty, insecurity, gender-related restrictions, weak infrastructure,

and uneven distribution of health facilities and health professionals [14, 15]. These barriers are particularly severe in maternal and newborn health, where improvements in service coverage and quality could have substantial effects on mortality reduction by 2030 [16]. In addition, the burden of infectious diseases, limitations in screening and prevention services, and the feasibility challenges of cancer screening in low-resource settings demonstrate that health policy implementation in Afghanistan must address both immediate service gaps and long-term system strengthening needs [17, 18]. Therefore, any model of policy implementation in Afghanistan must be sensitive to the realities of resource scarcity, regional inequality, fragile service delivery, and the need for evidence-based prioritization.

Health policy implementation in fragile and conflict-affected settings is closely connected to the broader agenda of resilient healthcare systems and sustainable development. Conflict zones require health systems that can maintain essential services under conditions of uncertainty, protect vulnerable populations, respond to public health emergencies, and adapt to rapidly changing political and economic environments [19]. The global literature on health equity and peaceful societies further emphasizes that health systems are not merely service delivery structures, but also instruments of social justice, gender equality, trust-building, and social stability [20, 21]. In Afghanistan, these issues are especially relevant because health policy implementation affects not only technical indicators but also public confidence in institutions, community participation, protection of vulnerable groups, and the perceived fairness of the state and service providers. A rights-based approach to health policymaking also underscores the need to place equity, dignity, accountability, and participation at the center of health system reform [22].

One of the central barriers to effective health policy implementation is weak governance. Good governance in public management is associated with transparency, accountability, rule-based decision-making, participation, administrative coherence, and the capacity to make high-quality decisions [23]. In the health sector, governance weaknesses may appear as excessive centralization, fragmented authority, unstable leadership, politicized decision-making, weak regulatory enforcement, inadequate coordination, and insufficient monitoring and evaluation. Studies on semi-centralized governance models and health administrative systems suggest that neither excessive centralization nor unmanaged decentralization is sufficient;

rather, effective governance requires a calibrated structure in which national standards are combined with local implementation authority and accountability [24]. For Afghanistan, this issue is crucial because a rigidly centralized model may fail to capture local realities, while a weakly coordinated decentralized system may intensify fragmentation and inequity. Therefore, a context-sensitive model must identify how authority, accountability, information, and resources should be distributed across levels of the health system.

Evidence-based policymaking and knowledge translation are also essential for closing the gap between policy formulation and implementation. Health systems increasingly require mechanisms that convert data, research evidence, monitoring results, and field feedback into operational decisions. Learning health system theory emphasizes that healthcare organizations should continuously collect data, analyze performance, learn from implementation experience, and use evidence to improve policies and services [25]. Interorganizational healthcare networks also show that implementation depends on multilevel relationships among governmental agencies, providers, academic institutions, civil society organizations, and external partners [26]. In Afghanistan, however, evidence use is often constrained by weak data infrastructure, limited analytical capacity, fragmented reporting systems, delayed information flows, and insufficient institutional mechanisms for translating knowledge into policy action. Similar implementation challenges have been identified in studies of health policy implementation, conflict of interest management, nursing service tariff-setting, and policy failure reduction in health systems, all of which highlight the importance of data quality, stakeholder alignment, risk identification, and managerial accountability [27-29].

Financial resources and budget allocation are another major determinant of health policy implementation. Even well-designed policies may fail when financing is unstable, insufficient, donor-dependent, or poorly aligned with policy priorities. Studies on health system efficiency emphasize the importance of using available resources in ways that maximize outcomes, reduce waste, and improve equity [30]. Evidence from Iran's healthcare system also shows that migrant populations and cross-border health needs can create financial pressures for hospitals and local health systems, a point that is relevant for countries such as Afghanistan where displacement, migration, and regional instability influence service demand and financing patterns

[31]. More broadly, public policy implementation during crises, including economic recovery policies during the COVID-19 pandemic, demonstrates that implementation capacity depends on the ability of institutions to redesign financial mechanisms, restructure support systems, and respond flexibly to changing needs [32]. In Afghanistan, financial constraints are closely connected to donor dependence, limited domestic fiscal capacity, procurement challenges, and uneven resource distribution across regions.

Infrastructure, technology, and digital readiness are increasingly important dimensions of health policy implementation. The experience of telehealth implementation in developing countries shows that digital technologies can expand access, improve continuity of care, support monitoring systems, and strengthen health information flows, but only when they are accompanied by infrastructure, workforce training, regulatory support, and user acceptance [33]. In Afghanistan, digital solutions may support data-driven management, remote consultation, disease surveillance, and service coordination; however, weak connectivity, insufficient equipment, limited technical capacity, and fragmented information systems may prevent digital tools from producing meaningful policy outcomes. Evidence from service delivery redesign in Kenya also demonstrates that implementation pathways must consider organizational readiness, local adaptation, training, supervision, and feedback loops if redesigned health services are to improve maternal and newborn outcomes [34]. These insights suggest that technological reform must be integrated into a broader implementation model rather than treated as an isolated technical intervention.

Participation, transparency, and social trust are also central to health policy implementation. Public policy literature has increasingly emphasized that participation improves legitimacy, responsiveness, and the quality of policy decisions, particularly when affected communities and stakeholders are included in agenda setting, implementation, and evaluation [35]. In health systems, participation is not limited to formal consultation; it includes community feedback, complaint mechanisms, patient voice, provider engagement, civil society oversight, and transparent communication. In Afghanistan, where public trust may be weakened by political instability, conflict, gender restrictions, and uneven access to care, participatory mechanisms are especially important for improving policy acceptance and implementation effectiveness. Studies on barriers to care after political transition in Afghanistan show that social and institutional trust influence whether people

seek services, comply with health recommendations, and perceive the health system as legitimate [12, 15]. Therefore, a model of health policy implementation must include mechanisms for accountability, transparency, and community engagement.

The broader public policy literature also shows that policy implementation challenges are not confined to the health sector. Studies of policy development and implementation in Afghanistan's tourism programs demonstrate that administrative fragmentation, weak institutional coordination, resource limitations, and political instability can undermine implementation across sectors [36]. Similarly, the exploitation of crises by extremist groups during the COVID-19 pandemic illustrates how insecurity and ideological mobilization can complicate governance, public communication, and institutional response in fragile regions [37]. Although these studies focus on different policy domains, they reinforce the idea that implementation in Afghanistan must be understood as a context-dependent process shaped by institutional weakness, insecurity, social complexity, and fluctuating political authority. A model designed for the health system must therefore incorporate contextual and intervening conditions rather than assume that implementation is a linear administrative process.

In recent years, international studies have increasingly focused on implementation drivers and barriers in health systems across low-resource and middle-income settings. Qualitative policy analysis on value-based healthcare implementation in Latin America highlights the importance of stakeholder incentives, institutional readiness, financing models, information systems, and governance alignment [38]. Research on the implementation of public health programs using the Mazmanian and Sabatier framework similarly shows that policy success depends on clear objectives, adequate resources, implementing agency capacity, target group responsiveness, and supportive socio-political conditions [39]. These findings are directly relevant to Afghanistan because they show that implementation models must integrate policy design, institutional capacity, actor behavior, and environmental conditions. Qualitative approaches are particularly suitable for such work because they can reveal the perceptions, lived experiences, and interpretive frameworks of actors who participate in or are affected by implementation processes [40].

