ISSN 3007-3170(O)
ISSN :3007-3162(P)
Social Sciences & Humanity Research Review

Unregulated Domains 0f Healing: A Socio-Medical Analysis of Faith Healers In Pakistan

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ARTICLE INFO

Keywords:
Faith Healers, Supernatural Elements, Medical Practitioners, Health Seeking Behaviors And Biomedical Distrust.

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ABSTRACT

This study aims to highlight the reliance of Pakistan's rural population on faith healers. As several studies reviewed in this paper demonstrate, there has been a surge in faith healing practices across the country. While these practices are at times perceived as improving wellbeing, the alarming concern is over-reliance on faith healers as the first point of contact, which contributes to delays in accessing formal healthcare. The study employed a qualitative meta-synthesis approach, identifying and analyzing existing literature across three domains: temporal, spatial, and relevance to the study's objectives. The findings revealed three recurring themes: 1) structural and economic barriers, 2) erosion of trust in medical practitioners, and 3) faith healers as custodians and safeguards against illness. The study concludes that the domain of faith healing in Pakistan remains unregulated and under-researched. Further primary studies in this area could provide healthcare policymakers with valuable insights to design interventions that secure and improve the lives of the rural population of Pakistan.

Introduction

Faith healing refers to an approach that relies on faith to treat or cure an illness rather than relying on formal medical methods. This method of healing is often led by deities or individuals believed to possess God –gifted abilities. But this raises the question: Can Faith Heal? To

address this question, a scholar, Norman (1984), discussed it in his notable work Can Faith Heal? According to him, faith cannot be defined by a single definition, as it is an abstract and subjective entity. Faith is an entrance into a group where questioning faith is prohibited in order to sustain it. This very nature makes faith fragile, as it can be shaken by skepticism or doubt. Healing, on the other hand, is easier to define. It is considered a state of being healthy emotionally, physically, and spiritually. When combined, these two elements suggest that faith healing requires adherence to faith as a prerequisite for experiencing healing (Oad, et al., 2024; Imran & Akhtar, 2023). Haslam (2009), Ironson (2002), and Hummer (1999) suggest that faith healing is associated with better health outcomes in terms of longevity, happiness, and life satisfaction. However, there remains a mystery surrounding whether faith alone can cure diseases once they are contracted. Hasanovic (2010) and Michalak (2007) argue that faith healing is not a phenomenon in itself; rather, it is the result of individual adherence to religious norms and values, such as abstaining from alcohol, avoiding smoking, limiting sexual partners, and maintaining proper hygiene before prayers. Returning to Norman's (1984) point, faith does not heal directly; instead, the rituals and practices associated with faith function as protective or avoidance mechanisms that reduce the likelihood of illness. Despite the prevalence of documented evidence on the ineffectiveness of faith healing, individuals and communities rely on faith healers (Hafeez, Khan & Jabeen, 2024; Irshad, Khan & Mahmood, 2024; Khan, Sarfraz & Afzal, 2019). Historically, faith healers were sought as a last resort when medical treatment had failed. (Wall, 2011). Alarmingly, they have now become the first point of contact for many seeking care, raising critical concerns about the growing acceptance of faith healers globally.

Throughout history, faith healers have often relied on the support of their communities and tribes, employing a range of practices to bridge the spiritual and physical worlds (Azhar & Imran, 2024). For instance, shamans, spiritual practitioners believed to connect the human and spiritual realms, are still active among indigenous African tribes (Toumaqin, 2022), and in parts of Kazakhstan (Gomez, 2001), where they are considered faith–healing shamans. In Brazil, faith healers are known as *bezenderios,* individuals with extensive knowledge of medicinal plants (Zank & Hanazakai, 2016). In the Philippines, faith healers called *gabaon* are thought to drive power from dreams and often present anthropomorphic features resembling deities, which enhance their perceived spiritual authority. (Lendu, 2024).

In the context of Pakistan, faith healing practices are widely observed in diverse forms. Common practices include dhammal (ritual dance), recitation of Quranic verses over patients, touching the tombs of saints, and seeking blessings by kissing or touching the feet of faith healers. Devotees also present offerings such as sweets, oils, money, scarves, shawls, or even gold, while others organize communal meals in the healer’s name within their localities (Charan & Xin, 2020). In some extreme cases, devotees may even resort to animal sacrifice as an act of devotion. In Pakistan, faith healers are commonly referred to as *baba, alim, fakir, or pir.* (Ahmed &Huber, 2021). These figures are often perceived as possessing insights beyond the reach of ordinary people. Their wisdom is believed to surpass scientific knowledge, enabling them to act as intermediaries who interpret contemporary challenges (Arooj, 2023). In doing so, they translate complex realities into forms that ordinary individuals can relate to and through which they can make sense of their personal struggles. In the medicinal sphere, faith healers often provide treatments through diverse methods, including homeopathy, Ayurveda, herbal concoctions, amulets, tuna rituals, and pouring water with whispering sacred texts, and even the inscription of Quranic verses on vegetables to be consumed for speedy recovery (Sommoro &Baloch, 2013). These practices are rarely documented in formal records; rather, they are transmitted orally from

