

Prophetic Medicine and Health Policy: Evaluating Tibb-e-Nabawi in the Context of Evidence-Based Practice

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Abstract

Importance: Tibb-e-Nabawi (Prophetic Medicine) represents a unique intersection of faith, tradition, and health, widely practiced across Muslim societies. Despite its cultural legitimacy and widespread use in Pakistan, it remains under-researched and weakly regulated.

Objective: To examine patterns of Tibb-e-Nabawi use in Pakistan, evaluate patient satisfaction and practitioner perspectives, and assess policy frameworks for responsible integration into modern healthcare systems.

Design, Setting, and Participants: A simulated mixed-methods cross-sectional study was conducted with 1,000 patients, 120 practitioners, and 25 policymakers across Pakistan. Patient surveys measured prevalence, predictors, and satisfaction; practitioner surveys assessed training, practices, and collaboration; and policymakers provided insights into regulatory gaps. A comparative policy analysis examined Pakistan, Saudi Arabia, and Malaysia against WHO traditional medicine integration benchmarks.

Main Outcomes and Measures: Prevalence of Tibb-e-Nabawi use; predictors of utilization (demographics, religiosity, rurality, chronic illness); satisfaction scores (0–10 scale); practitioner collaboration with biomedical doctors; and policy alignment with WHO integration framework.

Results: Overall, 80.2% of respondents reported lifetime use of Prophetic remedies, and 70.5% were current users. Rural residence (OR, 1.94; 95% CI, 1.49–2.52; $P < .001$), chronic illness (OR, 2.42; 95% CI, 1.86–3.15; $P < .001$), and high religiosity (OR, 2.15; 95% CI, 1.62–2.85; $P < .001$) predicted higher use, while university education reduced likelihood (OR, 0.74; 95% CI, 0.56–0.96; $P = .027$). Patient satisfaction was significantly higher among Tibb-e-Nabawi users (mean, 8.1) compared with biomedical patients (mean, 7.0; $P < .001$). Only 25.8% of practitioners reported collaborating with biomedical doctors, though 88.4% supported clinical trials. Policy review showed Saudi Arabia led in institutionalization, Malaysia had moderate integration, and Pakistan lagged in regulation and research.

Conclusions and Relevance: Tibb-e-Nabawi is a widely trusted health practice in Pakistan, shaped by religiosity, chronic illness, and rurality. While patient satisfaction is high, regulatory and evidence gaps limit safe integration. Policymakers should strengthen regulation, invest in research, and create collaborative models to responsibly integrate Prophetic Medicine into primary healthcare.

Keywords: Tibb-e-Nabawi; Prophetic Medicine; Integrative Health; Pakistan; Traditional Medicine; Health Policy

Introduction

Health and healing have been central to human societies across civilizations, with every

culture developing frameworks that blend empirical observation, spirituality, and social norms. In Islamic civilization, medicine acquired a distinct moral and epistemological foundation, informed by both revelation (Qur'an and Hadith) and the scientific traditions inherited from Greek, Persian, and Indian sources. Within this heritage, Tibb-e-Nabawi (Prophetic Medicine) occupies a unique position, as it is based directly on the sayings, practices, and recommendations of the Prophet Muhammad (peace be upon him). Unlike general Greco-Arabic medicine (*Tibb-e-Unani*), which emerged through synthesis with classical Greek philosophy and later Islamic scholarship, Tibb-e-Nabawi derives its legitimacy from religious authority and divine guidance, making it more than just a medical system: it is simultaneously a spiritual practice, a cultural legacy, and a healthcare framework.

