

Rural Health Inequality: A Case Study of Ancient Persian and Modern Iranian Herbal Medicine in South Punjab

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Abstract

Rural health inequality in Pakistan remains structurally embedded, with South Punjab experiencing limited access to formal healthcare infrastructure, workforce shortages and uneven service delivery. This study addresses the governance and accessibility problem arising from reliance on informal and traditional medical systems, particularly ancient Persian and modern Iranian herbal medicine, in underserved rural contexts. It advances two research questions, first how herbal medical systems are positioned within Pakistan's broader health framework, and second how these practices function within the socio economic and cultural landscape of South Punjab. Empirical evidence from interviews with experts (N=5) and their patients (N=20), where each expert accounts for five patients trained through apprenticeship-based learning, indicates strong socio-cultural acceptance driven by affordability, historical continuity and perceived therapeutic effectiveness, alongside concerns regarding standardisation and clinical validation. Recent literature between 2020 and 2026 supports this trend, including Hamid Reza Nasr in *Traditional Persian Medicine and Healing* (2021), Ali Abbas Rizvi in *Herbal Traditions in South Asia* (2023) and Sara Ahmed Khan in *Rural Health Systems in Pakistan* (2025), each emphasising the resilience of herbal systems under constrained health infrastructures. The findings demonstrate that herbal medicine in South Punjab operates as a compensatory healthcare mechanism within a structurally unequal system, sustaining access while remaining outside formal regulatory integration.

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Introduction

Rural health inequality refers to systematic disparities in access to healthcare services, quality of treatment and health outcomes between rural and urban populations. Global institutions such as World Health Organization and United Nations Development Programme define this inequality through indicators including service availability, workforce distribution and financial protection (Berman, 2016). These frameworks emphasise that rural populations experience delayed access to care, higher disease

burden and reduced preventive coverage. Structural determinants include geographic isolation, weak infrastructure and limited institutional investment. Health inequality is therefore not only a clinical issue but a governance and development challenge. Measurement frameworks often include maternal mortality rates, immunisation coverage and physician to population ratios. Rural health systems are frequently dependent on informal or traditional providers due to absence of formal facilities. This condition reinforces cycles of vulnerability and marginalisation. International policy discourse links rural inequality with broader socio-economic exclusion. The concept remains central to understanding healthcare dynamics in developing regions (Ensor, 2019).

In Pakistan, rural health inequality persists as a critical structural concern within the national health system. Public sector healthcare infrastructure is unevenly distributed, with a concentration of tertiary facilities in urban centres. Rural areas rely on basic health units that often lack trained personnel, equipment and medicine supply chains. The physician to patient ratio remains significantly lower in rural districts compared to metropolitan regions. Financial constraints further limit access as out of pocket expenditure dominates healthcare financing. Informal practitioners and traditional healers fill the service gap created by institutional deficiencies. Government initiatives have attempted expansion through primary healthcare reforms but implementation remains inconsistent. Health outcomes in rural Pakistan reflect higher maternal mortality and infectious disease prevalence. The regulatory framework does not fully integrate informal healthcare providers. This creates a parallel system operating outside formal oversight yet serving a substantial population segment (Ahmed, 2023) (Bhutta & Das, 2019).

Within this national context, South Punjab represents one of the most underserved regions in terms of healthcare access and equity. Major districts such as Multan, Bahawalpur, Dera Ghazi Khan and Rahim Yar Khan exhibit persistent disparities in service availability. Survey reports between 2024 and 2026 indicate that nearly 62 percent of rural households in Multan division depend on non-formal healthcare providers. In Bahawalpur division, access to qualified physicians remains below 40 percent in peripheral areas. Dera Ghazi Khan reports maternal health service coverage at approximately 45 percent, reflecting infrastructural limitations. Rahim Yar Khan shows increased reliance on traditional medicine, with surveys estimating usage rates above 55 percent. These figures illustrate a pattern of systemic under provision and adaptive reliance on alternative care systems. Infrastructure gaps are compounded by socio economic deprivation and low health literacy. Public investment remains insufficient to meet regional demand. The result is a fragmented healthcare landscape with uneven service delivery (Ali & Hussain, 2026) (Asim & Hussain, 2026) (Bhutta & Das, 2019).

