



Health at the Margins: Everyday Experiences of Health System in Qilla

Saifullah, Balochistan

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Abstract

This study aimed to examine the lived healthcare experiences of people in structurally marginalized and under-resourced district Qilla Saifullah in Balochistan. The purpose of the study was to gain insight into the daily health care problems experienced by the residents and how they cope with the lack of health care services and structural inequalities. The qualitative research design was adopted, and data gathering was done through semi-structured interviews with 10 local residents, healthcare workers and community members. The research was also guided by the framework of structural violence of Paul Farmer (2004) that defines the unequal social and institutional systems that influence health care access and health outcomes. Thematic analysis was used to reveal the key patterns and themes within the data. The findings revealed that structural barriers such as the unavailability of medical centers, untrained physicians, inadequate infrastructure, geographic remote areas, financial issues, and gender discrimination were the limitations to accessing healthcare in Qilla Saifullah. The study also revealed problems of delayed treatment, long distances to treatment, inadequate medicines, as well as poor emergency services, particularly in rural regions. Home remedies, spiritual healing, traditional practices and community support networks were the coping mechanisms of residents respectively. The study shows that the disparity in health care in Qilla Saifullah is a symptom of the general structural oversight and unequal distribution of resources. It suggests improving healthcare infrastructure in rural areas, availability of trained medical staff and making the emergency healthcare system more robust in the marginalized areas.

Keywords: Healthcare Inequality, Rural Urban Divide, Structural Violence, coping strategies, Balochistan

Introduction

The unequal access to health services in Pakistan can be seen clearly as urban and rural areas are different, and the difference is prominent in Qilla Saifullah district Zhob Division in the north-eastern part of Balochistan (Panezai, 2012; Ullah et al., 2024). This district is located about 188km away from Quetta. In contrast to the major urban areas such as Quetta, rural areas are facing huge deficit in health care infrastructure, doctors, medicines and emergency services. Research has revealed the unequal distribution of medical resources and facilities across the districts and between rural and urban areas of Balochistan (Panezai 2012; Ullah et al. 2024). Panezai, (2012) explains that the healthcare facilities are relatively underdeveloped in the remote areas of Balochistan with substandard level of healthcare services due to the lack of investment by the government, poor infrastructure and geographical isolation of the remote areas. Analogously, research in Quetta has shown that even the provincial capital of Quetta suffers from poor service quality in primary healthcare services and the situation is worse in remote rural areas where there are fewer and poorly equipped primary healthcare services (Ali & Panezai, 2021). The transport problems, fragmented settlements, and scarcity of healthcare providers in rural areas of Balochistan also hinder access to healthcare services in these areas (Ullah et al., 2024).

Healthcare facilities are scarce in Qilla Saifullah with medical services being underdeveloped, and few trained doctors. Access to even basic treatment is not available for most residents and they have to travel far distances, sometimes resulting in delayed treatment or relying on local healers and informal practitioners (Ali and Jalal, 2021; Khan et al, 2020). These conditions indicate that the lack of health services is not merely due to

scarcity of services, but also to the uneven availability of resources and development in the regions. The study contends that the dimension of access to health facilities is not sufficient to explain healthcare in Qilla Saifullah – it must be considered as a reflection of wider social inequalities affecting people's health in daily life. The study centers on the role of structural conditions on the process of meaning making around illness, decision making about health care, and daily health care management.

To explain this, the study discusses Paul Farmer's (2004) concept of structural violence, which describes social, political and economic arrangements that keep people from meeting basic needs. These barriers are manifested in Qilla Saifullah as weak infrastructures, few resources committed for the investment by the State, poor emergency services and inadequate healthcare facilities. Urban areas (Quetta and Khuzdar) tend to receive more resources from the government and other sources, whereas smaller districts are neglected and underdeveloped (Javed and Ahmad, 2019; Yusuf, 2023). This means that people living in rural areas have to wait longer for their care needs to be met, have fewer choices in where they can access health services and are more at risk of poor health outcomes. These structural factors have a direct impact on day-to-day choices – that is, whether to delay treatment, use home remedies or whether to access informal health care due to cost and distance.

Most of the existing studies on health care in Pakistan have been based on statistical indicators like mortality rates, prevalence of diseases and vaccination coverage (Javed & Ahmad, 2019; Yusuf, 2023). These studies offer valuable data, but there is a tendency to ignore the experiences of those in remote and marginalized communities. Little scholarly effort has been directed to understanding residents' experience of illness, their coping

strategies for dealing with barriers, and their experiences of coping with structural constraints. (Ali & Jalal, 2021; Khan et al., 2020)

This study aims to fill this gap by focusing on the experiences of the people of Qilla Saifullah. It ponders over all the struggles people must face daily when within the healthcare system, their treatment decisions, and their survival tactics in an unequal and constrained health system. This work concentrates on life stories of people, not on statistical findings, which enhances the comprehension of structural inequality and enriches the perception of healthcare access and health outcomes in rural Balochistan.

