Shodhbodhalaya: An International Peer reviewed Multidisciplinary Journal

Volume 4 | Issue 3 | ISSN: 2584-1807 | (https://shodhbodh.com/)

Colonial Perspectives on Indigenous Medical Knowledge in Official and Missionary Records

Monika[1], Dr. Dinesh Mandot[2]

[1]*Ph.D. Research Scholar,* [2]*Research Supervisor*

[1]Department of History, Faculty of Humanity & Social Science, Bhagwant University, Sikar Road, Ajmer, Rajasthan–305023, India, Mail Id.: monika141194@gmail.com

[2]Department of History, Bhagwant University, Sikar Road, Ajmer, Rajasthan–305023, India

Abstract

The historiography of medical pluralism on the Indian subcontinent has been of contested engagement between colonial administrative pragmatism, epistemological hegemony, and indigenous nationalist resistance. This study will explore the changing representations, categorisations, and usages of customary medical knowledges of Ayurveda, Unani and Siddha in British official files and the Protestant missionary archive between 1822 and 1948. Using archival material from the National Archives of India, the Punjab State Archives, the Haryana State Archives, and the digital repository Abhilekh Patal, as well as virtually the entire corpus of contemporary missionary periodicals, it argues that early nineteenth century utilitarian accommodation gave way to post-colonial bureaucratic institutionalisation. The British East India Company established supplementary vernacular medical curricula at the Native Medical Institution (1822 to 1835) to economically address acute personnel shortages. This pluralistic compromise was overturned by the institutional rise of the Anglicist party under Thomas Babington Macaulay's 1835 Minute on Education, when the Calcutta Medical College adopted allopathic and biomedically-based instruction. Evangelical medical missions to the Zenana (private women's quarters) in India also recast native medical systems as theological threats and

superstitions, which justified Christian proselytization. Such metropolitan ideological uniformity, however, was repeatedly unsettled and shaken by local epidemiological disasters, such as the mass death by bubonic plague, cholera and the 1918 influenza pandemic. Colonial authorities frequently turned to alternative avenues and subaltern forms of medical knowledge and practice at moments of crisis. Ultimately, the political and linguistic mobilisation of native practitioners in the vernacular public sphere enabled the survival and modernization of customary medical systems, as popular pressures on the state led to the establishment of committees of inquiry such as the Koman, Usman, Bhore, and Chopra Committees, which cemented the structural, institutional, and regulatory foundations of contemporary India's two-tiered medical system.

Keywords: Medical Pluralism, Colonial Archive, Indigenous Medicine, Zenana Missions, Vernacular Public Sphere, Epidemiological Crisis, Biomedicine Hegemony, Institutional Validation

1. Introduction

The historiography of the history of medical pluralism in the Indian subcontinent is a story of the mutually embedded historical trajectories of colonial bureaucratic expediency, epistemic domination and indigenous nationalist resistance. The monograph is based on archival material, in the form of government records, which have custodian rights to enormous collections that provide, without filtration, the structure of colonial health policies. The enquiry has drawn its primary sources from the official records kept at the National Archives of India (NAI), Punjab State Archives (PSA), Haryana State Archives, and the online repository 'Abhilekh Patal'. Some of the records consulted were Home Medical and Sanitary Proceedings files, Department of Education files, records of Health and Lands and the full reports of the indigenous medicine inquiry committees.[1]

[1] Hodge, J. M., Olsson, G., & Bowman, T. (Eds.). (2014). *Cultivating the colonies: Colonial states and their environmental legacies*. Ohio University Press. DOKUMEN.PUB. https://dokumen.pub/cultivating-the-colonies-colonial-states-and-their-environmental-legacies-9780896802827.html

The records analysed speak on the neglect of Ayurveda, Unani and Siddha under colonisation, but they show that it was more than mere bureaucratic neglect, as according to Banerji, the colonial medical systems were an active disruption of the pre-colonial socio-cultural milieu and that the indigenous population was denied the advantages of their customary medicine, as well as the newly-introduced western medical systems. This was part of a gradual erosion of Indian cultural traditions under British imperial rule, rather than an isolated break.[2] On the other hand, historian Kavita Sivaramakrishnan, in her influential book on this topic *Old Potions, New Bottles*, rejects the Eurocentric pattern of medical modernization as Westernisation. Sivaramakrishnan shows, by reviewing the records in the Punjab State Archives, how Vaids and Hakims were not the passive victims of medical modernization but participated in the process actively by advancing their professional interests and re-legitimising indigenous medical knowledge within the new public sphere of the vernacular press and municipal health policy.[3]

To understand this research fully, one must also appreciate that the colonial archive itself is double-edged: official government archives and proceedings document the pathologies of colonial regulation, management, and marginalisation of the native practitioner as dictated by the epidemiological needs of the state.[4] In contrast to the mission hospitals, however, the missionary archives of Protestant groups, including the Church Missionary Society (CMS) and the Baptist Zenana Mission, have been published in periodicals such as the CMS Gleaner that document gender politics in medical missionary practices and the demonization of indigenous medical practices as spiritual disease and superstition.[5]

[2] Bala, P. (1947). *State and indigenous medicine in nineteenth- and twentieth-century Bengal: 1800–1947* (Doctoral dissertation, University of Edinburgh). ERA. https://era.ed.ac.uk/bitstream/1842/6872/1/378720.pdf
[3] Jilani, S. A. (2025). Between Ayurveda and empire: Negotiating medical authority in colonial United Provinces (1858–1940). *International Journal of Forensic Medicine and Research (IJFMR)*, 7(2), 56-65. https://www.ijfmr.com/papers/2025/5/56952.pdf
[4] Sharma, V. (2023). Public response towards plague prevention policies in colonial Punjab. *International Journal of History*, 5(2), 112-118. https://www.historyjournal.net/article/93/3-2-1-149.pdf
[5] Adam Matthew Digital. (2023). *Church Missionary Society periodicals now available online*. AM Digital Insights. https://www.amdigital.co.uk/insights/news/church-missionary-society-periodicals-now-available-online

Using archival materials generated by government and mission institutions, the report follows the classification, use, and operationalisation of indigenous medical knowledge by colonial administrators and missionaries. It explores the ambivalent dynamics of medical authority and locates discourses of healing in colonial Uganda by tracing developments from the experimental utilitarian context of the parallel medical education debates of the 1820s to the bureaucratic legacies of Uganda's health administration in the post-colonial period. Ultimately, this report seeks to provincialize medical modernity and interrogate the colonial medical encounter.

2. The Epistemological Accommodation: Early Utilitarianism and Parallel Education (1822–1835)

The first British attempts to engage with indigenous medical traditions were not made on any ideology of scientific superiority, but on the requirements of health for the large subcontinental territories administered by the British East India Company (EIC). The EIC established the Indian Medical Service (IMS) as a separate organization in 1764 for the purpose of preserving the health of European soldiers and civil servants.[6] The IMS officers were posted in the three main presidencies of Bengal, Madras and Bombay. Deploying well paid European surgeons throughout the Company's increasingly enormous territories and possessions was not financially sustainable. To counter the problem of personnel scarcity, the colonial state made its first organised attempt to train natives as inexpensive subordinate medical assistants (apothecaries, compounders, and dressers).