one generation to the next (Arooj, 2023). This demonstrates that pirs, alims, fakirs, and babas are not merely providers of medical remedies but also custodians of culturally embedded practices that communities strive to preserve, even in the 21st century. An interesting dimension emerged when research was conducted in a few rural areas of Pakistan. The study revealed that faith healers often rely on plants for wound healing purposes. Most of these herbal concoctions originated from the estates of 29 affluent families who controlled the majority of local herbal production. These findings highlight how power dynamics intersect with faith healing practices, as the control of resources by elite families shapes both the accessibility of herbal remedies and the relationship between faith healers and formal healthcare systems (Siddique & Shah, 2019). A study conducted in rural areas of Khyber Pakhtunkhwa revealed that 75%of women reported visiting faith healers during pregnancy, while 66% of men preferred to seek treatment from hakims. (Khan & Ifitiqar, 2021).

While available literature highlights the widespread reliance on faith healers in Pakistan, evidence also suggests that many people simultaneously consult both medical professionals and faith healers, believing that biomedical treatment cannot be effective without spiritual guidance. This dual dependency raises critical concerns regarding the perceived abilities and limitations of healthcare professionals (Nisar, et al., 2025; Basharat, et al., 2023; Naz, et al., 2020). Moreover, much of the existing scholarship on faith healing in Pakistan has remained narrowly focused on specific issues such as mental illness, shrine rituals, or the belief in the evil eye, particularly in relation to children. Such a limited scope leaves a significant gap in understanding the broader reasons behind the persistent prevalence of faith healers and the deep dependency communities place on their practices. This gap calls for an exploration that bridges medical sciences and sociology to reveal the cultural, structural, and healthcare-related factors sustaining faith healing in contemporary Pakistani society.

Research Objectives:

1. To understand patients' reasons for approaching faith healers instead of formal healthcare services in rural Pakistan.
2. To explore faith healers' and medical professionals' perspectives on the role of faith healing in shaping treatment–seeking behaviors.

As a medical student, I have witnessed several instances where people in the intensive care unit pour *dam kiya hua pani (water with readings from sacred texts)* on patients who are in a patient bed, or place a taweez near their bed, thinking this will benefit them. Even when the one who caused them to be in intensive care is the Baba or Hakim (Faith Healer), whose medicines were meant to treat cancer, mental illness, and bodily infections. I have also witnessed rotten plants being placed under patients' pillows. Such experiences made me realize that even after advancements in medical facilities, people often consider faith healers as the first source to approach (Rasheed, et al., 2025; Shahzadi, et al., 2025; Naz, et al., 2022). This made me look for the demographic characteristics of the patients, and on identification, I realized most of them belong to the rural areas of Pakistan. This made me realize that people in rural areas often face barriers to formal healthcare due to the stigma attached to visiting hospitals, as people will come to know about their illness (Khoso, et al., 2024; Sultana & Imran, 2024; Ahmad, Bibi & Imran, 2023). Therefore, they choose faith healers, who are mostly located in secret caves and often carry a dual personality. When someone shares their problems with them, another spiritual being appears in them, which makes the decisions and prescribes the cure. Afterwards, that soul leaves the person's body, and the healer is no longer aware of the issues discussed (Chohan & Haq,

2025; Qazi, et al., 2025; Malik, Muzaffar & Haq, 2025). This side of cultural beliefs created a space for sociologists to further guide research.

As a sociologist, I always look closely at the roads, banners, posters, and advertisements on the walls. Most of them often talk about mardana kamzori (male infertility), weight loss phaki (concoction of herbs), illness caused by black magic or evil eye, or madness caused by possession of spirits. For all these issues, the faith healer is seen as the rescuer. Such things made me realize that growing illnesses and diseases are deeply rooted in cultural beliefs. People, even with education, also visit these individuals as they lose hope, and this gives a platform for faith healers to strengthen their position. This unregulated domain in Pakistan is causing many difficulties not only for individuals and communities but also affecting the healthcare initiatives of the state, as they are not utilized properly. The number of such cases and reported experiences is presented in the thematic analysis of the paper.