Ancient Persian and modern Iranian herbal medicine have emerged as adaptive healthcare responses within this regional context. These systems are grounded in centuries old medical traditions emphasising natural remedies, humoral balance and holistic treatment approaches. Their introduction into South Punjab is linked to cross border intellectual exchange, religious travel and informal training networks. Practitioners trained in Iran have transmitted knowledge through apprenticeship-based learning models. The system operates through herbal formulations, dietary regulation and personalised treatment protocols. Its appeal lies in low-cost structure and cultural compatibility with local healing traditions. Clinics are typically small scale and community embedded rather than institutionally formalised. The absence of regulatory barriers has facilitated rapid diffusion across rural districts. Patients perceive these practices as accessible and less invasive compared to biomedical treatments. This has enabled their integration into local health seeking behaviour (Ansari & Hussain, 2026).

Socio cultural acceptance of Persian and Iranian herbal medicine in South Punjab is shaped by trust, tradition and perceived efficacy. In Multan, acceptance levels are estimated at over 60 percent among rural populations seeking alternative care. Bahawalpur demonstrates similar trends, particularly among lower income groups prioritising affordability. In Dera Ghazi Khan, tribal and community networks reinforce the credibility of herbal practitioners. Rahim Yar Khan shows a growing urban periphery acceptance driven by dissatisfaction with public healthcare services. Patients often rely on word-of-mouth referrals and familial experience when selecting practitioners. Religious and historical affinities with Persian culture further strengthen acceptance patterns. The personalised nature of treatment enhances patient satisfaction and continuity of care. However, scepticism persists among educated urban segments regarding scientific validation. This creates a dual perception environment combining trust and caution. Overall, socio cultural alignment remains a key driver of utilisation (Hussain, 2026).

Practitioners trained in Iranian herbal medicine hold significant value within these communities due to their specialised knowledge and perceived authenticity. Their training involves direct mentorship under experienced healers, often within Iranian institutions or informal learning environments. This apprenticeship model emphasises experiential learning, diagnostic skill development and patient interaction. Communities regard such practitioners as custodians of a refined medical tradition. Their association with Iran enhances credibility due to the country's historical reputation in traditional medicine. Patients attribute higher efficacy to treatments administered by formally trained herbal experts. These practitioners often command greater trust compared to locally trained healers. Their role extends beyond treatment to advisory functions on diet and lifestyle. Economic accessibility further increases their relevance in low-income settings. This combination of expertise and affordability positions them as critical actors within the rural health system (Hussain, 2026).

Scholarly contributions provide critical context for understanding this phenomenon. Hamid Reza Nasr in *"Traditional Persian Medicine and Healing"* (2021) emphasises the epistemological depth and clinical logic of Persian medical traditions (Nasr, 2021). He highlights their adaptability across cultural contexts and sustained relevance in contemporary practice. Ali Abbas Rizvi in *"Herbal Traditions in South Asia"* (2023) examines the integration of regional herbal systems within plural medical environments. He identifies cross cultural transmission as a key factor in sustaining traditional practices (Rizvi, 2023). Sara Ahmed Khan in *"Rural Health Systems in Pakistan"* (2025) analyses structural deficiencies in rural healthcare and the compensatory role of informal providers. She argues that traditional medicine remains central to service delivery in underserved regions (Khan S. A., 2025). These works collectively establish the theoretical and empirical basis for the present study. They also highlight gaps in regulatory integration and policy recognition.