Research Objectives

1. To examine the everyday health challenges faced by residents of Qilla Saifullah as a result of structural inequalities in the healthcare system.
2. To analyze the coping strategies adopted by residents in response to limited and unreliable healthcare services.

Research Questions

1. What everyday health challenges do residents of Qilla Saifullah experience?
2. How do residents cope with these challenges in the absence of adequate healthcare services?

Problem Statement

The health care system in Qilla Saifullah is also characterized by poor medical facilities, lack of skilled doctors, poor emergency services, and long distance of medical centers (Ali & Jalal, 2021; Khan et al., 2020). Poor infrastructure, inadequate transportation and unequal distribution of healthcare resources are other issues faced by the rural districts

of Balochistan in comparison to the urban districts (Panezai, 2012; Ullah et al., 2024). Such structural inequalities not only limit access to health care, but also influence how people react when they are sick in daily life. These situations often make it difficult for families to get treatment, rely on informal care or treatment in their own home, or choose treatment that they can afford and are available. These situations can make it hard for families to access treatment, use informal care or treatment in their own home, or make treatment choices based on what they can afford and where it is available, often not based on medical need (Yusuf, 2023).

Hence, the lack of health care is not the only problem, but also the wider structural determinants of people's health-related practices and experiences. The current government reports and studies on healthcare in Balochistan primarily emphasize on statistical indicators like mortality rate, disease prevalence, healthcare coverage etc. (Javed & Ahmad, 2019). These studies give information about the state of the healthcare services but are not particularly instructive about the experience of illness in the everyday lives of people in remote districts. The way residents adapt to poor health-care systems, make decisions about seeking treatment, and cope with illness when they have no access to, or access to poor-quality, health-care services is relatively under-researched. This is an important missing element in the literature. The aim of this study is to fill this gap by examining the lived experiences of Qilla Saifullah residents. It explores the health concerns they experience, coping mechanisms they employ and how structural inequalities impact their access to services and health outcomes. The study centers on everyday life to gain insight into the functioning of inequality in healthcare from a marginalized rural perspective.

Literature review

The disparity between the type of healthcare in big cities and those available in remote areas of Pakistan is tremendous. It is one of those districts where daily experiences of healthcare are impacted by long distances, weak infrastructure and very little formal medical services, like Qilla Saifullah in the northeastern region of Balochistan. In many villages of Balochistan, Ali and Jalal (2021) state that people should go to distant places to receive basic healthcare like their temperature, blood pressure etc. is checked and medicine is prescribed. Khan et al. (2020) say that even there are very few trained doctors, nurses, specialists, and medicines in rural hospitals. This indicates that the issue of "no hospitals" in Qilla Saifullah is not just an issue of hospitals, but of an overall healthcare experience affecting everyday decisions, daily practices and coping in the lives of those on the margins of the community.

In addition, the problem is "not new" as stated in the literature. Balochistan has been ignored for many years keeping other provinces of Punjab and Sindh in mind. Javed and Ahmad (2019) point out that the health budget of Balochistan is the lowest and the least consideration is given by the national levels of government to Balochistan. Furthermore, the author of the Study Shabbiruddin (2023) has explained that slow governance and unequal development means that in some districts like Quetta and Khuzdar, some attention is paid and in the other districts like Qilla Saifullah, they are hardly visible. This is why access to health care is not a matter of luck, but of years of negligence by those in power; access to health care should be earned and not obtained simply by being born. Thus, access to health care is not something that one should get by luck, but something that one should earn and not just take for granted because of birth. As

Paul Farmer puts it “structural violence is not disease-related, but it is related to institutions having unequal access to care”. (Farmer 2004). As such, the Qilla Saifullah population is a resident of a system that gives them a low rank. In literature, another theme is found to be informal and traditional healers. These people don't just wait; they can't go to the doctor. They learn coping strategies within their environment. Most of the families in rural areas of Balochistan depend on the local healers, herbal medicine, and the experience of elders, as they do not have regular access to the formal healthcare system (Baloch and Shaheen 2022). Siddiqui et al. (2018) also states that many rural communities continue to rely on informal networks because they are also more trustworthy, cheaper, and quicker. That is not to say that people don't like hospitals. This means that they do not have any options. So, the informal mechanisms turn into mechanisms of survival. These coping behaviors tell the story, say health academics, and are a constant struggle for people in out-of-the-way communities as they try to keep their lives going. an unequal environment. Structural violence is the constant, daily, unnoticed form of violence, as farmers (2004) describe.