Given these theoretical and empirical considerations, the development of a localized model for health system policy implementation in Afghanistan is necessary. Existing studies have described major challenges in Afghanistan's health

system, including governance disruption, access barriers, service inequity, infectious disease burdens, maternal health constraints, workforce shortages, and the effects of political transition [9-11, 13, 41]. However, less attention has been paid to developing an integrated implementation model that connects evidence, governance, managerial stability, human resources, financial capacity, infrastructure, participation, accountability, and organizational learning within a single framework. Studies in Iranian and regional policy contexts have provided useful insights into policy palettes, social determinants of health issues, and public policy implementation analysis, but Afghanistan's distinct political, institutional, and service delivery context requires a model grounded in the perceptions of local experts and health system actors [2, 42, 43]. Therefore, designing such a model can contribute both to the scientific literature on policy implementation in fragile settings and to practical efforts aimed at improving health governance in Afghanistan.

The aim of this study was to design and explain a contextualized model for evidence-based health system policy implementation in Afghanistan.

2. Methodology

The present study, which aimed to design a model for health system policy implementation in Afghanistan, employed thematic analysis based on Braun and Clarke's six-phase framework (Braun & Clarke, 2006). The selection of this method was appropriate because health policy implementation in Afghanistan is a complex, multidimensional, and context-dependent phenomenon shaped by social, cultural, and political conditions, and its deeper layers cannot be revealed through purely quantitative methods. Thematic analysis makes it possible to identify and analyze meaningful patterns within the experiences, perceptions, and interpretations of different actors. Moreover, the inductive and interpretive nature of this method allows the main themes to emerge directly from the data without imposing predetermined theoretical frameworks, a feature that is highly important for studying the specific and indigenous conditions of Afghanistan.

The data for this section of the study were collected through semi-structured interviews with 16 health policymakers, executive managers, physicians, nurses, frontline workers, and academic experts in Afghanistan. After being recorded, the interviews were transcribed in full and compared with the audio files to ensure accuracy and

neutrality. The transcripts were then read several times by the researcher and another researcher to achieve deep familiarization with the data and to record preliminary points, analytical ideas, and key questions for entering the coding stage. This phase provided the necessary basis for a more precise understanding of the data and the beginning of systematic analysis.

3. Findings and Results

After familiarization with the data, open or initial coding was conducted inductively; that is, the researcher identified and labeled meaningful segments of the text in relation to the research questions without imposing predetermined concepts. This process was carried out systematically using MAXQDA 2020 software. During the open coding stage, 512 conceptual codes were extracted from the interview texts. Subsequently, these codes were compared, integrated, and classified to form axial and subthemes. The themes were then reviewed at two levels: first, in terms of the internal coherence of the codes under each theme, and second, in

terms of their fit with the entire dataset. As a result of this review, some themes were merged, removed, or divided into subthemes so that the final thematic map could provide a more accurate representation of the data.

In the final stages, the final themes were defined and named so that the nature, scope, and content of each could be clearly specified. In selecting the names, in addition to the researcher's analysis, the words and expressions used by the participants themselves were also employed so that the themes would remain closer to the data. This stage was conducted in collaboration with two researchers and in consultation with a professor familiar with qualitative methodology, which helped enhance the credibility of the findings. The final research report was developed in a coherent and evidence-based narrative form, in which the main themes were interpreted using direct quotations from participants and in connection with theoretical foundations and previous studies. Accordingly, the qualitative findings are presented in the form of the final model of health system policy implementation in Afghanistan.

Table 1. Characteristics of Participants

No.	Name	Occupation	Work Experience	Education
1	Saba	Physician	22	Cardiologist
2	Azimi	Physician	20	General Practitioner and Master's Degree in Health
3	Nezam	Senior Hospital Consultant	25	General Practitioner and Master's Degree in Public Administration
4	Niayesh	University Professor	18	Physician and PhD in Public Health Management
5	Rahmani	Executive Manager of Health Services	15	PhD in Public Health
6	Morsal	University Professor	20	Master's Degree in General Nutrition
7	Amani	University Professor	14	PhD in Sociology
8	Rezaei	University Professor	18	PhD in Management
9	Vafaei	Senior Employee of the Ministry of Health	15	Master's Degree in Technology Management
10	Oria	Head of a Non-Governmental Organization	20	Physician and Master's Degree in Public Health
11	Ensandost	Head of a Private University	22	PhD in Political Science
12	Sharafat	University Professor	22	PhD in Political Science
13	Safi	Manager at Avicenna Hospital	15	General Practitioner and Subspecialist
14	Modasser	Manager in the Judicial System	20	PhD in Criminal Law and Criminology
15	Abi	Senior Human Resources Consultant in Health	15	Physician and Master's Degree in Health Management
16	Amirzoy	University Professor	35	PhD in Law and Political Science

Open Coding

In the first step, during the open coding stage, the data from all interviews were carefully read and examined sentence by sentence. At this stage, each phrase, idea, or key concept containing meaning related to the research questions was extracted as an open code. This precise and meticulous process ultimately led to the identification of 512 initial open codes. These codes, which constituted the simplest semantic

units of analysis, served as the foundation for all subsequent analytical stages and provided a rich and detailed framework for understanding the experiences and expertise of the participants.

Open coding is the first and most fundamental stage in qualitative data analysis, during which the researcher approaches the raw data, namely interview transcripts, with an analytical and assumption-free perspective and attempts

to identify, name, and categorize the concepts embedded within them. These codes are formed either verbatim or with phrasing very close to the participants' statements and, as far as possible, do not carry the researcher's interpretive burden. The identification of 512 open codes in this study indicates

the richness of the data, the diversity of the participants' experiences, and the sufficient precision and depth of the coding process. These initial codes provided the raw material required for the next analytical stages, namely the formation of semantic clusters or axial codes.

Table 2. Axial Coding Results

Axial Code	Open Codes
Evidence, Data, and Knowledge Translation	Weak data quality; Weakness of data collection infrastructure; Weak reporting quality; Data and information; Valid data; Smart data; Limited use of evidence; Limited use of scientific evidence; Widespread weakness of evidence orientation; Disconnection between data production and decision-making; Possession of a knowledge translation mechanism; Evidence-based guidance of interventions; Use of data-based knowledge; Evidence-based reform; Data-driven management
Governance, Policy, and Managerial Stability	Dominance of political pressure over evidence; Influence of political pressure; Dependence of policies on political individuals; Institutional and political problems; Managerial instability; Instability in health system leadership; Hierarchical management culture; Rigid hierarchy; Centralization in decision-making; Arbitrary management; Experiential decision-making; Lack of binding laws; Institutional structure; Protection from political fluctuations; Continuity of leadership; Law-based institutionalization of evidence
Human Resources, Specialized Capacity, and Managers' Literacy	Shortage of trained personnel; Shortage of specialists in data and policy analysis; Specialized human resources; Human resource capacity building; Improving managers' literacy; Absence of a culture of evidence use; Reliance on personal experience; Culture of evidence acceptance; Reform of managerial culture; Transition from article orientation to problem orientation

Axial Coding

In the axial coding stage, the initial open codes, consisting of 512 codes obtained in the previous stage, were examined and reconsidered in greater depth. In this step, the aim was to create connections among apparently scattered codes and organize them within axial categories. This process was carried out by identifying conceptual relationships, thematic similarities, and causal or contextual sequences among the open codes. Axial coding functioned as a reframing and reorganization of the data at a more abstract level, in which each axial category formed a conceptual core around which related open codes were gathered. By specifying the dimensions, causal conditions, strategies, and consequences of each category, its analytical richness was increased and the groundwork for extracting the selective code was prepared. The axial codes of this study consisted of three codes entitled evidence, data, and knowledge translation; governance, policy, and managerial stability; and human resources, specialized capacity, and managers' literacy.