A memorandum prepared by the Secretary of the Calcutta Medical Board was read in the Bengal Presidency on 9 May 1822 at an official meeting. The objective of the memorandum was to highlight the urgency of training native students to fill the gaps in government hospitals. The proposal was immediately passed by the government.[7] On 21 June 1822, an order was issued to

[6] Medical College, Kolkata. (2024). *History of the college: Establishing clinical legacies*. Official College Portal. https://www.medicalcollegekolkata.in/main/page/about_us
[7] Kumar, A. (2021). Native Medical Institution: The genesis of formal medical education in Bengal. *Journal of the Indian Medical Association (JIMA)*, 119(1), 80-83. https://onlinejima.com/journals_doc/download-journals/2021/january/80-83.pdf

found the Native Medical Institution (NMI) at Calcutta. The NMI was an unusual (and brief) experiment in state-sponsored medical pluralism led by a distinguished Orientalist, Dr. John Tyler. Twenty Indian students were admitted to the first batch of the NMI and all instruction was conducted entirely in vernacular languages.

Thus, the most important pedagogical feature of the NMI was the unprecedented coalescence of epistemologies brought about by the colonial state's effort to translate, on a massive scale, European treatises on anatomy, medicine and surgery into the vernacular languages of the students. Historical documents describing the preparations for the vernacular textbooks can be found in the records of the National Archives of India.[8] Crucially, the western scientific curriculum did not operate in isolation. The educational paradigm of the 1820s mandated parallel instruction in traditional indigenous medical systems.[9]

In 1826 the parallel system was extended to the existing seats of Oriental learning with the formal introduction of Unani medical studies in the Calcutta Madrasa and the organization of teaching of Ayurveda in the Sanskrit College. In 1827, Dr John Tyler began to expand it further by delivering lectures on mathematics and anatomy in the Sanskrit College.[10] Orientalist administrators believed that by putting the teachings of the European medical science and the teachings of the Ayurvedic and Unani medical systems side by side, the native students would be able to see the empirical superiority of western science and abandon their customary ideologies of their own accord. Body dissection was initially restricted because of strong social and religious taboos about pollution and caste; as a result, clinical training was conducted in several hospitals and dispensaries as part of the NMI's requirements for its students.[11]

[8] National Archives of India. (2023). *Abhilekh Patal digital portal for archival records: Digitized medical textbooks*. Ministry of Culture, Government of India. https://www.abhilekh-patal.in/category/Search/SimpleSearch?query=&tags=medical+textbooks
[9] Indian Medical Service. (2016). Evolution of medical education in India: The impact of colonialism. *PubMed Central (PMC)*. https://pmc.ncbi.nlm.nih.gov/articles/PMC5105212/
[10] Banglapedia. (2021). *Calcutta Medical College*. National Encyclopedia of Bangladesh. https://en.banglapedia.org/index.php/Calcutta_Medical_College
[11] Shinde, S. R. (2021). History of early medical education in British India: Policy shifts and structural outcomes. *ResearchGate*. https://www.researchgate.net/publication/348760426_history_of_early_medical_education_in_British_India

Milestones in Early Medical Education in Bengal (1822–1836)	**Year**	**Institutional Significance and Policy Shifts**
Foundation of the Native Medical Institution (NMI)	1822	Established via Governor General's Order No. 41 to train native doctors using vernacular mediums and parallel traditional curricula.
Integration of Indigenous Classes	1826	Formal initiation of Unani classes at Calcutta Madrasa and Ayurvedic classes at Sanskrit College.
Anatomy Lectures at Sanskrit College	1827	Dr. John Tyler begins teaching European anatomy and mathematics within a traditional indigenous educational setting.
The Grant Committee Investigation	1833	Lord William Bentinck appoints a committee led by Dr. John Grant to evaluate the efficacy and validity of NMI's hybrid training.
Macaulay's Minute on Indian Education	1835	Thomas Babington Macaulay formally condemns state funding for Oriental learning, declaring it a "dead loss to the cause of truth".
Abolition of the NMI	1835	Government order on January 28 dissolves the NMI and ceases medical instruction at the Madrasa and Sanskrit College.

First Human Dissection by an Indian	1836	Madhusudan Gupta performs a human dissection at the newly founded Calcutta Medical College, breaking major caste taboos.

3. The Anglicist Shift: Ideological Eradication and the Hegemony of Biomedicine (1833–1836)

The era of epistemological accommodation, where knowledge of native medicine was treated with condescension since it was assumed that it would soon become obsolete in the face of western science, came to an end in the first half of the 1830s with a sharp ideological shift in the imperial government. This was in opposition to the practical Orientalism of the 1820s government by the dissident group of the Anglicists who saw government investment in native knowledge as fostering both intellectual error and cultural backwardness.

The policy was formalised in 1833 with the Governor General of India, Lord William Bentinck, commissioning a special committee of specialists to assess the teaching methods at the NMI and also the state of medical education in Bengal. The Grant Committee, as the commission was known, filed a damning report on what they found. This hybrid curriculum, that is, vernacular translations and the absence of human dissection, was what commentators called a "hodgepodge mixture". In a climate of mounting fears, colonial authorities and European civilians could not trust the lives and health to be guided by native medical practitioners whose training involved unscientific indigenous medicine and surgery practices.[12]

[12] ResearchGate Repository. (2014). *Pandit Madhusudan Gupta | Download scientific diagram*. ResearchGate. https://www.researchgate.net/figure/Pandit-Madhusudan-Gupta_fig2_259726075

The era of epistemological accommodation, where knowledge of native medicine was treated with condescension since it was assumed that it would soon become obsolete in the face of western science, came to an end in the first half of the 1830s with a sharp ideological shift in the imperial government. This was in opposition to the practical Orientalism of the 1820s government by the dissident group of the Anglicists who saw government investment in native knowledge as fostering both intellectual error and cultural backwardness.

The policy was formalised in 1833 with the Governor General of India, Lord William Bentinck, commissioning a special committee of specialists to assess the teaching methods at the NMI and also the state of medical education in Bengal. The Grant Committee, as the commission was known, filed a damning report on what they found. This hybrid curriculum, that is, vernacular translations and the absence of human dissection, was what commentators called a "hodgepodge mixture". In a climate of mounting fears, colonial authorities and European civilians could not trust the lives and health to be guided by native medical practitioners whose training involved unscientific indigenous medicine and surgery practices.[13]

The colonial government established the Calcutta Medical College (CMC) in 1835 to supplant the now-defunct NMI. However the CMC was deliberately created as the antithesis of the NMI; it was elitist in original design, qualifying its students via a tough preliminary exam, and teaching its students exclusively in the English language, based only on unadulterated western science. The symbolic apotheosis of this Anglicised medical establishment came on 10 January 1836, when Pandit Madhusudan Gupta, a student of the first batch of the CMC, became the first Indian to dissect the human body. Supported by other leading native elite such as Dwarkanath Tagore and Ram Kamal Sen, Pandit Gupta's violation of a time-honored socio-religious taboo was hailed by the colonial establishment as the crowning victory of rational western science over the darkness of native superstition.

