While exploring the issues pertaining women missionaries and medicine significant results were drawn. Among others, the cultural interchange and meeting of the women missionaries with the indigenous women is an important historical issue and a matter of continuing contemporary cultural significance. Equally important was the impact of their work. I would like to add that the aspect is one of the most interesting questions of research while studying mission history. Yet, it is difficult to fully assess the consequences of the mission work not only on the lives of the people whom they got in contact with but also on the lives of the women who worked under various mission societies. A lot is still under research. The impact of the movement on the western women missionaries themselves and on the leadership of the women’s mission boards had feminist implications.

Very often women missionaries have been linked to examinations of women and colonization and saw the former as bearers of modern ideas. While studying their discourse one does derive a picture of the women missionaries who showed how ordinary middle class women created institutions and organizational structures in foreign lands. Their workings throw light on the impact of modernity on colonialism and on women both as agents and subjects of reform.
As stated by Robert Young, Colonialism was pragmatic and until the nineteenth century generally developed locally in a haphazard way, while imperialism was typically driven by ideology from the metropolitan centre and concerned with the assertion and expansion of state power.¹ The power shared with the notion of equality of gender was seen in the mission context. When it came to the women missionaries they were equally shouldering the responsibility of ‘white man’s burden’ in stating the authority of the British Raj. The foundation of imperial power lies in its culture. Edward Said’s *Culture and Imperialism* begins from this premise that the institutional, political and economic operations of imperialism are nothing without the power of the culture that maintains them. As such the British missionaries are susceptible to analyzed as a concept of imperial advantage. And in view of these observation women missionaries carried cultural values with them that more or less remained unchallenged. Said’s point is that imperial culture was built upon assumptions so deep that they never went into discussions of social reform and justice.² Hence, the missionary movement functioned more as an activity of imperialism than colonialism. Missionary movement was interwoven with colonial government in ambiguous ways. Christianity expanded as a part of the British culture overseas. Members of various denominations recreated Churches, adapting themselves to the new environments. Voluntary Protestant mission societies set out to evangelise the ‘heathen’ world.

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The preceding chapters have been conceptualised on the notion that missions were not all about Christianization. What came as one of the strongest movements in the Church was the appearance of independent single women as missionaries. By the end of the nineteenth century, nowhere in the West had an avenue opened as large as the missionary societies that accommodated women to such an extent. As observed in Chapter two, the footage for the western women’s participation in any field ironically began with their work not in their own lands but overseas. Not only was their acceptance by both, were they accepted but, but within no time they gained high recognition for their work. The skilled women missionaries in medicine or education created a significant sphere of work that demanded the more specialized efforts of single women. While studying their lives one does conclude that their careers were limited by their self understanding of gender boundaries prevalent in their home countries during the nineteenth century. When they fought for gender equality in the Church they did not move towards breaking any barriers instead, they moved in separate parameters from that of the male counterparts. Their participation in their work pushed them away from the boundaries of their home. Hence, the gender ideology that they brought with them in the lands where they worked, was more constricted than rebellious, for the risk of losing their opportunities was far more if they confronted the men. They accommodated the previous assumptions of the gender issue in the Church rather than reinterpreting it. In the process, these women were accepted not as feminist rebels but as agents of reform. It was probably this side of theirs that made them a
success as medical missionaries. The timing was perfect. Colonialism was at its peak, single women were placing themselves in male dominated areas in the Church and in the medical profession and moreover the colonized lands became more inviting than ever before with the call to save the “heathen women”.

In Chapter Three, I discuss the challenge the women missionaries posed for the indigenous society, and not to forget their own women back home, by entering the zenana quarters. This was the foremost opportunity the western woman could not ignore if she wanted to find her way in the patriarchal structure of the Church. As observed in the chapter, zenana work did not give much success to the missionaries in terms of conversion but the missionary zeal grew many folds. The message to serve their “eastern sisters” became loud and clear in the West. A newly found feminist ideology reflected in the years that followed this intervention—an ideology that had womanhood bound by imperialism. The zenanas became more sensitive to the need for missionary women, an area of work that offered no protest from their menfolk. Zenana was a mere platform for a better acquaintance for both the parties, the missionary woman and the indigenous woman. In this context, I examined the literature written in this period. It helped to trace the social and the cultural concepts about the women of both the races invented in the writings. The Indian female long hidden behind the zenana suddenly becomes bare in these non-literary accounts. Probably nothing better illustrates the construction of the early missionary work than the zenana visits that labeled the
indigenous woman as a creature to be reformed, protected, and emancipated.