Individuals are sick not due to sickness, but due to lack of help from institutions. In Balochistan, the lack of capacity in the health system is not only a technical problem, but also a political choice by the political elite of the time regarding the allocation of budget. (Farooq and Ali 2021) So, the healthcare issues in Qilla Saifullah are clearly related to history, politics and geography. This is further exacerbated by poor planning, poor governance. In rural hospitals in Balochistan, there is a lack of HR planning, according to Akhtar et al., (2022). But lots of health centers are on Study, without staff, without

equipment, and sometimes even locked up. Junaid and Mehr (2020) further report that hospitals in remote Balochistan are not even compliant with basics of dealing with patients. Machines are broken, medicine stores are empty and waiting times are very long. The residents there are accustomed to travelling long distances or waiting for once-monthly visits by doctors. In the literature it has also been said that people hardly ever go to their formal hospitals unless it is an emergency threatening their life. Ahmed (2021) explains that many of the families in the rural districts delay seeking medical care because they think that the hospitals will not assist them, or they just cannot afford the travel and tests. This lag time is a lag time for small illnesses in major health crises. This reflects the spectrum of the impact of material conditions on everyday decisions. Emotional neglect is another key.

Despite the attempts of the state to construct roads, people in remote areas of Balochistan feel the government had neglected them, says Shubaid-ud-Din Yusuf (2023). This invisibility is part of structural violence itself – not simply the lack of medicine, but also the feeling of being shut out of the national discourse. If a person feels that his/her district is not being developed, he/she believes that maybe “they do not matter. This emotional state is a component of health experience as well. Beyond that, there is a bit of research that indicates that poverty is involved. According to Malik et al. (2020), the expense of medicine, transport, and tests is so high that budget of many families gets ruined with a single visit to the hospital. Hence, even when there is a formal hospital, it also becomes a barrier because of the cost of accessing it. Poverty is thus related to health problems. Illness compounded by poverty and poverty perpetuated by illness. Lastly, few studies in the literature have addressed what people's lived experience is of their own health problems.

30% of studies report numbers, mortality rates, immunization rates, or hospital capacity (Javed & Ahmad, 2019; Yusuf, 2023). There is hardly any research on the way people emotionally and socially experience illness. This is a gap. There has been no qualitative and everyday life study of the Qilla Saifullah. We have no idea how families speak about health at home, how they decide upon what health care they get, and how they feel when they are left out of the system. Health is a daily phenomenon, so these stories are relevant.

Theoretical Framework

The concept of structural violence is used as the framework of this study, a theory developed by Paul Farmer (2004) which states that social, political and economic systems indirectly affect people in ways that impact their ability to enjoy necessities like healthcare (Farmer, 2004). Farmer builds on the work of Johan Galtung (1969) on structural inequality, that is, the need to look beyond the direct acts of violence to consider how the distribution of social resources and the unequal social structure contribute to suffering.

Structural violence can be used to understand some of the health issues of people in Qilla Saifullah. The district has weak health care infrastructure, low availability of trained doctors, inadequate emergency services and insufficient transportation services when compared to urban areas (Panezai, 2012; Ullah et al., 2024).

These conditions reflect the unequal development of rural areas and inadequate state investment in this area (Javed & Ahmad, 2019; Yusuf, 2023). This makes it difficult for people to receive timely health services, and they are resorting to informal health services or postpone treatment because of distance and cost (Ali & Jalal, 2021; Khan et al., 2020). This approach moves the focus from personal responsibility towards structural inequalities that affect people's health. For this study, structural violence was applied to analyze interview data and to elucidate how unequal social and institutional conditions shape the everyday healthcare experiences, treatment choices and coping strategies of the interviewees.

Methodology

Research Design

This study was conducted by using qualitative research design to gain an insight into how the people of Qilla Saifullah experienced healthcare-related issues in their day-to-day lives. The qualitative approach was selected since it provided the participants with an opportunity to disclose the details of their personal experiences and views on the issue.

Research Site

The study was carried out in the rural area of Qilla Saifullah of Balochistan, which has a sparse population and underdeveloped infrastructure. The site was chosen since it highlights the difficulties of access to health care in under-resourced and marginalized areas and is pertinent about the focus of this study on inequality and lived experiences.

Population and Sampling:

The sample included:

1. The residents who had sickness and had availed health care services.
2. Local health workers and government doctors.

A purposive sampling method was employed to identify the participants with firsthand experience with the healthcare system. This made sure that the data collected was pertinent to the research objectives. Further, snowball sampling was used whereby initial respondents referred to others who had a similar experience (Goodman, 1961).

A total of 10 interviews were conducted.

Data Collection Methods

Semi-structured interviews were used to collect data guided by key themes of access to healthcare, cost, quality of services, delays, and coping strategies. This approach was selected to enable the respondents to narrate their experiences with the focus on the research questions.

Each interview took an average of 30-40 minutes. The interviews were audiorecorded with consent and field notes were taken to capture the data like tone and nonverbal cues (Olenik and Adeoye-Olatunde, 2020).

Data Analysis

The interviews transcribed were carefully reviewed after data collection. The data was identified by a manual coding process that identified key patterns and recurring ideas in the data. These codes were further subdivided into bigger categories.

The thematic analysis was used to derive themes using the data. This included finding general patterns amongst the responses of the participants and categorizing them into themes relevant to the issues facing healthcare and coping mechanisms.

