



Medical Pluralism in British Punjab: Necessity of Coexistence, Convergence in Diverse Socio-Cultural Fabric

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ABSTRACT

This research paper explores the coexistence and convergence of plural healthcare practices in British Punjab with a prime focus on the need for a diverse social order to accommodate multiple healthcare setups. The interdisciplinary conceptual framework of this research rests on the debate around the dynamics of medical pluralism and its implications for healthcare delivery, while combining medical anthropology, and historical sociology. The objective is to explore how different medical systems, both indigenous and contemporary, influence and interact with each other, hence serving as the driving forces towards their coexistence and sometimes convergence of these systems. The findings reveal a dynamic landscape of medical pluralism in the then British Punjab, with traditional Ayurvedic, Unani, and homoeopathic practices showcasing interactions between traditional and Western medical practices. Results support the fact that recognizing and integrating multiple medical traditions and practices is crucial for ensuring accessible and effective healthcare services for the population.



Introduction

The concept of medical pluralism refers to the coexistence and convergence of multiple medical systems within a particular society or region. (Minocha, 1980; Rastogi, 2020; Leslie, 1980) The term “medical pluralism”, employed by social scientists collectively, refers generally to healthcare practices observed across multiple healthcare systems. (Votova, 2012) The concept of medical pluralism was introduced by medical anthropologists to describe medical practices. (Hsu, 2008) Throughout history, there has been evidence of medical diversity. (Baer, 2008) Different civilizations like Indian, Arabic, Chinese, and Egyptian have developed extensive systems using various techniques and ideas, resulting in tens of thousands of medical traditions worldwide. (Grossinger, 1987) Like other parts of the world, there are several different medical systems in British Punjab, including allopathic, traditional, indigenous, and alternative medicine. These healthcare systems have evolved over thousands of years due to social, economic, cultural, and environmental changes, impacting delivery, patient outcomes, and population well-being. In British Punjab, medical pluralism is common place yet there is a lack of thorough study examining the need for these disparate medical systems to coexist and integrate. Hence, researching medical pluralism in British Punjab is crucial to comprehend the region’s dynamic healthcare systems that, for the sake of improvement of public health, used to adopt and adapt themselves to the advantages of the contemporary medical systems.

Objectives

The purpose of this study is to investigate the necessity for various medical systems’ convergence and hence coexistence in British Punjab. The key objectives of this research are to determine the elements that

lead to the coexistence of multiple medical systems, to investigate the potential for integration and collaboration between various medical systems, and to assess the effects of pluralistic healthcare on public health and patient outcomes.

Research Questions

The research seeks to answer the following questions:

- What were the historical, cultural, and socio-economic factors contributing to the coexistence of multiple medical systems in British Punjab?
- What were the opportunities and challenges for collaboration and integration between allopathic, traditional, and complementary medicine in British Punjab?

Factors contributing towards the plural medical healthcare systems in the Indian subcontinent

Indian subcontinent may be presented as a melting pot of diverse medicinal practices, a welcoming home to multiple cultures presenting their peculiar medical practices that would settle in the diverse environment of the subcontinent.

The Ayurvedic system of medicine originated thousands of years ago on the Indian subcontinent (Sharma, 1992) and has persevered through time and cultural changes. The Rigveda and Atharvaveda, ancient Indian Vedic writings, are the foundations of Ayurvedic medicine. These texts detail the therapeutic methods and natural cures used by sages and healers during that time. Notable works include Charaka Samhita, Sushruta Samhita, and Ashtanga Hridaya, which were created from oral knowledge. These texts are considered the basic scriptures of Ayurvedic medicine, preserving the knowledge and methods of this ancient medical system. (Plumptre, 2023) Various philosophical, cultural, and scientific factors have shaped the growth and development of Ayurvedic medicine over the ages. In many Eastern countries, particularly India, where a sizable portion of the populace either entirely or in combination with modern medicine relies on this method, it remains popular as an alternative form of healthcare even today. (Britannica, 2024)

