Kurdish Studies
September 2024
Volume: 12, No: 03, pp 717-727
ISSN: 2051-4883 (Print) | ISSN 2051-4891 (Online)
www.KurdishStudies.net

**DOI:** 10.67145/ks.v12i3.4158

# Health Security Governance Initiatives in North and South Waziristan Districts in Post 25th Amendment: An Appraisal

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**Abstract**
**The 25th Constitutional Amendment of 2018 changed the constitutional, political and administrative position of the formerly Federally Administered Tribal Areas (FATA) of Pakistan and merged it with Khyber Pakhtunkhwa (KPK). The merger was an important effort to integrate historically separate, and conflict-prone region into a constitutional and administrative system of Pakistan. One of the sectors that underwent this transformation was the health sector which institutional integration paved way to widen healthcare accessibility, rejuvenate infrastructure, enhance human-resource capacity, enhance disease surveillance and increase emergency preparedness. North and South Waziristan are especially significant in investigating these developments since a long history of conflict, physical isolation, displacement, insecurity, and a poor infrastructure and health supply shortage have been limiting the provision of healthcare in the past. This paper will analyze and evaluate the health-security governance programs in post-25th Amendment North and South Waziristan. It follows a qualitative approach to research with secondary materials, such as official government documents, provincial health-sector records, peer-reviewed literature etc. Through the analysis of the post-merger governance, it is revealed that such important developments involving the integration of the district health administration into the provincial system, rehabilitation and upgrading of the health facilities, sustained immunization and disease-surveillance, increased emergency response and increased involvement of non-state actors. These developments are, however, limited by the infrastructure gaps, national shortages and inequitable distribution of health workers, scarce and uneven number of women working in the frontlines, rugged terrain, insecurity, poor routine immunization efforts and information systems, poor community resistance.**

***Keywords:*** Health Security, 25th Amendment, formerly Federally Administered Tribal Areas.

## 1. Introduction

Adopting the 25th Constitutional amendment (2018) bringing the former Federally Administered Tribal Areas (FATA) under the ambit of the Pakistani state constitutes an important institutional shift in the structuring of the North and South Waziristan, as it brings the mandate of state laws, administration, and constitution to areas that were previously administered by customary institutions, with little or no public infrastructure, and through non-legal and non-formal systems of authority. As the case of gendered control in South Waziristan shows, however, formal legal integration has not upset customary institutions or necessarily bridged the gap between the state and local law; it continues to be governed by a combination of state institutions, traditional leadership, jirga-based, security based, social norms, and uneven distribution of public services within and between the state and the local sphere. This is especially relevant in the context of understanding governance and practices around health security in North and South Waziristan, as health security is contingent on access to, and involvement in, a variety of health services beyond hospitals and vaccination and disease surveillance, emergency response and maternal and child-health services being locally legitimate, institutionally coordinated, gender responsive and accepted by those affected by conflict, poverty, displacement, mobility and infrastructural isolation(Karim 2022).

The paper discusses how the post 9/11 security landscape had deeply impacted Pakistan in both general and this specific context in particular, as movement within the former FATA and daily life and development were significantly interrupted by militancy, counter-terrorism, displacement and insecurity. Given its strategic location up against Afghanistan, FATA revitalized to become a focal point of counterterrorism operations in Pakistan, while external support in various sectors of relief extended beyond military and security to health, education, disaster management, refugees and development programs coverage started growing gradually. The paper, therefore, forms an important basis for a discussion on the impact of conflict and security-oriented interventions in governance and provision of services in the areas like North and South Waziristan where these two regions were integrated within Khyber Pakhtunkhwa later.(Yaqoob and Sattar 2021).

The year 2018 brought a significant shift in the governance mechanism of the then FATA (North & South Waziristan). Militancy, counter-terrorism, displacement and institutional neglect for years had damaged social services including health, and the health service system was mostly regarded as poor and there was a feeling that many health facilities were under the influence of conflict. Post-merger, there was a growing association between health governance with provincial and district administration, but there was still a certain improvement in health services delivery; however, there were still many deficiencies, with a majority of respondents showing a low satisfaction with the health service conditions in the institutions.

Health security governance comes across from providing for medical facilities to institutional capacity, access to and continuity of health services, protection of health facilities, cooperation between institutions and the capacity of government bodies to respond to health vulnerabilities in conflict. Accordingly, this study critically reviews the health security governance efforts implemented in North and South Waziristan following 25th amendment, also lightened up that how far health security governance following the merger equips Pakistani health services to overcome the long-standing health system failures and enhance health security despite persistent post-militancy challenges of weak institutional capacity, inadequate infrastructure, and limited service delivery(Baber 2023).

Furthermore, according to the author, the intensity of security threats is enhanced by a combination of poverty, social vulnerability, poor institutional development and weak governance capacity in fragile and conflict-affected areas. It highlights governance and institutional capacity, which are fundamental to the effective management of a crisis and the development of resilience; and a broader human-security approach emphasizing the health, well-being, and safety, livelihoods, and socio-economic well-being of communities. This is especially true of North and South Waziristan, after the introduction of the 25th Constitutional Amendment, which has created new institutional mandates for provision of basic public service in most conflict affected regions of the country. In the context of public health, health security is more than just the provision of healthcare services and structures: institutional capacity, framework, access to health services, preventive care, emergency response, coordination, and community resilience are all part of health security. The paper's focus on strengthening institutional capabilities and the adoption of integrated - and locally responsive - healthcare governance also serves as an analytical framework for determining whether post-merger healthcare projects have improved the state's governance capacity to respond to healthcare vulnerabilities, and consequently its capacity to enhance the human security in North and South Waziristan(Makki et al. 2022).

This paper emphasizes that robust governance framework, institutional coordination, human resource management, health information systems, monitoring and accountability, and sustainability of funding are as important as health facilities in building a health-secure environment in fragile and underserved areas. It demonstrates that in response to the gaps in prevailing health services delivery models, the KP government has been putting in place innovative health-management practices. The research also shows that better governance, digital information technology, staffing and performance monitoring can lead to better service delivery, while low resource availability, poor accountability and lack of institutional capacity are salient issues(IFEJIKA 2023).

**Literature Review**

World security is moving into a new era of transition from the state-centric concept of security towards human security. Traditional security is defined by realist and neorealist theories, which are based on concepts of state sovereignty, military power, and territorial defense against external threats. But with globalization, technology, environmental issues and the Human Rights movement, the challenges in today's world are more and more multi-jurisdictional. The human security paradigm is based on liberal and constructivist approaches, and extends security to helping people protect against non-military threats such as health crises, poverty, and so on, focusing on "freedom from fear" and "freedom from want. This multi-dimensional approach extends the involvement of a wider range of actors, including NGO's and international institutions, to show the need for a more comprehensive strategy, beyond military 'defense'. To effectively manage current global challenges, however, a mixed approach between state-centric defense and human-centric protection mechanisms is needed(Rasool and Anwar 2019).