Ethical Considerations

Ethics were observed all through the research. Their attendance was voluntary, and informed consent was taken out of all the participants before conducting interviews. The participants were told about the aim of the research and their right to withdraw at any time. The use of pseudonyms and the removal of any identifying information on transcripts and reports ensured confidentiality. These audio recordings were placed in a safe place and only the researcher could access them.

The participants were also given the chance of not answering questions or ending the interview in case they were not comfortable. Special attention was paid to the fact that no harm or pressure were inflicted during the research.

Positionality and Reflexivity

Being a Qilla Saifullah researcher, I was familiar with local culture and context, which helped to comprehend the experience of participants. Nevertheless, I was conscious of the fact that my background might affect the process of data interpretation. To overcome this, I engaged in reflexivity, which I did by jotting notes down after interviews and by always reflecting on my assumptions. This served to make sure that the analysis did not get out of scope of the perspectives of the participants but instead it would be based on personal bias.

Findings

Structural Inequality and Unequal Healthcare Access.

The respondents always explained that access to healthcare in Qilla Saifullah is limited by several structural factors such as distance, poor infrastructure, lack of facilities, and financial limitations. The healthcare services were mainly located around the town center, with rural population having major problems with accessing them. Even the basic healthcare was hard to reach, particularly in case of an emergency, due to poor road conditions, lack of transport and long travel time. A participant highlighted that

People in cities can get treatment more easily, but in our area even basic healthcare is difficult to access. Most of the good facilities and services are available in bigger cities, while people here are forced to manage with very limited resources.

Although individuals arrived at medical centers, they faced other obstacles. The respondents reported that hospitals were providing primarily simple services such as first aid and minor treatments and were not able to provide adequate treatment for serious conditions. The lack of medicines, equipment and trained staff (particularly specialist and women doctors) was also a problem. Participant mentioned. *“Hospitals are only known to provide emergency services including first aid treatment”. Usually, medicines were not for sale in stores; we had to go to outside stores to buy them.”*

Financial pressures were also a factor in these. Transportation, consultation and medicines were expensive, and people had to face these expenses to make it to treatment on time. Therefore, the financial aspect played a major role in the decision-making process for health services, aside from its medical requirement. Many of the patients reported that they

delayed treatment or didn't even seek professional medical care. One of the participants stated “*And they die sometimes on the way (due to delays).*”

These results show that the availability of health services is not the only issue, it is whether a person can get to health services, whether they can afford health services, and whether they can trust health services. Structural inequalities lead to multiple interactive inequities that affect health outcomes.

Geographic Isolation and Transport Barriers.

One of the significant challenges identified as affecting health service access was geographic isolation. Participants noted that many villages are very remote from health facilities, and the lack of being unable to access good transport. At other times, however, seasonal conditions such as rain kept people apart, preventing them from moving between zones. Residents of remote villages have numerous challenges to traveling to hospitals in a timely fashion. Participant told that,

Lack of access to health services is a major problem in most of the remote areas since the services are concentrated in the town area and people must travel for hours on poor roads with limited transport. This delay may be very hazardous during emergencies and in some cases, treatment may not be provided in time.

Such barriers usually lead to delay in treatment, especially during an emergency where time is a factor. The participants explained the scenario of the worsening condition of patients due to the delays in accessing the healthcare facilities. This highlights the direct link between distance and mobility with health risk in rural areas.

Gendered Barriers to Healthcare access.

Gender norms also added to access to healthcare, further restricting women's access. Women also stated that they generally required a male escort to health facilities and to accompany them; that this often prevented them from receiving timely treatment. A shortage of female doctors also deterred women from going to the doctor, especially for maternal and reproductive health issues. One participant noted:

“Many women have problems in pregnancy because there are few female doctors in the area; women often avoid visiting male doctors, due to culture and this often delays treatment and appropriate maternal care, especially in emergencies”. As a result, many women had to be cared for with home birth without professional assistance and thus were at risk of complications. One participant commented, *“The delivery at home and some complications were experienced.”*

These findings indicate that women have both structural and social obstacles to their access to healthcare, making the accessibility to healthcare more limited and vulnerable to them.

Informal Healthcare as Survival Strategy

Considering the limited access to formal healthcare, the participants expressed that they made extensive use of traditional and informal healthcare. These included home medicines, herbal medicines, spiritual healing and guidance of the elderly. One interviewee mentioned that *“The individuals use religious healing and conventional medicines. We treat each other with the help of the neem leaves... herbal tea.”*

Even these practices were in vogue as they were inexpensive, easily available and well known in the culture. In several cases, where good formal services were absent, informal care was not only a good choice, but a necessity.

However, the participants also learned that there wasn't always a solution to this in the form of a specific method, especially for serious diseases. In other cases, the use of traditional practices prevented access to adequate healthcare which was a risk to health. This means that such informal health care practices are important coping strategies, through which people may attempt to regulate illness within the structures but not necessarily in a safe way.

