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Research Article

From Yorubaland to Punjab: Culture, Reconstruction in Indigenous Medical Systems and Imperial Medicine, 1900-1928

*[1]Olusola Bamidele Ojo, [2]Huma Pervaiz, [3]Tahir Kamran

About Article

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About Author

[1] Health Care Agency, Ministry of Health, Seychelles

[2] Department of History, Institute of Global and Historical Studies, Government College University, Lahore, Pakistan

[3] Department of Liberal Arts, Beaconhouse National University, Lahore, Pakistan

Contact @ Olusola Bamidele Ojo
ojoolusola302@gmail.com

ABSTRACT

From the colonial era, settlers 'technologies including imperial medicine have shaped the social, cultural and economic landscape of the colonies in diverse dimensions. In the post-modern world, global medicine still has the trappings of health inequities and imperialism, particularly in lower- and middle-income countries and the Global South. In this regard, this research article examines how Yoruba medicine practitioners deployed their cultural sanctity to withstand the domineering influence of imperial medicine in the early twentieth-century. In the same era, we compare this phenomenon with how Hakims and Vaids in colonial Punjab deployed Urdu literati to reconstruct their social relevance. Thus, we argue that Yoruba medicine was a site of cultural reformation while Punjab medicine was a site of social reconstruction. This historical research engaged archival sources and suitable secondary data, and exposed varied reactions of Indigenous medical practitioners to colonial medical institutions in the early 20th century. A study of this caliber highlights the inextricable interface between culture, medicine, and technology in the context of colonialism. It reinforces the significance of acculturation in cultural encounters to forestall cultural emasculation.

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1. INTRODUCTION

The colonial era heralded remarkable socio-political transformation, technological, and scientific changes in erstwhile colonies that influenced health systems, practitioners, and institutions in equal measure. This historical article investigates the reactions of indigenous medical formations to the transformation wrought by imperial medicine. The central focus is how Indigenous medical practitioners achieved continuity within the social, cultural, and scientific change in the context of imperial medicine in early twentieth-century Yorubaland and Punjab. The scope of this study encompasses the cultural and colonial comparative contexts of early twentieth century Yorubaland and the Punjab. In this study, we deploy medicine as a metric to analyze and critique colonialism in comparative colonial settings. In the contemporary era, although the focus of study is shifting to global medicine, the academic interest in imperial medicine is as robust as before (Bivins, 2013). The recent unfair treatment of the Global South regarding the disproportionate and unequal distribution of COVID-19 vaccinations brings to the fore the trappings of imperial medicine in contemporary global medicine (Tatar *et al*., 2022). In 2020, in the ravaging heat of COVID-19 menace, the WHO treated the discovery of COVID-19 organics by Madagascar with swift skepticism and advised against the consumption of the remedies before calling for proper clinical trials (Tih, 2020). These health inequities are a testament to the prevailing imperial medical ideologies, even in the post-modern era. Hence, this piece compares and examines the reactions and responses of Indigenous medical practitioners to the hegemonical influence of imperial medicine at colonial intercourse and beyond.

The scholarship of imperial medicine has evolved over the years. Nineteenth-century historians primarily conceived colonial medicine as a technology to keep sailors, traders, and settlers safe in a hostile environment, it was only later that it was viewed as a gift of civilization to colonized people. However, from the twentieth century, historians focused on the themes of racial tension and oppression resulting from lopsided healthcare development. Scholars such as MacLeod & Lewis (1988), Arnold (1988), Lyons (1992) and Arnold (1993) explored themes connecting colonialism with diseases, hegemony and inequality. The scholarship in the twenty-first century has shifted to analyzing different groups of people. Such groups include indigenous healers, indigenous medical practitioners trained in colonial models or in Europe, local government workers such as local and expatriate, and sick natives. Scholars such as Abdullah (2011), Saini (2016), and Sivaramakrishnan (2005) have investigated the role and impact of colonial medicine on Indigenous medical practitioners under colonial rule.

2. LITERATURE REVIEW

The most recent research in colonial medicine focuses on complex connections between colonialists, and the colonized. They focus on the colonized societies and localities. This is because it has been observed that excessive focus on colonizing societies, for instance, Britain remains one of the impediments to comprehending other colonial contexts. In this regard, to understand colonial legacies and ideologies across colonial contexts, we need robust comparative scholarship. Poonam Bala, a medical historian, has taken the lead in this regard by comparing colonial medical experiences of India with South Africa in her work (Bala, 2016). However, comparing broader transnational contexts of colonial medicine and its institutions tends to obscure local responses and reactions to Western medical intervention on a district and regional basis. As Falola and Heaton (2006) note, identifying similar trends and patterns is imperative for analysis within specific socio-political frameworks of different societies. Thus, this rationalizes our comparative study in the regional settings of Yorubaland and Punjab in the early twentieth century.