The current governance arrangement for health security in North and South Waziristan was given new urgency due to the 25th Constitutional Amendment 2018. The two districts have been beset by health security challenges due to historical factors such as militancy, insecurity, geographical isolation, weak institutional capacity, lack of health infrastructure, as well as lack of access to health services. The government has been introducing various programs and initiatives during the post-merger period, such as increasing facility, recruiting health staffs and introducing the health system to the provincial administrative structure, but some doubts are still lingering about their effectiveness and accessibility, implementation and sustainability. This study thus evaluates the health security governance programs in North and South Waziristan on the human security, non-traditional security and post-conflict reconstruction frameworks, and considers health as an ingredient of human and societal security in areas where conflict is an ongoing phenomenon(Saood and Salahuddin 2022).

The author takes a human-security approach to health security and contend that infectious diseases pose major threats to life beyond security. Informed by the Qur'an, Sunnah and the medical literature, the study emphasizes the importance of preventive health, cleanliness, containment of disease, quarantine and collective responsibility in the context of health security. It also underscores such measures as limiting unnecessary movement and gatherings, hygiene, preventing transmission of disease and providing protection to vulnerable groups in times of pandemic. Its holistic view in this article shows that health security is not just about medical response, it is also about social, institutional and preventive measures. From this lens, it is possible to examine the level of health security governance in North and South Waziristan following the 25th Constitutional Amendment, which proved a turning point in the history of health security governance in these regions.(A. U. Khan et al. 2021).

This literature demonstrates how colonial forms of administration remained in place for more than seven decades in the dismantled Federally Administered Tribal Areas (FATA) and continued to operate even after it became a part of Pakistan in 1947. The Frontier Crimes Regulation (FCR) of 1901 was initially implemented by the British authorities as a buffer zone, but it was based on punitive collective measures, tribal patronage, and denied formal legal rights and state services to the residents. After independence (in 1947), successive governments in Pakistan maintained this exclusionary system for strategic, political control and opposition from the entrenched tribal elites. In May 2018, the 25th Constitutional Amendment was passed that abolished the FCR and added new constitutional protections to the merged districts, but empirical evaluations show that legal reforms have outrun administrative practice. In reality, newly appointed Deputy

Commissioners often exercise the discretion of former political agents, while informal jirgas increasingly supplant formal courts, and converted tribal militias are under-staffed in policing. In addition, on-going security challenges and institutional stability are affecting governance delivery in the region(S. Khan 2021).

The author analyzes the governance issues and loss of trust of the community in Pakistan's seven merged districts after the 25th Constitutional Amendment in the context of Human Rights. A secondary data analysis using the theories of Legitimacy Theory, Rights Based Approach and the State Fragility frameworks, the study shows that, formal legal reform has not produced substantive rights on the ground. Enforced disappearances, extrajudicial detention, unaddressed land conflicts and gender-based marginalization continue to plague residents of the former FATA. These rights gaps are exacerbated by administrative vacuums, non-functioning court infrastructure, non-existent land records and poorly trained police officers. Moreover, communities continue to rely on customary Jirga mechanisms despite well documented rights violations because of a deep trust deficit between them and the formal institutions, such as the police, courts and Dispute Resolution Councils, which are perceived to be non-local. Finally, the paper argues the need for ongoing institutional capacity, procedural justice, and community trust-building to be able to realize rule of law through constitutional integration(A. R. Shah 2020).

The distribution of endemic wild poliovirus type 1 (WPV1) is limited to security-sensitive subnational geographies including South Khyber Pakhtunkhwa, Pakistan, where high insecurity, community boycotts and low routine immunization coverage have adversely affected routine SIAs. For the purposes of investigating operational solutions to these ongoing obstacles, the evaluated polio vaccination strategies in all South KP districts, in a retrospective analysis. In order to safeguard vaccinators and guarantee coverage, the program changed from a national schedule of vaccines to operational modalities based on security, with staggered implementation, a shorter duration of the campaign and fix site vaccinations. In addition, special measures were taken to promote access to high-risk and hard-to-reach groups such as mobile biker groups, permanent mobile posts at border crossings, and ring-fencing vaccination posts around insecure zones. One of the strategic approaches to this was the synergy between the Polio Eradication Initiative and Expanded Program on Immunization that integrated health camps, extended outreach and targeted fractional-dose inactivated poliovirus vaccine campaigns to provide multiple antigens. While these integrated efforts identified 315,223 zero-dose children, most campaigns failed to meet national quality standards due to monitoring challenges and security constraints, and succeeded in linking 64% of children identified to routine immunization schedules(Saood and Salahuddin 2022).

While studying the transition after the conflict in North Waziristan, Makki studied the porousness of the borderland dynamics in the past that led to a strong informal cross-border trade, which supported the livelihoods in the border regions, and was also used as a pretext for financing terrorism. The state application of counterterrorism measures including Operation Zarb-e-Azb led to the emphasis on hardening the borders, physical barriers and formalizing transit points such as Ghulam Khan terminal to prevent militancy. The authors, however, challenge the notion of securitization that is purely state-based, as it distorts local socio-cultural identities and the economic lives of people. But the authors are critical of the purely state-based securitization as it is constraining socio-cultural identities and economic survival in the local context. In the end the study suggests that durable peace can only be secured by addressing the needs of the state for security and balancing these with the process of integrating trade across borders and diversifying local economies(M. A. Shah 2018).

This study explores the role of Deobandi Ulema in Pashtun resistance to polio vaccination in KP Province, Pakistan. The study uses qualitative ethnographic approaches to point to the divisions between those high-ranking religious leaders who support immunization and lower-tier local religious figures who spread conspiracy theories through fatwas and digital platforms. This localized "reluctant religiosity" leads to targeted violence against frontline vaccinators, and to "demand-based refusals" of the vaccine-led drives by neglected communities which use them as a way of negotiating for much needed civic infrastructure. In conclusion, the authors believe that the real challenge to eradicate polio in Pakistan is essentially socio-political which requires direct involvement with the religious leaders and the community to provide healthcare services(Makki and Iftikhar 2022).