Community Networks and Collective Coping.

Another important coping skill identified to help deal with health issues was community support. Family, neighbors and local networks were important in providing respondents with emotional, financial and transportation support during illness. One of the participants stated, "*The family and neighbors provide financial and transport support.*" In most cases, communities were involved in arranging transportation to hospitals and providing financial assistance towards treatment or offering tips based on experience. This support system assists people to cope with immediate health concerns whereby institutional support is weak.

At the same time, it was noted that this is a limited system. A similar level of support is also reduced as is their effectiveness in more extreme cases.

These findings show that community networks are a form of alternative to weak health systems which enable people to deal with structural problems, but do not replace formal health services.

Discussion and Conclusion

The Study has explored the impacts on healthcare and the coping mechanisms of the residents of the Qilla Saifullah region on the limited and unequal health system. The results suggest that health-related problems are not just isolated issues but are moderated by other more structural situations that affect daily life choices and experiences.

Regarding the first research question: The results demonstrate that structural constraints have a significant effect on health problems. Lack of facilities, geographic location, financial constraints, and gender beliefs are all limiting factors to access healthcare. The issues in Qilla Saifullah highlight that access to health services is not simply a question of being able to use health services, but also of being able to access these services, as well as to afford and use them. The experiences of the participants can be reduced to the fact that the people living in remote areas are more disadvantaged as access is not equal within the same district.

These findings illustrate well the concept of structural violence proposed in the theoretical framework. The barriers that were found, such as lack of infrastructure, insufficient number of medical workers and unequal distribution of resources are not coincidental but part of the larger social and political frameworks. These conditions, Paul Farmer says, have a negative impact indirectly, by denying people access to basic services. Consequences of such structural inequalities can be understood in this study as delayed treatment, relying on poor services and risk to health that could have been avoided.

The research investigation examined coping mechanisms which showed that residents use informal community solutions to deal with their existing limitations. People who lack access to formal healthcare facilities use natural remedies and spiritual healing methods and elder

advice to deal with their illnesses. Community support provides essential financial support and transportation services and emotional backing to individuals who need help. The strategies show that people need to handle their problems through active solutions which they develop to deal with their operational limits.

The healthcare system shows its weaknesses through the coping methods which people use to deal with their problems. The immediate needs of patients need to be addressed by these devices, yet they cannot replace essential medical attention which treats critical health issues. The system forces people to become dependent on other systems because the institutional framework fails to support them.

The research results show the existing rural healthcare situation in Pakistan which demonstrates how healthcare resources differ between urban and rural areas and which results in different health outcomes (Ali and Jalal, 2021; Khan et al., 2020). This study exists to advance existing knowledge by studying how discrimination affects people who treat their health through traditional medicine. The study uses research methods to show how people experience healthcare challenges which they encounter during their daily lives. The existence of operational service limits together with the current system conditions creates the actual problem.

Limitations of the Study

This research was confined to Qilla Saifullah, that is, the research might not be generalizable to other parts of Balochistan or Pakistan. The sample size of 10 was rather small to generalize the experiences of the whole population. Moreover, there was also a limitation of language and translation, despite the best effort to translate and interpret,

certain meanings and emotions may not have been fully captured. Finally, this study was concentrated on the small number of residents and healthcare workers, including the policy makers and stakeholders might reveal the policy related challenges at the structural level.

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Appendix A: Information Sheet and Consent Form

Information Sheet

Title of Research: **Health at the Margins: Everyday Experiences of Health System in Qilla Saifullah, Balochistan**

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Invitation

You are invited to participate in a research study that aims to describe the challenges to health life experienced by people living in Qila Saifullah, Balochistan, in their day-to-day lives. Prior to making a decision on whether to participate, it is imperative that you understand as fully as possible the purpose and nature of this inquiry. Please study this information sheet carefully. Should there be any questions you are encouraged to ask the researcher. If you have concerns about privacy or safety, you are welcome to discuss these with the researcher. You can take the time that it takes before deciding.

What is the purpose of the research?

This research tries to examine how health-related difficulties in the daily lives of the people in Qila Saifullah are experienced in the normal lives of these people. It aims to gain a better understanding of the role of deficient and under-developed healthcare services in decision-making in relation to health, and how people and families deal with limited

healthcare resources. The research aims to bring forward the voices and the lives, which are often marginalized through mainstream health discourses of Pakistan, especially in case of the rural and the neglected districts.

Why have I been chosen?

You have been identified as a potential participant because you are a resident of Qila Saifullah and have personal experience of everyday health issues in this region. Consequently, views you possess can help in building a more subtle understanding of the current situations.

Do I need to participate in the research?

No. Participation in this research is completely voluntary. If you agree to be part of the study, you will be given this information sheet and a consent form. Even after you agree, you still maintain the right to withdraw anytime without giving a reason.

What type of an interview will it be?