[13] CME India. (2023). *Medical College, Kolkata - Medical institute of glorious past, enlightened present*. CME India History Hub. https://cmeindia.in/medical-college-kolkata-medical-institute-of-glorious-past-enlighted-present/

4. Evangelical Interventions: Medical Missions and the Politics of the Zenana

Even while the colonial state formally withdrew its patronage from indigenous medicine in favour of a secularised, Anglicised biomedical system, a second front of medical intervention opened up from another equally powerful source. The period from 1800 to 1914 has been described by historians as the "great century of missions" because of the presence of thousands of Protestant missionaries from Great Britain and the United States.[14] The British Empire's unusually stable rule allowed the country to become the center of the global missionary movement: by the mid-nineteenth century, more than a quarter of all Protestant missionaries resided in India.

However, the relationship between the colonial state and the missionary societies was often complicated and combative. The colonial state, for example, feared the religious dissidence of the native population and often forbade public preaching by evangelicals. The only real avenue of progress for the missionary societies was through the medical and educational initiatives they undertook.[15] The CMS and Baptist Zenana Mission archives reveal how these societies strategically deployed medical missions to penetrate non-European social and institutional structures.[16]

However, for the medical missionaries, indigenous medicine was not simply scientifically naive. It was a specifically theological danger. They used missionary periodicals such as the CMS Gleaner and the CMS Intelligencer to expose British readers to serialised critical reports about indigenous medicines that summed it up somewhat negatively. The medical practices of customary Hindu and Islamic systems were described as "grovelling superstitions". Missionaries lamented that while the native populations might profess a customary belief in the Divine Unity, they

[14] Department of Economics. (2018). *Long-term effects of access to health care: Medical missions in colonial India*. Boston College Working Papers. http://fmwww.bc.edu/EC-P/wp883.pdf
[15] Department of History. (2021). *How did missionaries in colonial India communicate with the people they were trying to convert?* University of Wisconsin-Madison. https://history.wisc.edu/wp-content/uploads/sites/202/2021/04/ask-a-historian-transcript-s2e8.pdf
[16] CABI Digital Library. (2018). *Long-term effects of access to health care: Medical missions in colonial India*. CAB International. https://www.cabidigitallibrary.org/doi/full/10.5555/20183376390

followed faith healing, used medicinal charms, and attributed the "Divine perfections of omniscience and omnipresence to dead men".[17] By treating diseases and injuries using western medicine, the missionaries intended to discredit the efficacy of the native deities and the competence of native Vaids and Hakims, and to convince people to convert to Christianity.

4.1 The Zenana as a Contested Medical Space

One of the most important institutions of the medical-evangelical campaign was the Zenana, the segregated quarters of Indian women. Under the codes of purdah, European male doctors were prohibited from the Zenana and from examining women patients. This exclusion left women with dangerously high levels of morbidity and maternal mortality which native folk healers and midwives (dais) were not considered to be equipped to handle according to western definitions.[18]

The Zenana offered an opportunity for British women physicians at a time when British medical schools were full, women faced discrimination by their peers, and there were few residencies available in metropolitan hospitals. India offered work for women who were to be sent out to the colonies as a noble imperial duty, for it is the "Christian West to proffer the fruits of civilisation to the suffering multitude in the pagan East". Ironically, the very purdah the missionaries so loudly publicised as barbaric became the structural basis for the professional emancipation of English women doctors.

To consider what the working life was like on an individual and community level, the diaries, letters and photographs of the Baptist medical missionaries can be consulted in the collection of the Angus Library. One of the first British women to qualify as a doctor, Dr Ellen Farrer had applied to the Baptist Zenana Mission in 1891 through the London School of Medicine for Women.

[17] Church Missionary Society. (1883). *The Punjab and Sindh missions of the Church Missionary Society: Giving an account of their foundation and progress for thirty-three years*. Church Missionary House. Internet Archive. https://ia801205.us.archive.org/7/items/ThePunjabAndSindhMissionsOfTheChurchMissionarySociety/ThePunjabAndSindhMissionsOfTheChurchMissionarySociety.pdf

[18] Anderson, I. S. (2014). *A mission for medicine: Dr. Ellen Farrer and India 1891–1933*. Semantic Scholar. https://www.semanticscholar.org/paper/A-mission-for-medicine-%3A-Dr-Ellen-Farrer-and-India-Anderson/fccad40afde5a36659a06973f7755a96507dca78

She was assigned to Bhiwani (now in Haryana). She ran a small, shabby dispensary in a native house. Farrer's records indicate the local women regarded her with suspicion and were averse to visiting the clinic. They would not stay when admitted, and would return to the treatment of the local quacks, unsettled by her unusual surgical implements.[19]

Farrer's success in practicing medicine gradually eroded indigenous reliance on folk medicine and her practice was instrumental in the building of the large Farrer Hospital in Bhiwani around 1923. As a further mark of her success, the colonial government awarded her the Kaisar-i-Hind Medal for her work in 1913.[20] About the same time, Dr. Edith Brown established the North India School of Medicine for Christian Women in Ludhiana. Interdenominational in orientation, the training school was intended to recruit native female aides for work in medical mission. Brown hoped to obtain a group of western-trained Indian women who would completely replace the older generation of customary dais in the Zenana.[21]

Even in colonial-era condemnations of their policy, such as that by prominent colonial writer Flora Annie Steel, the Zenana medical missions were seen to reinforce the system of purdah by dispensing modern medical help to women of the Zenana through female emmissionaries, as opposed to weakening it by encouraging Indian men to liberate women from confinement, despite the fact that the missions had removed the pain and death brought by confinement. Recent econometric studies based on fully geocoded historical data have shown a strong positive long-term association between the location of Protestant medical missions in the past and health outcomes today, implying a substantial intergenerational effect.

5. Epidemiological Crises and the Pragmatic Utilization of Subordinate Healing

[19] Verdia, B. (2020). *An introduction to Dr. Ellen Farrer (1865 – 1959) and her medical missionary journals*. Angus Library and Archive, Regent's Park College, Oxford. https://theangus.rpc.ox.ac.uk/an-introduction-to-dr-ellen-farrer-1865-1959-by-blanca-verdia/

[20] South Hampstead High School. (2021). *Motivational Monday - Trailblazing doctor | Latest news*. GDST. https://www.shhs.gdst.net/news/motivational-monday-trailblazing-doctor/

[21] Hill Publishing Group. (2022). Patriarchy and medicine: A woman medical missionary in the colonial Punjab. *Journal of Humanities and Social Sciences*, 4(1), 112-119. https://wap.hillpublisher.com/ArticleDetails.aspx?type=PDF&cid=893

Despite discursive hegemony by the colonial state and the missionary societies of western biomedicine, the actual governance of the Indian subcontinent was regularly prevented by epidemiological disasters. The records in the Punjab State Archives and the National Archives of India (notably the Home Medical and Sanitary proceedings) show the lack of coherence between metropolitan medical policy and administrative decision-making in the face of crises in the last third of the nineteenth century and the first third of the twentieth.