Similarly, Unani healthcare medical knowledge from Greece, Arabia, Persia, and India is combined to form Unani medicine, often referred to as Yunani medicine, founded on the teachings of Hippocrates and Galen. (Husain, 2010) During the Mughal era, it gained popularity. It emphasizes the need to maintain a balance of physiological fluids for health and well-being and is founded on the theories of the four humours. (Lloyd, 2009)

Siddha medicine has its roots in ancient Tamil culture and is derived from the teachings of the highly esteemed saints and sages known as the Siddhars. This technique combines herbs, minerals, and yoga to heal while focusing on creating a balance between the three humours. Its use was primarily restricted to South Indian regions where Tamil is spoken. The comprehensive approach of the Siddha medical system emphasizes eating healthily, changing one's lifestyle, and treating illnesses using higher-order and herbal medications when needed. (Prakash, 2021)

In the sixteenth century, the Portuguese promoted an open exchange of ideas by bringing Western medicine to the subcontinent. However, the link became strained in the 17th century when Portuguese constraints made Hindu physicians illegal. (Wujastyk, 1995) Towards the end of the seventeenth century, Dutch East India authorities also became quite interested in the local flora and animals of the Malabar Coast. (Bose, 1971)

The British East India Company arrived in India in the early seventeenth century. British officials in the Indian subcontinent used to frequently adopt local regimens and treatments for their ailments because they were eager to learn from the local hakims and vaidyas. (Aris, 1997) Because native practitioners spoke the local languages fluently, missionaries were able to teach and learn from them more effectively. Indians, on the other hand, showed a special interest in British surgeons. (Wujastyk, 1995) Western medicine was widely practised in large cities and towns by the end of the 1800s. Because of their declining social status and the absence of official sponsorship, hakims and vaidyas felt abandoned and threatened. (Saini, 2016) Moreover, Ayurvedic and Unani practitioners were considered "non-scientific" and marginalized. (Sebastia, 2012) Western medicine focuses on diagnosis and treatment using modern technology, creating a divide between traditional and Western medicine. (Sivaramakrishnan, 2006) The formalization of the British Pharmacopoeia in 1858 led to criticism of indigenous remedies. The formal government stopped supporting Indian medicine in 1835. (Gupta, 1976) In Punjab, the British approach towards healthcare system was going to become more Eurocentric than indigenous as the time passed by.

The recurrent epidemics in Punjab and British healthcare management

After the annexation of Punjab in 1849, the British government established a new system of governance, leading to the development of a health policy aimed at providing medical assistance to rural residents and employees. (Latif, 1964) Following the policy, British authorities opened two medical schools, the Allopathic Medical School and the School of Anatomy in Lahore, which were abolished later. (Hume,

1977) In the same way, colonial authorities constituted their medical setup in Punjab. They built extensive hospitals and dispensaries in Punjab to provide the people of the region with the benefit of medical care. Additionally, the British administration initiated a sanitary program to enhance public health; yet, infectious diseases continued to break in Punjab.

Punjab saw several epidemics and other illnesses throughout British rule, including cholera, dysentery, diarrhoea, fevers, particularly malaria, influenza, plague, smallpox, respiratory and other infectious diseases. These illnesses devastated the lives of millions of people and affected the social and economic conditions of Punjab. Between 1901 and 1940, 129,984 people died from cholera, 462,492, dysentery and diarrhea 462,492 and 12,510,377 from fevers. There were 3,150,179 deaths from plague and 326,913 fatalities from smallpox. (Chandra, 1941) The British government took many measures to prevent and eliminate these diseases. The British authorities established commissions, boards, and research to manage these issues. (Mushtaq, 2009) They established hospitals, and dispensaries, and initiated vaccination inoculation programs in Punjab. They also established a sanitary board in Punjab and launched hygienic reforms.