Chapter Four has focused on the women medical missionaries in establishing hospitals and how they contributed in engaging the indigenous women. With the building of mission hospitals, the imperialistic agenda of the women missionaries is evident yet, at the same time building ties of trust with the indigenous women could not be hidden either. The encounter of western medicine with the local population brought the women missionaries to an understanding of the former in their own right and not as potential converts. In Punjab, they saw a large scope of work not only in terms of evangelization but also in bringing western medical facilities. The rise of hospitals came through with the response of the indigenous women whereas the closing of an odd hospital happened due to the lack of funds from the mission societies and not due to the poor attendance of the patients. Though, when it came to their general approach both the land and people, were clubbed as one area of attention, the direction of work moved towards women. The missionaries always remained aware of the divergent needs of women and children according to their social ranking that added to the acceptability factor towards missionary work.

What came to be seen in these hospitals was a flow of trained indigenous women as medical subordinates. This resulted in an air of superiority running throughout the formative years of the hospitals. Although records do not direct the inability felt by the missionaries towards the local women
yet the tone of the written material suggests that the latter need to follow a certain hierarchal ladder to reach up to the standards required by the medical mission work. However, the early endeavors paved the way for the Punjabi women to participate in activities which were earlier shut for them and in the following years the hospitals showed the process of blurring the boundaries that separated the superiority of the white woman to that of the indigenous woman.

Chapter Five deals with Edith Brown, one of the pioneers of the medical missionary movement. Like most of her fellow members Dr. Brown was trained back home in Great Britain but started her career in India. She was one of the early qualified doctors to work for the Baptist Mission Society. An ideal example of a Christian missionary woman who had the combination of sophistication, conservativeness and above all was a reformer, concerned and anxious to bring about changes for the local women. And because of her more daring and persistent nature, Dr. Brown was successful in her venture. The Christian Medical College and Hospital at Ludhiana campaigned not only to provide medical facilities but also medical education to the local woman. In the latter context, some controversies arose between her and the government on the question of Christianity and the imparting of medical education on secular lines. Probably this is one area where the strong Christian character of Edith Brown is seen. The argument was clear – a missionary hospital had to be under Christian influence where as the government believed a neutral policy would work better for the acceptance of western medicine. The work of the Hospital was closely knitted with
religious beliefs that it was often not possible to delink the issues separately. Here, what Dr. Brown found was a constant challenge, for her institution was not definitely imparting religion-free medicine. During the years that followed issues on religious front were settled with a mutual understanding, for both the British officials and Dr. Brown agreed in principle the dire need of a woman hospital and a medical college. To make her work a success Dr. Brown accommodated the indigenous social customs with mission medicine. After all, when it came to the relationship between both the missionary doctor and the indigenous patient, it was not just the dispersal of medical treatment but a contact between two cultures that mattered the most. Dr. Brown was quick to understand as to what to accept and reject from the encounter to gain confidence from the indigenous society. Besides the compromising factor, it was the ‘Christian humanitarian’ side of the missionary doctor that made her highly popular amongst the women of Punjab.

In the early phases of the coming of western medicine, the greatest hurdle faced by the missionaries and the colonial government was the indigenous methods of childbirth. They attempted to deal with it by diffusing western medicine. As seen in Chapter Six, in this context the dai became the central figure of this intervention and so rose the contested area of debate that further shaped the western perception of the indigenous culture and society. The dais had to be worked upon by the colonial intrusion, not only to reconstruct the indigenous child birth techniques but also to bring about a cultural change for she was an integral part of the indigenous cultural practices as well.
The complex processes at work in the introduction of western techniques in childbirth methods have been dealt with throughout the chapter. Despite the efforts of the colonial government and the missionaries to ‘transform’ the dais, a very limited section of them could be brought under the training. The intention was strong but the impetus to push the dais for training was never motivating enough. Although, the displacement of the dais was not a success, the more fundamental factor in this development was that the western-trained midwives found a firm footing in the indigenous society and did find work for themselves in most towns of Punjab.