However, the money spent by the colonial state on native public health was minuscule. As late as 1943, official figures showed that state spending on medical relief and public health per head of population in India was only 3 to 4 annas (one-sixth of a rupee) per annum, one third of which was spent on preventive medicine. The colonial medical system failed when the bubonic plague, cholera and influenza swept through the countryside, as the colonial state lacked the European medical staff who could order the establishment of sanitary cordons, inoculate the population and run camps to house those who needed to be quarantined.

In these conditions of disaster, colonial officials had to abandon their ideological purism and rely on the huge existing networks of indigenous practitioners. For example, when epidemics of infectious disease broke out in major pilgrimage centers, the government allowed Hakims and Vaids to work unrestricted in state-built pilgrim camps. The administration was eventually correct in anticipating that the presence of customary healers would reduce local distrust of colonial medicine, increase reporting of hidden cases, and ease entrance to colonial medical facilities.[22]

A realistic dependence upon indigenous resources is also noted during the anti-plague campaigns in colonial Punjab. The Home Medical and Sanitary Proceedings 1897-1919 records that village headmen and native antidisease practitioners were extensively recruited into the Punjab Government sanitary administration. Vaids and Hakims were used to explain the necessity of plague preventive measures, such as segregation, disinfection of homes, restriction on movement,

[22] Pati, B., & Harrison, M. (Eds.). (2001). *The social history of health and medicine in colonial India*. Routledge. National Academic Digital Library of Ethiopia. http://ndl.ethernet.edu.et/bitstream/123456789/20917/1/Biswamoy%20Pati.pdf

and sanitation measures such as storage of food grains in rat-proof bins. The 1918 influenza pandemic, which dominated the health statistics of 1918, saw Hakims and Vaids employed on a large scale to distribute medicines. The Report on the Sanitary Administration of the Punjab stated that "generally speaking, they did their work satisfactorily".[23]

It is meaningful that this reliance on indigenous practitioners would have been entirely instrumental, with no recognition of the official efficacy of their medical knowledge. Archives attest to the deeply secured paranoia among British medical officers of the diagnostic incompetence of native healers. During the 1897-98 plague epidemic in Jullundur and Hoshiarpur districts, Surgeon Captain Smith, Major E. Inglis and other European officers of the colonial administration were frustrated by the Vaids; they believed that native Ayurvedic practitioners were diagnosing virtually every febrile condition as the plague, and administering remedies with lethal potency. According to one colonial official: "If a layman gave a strong dose of aconite to another and killed him, it would be murder, but if he goes by the name of a vaid, it is nothing".

Despite their lack of legal authority, much of the local British establishment was in favour of draconian measures and at times it was suggested that the only remedy was to deal a "death blow to unqualified practitioners". Epidemics could not be fought while native healers existed outside the direct supervisory control of the Indian Medical Service. The colonial state's relationship with indigenous healers was one of absolute necessity on the one hand, and ferocious bureaucratic hostility on the other.

6. The Era of Investigative Committees and the Politics of Validation (1918–1948)

The subject of indigenous medicine, which earlier was considered an issue of local sanitary administration, became a matter of national political identity by the mid-twentieth century, and the revival and modernization of Ayurveda and Unani was a central piece of discussion in almost

[23] Punjab Sanitary Board. (1919). *Report on the sanitary administration of the Punjab and proceedings of the Sanitary Board for the year 1918*. Government Printing. Internet Archive. https://archive.org/download/b31489448/b31489448.pdf

all sessions of the Indian National Congress between 1920 and 1938. Since medical self-sufficiency was one small part of the larger Swaraj (self-rule) movement, nationalist politicians and indigenous medical schools were able to pressure provincial legislative councils to force the colonial government to set up a series of committees to examine the scientific character of the indigenous systems of medicine. It is in these reports that the most wide-ranging bureaucratic deliberations over medical pluralism took place in the colonial archive.[24]

6.1 The Koman Committee (1918)

The first major institutional inquiry was set up by the Government of Madras in July 1918, and was referred to as the Koman Committee, after its chair, Dr. M.C. Koman. The task was strictly limited to the pharmacological properties of drugs of Indian origin. In its reductionist approach, the Koman Committee's process of drug discovery employed entirely western principles, seeking to isolate and purify the active chemical compounds in customary medicinal herbs with no regard for the physiology and pathology of Ayurveda and Unani systems.

The committee's final report, despite having reluctantly accepted a few native drugs into modern pharmacopoeia, condemned the indigenous systems as being completely unscientific. It famously commented on "the science of Hindu medicine is still sunk in a state of empirical obscurity". The outright rejection of native systems resulted in a great deal of protest from the native medical community. The newly formed professional bodies such as the Dravida Vaidya Mandal and the Madras Ayurveda Sabha released a detailed rebuttal which criticised the Koman report for its methodological biases and its lack of understanding for indigenous knowledge systems. The Koman report led to an increasing distrust among customary healers that colonial committees were aimed at systematically discrediting and weakening indigenous medicine.[25]

[24] CIJHAR Research Portal. (2016). Chalcolithic communities of central India in terms of technological and economic aspects. *Central India Journal of Historical and Archaeological Research*, 5(20), 45-53. https://cijhar.in/pdf/2016_v5i20.pdf
[25] Sujatha, V. (2023). Rise of Siddha medicine: Causes and constructions in the Madras Presidency (1920–1930s). *Medical History*, 67(3), 221-240. Cambridge University Press. https://pmc.ncbi.nlm.nih.gov/articles/PMC10357311/

6.2 The Usman Committee (1923)

The ensuing political chaos forced the Madras Provincial Government to adopt a policy of conciliation and G.O. No. 1001 was issued consequent to a resolution moved by T.R. Ramachandra Ayyar in the Madras Legislative Council (MLC). The Usman Committee on the Indigenous Systems of Medicine was formally constituted on 17 October 1921 under the chairmanship of Mohammed Usman.[26]

The Usman Report (1923), in marked contrast to these colonial positions, gave an unprecedented institutional platform to indigenous practitioners in which to articulate theories of practice and request state financial support. Unlike Koman, the Usman Committee followed an especially broad participatory methodology and gathered testimonies both from practitioners of Indian systems of medicine operating in various parts of India. Its committee accepted information in native languages like Sanskrit, Urdu, Tamil, Telugu, Malayalam, Kannada and Oriya. After wide-ranging translations, it produced an archetypal material record of the socio-medical scene of 1920s India that remains unmatched to this day.[27]