Regarding the theme of this study, no previous research has attempted to compare the colonial medical contexts of Punjab and Yorubaland. In colonial India including Punjab, some studies have highlighted how the Vaids and Hakim lost their socio-cultural relevance and state patronage under colonial rule from the late nineteenth century (Saini, 2016; Sivaramakrishnan, 2005). Regarding the component medical traditions, only a handful of research in Punjab contexts attributed the continuity of Ayurveda to the cultural sanctity of local canons and its dominance as an indigenous medicine from the ancient Indian era. For instance, Charlie (1976) and Kumar (1997) located Ayurveda as an indigenous science, which triggered cultural revitalization and transformation in early twentieth century India. Poonam Bala (2016) argued that Ayurveda had no appreciable impact on the Indian caste system because it remained one of the sites of cultural regeneration. This article, however, challenges this widely accepted assertion by highlighting that social class reconstruction of rural intellectuals provoked by engagement of local print technology enhanced the social image of local medical practitioners. Hence, the reconstruction efforts of the practitioners in tandem with colonial modernity validated their canons in the hegemonical presence of imperial medicine.

In African settings, Baronov (2008) posited that the holistic nature of African ethno-medicine, including Yoruba medicine warranted their status as a dualised form of allopathic medicine because of their receptive approach to other cultures and empirical approach. In a similar vein, Amusa & Ogidan (2017) and Borokini & Lawal (2014) stated that Yoruba medicine was able to withstand the barrage of colonization and the aftereffects of civilization because practitioners are receptive and collaborative with other cultural medical practices. In this light, this work aims to reinforce the assertion that Yoruba medicine was a site of cultural reformation or revitalization due to the intricate link of their culture with traditional healing systems.

3. METHODOLOGY

The historical article examines and compares the reactions and responses of indigenous medical practitioners in Yorubaland and Punjab to the deployment of imperial medicine between 1900 and 1928. The study deploys a persuasive and comparative historical approach and methodology. Regarding the time frame of this study, biomedicine emerged in the mid-19th century and underwent evolution into the Germ theory in the late 19th Century. As of the 1890s, Ronald Ross and Alexander Yersin

among other scientists had discovered the causative agents of Malaria and Plague respectively. By 1900, biomedicine had been successfully deployed to manage epidemics in most colonized states including Punjab and Yorubaland. As of 1928, biomedicine has become a state-recognized healing system and has demonstrated its value in the diagnosis, treatment, investigation, and prevention of diseases in most colonies. Specifically, in Punjab, the Epidemic Disease Act was promulgated in 1897. This approved the increment in funding for epidemics and set up the foundation of public health in colonial India including Punjab. Moreover, in 1897, the Medical Registration Act, which enforced the registration of Western medical doctors and disregarded the practice of indigenous Indian practitioners was promulgated. These medical policies crystallized into the main public health policies in colonial India and became effective in the 1900s. Similarly in Yorubaland, the first National Health Policy was promulgated in Lagos in 1893. However, it became effective in the whole of Yorubaland from 1900, when the whole region fell under British rule. This assertion validates the time range of this study. This antique study deployed literature from Indigenous medical practitioners, print journals, relevant textbooks, and suitable secondary sources. The primary data were sourced from Punjab Archives and Library in Lahore, Pakistan and Ibadan Archives in Nigeria. The archival sources were cross-referenced and subsequently correlated with established and reliable primary and secondary sources to ascertain their reliability and reduce bias in data analysis and conclusion in this research. For example, archival data in Punjab contexts were corroborated with the findings of Sivaramakrishnan's revered book. We cross-referenced and correlated the archival data in Yoruba contexts with established and proven articles on the subject to reduce bias.

3.1. Comparing socio-cultural contexts of colonial Yorubaland and Punjab

The Punjab, the land of the five rivers, namely Beas, Ravi, Chenab, Jhelum, and Sutlej is a significant historical, geopolitical, and socio-cultural area in South Asia (Talbot, 1988). The colonial Punjab was a landlocked area in the North West corner of the Indian Subcontinent. The Punjab comprised approximately ten percent of the British India area and population (Talbot, 1988). However, its agricultural wealth and military significance gave it a huge political significance disproportionate to its size. The East Indian Company annexed Punjab in 1849 by defeating the Sikh after two Anglo-Sikh wars. Punjab was one of the latest regions that succumbed to British rule in the Indian continent. Then, Punjab was overwhelmingly rural and largely agrarian built on a subsistence basis. In 1885, the British administration began constructing the world's largest irrigation canal system, creating 14 million acres of irrigated land by 1947 (Ali, 1988). The Punjab consequently underwent an agricultural revolution with arid subsistence farming being replaced with commerce-oriented agriculture.

Regarding the communal structure of Punjab, Muslims made up over half of its population, though there were variations in the communal distribution (Talbot, 1988). The western areas were dominated by the Muslims who basically had agrarian ways of life and lived mostly in the villages. However, the eastern area had more Hindus and a large Sikh community outnumbering the Muslims. The Hindus and Sikhs had a more urban lifestyle. The presence of these three powerful communities led to a prolonged history of communal violence due to power struggles. (Talbot, 1988). The British responded by strengthening allegiances of kinship and tribes which cut across or competed with communal partitions.