The significance of this research lies in its interdisciplinary approach, combining insights from medical sciences and sociology to contribute to the literature on faith healers as an unregulated domain in rural areas of Pakistan. Moreover, the findings are valuable for policymakers in formulating strategies to regulate faith healers and to strengthen healthcare initiatives.

Literature Review

Global Empirical Evidence

A study was conducted by Lee, Coleman, and Nakaziba (2024) in the rural areas of Uganda. The objective of the study was to analyze the perspectives of traditional healers, faith healers, and biomedical providers about mental illness treatment. The study utilized a qualitative methodology. The tools of data collection were focus group discussions and interviews with 24 traditional healers, 20 faith healers, and 23 biomedical providers. This study revealed crucial perspectives on the intricate relationship between faith healers, spiritual practitioners, and healthcare providers. The study identified three main themes. Firstly, biomedical providers considered spiritual healers to be a helpful source (Yazidi & Rana, 2025; Feng, et al., 2023). However, when asked about traditional healers, the biomedical providers' responses and experiences showed the opposite, as most participants labeled traditional healers as harmful (Ali, et al., 2020; Ali, et al., 2020; Xu, et al., 2019). The second theme explored the perspectives of spiritual healers, who believed that biomedical providers and spiritual healers both play a crucial role in community health if they collaborate (Shah, et al., 2025; Haq, et al., 2024; Noor, et al., 2024). On the contrary, spiritual healers shared that traditional healers provide only temporary comfort, but in the long run their cures often deteriorate the health of individuals. The last theme combined both perspectives and explored the role of power dynamics among biomedical providers, spiritual healers, and traditional healers. The significant theme that emerged was the prospects and challenges of collaboration. This perspective suggested that there must be a balance with practical consideration in collaborative care regarding beliefs about power, authority, and psychological disorders (Lee, 2024).

Empirical Evidence from Pakistan

A research study was carried out in rural Punjab. In this ethnographic study, participant observation and unstructured interviews were utilized as data collection tools. The objective of this research was to analyze *tona* as a healing belief practice in young children. According to the author, the people of Punjab believe that evil spirits cause illnesses in children; for that reason, a fusion of religious prayers with magical deeds is performed to drive out spirits (Saher, Masih & Raju, 2021; Hewawitharana, et al., 2020; Masih, et al., 2020). The spiritual leader, known as the Imam, recites Quranic verses and writes them on vegetables such as *loki* or *bengan* and

sometimes on amulets, commonly known as *tawiz*, to safeguard against evil powers and to ward off illnesses. Moreover, the author emphasized that the legitimacy and perceived efficacy of these therapeutic practices are often reinforced by religious components (Qamar, 2015).

In AJK, a qualitative research study was conducted in which patients with different mental illnesses were interviewed using DSM-5 criteria. The main purpose of this research was to examine the prevalence and effectiveness of supernatural and spiritual healing practices used in Pakistan for mental illnesses. Considering the methods of healing, amulets were used in 100% of cases, while dumm was employed in 80% and geomancy in 20%. Despite being commonly practiced, the efficacy of these methods was measured at merely 15%, indicating that although they have strong cultural foundations, such practices remain ineffective in meeting psychological needs and often result in delays in seeking professional help. The findings further emphasized that patients with low income are more inclined to consult spiritual leaders, followed by the working class, and based on these results, the study suggested that people suffering from mental illness should seek professional help instead of consulting spiritual healers (Naeem et al., 2023).

A qualitative exploratory study was undertaken in Sindh, titled *"People's Attitudes Toward Shrine-Based Faith Healing in Pakistan."* In-depth interviews (IDIs), FGDs, and participant observation were used as data collection tools. The main aim of this study was to examine the reasons behind healing through faith, along with the symbolic and ceremonial practices utilized during the healing process (Danish, Akhtar & Imran, 2025; Mankash, et al., 2025; Hafeez, Yaseen & Imran, 2019). The study also focused on the economic and socio-demographic factors influencing visitation to shrines. Since it was conducted in a rural setting, the study revealed that health-seeking practices are shaped by the intersection of cultural standards, faith beliefs, limited healthcare accessibility, and financial constraints. Several key findings emerged. The first theme showed that financial constraints led individuals to seek shrine-based healing, as it was more accessible and inexpensive (Phulpoto, Oad, & Imran, 2024; Oad, Zaidi, & Phulpoto, 2023). The second theme highlighted a lack of trust in biomedical providers and fear of misdiagnosis, which caused participants to turn to spiritual healing. The main theme indicated the adoption of mixed treatment approaches, combining spiritual and biomedical practices to achieve better outcomes. Another theme revealed that participants often associated diseases with evil spirits, the evil eye, or witchcraft, which reinforced reliance on spiritual healing. These findings underline the necessity for authorities and healthcare professionals to comprehend cultural and economic factors to address healthcare disparities in marginalized communities (Abro, Soofi, Hussain, & Sadruddin, 2025).