Axial Code: Evidence, Data, and Knowledge Translation

This axis concerns the gap between data and decision-making, weak data quality, and the need for systematic use of evidence. In this axis, the main issue is that health policymaking in Afghanistan lacks sufficient data support and scientific evidence, and there is no effective connection between knowledge production and decision-making.

In the interviews, one of the most fundamental findings was that the main problem in Afghanistan's health system is not an absolute lack of data, but rather the disconnection

between data production and decision-making. In particular, Nezam, in the third interview, emphasized that data and reports are produced at different levels, but they "do not enter the policymaking process at the moment of decision-making," and for this reason, evidence has not become part of the foundation of decision-making. This view indicates that even when data exist in the system, as long as the knowledge translation mechanism is inactive, data cannot have a real effect on policy formation. Therefore, within this axis, the issue is not merely information collection, but the institutionalization of data use in decision-making.

Another dimension of this axis is the weakness of data quality, registration, and reporting. Morsal, in the sixth interview, explained that clinical and field data are not always "accurate, complete, and up to date," and that if "registration and reporting are not carried out properly, the problem is not seen at the policymaking level." She also referred to the weakness of the health information system, the shortage of digital facilities, and the absence of sufficient training for data registration and analysis. In the same vein, Vafaei, in the ninth interview, emphasized the fragmentation, inconsistency, and delayed nature of data and stated that this situation causes managers to rely on personal experience or limited reports. These two interviews show that the chain of evidence production faces structural weaknesses from the outset, and that data suffer from quality and validity problems before reaching the analytical level.

At the local level, the interviews also show that the use of evidence is limited and that data are often produced more for submission to the center than for local decision-making.

Rahmani, in the fifth interview, stated that many local managers have data but do not have the skills to analyze them; as a result, decisions are made mainly based on central guidelines, project requirements, and managerial experience. He emphasized that “local feedback is very important” and that if a policy does not produce results in a province, there must be the possibility of modifying it. This perspective highlights the position of knowledge translation; that is, data acquire policy value when they are analyzed at the same level at which they are produced and lead to decision modification. Here, the role of universities and support teams also becomes important, as they can contribute to improving analytical capacity at the provincial level.

Another part of the interviews focused on valid data, a national dashboard, and data-driven management. Vafaei, in the ninth interview, explained that data are currently “fragmented, inconsistent, delayed, and sometimes unreliable,” and that this forces managers to rely on individual experience and speculation. He suggested that data should be “rapid, accurate, comparable, and analyzable” and referred to the creation of a national health management dashboard that could display clinical information, costs, human resources, equipment, and performance indicators within a single framework. On the other hand, Oria, in the tenth interview, approached this same point by stating that data are not merely for reporting to the center, but must become tools for better service management. These two interviews show that, in order to move beyond experiential decision-making, the health system requires analytical tools and integrated data infrastructure.

The interviews emphasize the necessity of institutionalizing knowledge translation and creating formal mechanisms for the use of evidence. Nezam, in the third interview, and Niayesh, in the fourth interview, stated that a policy document should not enter the approval stage without data documentation, problem analysis, and scientific justification. In later interviews, particularly by Rezaei in the eighth interview and Sharafat in the twelfth interview, emphasis was placed on formal connections among the government, universities, and research centers, the creation of an official unit or secretariat for evidence-based policymaking, and the requirement of an “evidence appendix” for national health programs. This set of views indicates that health policy implementation in Afghanistan becomes sustainable and effective only when data, knowledge, and decision-making are connected within a coherent institutional cycle; a cycle in which evidence is not

a decorative appendix, but the foundation of decision-making.

Axial Code: Governance, Policy, and Managerial Stability

This axis refers to weak governance, centralization, managerial instability, and the influence of politics on decisions. It shows that health policy implementation in Afghanistan is confronted with challenges related to governance, managerial stability, and political interventions.

This axis shows that health policy implementation in Afghanistan is directly affected by weak governance, centralization, managerial instability, and political interventions. In the third interview, Nezam explicitly explained that the main sources of decision-making in the health system are a combination of political pressures, donor conditions, and managers’ personal experiences. He emphasized that in such an environment, scientific evidence does not acquire a stabilizing role, and with the change of a single political figure, the entire health planning structure is transformed. This situation shows that health policymaking is governed more by political and arbitrary considerations than by data analysis and institutional logic.

Managerial instability is also one of the most important barriers to sustainable policy implementation within this axis. Rezaei, in the eighth interview, stated that the culture of decision-making in the health system is immediate and unstable, and that with every managerial change, priorities also change, in such a way that many previous processes are halted or forgotten. He considered this situation to be a barrier to the formation of institutional memory and the continuation of evidence-based policies. In the same regard, Rezaei emphasized the necessity of leadership continuity, the creation of a safe organizational environment for data use, and the transformation of evidence-based decision modification into a managerial advantage.

On the other hand, Vafaei, in the ninth interview, referred to the role of weak information and directive decision-making in intensifying governance problems. He stated that clinical and field data are not always accurate, complete, and up to date, and that if registration and reporting are not carried out properly, the problem is not seen at the policymaking level. Vafaei emphasized that, in many cases, decision-makers do not pay sufficient attention to field evidence, and that directive and traditional decision-making prevails over analytical decision-making. This view shows that the gap among data, analysis, and decision-making is one of the main factors underlying weakness in health governance.

In these interviews, the lack of a stable institutional structure and binding laws was also raised as a major barrier. Nezam suggested that a national knowledge translation committee should be established and that scientific evidence should be lawfully incorporated into the process of preparing bills and policies. On the other hand, Rezaei also emphasized the creation of an official unit or secretariat for evidence-based policymaking, the mandatory nature of the evidence appendix, the strengthening of the health information system, and the creation of a reliable data bank. These suggestions show that in order to reduce the dependence of decisions on individuals and political fluctuations, permanent and formal mechanisms must be institutionalized in the health system.

This axis emphasizes the necessity of protecting policies from political fluctuations and strengthening accountability and leadership continuity. Vafaei, in the ninth interview, noted that sustainable political support, transparency, and positive pressure from civil society and the media can help improve the use of evidence and reduce arbitrary decision-making. Therefore, health policy implementation in Afghanistan will achieve stability and effectiveness only when governance moves beyond a person-centered and temporary state and is organized based on stable institutions, binding laws, an evidence appendix, and accountable management.

Axial Code: Human Resources, Specialized Capacity, and Managers' Literacy

This axis concerns the shortage of specialized human resources, weak managerial knowledge, and the need for capacity building. One of the serious barriers to policy implementation is the shortage of human resources familiar with data analysis, policymaking, and the application of evidence.

This axis shows that one of the fundamental barriers to health policy implementation in Afghanistan is the shortage of specialized human resources and the weak analytical capacity of managers. In the third interview, Nezam explicitly stated that many policymakers prefer to make decisions based on intuition and personal experience rather than using analytical reports. He explained this situation in connection with a hierarchical management culture and limited financial resources for research, showing that under such conditions, scientific evidence and data analysis do not find an adequate place in decision-making. This finding indicates that the issue is not only the absence of data; rather, the lack of human resources familiar with the application of data and evidence also plays a decisive role.