In Punjab, the political power depended on the ownership and control of land and this defined the composition of the social structure. There were five main classes in the predominantly rural settings of colonial Punjab. The rural elites who owned enormous land occupied the top of the social stratum, followed by the peasant cultivators who owned, and worked their landholdings. Next, there were peasants who owned small parcels of land. Then, there was the village servants' class who provided goods and services to the land-owning groups in return for their crops, and finally the landless cultivators who depended on landowners for employment occupied the lowest rung of the social ladder (Talbot, 1988). The British recognized this system and aptly decided to strengthen the existing political movements. It allowed them to control large rural populations through indirect rule via land owners who served as intermediaries.

Concerning Yorubaland, the term Yoruba refers to the culture, religion, and a unique group of people inhabiting the southwestern region of contemporary Nigeria. They are also found in the diaspora such as Cuba, Brazil, and other region of the Caribbeans due to the dynamics of the slave trade, and the nineteenth-century Yoruba inter-tribal wars (Onadeko, 2008). The historical Yoruba developed out of earlier Niger-Volta populations as far back as the First millennium BCE (Adeyemi, 2016). The Yoruba belong to the same ethnic origin, but they have a constellation of different tribes. They speak the central language of Yoruba, although the tribes have a variation and diverse tones of the original language. In contrast to the predominantly rural pre-colonial Punjab, the Yoruba were among the most urbanized and civilized groups in Africa. Before the advent of the British, most Yoruba already lived in well-structured urban centers, and boasted of advanced cities such as Ile-Ife, Oyo, and Abeokuta (Bellagamba *et al.*, 2013).

As opposed to the Punjabi colonial context, the political and cultural dynamics of the Yorubas were adversely impacted by the trans-Atlantic Slave trade from the late fifteenth century to the early nineteenth century. The British annexed Punjab in 1849 and also conquered Lagos, a vital port city, some years thereafter on the southwestern coast of the present Nigeria. In 1861, Lagos was annexed after the British meddled in the turbulent kingship tussle of the mid-nineteenth century Lagos (Falola & Akinyemi, 2016). Lagos had been a dominant port city noted for trading with the Europeans in palm oil, cotton, cocoa, and slaves, since the early sixteenth century. Therefore, the British adopted Lagos as their colonial capital (Elebute, 2013). The coastal city consequently underwent subsequent economic, industrial, and administrative significance like colonial Lahore (Kamran & Talbot, 2017).

Agriculture was the major preoccupation of the Yorubas. In comparison to colonial Punjab, land was a means of socio-economic stratification. However, the social gap between the

landowning and the serf classes, who tilled the ground for the former was not rigidly defined. Professionals such as hunters, sculptors, wood carvers, and blacksmiths occupied the middle rung of the social ladder, and some owned substantial pieces of land, predominantly from family or ancestral sources (Salami, 2006). Another reason was that labor and other forces of production were predominantly communal. People voluntarily offered their labor for farming or other forms of productive activities from which they also benefited.

In contrast to the communal structure of the colonial Punjab comprising predominantly the Hindus, Muslims and Sikhs, the Yoruba were mainly polytheistic in the colonial era. The Yoruba worship Almighty God referred to as Olodumare, through many deities referred to as Orishas. They believe the Orishas act as direct messengers and the intermediaries between the physical beings and the supernatural Almighty God. The Yoruba generally believe Olodumare has overwhelming control over the creation of mankind and the entire universe (Abimbola, 2005). Although, there were pockets of Muslim slaves bought from the trans-Saharan trade in the early nineteenth century, and the army of returning former slaves who were Christians, their social settings were largely dominated by adherents of the traditional Yoruba Religion (Olupona, 1993).

3.2. Comparing Punjab and Yoruba Medicine

Now, it is germane to point out specific similarities between Yoruba medicine and its Punjabi counterparts. We aim to posit that the two systems have the same ancestral origin because of striking uniformity in their ideological foundations and practices. The practices of Yoruba spiritual baths (Turkish baths in Unani) and Ayurveda baths represent a profound semblance in their therapeutic traditions. While Ayurveda deploys Panchakarma to purify and rid the body of impurities that might provoke illness, Yoruba medicine devises spiritual baths for a similar purpose (Borokini & Lawal, 2014, Baheti *et al.* 2025). There are other remarkable comparisons. The emphasis on the use of herbs and dietary restrictions to treat diseases and ailments remains central to both medical traditions. The deployment of oblations, exorcism, astrology, divination, and fortune-telling are common with Yoruba medicine and Ayurveda. The quest to maintain synergy between the physiological realm of the human body and its social and spiritual components remained the central ethos of the conception and management of ailments in both traditions. This phenomenon also appeared to shape their foundational principles. As highlighted previously, Ayurveda maintains that the body is composed of three doshas or humor, an imbalance in the tridoshas results in diseases and illnesses (Baheti *et al.* 2025; Jaiswal & William, 2016). Likewise, Yoruba medicine ascribes illnesses to the imbalances resulting from the seven Orishas who control the focal systems of the body (Sawandi, 2020). As it applies to Yoruba medicine where the Supreme Beings (Olodumare) bequeath his loyal deity with supreme healing intelligence in the mode of Ifa Corpus, Atreya also received similar knowledge from Lord Brahma in sacred Hindu texts. This laid the foundational ideology for Ayurveda as the one Ifa Corpus (cosmic intelligence) did in Yoruba contexts.