Another qualitative study was conducted to explore the experiences of family caregivers of patients with schizophrenia within the Baloch community. Using purposive sampling, 21 participants were interviewed in Sistan and Baluchistan Province, including family caregivers, a psychologist, a prayer writer, and a lay individual. The study identified two key themes. The first showed that in Baloch culture, symptoms of schizophrenia were often misinterpreted as supernatural phenomena such as jinn possession, black magic, or bewitchment. These misinterpretations created conflicts with biomedical treatments and increased reliance on unconventional practices. The second theme emphasized the role of religious practices, such as prayer and recitation, as means of protection against perceived supernatural forces (Darban, Safarzai, & Sabzevari, 2023).

Theoretical Framework

Health Belief Model : The model was developed when doctors realized the delays in accessing healthcare, even when patients, through early detection and screening, could have identified and

prevented severe diseases. Doctors were concerned about people's refusal to get their illnesses diagnosed. These practices and patterns helped the psychologist understand the core reason behind this refusal, which led a group of social psychologists to propose a theoretical model related to health beliefs, called the Health Belief Model. The model proposed that human action regarding health depends on two things: the first is the value associated with the goal, and secondly, belief in effectiveness. The model also sheds light on four dimensions why people delay in healthcare and prefer a spiritual healer. The first dimension is perceived susceptibility, which refers to the likelihood of contracting a disease. In rural areas of Pakistan, people avoid healthcare due to the belief that faith alone guides and protects them from illness. Secondly, perceived severity refers to the seriousness of the illness; for instance, minor illnesses are often attributed to supernatural forces such as the evil eye or someone's word of praise during an event (Kayani, et al., 2023; Khan, et al., 2021). Thirdly, perceived benefits: refer to the belief that modern healthcare is effective. People, particularly in Pakistan, believe that modern healthcare is Western propaganda to impose modern religious and cultural values, so they avoid hospitals and prefer spiritual healers as a source of quick relief from illness. Lastly, perceived barriers refer to the obstacles people often encounter in accessing the right healthcare. In every rural area of Pakistan, finding a spiritual healer is easier than finding a hospital due to the expensive commute, accommodation costs, and doctor fees. Besides this, the social stigma of visiting doctors, particularly for sexual health, is often linked with questioning or exclusion of people's masculinity or femininity, which further discourages seeking help from healthcare professionals and increases the reliance on spiritual healers.

By incorporating these four dimensions, HBM provides a useful lens to understand how cultural beliefs, values, and stigma shape the negative perception of healthcare, reinforce the authority of spiritual healers, and contribute to the declining trust in authority in formal healthcare institutions.

The Health and Discrimination Framework

The Health and Discrimination Framework is a relatively new framework that combines public health and sociology. The framework explains the formation of stigma and its operation within the healthcare system. This model focuses that there are several drivers, including fear, blame, cultural stereotypes, and other related factors (Shah, et al., 2025; Haq, et al., 2024; Noor, et al., 2024). These drivers are either strengthened or weakened through the mediums known as facilitators, such as state laws, tribal leaders' orders, social norms, and unspoken values, as well as access to healthcare.

Stigma unfolds in two ways: experiences and practices. Experiences in this context are the lived realities of individuals who are subjected to stigma. It may include direct discrimination, which consists of verbal abuse, exclusion from society, and deprivation of social and familial services. Internalized stigma is a state where an individual internalizes negative perceptions and perspectives and begins to fear and doubt themselves. Perceived stigma refers to where individuals are constantly thinking about how the in-group members are going to treat them. Anticipated stigma occurs when individuals fear being labelled once their disease becomes known to other. This also led to secondary stigma, where individuals feel that not only they but their families and caregivers will be labeled because of their association with the individual suffering from illness (Hsu, Huang, & Huynh, 2023; Nguyen et al., 2022).

Practices refer to the social beliefs, behaviors, and attitudes that reinforce stigma. These include stereotypes such as believing that someone with a psychological illness is cursed, visiting a gynecologist reduces marriage proposals, and confessing to a hazardous disease brings shame, or that a person working in a government job, or that a person must have earned it through illicit

means that's why a person is suffering from a disease. Such stereotypes led to discriminatory behaviors, including labelling, gossip, and social exclusion. Together, these practices reinforce stigma and discourage individuals from seeking formal healthcare.