This study advances two core research questions with expanded analytical components. The first examines how herbal medical systems are positioned within Pakistan's broader health framework, including regulatory recognition, institutional exclusion and interaction with biomedical and traditional systems. It further investigates legitimacy perceptions among policymakers and practitioners. The second question evaluates how these practices function within the socio economic and cultural landscape of South Punjab. This includes analysis of accessibility, affordability and patient trust across districts such as Multan, Bahawalpur, Dera Ghazi Khan and Rahim Yar Khan. It also assesses the influence of socio-economic class on healthcare choices. Additional components include perceived efficacy, continuity of care and practitioner patient relationships. Expert interviews provide institutional and operational

perspectives. Patient responses capture experiential and cultural dimensions of healthcare utilisation. This structured approach ensures comprehensive evaluation aligned with the study's objectives.

Research Methodology

This study adopts a qualitative case study design to examine rural health inequality and the role of Persian and Iranian herbal medicine in South Punjab. The methodological approach is grounded in interpretivist epistemology, focusing on lived experiences and practitioner knowledge systems. Data collection relies on semi structured interviews, enabling flexibility while maintaining analytical consistency. The design integrates practitioner based and patient-based perspectives to ensure triangulation. A total sample of experts (N=4) and patients (N=20) is constructed to capture both institutional and experiential dimensions. Each practitioner contributes five patients to maintain proportional representation. The study applies purposive and snowball sampling techniques to identify relevant respondents. Analytical procedures are aligned with thematic coding and comparative interpretation. This structure ensures coherence between research questions and empirical investigation.

1) Sampling Strategy and Field Selection

The sampling framework combines purposive selection of practitioners with snowball identification of patients. Practitioners were selected based on their formal or informal training in Iranian herbal medicine and active clinical presence in South Punjab. Snowball sampling was employed to identify patients through practitioner networks, ensuring authenticity of treatment experience. Each practitioner provided access to five patients, resulting in a total patient sample of twenty. This distribution allows balanced representation across different localities and practitioner profiles. The sampling design reflects established ethnomedical research practices where community-based networks facilitate data access. Field sites include Multan, Bahawalpur, Dera Ghazi Khan and Rahim Yar Khan. These locations were selected due to documented reliance on traditional medicine and limited formal healthcare access. The approach ensures contextual depth and geographic diversity. Sampling saturation was achieved when recurring patterns emerged across interviews.

2) Practitioner Profile and Training Background

This study includes four practitioners trained in different regions of Iran, each representing a distinct transmission pathway of herbal knowledge. Their profiles are presented below to establish credibility and analytical grounding.

Practitioner	Training Location in Iran	Mode of Learning	City of Practice in South Punjab
Syed Abbas Shah	Tehran	Institutional apprenticeship	Multan
Khalid Ali Shad	Qom	Religious scholastic training	Bahawalpur
Aoun Shah Bukhari	Mashhad	Traditional mentorship	Dera Ghazi Khan
Fazl-e-Asghar	Hamadan	Hybrid clinical exposure	Rahim Yar Khan

These practitioners represent diverse epistemological foundations within Iranian herbal medicine. Their training reflects a combination of formal instruction and experiential learning. This diversity enhances the analytical robustness of the study. Each practitioner operates within a community-based clinic setting. Their inclusion ensures representation of different operational models. The table establishes the transnational dimension of knowledge transfer. It also supports evaluation of how training origin influences practice patterns.

3) Patient Sample Distribution

The patient sample is structured to ensure equal representation across practitioners and locations. Each practitioner contributes five patients, resulting in a total of twenty respondents. The distribution is presented below.

Practitioners	Number of Patients	City Location
Syed Abbas Shah	5	Multan
Khalid Ali Shad	5	Bahawalpur
Aoun Shah Bukhari	5	Dera Ghazi Khan
Fazl-e-Asghar	5	Rahim Yar Khan
Total	20	South Punjab

This structure ensures balanced data collection across geographic and practitioner categories. Patients were selected based on active engagement with herbal treatment for at least one month. This criterion ensures informed responses regarding treatment outcomes and satisfaction. The sample captures variation in socio economic background and health conditions. It enables comparative analysis across districts. The distribution also supports evaluation of regional differences in acceptance and utilisation.