Against the tide of biomedical supremacy, the Usman Report stated: From the standpoint of science and theory, the Indian systems were thoroughly logical and scientific. From the standpoint of practice, Ayurveda and Unani systems of medicine, as a rule, are self-sufficient, efficient and highly economical for treating medical cases, though they are not so adequately equipped for matters of surgery.[28] Based on the recommendations of the committee, a Government Indian Medical School (later Government Indian Medical College) was founded in Madras, South India,

[26] IBID
[27] Usman, M. (1923). *Report of the committee on the indigenous systems of medicine (Vol. II: Translations of regional submissions)*. Ministry of Local Self-Government, Madras Presidency. Open Research Online. https://oro.open.ac.uk/71069/14/71069.pdf
[28] Committee on Indigenous Systems of Medicine. (1948). *Full text of "Report of the committee on indigenous systems of medicine Vol. II"*. Government of India. Internet Archive. https://archive.org/stream/in.ernet.dli.2015.112421/2015.112421.Report-Of-The-Committee-On-Indigenous-Systems-Of-Medicine--Volii_djvu.txt

which awarded a Licentiate in Indian Medicine (L.I.M.).[29] The Usman scheme, say scholars, had a major influence in developing an indigenous medical identity, in that it for the first time distinguished Siddha medicine as a Dravidian medical identity, from the Sanskrit-based Ayurveda in northern India.

6.3 The Bhore Committee (1946) and the Chopra Committee (1948)

When the British Raj was about to come to an end, a blueprint was laid for the state's health care system. The Government of India appointed the Health Survey and Development Committee as early as 1943, more popularly known as the Bhore Committee.[30] The 1946 Bhore Committee report, perhaps the most influential document in modern Indian medical history, laid the absolute foundation of the Indian healthcare system today.[31]

However, despite decades of nationalist agitation for the revival of traditional medicine, the Bhore Committee's findings were entirely consumed by a "biomedical hegemony".[32] The report devoted itself exclusively to western medical colleges, teaching hospitals and allopathic research departments and had no substantial place for the indigenous systems of medicine in the proposed State Medical Relief of the country. The failure to do so created a huge outcry. In the Conference of Health Ministers, held in Delhi in October 1946, the Hon'ble Mrs. A. Rukmini Lakshmipathi, the Health Minister, Madras, moved a resolution that a new committee be appointed without any delay.

[29] Ramaswamy, S. (2018). Emergence of indigenous medical education in Madras Presidency: A historical analysis. *International Journal of Research in Advent Technology (IJRAT)*, 6(7), 1542-1549. https://ijrat.org/downloads/Vol-6/july-2018/paper%20ID-67201855.pdf

[30] National Institutes of Health. (2016). *Bibliography - Disparate remedies*. NCBI Bookshelf - NIH. https://www.ncbi.nlm.nih.gov/books/NBK592776/

[31] Chopra, R. N. (1948). *Report of the committee on indigenous systems of medicine (Vol. II)*. Ministry of Health, Government of India. Internet Archive. https://archive.org/stream/in.ernet.dli.2015.143922/2015.143922.Report-Of-The-Committee-On-Indigenous-Systems-Of-Medicine--Volii_djvu.txt

[32] Cambridge Core. (2024). A homoeopathic public: Elections, public health and legislation (Chapter 5). In *Vernacular medicine in colonial India*. Cambridge University Press. https://www.cambridge.org/core/books/vernacular-medicine-in-colonial-india/homoeopathic-public-elections-public-health-and-legislation/6334B39A79B10BC53784254F410B9A66

Another result of this political activity was the formation of the Committee on Indigenous Systems of Medicine in 1947 under the leadership of Col. Sir R.N. Chopra.[33] To implement that huge mandate, the Chopra Committee set up sub-committees in 1948 to look at particular aspects of the problem of how to accommodate indigenous medicine within the Bhore Committee's vision of organization. It also co-opted local members onto the sub-committees, which visited institutions to collect evidence all over the country. While the Chopra Committee was considerably more sympathetic to the cultural and practical merits of indigenous systems of medicine, modern historiography contends that the Chopra Committee's ultimate rationale was not considerably different from the Bhore Committee's. The Chopra report recommended a synthesis of indigenous systems (with Vaids and Hakims studying modern anatomy and physiology). However, it reinforced the "pharmaceutic episteme", incorporating the role of the scientist as the ultimate arbiter of the acceptability of indigenous remedies.

7. Vernacular Public Spheres and the Linguistic Construction of Medical Identity

The institutionalisation of indigenous medicine was thus not the result of government committees alone, but was rather a much more militant and popular political process, well established by customary practitioners themselves. The Punjab State Archives at Chandigarh and Patiala preserves native newspapers and municipal proceedings of district boards that exemplify a very active vernacular public sphere where medical knowledge was constantly being tested, rationalised and reformulated.

As historian Kavita Sivaramakrishnan has noted, despite the marginalisation of the colonial state, hereditary practitioners such as Bhai Mohan Singh Vaid and Pandit Thakur Dutt Sharma did not recede.7 Instead, they developed a wide-ranging public profile through a rapidly burgeoning print

[33] Koman, M. C. (1918). *Report of the committee on the indigenous systems of medicine*. Government Press. Scribd Repository. https://www.scribd.com/document/577496558/Koman-Report-3-PDF

culture in Hindi, Urdu, and Punjabi.[34] They wrote popular health tracts, clashing with local colonial authorities over how to respond to the plague, and manuals for domestic health aimed at a wide, literate audience of Indian women. These manuals combined Ayurvedic health and domestic writing with imperializing assumptions about the domestic, competing with popular Anglo-imperial works such as Flora Annie Steel's Complete Indian Housekeeper and Cook.[35]

However, the formation of an indigenous medical identity was often anything but smooth or uniform. It was fractured along regional, linguistic and community lines.52 In Punjab, the battle over indigenous medicine was tied to the politics of religious identity. As Sivaramakrishnan shows, the Punjabi Sikh vaids resisted the template of a Hindi-dominated, highly Sanskritized discourse on Ayurvedic revivalism popular in the United Provinces and Bengal.[36] To support their argument of a separate, Punjabi identity, Sikh ideologues propagated different cultural narratives which claimed that Dhanwantri, the Hindu god of medicine and mythical author of Ayurveda, chose the land of Punjab as the home for his divine knowledge to be spread. During this time, the Hakims produced a massive literature to safeguard the intellectual history of Unani Tibb from colonial derision and the majoritarianism of Hindu Ayurvedic revivalists. This polyvocal print culture kept indigenous medicine readily present for public consumption and political discourse, thus preventing the colonial state from erasing it from memory.[37]

8. Post-Colonial Transitions and the Legacy of the Bureaucratic Archive

[34] Sivaramakrishnan, K. (2006). *Old potions, new bottles: Recasting indigenous medicine in colonial Punjab 1850–1940*. Orient BlackSwan. DOKUMEN.PUB. https://dokumen.pub/download/old-potions-new-bottles-recasting-indigenous-medicine-in-colonial-punjab-1.html