Explanatory Model of Illness (Kleinman, 1978)

In 1978, a medical anthropologist, Arthur Kleinman, put forward that individuals and communities sees illness not only through the biological lens but also through the lens of cultural belief and moral systems, which he called explanatory models of illness. Through this, objective illness, an abstract concept, turns into a subjective experience, which is open to interpretations. Kleinman proposed that to understand patients' narratives and experiences regarding illness, it is essential to consider their cultural behaviors and attitudes, for which he suggested an explanatory model. This model includes a series of questions ranging from naming the illness to what caused the illness, treatment of the illness, and the authority responsible for making treatment decisions.

Methodology

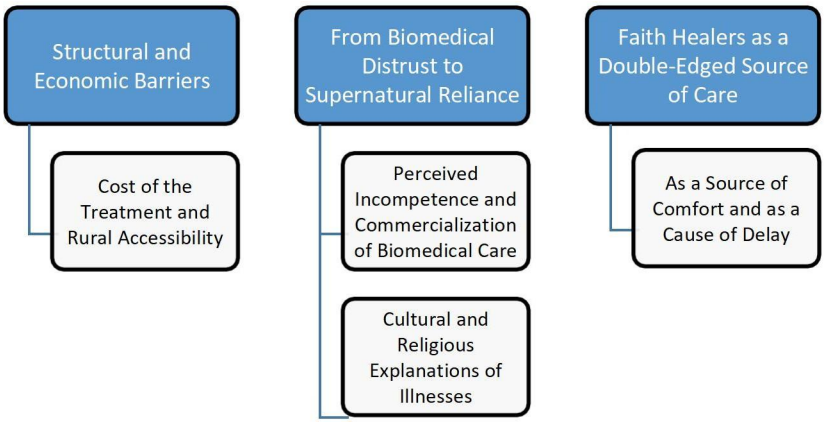
The study utilized a qualitative meta-synthesis approach. Qualitative meta-synthesis is a methodology in which researchers explore, explain, interpret, and integrate findings from various qualitative studies to elucidate phenomena, interpret, and reinterpret patterns and themes, and construct novel insights regarding the researched topic.

The research was initiated with the systematic selection and search of the relevant studies, followed by the extraction of participants' narratives, lived realities, and quotes to identify and develop preliminary themes. To further strengthen the research scope and validity, particularly the segment of data analysis, Braun and Clark's six step framework was utilized. Lastly, the emerged themes were interpreted and presented in the paper.

The study utilizes secondary data sources, which include published articles, journals, and books. During this phase, ethical considerations were strictly adhered to, and all data presented in the paper were properly cited to ensure trustworthiness, transferability, and validity of the research. After ethical consideration, the selection of these documents was guided by three main dimensions: relevance to the research topic, which includes stigma, belief systems, and faith healers. Second, spatial considerations, focusing on the rural areas of Pakistan. Third, the temporal scope, which covers the period from 2015 to 2025, was chosen to capture contemporary perspectives despite advancements in medical healthcare.

Thematic Representation, Analysis and Discussion

Thematic Map of the Study



Structural and Economic Barriers

This theme sheds light on the structural and economic barriers, including financial constraints, inadequate access to healthcare facilities, and costly procedures.

Subtheme 01: Cost of Treatment and Rural Accessibility

The Economic Survey of Pakistan (2024) reported that the budget allocated to health is approximately 0.9% of the GDP in the fiscal year 2024-2025, compared to 1.1% in the fiscal year 2019-2020. In 2020, a research study highlighted that out-of-pocket expenditure in Pakistan is approximately 4000 to 5000 (Riaz, 2020). The average monthly salary of a person is around 32000, and on this income, the average household size is 6.9 people has to survive (Alam, 2025). This data captures the essence of poverty, state spending on healthcare, and average household expenditure on health. With such a limited salary, covering school fees, providing two daily meals, meeting commuting costs, and then managing healthcare becomes extremely difficult.

A participant from rural Sindh reported, *"We come from a poor family ...I cannot bear huge expenses of doctor fees and medicines. For us, going to the shrine and praying here is our only source of healing"* (Memon, Abro &Soofi, 2025).

Another participant reported, *"I do not often go to doctors because it is expensive and far"* (Memon, Abro &Soofi, 2025).

Participants reported, "*To get treatment, we need to travel from our village to main Gilgit, then to Islamabad, and then to Karachi, which requires an ample amount of money. Even for travelling to Gilgit, you must have 50 thousand and which is a huge amount for us".* (Akbar, 2020).

A medical practitioner reported, "*When patients do not get their desired treatments after spending so much money, they start going to faith healers who are often readily available and offer cheap treatment".*

Another medical practitioner quoted*, "When poverty and ignorance compel people to try out these mysterious modes of treatment".*

The faith healers in Pakistan are often considered a source of comfort because their fees are relatively affordable. Several studies have also reported that many faith healers are less motivated by money and more by maintaining the status quo, power, and spiritual authority. In such contexts, faith healers may even perform their practices voluntarily or without charge, making them an accessible alternative for poor households. (Sharma et al., 2020).