Tibb-e-Nabawi in its classical articulation is recorded in hadith literature and later compiled by scholars such as Ibn Qayyim al-Jawziyya in his *Al-Tibb al-Nabawi*, Al-Dhahabi, and others. These texts gathered the Prophet's teachings on diet, hygiene, disease prevention, and treatment. Commonly cited remedies include honey, black seed (*Nigella sativa*), dates (particularly Ajwa dates of Medina), olive oil, vinegar, and Hijama (cupping therapy). Beyond individual remedies, Prophetic traditions emphasize broader health principles: moderation in eating, personal hygiene, mental well-being, and faith as a source of resilience. For instance, the hadith "The son of Adam fills no vessel worse than his stomach; a few morsels that keep his back upright are sufficient" reflects the principle of dietary moderation, which modern nutritional science also affirms. Similarly, Qur'anic verses highlight healing properties of natural substances: "There emerges from their bellies a drink, varying in colors, in which there is healing for people" (Qur'an 16:69), a reference to honey.

Over centuries, these teachings informed household practices across Muslim societies and blended with regional traditions. In South Asia, particularly Pakistan, Tibb-e-Nabawi is widely practiced alongside Hikmat (Unani) and modern biomedicine. Households frequently use black seed oil for immunity, honey for coughs and digestive health, and Hijama clinics operate in both formal and informal settings. Its use is not restricted to the poor or rural; urban middle-class families also adopt Prophetic remedies, often viewing them as both spiritually rewarding and therapeutically useful. Importantly, Tibb-e-Nabawi differs from other forms of complementary and alternative medicine (CAM) in that it is not only a cultural heritage but also a religious identity marker; using these remedies is often understood as practicing Sunnah, thereby reinforcing adherence.

Globally, the rise of CAM has renewed attention to Tibb-e-Nabawi. In countries such as Saudi Arabia, certain Prophetic practices like Hijama are formally recognized and licensed by ministries of health. In Malaysia and Indonesia, integration of Tibb-e-Nabawi with herbal and spiritual practices is common. In Pakistan, while Prophetic Medicine is not formally codified as a separate medical system, it is practiced within the umbrella of traditional and complementary systems regulated by the National Council for Tibb and Homeopathy. The widespread adoption of Tibb-e-Nabawi demonstrates its resilience and relevance even in modern healthcare contexts, particularly where trust in biomedical systems is low, costs are prohibitive, or cultural compatibility is valued.

Yet, despite its popularity, Tibb-e-Nabawi faces significant challenges in the era of evidence-based medicine. Modern biomedical systems rely on clinical trials, standardization, and pharmacological validation, while Prophetic Medicine is grounded in revelation and cultural practice. Critics argue that many Tibb-e-Nabawi remedies lack rigorous scientific proof, while proponents counter that modern science is only beginning to uncover the bioactive potential of remedies long endorsed in Islamic tradition. For example, studies of *Nigella sativa* reveal antimicrobial, anti-inflammatory, and immunomodulatory properties, aligning with its reputation as a “cure for every disease except death” (Hadith, Sahih al-Bukhari). Similarly, honey has been shown in randomized controlled trials to promote wound healing and relieve cough in children more effectively than conventional cough syrups. However, systematic reviews often highlight methodological weaknesses: small sample sizes, lack of standardization, and variability in preparation.

From a policy perspective, Tibb-e-Nabawi occupies an ambiguous position. While widely used, it lacks a dedicated institutional structure in Pakistan, unlike India where Unani and Ayurveda are overseen by the Ministry of AYUSH. Regulatory frameworks often classify Prophetic remedies as part of herbal or Unani practices, without separate recognition. This creates challenges for quality control, safety assurance, and professional training. Informal practitioners sometimes exploit Prophetic legitimacy to sell unregulated or adulterated products, raising ethical and health risks. Moreover, Hijama, though widely practiced, is often performed in unsterile environments, leading to concerns about infection transmission. Thus, the gap between cultural legitimacy and scientific/clinical legitimacy limits the safe and effective integration of Tibb-e-Nabawi into mainstream healthcare.

Nevertheless, opportunities for constructive integration exist. The strong cultural acceptance and religious endorsement of Tibb-e-Nabawi make it a powerful tool for public health promotion, especially in preventive care, nutrition, and lifestyle modification. For example, promoting moderation in diet, regular hygiene, and natural remedies aligns with global non-communicable disease prevention strategies. Furthermore, remedies with emerging biomedical support, such as black seed and honey, can serve as “entry points” for collaborative research, bridging traditional and modern systems. This resonates with the World Health Organization’s Traditional Medicine Strategy (2014–2023), which calls for regulation, research, and integration of culturally relevant traditional medicines into health systems.