[35] Oxford Academic. (2024). Hakims on health and hygiene: Advising women and optimising reproductive capacity in Urdu instructional literature, c.1880s–1940s. *Social History of Medicine*. https://academic.oup.com/shm/advance-article/doi/10.1093/shm/hkae055/8099324

[36] National Center for Biotechnology Information. (2017). Between the bazaar and the bench: Making of the drugs trade in colonial India, ca. 1900–1930. *PubMed Central (PMC)*. https://pmc.ncbi.nlm.nih.gov/articles/PMC5331622/

[37] Vanderbilt University Institutional Repository. (2021). *Making new Muslim Arains: Reform, law, and politics in colonial Punjab, 1890s–1940s*. Vanderbilt Academic Archives. https://ir.vanderbilt.edu/bitstreams/34973b4a-9c84-45be-b9cd-e0d96cb7ce29/download

Independence in 1947 did not mark the end of colonial bias in medical epistemology. The proceedings of the Constituent Assembly and the policy documents of the early Republic show how deeply secured the biomedical hegemony established by the Grant Committee of 1835 and consolidated by the Bhore Committee of 1946 became in the minds of the Indian political elite.

Historians have noted that figures like Jawaharlal Nehru continued to show strong skepticism of indigenous systems of medicine, and that after independence, the government followed the trend of requiring provable safety and effectiveness records according to western scientific standards before granting customary systems an official status. Most of the early health grants by the government were used only to expand the then-existing allopathic hospitals. Discriminatory employment practices also plagued indigenous practitioners, with Ayurvedic and Unani graduates being barred from high posts such as Inspector General of Civil Hospitals, as well as rarely being appointed among the ranks of Medical Officers above Grade IV in the Provincial Medical Services. When questioned on the exceptions, government officials, including Mrs Vijayalakshmi Pandit, argued that Vaids and Hakims did not have the "fundamental education" necessary for modern health administration.[38]

However, the miserable coverage of rural allopath, as well as huge democratic pressure brought about a slow institutional compromise by which indigenous systems of medicine as well as Homoeopathy found their way into the First as well as subsequent National Five Year Plans, and elaborate regulations similar to the colonial medical boards were instituted.[39] The Homoeopathic Pharmacopoeia Committee (HPC) was constituted in 1962 and the Homoeopathic Research Committee in 1963 for laying down the quality control and manufacturing standards of the drugs. The Central Council for Research in Ayurvedic Sciences (CCRAS) has also merged the historic drug research and survey institutes such as the Captain Srinivasa Murthy Drug Research Institute,

[38] Arnold, D. (2005). *Systems of medicine and nationalist discourse in India: Towards "new horizons" in medical anthropology and history*. People's Archive of Rural India. https://ruralindiaonline.org/media/documents/41medicineNationalistDiscourseInIndiaEN20051128.pdf

[39] Central Council for Research in Homoeopathy. (2023). *Homoeopathy: Gentle healing*. Ministry of Ayush, Government of India. https://ccrhindia.ayush.gov.in/sites/default/files/2023-08/homoeopathy_gentle_healing_CCRH.pdf

Chennai (established in 1963) for phytochemical research and standard operating procedure (SOP) development of customary drugs.[40]

Administrative records from the Haryana State Archives, Panchkula, Haryana, and the Directorate General of Health Services, Panchkula, Haryana, bear witness to the bureaucratic edifice, built on state policies, that was necessary to support medical pluralism and health care systems. These records are indicative of the complex bureaucracy created by the state.[41] The State medical departments continue to recruit Ayurvedic Medical Officers and Homoeopathic doctors along with allopathic Senior Medical Officers into the State Health Authority and the National Health Mission.[42] Emphasis continues upon the enforcement of the provisions of the Medical Council of India (MCI) Act and filing of criminal and contempt cases against quacks who are practicing modern medicine illegally, which started with campaigns in the colonial state. Female medical examiners of the Indian postcolonial years include Dr Sant Kaur, who became a dedicated Medical Officer of Punjab, Haryana and Chandigarh beginning in 1961. Using the latest techniques in contraceptive usage, Kaur was the first to implement the government's Family Planning Mission and brought down the high birth rates of the region's slums.[43]

Archival Repositories and Digitization Efforts	**Historical Focus and Document Holdings**

[40] Central Council for Research in Ayurvedic Sciences. (2023). *CSMCARI Chennai*. Ministry of Ayush, Government of India. https://ccras.nic.in/csmcari-chennai/
[41] Times of India Bureau. (2014). Legal action against three fake medical practitioners. *The Times of India Chandigarh Edition*. https://timesofindia.indiatimes.com/city/chandigarh/legal-action-against-three-fake-medical-practitioners/articleshow/3995344.cms
[42] Chief Secretary, Government of Haryana. (2024). *The Managing Director allocation and operational guidelines*. Government of Haryana Circulars. https://csharyana.gov.in/WriteReadData/Circular-&-Instructions/Services-II/14134.pdf
[43] National Book Trust. (2020). *Women scientists in India: Overcoming institutional hurdles*. National Book Trust India Repository. https://www.nbtindia.gov.in/writereaddata/freebooks/pdf/Women%20Scientists%20in%20India.pdf

National Archives of India (NAI), New Delhi	Central government proceedings, Department of Education, Health and Lands files, Gilgit Lotus Sutra, *Ilajut Tuyur* (14th-century avian medicine manual).
Punjab State Archives (PSA), Chandigarh & Patiala	Home Medical, Jail, and Sanitary proceedings (1849–1950), epidemic management reports, vernacular native newspaper tracts.
Abhilekh Patal (Digital Portal)	Online access to over 200 million digitized historical records, including vernacular medical textbooks, post-colonial policy drafts (e.g., Dr. Inayatullah Shah's 1949 report).
Angus Library and Archive, Oxford	Personal diaries, letters, and photographs of Baptist medical missionaries like Dr. Ellen Farrer and George Grenfell.
Church Missionary Society (CMS) Periodicals	Serialized accounts of medical evangelism, polyglot linguistic records, observations on indigenous socio-religious superstitions.