In this localized case study of Bajaur District in the FATA–Khyber Pakhtunkhwa merger, Muhammad examines the socio-economic, political and legal changes that took place after the merger. The study is based on the premises of Modernization Theory, and follows a sequential explanatory mixed methods approach with official administrative data, qualitative key informant interviews, and a primary survey of 100 local respondents. Results show considerable support for constitutional integration, with 64% of respondents being content with the integration. In the KP Provincial Assembly elections 2005, 98% had voted in favor of parliamentary elections. 95% said they felt the political environment had improved. 70% said the community had improved peace and security, with 60 percent saying it was better. In spite of the rejection level of 0% for the colonial era Frontier Crimes Regulation (FCR), it is worth noting that this was the lowest rejection rate recorded in the past 10 years. The end of the bureaucratic Political Agent rule. There is still a lot of institutional strife, in particular, 68% of respondents prefer the traditional Jirga dispute-resolution system to formal state courts because it is cheap and quick to resolve disputes. 50% doubt the KP administration's ability to run the district. In the end, the author concludes that although integration has stripped oppressive governance mechanisms, Bajaur will need to find ways to address the delayed funding of infrastructure, institutional transition issues, and ongoing security challenges along the Afghan border to ensure long-term stability in the region(Wazir et al. 2023).

The author analysis is based on the principles of Social Role Theory, revealing that the 25th Constitutional Amendment, judicial extension, and progressive electoral provisions provided legal rights, but de facto participation is still very restricted as a result of entrenched patriarchal order and informal governance systems. The research highlights the interaction of tribal practices and traditions based on Pashtunwali and the general lack of literacy, economic empowerment and security concerns of women in the conflict situation, which has restricted their freedom of movement and voting. The research shows that social enforcement mechanisms of Pashtunwali such as Purdah (veil), Tor (stigma) and Peghor (satire), intersect with the widespread female illiteracy, economic disempowerment and security concerns caused by the conflict situation and

have thus greatly limited women's mobility and the ability to vote. Despite this, he sees emerging opportunities for women to exercise agency, especially in bold candidates stepping forward for elections and marginally greater participation in electoral cycles over the past few years. The study concludes that legislative and institutional changes are 'always' inadequate alone, and that meaningful political inclusion must be achieved through a comprehensive approach that considers socio-cultural factors, economic entanglements and lack of awareness(Yadav 2022).

A similar trend was observed in Pakistan, where strong connections between the performance of the health system and governance structure were found. In addition, governance, financing, service delivery, human resources, medicines and health information were identified as interconnected components of health-system performance by Nishtar and colleagues in their assessment of the health system in Pakistan after the 18th Constitutional Amendment. The study concluded that complex governance issues and underinvestment had limited the health system and that decentralization had opened up opportunities, as well as institutional challenges. This discovery offers a valuable conceptual basis to look at the situation in the merged districts after the 25th Amendment. The experience of provincial health governance, however, cannot be replicated in former FATA since the merged districts came to the provincial system with unique historical, geographical, security and institutional characteristics(Akhtar 2019).

Another area of development in the literature has been on the link between health security and human security. Rising awareness of health being more than a welfare issue, as it can affect individual and community security if they become ill, lack access to healthcare, are displaced or live in poverty, makes it more important to human security than ever before. This is especially important in conflict-affected societies where security threats and the associated social and environmental consequences may have a double negative effect on health systems and access to health. Therefore, a health security assessment of Waziristan must do more than just look at the provision of direct health services, it must also take account of the institutional context in which they are provided(B. Khan et al. 2023).

The other major thread is about how decentralization relates to health governance. The experience of Pakistan after the 18th Constitutional Amendment provides a good example that devolution of responsibilities does not ensure effective health governance. While devolution increased the role of the provinces in health, research found that certain problems remained, such as institutional coordination, health information, financing, human resources, regulation and accountability. In the same vein, studies on constitutional changes in Pakistan have pointed to the importance of evaluating the formal devolution as well as the institutional capacity of health departments to undertake the formal devolution effectively(Khalid Sandhu and Makki 2023).

The constitution and administrative structure of KP was extended to the old tribal areas in the 25th Amendment, but institutional integration is more than just the mere incorporation of a territory. Good health governance relies on the availability of operational facilities, staff, sustainable funding, medicines, referral arrangements, information systems, administrative coordination and community engagement and monitoring processes. Therefore, the mere presence of a government program simply does not mean improved health security(Aziz et al. 2023).

Much has been written about the 25th Constitutional Amendment and its shift from exceptional regime of tribal administration to constitutional governance. The removal of the Frontier Crimes Regulation (FCR) and extension of constitutional, administrative, judicial and political bodies was a radical shift in the formerly FATA. For example, recent literature on the subject of South Waziristan has discussed the process of merger as the shift from an historically exceptional administrative system to constitutional governance and underscored the remaining challenges that lie with the institutions of this shift(Dawar 2022).

**Define Health Governance**

The health governance as a multi-sectoral operational framework which plays a vital role throughout the process of implementation to bring tangible health benefits in the country's context of achieving Universal Health Coverage. In this regard, successful governance depends on the presence of legally binding frameworks setting in terms of reference to health agencies, protecting the rights of patients and establishing mechanisms of regulatory accountability. It also requires political stability and policy continuity so that policy changes don't impede or derail longer-term health agendas and welfare programs. Governance needs to be strong, with good regulatory oversight to ensure that services are delivered and that there is adherence to a consistent quality standard in empanelment of hospitals, and to control the growing private health sector. In addition, it includes the inter-institutional and interdepartmental coordination, including coordination between federal and provincial sectors, between health and planning and financial sectors, as well as the involvement of all stakeholders in an inclusive manner to facilitate evidence-based decision-making and equitable distribution of resources. On the other hand, the public sector governance gap is seen as weak coordination, high level of uneven distribution in the health workforce and absence of a unified health information system nationwide(Altaf Ullah and Hayat 2018).

**Brief about Merger**

The author discusses the 25th Constitutional Amendment of May 2018 for the constitutional integration of the Federally Administered Tribal Areas (FATA) into the province of Khyber Pakhtunkhwa (KP) as a crucial attempt to expand democratic governance and federalism to a historically marginalized area. Nearly seven decades the tribal belt was administered by the draconian colonial Frontier Crimes Regulations (FCR) without any fundamental constitutional rights and no access to the higher courts, which resulted in serious shortcomings of administration and administration turned into a vacuum in the post-9/11 incident. To address this gap, the constitution merged the FCR, gave the Supreme Court and KP High Court more power, increased the size of the KP Provincial Assembly by 23 and recommended that KP be awarded 3% annual funding over 10 years under the National Finance Commission (NFC) Award, to improve infrastructure in the province. However, the post-merger transition has various structural blockages, including inter-provincial resistance to the release of NFC funds, bureaucratic sluggishness, and delayed development of civil courts and local institutions, which have exacerbated local disillusionment and socio-political tensions. The authors conclude that the process of judicial set up in the region must be expedited, integration of reformed Jirga mechanisms into formal judiciary process is necessary and the fiscal

development promises must be acted upon swiftly and quickly to avert regional alienation and to attain real federal integration(Ali et al. 2020).