A rural Punjab participant quoted, "*Pir charges are five hundred rupees and his remedies provide quick relief."*(Kamar, 2015)

Another participant from rural areas of Gilgit Baltistan reported, "*Pir works here voluntarily, and when asked to pay, he says to pay to the community or organize a communal meal event."*(Akbar, 2020).

Another Participant reported, "*They do not ask for any fees, with your will, whatever you give, they just accept that….If you do not give them money, they will even get your treatment done"*.(Akbar, 2020).

During the focus group discussion, participants reported, "*The shrine is like our local clinic, and it is open 24 hours, and faith healers are always there to listen to our problems and cure illnesses".* (Abro, 2023).

These narratives from participants represent Pakistan as a developing country where many people struggle with poverty, sometimes barely affording one meal a day, and where energy and economic crises are evident. The excessive burden of formal healthcare often becomes unaffordable for ordinary people. For instance, the experience of a participant from Gilgit-

Baltistan, who described the need to change three routes just to reach professional healthcare, contrasts sharply with the accounts from Punjab, where shrines, spiritual leaders, and faith healers were reported to be easily available 24/7 within local communities. This indicates that delays in formal healthcare are not simply a matter of individuals choosing faith healers, but rather the outcome of structural inefficiencies that compel such choices. As one participant emphasized, if offering sweets or organizing a communal meal can bring healing, then spending 50,000 rupees on treatment becomes unimaginable. In this way, state inefficiency and policy gaps indirectly fuel the mushrooming presence and authority of faith healers across rural Pakistan. These narratives from rural areas of Pakistan can be better understood through the Health Discrimination Framework. They demonstrate how rural populations experience systematic neglect and exclusion in healthcare access. For instance, the participant's account of changing multiple routes to reach a hospital illustrates that metropolitan centers are equipped with formal healthcare facilities, while rural areas remain underserved. A recent study by Shoaib, Hassan, and Hannan (2025) further supports this, showing that developed districts are 16.59 times healthier than the least developed districts. This reflects the state's discriminatory attitudes toward rural communities. The absence of regulatory oversight in these areas allows faith healers to dominate local health practices, drawing on ancestral wisdom rather than scientific evidence. While research has occasionally discussed urban quacks and cases of medical negligence in cities, the lives of rural populations are more often left at the mercy of faith healers. This aligns with the theoretical notion that the state implicitly creates "zones of safety" where formal healthcare is ensured, and "zones of sacrifice" where marginalized groups rely on unregulated alternatives (Melamed et al., 2018). These accounts show the reasons behind the prevalence of faith healers. These accounts demonstrate that the prevalence of faith healers is not simply the result of people's reliance on them, but rather the consequence of inefficient policymaking and chronic neglect in the provision of rural healthcare facilities.

From Biomedical Distrust to Supernatural Reliance

According to the Pakistan Medical and Dental Council (2018), 190,325 registered doctors were serving the national population reported in the 2018 census. This translates to roughly one doctor for every 1000 patients. Another study in 2019 highlighted an even greater burden, estimating that a single doctor caters to around 1200 patients, whereas one quack is available to nearly 350 patients (Mustaq, 2019).Such disparities reveal how the shortage of qualified doctors creates a vacuum in healthcare provision, leaving space for quacks and faith healers to step in as accessible alternatives. Within this context, the erosion of trust in biomedical care, coupled with the cultural availability of supernatural and religious explanations, drives further deviation from formal medicine toward reliance on faith healers. The nuances of this transition are explored in the following subthemes.

Sub Theme 01: Perceived Incompetence and Commercialization of Biomedical Care

A participant from rural areas of Sindh quoted, "*One doctor said I had kidney failure, another said it was a liver issue This showed me doctors do not know. So I came to a faith healer"* (Memon, 2025).

A participant from rural areas of Punjab reported, "*I have taken her (his daughter) to a couple of hospitals, and even after that, my daughter had not improved. They are all there to make money"* (Majhajan, 2021).

"I have taken her to a couple of hospitals, and they are all making money, so I visited her. (Faith healer)"(Khan,2021). Another participant quoted the above experience.