4) Data Collection Techniques

Data were collected through semi structured interviews conducted in local languages to ensure clarity and participant comfort. Interview guides were designed separately for practitioners and patients to address distinct analytical dimensions. Practitioner interviews focused on training background, treatment methods, regulatory perception and patient interaction. Patient interviews addressed trust, affordability, perceived efficacy and continuity of care. Each interview lasted between 25 to 40 minutes, ensuring depth without respondent fatigue. Field notes were maintained to capture nonverbal cues and contextual observations. Audio recording was employed with participant consent to ensure accuracy. The methodology aligns with ethnomedicinal research standards where qualitative depth is prioritised. Data collection continued until thematic saturation was achieved. This approach ensures reliability and consistency across responses.

5) Analytical Framework and Tools

This study employs thematic analysis to interpret qualitative data in alignment with research questions. Transcribed interviews were coded using open and axial coding techniques to identify recurring patterns. Categories were developed around governance positioning, socio cultural acceptance and healthcare accessibility. Comparative analysis was conducted across practitioner

and patient responses to identify convergence and divergence. Analytical tools include manual coding matrices and qualitative data organisation frameworks. The study also integrates frequency mapping to quantify dominant themes within responses. This hybrid qualitative quantitative approach enhances analytical precision. Reliability was ensured through repeated review and cross validation of coded data. The framework enables systematic evaluation of both research questions. It also supports integration of empirical findings with theoretical constructs.

6) Evaluation of Research Questions

The first research question is evaluated through analysis of practitioner responses regarding regulatory positioning and institutional interaction. Sub components include recognition status, operational autonomy and engagement with formal healthcare systems. The second research question is assessed through patient centred data focusing on accessibility, trust and socio-economic influence. Cross comparison between districts enables identification of regional variations. The methodology ensures that each research component is addressed through targeted data segments. Triangulation between practitioner and patient data strengthens validity. Analytical outputs are mapped against broader health system dynamics in Pakistan. This structured evaluation ensures that findings are both contextually grounded and theoretically informed. The methodology therefore provides a comprehensive framework for addressing rural health inequality through the lens of herbal medical practice.

Empirical Answers to Research Questions

Positioning of Herbal Medical Systems within Pakistan's Broader Health Framework

The empirical findings indicate that herbal medical systems derived from Persian and Iranian traditions occupy a peripheral yet functionally significant position within the healthcare structure of Pakistan. These systems operate outside formal regulatory recognition yet remain embedded within community level service provision. Practitioners report no formal licensing pathway specific to Iranian herbal medicine, which places them in a legally ambiguous category. Despite this, there is no systematic enforcement action against their practice, indicating passive tolerance by state authorities. Interaction with biomedical systems is minimal and largely informal, with no structured referral mechanisms. Traditional systems such as Unani medicine provide a partial point of overlap, yet Iranian herbal practice remains distinct in epistemology and method. Practitioners perceive their legitimacy as grounded in experiential success rather than institutional validation. Policymakers are largely absent from this domain, resulting in limited policy engagement or strategic oversight. This creates a fragmented governance structure where multiple systems coexist without integration. Patients navigate between systems based on personal preference and perceived outcomes. The overall positioning reflects a hybrid configuration marked by exclusion at the institutional level and acceptance at the societal level (Ansari & Hussain, 2026).

- Practitioners report zero formal accreditation pathways specific to Iranian herbal medicine within national health regulatory bodies.
- Informal tolerance is observed, as no practitioner reported legal obstruction or closure of clinics.
- Interaction with biomedical practitioners occurs only at the level of patient choice rather than institutional coordination.

- Overlap with Unani practitioners exist in herbal usage but differs in diagnostic frameworks and training lineage.
- Policymaker engagement is absent, with no respondent indicating awareness of formal consultation or policy inclusion.
- Patients often combine treatments from multiple systems, reflecting adaptive healthcare behaviour.
- Legitimacy is constructed through treatment outcomes and community reputation rather than certification.
- Regulatory absence creates operational freedom but limits standardisation and accountability.
- The system persists due to demand driven utilisation rather than institutional support.
- This configuration confirms the existence of a parallel healthcare subsystem within the national framework (Bukhari, 2023).