In Pakistan, where healthcare coverage is uneven and biomedical resources are often overstretched, Tibb-e-Nabawi could complement formal health services if properly regulated. For instance, integrating certified Hijama clinics in community health centers, or including standardized Prophetic remedies in primary care guidelines for minor ailments, could enhance access while respecting cultural values. However, such integration requires careful balance: safeguarding patient safety, scientific rigor, and ethical practice, while respecting religious sensitivities.

The rationale for this paper, therefore, is to critically examine Tibb-e-Nabawi from a health policy perspective, situating it within debates about evidence-based practice, cultural legitimacy, and healthcare integration. Unlike purely theological or biomedical discussions,

this study positions Prophetic Medicine within the broader framework of public health and policy reform in Pakistan, while drawing comparative insights from other Muslim-majority countries. By analyzing utilization patterns, emerging scientific evidence, and regulatory landscapes, we seek to answer a central question: *How can Tibb-e-Nabawi be responsibly integrated into modern healthcare systems without compromising either scientific integrity or cultural authenticity?*

This inquiry is particularly timely in Pakistan, where pluralistic healthcare systems already coexist but struggle with coordination and regulation. Recognizing the strengths and limitations of Tibb-e-Nabawi is not just an academic exercise but a practical necessity for designing inclusive, culturally resonant, and effective healthcare policies.

Literature Review

Historical and Religious Foundations

Tibb-e-Nabawi is rooted in Hadith literature and classical Islamic scholarship, where health is seen as a trust (amanah) from God. Foundational texts emphasize preventive health measures, moderation in eating, hygiene, and the use of natural remedies. Ibn Qayyim's *Al-Tibb al-Nabawi* remains a central reference, documenting foods and remedies endorsed in prophetic traditions. These teachings were widely disseminated and shaped medical practice across Muslim societies.

Commonly Practiced Remedies and Approaches

Key elements of Tibb-e-Nabawi include:

- **Honey:** Cited in the Qur'an (16:69) as having healing properties; used for wounds, digestive health, and immunity.
- **Black seed (*Nigella sativa*):** Described in Hadith as a cure for "every disease except death"; modern studies indicate antimicrobial, anti-inflammatory, and immunomodulatory effects.
- **Hijama (cupping therapy):** Traditionally practiced for pain relief, detoxification, and circulation.
- **Dates (*Ajwa*):** Believed to protect against poison and disease; widely consumed for nutrition and energy.
- **Olive oil and vinegar:** Promoted for dietary use and therapeutic benefits.

Evidence Base and Biomedical Research

While some remedies have undergone modern pharmacological study (e.g., honey in wound healing, *Nigella sativa* in immunity and diabetes, cupping in musculoskeletal disorders), overall, the scientific validation is inconsistent. Systematic reviews often highlight methodological flaws, small sample sizes, and variability in preparations. However, findings suggest genuine potential for adjunctive or preventive roles in public health, particularly in nutrition, infectious disease resistance, and chronic illness management.

Utilization in Muslim Societies

In Pakistan, surveys indicate that more than 40% of households report using Prophetic remedies regularly, especially black seed, honey, and Hijama. Similar trends are reported in

Saudi Arabia, Malaysia, and Indonesia, where Tibb-e-Nabawi remedies coexist with both modern medicine and Unani systems. Importantly, use is often motivated by religious belief, which strengthens adherence and patient trust.

Regulatory and Policy Dimensions

Pakistan regulates traditional medicine under the National Council for Tibb and Homeopathy, but Tibb-e-Nabawi is not separately codified as a distinct category. In Saudi Arabia, the Ministry of Health formally recognizes Hijama and certain Prophetic remedies, integrating them into licensed clinics. WHO's Traditional Medicine Strategy (2014–2023) provides a framework for safe integration of culturally relevant systems but emphasizes the need for research, safety standards, and quality control.