The lived realities of participants clearly highlight that in the era of commercialization, even necessities such as healthcare have become projects of profit-driven capitalism. Participants' experiences suggest that communities are increasingly aware of the exploitative nature of medical and pharmaceutical practices. One study revealed that some medical practitioners themselves admitted that in the world of information, professional training is no longer viewed as essential, as knowledge can be accessed through multiple data sources (Khan et al., 2020). While this may appear acceptable, such attitudes often contribute to malpractice and medical negligence. Another study showed that only 27% of participants believed their private medical records were securely maintained, while contrasting evidence suggested that faith healers were perceived as more trustworthy because they did not rely on documentation and were less likely to disclose patients' secrets (Nass et al., 2009). Due to severe negligence and medical errors committed by doctors, people have turned to faith healers in search of better health outcomes. Within the lens of the Health Belief Model (HBM), individuals fear that the negligence and incompetency of biomedical professionals may cost them their lives, thereby increasing their perceived susceptibility to a worsening prognosis. In such instances, the perceived benefit lies in distancing from medical professionals and instead seeking faith healers, who provide spiritual comfort. Furthermore, the incompetency of doctors is regarded as a perceived barrier. Participant narratives illustrate that the failure of medical treatment functions as a negative cue, while spiritual cures serve as positive cues.

Sub theme 02: Cultural and Religious Explanations of Illness

"My child cried all night for days… doctors couldn't help… this may be due to an evil eye."(Memon et al., 2025)

"We visited a religious healer… he recited Quranic incantations on a bengan and advised us to hang it in the courtyard… as soon as the bengan dries out, the baby will recover" (Qamar, 2015).

"I rub the lamp oil on the places that hurt and drink a bit of salt. I believe this will cure my condition."

"My teacher used to say that for spiritual healing, you must repent from all kinds of sins, you must offer midnight and after sunrise prayers along with the 5 times mandatory prayers, and you must not make this field a source of your income"(Memon et al., 2025).

The narratives reflect a harsh social reality in which old cultural practices are followed unquestioningly. Attempts to challenge or question these practices often expose individuals to stigma, discrimination, or social isolation. The situation becomes even more rigid when religious beliefs are invoked, as they are considered sacred and beyond scrutiny. Questioning their healing efficacy is frequently condemned, with individuals being labeled as "possessed by evil" or surrounded by negative energies.

Participants' accounts reveal how childhood illnesses are often attributed to the evil eye, medical conditions are linked to jinn possession, and cures are sought through Quranic recitations, blessed water, or ritual practices. Such practices may create a placebo effect, where individuals experience (Fakhrou, 2024). A sense of improvement simply through repeated rituals and the psychological comfort they provide. Moreover, in a society where blasphemy laws hold significant weight, people fear openly questioning faith healers, who are revered as *pir*, *baba*, or *alim*, figures believed to have access to the unseen and a unique connection between the spiritual and human worlds.

Several studies have pointed out that adherence to religious practices often promotes positive health outcomes by discouraging harmful behaviors such as drinking, smoking, or engaging in risky lifestyles (Freeman, 2021). However, this belief raises difficult questions: if illness is

framed solely as a consequence of spiritual weakness, does it imply that those who suffer lack religious devotion? If that were true, then revered religious figures and saints would never experience illness, a claim that is clearly untrue.

In rural communities, people frequently observe recovery following visits to faith healers, reinforcing the perception of their efficacy. The devotees who organize communal meals or give offerings often report feelings of joy and spiritual satisfaction, which further sustains their trust in healers. Yet, as participants noted, when a child's earliest illness is attributed to the evil eye rather than treated by medical professionals, the likelihood of recognizing and addressing health issues in later stages of life diminishes. This cycle entrenches reliance on spiritual explanations and practices, perpetuating medical neglect from birth into adulthood.

These insights align with Arthur Kleinman's Explanatory Model of Illness, which highlights that, due to deeply rooted cultural and religious beliefs, people tend to misinterpret diseases through their cultural and religious lenses, which hinders their decision-making and their understanding of the disease process. This is evident in the participants' narratives, as they considered a child's crying to be due to the evil eye rather than any illness. Furthermore, the recommendation of a spiritual leader, who associates healing with righteous behavior, worship, and repentance, highlights how frequently spiritual leaders hold authority in matters of sickness instead of healthcare professionals.

Faith Healers as Double-Edged Source of Care

A study conducted by Moydeein and Amber (2007) highlighted that in Muslim countries, the concept of faith healers is strongly rooted in religion. Their findings suggest that regardless of geographical context, individuals often seek a guide or supporter who can inject hope into their lives. Faith healers strategically construct their identities around being pious and religious figures, presenting themselves as intermediaries who can manipulate spirits believed to cause harm. In doing so, they propagate the notion that biomedical doctors are limited and fail to address the spiritual dimensions of illness.

In Pakistan, this perception is reinforced by structural inefficiencies, biomedical negligence, and the capitalist agendas of pharmaceutical companies. Together, these factors foster doubt toward formal healthcare and strengthen the belief that true healing resides in supernatural and divine powers. As a result, faith healers become symbols of comfort and hope while simultaneously contributing to delays in seeking formal medical care.