Regulatory Recognition and Institutional Exclusion

The study demonstrates that regulatory recognition of Iranian herbal medicine is effectively non-existent within Pakistan's formal health governance architecture. Practitioners operate without registration under bodies such as national or provincial health authorities. This absence of recognition results in institutional exclusion from policy frameworks, funding mechanisms and professional networks. Experts highlight that existing regulations are designed primarily for biomedical and recognised traditional systems such as Unani and homeopathy. Iranian herbal practice does not fall within these predefined categories, leading to administrative invisibility (Hosseini, 2022). Patients are largely unaware of this regulatory gap and base their trust on personal experience rather than legal status. The lack of institutional inclusion restricts opportunities for professional development and standardised training. Practitioners rely on self-regulation and peer networks to maintain service quality. This creates variability in practice standards across different locations. Institutional exclusion also limits the potential for research collaboration and data integration. The findings confirm that regulatory frameworks have not adapted to transnational medical practices entering the local context.

Regulatory Dimension	Status Observed	Implication
Licensing	Absent	Legal ambiguity
Accreditation	Not available	No standard training validation
Monitoring	None	No quality control mechanism
Policy Inclusion	Excluded	No formal recognition
Institutional Support	None	No funding or integration

Interaction with Biomedical and Traditional Systems

The interaction between Iranian herbal medicine and existing healthcare systems in Pakistan is characterised by parallel operation rather than integration. Biomedical practitioners do not formally recognise or collaborate with herbal practitioners trained in Iranian traditions. Patients independently decide when to shift between systems based on treatment outcomes. In some cases, patients use herbal remedies alongside prescribed biomedical treatments without informing either practitioner. This lack of coordination introduces potential risks related to drug interactions and inconsistent care. Traditional systems such as Unani medicine provide a limited interface due to shared use of herbal ingredients.

However, diagnostic approaches differ significantly, reducing the scope for integration. Practitioners report no institutional platforms for interdisciplinary engagement. This reinforces professional isolation and limits knowledge exchange. Patients act as the primary link between systems, navigating treatment pathways based on personal judgement. The absence of structured interaction reflects broader fragmentation within the healthcare system. This condition supports the persistence of multiple independent care streams (Ali & Hussain, 2026) (Berman, 2016).

Legitimacy Perceptions among Practitioners and Patients

Legitimacy within Iranian herbal practice is constructed through social validation rather than institutional endorsement. Practitioners emphasise lineage based training and experiential knowledge as key sources of authority. Patients evaluate legitimacy based on treatment outcomes, practitioner behaviour and community reputation. Trust is reinforced through repeated successful interactions and referrals within social networks. The absence of formal certification does not significantly reduce patient confidence. However, some respondents express concern regarding the lack of standardisation and verification. Practitioners acknowledge that untrained individuals entering the field may undermine credibility. Despite this, established practitioners maintain strong patient loyalty. Legitimacy is therefore dynamic and context dependent rather than fixed (Bukhari, 2023). The findings indicate that socio cultural acceptance compensates for regulatory absence. This form of legitimacy sustains the practice within the broader healthcare environment.

Legitimacy Indicator	Patient Response (N=20)
High Trust	12
Moderate Trust	06
Low Trust	02
Concern Over Certification	08

Functioning within the Socio Economic and Cultural Landscape of South Punjab

The second research question is addressed through analysis of how Iranian herbal medicine operates within the socio economic and cultural environment of South Punjab (Ahmed, 2023). The findings indicate that accessibility and affordability are primary drivers of utilisation across districts such as Multan, Bahawalpur, Dera Ghazi Khan and Rahim Yar Khan. Patients report that herbal clinics are easier to access compared to distant public hospitals. Cost of treatment is significantly lower, making it viable for low-income households. Cultural familiarity with herbal remedies enhances acceptance. Practitioners adapt treatment methods to local contexts, increasing relevance. Socio economic constraints limit access to biomedical care, reinforcing reliance on alternative systems. Community networks play a central role in information dissemination. Patients often follow recommendations from family members and peers. The system functions as an adaptive response to structural healthcare gaps. This operational model reflects a combination of necessity and cultural alignment.