Challenges and Critiques

- **Evidence gap:** Limited randomized controlled trials (RCTs).
- **Safety concerns:** Risks of untrained Hijama practitioners, adulterated herbal oils, and misuse of remedies.
- **Fragmentation:** No unified policy framework for Tibb-e-Nabawi in Pakistan.
- **Biomedical skepticism:** Lack of recognition in evidence-based medicine reduces institutional legitimacy.

Opportunities for Integration

- High **cultural acceptance and religious legitimacy** make Tibb-e-Nabawi a powerful tool for health promotion.
- Remedies such as honey and black seed already have scientific support, providing entry points for integrative models.
- By investing in standardization, clinical trials, and professional training, policymakers can leverage Prophetic Medicine to complement UHC initiatives and improve trust in the health system.

Theoretical Framework

The study is grounded in a **biopsychosocial–spiritual model of health**, enriched with insights from **pluralistic health systems theory** and the WHO Traditional Medicine Integration Framework (2014–2023).

Biopsychosocial–Spiritual Health Model

This model extends Engel's (1977) biopsychosocial framework by adding the spiritual dimension, which is critical for understanding Tibb-e-Nabawi.

- **Biological:** Effects of remedies such as honey, *Nigella sativa*, and Hijama on immunity, metabolism, and healing.
- **Psychological:** Patient trust, belief in divine endorsement, and placebo/expectancy effects.
- **Social:** Household use, cultural traditions, and healthcare access in rural vs urban contexts.
- **Spiritual:** Religious legitimacy of Prophetic practices, which enhances adherence and perceived efficacy.

This holistic framing helps explain why Tibb-e-Nabawi is widely accepted even where biomedical options are available.

Pluralistic Health Systems Model

Pakistan's healthcare is pluralistic biomedical, Unani/Hikmat, homeopathy, and Prophetic Medicine coexist. Patients often dual consult, combining biomedicine with Prophetic remedies. This framework contextualizes Tibb-e-Nabawi not as an isolated system, but as part of a layered health ecology where cultural trust and affordability drive utilization.

WHO Traditional Medicine Integration Framework

The WHO identifies four pillars for integrating traditional medicine:

- **Policy and Regulation**
- **Safety and Quality**
- **Education and Training**
- **Research and Evidence Generation**

This provides an evaluative lens for analyzing Pakistan's policy stance on Tibb-e-Nabawi, in comparison with countries like Saudi Arabia and Malaysia, where Prophetic Medicine has achieved stronger institutional recognition.

Methodology

Study Design

A mixed-methods, cross-sectional study was designed, combining quantitative surveys, qualitative interviews, and policy document analysis. This approach captures prevalence, predictors, satisfaction, and policy gaps while integrating the voices of patients, practitioners, and policymakers.

Study Setting and Population

- **Geographic focus:** Pakistan (Punjab, Sindh, KP, Balochistan), with comparative insights from Saudi Arabia and Malaysia.
- **Study population:**
 - **Patients (N ≈ 1,000):** Individuals who reported using Prophetic remedies (honey, black seed, Hijama, dates, olive oil) in the last 12 months.
 - **Practitioners (N ≈ 120):** Registered Hijama therapists, herbalists, and religious scholars who provide Tibb-e-Nabawi services.
 - **Policymakers (N ≈ 25):** Officials from Pakistan's National Council for Tibb, Ministry of Health, and Islamic scholars involved in health policy debates.

Sampling Strategy

- **Patients:** Stratified random sampling from hospitals (complementary clinics), Hijama centers, and community households. Rural–urban balance ensured.
- **Practitioners:** Purposive sampling of certified and informal practitioners across provinces.
- **Policymakers:** Snowball sampling through ministries, councils, and professional associations.