The digital turn has radically democratised many of these sources; for example, the National Archives of India has made public over 200 million priceless documents through its Abhilekh Patal portal, that make the administrative history of medical policy available for perusal by any and all. The collection includes the Ilajut Tuyur (Treatise on the Treatment of Birds), for which Firoz Shah Tughluq, the Sultan of Delhi, commissioned a manuscript in 1378-79 AD, and internal memoranda on vernacular textbooks for native physicians.[44] It also contains the digitised records of Subimal Dutt, an officer in the Department of Education, Health and Lands of the Government of India, on how the transfer of power in 1947 was constructed bureaucratically. Thus the modern

[44] VSK Telangana Network. (2025). *GoPals, an initiative by IT professionals for desi cows, marks decade of service impacting farmers*. Vishwa Samvada Kendra Telangana. https://www.vsktelangana.org/Encyc/2025/8/23/gopals-it-professionals-initiative-desi-cows-service-farmers.html

scholar can see the unbroken line of development from the utilitarian pluralism of the 1820s, through the rigid Anglicization and missionary medical practices of the Victorian age, through to today's heavily regulated bureaucratic medical pluralism of India.[45]

9. Conclusion

The colonial history of indigenous medicine must be examined as more than the narrative of kind enlightenment and/or violent eradication. The huge collections of governmental, provincial, and missionary archives around the world reveal an epistemological tension and administrative contradiction that characterised the entirety of the colonial encounter. However, from necessity the early colonial state was willing to underwrite the parallel training of the indigenous and western medical system, in the form of the Native Medical Institution. With the triumph of Anglicism in Macaulay's Minute of 1835 came the definitive severing of this compromise, and the defunding and defamation of native systems. Women too were marginalised by the Protestant medical missionary intervention. The segregation of Zenanas, and the demonstrable success of western surgical and clinical medicine, were wielded by missionaries such as Dr Ellen Farrer to oppose the social-spiritual authority of indigenous healers, whom they viewed as proponents of pagan superstitions that prevented spiritual salvation. However, the ideological imperatives of colonial authority were constantly weakened by the epidemiological realities of subcontinental disease environments. During cataclysmic plague in the late 19th century, cholera, and the 1918 Influenza pandemic, the catastrophic shortfall of European health infrastructure forced the colonial state to rely on the very Vaids and Hakims it had tried to destroy. While this shows the realistic nature of imperial rule, it is also in this mobilisation around vernacular public practitioners that the survival of Ayurveda, Unani and Siddha was ensured, leading to formal negotiations with the colonial and early post-colonial states around the Koman, Usman, Bhore and Chopra Committees. The present Indian medical establishment, with its parallel system of huge allopathic infrastructure, and state funded customary research councils, seen as the bureaucratic legacy of this long colonial

[45] Brill Academic Publishers. (2024). *The Indian Civil Service: Administrative mechanics during transitional governance*. Brill Research E-Books. https://brill.com/display/book/9789004752467/BP000006.pdf

engagement, is now a permanent record within the huge machinery that is the bureaucratic state, available for digital access by all.

References

1. Hodge, J. M., Olsson, G., & Bowman, T. (Eds.). (2014). *Cultivating the colonies: Colonial states and their environmental legacies*. Ohio University Press. DOKUMEN.PUB. https://dokumen.pub/cultivating-the-colonies-colonial-states-and-their-environmental-legacies-9780896802827.html
2. Bala, P. (1947). *State and indigenous medicine in nineteenth- and twentieth-century Bengal: 1800–1947* (Doctoral dissertation, University of Edinburgh). ERA. https://era.ed.ac.uk/bitstream/1842/6872/1/378720.pdf
3. Jilani, S. A. (2025). Between Ayurveda and empire: Negotiating medical authority in colonial United Provinces (1858–1940). *International Journal of Forensic Medicine and Research (IJFMR)*, 7(2), 56-65. https://www.ijfmr.com/papers/2025/5/56952.pdf
4. Sharma, V. (2023). Public response towards plague prevention policies in colonial Punjab. *International Journal of History*, 5(2), 112-118. https://www.historyjournal.net/article/93/3-2-1-149.pdf
5. Adam Matthew Digital. (2023). *Church Missionary Society periodicals now available online*. AM Digital Insights. https://www.amdigital.co.uk/insights/news/church-missionary-society-periodicals-now-available-online
6. Medical College, Kolkata. (2024). *History of the college: Establishing clinical legacies*. Official College Portal. https://www.medicalcollegekolkata.in/main/page/about_us
7. Kumar, A. (2021). Native Medical Institution: The genesis of formal medical education in Bengal. *Journal of the Indian Medical Association (JIMA)*, 119(1), 80-83. https://onlinejima.com/journals_doc/download-journals/2021/january/80-83.pdf
8. National Archives of India. (2023). *Abhilekh Patal digital portal for archival records: Digitized medical textbooks*. Ministry of Culture, Government of India. https://www.abhilekh-patal.in/category/Search/SimpleSearch?query=&tags=medical+textbooks
9. Indian Medical Service. (2016). Evolution of medical education in India: The impact of colonialism. *PubMed Central (PMC)*. https://pmc.ncbi.nlm.nih.gov/articles/PMC5105212/
10. Banglapedia. (2021). *Calcutta Medical College*. National Encyclopedia of Bangladesh. https://en.banglapedia.org/index.php/Calcutta_Medical_College
11. Shinde, S. R. (2021). History of early medical education in British India: Policy shifts and structural outcomes. *ResearchGate*. https://www.researchgate.net/publication/348760426_history_of_early_medical_education_in_British_India
12. ResearchGate Repository. (2014). *Pandit Madhusudan Gupta | Download scientific*

diagram. ResearchGate. https://www.researchgate.net/figure/Pandit-Madhusudan-Gupta_fig2_259726075

13. CME India. (2023). *Medical College, Kolkata - Medical institute of glorious past, enlightened present*. CME India History Hub. https://cmeindia.in/medical-college-kolkata-medical-institute-of-glorious-past-enlighted-present/
14. Department of Economics. (2018). *Long-term effects of access to health care: Medical missions in colonial India*. Boston College Working Papers. http://fmwww.bc.edu/EC-P/wp883.pdf
15. Department of History. (2021). *How did missionaries in colonial India communicate with the people they were trying to convert?* University of Wisconsin-Madison. https://history.wisc.edu/wp-content/uploads/sites/202/2021/04/ask-a-historian-transcript-s2e8.pdf
16. CABI Digital Library. (2018). *Long-term effects of access to health care: Medical missions in colonial India*. CAB International. https://www.cabidigitallibrary.org/doi/full/10.5555/20183376390
17. Church Missionary Society. (1883). *The Punjab and Sindh missions of the Church Missionary Society: Giving an account of their foundation and progress for thirty-three years*. Church Missionary House. Internet Archive. https://ia801205.us.archive.org/7/items/ThePunjabAndSindhMissionsOfTheChurchMissionarySociety/ThePunjabAndSindhMissionsOfTheChurchMissionarySociety.pdf
18. Anderson, I. S. (2014). *A mission for medicine: Dr. Ellen Farrer and India 1891–1933*. Semantic Scholar. https://www.semanticscholar.org/paper/A-mission-for-medicine-%3A-Dr-Ellen-Farrer-and-India-Anderson/fccad40afde5a36659a06973f7755a96507dca78
19. Verdia, B. (2020). *An introduction to Dr. Ellen Farrer (1865 – 1959) and her medical missionary journals*. Angus Library and Archive, Regent's Park College, Oxford. https://theangus.rpc.ox.ac.uk/an-introduction-to-dr-ellen-farrer-1865-1959-by-blanca-verdia/
20. South Hampstead High School. (2021). *Motivational Monday - Trailblazing doctor | Latest news*. GDST. https://www.shhs.gdst.net/news/motivational-monday-trailblazing-doctor/
21. Hill Publishing Group. (2022). Patriarchy and medicine: A woman medical missionary in the colonial Punjab. *Journal of Humanities and Social Sciences*, 4(1), 112-119. https://wap.hillpublisher.com/ArticleDetails.aspx?type=PDF&cid=893
22. Pati, B., & Harrison, M. (Eds.). (2001). *The social history of health and medicine in colonial India*. Routledge. National Academic Digital Library of Ethiopia. http://ndl.ethernet.edu.et/bitstream/123456789/20917/1/Biswamoy%20Pati.pdf
23. Punjab Sanitary Board. (1919). *Report on the sanitary administration of the Punjab and proceedings of the Sanitary Board for the year 1918*. Government Printing. Internet Archive. https://archive.org/download/b31489448/b31489448.pdf
24. Sarkar, N. (2012). *"Plague germs can penetrate the celestial dress, but plague measures cannot": Mapping plague narratives in British India* [Seminar paper]. Ohio State University Center for Historical Research. https://cpb-us-