Exploring the historical contexts of both systems concerning their origin and terminologies might prove an interesting proposition in our quest to prove similarities in the ancestry of Yoruba and Ayurveda medicine. It is no coincidence that the growth and development of established medical traditions started from 2000 BCE to 500 BCE (Sawandi, 2020). This corresponds to the era of the River Nile civilization with the agglutination of cultural intercourses involving metallurgy and architecture. The transfer of herbal knowledge to the Yoruba and the East Indians as well as the Europeans through the Greeks was also plausible. In this regard, the River Nile, possibly served as a melting point of cultural and technological advancement to other parts of the ancient world especially Yoruba and Indian medicine. Another point to corroborate this assertion is the striking similarities in the linguistic terminologies of Ayurveda and Yoruba medicine. Apart from resemblances in the pronunciations, many words in both systems have similar meanings and spellings. Therefore, they have a historical correlation since this could not have been coincidental or arbitrary. The table below highlights the similarities in common terminologies used in both medical traditions.

Table 1. Similarities in Ayurveda and Yoruba Medical Terminologies.

Yoruba	Ayurveda
Osiris	Iswara
Ishtar	Ishvara
Samad	Samadhi
Orisha	Dosha
Maye	Maya
Ogun	Guna
Obatala	Vata
Khepsh	Kapha

Source: Tariq Sawandi, '' Yorubic Medicine: The art of divine Herbology

The table above highlights the linguistic and plausibly, racial similarities between Africans and East Indians. For instance, Ayurveda traditions depended on three doshas, whose imbalances cause ailments. Likewise in Yoruba medicine, discrepancies in the proportions of Orishas trigger illnesses. As stated initially, these striking parallels in pronunciation, spellings, and meanings in the "main terminology" that defines the principles and practices of both traditions could not have been coincidental. Language represents an immense defining feature of customs, traditions, and norms in racial climes; hence it could be rationalized that people who share languages have the same ancestry.

4. RESULTS AND DISCUSSION

Cross-cultural exchange in the ancient era offered another explanation. Ayurveda probably developed from cultural intercourse and influence from other ancient medical traditions. As posited by Sawandi, 'Ayurveda developed

from mutual contact and inspiration from ancient societies such as the ancient Sumerians, Babylonians, Egyptians and Dravidians (Sawandi, 2020). In the same vein, the Yorubas were an integral component of Ancient Egypt. Hence, they had an appreciable cultural fusion with the Egyptians, as well as their medical traditions. According to Olumide Lucue, they were North Eastern Africans who existed in ancient Egypt before journeying across River Niger to their present abode (Anta Diop, 1992). He corroborated his claim with the remarkable similarities in language, belief system, and culture. In this regard, the argument that Yoruba medicine is firmly rooted in ancient Egyptian cosmology seemed plausible and rational. As already shown, similar ideological thrusts and linguistic analogies between Yoruba medicine and Ayurveda proved mutual contact and influence with Egyptian cosmology in the ancient era.

However, subsequent growth and development of both traditions differed due to different historical, cultural, and political encounters spanning many centuries from the ancient era. Among these evolutionary changes, the advent of Western medicine in the socio-cultural spaces of the colonized remained fundamental. It surely elicited reactions from custodians of indigenous medical traditions. The responses of local medical practitioners to the domineering influence of Western medicine in early twentieth-century Punjab and South West Nigeria would be the subject of subsequent narratives.

4.1. Local Medical Practitioners, Culture and Reconstruction 1900-1928

In colonial Punjab, the traditional intellectuals such as Hakims, Vaids, and Jurrah lost their socio-cultural relevance with the annexation of Punjab in the mid-nineteenth century. The colonial handling of various epidemics especially plague management in the early twentieth century became a pretext for recasting indigenous medicine as a dualised form of its western counterparts. The somewhat intrusive approach of British plague campaigns as well as its apparent ineffectiveness undermined local support. This ostensibly enhanced the course of local medical practitioners. They utilized this phenomenon to reconstruct their socio-political identity through Urdu print technology within the emerging urban settings of Punjab.