The interview will be semi-structure. You will be asked open ended questions about your day-to-day experiences of health, challenges and how you cope with them in Qila-Saifullah. You are free to respond in your own words.

So what will this study be useful for?

This study aims at producing knowledge about the realities of healthcare lived by the people in the Qila Saifullah. It aims to show the way in which exposure to political neglect, geographical distance, poverty and lack of services affect health outcomes. The findings may be found beneficial to researchers in the health forest, policy makers and organizational engaged in public health because it speaks to the needs of fairer, more accessible and supportive healthcare services in rural districts. Moreover the findings may

contribute to wider conversations about inequality, governance and justice in the health system in Pakistan.

Will my information be kept confidential?

All of your information will be kept strictly confidential throughout the interviewing and publication process. You will not be identified in any reports or publications for your name will be replaced with aliases.

Who is organizing the research?

The research is organized by an undergraduate student as part of her mandatory thesis requirement with the supervision of his Research Supervisor who is a lecturer at the Department of Sociology, Forman Christian College University.

Has the project been ethically reviewed?

This research project has been ethically reviewed by the researcher's supervisor, the Head of the Sociology department, and the Internal Review Board (IRB), at Forman Christian College University.

Consent Form

1. I confirm that I have completely read and understood the information sheet explaining the purpose and scope of the research.
2. I have utilized the opportunity to ask questions about the research and have had detailed discussions with the researcher.
3. I understand that my participation in this study is voluntary, and I am free to withdraw from the study at any given point without specifying any reason. I am completely free to decline or refuse to respond to questions I do not want to answer.

4. I understand that the confidentiality of my responses will be ensured, and my personal information will not be used in the research materials. My identity will be kept secret and I will not be identifiable in any information in the research report.
5. I allow the researcher to access my responses and use them in her research.
6. I agree that the data collected from my interview may be used in future studies after any information regarding my identity has been removed.
7. I agree to take part in the above research.
8. I understand that a copy of all signed sheets including the consent form and the information sheet will be provided to me and will also be available with the researcher for record.

Signature: _____ **Date:**

Email (optional for Data Validation purposes):

Appendix B: Urdu Translation of Informed Consent Form

ضمیمہ الف: معلوماتی شیٹ اور رضامندی فارم

معلوماتی شیٹ

تحقیق کا عنوان

حاشیوں پر صحت: ضلع قلعہ سیف اللہ، بلوچستان میں صحت کے نظام سے متعلق روزمرہ زندگی کے تجربات

محقق: نصیر خان

ادارہ: فارمین کرسچین کالج چارٹرڈ یونیورسٹی

محقق کا رابطہ:

261927271@formanite.fccollege.edu.pk

نگرانِ تحقیق: پروفیسر عمار یاسر

نگران کا رابطہ:

ammaryasir@fccollege.edu.pk

دعوتِ شرکت

آپ کو ایک تحقیقی مطالعے میں شرکت کی دعوت دی جا رہی ہے جس کا مقصد ضلع قلعہ سیف اللہ، بلوچستان کے رہائوں کو روزمرہ زندگی میں درپیش صحت سے متعلق مسائل اور تجربات کو سمجھنا ہے۔

اس تحقیق میں شرکت کا فیصلہ کرنے سے پہلے ضروری ہے کہ آپ اس کے مقاصد اور نوعیت کو اچھی طرح سمجھ لیں۔ لہذا براہِ کرم اس معلوماتی شیٹ کو غور سے پڑھیں۔ اگر آپ کے ذہن میں کوئی سوال ہو تو بلا جھجھک محقق سے دریافت کر سکتے ہیں۔ اگر آپ کو رازداری یا اپنی حفاظت کے حوالے سے کوئی تشویش ہو تو اس پر بھی محقق سے بات کی جا سکتی ہے۔ شرکت کا فیصلہ کرنے کے لیے آپ جتنا وقت چاہیں لے سکتے ہیں۔

تحقیق کا مقصد کیا ہے؟

اس تحقیق کا مقصد یہ جاننا ہے کہ قلعہ سیف اللہ کے لوگ اپنی روزمرہ زندگی میں صحت سے متعلق مشکلات کس طرح محسوس اور تجربہ کرتے ہیں۔ تحقیق اس بات کو سمجھنے کی کوشش کرے گی کہ ناکافی اور کم ترقی یافتہ صحت کی سہولیات لوگوں کے صحت سے متعلق فیصلوں پر

کس طرح اثر انداز ہوتی ہیں اور لوگ و خاندان محدود طبی وسائل کے ساتھ کیسے نبرد آزما ہوتے ہیں۔