On the other hand, Rezaei, in the eighth interview, emphasized that the desired model of policy implementation should be based on specialized human resources in the fields of statistics and research. He explained that even if data are available, without managers who have the ability to understand, interpret, and apply them, the model will fail. Rezaei also emphasized the reform of attitudes and the strengthening of evidence literacy among managers, considering this one of the main pillars of capacity building. From his perspective, the training and empowerment of managers must be designed in such a way that the use of data and evidence becomes a managerial skill rather than a secondary matter.

In the same regard, Vafaei, in the ninth interview, emphasized the improvement of data literacy among middle and local managers and stated that training programs should be short-term, practical, and problem-oriented. He considered skills such as reading indicators, analyzing trends, identifying data errors, using dashboards, and converting findings into managerial decisions to be requirements of this capacity building. Vafaei also clarified that the main challenge is not only the absence of a digital system, but also the weakness of the culture of data use and the shortage of analytical capacity at middle levels of management. This view indicates that improving managers' literacy is a prerequisite for converting data into decisions.

Another part of the findings emphasizes the transition from article orientation to problem orientation and the changing role of universities and research centers. Rezaei, in the eighth interview, stated that academic institutions should not focus merely on producing articles, but should participate directly in solving the problems of the health system. He considered the establishment of advisory councils and formal connections among the government, universities, and research centers as a way to direct research toward executive challenges. Also within this framework, the shortage of specialists who can translate data into the language of policy is raised as one of the key gaps; a gap that prevents knowledge from being transformed into effective action.

This axis shows that sustainable health policy implementation in Afghanistan requires human resource capacity building, improvement of managers' literacy, strengthening of the culture of evidence acceptance, and the creation of an effective link among universities, the government, and research centers. In the third, eighth, and ninth interviews, it was repeatedly emphasized that there is insufficient training for data registration and analysis and

that decision-makers often do not pay sufficient attention to field evidence. Therefore, in order to move beyond experiential and intuitive decision-making, a system must be formed in which specialized human resources, problem-oriented training, and an evidence-based managerial culture are strengthened simultaneously.

Selective Coding

Evidence-Based Health System Policy Implementation in Afghanistan

This phenomenon refers to a situation in which health decisions are made and implemented not on the basis of personal preferences, momentary reactions, or external pressures, but on the basis of data, scientific evidence, knowledge translation, and the real needs of the people. The research findings clarified that the main issue is not the absolute shortage of data, but the disconnection between data production and decision-making. This is precisely the point at which “evidence” must be translated into policy. In this regard, Saba, in Interview 1, emphasized that the model should be “indigenous, flexible, and equipped with a knowledge translation mechanism,” and that evidence should be “translated into the language of policymaking.” Therefore, the core phenomenon of this study is not merely the existence of data, but the capacity to transform data into decisions and decisions into action.

Nezam also emphasized in Interview 3 the “law-based institutionalization of evidence” in the process of preparing bills and proposed the establishment of a “national knowledge translation committee.” This statement shows that the phenomenon under consideration is not individual or case-based in nature, but requires a stable institutional mechanism. In fact, the core phenomenon is realized when evidence moves beyond the level of recommendations and articles and enters the formal policymaking cycle. The same meaning is observed in Rezaei’s interview, where he stated that evidence should be the “central pillar of decision-making” and that its use should not depend on individuals’ interests. This alignment shows that the main phenomenon is evidence-based health governance.

Causal Conditions

Causal conditions are the factors that create the basis for the formation of the main problem. In this study, the most important cause is the disconnection between evidence production and its use in decision-making. In several interviews, participants, including Saba and Rezaei, explained that data exist, but their transformation into policy decisions faces barriers. Saba stated that to move toward the desired model, it is necessary to move from “arbitrary

management” to “data-driven management.” This statement clearly shows that the main cause of inefficiency is the absence of a knowledge translation mechanism and the weakness of an evidence-based decision-making culture.

On the other hand, Nezam referred to structural resistance and the need to reform managerial culture. This issue shows that even if data exist, if managers do not have the ability to interpret evidence or if the organizational structure resists change, policy implementation will not be possible. In the same regard, Sharafat also emphasized the training of senior and middle managers. Therefore, the shortage of data literacy and specialized capacity is one of the fundamental causes of this issue. In other words, health policymaking in Afghanistan is deprived not only of data, but also of the human capacity required to understand and use data.

The interviews also show that financial resources and executive infrastructure are among the important causal conditions. In the open codes, “shortage of financial resources,” “weakness of systematic reporting,” and “weakness of health information infrastructure” were identified as recurring factors. Sharafat, in Interview 12, emphasized the strengthening of the health information system and the creation of a reliable data bank. This statement indicates that even if policy will exist, evidence-based policy implementation cannot be realized without information infrastructure and sufficient budget. Therefore, the causal conditions of this study can be summarized at four levels: weakness of knowledge translation, weakness of managerial capacity, shortage of resources, and inefficiency of executive infrastructure.

Intervening Conditions

Intervening conditions are factors that can facilitate or disrupt the pathway through which causal conditions and strategies exert their effects. In this study, managerial instability and political fluctuations are among the most important intervening conditions. Rezaei stated that the use of evidence should not depend on individuals’ interests or project pressures, because with changes in managers, the policymaking path is also disrupted. This statement shows that managerial changes can weaken any effort to institutionalize evidence. Consequently, managerial stability is one of the important intervening variables in implementing the model.

On the other hand, public trust and community participation also play an intervening role in this process. Amani, in Interview 7 and also in earlier evidence, emphasized the absence of complaint and feedback mechanisms, insufficient attention to people’s voices, and

weak public trust. These factors cause even a correct policy to encounter resistance or distrust at the implementation stage. In fact, if people and civil society do not regard themselves as partners in health policy, the translation of evidence into action will face difficulties. This finding is consistent with the axial code of “participation, accountability, transparency, and public trust.”

Dependence on external actors and financial constraints are also other important intervening conditions. Sharafat stated that policymaking should not be excessively dependent on external actors and should be based on internal capacity and indigenous evidence. This point shows that in an environment such as Afghanistan, any implementation model that depends on external resources or consultations will be vulnerable to environmental fluctuations. Therefore, the intervening conditions of this study include political fluctuations, weak public trust, external dependence, structural resistance, and institutional discontinuity.

Contexts

Contexts are the settings in which the phenomenon and strategies take shape. In this study, the context of health policy implementation in Afghanistan is characterized by a hierarchical managerial culture, weak information infrastructure, limited human capacity, and the absence of structural connections between universities and the government. Nezam emphasized the necessity of reforming managerial culture, which shows that the current institutional environment is not yet prepared for data-driven policymaking. Sharafat also referred to the necessity of formal connections among the government, universities, and research centers, a point that indicates that the link between knowledge and policy has not yet been institutionalized in the existing context.

Saba, in Interview 1, also explained that the model should be “flexible” and “aligned with field realities.” This expression shows that the Afghan context, due to regional differences, resource limitations, and executive complexities, requires policies compatible with the environment. In the same regard, weak data literacy and the absence of health information infrastructure limit the context for evidence-based policymaking. Therefore, the contexts for implementing the model include an unstable organizational structure, a non-learning managerial culture, weak infrastructure, and insufficient connection between knowledge producers and decision-makers.