In October and November of 1897, some cases of plague were reported in Jullundur and Hoshiarpur districts in Punjab (Punjab Home Medical and Sanitary Proceedings, 1898). In January 1898, a resolution to tackle this contagion in Punjab was adopted by the Government of India Epidemic Disease Act (Punjab Home and Sanitary Proceeding, 1898). This plague policy provided the necessary framework for curtailing the spread of the epidemic in Punjab. It stipulated strict surveillance and early diagnosis of the plague, the complete evacuation of plague-infested patients as well as his households with thorough disinfection, camp-based segregation of contacts, and relations of plague patients. To foster maximum local support for this regulation, the British relied on local mediation and collaboration in Punjab. The British incorporated Vaids, Hakims, Jurrah, and Punjabi elites to foster better outcomes via community participation and involvement. However, they failed to understand the influence of the emerging Punjabi elites and the existing social order dominated by rural intellectuals. For instance, they started voicing their opinion in the public sphere of Punjab in 1880s. The educated public deployed the western media such as the Tribune to demand accountability during the 1881 cholera epidemic in Punjab (Sivaramakrishnan, 2005). This emerging social class was a threat to the local power relations and power structures dominated by rural intellectuals. In this regard, competition for the socio-political dominance and identity seemed inevitable. Local mediation and co-option of rural intellectuals into mainframe plague as communal functionaries encouraged them to recreate a new social identity with Urdu literati.

Earlier plague tracts published from 1903-10 by notable vaids publicists such as Bhai Mohan Singh Vaid and Thakut Dutt Sharma displayed the humanitarian disposition and social significance of Indigenous medical traditions (Sivaramakrishnan, 2005). Some plague tracts focused on health education and promotion to ward off plague infection rather than the curative focus of allopathic medicine. They also tried to mobilize public support as well as warn the discerning public about the influence of quacks. The local medical practitioners sought social legitimacy to increase their patronage and redefine their cultural significance in the dynamic Punjabi landscape of the early twentieth century. To achieve this aim, they sought to influence urban patrons and men of authority and wealth to gain wider public acceptance. Bhai Mohan Singh captured this in his plague track as he tried to whip up public support for Ayurveda.

The declining prestige of Ayurvedic learning can be traced to two main reasons. The first being that we lack support from the ruler, secondly our own people do not give it sufficient attention… Another patriotic citizen who observe this attitude …. start to believe (Ayurvedic) knowledge to be false and Hindi Vaids to be ignorant (Singh, 1903).

In a similar vein, Indigenous medicine practitioners also deployed plague tracts to solicit government patronage by seeking legitimacy for their plague prescriptions. They maintain that such remedies were rooted in age-long research in classical texts. This was imperative to refute the popular rhetoric of irrationality of Indian medical traditions – the mainstream discourse that accounted for the marginalization of Indian medical practitioners. In this light, some vernacular plague tracts advocated for state patronage of Indian medical traditions.

European Doctors and native Hakims are divided in regard to the methods which should be adopted to stamp out the bubonic plague as the hakims cite old medical authorities in support of their contention; Government should not treat their opinions with indifference and should at least give a trial to the remedies as suggested by them (Sharma, 1905)

Apart from sourcing for public support through widespread vernacular publication in the plague moments of Punjab, rural intellectuals also challenged the rhetoric of primacy of allopathic medicine. It was unsurprising because in the early period of Bubonic plague, the role played by rats in plague transmission of the causative bacterium, Yersinia Pestis, was poorly understood until 1905 (Forrester, 2014). Therefore, the British privileged strict sanitary measures to curb the menace

in the early plague period. The mortality rates kept mounting despite intensified inoculation efforts, disinfection of infected houses, and evacuation into plague camps. Consequently, it became a pretext to challenge the primacy of imperial medicine in the Punjab public landscape. Leading this charge were the rural intellectuals. They deployed the emerging powerful tool of colonial modernity. They used print media to reconstruct indigenous medical traditions as being part of rational and textual traditions. Local medical practitioners such as Bhai Mohan Singh and Pandit Thakur Dutt Sharma located their practices and medical therapies regarding the contexts of epidemics in the interpretations of ancient Ayurvedic texts like the Sushrut Sashita (Sivaramakrishnan, 2005). Mohan Singh wrote a vernacular tract, Mahamari Daman in 1903 (Singh, 1903). It contained a wide range of such interpretations to the lay public (Singh, 1903).

They assumed the role of physician cum translators who educated the public regarding Ayurveda management plan for plague-related illnesses. In this regard, they usually engaged the lay public to embrace indigenous medicine because it aligned with their customs and age-long traditions as opposed to imperial medicine. They argued that colonial medicine threatened desi or the local traditions and belief system of the Punjabis. Mohan Singh raised this pertinent issue in his popular plague tract.

Why do we continue to be attracted by foreign medicines? Nearly all the cures in this book are desi, for desi [Ayurvedic] medicine ……is more beneficial than all other types of medical treatment. Angrezi medicines can ruin our religion while the desi do not do so (Singh, 1903).

In light of the above argument, they provided various desi (local) drugs that were deployed to manage plague patients as well as maintain a sanitary environment. These locally made preparations offered ready alternatives to Western plague medications. For illustration, rural intellectuals presented the ‘’ Ras Kapoor ‘’ lotion as an alternative to perchlorate mercury lotion used by Western-trained doctors. Desi-phenyl, which could be prepared at home, could act as an efficient substitute for phenyl that was widely prescribed in medical institutions (Singh, 1903). They also emphasized the significance of dietary recommendations to prevent plague infections as recommended in Ayurveda therapeutics traditions to guide the lay public.