**Conceptual and Analytical Frame work**

This study adopts Multi-level Governance Theory with the Health Security and Health Systems Resilience as an underpinning theory. It explores the impact of the merger of the former FATA into Khyber Pakhtunkhwa under the post–25th Constitutional Amendment, on the health-security governance in North and South Waziristan. The overall framework conceptualizes health security as a product of coordination between all actors at the, provincial, district, health-facility, security, development and community levels. It evaluates important governance activities: disease surveillance, immunization, emergency preparedness, strengthening of health facilities, deployment of health workers, referral systems, health information management and community participation in governance activities, at the institutional level. At community level: Resource allocation, vertical and horizontal coordination, accountability. All of these are likely to impact on prevention, early detection of health threats, emergency response, continuity of essential services, equitable access, and community resilience. However, insecurity, displacement, challenging geographies, poor infrastructure, poverty, gender barriers and lack of trained health personnel can influence their effectiveness. The study comparatively appraises North and South Waziristan in order to identify the achievements of post-merger health-security governance and the gaps, even the differences on district level.

**Research Questions**

What budget allocations have been given in the health sector in North and South Waziristan post 25th constitutional amendment?

What is the difference between the approved health budgets, funds released and the actual expenditure in the North Waziristan and South Waziristan?

What changes are needed in the health sector to ensure that all resources are allocated equitably, on time, based on need, and efficiently in North & South Waziristan?

**Research Methodology**

This study will be qualitative in nature and use a case-study design to explore and evaluate health security governance efforts in North Waziristan and South Waziristan after the enactment of the 25th Constitutional Amendment to the Constitution of Pakistan. Qualitative research is appropriate as it aims to examine processes, institutional arrangements, perceptions, implementation experiences, and governance challenges which cannot be sufficiently captured based on numerical indicators. Case-study research allows for an in-depth examination of complex policy and governance issues in their real-life context and allows multiple qualitative sources of evidence - such as interviews and documents observations.

The two districts of North and South Waziristan will be considered as separate but inter-connected cases. Prior to the incorporation of the two districts into Khyber Pakhtunkhwa in 2018, both districts were part of the Federally Administered Tribal Areas. But the experiences of their history, administrative abilities, geographical location, conflict experiences, health-facility availability, population needs, and local governance context may vary. In the next step, studying both districts will therefore enable comparison of the design, implementation and experience of health governance reforms since the merger at district level.

Document analysis will be used as a second major source of data. These documents will include text and development-related information on the 25th Constitutional Amendment, health policies of Khyber Pakhtunkhwa Province, health-sector development plans, annual development program documents, budget statements, district health plans (when available), health-facility reports, monitoring reports, policy notifications, Sehat Sahulat Program documents, public-health surveillance documents, immunization program and polio program documents, development partner reports and published academic research. Where available, newspaper reports and reliable civil-society reports will also be examined that offer background information on access to health services, institutional changes, public concerns, and implementation shortcomings.

**Health Security Initiatives in Selected Case Studies**

**Zoonotic Disease Governance**

In analyzing the health security governance of Pakistan, the authors scrutinize the presence of systemic vulnerabilities and compliance gaps in the International Health Regulations (IHR 2005) in addressing zoonotic threats like Crimean-Congo Hemorrhagic Fever, Swine Flu and Ebola. Pakistan has made commitments to IHR (2005) provision in June 2007 but its outbreak containment capacity is being hampered due to structural, legal and operational gaps. Some of the main problems are: porous borders with neighboring countries such as Afghanistan, which allow pathogens to spread across borders in the unregulated movement of livestock and nomadic herd movements; policy fragmentation from inter-provincial policy devolution under the Eighteenth Constitutional Amendment. The situation is further exacerbated by the institutional vulnerabilities, which include the lack of effective legislation for animal quarantine and slaughter, lack of personal protective equipment and vaccines, reliance on a single high tech diagnostic center at the National Institute of Health, Islamabad and the absence of effective vaccine manufacturing facilities. The authors suggest a dual integrated governance approach, namely horizontal multi-agency coordination, and vertical top-down and bottom-up institutional oversight, to sustainably enhance disease surveillance, quarantine enforcement and regional biosecurity capacities to counteract these ongoing risk. (Dr. A. U. Khan and Jaspal 2005).

**Vector-Borne Disease Governance**

This article examines vector-borne diseases (VBDs), specifically Dengue and Zika viruses, through the lens of non-traditional health security in Khyber Pakhtunkhwa (KP), Pakistan. Grounding their analysis in human security and

securitization theory, the authors conceptualize infectious pathogens as existential threats to individuals rather than conventional state-centric military concerns. Through empirical evidence from outbreaks in regions such as Swat, the study demonstrates how public health vulnerabilities are severely exacerbated by institutional bottlenecks, including delayed administrative funding, insufficient hospital surge capacity, weak inter-agency coordination, unhygienic local environments, and refugee mobility. Ultimately, the paper advocates for a multi-pronged biosecurity strategy combining vector surveillance and structural governance reforms with Islamic principles of cleanliness (Taharat) and preventive hygiene as a socio-religious framework for public health compliance (Amir Ullah and Naeem Badshah 2017).

**Plant Biosecurity and Agricultural Health**

Within a non-traditional security approach, the authors explored Pakistan's plant biosecurity governance, seeing agro-terrorism and biological hazards as key challenges to the security of the society. The Pakistan biosafety Rules (2005) and the Plant Quarantine Act (1976/2006) are among the regulatory frameworks that are present in Pakistan, despite these, there has been a lack of effective implementation. Implementation, however, is significantly hampered by lack of adequate staffing, inadequate funding and agricultural imports from Afghanistan, through the porous border, are not inspected, and there are administrative barriers between settled and tribal populations. To mention the fact that the state had been preoccupied with traditional military security in the Global War on Terror and there was no regional coordination in SAARC. The authors call for a dual institutional approach comprising a Provincial Biosecurity Commission (central) and a three-tiered local surveillance system. (Jaspal and Khan 2017).

**Initiatives for Health Governance in North Waziristan**

**Descriptive Analysis**

The budgetary record for 2019 to 2023, exhibits a steady shift in North Waziristan, from a basic process of restoration and expansion of health infrastructure, to a more institutionalized approach of health-governance. These were the major interventions undertaken which included establishment and upgrade of health facilities to Community Health Units, opening of about 18 of them, The opening budget for these CHCs/CDs in North Waziristan was about Rs.12.0 million, of which Rs.10.98 million were spent, and the left-over budget was used for other avenues like. mobile hospital services, solarization of health facilities, addressing of staff deficits, extended care after hours services, improvements in the Expanded Program on Immunization (EPI), nutrition, family planning and disease control interventions.