Strategies

Strategies are practical responses to causal and intervening conditions. In this study, the most important

strategy is the institutionalization of evidence through formal instruments such as an evidence appendix, a policymaking secretariat, and a knowledge translation committee. Nezam explicitly stated that strengthening this approach requires the “law-based institutionalization of evidence” in the process of preparing bills. This proposal shows that if evidence does not become mandatory within the formal structure, it will remain at the level of recommendation. Therefore, the first strategy in the model is the formalization of evidence within the policymaking cycle.

The second strategy is strengthening human capacity. Sharafat and Saba both emphasized the training of managers and the improvement of evidence literacy. Saba stated that middle and senior managers should reform their attitudes and strengthen their evidence literacy based on scientific findings. This indicates that implementing the model is not possible without empowered human capital. Therefore, managerial training is not a supplementary measure, but part of the main strategy for transforming evidence into decisions.

The third strategy is institutional linkage between universities and the government. Sharafat suggested that universities should move beyond article orientation and become involved in problem solving, and that a “health policy clinic” should be established. This strategy directly targets the problem of the disconnection between knowledge and policy. Alongside this, the use of policy briefs, formal connections with research centers, and the production of reliable data contribute to the institutionalization of knowledge translation. Therefore, the main strategies of this model are based on three pillars: institutionalization, empowerment, and linking knowledge with decision-making.

Consequences

If the above strategies are implemented properly, the expected consequence will be data-driven, sustainable, and accountable health governance. Rezaei repeatedly emphasized that decision-making should be forward-looking and data-based; therefore, the result of such an approach would be movement from reactive decisions toward policies based on evaluation and comparison. This consequence is consistent with the codes “results-oriented” and “evaluation-oriented.” In other words, when policies are formulated on the basis of evidence, interventions with the highest efficiency are selected and resources are allocated more effectively.

Another consequence is continuous policy reform and organizational learning. In Rezaei’s statements, decision

reform based on new data is not a sign of weakness, but a sign of responsible governance. This perspective has an important consequence: the health system is transformed from a static structure into a learning structure. Saba and Sharafat also emphasized a learning and problem-oriented organizational culture; therefore, the final result of this model is the formation of an organization that learns from errors and adapts itself to new realities.

At the social level, another important consequence is the increase of public trust, transparency, and accountability.

Amani stated that when people are not seen in health policy, even a scientific policy may fail. Therefore, through the institutionalization of participation and transparency, public trust is strengthened and policy implementation faces less resistance. Ultimately, this model can lead to justice orientation, policy continuity, and optimal resource allocation, because decisions are made not on the basis of pressure, but on the basis of real needs, valid evidence, and continuous evaluation.

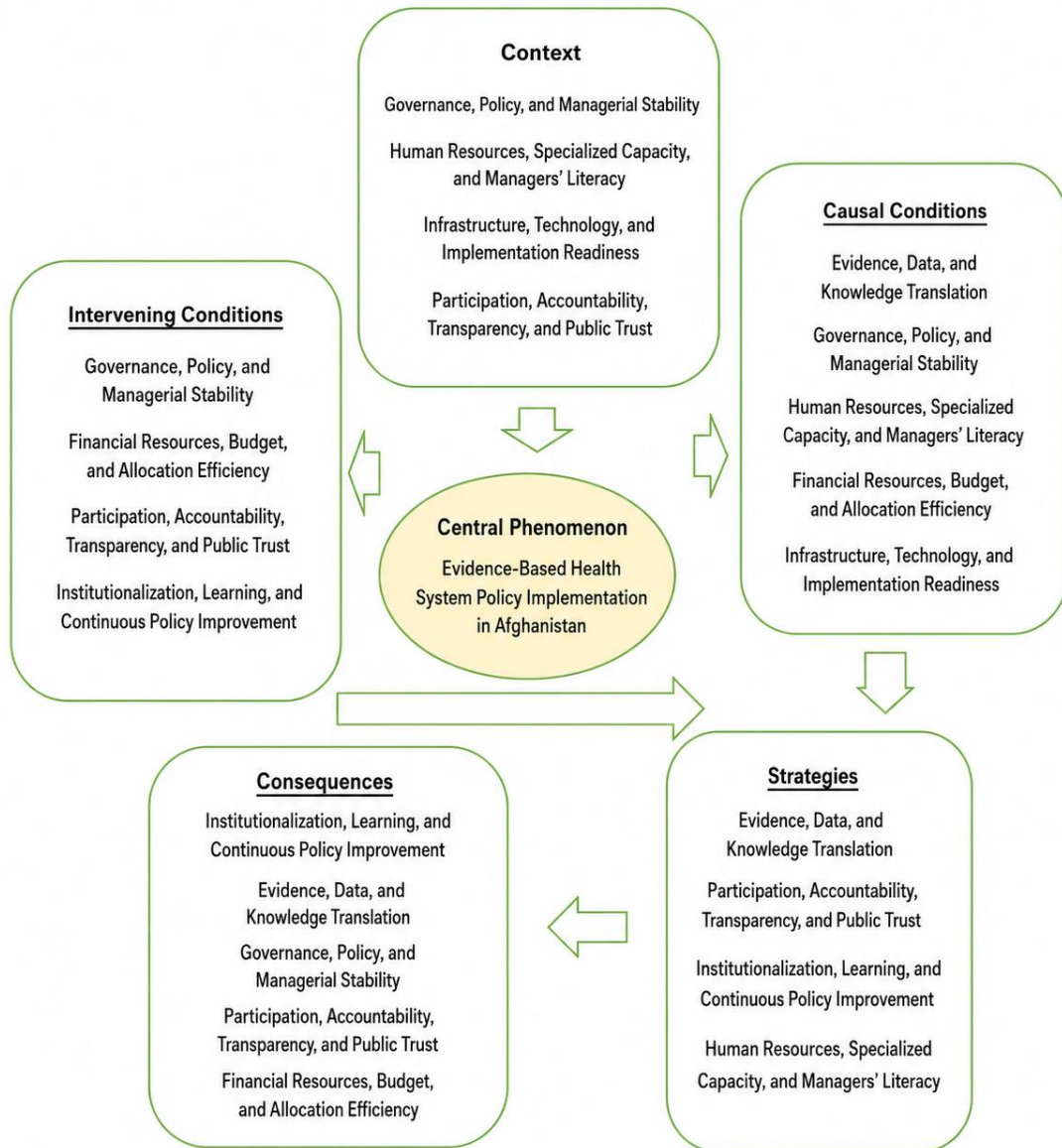


Figure 1. Paradigmatic Diagram of the Study

4. Discussion and Conclusion

The present study aimed to design a contextualized model for health system policy implementation in Afghanistan. The findings showed that evidence-based health system policy implementation in Afghanistan is the central phenomenon around which the model is organized. This result indicates that the main challenge of the Afghan health system is not only the formulation of appropriate health policies, but also the translation of data, evidence, managerial capacity, governance mechanisms, financial resources, and social accountability into practical implementation. The emergence of evidence-based implementation as the selective code is consistent with public policy theories emphasizing that policy success depends on the interaction between policy design, implementation capacity, institutional context, actor behavior, and evaluation mechanisms [1-4]. This finding also aligns with studies showing that implementation failure in health systems often arises from weak evidence use, inadequate prioritization, poor coordination, and insufficient attention to operational risks [27-29]. Therefore, the proposed model confirms that implementation should be understood not as the final administrative phase of policymaking, but as a continuous, evidence-informed, and institutionally embedded process.