In Punjab, epidemics of malaria, cholera, smallpox, plague, dysentery & diarrhoea, and respiratory diseases were a big reason for deaths during the British period. From 1900-1940, 462,492 deaths occurred due to only Dysentery & Diarrhoea disease. Many Deaths and various diseases occurred periodically and with varying degrees of severity.

Cholera

Cholera was a recurrent disease in British Punjab. Cholera caused a large number of deaths in colonial Punjab. The First Cholera Pandemic, which began in 1817-21, was a series of epidemics in the Indian subcontinent (Harrison, 2019) originating in Bengal in 1817, spread to the north in the United Provinces and Punjab in 1818, and eventually to the Central Provinces, Bombay Presidency, and the entire peninsula. The first pandemic, which swept the world, also originated in Bengal, spread through the Punjab in 1826, into Central Asia, reached Europe in 1830, and reached America in 1832. The Punjab has been a significant gateway for spreading the disease, with multiple epidemics originating from the region. The 1830s, 1840s, and 1860s epidemics have been linked to social discontent, heightened social strife, and served as a catalyst for municipal reform and the advancement of public health. (Arnold, 1986) Since 1867, the Punjab has been keeping a series of statistical records on the mortality caused by the disease, similar to other provincial governments. (Yacob, 1944) This pandemic in 1840-1849 killed up to a million people in Europe and 53,293 deaths in England. The second pandemic occurred in 1866-1870. In the decade of 1870s, 47,957 lost their lives due to this pandemic. (Bellew, 1878)

Fevers

In 1881, Amritsar saw a severe fever outbreak, leading to an increase in mortality rates to 356 and 211 per 1,000 people in October and November respectively. According to the figures of the 1891 census, Over the past 10 years, Amritsar's population has shrunk by 11%. (Maclagan, Census 1891, 1892) The number of deaths in this city over the past ten years exceeded the number of births by 20,000. The greatest number of deaths during this period were attributed to "fevers," which were mostly caused by malaria, particularly in 1908. (Tumbe, 2020) In the northwest, epidemic-related mortality remained rather high until the 1920s. (Tandon) Between 1850 and 1947, the area witnessed fifteen significant malaria outbreaks that caused 51,77,407 mortality. (Major F. Norman White)

Among fevers, Malaria was very prominent. In addition to the relief afforded at hospitals and dispensaries, special measures had been adopted from year to year to place large quantities of quinine within easy reach of the poor and people residing in villages and out-of-the-way places. The District Boards annually purchased thousands of rupees worth of quinine and distributed it gratuitously to those who could not afford to pay for it. Arrangements were also made to sell piece packets of quinine through Branch Post offices and other agencies. Societies were also formed in certain districts to promote the use of quinine as a prophylactic. A special Malaria Medical Department was established in May 1910 to investigate and report on the conditions producing endemic and epidemic malaria in all parts of the province. This Department conducted a thorough investigation into the normal prevalence of malaria in adults and children throughout the year, as well as a systematic study of the disease in general. It also conducted a malaria survey of the entire province and investigated the relationships between malaria, rainfall, and subsurface water, as well as the causes and history of the epidemic, the habits of anopheline mosquitoes and their relationship to malaria, and the study of fever statistics in general. (Pandit, 1912). Furthermore, in areas where malaria was endemic, the British government undertook efforts to control mosquito populations and minimize the transmission of the disease. This included the use of larvicides, mosquito nets, and environmental modifications to reduce mosquito breeding sites. Despite all these measures malaria caused thousands of deaths in Punjab. However, malaria control efforts helped in reducing the prevalence of the disease and

mitigating its impact on the population.

Influenza

The 1918 influenza pandemic killed more than fifty million people (Humphries, 2014). In the province of Punjab, this figure was 1,565,560 (Forster W., 1919).