The health governance pattern was increased during 2020-2022. Proportional allocation of the budget to support maintenance of health facilities and capacity building of population to run them. The North Waziristan district has allocated Rs.11.282 million for the removal of staff deficiency, Rs.8.365 million has allocated for Solarization of existing AHQ/THQ Hospitals, and allocated funds for Health Management Information System, AIDS, hepatitis and TB control etc. Further, the data from the year 2021 can be seen as an illustration of institutional convergence, in the sense of investments made in doctors, nurses, paramedics and disease-control programs.

Since 2022, the focus shifted more towards operationalization and sustainability of the health system. For doctors and regularized health-sector projects of about Rs.37.93 million was spent, Rs.30.79 million in 2022 was spent under the Accelerated Implementation Program (AIP) in the merged districts. This was followed by an increase in expenditure of Rs.91.59 million for nurses and paramedics, Rs.28.47 million for salaries/operational costs, and Rs.26.40 million for doctors in 2023.

**Major Initiative for health-governance in North Waziristan 2019 – 2023**

**1st position in the Plan, at the governance level, identifies a key initiative on the budget data.**

Health infrastructure repeated allocations and expenditure between 2019 and 2023 for establishment/upgradation of Health care and Family services (HFs) to Community Health Unit (CHUs), opening of 24 hospitals/satellites Clinical Decision Support and Tehsil Head Quarters (CDs/THQs) and solarization of Agency for Health care research and quality (AHQ/THQ) hospitals

Hospital services AHQ/THQ hospital strengthening and associated facilities Recurrent investment in hospital: infrastructure and utilities. Human resources Fill vacancies of doctors and nurses, paramedic staff Raising a major expenditure from 2021 onwards Preventive health including EPI, family planning, nutrition, aids/hepatitis and TB control Recurrent annual allocations Health and Mobility Mobile (Hospital) Program, Phase III Continue allocation/expenditure for 2019-2020 period System Health information Health Management Information System Expenditure reported in 2019-2021.

**Table 1.1**

| Year | Initial Budget (Million) | Expenditure (Million) | Percentage of Expenditure |
|---|---|---|---|
| 2019 | 78.17 | 43.08 | 55.1% |
| 2020 | 115.85 | 115.85 | 100.0% |
| 2021 | 130.10 | 130.10 | 100.0% |
| 2022 | 149.93 | 149.93 | 100.0% |
| 2023 | 195.48 | 195.48 | 100.0% |
| 2019–2023 | 659.43 | 634.44 | 91.02% |

The movement is thus not one of increments or augmentations of financial allocations. It reflects a shift in the nature of health governance: the first few years had a focus on setting up or restarting health infrastructure and operating room staff; the following years focused increasingly on financing specialists, nursing staff, paramedics, operating room expenses and preventive programs. This indicates that the subsequent health post-merger concern shifted from bodily reconstruction to health services functioning in health institutions.

**Initiatives for Health Governance in South Waziristan.**

**Descriptive Analysis**

South Waziristan has a much wider and more significant portfolio of health-development activities than North Waziristan. Establishment and upgradation of existing health facilities to CHU, establishment of one category-D hospital at Makin, and rehabilitation of existing health facilities in 2019 included the upgrades of civil hospitals to CHC level, solarization of health facilities, establishment of 19 CHCs, opening 18 CHCs, mobile hospital services, EPI, nutrition, family planning, and diseases control. The major significance was the model that of a Public-Private Partnership for the operationalization of the Model Hospital at Sholam whose final amount was changed to Rs.117.861 million and Rs.104.511 million was spent against it.

The shortage of staffs, mobile hospitals and preventive-health programs. Two PPP schemes with six Type-D hospitals each – one for Mola Khan Sarai and one for Toi Khula – had particularly large final allocations – in the case of Mola Khan Sarai, some Rs.149.715 million was allocated and in the case of Toi Khula, some Rs.188.715 million was allocated, with all the amounts being recorded as spent.

In 2021-2023, human resources and service delivery partnerships went part and parcel of the South Waziristan health-governance model, along with infrastructure. During 2021, the key areas of rehabilitation, CHCs, Category-D hospitals, doctors, nurses and paramedics, PPPs for Type-D hospitals and family planning and EPI received areal attention and significant resources were allocated in these sectors.

**Table 2.2**

| Year | Initial Budget (Million) | Expenditure (Million) | Percentage of Expenditure |
|---|---|---|---|
| 2019 | 289.51 | 190.28 | 65.7% |
| 2020 | 700.74 | 700.74 | 100.0% |
| 2021 | 600.19 | 600.19 | 100.0% |
| 2022 | 239.06 | 239.06 | 100.0% |
| 2023 | 394.07 | 394.07 | 100.0% |
| 2019–2023 | 2223.57 | 2124.34 | 93.14% |

The South Waziristan dataset thus shows about Rs.2.860 billion of final/revised health allocation between 2019-2023 whereof about Rs.2.223 billion is progressive expenditure, which equals about 93.14 percent utilization. Unlike in the case of North Waziristan, a much larger amount has been allocated to it in aggregate of which a higher share is linked to hospitals construction/rehabilitation and not only a single health expenditure category that is preventive health.

**Comparison between North and South Waziristan**

Comparing the health-security governance between North and South Waziristan is meaningful only if the differences in the demographic, geographical, institutional and security landscape of the two districts are taken into account. As per the 2023 Population and Housing Census, the population of North Waziristan is 693,332 in an area of around 4,707 square kilometers while the population of South Waziristan is 888,675 in an area of around 6,620 square kilometers. The two districts are mainly rural and have low population densities (147 persons per sq.km. in North Waziristan and 134 persons per sq.km. in South Waziristan). These demographic and spatial variations are significant because the same amount of expenditure or the same number of facilities does not provide the same service if the population size, territorial extent, settlement pattern, and accessibility conditions are different in the district,

An additional dimension is added through the facility-level comparison. According to the present list of facilities from Khyber Pakhtunkhwa Health Department, there are 13 listed public health facilities in North Waziristan, this includes DHQ Hospital Miran Shah, THQ Hospital Mir Ali, BHUs, and 23 facilities in South Waziristan which includes DHQ Hospital Wana, civil hospital, category-D facilities, BHUs and other facilities listed. This translates into about 1.88 listed facilities per 100,000 population in North Waziristan and 2.59 listed facilities per 100,000 population in South Waziristan on a population adjusted basis. On the other hand, population of each listed facility in North Waziristan is about 53,333 persons while in South Waziristan 38,638 persons. This implies that the nominal facility network is more spread out in South Waziristan, relative to population. However, a facility's number alone does not indicate its effectiveness in providing coverage, as one facility could be very different in terms of staffing, the services it offers, its geographic region, its operating hours, its equipment, its medicine supply and its accessibility.