Accessibility and Affordability

Accessibility and affordability emerge as dominant factors influencing patient engagement with herbal medicine. Clinics are located within or near residential areas, reducing travel time and cost. Treatment fees are flexible and often negotiated based on patient capacity. This contrasts with fixed pricing in formal healthcare facilities. Patients report that herbal medicine is particularly useful for chronic conditions

requiring long term care. The absence of consultation fees in some cases further enhances accessibility. Practitioners maintain informal payment structures to retain patient loyalty. This creates a patient centred economic model. However, lack of price regulation leads to variability across practitioners. Patients accept this variability due to perceived benefits. The findings confirm that economic considerations are central to healthcare decision making in rural contexts.

Economic Factor	Patient Response (N=20)
Affordable	15
Moderately Affordable	04
Expensive	01

Patient Trust and Socio-Cultural Acceptance

Patient trust is closely linked to socio cultural acceptance of herbal medicine in South Punjab. Historical familiarity with herbal remedies creates a favourable environment for adoption. Religious and cultural ties with Persian traditions enhance credibility. Patients perceive herbal treatment as natural and less harmful compared to synthetic medicine. Practitioners reinforce trust through personalised care and regular follow up. Community endorsement plays a critical role in sustaining patient flow. Differences across districts reflect variations in literacy and exposure to biomedical systems. Multan and Bahawalpur show higher acceptance due to stronger urban rural interaction. Dera Ghazi Khan and Rahim Yar Khan exhibit deeper reliance due to limited healthcare alternatives. Trust is therefore both culturally embedded and structurally reinforced. This dynamic ensures continuity of practice across generations.

Influence of Socio-Economic Class and Continuity of Care

Socio economic class significantly influences engagement with herbal medical systems. Lower income groups demonstrate higher reliance due to financial constraints. Middle income groups adopt a mixed approach, combining herbal and biomedical treatments. Higher income groups show selective engagement, often for chronic or unresolved conditions. Continuity of care is maintained through long term relationships between patients and practitioners. This contrasts with episodic care in formal healthcare systems. Practitioners maintain patient records informally, relying on memory and repeated interaction. This strengthens interpersonal trust but limits data standardisation. Patients value continuity as it enhances treatment consistency. However, absence of formal documentation restricts clinical evaluation (Bhutta & Das, 2019). The findings indicate that socio economic factors shape both access and treatment patterns. This reinforces the role of herbal medicine as a complementary yet essential healthcare option.

Conclusion

“Health is not valued till sickness comes”, observed Thomas Fuller, a statement that captures the underlying reality of healthcare behaviour in underserved regions. This study has demonstrated that rural health inequality in Pakistan, particularly in South Punjab, has created structural conditions where alternative medical systems are not optional but necessary. Ancient Persian and modern Iranian herbal medicine have emerged as functional responses to gaps in accessibility, affordability and institutional reach. The findings confirm that these systems operate within a parallel yet socially legitimised healthcare space, sustained by patient trust and economic feasibility. Regulatory absence has neither eliminated

these practices nor reduced their utilisation, instead it has reinforced informal governance mechanisms. Practitioners trained in Iran maintain credibility through experiential knowledge and community engagement. Patients rely on these services as primary or complementary care depending on socio economic position. The study establishes that medical pluralism in South Punjab is driven by necessity rather than preference. It further confirms that institutional exclusion coexists with strong socio-cultural acceptance. The evidence supports a recalibration of health governance to recognise and manage such systems. This study concludes that Iranian herbal medicine in South Punjab functions as a stabilising yet unregulated component of rural healthcare, addressing inequality while remaining structurally marginalised.

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