Smallpox

During the British era, the smallpox epidemic also caused a lot of loss of life, millions of people died due to this epidemic. The smallpox epidemic claimed 40,271 lives in 1878; 49,489 lives in 1879 which increased up to 45084 in 1896. Overall, 820,902 people died between around 1868 and 1940. The vaccination program was started by the British government to stop the smallpox pandemic. In total, 4,64,886 first immunizations and 233 booster shots were given in 1882; then 5,81,664 in 1891; and between 1897 and 1898, around 845,491 persons were immunized. (Sohal, 2015)

Plague

Punjab's gross mortality graph over the past 26 years had experienced extreme oscillations due to epidemic outbreaks of certain diseases, particularly the plague, which caused around 3,000,000 deaths between 1901 and 1924. The population of the Punjab was reduced by 0.18 per 100 in British territory and 0.48 per 100 in the States under British rule. The disease was latent from 1919 to 1922, but a severe epidemic in 1924 and another in 1926 led to 360,000 deaths. (Forster, 1927) According to data, cholera outbreaks increased in the late 19th century, two decades before the country's death rates peaked, and then sharply declined, especially following World War II. (Klein, 1994)

British government's reforms to manage epidemics

While implementing policies to counter the plague, malaria, and smallpox outbreaks, significant efforts were made to ensure that the major towns would have access to clean drinking water and public health services. Furthermore, British authorities implemented several initiatives to address public health concerns. Sanitary Reforms were done in this regard. To improve military hygiene, the Military Cantonment Act was initially passed in 1864. As part of the British government's sanitary program to enhance public health services, sanitary departments were established in every province and a national sanitary authority was established in 1870. The Punjab Municipal Act was also implemented in 1897 along with the Epidemic Disease Act and the Indian Nursing Council Act of 1911 in 1947. The British government initiated the sanitary programme in Punjab to address public health challenges. This included the improvement of water supply systems, drainage, and sewage disposal, aimed at reducing the spread of water-borne diseases such as cholera. Despite that, the British authorities established public health departments in Punjab to oversee disease surveillance, prevention, and control. These departments played a crucial role in implementing measures to combat infectious diseases and improve overall public health. In addition, Sanitary reforms led to improvements in environmental conditions, resulting in reduced transmission of water-borne diseases. The establishment of public health departments facilitated better disease surveillance and the implementation of preventive measures, contributing to the control of infectious diseases. By 1901, there were 245 healthcare units for the population of 22,455,819. (Reid, 1902; Rose, 1902).

Similarly, the water supply schemes of Lyallpur, Amritsar, Sargodha and Ludhiana were completed in 1903-04, 1904-05, 1905-06 and 1908-09, respectively. Thus, with Delhi, Simla, Ambala and Lahore, 8 cities and towns in the province enjoyed a copious supply of piped water for drinking purposes. But an abundant water supply was apt to prove a nuisance unless it was accompanied by a drainage scheme. Moreover, the unsystematic laying out of the older towns made the drainage of dirty water an imperative necessity from a sanitary point of view. During early 1900s, steps were taken to either improve or newly construct the drainage channels in various cities and towns, including, Delhi, Jagraon, Gujrat, Lahore, Sargodha, Ambala, Chiniot, Multan, Rawalpindi, Muktsar, Ferozepur, Amritsar, Simla, Lyallpur, Fazilka, Campbellpur and Pind Dadan Khan.

In 1925 a standard plan for a small and compact dispensary was laid down and the government agreed to give a grant of Rs. 5,400/- for the construction and Rs. 1,600/- for the equipment of each such dispensary. From 1925 to 1930, 359 new dispensaries opened. In this decade, Simla's Lady Reading Hospital for Women and Children and Lahore's Lady Aitchison Hospital were founded. The only school from which women could be appointed as sub-assistant surgeons was the Punjab Medical School for Women, which later became a part of the Women's Christian College in Ludhiana. Fifteen new women hospitals, including the Government Hospital for Women and Children in Lahore, opened in different districts throughout this decade. In 12 of the city's existing civil hospitals as well as one dental hospital, separate sections were opened for women. By 1941 there were 1066 healthcare units for 28,418,819 persons in the British territory of Punjab. Thus, there was only one unit available for 91656.40 persons. To attain the ideal of one dispensary for every hundred square miles or every 30,000 of the population 375 new dispensaries in rural areas. Similarly, there was a