Another significant difference that is not amenable to monetary investment is geographical accessibility.

The low population densities of both districts mean that health care facilities will have to cover relatively large areas, and both districts have isolated rural settlements and rugged terrain. While South Waziristan has a much larger geographical area,

its population density is somewhat lower than that of North Waziristan which has a smaller area. Thus, the costs of providing services geographically distributed may be higher in South Waziristan than in North, and even in North, access may be difficult even if the area is smaller in size. Alongside expenditure and facility numbers, therefore, roads, mountainous terrain, travel time, seasonality of access, availability of ambulances and the distance between settlements and facilities should also be taken into account.

It is also not possible to make a direct comparison due to security conditions and displacement of populations. The districts have long-term security problems and population shifts, which pose a threat to the continuity of health services and puts strain on services. Medical movements (such as security restrictions on movement of medical personnel, vaccination teams, ambulances, and patients), and movement of people to and from their places of origin can temporarily change the population in need of healthcare services. It is not, therefore, possible to evaluate only on the presence of the facility, rather the entire environment of the locality has to be considered as unsafe or geographically isolated. It depends on the patient's ability to access it, on staff attendance and whether medicines and equipment are available, whether essential services are still available during disruption, and more.

**Findings**

These comparison results are significant when looking at governance within health services in the two districts. First, the multi-dimensional investment strategy supported health governance after the merger and not a single program of building the hospital. The budget portfolio includes the physical infrastructure, human resources, preventive medicine, health information systems, mobile service delivery, utilities, disease-control programs and operational expenditure. From a governance point of view, this is significant because for a health system to function, physical facilities are needed, as well as the people who will operate it, recurrent funding and mechanisms for delivering preventive and primary healthcare. The data illustrate that over time these various components were added more and more into the budgetary structure.

Second, the data shows there is a definite shift from the infrastructure to the system operationalization. Numerous health facility related projects are included in the earlier allocations that involve establishing, opening, rehabilitating and solarizing health facilities. A significant share of the funds was going towards doctors, nurses, paramedical staff, running the hospital and implementing prevention campaigns until 2021-2023. For instance, in 2023, Rs.91.59 million was recorded in North Waziristan for conducting activities related to the health workers and hospital PPPs, and there was no break in this expenditure in South Waziristan.

Third, the health-development envelope of South Waziristan is much higher in the provided data. It had total been allocated around Rs.2.223 billion as compared to approximately Rs.659.43 million allocated to North Waziristan. This difference cannot however be automatically assumed to be a difference in the relative commitment of governments as project composition, population, geographical coverage, inherited infrastructure, project scale and the presence of large PPP and hospital-construction projects may also influence the difference in governmental commitment. The data only confirm the amount of the gap; they do not directly determine the sufficiency of funding to meet health needs.

Fourth, financial utilization rate was largely high after the initial phase but high expenditure does not guarantee quality and equity in health. The aggregate utilization was ~91.02 percent in North Waziristan and ~93.14 percent in South Waziristan during the period. However, a few individual projects report lower or zero spending. One example is several projects for North Waziristan in the year 2019, which have recorded no release and expenditure.

Consequently, whatever has been invested in those areas much isn't there physically present. Most of the population still visit big cities like Bannu, D.I.K and Peshawar for health issues resolutions. There is much gap to be looked into it.

**Monitoring of the financial disbursement shall be reviewed.**

**Challenges to Health Governance in North Waziristan.**

The first big hurdle in health facilities in the first major area we visited in North Waziristan has been the shift from setting-up to continuous provision of services as is reflected in the budget evidence. Many of the initial portfolio projects relate to the opening of CHCs/CDs, modernization, solarization and staff shortages. This suggests that a lot of initial investments were needed in the health system to enable it to function as a coherent district-level network. Moreover, projects on mobile hospitals and the Health Management Information System point out to the fact that there are some drawbacks in the fixed facility health coverage, which needs to be compensated for.

The availability of and retention of human's resources is a second challenge. The fact that doctors' posts, nurses' posts and paramedics' posts were allocated again and again, additional projects were taken for combating shortage of staff, it is an indication that infrastructure was not adequate to provide services. Financing data indicates that the one aspect of the governance discourse, where staffing was a priority, was signaled by the big jump since 2021 when it became an important element of the health-worker financing. This is especially true of remote districts where institutional support for a health workforce is more challenging than building buildings.

The third is unfinished implementation of individual infrastructure/utility projects. In the case of projects from North Waziristan, 2019 has final budgets, but no release/expenditure is recorded in that year while solarization project in AHQ Miranshah and THQ Mirali has a final budget of zero in 2020 despite the availability of an original budget.

Its fourth challenge is reliance on recurring public funding for continuity. It is only from 2022 that the salaries and other running expenses of regularized heath sector projects are explicitly shown. This is because the establishment of facilities entails an ongoing financial commitment. Therefore, funding in North Waziristan needs to be made recurrent and predictable with a lesser project-based approach to the health system.

**Challenges in Health Governance in South Waziristan**

Poor Health Infrastructure: Limited access to primary health care facilities and the need for upgrading, rehabilitation, medical equipment and regular supplies in existing facilities. There is also a shortage of secondary and specialist health care services which leads to reliance outside the district.