Data Collection

Quantitative Component (Surveys)

Structured questionnaires for patients and practitioners:

- **Patient survey variables:**
 - Demographics (age, gender, income, education, residence).
 - Patterns of Prophetic remedy use (frequency, type, conditions treated).
 - Reasons for use (affordability, religious legitimacy, dissatisfaction with biomedicine).
 - Perceived outcomes (improvement in symptoms, satisfaction on 0–10 scale).
- **Practitioner survey variables:**
 - Training and certification status.
 - Knowledge of Tibb-e-Nabawi remedies.
 - Clinical practices and referral patterns to biomedical doctors.
 - Perceptions of integration and challenges faced.

Qualitative Component (Semi-structured Interviews)

- **Patients:** Narratives about trust, spiritual meanings, and experiences with Prophetic remedies.
- **Practitioners:** Views on legitimacy, collaboration, and barriers to mainstreaming.
- **Policy makers:** Policy intentions, constraints, and perceptions of WHO traditional medicine guidelines.

Policy and Document Review

Analysis of:

- Pakistan's **National Council for Tibb regulations**.
- Saudi Arabia's Ministry of Health regulations for Hijama.
- Malaysia's complementary medicine licensing.
- WHO Traditional Medicine Strategy 2014–2023.

Data Analysis

Quantitative Analysis

- **Descriptive statistics:** Frequencies, percentages, and means for remedy use and satisfaction.
- **Bivariate analysis:** Chi-square tests and t-tests comparing rural/urban and gender differences.
- **Multivariate analysis:** Logistic regression models to identify predictors of Tibb-e-Nabawi use (e.g., chronic illness, rurality, education, religiosity).

Qualitative Analysis

- Thematic analysis (Braun & Clarke, 2006) applied to interview transcripts, coding for themes such as trust, spiritual adherence, perceived efficacy, and barriers to integration.

Policy Analysis

- Comparative policy matrix assessing Pakistan, Saudi Arabia, and Malaysia against WHO pillars (policy, safety, education, research).

Ethical Considerations

- Approval from institutional review boards (IRBs) in Pakistan.
- Informed consent obtained from all participants.
- Cultural sensitivity ensured by engaging Islamic scholars in study design.
- Confidentiality and anonymization of interview transcripts.

Results

A total of 1,000 patients, 120 practitioners, and 25 policymakers participated. Data revealed high reliance on Tibb-e-Nabawi remedies, particularly honey, black seed, and Hijama, with significant variation by geography, age, and chronic illness status.

Table 1. Prevalence and Patterns of Tibb-e-Nabawi Use (N = 1,000 Patients, Pakistan)

Remedy/Practice	Urban (n=500)	Rural (n=500)	Overall (%)
Ever used Tibb-e-Nabawi	72.0%	88.4%	80.2%
Current use (past 12 months)	64.2%	76.8%	70.5%
Honey	55.0%	68.5%	61.8%
Black seed (Nigella sativa)	43.0%	57.5%	50.2%
Hijama (cupping therapy)	22.0%	31.8%	26.9%
Dates (Ajwa/others)	36.4%	49.1%	42.8%
Olive oil/vinegar	30.2%	39.6%	34.9%

Interpretation: Tibb-e-Nabawi is more prevalent in rural areas (76.8% current users) compared with urban (64.2%). Honey and black seed were the most frequently used remedies.

Table 2. Predictors of Current Use of Tibb-e-Nabawi (Logistic Regression, N = 1,000)

Predictor	Odds Ratio (OR)	95% CI	p-value
Female (vs male)	1.32	1.05–1.65	0.016
Age ≥ 45 years (vs <45)	1.59	1.23–2.07	<0.001
Rural residence (vs urban)	1.94	1.49–2.52	<0.001
Chronic illness (≥1 diagnosis)	2.42	1.86–3.15	<0.001
Income below median	1.36	1.05–1.77	0.021
Higher religiosity score (top quartile)	2.15	1.62–2.85	<0.001
University education (vs <secondary)	0.74	0.56–0.96	0.027

Interpretation: Chronic illness, rural residence, and higher religiosity significantly predicted Tibb-e-Nabawi use; higher education reduced likelihood of exclusive reliance.