shortage of trained medical staff. The number of Midwives, vaccinators, compounders, nurses, masseurs, etc. was Males 4,111 and Females 7,175. Examinations were held annually at the Medical College, Lahore, and diplomas and certificates were granted to those passing the tests prescribed for midwives and Dais. The number of candidates who passed the examinations successfully, during the 10 years (1903—1912), was Midwives 44 and Daies only 141 in big cities. (Pandit, 1912) The fact that only 14 Dais and 4 midwives on average qualify each year throughout the province indicates that there is a shortage of qualified Indian midwives and nurses. Likewise, the number of government medical officers was only 1288 till 1941. Only one Surgical and Veterinary instrument factory was in Sialkot for the whole province. (Pandit, 1912)

The above statistics show that in a large and populated province like Punjab where millions of people used to die every year due to frequent epidemics, providing Western medical facilities were still a big challenge for the British administration in Punjab. And the British Government in India could no more side with the adherents of the allopathic school, who had asserted in 1858 that they ought to supervise the medical and health programs of the South Asian governments as well as those of the East India Company. (Hume J. C., 1986) Due to the severity of epidemics and seasonal diseases, despite criticisms from proponents and advocates of the Western medical system, the British administration had to hire the services of local Hakims and Vedas with the adaption of indigenous medical practices.

Co-existence and convergence of British with the indigenous healthcare practices

Because Hakims and the Vedas were more accessible to the general public, with their matabs in market places and residential areas and their medications being inexpensive and easily obtainable to make up a portion of the food they consumed every day. In this regard, the Women of the Punjab were also involved and educated in the prevention, and treatment of the recurrent epidemics like Plague. People were asked to use solar heat and desiccation using dried cow-dung cakes and *Neem* leaves. Rat destruction was also carried out throughout the year. The rat-destruction campaign involved trapping, baiting, smoking with *Neem* Batts, and using stoves. (Stainton, 1916) In addition, British authorities had to engage Hakims to succeed in their health programmes. In this regard, Hakims distributed Western medicines and implemented sanitary arrangements in different districts. (Griffin, 1870).

Despite receiving no government assistance throughout the epidemic, the indigenous healthcare professionals assisted the government in reforms and provided voluntary services to the public. (Huzuri, 1935) During epidemics, Hakims rendered their services in vaccination operations. In 1876 and 1877-78 Hakims vaccinated 1804 and 2645 persons respectively. (Griffin., 1878) In 1880 British Government employed 119 Hakims for their dispensaries. (Townsend, 1881) In 1897 Hakim Muhammad Sharif published a pamphlet on the “Bubonic Plague and How to Prevent It”. Seventy thousand copies of this pamphlet were distributed in plague-stricken areas of Punjab without any cost. This pamphlet was translated into English with the approval of Deputy Commissioner Mr H. Calvert. (Sappol, 2013)

Similarly, brochures on influenza, smallpox, malaria, and cholera were published for public awareness and healthcare needs. Moreover, in the annual Tibbi conferences, Hakims and Vedas exchanged their family medical prescriptions during the yearly Tibbi conferences to preserve and promote indigenous medicine. These prescriptions were also published for the general public welfare. (Singh, 1916) Hakims and Vade supplied their medicines through post offices. Owing to their training, Native Hakims also benefited from Western medications and therapeutic techniques, such as the use of stethoscopes, thermometers, x-ray equipment, and medical laboratories. Their Matabs had the names “*Shifakhana Angrezi o Unani*” (i.e., training centres for Western medical practices).