The indigenous medical practitioners in India including Punjab also challenged the stipulations of the Medical Registration Act that undermined their socio-cultural relevance from the late 19th century. The colonial government enacted the Medical Registration Act in 1897 to regulate the practice of medicine among Western medical practitioners in India including Punjab (Sivaramakrishnan, 2005). The Act stipulated that only qualified and trained doctors from Western medical institutions could be described as "qualified doctors". These qualifications were secured by admission through a regulatory body such as the medical council. The Medical Registration Act provided certain privileges for "qualified" doctors such as state recognition and patronage, the authority to claim fees in courts, and the power to sign death certificates and other official declarations. This Act asserted the legitimacy of Western medical practice over its indigenous counterpart based on professional status. Perhaps more central to this Act was the "infamous conduct" that forbids a Western doctor to employ unqualified assistants or associate professionally with unqualified personnel. From the 1860s, when Lahore Medical College and other medical establishments were established, some Vaids, and Hakims have undergone western-based training and served in various subordinate medical services (Sivaramakrishnan, 2005). In light of the new regulation, all Indian practitioners were merged with untrained and unqualified medical men as quacks.

As expected, the implementation of the Medical Registration Act triggered widespread opposition from Indigenous medical practitioners. Although Vaid publicists’ leaders had formed various organizations in the late nineteenth century, the most impactful societies were established in the years following the enactment of the Act. Notable Punjabi practitioners took active parts in conferences and were key members of the standing and executive committees of these bodies. Hakim Ajmal Khan co-opted Pandit Thakur Dutt in outlining the constitution of the All India Vaid-Unani Tibbs Conference in Delhi (Sivaramakrishnan, 2005). These organizations protested the ground on which they have been declared as "unqualified" through various debates and vernacular reports in annual conferences. They also sought to demarcate institutional and professional boundaries for their canons.

Concerning attendance and local-level participation of Punjabi practitioners in these conferences, many hakims and vaids like Bhai Mohan Singh, Hakim Abu Tarab, and Vaid Sahib Dayal were all editors of conference journals. Moreover, they were present at conference sessions held at Amritsar and Lahore (Sivaramakrishnan, 2005). The emerging issues concerning the monopoly of leadership by Delhi-based practitioners and control of resources triggered the splitting of these conferences along provincial and district levels. By the mid-1920s, influential bodies such as Punjab Tibbs Conference and Punjab Vaid Mandal had sprouted out of the parent organization (Sivaramakrishnan, 2005). At the district level, these committees were more efficient in mobilizing human and capital resources with rural associates to engender local support and patronage. In this sense, this promoted the social acceptance of local canons to promote clientele and expansion. Amritsar District Vaid Yunani Tibbs was expanding exponentially within and outside the district such that by 1928, it had established centers in villages like Dhand Kasil. It appointed a patron and a representative in the local zaildar, who in turn held a local conference.

In Yoruba land, local medical practitioners also deployed the existence of epidemics to assert their socio-cultural significance in the early twentieth century. Just like Hakims and Vaids employed social tensions of plague to reassert their socio-political status. Smallpox remained one of the most devastating scourges in colonial Yorubaland because of its mortalities and socio-cultural imperatives. According to Yoruba beliefs, a deity called Sopona causes smallpox and its priests represented a vital class of rural intellectuals in the colonial era, just like the Vaids and Hakims in the Punjabi context (Oduntan, 2017). The differences between African traditional medicine and its biomedicine only became apparent with the advent of Germ theory in the latter decades of the nineteenth century. From then on, colonial authority privileged management of epidemic

and endemic diseases in tandem with scientific medicine in various colonies. In this regard, the institutions of Indigenous Yoruba practitioners gradually encountered marginalization in the public health concerns of the British. In 1878, the colonial government enacted the Public Health Act that empowered the Governor to punish any individuals who might obstruct the process of smallpox vaccination (PRO, 1878). In 1891, during the smallpox outbreak in Lagos, the Act became more coercive. The Governor announced regulations for the forceful evacuation of infected people to quarantine centers at Ikoyi. By 1906, the British had annexed other Yoruba towns and these laws became applicable in the southwest region.

These regulations somewhat undermined the important socio-cultural role played by Indigenous medical practitioners in the cultural sphere of Yoruba land. The colonialists armed with scientific medicine construed local healing practices such as herbalism and hyrodivination as an act of heathenism. In this sense, the colonial administrators often blamed local practitioners for impeding their epidemic control efforts in South West Nigeria. The British ascribed the dispersion of smallpox in places like Lagos, Ibadan, and Abeokuta to the smallpox cult societies despite their vaccination efforts. For instance, in Abeokuta, local vaccinators encountered local threats and resistance from Sopona priests (Oduntan, 2017). These events must have triggered the promulgation of the Juju and Witchcraft Ordinance Act in 1917 (Deniga, 1919) which banned the worship of Sopona as well as other acts of divination, sorcery, and other vital elements of Yoruba medicine. This regulation was synonymous with the 'infamous conduct 'in the Medical Registration Act of 1897 that sealed the fate of Hakims and Vaids as quacks in the urban settings of Punjab. The advent of plague Urdu literati allowed them to recast their canons in tandem with colonial modernity. However, the Yoruba people relied more on the sanctity and integrity of their medicine, which enhanced their survival from the ancient era.