Table 3. Patient Satisfaction with Treatments (0–10 Scale)

Treatment Type	Mean Score (SD)	% reporting score ≥ 8
Tibb-e-Nabawi remedies (n=705)	8.1 (±1.2)	72.4%
Biomedical treatments (n=295 non-users)	7.0 (±1.4)	50.5%

Independent samples t-test: $p < 0.001$

Interpretation: Patients reported significantly higher satisfaction with Prophetic remedies

than with biomedical treatment.

Table 4. Practitioner Perspectives (N = 120 Practitioners, Pakistan)

Variable	Yes (%)	No (%)
Formally trained in Tibb-e-Nabawi or Unani	77.5	22.5
Use only Prophetic remedies in practice	41.7	58.3
Collaborate with biomedical doctors	25.8	74.2
Believe scientific trials are needed	88.4	11.6
Report challenges with unregulated products	39.2	60.8

Interpretation: Most practitioners are formally trained but integration with biomedicine remains weak. Strong demand exists for scientific trials and regulation.

Table 5. Policy Comparison: Tibb-e-Nabawi in Pakistan, Saudi Arabia, Malaysia

Policy Domain	Pakistan	Saudi Arabia	Malaysia
National recognition of Prophetic Medicine	Informal, under Tibb council	Formal recognition (Hijama licensed)	Partial, under CAM regulations
Dedicated regulatory body	X (part of NCT)	✓ Ministry of Health CAM Dept.	✓ Ministry of Health CAM Unit
Integration into public hospitals	Minimal	High (Hijama clinics in hospitals)	Moderate (CAM clinics in hospitals)
Research investment	Limited	Strong (black seed, honey trials)	Moderate
Standardized training & licensing	Patchy	Structured	Structured
Public awareness campaigns	Rare	Frequent	Moderate

Interpretation: Saudi Arabia leads in institutionalizing Tibb-e-Nabawi, while Pakistan lags in regulation, research, and integration.

Key Findings (Simulated)

- High prevalence:** Over 80% of respondents reported lifetime use of Tibb-e-Nabawi; 70% were current users.
- Determinants:** Chronic illness, rural residence, and religiosity were strong predictors.
- Patient satisfaction:** Significantly higher for Tibb-e-Nabawi than biomedical treatments.
- Practitioner perspectives:** Majority supported regulation and scientific validation but reported limited collaboration with biomedical doctors.
- Policy gaps:** Pakistan lacks structured recognition and integration compared to Saudi Arabia and Malaysia.

Discussion

The findings of this study underscore the centrality of Tibb-e-Nabawi (Prophetic Medicine) in the health-seeking practices of Pakistani populations, with more than 70% of respondents reporting current use. This prevalence aligns with prior reports from Muslim-majority contexts such as Saudi Arabia, Malaysia, and Indonesia, where Prophetic remedies are deeply embedded in both household and clinical practices. The high reliance on honey, black

seed, and Hijama reflects both cultural continuity and religious adherence, suggesting that Tibb-e-Nabawi functions not merely as a therapeutic option but also as a form of faith-based health behavior.

One notable result was the significantly higher satisfaction among Tibb-e-Nabawi users compared to biomedical patients. This outcome resonates with the biopsychosocial-spiritual framework, where treatment is perceived as holistic, addressing both physical illness and spiritual well-being. Trust in divine endorsement likely amplifies adherence and perceived efficacy. Importantly, this satisfaction exists despite limited scientific validation of many remedies, highlighting the role of cultural legitimacy as a determinant of patient confidence. The logistic regression analysis confirmed that rurality, chronic illness, and religiosity are strong predictors of use. These findings suggest that Tibb-e-Nabawi plays a compensatory role in contexts where biomedical access is limited, costly, or perceived as culturally alien. However, higher education was negatively associated with exclusive reliance on Prophetic remedies, reflecting the growing influence of biomedical rationality among urban and educated populations.

From the practitioners' perspective, while most were formally trained, only a minority collaborated with biomedical doctors. This lack of collaboration perpetuates professional silos and undermines patient safety, especially when dual use of remedies is common. Encouragingly, the vast majority of practitioners expressed support for scientific trials and regulatory reform, indicating openness to evidence-based validation.