Like other parts of India, Punjab saw a parallel development between the local and Western medical systems in terms of providing healthcare to the public. However, this sought to be manipulated when the government and medical professionals began to take aggressive actions against the indigenous medical systems. As a result, they started competing with one another. Western medicine began to diverge from indigenous medicine in the late 1800s. Western practitioners in India and Britain gave up the medical diagnostic foundation based on humor as a result of growing professionalization. The expansion of the pharmaceutical business in Britain, which was inspired by Germany, which at the time had one of the largest pharmaceutical industries, strengthened this mindset. Western medical professionals thus began to see indigenous medicine as fundamentally marginal. Many Indian practitioners advocate for greater use of refined Western pharmaceuticals. In addition, the government prioritised domestic products, stating the unrefined condition of traditional medicine as a result of the coherence of Western drugs in the country. (Bala, 1987) Trained in Western medicine, Indian and Western practitioners started to disassociate themselves from the cultural and literary backgrounds of indigenous medications. (Arnold, 1985)

The Bombay Medical Association rejected Greek and Ayurvedic therapies in 1910 and supported the Punjab Medical Registration Act 1916, a medical regulation that required Western and indigenous medicine

practitioners to be qualified. (Husain, 1995) The Medical Registration Act was deemed unsuitable for indigenous medicine due to backlash, leading to the establishment of alternative treatments in Agra and Awadh, Vedic colleges at Banaras Hindu University, and a research centre. (Nabi, 1976)

The above discussion shows a large number of deaths during the British period in Punjab caused by various epidemics. Despite these epidemics, other seasonal diseases and fevers were also a big reason for deaths. To address public health concerns, the British government took many measures across the Punjab. However, due to the vast expanse of Punjab, these measures were insufficient and unable to provide medical services.

Owing to climate shifts, epidemic ailments have been spreading over the subcontinent at different ages throughout history since ancient times. One of the many causes of the Indus Valley Civilization's demise was epidemic illnesses. In the Middle Ages Malaria, Cholera, smallpox, and plague diseases were spread many times under Babur, Jahangir, and Shah Jahan's rule. Physicians from Iran and Central Asia were attracted to the courts of almost every Mughal emperor. The high knowledge of Mughal India was produced and controlled by Iranian physician families called Hakims. They constituted the medical community of Persian literature. (Alvi, 2008)

During British rule, Vaidyas and Hakims were also trained and their network was used to spread the allopathic system of medicine. (Ruhil, 2015) Hakims and Vaidyas cooperated with the government to provide relief to the public. Despite all these, the colonial rule in Punjab altered the relationship between the indigenous medical system and the state, leading to the adoption of one system as official and policy formulation. (Sujatha and Abraham, 2009) Hakims and Vedas of Unani and Ayurvedic medicine provided treatment to the public. Due to their efficacy, instant availability, and centuries of expertise, both of these methods of treatment were extremely popular among the general population. The majority of people continued to use the indigenous forms of therapy even after European nations arrived on the subcontinent and had introduced Western medicine. Herbs, as well as other oils and extracts, were the mainstay of local healing procedures and were widely accessible throughout the subcontinent. That was the cause of the low cost of this treatment plan.