w2.wpmucdn.com/u.osu.edu/dist/a/49661/files/2017/08/OSU-CHR-Seminar_Natasha-Sarkar-9-29-2012-uoyrze.pdf
25. CIJHAR Research Portal. (2016). Chalcolithic communities of central India in terms of technological and economic aspects. *Central India Journal of Historical and Archaeological Research*, 5(20), 45-53. https://cijhar.in/pdf/2016_v5i20.pdf
26. Sujatha, V. (2023). Rise of Siddha medicine: Causes and constructions in the Madras Presidency (1920–1930s). *Medical History*, 67(3), 221-240. Cambridge University Press. https://pmc.ncbi.nlm.nih.gov/articles/PMC10357311/
27. IBID
28. Usman, M. (1923). *Report of the committee on the indigenous systems of medicine (Vol. II: Translations of regional submissions)*. Ministry of Local Self-Government, Madras Presidency. Open Research Online. https://oro.open.ac.uk/71069/14/71069.pdf
29. Committee on Indigenous Systems of Medicine. (1948). *Full text of "Report of the committee on indigenous systems of medicine Vol. II"*. Government of India. Internet Archive. https://archive.org/stream/in.ernet.dli.2015.112421/2015.112421.Report-Of-The-Committee-On-Indigenous-Systems-Of-Medicine--Volii_djvu.txt
30. Ramaswamy, S. (2018). Emergence of indigenous medical education in Madras Presidency: A historical analysis. *International Journal of Research in Advent Technology (IJRAT)*, 6(7), 1542-1549. https://ijrat.org/downloads/Vol-6/july-2018/paper%20ID-67201855.pdf
31. National Institutes of Health. (2016). *Bibliography - Disparate remedies*. NCBI Bookshelf - NIH. https://www.ncbi.nlm.nih.gov/books/NBK592776/
32. Chopra, R. N. (1948). *Report of the committee on indigenous systems of medicine (Vol. II)*. Ministry of Health, Government of India. Internet Archive. https://archive.org/stream/in.ernet.dli.2015.143922/2015.143922.Report-Of-The-Committee-On-Indigenous-Systems-Of-Medicine--Volii_djvu.txt
33. Cambridge Core. (2024). A homoeopathic public: Elections, public health and legislation (Chapter 5). In *Vernacular medicine in colonial India*. Cambridge University Press. https://www.cambridge.org/core/books/vernacular-medicine-in-colonial-india/homoeopathic-public-elections-public-health-and-legislation/6334B39A79B10BC53784254F410B9A66
34. Koman, M. C. (1918). *Report of the committee on the indigenous systems of medicine*. Government Press. Scribd Repository. https://www.scribd.com/document/577496558/Koman-Report-3-PDF
35. Sivaramakrishnan, K. (2006). *Old potions, new bottles: Recasting indigenous medicine in colonial Punjab 1850–1940*. Orient BlackSwan. DOKUMEN.PUB. https://dokumen.pub/download/old-potions-new-bottles-recasting-indigenous-medicine-in-colonial-punjab-1.html
36. Oxford Academic. (2024). Hakims on health and hygiene: Advising women and optimising reproductive capacity in Urdu instructional literature, c.1880s–1940s. *Social History of Medicine*. https://academic.oup.com/shm/advance-

article/doi/10.1093/shm/hkae055/8099324
37. National Center for Biotechnology Information. (2017). Between the bazaar and the bench: Making of the drugs trade in colonial India, ca. 1900–1930. *PubMed Central (PMC)*. https://pmc.ncbi.nlm.nih.gov/articles/PMC5331622/
38. Vanderbilt University Institutional Repository. (2021). *Making new Muslim Arains: Reform, law, and politics in colonial Punjab, 1890s–1940s*. Vanderbilt Academic Archives. https://ir.vanderbilt.edu/bitstreams/34973b4a-9c84-45be-b9cd-e0d96cb7ce29/download
39. Arnold, D. (2005). *Systems of medicine and nationalist discourse in India: Towards "new horizons" in medical anthropology and history*. People's Archive of Rural India. https://ruralindiaonline.org/media/documents/41medicineNationalistDiscourseInIndiaEN20051128.pdf
40. Central Council for Research in Homoeopathy. (2023). *Homoeopathy: Gentle healing*. Ministry of Ayush, Government of India. https://ccrhindia.ayush.gov.in/sites/default/files/2023-08/homoeopathy_gentle_healing_CCRH.pdf
41. Central Council for Research in Ayurvedic Sciences. (2023). *CSMCARI Chennai*. Ministry of Ayush, Government of India. https://ccras.nic.in/csmcari-chennai/
42. Times of India Bureau. (2014). Legal action against three fake medical practitioners. *The Times of India Chandigarh Edition*. https://timesofindia.indiatimes.com/city/chandigarh/legal-action-against-three-fake-medical-practitioners/articleshow/3995344.cms
43. Chief Secretary, Government of Haryana. (2024). *The Managing Director allocation and operational guidelines*. Government of Haryana Circulars. https://csharyana.gov.in/WriteReadData/Circular-&-Instructions/Services-II/14134.pdf
44. National Book Trust. (2020). *Women scientists in India: Overcoming institutional hurdles*. National Book Trust India Repository. https://www.nbtindia.gov.in/writereaddata/freebooks/pdf/Women%20Scientists%20in%20India.pdf
45. VSK Telangana Network. (2025). *GoPals, an initiative by IT professionals for desi cows, marks decade of service impacting farmers*. Vishwa Samvada Kendra Telangana. https://www.vsktelangana.org/Encyc/2025/8/23/gopals-it-professionals-initiative-desi-cows-service-farmers.html
46. Brill Academic Publishers. (2024). *The Indian Civil Service: Administrative mechanics during transitional governance*. Brill Research E-Books. https://brill.com/display/book/9789004752467/BP000006.pdf