Lack of Healthcare Professionals: Shortage of doctors, nurses, female paramedics, female specialists, and doctors' assistants are significant problems. Security, access to housing, remote location, and challenging working conditions may present challenges to sustaining adequate staffing at remote facilities.
Geographical isolation and difficult terrain: mountainous terrain, dispersed settlements, and distances between communities and health facilities, impede access to health care. During adverse weather conditions, transportation difficulties can further delay patients' access to emergency and routine medical services.
Poor Referral and Emergency Services: Patients in need of specialized treatment should be referred to larger hospitals which are not located in their close vicinity. However, there is limited availability of ambulance services, transportation challenges, and delayed referrals which can pose extra risks, especially in cases of maternal emergencies, trauma, and severe illness.
Medicine and Medical Equipment Constraints: Frequent availability of necessary medicines, diagnostic equipment, lab facilities and other medical supplies are essential for proper healthcare delivery. When procurement, transport or distribution is interrupted, the health facilities ability to continue their services may be diminished.
Healthcare Challenges: Maternal and Child Health (MCH): Women and children in remote communities have specific challenges to access to healthcare. Fewer women health workers and health centres, less maternal and child health services and less emergency obstetric services may impact access to those services.
Geographically Dispersed and Hard to Reach Populations: Immunization coverage and disease-control programs are challenging to maintain in geographically dispersed and hard to reach populations. Additional difficulties for health authorities include disease surveillance, community mobilization and uninterrupted health outreach services.
Lack of access to safe drinking water, sanitation and hygiene facilities can lead to preventable diseases and overall health-security goals. Water, sanitation, waste-management, and electricity systems are also crucial on healthcare facilities.
Security and Operational Constraints: The security environment may impact the mobility of healthcare workers, outreach teams, ambulances, and patients. Security and related disruptions can also negatively impact vaccination drives, health outreach, disease monitoring, and routine health facility operations.
Limited Health Governance and Institutional Capacity: After the merger of FATA into Khyber Pakhtunkhwa, development of effective administrative and institutional capacity is a concern. The need for coordination is crucial between the district health authorities, the provincial department, local administration, and other actors to prevent duplication of services and service continuity.
Inadequate Community Awareness and Participation: Inadequate awareness of preventive healthcare, maternal health, vaccination, nutrition, sanitation and early treatment can influence the utilization of healthcare.
There is a role for community elders, religious leaders, women and local organizations in regard to health awareness and acceptance.
Socioeconomic Barriers: Households may be less likely to access care due to poverty, unemployment and transportation costs, among other indirect costs. These barriers are especially relevant when treatment is needed, but outside the district.
Weak digital connectivity and limited use of telemedicine and electronic health-management systems limit digital opportunities for consultation, disease surveillance, digital record keeping and real-time monitoring of healthcare facilities.
Sustained institutional investment as opposed to single development interventions is needed to bring about health improvements. If interventions are project-based or rely on temporary programs, sustaining services, staff, medicines, equipment etc. can be a challenge once the project is over.

**Recommendations**

Strengthening Primary Healthcare Infrastructure: Better and more attention should be given to the strengthening of Basic Health Units (BHUs), Rural Health Centers (RHCs), civil dispensaries and other primary health care facilities located far from the access points in North and South Waziristan. The basic medicines, diagnostic equipment, electricity, water supply, ambulances and essential emergency services should be provided in existing facilities in adequate amounts and at an appropriate distance, so that communities are not forced to travel long distances for basic treatment.
Improvement in Human Resources for Health: The availability of qualified doctors, nurses and paramedics, Lady Health Workers (LHWs) and health care professionals in general should be increased. Health staff in remote and challenging areas may be able to stay longer by means of special incentives, such as hardship allowances, accommodation, secure transportation and professional development. Internal staffing, especially of women, can also enhance continuity of services and community acceptance.
Improved coordinated Maternity Health care: Maternal, neonatal, and child health should continue to be a focus in the post-merger health governance structure. Ensure adequate coverage of dedicated maternal and child healthcare units, antenatal and postnatal services, skilled birth attendance, immunization, nutrition programs and referral.
Improving Immunization and Surveillance: There is a need to develop a coordinated disease surveillance system in North and South Waziristan to prevent the outbreaks from getting out of hand. Other communicable-disease programs such as routine immunization, polio, tuberculosis control, hepatitis prevention, and others should be linked with the district-level surveillance systems. Digital reporting systems can help to enable timely sharing of information between remote health facilities and district and provincial levels.
Building an Integrated Health-Security Governance Mechanism: Health security needs to be integrated into the overall governance structure following the 25th Constitutional Amendment must be developed. District health authorities, provincial health department, local government, emergency response services, development agencies and other relevant stakeholders should work together on agreed coordination mechanisms. This would minimize institutional fragmentation and the continuity of health interventions.

Increase Civil – Military Coordination in Health Emergencies: Security challenges in these two districts are historical and continue, which may require the maintenance of mechanisms for civil-military coordination in emergencies, epidemics, natural disasters, displacement and access to remote areas. But routine health care delivery should be progressively strengthened via civilian health institutions so that emergency health care supports the civilian health system instead of replacing it.

Enhanced Health Access in Remote and Border Regions: Mobile medical units, outreach services, community-based health care programs and telemedicine to be expanded in remote and border communities. Regions with difficult terrain to access fixed health facilities and security challenges should be given special consideration.

Improving Women's Access to Healthcare: Improve female health workers (doctors, nurse, midwives, LHWs and women friendly health facilities). Awareness building in the community should include maternal health, reproductive health, vaccination, nutrition and preventive health. More women in the local health sector would also increase women's access to healthcare for those that are culturally or mobility constrained.

Transparent Health Budgeting and Monitoring: Allotments in the health sector for North and South Waziristan should be backed by transparent monitoring of health expenditures, measurable goals, periodic health expenditure audits, and publicly available reporting on progress. Health authorities, local representatives and community members can participate in the district-level monitoring mechanisms that can ensure that the resources provided are reaching the persons for whom they were intended.

The Involvement of Community in Health Governance: Local communities, elders, religious leaders, civil society, youth and women should be engaged in health-planning and monitoring activities. Engaging the community can facilitate the identification of local priorities, build confidence in the community, combat misinformation, and help increase the utilization of health services.

Improving Emergency and Referral Services: health facilities should be linked up via an effective referral system with ambulances, emergency communication and appointed referral hospitals. Adequate hospital capacity needs to be established at district level to handle emergencies, which can't be dealt with at the primary health care level, to minimize the time to seek specialist treatment.

Gradual introduction of digitalization of Health Governance: electronic health records, digital disease surveillance, telemedicine, online medicine inventories, and digital monitoring of health facilities should be gradually introduced. Digital systems can enhance accountability, enable evidence-informed decisions, and enable provincial governments to better manage remote facilities.

District-Specific Health Planning: North and South Waziristan does not necessarily have to be the same administrative or health context. The planning of health plans should be based on the demographic, geographical, security, infrastructure and epidemiological situation of the district. Regular district health evaluations can be conducted to update priorities based on new needs.

Long-Term Institutional Sustainability: Lastly, health programs should shift from a short-term approach to institutional change and move towards sustainable institutional development after the 25th Amendment. The goal should be to create a health governance body that is functional, accessible, accountable and community responsive, with the power of the state institutions to ensure coverage of health services whatever the security or political context. This would help make the constitutional and administrative reforms after the merger a reality in terms of health security and human security for the people of North and South Waziristan.

