

The Cost of Custom: Cultural Barriers to Healthcare Access in Rural Pakistan

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ABSTRACT

Access to healthcare in pastoral Pakistan is intricately linked to traditional customs and artistic beliefs, and it is not just a question of finances or structure. A common interpretation of illness is that it is caused by supernatural forces like black magic, nazar (the evil eye), or jinn. In these situations, families place a higher value on seeing peers, faqeers, or babas in order to seek dam (ritual healing through recitation of the Quran), taweez (amulets), or prescribed prayers, frequently prior to or in place of seeking medical advice. Despite being socially comforting, these practices lead to treatment and opinion detentions, which prevent many cases from receiving timely or appropriate care. The effect on mental health is particularly noteworthy. Professional care is limited, with less than 500 psychiatrists serving over 240 million people. Additionally, the stigma associated with mental illness contributes to the dependence on spiritual explanations. In addition to having less autonomy, women continue to face cultural barriers that prevent them from visiting clinics. These disparities are widened by poverty, illiteracy, and skepticism of contemporary healthcare, which leads to cycles of untreated sickness, avoidable complications, and needless death. This tract examines the “cost of custom” the heavy burden of artistic practices that overshadow medical interventions. It argues for culturally sensitive strategies that integrate mindfulness juggernauts, collaboration with community leaders, expansion of pastoral internal health services, and the integration of spiritual perspectives into holistic models of care.

Keywords:

Cultural barriers; Rural healthcare; Spiritual healing; Pakistan; Mental health; Peer faqeer; Dam; Taweez; Stigma; Access to care

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INTRODUCTION

Pakistan's rural heartlands and urban centers continue to be divided, which is reflected in the country's healthcare system. Though access is still unequal, hospitals, medical schools, and psychiatric services in urban areas offer comparatively modern care. On the other hand, rural communities, which are home to almost two-thirds of the population, still interpret

illness according to ancient traditions. Disease is rarely seen as a biological process in these communities; instead, it is understood in terms of cultural and spiritual frameworks that provide purpose to suffering.

A child with seizures may be allowed to be held by a jinn; a woman floundering with depression may be considered accursed by the evil eye; a man with schizophrenia may be

labeled as insane and ostracized. In each case, the family's first instinct is frequently not to seek medical advice but to turn to a peer, faqeer, or baba who enjoys original trust and authority. The treatments offered levee, taweez, and special prayers, offer spiritual comfort and support collaborative bonds but constantly delay biomedical opinion and treatment.

These cultural customs frequently serve as structural barriers rather than being harmless traditions. They ensnare communities in cycles of postponed treatment and deteriorating illness by intersecting with poverty, illiteracy, gender inequality, and stigma. This is particularly evident in the field of mental health, where resources are becoming increasingly limited and stigma is already very strong. Rural Pakistan will continue to be torn between tradition and care unless these obstacles are removed with tact and consideration for cultural values.

Pressing the Cultural walls to Healthcare Access in Rural Pakistan

1. Spiritual Interpretations of Illness: Rather than being biological diseases, many conditions are explained as black magic, evil eye, or jinn possession.
2. Dependency on Peers/Faqeers: Families delay medical conversations by initially relying on traditional healers to define levee or taweez.
3. Smirk and Labeling: Families are discouraged from obtaining medical assistance when cases are termed "Pagal" (frantic) or kept.
4. Gender Inequality: Women are less able to move about and have less influence over healthcare decisions.
5. Lack of Professionals: Out of 240 million people, most of whom live in

cities, there are less than 500 psychiatrists.

6. Poverty and Distance: Families in rural areas are unable to pay for hospital visits or transportation.
7. Ignorance and Ignorance People in communities constantly fail to discern between medical symptoms and superstition.
8. Generational Beliefs Family-inherited customs foster mistrust of medical professionals and strengthen dependence on tradition.
9. Distrust of Medical Professionals Healers are occasionally viewed as religious, while croakers are allowed to be profit-driven.
10. Treatment Detainments Conditions may have grown to unrecoverable or severe stages by the time families seek medical attention.

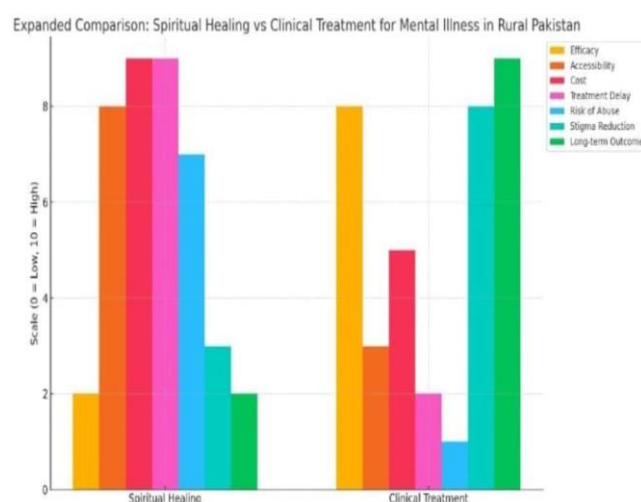


Fig1: Healthcare-Seeking Behavior in Rural Pakistan

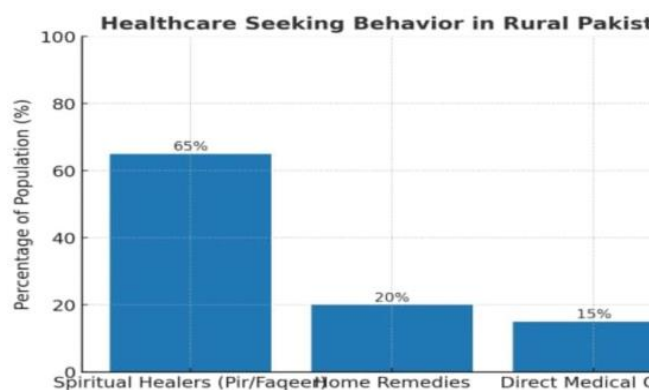


Fig2: Comparison showing spiritual believes and clinical care

Here's the comparison showing spiritual believes and clinical care in health issues in rural areas of Pakistan

CONCLUSION

In conclusion, access to healthcare in rural Pakistan is deeply influenced by cultural traditions, spiritual beliefs, and social norms that often outweigh medical reasoning. Illness is frequently interpreted through supernatural explanations such as black magic, nazar, or jinn, leading many families to seek help from spiritual healers before consulting trained healthcare professionals. While these practices may provide emotional reassurance and reflect deeply rooted community values, they can also delay diagnosis, treatment, and recovery, especially in serious physical and mental health conditions. The burden is even greater in the case of mental illness, where stigma, shortage of psychiatrists, and lack of awareness further limit timely intervention. Women in rural areas face additional barriers due to restricted autonomy and gender-based cultural limitations, making healthcare access even more unequal. Poverty, illiteracy, and mistrust of modern healthcare systems continue to strengthen these harmful cycles. Therefore, addressing healthcare challenges in rural Pakistan requires more than expanding infrastructure alone. It demands

culturally sensitive and community-based solutions that respect local beliefs while promoting evidence-based care. Collaboration with religious leaders, public health education, improved rural mental health services, and holistic care models can help bridge this divide and reduce the heavy cost of custom on health outcomes.

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