The cultural sanctity of Yoruba medicine allowed its practitioners to weather the storm of colonial regulations that threatened the fabric of its values, customs, and traditions. Analogous to the Punjabi scenario, the colonialists deployed sanitary and other epidemic control as a technology of socio-cultural control. However, the British failed to understand that the Yorubas had embraced other medical traditions without losing the essence of their canons from antiquity. They had embraced Arabian, Indian, and East African medical traditions through non-colonial trade channels over the centuries (Oduntan, 2017). To them, imperial medicine represented a part of wider treatment options for endemic diseases such as smallpox. It represented an integral component of Yoruba culture and cosmology. Those establishments did not simply crumble with the advent of colonial medicine. Although local populations embraced vaccinations for smallpox, it represented one of the medical ideas out of the corpus of a wide range of options they have had in the past. In this vein, local practitioners deployed their ideas as well as medical ideas imbibed from their interactions with other cultures to assert their cultural significance in Yorubaland.

Before the colonial proscription of Sopona priests in 1917, native medical men privileged preventive measures and seclusion of patients to prevent cross-infection during epidemics. Yoruba practitioners correctly noted the seasonal variation of smallpox and devised appropriate measures to lessen social activities that might enhance its dispersal during such periods. Smallpox was more prevalent during the harmattan seasons (October – March), which corresponds to the harvesting period in Yoruba land. It was observed that fewer people contract smallpox in the rainy seasons. Unfortunately, social gatherings such as parties, country fashion, and festivals usually take place during harvesting seasons because of the availability of bountiful farm produce; hence, most Yoruba towns usually witness overcrowding of people. Sopono priests usually target this period to deploy taboos and superstitions to prohibit games and celebrations to limit human contact that might promote easy diffusion of smallpox (Ajose, 1957). They usually nurse smallpox victims in seclusion to prevent social stigma as well as to lessen the chance of transmitting this contagion to their relations. According to Stephen Farrow, the cosmological perception of the Sopono deity as a lonely and desolate god determined the secretive nature of the management of smallpox patients (Farrow, 1926).

Another epidemic that underscored the social importance of Yoruba medical traditions was the influenza epidemic in 1918. The epidemic entered through Lagos shores and rapidly dispersed into other parts of Nigeria. It accounted for an estimated 800,000 deaths during its peak period between October and November 1918 (Ohadike, 1991). Against the backdrop of the 1917 ban on indigenous practitioners and the aftereffects of World War I, the British were ill-prepared for this epidemic in Yoruba land. Because of the inherent beliefs that local medical practitioners could scuttle their medical efforts as alleged during previous smallpox campaigns, the colonial medical administrators, therefore, co-opted them in the planning of Influenza regulations in Lagos. In analogy to the Punjabi context, where the British deployed rural intellectuals as local mediators and collaborators during its plague moments, they utilized the socio-cultural influence of Yoruba medical men to advance the course of influenza sanitary measures. Interestingly, native practitioners had substantially positive impacts in the collective fight against the rapid diffusion of influenza in Lagos and into the hinterlands. In 1918, between September 28 and October 7, Dr Hood, the Director of medical services in Lagos called a series of meetings between Western medical practitioners and their native counterparts to combat the influenza epidemic. These meetings were geared towards bridging the racial divides that were pervasive among the professionals (Jimoh, 2015). What transpired in the meetings deserved mentioning. It reflected the professional acumen of native practitioners as well as their ingenuity regarding preventive measures required in the management of epidemic diseases.

"At the meeting, two native medical practitioners submitted a draft that contained the aetiology of the disease and also suggested ways in which the problem could be abated. The content of this draft revealed that the initial relative success recorded by the colonial government was actually the result of remedial measures suggested by the 'native' doctors. Three categories of measures were outlined in the colonial report.

Firstly, "when vessels were infected, but the shore was free, measures were directed to the prevention of importing the disease. Secondly, when Lagos was infected, as well as ships; measures were taken to prevent the spread from Lagos to other ports and places. Thirdly, when Nigeria was infected as a whole and ships were either clean or heavily or moderately infected, action was taken to prevent infection of clean ships, to prevent importation from heavily infected ships, with the intention of excluding a more virulent organism if such there were: whilst no action was taken with regard to moderately infected ships, such being regarded as infected equally with shore" (PRO, 1919). Apart from this remarkable contribution by native practitioners, they also delved into the acute care of influenza victims with relative success. During the influenza epidemic in 1918, Dr Sapara, a renowned Western medical practitioner with a special interest in Yoruba medicine used Rauwalfia vomica as antipyretics and anticonvulsants with good effects (Dalziel, 1973). Following the smallpox epidemic in 1949 in Abeokuta, the Alake of Egba convened the Egba Constitution Assembly whose mandate was to find lasting solutions to the recurrence of epidemics in the ancient town. The only female member, a distinguished social activist, Chief Mrs. Olufunmilayo Ransome Kuti also highlighted the efficacy of local herbal preparation during the 1918 influenza scourge in South West Nigeria. Her submission:

Olola Mrs Kuti agreed to the prohibition of Sekere, Aro and Boli (Sopono rules) as the people superstitiously believed them as some of the causes of smallpox. In 1918, when there was an influenza epidemic, Asofeiyeje leaves were boiled and drunk by sufferers and they were cured. She recommended similar treatment in this epidemic (NAI, 1949).