**Conclusion**

Finally, the study finds that much has been invested and developed in North and South Waziristan after the 25th Constitutional Amendment but significant positive development is yet to be seen in terms of health-security condition of the local population due to the investments. It concludes that despite a lot of investment and development taking place after 25th Constitutional Amendment there are not enough perceived or comprehensive changes in the health-security situation of the people of North Waziristan and South Waziristan. There are significant financial investments that are not reflected in the service delivery, as shown by persistent challenges in providing health services, such as shortage of qualified health personnel, weak health services referrals, geographical isolation and difficulties in maternal and child health services, as well as lack of adequate health services infrastructure. Therefore, just having development projects and budgetary allocations does not indicate improved health security. The results indicate that implementation, sustainability, coordination, and effectiveness of the health-related interventions are more of an issue than just investment. Therefore, a need is there for a change in approach in health governance in both districts from being investment oriented to outcome-oriented health governance that centers on functional health facilities, trained personnel, available medicines, emergency and referral services, disease surveillance, community engagement and transparent monitoring. Finally, the effectiveness of post-merger health governance should be evaluated based on the impact of the investments made, in terms of people's access to healthcare services and the health security of people in North and South Waziristan in a sustainable way.

**Footnote**

1. Note: The tabulated data is just review of the yearly investment into the health care system in North Waziristan. Each project details are present in thesis.
2. Note: The tabulated data is just review of the yearly investment into the health care system in South Waziristan. Each project details are present in thesis.

**References**

1. Akhtar, Shahzad. 2019. “Decline of Insurgency in Pakistan’s FATA: A Counterinsurgency Perspective.”

2. Asian Survey 59 (4): 693–716.
3. Ali, Ghulam, Muhammad Ilyas Ansari, and Malik Firdous. 2020. "FATA Merger to Khyber Pakhtunkhwa: Problems and Prospects for Federalism in Pakistan." Global Political Review 5
4. (1): 224–33.
5. Aziz, Muhammad Abdul, Musheerul Hassan, Aman Ullah, Zahid Ullah, Renata Sõukand, and Andrea Pieroni. 2023. "Keeping Their Own and Integrating the Other: Medicinal Plant Use among Ormurs and Pathans in South Waziristan, Pakistan." Journal of Ethnobiology and Ethnomedicine 19 (1): 62.
6. Baber, M. Z. U. 2023. "Governance Situation in Khyber Pakhtunkhwa and Fulfilment of SDGs: A Critical Analysis and Way Forward." KJPP 2 (2): 41.
7. Dawar, Asif Iqbal. 2022. Questioning the Security-Development Nexus in Post-Conflict North Waziristan: A Qualitative Fieldwork Research about Reconstruction Practices and Their Impact on Societal Power and Gender Relations (2015-2019).
8. IFEJIKA, Solomon I. 2023. "Pakistan: Axing the Roots. Political and Economic Marginalization and Rise of Militancy in Pakistan's Federally Administered Tribal Areas." Conflict Studies Quarterly, no. 42: 43.
9. Jaspal, Zafar Nawaz, and Amir Ullah Khan. 2017. "Plant Biosecurity Governance Dilemma in Pakistan: The Case Study of Khyber Pakhtunkhwa." J. Pol. Stud. 24: 245.
10. Karim, Muhammad Arsalan. 2022. "Governance and Conflict in Pakistan: Developing a Conflict Prevention and Reduction (CPR) Model to Promote Peace in Baluchistan and the Federally Administered Tribal Area (FATA)." PhD Thesis, The University of Waikato.
11. Khalid Sandhu, Aleena, and Muhammad Makki. 2023. "Post-Conflict Rehabilitation: Understanding the Role of Civil-Military Cooperation in Supporting Child Protection Units (CPUs) in Newly Merged Districts (NMDs), Pakistan." Journal of Human Security 19 (1): 53–62.
12. Khan, Amir Ullah, Hifazat Ullah, Muhammad Imran, Farzana Iqbal, and Sheraz Ahmad. 2021. ISLAMIC CONCEPT OF GLOBAL HUMAN HEALTH SECURITY AND ZOONOSIS: A CASE STUDY OF CORONA AND HANTA VIRUSES.
13. Khan, Bakhtiar, Sajad Ali, and Arif Khan. 2023. "A Historical Overview of Reforms in the Erstwhile Federally Administered Tribal Areas (FATA), Pakistan." Journal of Humanities, Social and Management Sciences (JHSMS-Asia) 4 (1): 15–27.
14. Khan, Dr Amir Ullah, and Dr Zafar Nawaz Jaspal. 2005. Health Security Governance and Zoonotic Diseases in Pakistan: The International Health Regulations (2005) Angle.
15. Khan, Saeed. 2021. "The Challenge of Reforming the FATA Region of Pakistan: A Critical Analysis of Its Merger into Khyber Pakhtunkhwa Province." ISSRA Papers 13: 131–46.
16. Makki, Muhammad, and Waseem Iftikhar. 2022. "Transformation in Political Economy of Post-Conflict North Waziristan, Pakistan." Journal of Asian and African Studies 57 (3): 497–513.
17. Makki, Muhammad, Faryal Khan, and Syed Ali Akash. 2022. "Contested Peace: Duality of Security in Post-Conflict North Waziristan." Asian Security 18 (1): 75–91.
18. Rasool, Sajad, and Zahid Anwar. 2019. "Operation Zarb-e-Azb, IDPs, and the Life in Camps." Review of Human Rights 5 (1): 33–54.
19. Saood, Ali, and Zeeshan Salahuddin. 2022. "Polio-Free Pakistan: The Challenge of High-Risk Districts."
20. Tabadlab| Understanding Change.
21. Shah, Abdur Rehman. 2020. "THE RISE OF THE PASHTUN PROTECTION MOVEMENT (PTM): POLEMICS AND CONSPIRACY THEORIES." Asian Affairs 51 (2): 265–85.
22. Shah, Mian Abid. 2018. "Political Reforms, Local Elites and Power: A Study of the Federally Administered Tribal Areas (FATA) of Pakistan." PhD Thesis, University of Bath.
23. Ullah, Altaf, and Syed Umar Hayat. 2018. "The Merger of FATA with Khyber Pakhtunkhwa: An Historical Analysis." J. Pol. Stud. 25: 39.
24. Ullah, Amir, and Syed Naeem Badshah. 2017. "Health Security Threats of VBDs in KP, and Islamic Concept of Cleanliness: Case Study of Dengue and Zika Viruses." Al-Azhār 3 (02): 13–37.
25. Wazir, Adnan, Ikram Badshah, Zahid Ali Shah, and Uzma Rahim. 2023. "Tuu Karrai Spi : Deconstructing Aman Committees and Life in South Waziristan." Critical Asian Studies 55 (2): 193–210.
26. Yadav, Abhishek. 2022. "Prioritizing Human Security in Pakistan's Erstwhile Federally Administered Tribal Areas (FATA)." The World Research of Political Science Journal, 5–1.
27. Yaqoob, Shahid, and Noman Sattar. 2021. "Aid and Irritants in Pak-US Relations in the Wake of 9/11 Incident." Liberal Arts and Social Sciences International Journal (LASSIJ) 5 (1): 266–78.