The daily diet of native people also contained a lot of herbs which could help them fight against the possibilities of different illnesses. Similarly, Biryani, a food item was being attributed to Mumtaz Mahal the empress of Mughal ruler Shahjahan. She observed the Mughal troops at the army barracks to be underweight and frail. To ensure that the soldiers were getting a balanced diet, she ordered the chef to create a unique meal that would blend rice and meat. It was cooked over a wood fire after meat, saffron, and fragrant spices were added. (Pal, 2016) Likewise, Nihari, attributed to Jahanara the daughter of Emperor Shahjahan is the result of the study of Hikmat, is being consumed as a preventive measure against sinus infections, the common cold, and feverish episodes during Delhi and Lucknow's winters, it also became well-known as a food that kept one warm during dipping temperatures. (Tirmizi, 2014) Asfand (Kue-Syrian) which is called Harmal in Arabic the fumigation of this harmal and loban was also continued as useful remedy in flu. These herbs have antibacterial and anti-viral properties. Ibn e Sina mentioned many benefits of this herb. Even today villagers of the Indo-Pakistan sub-continent burn cow-dung cakes and *Neem* leaves to protect their animals from mosquitoes and other poisonous insects. In the subcontinent, the use of sweet lime is common for different diseases. Likewise, Hakims and Vedas used Khoob kalan, (*Sisymbrium* seeds) Unnab, and Munaqqa as very effective medicines for cough, fevers, smallpox, cholera and many other diseases. Gaozaban, Gulle Banafsha, Oils of different vegetables and dry fruits were also used in various illnesses. Not only during epidemics and disease but also during the First and Second World Wars these indigenous medical practitioners had provided healthcare facilities through their herbal treatments and the adoption of some allopathic healthcare practices. (Dehlvi, 1944).

It may be concluded that Punjab was a large province of British India. During British rule, many diseases and epidemics broke out in this region. Although the British established many institutions, hospitals, and dispensaries, and started water supply and sanitation, vaccination, inoculation and fumigation programmes, these arrangements were not enough and sufficient for the large size of area and population of Punjab. Practically remote villages were deprived of these facilities. So, a large number of the rural population relied on indigenous medicines and healthcare practices. As far as the questions that what historical, cultural, and socio-economic factors contributed to the coexistence of multiple medical systems in British Punjab and opportunities and challenges for collaboration and integration between allopathic, traditional, and complementary medicine in British Punjab are concerned, many social, political and economic issues were hindered from adopting Western medicines. Apart from being a sizable province in terms of both land size and population, British Punjab was home to a diverse range of religious, cultural, social, and economic origins. There were both conservative and non-conservative, radical persons in these

various classes. Conversely, certain individuals combined innovation with tradition. They had reservations, particularly about women. However, because of the epidemic's intensity and the resulting losses, Punjab's population not only adopted modern medicine but also benefited from indigenous medical care. British authorities also responded to this circumstance by gaining knowledge of it. The creation of hospitals exclusively for women and the training of female physicians and other medical professionals specifically for women are indications of this. Despite the local population's initial resistance to the Western medical system, they were forced to accept both the local and contemporary medical systems every year because of various epidemics. The British authorities were compelled to collaborate with the Vedas and Hakims as a result of these epidemics. Likewise, both Western and Indigenous methods of treatment can benefit from each other just like past. Although some portion of the population especially in urban areas used Western medicines. However, Punjab's rural communities, which lacked hospitals to begin with, continued to rely on traditional medical practices. Some inhabitants of cities also gained from getting both Western and indigenous medical care. Numerous diagnostic instruments, including x-ray machines, thermometers, stethoscopes, and labs for analysing blood samples, have been made possible by technological advances. However, this does not suggest that indigenous treatments have become outdated. Instead, they included powerful therapies for a wide range of illnesses. That is why their popularity among the people is still intact. Generally, people benefit from both treatments. And sometimes both types of drugs are used together. It is observed most of the people use tea and pain reliever tablets at the same time. Hakims were using stethoscopes, thermometers and injections. Despite that numerous steps were taken by the British government to contain epidemics and other illnesses. The government had frequently sought assistance from hakims; and if hakims were being allowed to take advantage of the local healthcare systems, as opposed to being trained in an entirely different mode of treatment, the death rate would have naturally decreased because these indigenous treatments were well-known to the public. Careful study of the available material reveals that no single system cures all diseases. Moreover, centuries-old proven medical knowledge cannot be ignored. Even now, in most countries of the world, along with the Western medical system, indigenous medical systems are also working. Owing to their efficiency, swift availability, and public appeal, they continue to be popular, which is why UNESCO, a United Nations institution, is working to promote these systems. That is why, a plural medical system is the need of time and in the public interest of Punjab.

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