One of the most important findings of the study was the identification of “evidence, data, and knowledge translation” as a core component of the implementation model. Participants emphasized that the problem in Afghanistan is not merely the absence of data, but the disconnection between data production and decision-making. This finding is strongly supported by the learning health system perspective, according to which health systems must continuously collect, analyze, and use data to improve services, policies, and organizational learning [25]. It is also consistent with research on multilevel healthcare networks, which highlights the importance of linking institutions, professionals, data systems, and decision-makers in order to convert knowledge into coordinated action [26]. In the Afghan context, this issue is especially critical because fragmented information systems, weak reporting quality, and delayed data flows reduce the capacity of managers to make timely and evidence-based decisions. Similar findings have been reported in studies on health service redesign, telehealth adoption, and policy implementation in developing settings, where the effectiveness of reform depends on information infrastructure, feedback loops,

digital readiness, and institutional capacity for evidence use [33, 34, 38].

The second major result concerned “governance, policy, and managerial stability.” The findings showed that centralized decision-making, political pressure, managerial instability, and weak institutional continuity are among the most serious barriers to health policy implementation in Afghanistan. This result is consistent with public management research showing that good governance improves the quality of public decision-making through accountability, transparency, rule-based procedures, and institutional coherence [23]. It also corresponds with implementation theories that emphasize the need to balance top-down authority with bottom-up adaptation, because excessive centralization weakens responsiveness to local conditions, whereas uncoordinated decentralization may intensify fragmentation [5, 6]. In Afghanistan, the importance of governance is amplified by political instability, contested authority, and the historical fragility of public institutions [8, 9]. Studies on Afghanistan’s health system after the Taliban takeover similarly show that governance disruption, uncertainty in institutional relations, and unstable authority structures have affected service delivery, provider behavior, and cooperation with health authorities [10, 11, 13]. Thus, the present findings confirm that health policy implementation in Afghanistan cannot be strengthened without stabilizing governance arrangements and protecting implementation processes from short-term political fluctuations.

Another important result was the role of “human resources, specialized capacity, and managers’ literacy.” Participants repeatedly stated that even when data are available, the lack of managers who can interpret indicators, analyze trends, use dashboards, and translate evidence into managerial decisions prevents effective implementation. This finding aligns with the literature on street-level bureaucracy, which shows that policies are interpreted and operationalized by frontline actors and local managers whose discretion, values, knowledge, and practical capacity shape implementation outcomes [7]. It is also consistent with studies on policy implementation frameworks emphasizing that implementing agencies require adequate technical, administrative, and human capacity to achieve policy objectives [39]. In Afghanistan, workforce-related implementation barriers are particularly important because health services are affected by shortages of trained personnel, uneven regional distribution of providers, limited professional development opportunities, and weak analytical

capacity at middle and local management levels. Evidence on the availability and distribution of health services across Afghanistan also supports this result by showing that regional inequalities in health resources affect access and implementation capacity [14]. Therefore, the findings suggest that health policy implementation in Afghanistan requires not only more human resources, but also more policy-literate, data-literate, and evidence-oriented managers.

The study also found that financial resources, budget constraints, and allocation efficiency operate as causal and intervening conditions in health policy implementation. This result means that policies may fail not only because of technical design problems, but also because of insufficient, unstable, or inefficiently allocated resources. Previous research on health system efficiency confirms that health systems must allocate limited resources in ways that maximize outcomes, reduce waste, and support equity [30]. In fragile and resource-constrained settings, financial weakness also limits workforce development, infrastructure improvement, procurement, monitoring, and continuity of essential services [19]. Evidence from Iran regarding financial challenges arising from migrant populations shows how cross-border and population mobility pressures can burden local hospitals and health systems, a concern that is relevant to Afghanistan due to displacement, migration, and humanitarian need [31]. In addition, the experience of policy restructuring during the COVID-19 pandemic demonstrates that effective implementation during crisis requires flexible financial arrangements and administrative responsiveness [32]. Accordingly, the present findings indicate that sustainable financing and rational allocation must be treated as integral elements of the implementation model, not as external support conditions.

Infrastructure, technology, and implementation readiness were also identified as important conditions in the model. Participants emphasized weak health information infrastructure, limited digital tools, inadequate facilities, and insufficient readiness for implementing data-driven reforms. This finding is consistent with evidence on telehealth and digital health adoption in developing countries, which indicates that technology can support access, monitoring, coordination, and continuity of care only when infrastructure, user capacity, regulatory support, and organizational readiness are present [33]. It also aligns with studies of maternal and newborn health service redesign, where implementation success depends on practical pathways that include training, supervision, feedback, and

adaptation to local contexts [34]. In Afghanistan, infrastructure is not only a technical requirement but also a determinant of equity, because physical distance, insecurity, transportation problems, and weak facilities reduce access to care. Studies on maternal healthcare access, cancer screening feasibility, infectious disease control, and mortality projections in Afghanistan support this interpretation by showing that service improvement depends on strengthening basic infrastructure, referral systems, screening capacity, and delivery platforms [15-18].

Another key finding was the significance of participation, accountability, transparency, and public trust. The model indicates that health policy implementation is more likely to succeed when communities, civil society, service providers, and local actors are involved in feedback, monitoring, and problem identification. This finding is consistent with research on social participation in policymaking, which shows that participation strengthens legitimacy, responsiveness, and implementation quality [35]. It also aligns with rights-based approaches to health policy, which emphasize dignity, accountability, equity, and the inclusion of affected populations in policy processes [22]. In Afghanistan, public trust is particularly important because social restrictions, political transition, poverty, and insecurity may weaken people's willingness or ability to use health services. Previous studies on barriers to care after the 2021 socio-political changes and maternal healthcare utilization under the Taliban regime show that trust, gender norms, community conditions, and institutional responsiveness significantly affect access to services [12, 15]. Therefore, the present findings suggest that implementation models in Afghanistan must include mechanisms for community voice, complaint handling, transparent reporting, and accountability to service users.

The findings further showed that institutionalization, learning, and continuous policy improvement are both strategic requirements and expected consequences of successful implementation. This result indicates that health policy implementation should not be treated as a one-time administrative act, but as a continuous cycle of implementation, monitoring, feedback, correction, and learning. This is consistent with theories of learning health systems and public policy evaluation, which emphasize that policy effectiveness improves when institutions use evidence to revise decisions and adapt to changing realities [2, 4, 25]. It also corresponds with studies showing that policy implementation in complex systems requires adaptive governance, interorganizational coordination, and

mechanisms that institutionalize knowledge use beyond individual managers [26, 38]. In Afghanistan, where managerial turnover and political instability can disrupt institutional memory, this finding is particularly significant. The model therefore suggests that evidence appendices, policy secretariats, knowledge translation committees, and formal links between universities and government can help preserve continuity and reduce dependence on individual decision-makers.

The results also correspond with broader studies on Afghanistan and fragile policy environments. Research on Afghanistan's healthcare challenges emphasizes that health policy implementation is shaped by political uncertainty, donor dependence, human resource problems, access barriers, and weak governance [10, 11, 41]. Studies of policy development and implementation challenges in Afghanistan's tourism sector similarly show that implementation problems are not limited to health, but reflect wider administrative and institutional weaknesses [36]. Moreover, research on social issues in health, global health equity, human rights, and conflict-zone health systems demonstrates that effective health policy implementation must be connected to social justice, equity, resilience, and protection of vulnerable populations [19-21, 43]. Even studies outside the direct health policy field, such as research on crisis exploitation and socio-political instability, show that insecurity and political fragility can affect public communication, trust, institutional legitimacy, and service continuity [37]. These studies support the present model's emphasis on context, intervening conditions, and the need for adaptive and resilient implementation mechanisms.