Sub Theme 01: Faith Healers as Source of Comfort and Cause of Delay

The dual role of faith healers can be seen in the participants' lived experiences.

A participant shared that *"Sain is a doctor from Allah… the shrine is like a hospital where he does operations in dreams"* (Ameer, 2025).

A participant from rural GB shared that: "*Well, I have brought my mother here, she has a high blood pressure issue, she often complains of headache, she says she feels well by drink the water on which Khalifa has to recite dam Darood as compared to medicine. So that's why I have brought her to the faith healer*" (Akbar, 2020).

A participant from Punjab reported, "*We visited a religious healer in the neighboring village. Before religious healing, his face was pale... but now but now you can see his fresh and active"* (Qamar, 2015).

A study highlighted that individuals suffering from chronic conditions such as kidney problems, reproductive issues, or other long-term illness often embark on a journey to shrines before accessing biomedical care. This was reflected in the participants' experiences of suffering from high blood pressure. Increasingly, the same pattern was noted even for minor problems like

toothaches and stomachaches, where faith healers were reported to recite Quranic verses and provide blessed water or amulets (Moydeein & Amber, 2007). An underexplored but emergent dimension that faith healers extend their influence beyond the biomedical domain into socio-economic issues by offering shelter and communal meals to those in need. For individuals living in constant fear of losing shelter or facing starvation, these acts of support provide immediate relief, which can manifest as a sense of improved well-being. Observers often interpret such improvement as miraculous healing, thereby strengthening collective belief in the healers' power. This aligns with the Health Belief Model, where witnessing others' recovery or wellbeing reinforces personal trust in faith healers. Over time, such practices contribute to the normalization of supernatural explanations of illness. For instance, a Pew Research Centre (2012) report noted that 50%Paksitani believe in witchcraft. In a survey of 39 countries, respondents from 20 Muslim –majority countries affirmed belief in the evil eye. Additionally, around 41%of Pakistanis reported wearing amulets as a protective shield.

These research findings and participants' narratives clearly demonstrate that faith healers are perceived as a source of relief and comfort due to their accessibility and constant availability. At the same time, this very accessibility contributes to delays in seeking formal health care, which remains inaccessible and limited in many rural areas of Pakistan.

Conclusion

This study explored the reasons behind the reliance on faith healers as the primary source of care in the rural communities of Pakistan and how access to formal healthcare is hindered by this. This research was grounded in a qualitative meta-synthesis, guided through the lenses of the Health and Discrimination Framework, the Health Belief Model, and Kleinman's Explanatory Model. It illustrated socio-cultural, personal, and religious factors promoting reliance on faith healing. Three key themes surfaced. The first theme, structural and economic barriers—how financial constraints and lack of accessibility to formal healthcare cause people to consult faith healers, since they are easier to access and inexpensive. The second, distrust in biomedical systems, influenced by misdiagnosis, medical malpractice, and errors that promote belief in the illness interpretations of faith healers. Lastly, faith healers act as double-edged figures; they serve a dual role as a source of solace yet cause postponement of timely biomedical care. Overall, trust in faith healers goes beyond superstition; it embodies entrenched structural neglect, persistent inequality, and culturally embedded norms.

Recommendations

1. The state should strictly regulate street wall paintings and advertisements displaying contact numbers of babas and pirs. Such unmonitored promotions provide legitimacy to unqualified healers and must be treated as a public health concern.
2. Public awareness campaigns should emphasize that blind obedience to religious claims without validation can be harmful. Encouraging individuals to demand authentic references from sacred texts can protect communities from exploitation while respecting religious values.
3. Medical students who utilize state-funded education but later leave the medical profession to pursue alternative careers or simply for prestige should face accountability measures. Such practices not only waste resources but also deprive deserving candidates of opportunities to serve in the healthcare system.
4. The state should invest in quarterly medical camps and improved infrastructure in rural areas. These initiatives can reduce dependency on faith healers by making biomedical services more accessible and trustworthy.

5. Media portrayals of illness, particularly psychological conditions, often reinforce beliefs in jinn possession or the evil eye. Dramas should be scrutinized to prevent misleading narratives that normalize faith healing as the primary treatment.

Future Implications

1. Most existing studies on faith healers in Pakistan focus on psychological illnesses. There is as pressing need to explore how communities rely on faith healers for non-psychological conditions particularly reproductive health and infectious diseases.
2. Future research should continue bridging medical sciences with anthropology and sociology to capture the structural, cultural and behavioral dynamics that sustain reliance on faith healers.

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