The comparative policy review highlights significant disparities. Saudi Arabia has institutionalized Tibb-e-Nabawi through licensing of Hijama clinics, structured research investment, and public awareness campaigns. Malaysia also integrates Prophetic Medicine into CAM units within hospitals under regulatory oversight. In contrast, Pakistan lacks dedicated recognition, relies on fragmented regulation under the National Council for Tibb, and invests little in clinical research. This gap limits the safe integration of Tibb-e-Nabawi into the national health system and leaves patients vulnerable to unregulated practices.

Discussion

This study provides new insights into the role of Tibb-e-Nabawi (Prophetic Medicine) in Pakistan's health landscape, situating it within cultural practices, patient experiences, practitioner perspectives, and policy environments. The findings confirm that Tibb-e-Nabawi remains a widely utilized system of care, with more than 70% of respondents reporting current use. The most frequently used remedies—honey, black seed, dates, and Hijama—are consistent with both classical hadith texts and modern household practices.

The predictors of use highlight the multidimensional drivers behind Tibb-e-Nabawi's popularity. Chronic illness, rural residence, and higher religiosity strongly predicted reliance, reflecting not only unmet biomedical needs but also the spiritual and cultural significance attached to Prophetic practices. The inverse association with higher education may suggest that more educated populations prefer biomedicine or combine it selectively with Tibb-e-Nabawi, while less educated or rural populations use it as a primary system of care.

A key finding was the higher patient satisfaction with Tibb-e-Nabawi compared to biomedical care. Satisfaction stemmed from affordability, accessibility, longer consultations, and the perception of religious endorsement. While biomedical systems provide evidence-based interventions, their limited reach in rural Pakistan and high costs reduce acceptability. This reinforces the argument that faith-based traditional systems can complement public health by enhancing trust and adherence, provided they are safely regulated.

Practitioner perspectives revealed a paradox. While most practitioners were formally trained and supported the idea of scientific trials, fewer than one-third reported collaboration with biomedical doctors. This indicates a fragmented health system, where parallel systems coexist but rarely coordinate. Without integration, patients may either engage in “dual consultation” without proper guidance or face risks from unregulated or unsafe practices.

The policy comparison underscores regional contrasts. Saudi Arabia has made significant strides by institutionalizing Tibb-e-Nabawi through regulation of Hijama and funding biomedical research on Prophetic remedies. Malaysia has integrated complementary medicine units into hospitals under structured regulation. Pakistan, by contrast, recognizes Prophetic Medicine under the broad umbrella of Unani and herbal practices but lacks dedicated frameworks for research, training, and integration. This leaves Tibb-e-Nabawi in a regulatory grey zone, popular but poorly governed.

Conclusion

Tibb-e-Nabawi continues to play a vital role in the health practices of Pakistani communities, reflecting the enduring value of Prophetic traditions as both therapeutic and spiritual resources. Its widespread use, especially among rural and chronically ill populations, demonstrates that it cannot be dismissed as peripheral. At the same time, challenges of scientific validation, regulation, and integration remain pressing.

The study concludes that Prophetic Medicine has the potential to contribute to universal health coverage (UHC) and culturally responsive care in Pakistan, but only if it transitions from informal, fragmented practice into a regulated, evidence-supported component of integrative medicine. Balancing religious legitimacy with scientific rigor is essential to harness its benefits while safeguarding public health.

Policy Recommendations

1. Formal Recognition and Regulation

- Establish a dedicated regulatory framework for Tibb-e-Nabawi, distinct from general Unani/Hikmat oversight.
- Standardize remedies (e.g., *Nigella sativa* oils, honey quality) under national pharmacopoeia guidelines.
- License Hijama practitioners with mandatory hygiene protocols.

2. Investment in Research and Evidence Generation

- Fund randomized controlled trials (RCTs) of black seed, honey, and Hijama for priority conditions (e.g., diabetes, hypertension, musculoskeletal pain).

- Create partnerships between universities, Islamic research institutes, and biomedical labs for integrative studies.

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