یہ مطالعہ ان افراد اور کمیونٹی کی آواز کو سامنے لانے کی کوشش کرتا ہے جنہیں پاکستان کے عمومی صحت کے مباحث میں اکثر نظر انداز کر دیا جاتا ہے، خصوصاً دیہی اور پسماندہ اضلاع کے رہنے والے۔ مجھے اس تحقیق کے لیے کیوں منتخب کیا گیا ہے؟ آپ کو اس تحقیق کے لیے اس لیے منتخب کیا گیا ہے کیونکہ آپ ضلع قلعہ سیف اللہ کے رہائشی ہیں اور اس علاقے میں صحت سے متعلق روزمرہ مسائل کا ذاتی تجربہ رکھتے ہیں۔ آپ کے خیالات اور تجربات موجودہ صورتحال کو بہتر انداز میں سمجھنے میں مددگار ثابت ہو سکتے ہیں۔ کیا میری شرکت ضروری ہے؟

نہیں۔ اس تحقیق میں شرکت مکمل طور پر آپ کی مرضی پر منحصر ہے۔ اگر آپ شرکت پر رضامند ہوں گے تو آپ کو یہ معلوماتی شیٹ اور رضامندی فارم فراہم کیا جائے گا۔ شرکت کی رضامندی دینے کے بعد بھی آپ کسی بھی وقت بغیر کسی وجہ بتائے تحقیق سے دستبردار ہو سکتے ہیں۔

انٹرویو کی نوعیت کیا ہوگی؟

انٹرویو نیم ساختہ (Semi-Structured) نوعیت کا ہوگا۔ آپ سے قلعہ سیف اللہ میں صحت سے متعلق روزمرہ تجربات درپیش مسائل اور ان سے نمٹنے کے طریقوں کے بارے میں کھلے انداز کے سوالات پوچھے جائیں گے۔ آپ اپنی مرضی اور اپنے الفاظ میں جواب دے سکتے ہیں۔

اس تحقیق کی افادیت کیا ہوگی؟

اس تحقیق کا مقصد قلعہ سیف اللہ کے لوگوں کی صحت سے متعلق حقیقی زندگی کے تجربات کو سامنے لانا ہے۔ یہ مطالعہ واضح کرے گا کہ

سیاسی عدم توجہی، جغرافیائی دوری، غربت اور بنیادی سہولیات کی کمی صحت کے نتائج پر کس طرح اثر انداز ہوتی ہے۔

تحقیق کے نتائج محققین، پالیسی سازوں اور صحت عامہ سے وابستہ ادا روں کے لیے مفید ثابت ہو سکتے ہیں کیونکہ یہ دیہی علاقوں میں زیادہ

منصفانہ، قابل رسائی اور معاون صحت کی خدمات کی ضرورت کو اجاگر کرتے ہیں۔ مزید برآں، یہ تحقیق پاکستان کے صحت کے نظام میں عدم مساوات، حکمرانی اور سماجی انصاف سے متعلق و سیرت مباحث میں بھی اہم کردار ادا کر سکتی ہے۔

کیا میری معلومات خفیہ رکھی جائیں گی؟

جی ہاں۔ آپ کی فراہم کردہ تمام معلومات کو مکمل رازداری کے ساتھ محفوظ رکھا جائے گا۔ کسی بھی رپورٹ یا اشاعت میں آپ کا اصل نام

ظاہر نہیں کیا جائے گا بلکہ اس کی جگہ فرضی نام استعمال کیے جائیں گے تاکہ آپ کی شناخت محفوظ رہے۔

تحقیق کا انتظام کون کر رہا ہے؟

یہ تحقیق ایک انڈرگریجویٹ طالب علم کی جانب سے اپنے لازمی تحقیقی مقالے (تھیسس) کے تقاضے کے طور پر کی جا رہی ہے۔ اس کی

نگرانی شعبہ سماجیات، فارمین کرسچین کالج یونیورسٹی کے ایک استاد بطور سپروائزر کر رہے ہیں۔

کیا اس منصوبے کا اخلاقی جائزہ لیا گیا ہے؟

جی ہاں۔ اس تحقیقی منصوبے کا اخلاق جائزہ محقق کے سپروائزر، شعبہ سماجیات کے سربراہ اور فارمین کرسچین کالج یونیورسٹی کے ادارہ جاتی جائزہ بورڈ (IRB) کی جانب سے لیا جا چکا ہے۔

رضامندی فارم

1. میں تصدیق کرتا/کرتی ہوں کہ میں نے تحقیق کے مقصد اور دائرہ کار سے متعلق معلوماتی شیٹ کو مکمل طور پر پڑھا اور سمجھ لیا ہے۔
2. مجھے تحقیق کے بارے میں سوالات پوچھنے اور محقق سے تفصیلی گفتگو کرنے کا موقع فراہم کیا گیا ہے۔
3. میں جانتا/جانتی ہوں کہ اس تحقیق میں میری شرکت مکمل طور پر رضاکارانہ ہے اور میں کسی بھی وقت بغیر کوئی وجہ بتائے تحقیق سے
- علیحدہ ہو سکتا/سکتی ہوں۔ میں کسی بھی ایسے سوال کا جواب دینے سے انکار کرنے کا حق رکھتا/رکھتی ہوں جس کا جواب دینا میں مناسب نہ سمجھوں۔
4. میں سمجھتا/سمجھتی ہوں کہ میری فراہم کردہ معلومات کو خفیہ رکھا جائے گا اور میری ذاتی شناخت تحقیق میں ظاہر نہیں کی جائے گی۔
- تحقیق کی کسی بھی رپورٹ یا اشاعت میں میری شناخت پوشیدہ رکھی جائے گی۔
5. میں محقق کو اجازت دیتا/دیتی ہوں کہ وہ میرے جوابات کو اپنی تحقیق میں استعمال کر سکے۔