Finally, the findings contribute to implementation theory by offering an integrated model in which evidence, governance, managerial stability, human resources, financing, infrastructure, participation, and organizational learning are interconnected. This integrated structure is consistent with meta-synthetic and framework-based approaches to public policymaking, which emphasize that policy implementation must be analyzed through multiple categories rather than through isolated variables [1, 42]. The study also confirms that qualitative inquiry is appropriate for understanding complex transitions, organizational meanings, and lived experiences of actors in policy environments, because implementation is shaped by perceptions, interpretations, and contextual judgments as much as by formal rules [40]. Overall, the proposed model suggests that improving health policy implementation in

Afghanistan requires movement from fragmented, experience-based, and politically vulnerable decision-making toward a structured, evidence-based, participatory, and learning-oriented governance system.

This study had several limitations. First, although the participants were selected from relevant expert groups, the findings are based on a qualitative sample and therefore cannot be statistically generalized to all actors in Afghanistan's health system. Second, the study relied on interview data, and participants' responses may have been influenced by personal experience, professional position, institutional affiliation, or cautiousness in discussing politically sensitive issues. Third, because Afghanistan's health system is highly dynamic and affected by rapid political, economic, and humanitarian changes, some implementation conditions may change over time. Finally, access to some categories of stakeholders, especially remote local managers, community representatives, female service users, and provincial-level frontline staff, may have been limited, which could affect the comprehensiveness of the perspectives included in the model.

Future research should test and refine the proposed model using mixed-methods designs and larger samples from different regions of Afghanistan. Quantitative studies can examine the relative importance of the identified components and assess the relationships among governance, evidence use, managerial capacity, financing, infrastructure, participation, and implementation outcomes. Comparative studies across provinces can also show how local conditions influence policy implementation and whether the model requires regional adaptation. In addition, future studies should include the perspectives of patients, women, rural communities, community health workers, donor organizations, and non-governmental service providers in order to provide a more comprehensive understanding of implementation barriers and facilitators. Longitudinal research would also be valuable for examining how the proposed model performs over time and under changing political and institutional conditions.

For practice, health policymakers in Afghanistan should establish formal mechanisms for evidence-based decision-making, including a national knowledge translation committee, mandatory evidence appendices for major health policies, and regular use of health information dashboards. Health managers at national and provincial levels should receive practical training in data literacy, policy analysis, monitoring, evaluation, and adaptive management. The Ministry of Public Health and partner organizations should

also strengthen coordination between government, universities, research centers, hospitals, and civil society organizations so that research is directed toward real implementation problems. In addition, policy implementation should be supported by stable leadership arrangements, transparent resource allocation, community feedback mechanisms, and continuous monitoring systems. These actions can help transform health policy implementation from a fragmented and reactive process into a more accountable, evidence-based, and learning-oriented system.

Authors' Contributions

Authors equally contributed to this article.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

All procedures performed in this study were under the ethical standards.

References

- [1] P. A. Sabatier, *Theories of the Public Policy Process*. Saffar Publications (in English), 2017.
- [2] W. N. Dunn, *Public Policy Analysis: An Integrated Approach*. Tehran: SAMT Publications (in English), 2024.
- [3] S. M. Alvani and F. Sharifzadeh, *The Process of Public Policy-Making*. Tehran: Allameh Tabataba'i University Press (in English), 2024.
- [4] A. Monavarian, *Implementation and Evaluation of Public Policy*. Tehran: Ketab-e Mehraban (in English), 2022.
- [5] A. Buzogany and H. Pulzl, "Top-Down and Bottom-Up Implementation," in *Handbook of Public Policy Implementation*: Edward Elgar Publishing, 2024, pp. 116-126.
- [6] H. B. Shahi, "Significance of Bottom-Up Approach for Policy Implementation," (in English), *PAAN Journal*, vol. 30, no. 1, pp. 1748-1752, 2024, doi: 10.3126/panj.v30i1.66101.
- [7] J. Kjaerulff, "Discretion and the Values of Fractal Man: An Anthropologist's Perspective on Street-Level Bureaucracy," (in English), *European Journal of Social Work*, vol. 23, no. 4, pp. 634-644, 2020, doi: 10.1080/13691457.2018.1553150.
- [8] G. M. Nagra, A. Nawaz, M. Imran, M. Javed, and G. Mustafa, "People, Politics, and Society: A Historical Analysis of Afghanistan," (in English), *Remittances Review*, vol. 9, no. 2, pp. 539-556, 2024.
- [9] A. Qarizadeh, "The Evolution of the Management of Basic Health and Hospital Services in Afghanistan," (in English), *Jami University Scientific-Research Quarterly*, pp. 21-32, 2024, doi: 10.61438/jsrq.v7i4.11.
- [10] S. Arif, K. F. Rezaie, S. Madadi, and S. H. Mousavi, "Afghanistan's Healthcare under Taliban: What Are the Challenges?," (in English), *Medicine, Conflict and Survival*, vol. 39, no. 1, pp. 93-99, 2023, doi: 10.1080/13623699.2023.2170576.
- [11] M. Basij-Rasikh, E. S. Dickey, and A. Sharkey, "Primary Healthcare System and Provider Responses to the Taliban Takeover in Afghanistan," (in English), *BMJ Global Health*, vol. 9, no. 2, 2024, doi: 10.1136/bmjgh-2023-013760.
- [12] A. Lamberti-Castronuovo *et al.*, "Exploring Barriers to Access to Care Following the 2021 Socio-Political Changes in Afghanistan: A Qualitative Study," (in English), *Conflict and Health*, vol. 18, no. 1, p. 36, 2024, doi: 10.1186/s13031-024-00595-4.
- [13] A. Paterson, J. Palmer, and E. Sondorp, "Health System Governance Cooperation with Unrecognised Health Authorities: A Political Economy Analysis in Afghanistan and Northwest Syria," (in English), *Conflict and Health*, vol. 19, no. 1, p. 30, 2025, doi: 10.1186/s13031-025-00669-x.
- [14] N. Hegazy *et al.*, "The Availability and Distribution of Health Services and Resources across Different Regions in Afghanistan," (in English), *Frontiers in Public Health*, vol. 12, p. 1371104, 2025, doi: 10.3389/fpubh.2024.1371104.
- [15] S. Ibrahim, S. Yeo, K. Yusuf, Z. Akrami, and K. Roy, "Factors Hindering Access and Utilization of Maternal Healthcare in Afghanistan under the Taliban Regime: A Qualitative Study with Recommended Solutions," (in English), *Healthcare*, vol. 13, no. 9, p. 1006, 2025, doi: 10.3390/healthcare13091006.
- [16] F. Maruf, H. Tappis, R. Augustin, T. van den Akker, and Y. Tam, "Potential Impact of Maternal and Newborn Health Improvements in Afghanistan: Projection of Mortality to 2030," (in English), *Maternal and Child Health Journal*, pp. 1-8, 2025, doi: 10.1007/s10995-025-04108-4.
- [17] M. Y. Essar, A. Siddiqui, and M. G. Head, "Infectious Diseases in Afghanistan: Strategies for Health System Improvement," (in English), *Health Science Reports*, vol. 6, no. 12, p. e1775, 2023, doi: 10.1002/hsr2.1775.
- [18] M. Shahid *et al.*, "Cancer Screening in Afghanistan: A Narrative Review of Feasibility, Barriers, and Evidence-Based Strategies for Low-Resource Settings," (in English), *Cureus*, vol. 18, no. 1, 2026, doi: 10.7759/cureus.101346.
- [19] C. N. Ugwu *et al.*, "Sustainable Development Goals (SDGs) and Resilient Healthcare Systems: Addressing Medicine and Public Health Challenges in Conflict Zones," (in English), *Medicine*, vol. 104, no. 7, p. e41535, 2025, doi: 10.1097/MD.00000000000041535.
- [20] V. Percival *et al.*, "The Lancet Commission on Peaceful Societies through Health Equity and Gender Equality," (in English), *The Lancet*, vol. 402, no. 10413, pp. 1661-1722, 2023, doi: 10.1016/S0140-6736(23)01348-X.
- [21] B. Singh, "Reimagining Human Rights: Harnessing the Power of Law for Global Health and Sustainable Development Goals," (in English), *Human Rights in the Global South*, vol. 2, no. 2, pp. 93-105, 2023, doi: 10.56784/hrsgs.v2i2.65.
- [22] L. Bahrami, "Analyzing the Implications of a Rights-Based Approach to Policy-Making in Women's Health," Doctoral