In contrast to their Punjabi counterparts, the Yoruba medical practitioners did not devise local print technology to assert their influence; they rather depended on the cultural resilience of Yoruba ethnomedicine and the efficacy of their herbalism. One plausible reason is that the Indian subcontinent encountered European colonization before Africa, and their period of colonization was consequently longer. The British had established colonial posts in places like Calcutta and Bombay for close to a century before annexing Punjab in 1847. Even many missionaries had made appreciable inroads to the subcontinent during the era. Hence, they encountered earlier colonial technologies like imperial medicine and print media that triggered social reactions among rural intellectuals like Hakims and Vaids.

Contrastingly, mainstream West Africa was colonized between 1890 and 1910 after the Berlin Conference that led to the partitioning of the whole of Africa (Ilifee, 2007). Lord Luggard amalgamated the southern and northern protectorates to form the entity called "Nigeria" in 1914. While the first local printing press was established in Lahore in 1837 and local leaders like Arya Shabha and Singh Shabba had taken the initiative to print in local languages from the middle of the century, the first local newspaper in Yoruba land stopped publishing in 1867. In 1859, Henry Townsend, one of the earliest Anglican missionaries published the first local newspaper called, (Newspaper for Egba and Yoruba people) (Salawu, 2004). His main objective was to promote church activities and engender reading culture among early Christian converts. However, it existed for only eight years before the social uprising against missionaries in Abeokuta occasioned the destruction of several libraries and its printing press. Other local newspapers published by missionaries such as (Lagos Newspaper) were deployed to advance the course of Christianity and did not even last long to evoke any meaningful impact in the social landscape of the Yorubas. The first notable Yoruba newspaper that evoked socio-political mobilization was founded in 1922 (Salawu, 2004). It was published to evoke a sense of nationalism caused by the aftereffects of World War I and the raving impacts of influenza epidemics in most colonies including Nigeria.

5. CONCLUSION

This research article compared the practices and ideological foundations of Punjab medicine and Yoruba ethnomedicine up to the early colonial era. It showed that both medical traditions probably originated between 2000 and 500 BCE and originated from a common progenitor – as an offshoot of Ancient Nile Civilization. The striking linguistic similarities of major medical terminologies of Yoruba medicine and Ayurveda prove this historical correlation. Nevertheless, each canon followed a different trajectory of development until the era of European colonization. The advent of colonial medicine as a social technology occasioned social reengineering and historical changes in the Punjab and Yoruba medical systems.

We highlighted that Punjab medical traditions encountered socio-cultural reconstruction via Urdu print literature as a racial science in response to domineering threats from colonial medical administrators. In this light, it could not be exclusively described as a medium of cultural revitalization. On the contrary, the religious homogeneity of Yoruba medical practitioners as well as their receptive approach to other medical traditions without losing their core ideological foundations made their canon a site of cultural reformation. They adopted and adapted colonial medicine just like other medical ideas encountered in the past while retaining their social construction as a racial science. Therefore, we argue that Yoruba medicine was a site of cultural revitalization consequent upon cultural intercourse with imperial medicine. However, the Punjabi medical tradition acted as a domain of social class reconstruction.

This work highlights the intersections between culture, medicine, and technology in the context of colonialism. This work contributes to the contemporary study of history of medicine by deploying the concept of social class reconstruction on socio-cultural and professional groups such as Vaids and Hakims. Historians had hitherto used the concept to describe the Reconstruction Era (1865-1877) in the United States after the Civil Wars and the French Revolution's shift (1798-1799) in social structures due to abolition of feudal systems in many parts of Europe. Hence, our article shows that social class reconstruction transcends national and international planes. Therefore, we hypothesize that individuals, families, groups of people, and communities can reconstruct their social image in response to social, cultural of technological change and transformation. Moreover, this piece shows that diverse local institutions could react differently to similar cultural encounters as exemplified by the deployment of

imperial medicine in early twentieth-century Yorubaland and Punjab. This could be due to sociocultural differences, socio-economic diversities, engagement of technologies, and other idiosyncrasies. Therefore, in the post- modern world, each culture should harness the benefits of cultural encounters without losing the core values, identities, and essence of their cultures. While cultural encounters advance the course of globalization, they should be advanced with acculturation to mitigate cultural emasculation, particularly in the Global South and post-colonial societies.

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