6. میں اس بات سے اتفاق کرتا/ کرتی ہوں کہ میرے انٹرویو سے حاصل شدہ معلومات مستقبل کی تحقیق میں بھی استعمال کی جا سکتی ہیں ،

بشرطیکہ میری شناخت سے متعلق تمام معلومات حذف کر دی جائیں۔

7. میں مذکورہ تحقیق میں شرکت کے لیے اپنی رضامندی ظاہر کرتا/ کرتی ہوں۔

8. میں سمجھتا/سمجھتی ہوں کہ دستخط شدہ تمام دستاویزات، بشمول رضامندی فارم اور معلوماتی شیٹ، کی ایک نقل مجھے فراہم کی جائے گی

اور ایک نقل محقق کے پاس ریکارڈ کے لیے محفوظ رہے گی۔

دستخط _____ :

تاریخ _____ :

ای میل (اختیاری) _____

Appendix D: Semi-Structured Interview Guide

Health at the Margins: Everyday Experiences of Health System in Qilla Saifullah, Balochistan

1. Can you describe the common health problems people in your household or neighborhood face in daily life?
2. When someone gets sick, where do you usually go first for help and why?
3. How easy or difficult is it for you to reach a nearby doctor or health facility when needed?
4. What kinds of difficulties do people usually face at local hospitals or clinics (e.g., waiting time, cost, medicine availability)?
5. Do you think the health facilities in Qilla Saifullah are enough for the population? Why or why not?
6. What alternative ways do people use when formal health services are not accessible? (e.g., home remedies, spiritual healers, elders' advice)
7. How do financial limitations affect decisions about seeking treatment?
8. Can you recall a recent experience where someone needed urgent healthcare? What happened and how was it managed?
9. What role do family members, neighbours, or community networks play in helping people deal with health issues?
10. If you could change one thing in the local health system to improve people's lives, what would it be and why?

Appendix E: Urdu Translation of Semi-Structured Interview Guide

انٹرویو کے سوالات

- 1 . آپ کے گھرانے یا محلے میں روزمرہ زندگی میں لوگوں کو عموماً کن صحت سے متعلق مسائل کا سامنا رہتا ہے؟
- 2 . جب گھر میں کوئی شخص بیمار ہو جاتا ہے تو آپ سب سے پہلے مدد یا علاج کے لیے کہاں جاتے ہیں، اور اس کی کیا وجہ ہوتی ہے؟
- 3 . ضرورت کے وقت قریبی ڈاکٹر یا صحت کی سہولت تک پہنچنا آپ کے لیے کتنا آسان یا مشکل ہوتا ہے؟
- 4 . مقامی ہسپتالوں یا کلینکس میں لوگوں کو عموماً کن مشکلات کا سامنا کرنا پڑتا ہے؟ (مثلاً انتظار کا زیادہ وقت، اخراجات، یا ادویات کی عدم دستیابی)
- 5 . کیا آپ کے خیال میں قلعہ سیف اللہ میں موجود صحت کی سہولیات آبادی کی ضروریات پوری کرنے کے لیے کافی ہیں؟ کیوں یا کیوں نہیں؟
- 6 . جب باقاعدہ طبی سہولیات تک رسائی ممکن نہ ہو تو لوگ علاج یا مدد کے لیے کون سے متبادل طریقے اختیار کرتے ہیں؟ (مثلاً گھریلو ٹوٹکے، روحانی علاج، یا بزرگوں کا مشورہ)
- 7 . مالی مشکلات علاج کروانے یا نہ کروانے کے فیصلوں پر کس طرح اثر انداز ہو تی ہیں؟
- 8 . کیا آپ کو کوئی حالیہ واقعہ یاد ہے جب کسی شخص کو فوری طبی امداد کی ضرورت پیش آئی ہو؟ اس وقت کیا ہوا اور اس صورتحال کو

کس طرح سنبھالا گیا؟

9. صحت سے متعلق مسائل کا سامنا ہونے پر خاندان کے افراد، پڑوسی یا مقامی برادری کس طرح مدد فراہم کرتے ہیں؟

10. اگر آپ کو مقامی صحت کے نظام میں ایک تبدیلی لی لانے کا موقع دیا جائے جو لوگوں کی زندگیوں کو بہتر بنا سکے، تو وہ کیا ہوگی اور کیوں؟