- dissertation in Management, Tarbiat Modares University, Faculty of Humanities, 2024.
- [23] A. R. Sari, "The Impact of Good Governance on the Quality of Public Management Decision Making," (in English), *Journal of Contemporary Administration and Management (ADMAN)*, vol. 1, no. 2, pp. 39-46, 2023, doi: 10.61100/adman.v1i2.21.
- [24] M. A. Kiani, "Designing a Semi-Centralized Governance Model for the Health System in Iran," Doctoral dissertation in Geography, Political Geography, University of Tehran, Faculty of Geography, 2025.
- [25] M. I. Harrison and S. M. Shortell, "Multi-Level Analysis of the Learning Health System: Integrating Contributions from Research on Organizations and Implementation," (in English), *Learning Health Systems*, vol. 5, no. 2, p. e10226, 2021, doi: 10.1002/lrh2.10226.
- [26] G. Van der Weert, K. Burzynska, and J. Knoben, "An Integrative Perspective on Interorganizational Multilevel Healthcare Networks: A Systematic Literature Review," (in English), *BMC Health Services Research*, vol. 22, no. 1, p. 923, 2022, doi: 10.1186/s12913-022-08314-6.
- [27] M. J. Esmacili Seraji, K. Sina, and T. Enayati, "Designing a Model for Implementing Health Policy in the Administrative System with Emphasis on Conflict of Interest Management," (in English), *Razi Medical Sciences*, vol. 30, no. 6, pp. 248-256, 2023.
- [28] H. Nematian Saghi, "Pathology of the Implementation of Nursing Service Tariff-Setting Policy in Human Resource Management," Master's thesis in Public Administration, Human Resource Development, Payame Noor University of South Khorasan Province, Birjand Payame Noor Center, 2025.
- [29] M. S. Abolhasani, M. Ziaeddini, and M. A. Nikbakhsh, "Identifying and Prioritizing Measures to Reduce the Failure of Health-System Policy Implementation Based on Failure Mode and Effects Analysis and Fuzzy TOPSIS," (in English), *Occupational Medicine Quarterly*, vol. 16, no. 1, pp. 11-30, 2024.
- [30] R. Mbau *et al.*, "Analysing the Efficiency of Health Systems: A Systematic Review of the Literature," (in English), *Applied Health Economics and Health Policy*, vol. 21, no. 2, pp. 205-224, 2023, doi: 10.1007/s40258-022-00785-2.
- [31] A. Aghaei Hashjin, M. H. Ghafoori, M. Ghane, and B. Darvishi Teli, "Financial Challenges in Iran's Healthcare System Arising from Migrant Populations: Evidence from Two Hospitals in Yazd Province," (in English), *BMC Health Services Research*, 2026, doi: 10.1186/s12913-025-13755-w.
- [32] L. Agustin and M. Y. Solikin, "Analysis of SMEs Credit Restructuring Policy in Economic Recovery during the COVID-19 Pandemic," (in English), *Jurnal Muara Ilmu Ekonomi dan Bisnis*, vol. 5, no. 2, pp. 405-416, 2021, doi: 10.24912/jmie.v5i2.13087.
- [33] J. Ye, L. He, and M. Beestrum, "Implications for Implementation and Adoption of Telehealth in Developing Countries: A Systematic Review of China's Practices and Experiences," (in English), *NPJ Digital Medicine*, vol. 6, no. 1, p. 174, 2023, doi: 10.1038/s41746-023-00908-6.
- [34] M. Chen *et al.*, "Implementation Pathways of a Health Services Delivery Redesign Model to Improve Maternal and Newborn Outcomes in Kenya," (in English), *BMJ Global Health*, vol. 11, no. 1, 2026, doi: 10.1136/bmjgh-2024-018240.
- [35] E. Ahmadi and P. Aftabi, "Examining the Position of Social Participation in the Process of Conservation and Management Policy-Making for World Heritage Cities," (in English), *Baghe Nazar*, vol. 19, no. 115, pp. 69-80, 2022.
- [36] E. M. Varimach, "Explaining Policy Development and Implementation Challenges of Afghanistan's Tourism Programs," Master's thesis in Tourism, Tourism Marketing, University of Science and Culture, Faculty of Tourism Sciences, Tehran, 2025.
- [37] U. Botobekov, "How Central Asian Salafi-Jihadi Groups Are Exploiting the COVID-19 Pandemic: New Opportunities and Challenges," in *Religious Studies*, vol. 21, 2021, p. 107.
- [38] M. Touchton, H. Arreola-Ornelas, K. A. Arizmendi-Barrera, V. V. Enciso, and F. M. Knaul, "Drivers and Barriers for the Implementation of Value-Based Healthcare in Latin America: A Cross-Country Qualitative Policy Analysis," (in English), *The Lancet Regional Health - Americas*, vol. 53, 2026, doi: 10.1016/j.lana.2025.101307.
- [39] G. Maisarah and R. Yusran, "Exploring the Key Factors in the Implementation of the GERMAS Policy: A Public Management Perspective Using the Mazmanian and Sabatier Framework," (in English), *Journal of Educational Management Research*, vol. 4, no. 4, pp. 1870-1879, 2025, doi: 10.61987/jemr.v4i4.1144.
- [40] C. Flores, "A Qualitative Phenomenological Study of Military Veterans' Lived Experiences with the Cultural Transition Process: Navigating from the Military Culture to Civilian Life," 2025.
- [41] F. G. M. Yar, "Analysis of Challenges and Opportunities for Improving the Health System in Afghanistan: Innovative Approaches and Sustainable Solutions," (in English), *Jurnal Sosial Teknologi*, vol. 4, no. 10, pp. 923-941, 2024, doi: 10.59188/jurnalsostech.v4i10.27615.
- [42] N. Eskandari Nia, K. Daneshfard, and A. Faghihi, "The Public Policy-Making Palette: An Integrated Study Using Meta-Synthesis and the Delphi Technique," (in English), *Public Policy-Making in Management*, vol. 11, no. 4, 2020.
- [43] A. Hodoudi, M. H. Asadi Davoudabadi, and A. Roshanaei, "Sociology of Social Issues in Iran in the Field of Health," (in English), *Journal of Mashhad University of Medical Sciences Faculty of Medicine*, vol. 65, no. 1, pp. 521-544, 2022.