Chapter Seven is studied with the perspective of making a detailed picture as to what contemporary work was carried by the colonial government along with the women missionaries. A striking similarity seen in both their work was the imperialistic behavior. Medical care was regarded as a valuable task in helping the suffering indigenous women, however the rhetoric was hard to hide. The establishment of state hospitals was for the army, the civilians placed in high administrative posts and medical education but most definitely not for women. But when it did happen, the British government linked medicine with the “colonization” of women, the only ‘tool’ through which the latter could be reached out. Although their symbolic importance was considerable, hospitals for women were few in number till the turn of the century. From the early twentieth century, however the medical care of women and children began to receive more attention and a number of medical institutions opened all over Punjab. The monopoly of western medicine of the missionaries in
Punjab was undercut during this period. The potential of western medicine was recognized within the Punjabi community, although the choice of accepting colonial medicine was with the indigenous woman patient. The government hospitals had male staff working with the women doctors, interestingly this did not hinder the coming of women patients to these hospitals. How good was the care offered to women in the government hospitals? Since most women restored medical facilities in desperate circumstances the hospitals were bound to show a high death rate. This occurred due to many factors, religious barriers were one of them. For the government it was more State versus traditional medicine rather than State versus mission medicine. As seen in the previous chapter, indigenous birthing practices were the most challenging area to confront for western medicine. Behind these initiatives lay concerns over the effects of lapses on imperial efficiency, but also the recognition that women had been neglected by the colonial government.

Chapter Eight studies the growth of the Christian Medical College and Hospital (CMC) in Ludhiana, the initial phase being discussed earlier in chapter five. The hospital had a clear agenda in imposing its own forms of discipline and rituals on patients. Holy rituals were deliberately parted in order to show the Christian virtues. The institution believed in “modern”, “Western” medicine, but it also maintained at its core a spiritual and evangelical component. Despite financial difficulties, both medical students and the take up of out-patient and in-patient treatment did increase substantially throughout the 1930’s and 1940’s. This coincided with the tuberculosis becoming much
more successfully treatable and hospital figures reflecting this, as observed in the chapter. Maternity cases also formed a significant proportion and taking the opportunity to introduce the patients to health education, child care and nutrition as well as to Christian evangelism. Although the wave of nationalism did bring about anti-Christian missionary feeling among the indigenous society, yet the approach after independence remained somewhat ambiguous. While many mission hospitals had to be closed in India in the early years of independent India due to lack of funds or government support, the response towards CMC was more positive. Due to adequate and timely aid from the Christian Medical Association of India, Burma and Ceylon and from the Central and Punjab government, the hospital could survive the dire straits created by the partition days. The years that followed witnessed tremendous growth of the hospital and college with the upgradation for MBBS and the admission of male students. During the 1950s and 1960s, the hospital saw major changes in its staff. It was clear that Christian missionary organizations had to review their missionary strategies towards medical institutions. Like most of the mission hospitals in India, the CMC replaced the white missionaries with the native missionaries. It was a by-product of the newly won freedom. Controls were now placed on indigenous staff with a few foreign funding bodies. Friends at Ludhiana, UK and the Ludhiana CMC Board USA, Inc are actively till date giving support to the cause of medical health care and medical education for the CMC.
As elsewhere even women in India were taken to represent a society's true nature and worth. It is in the act of constructing themselves as the agents or subjects in the discourse about Indian women that we can locate process of women missionary activism. The British women established space for themselves in a variety of ways—by writing, by travelling and most commonly by undertaking educational and medical work. It was a breakthrough for women to help their 'colonial sisters' that further opened doors for women missionaries that gave them scope for independent action. Such activities, as Metcalf states, lead to blurred gender roles. A conflict was exposed between 'Victorian womanhood' and that of masculine assertion of ordering rationality in the face of an India where disease and disorder raged unchecked. On one hand, if the woman missionary, was fighting with her 'masculine' and 'feminine' virtues on the other hand there was a constant conflict with her role as a doctor and an evangelist. Caught between plural identification, the medical woman missionary asserted the authority of the western world vis-à-vis colonialism.

There was no doubt that the facilities offered by the missionaries did promote western medicine, what they couldn't promote is Christianity itself. Social pressures made the missionaries more non-aggressive in their religious approach. The women missionaries soon realized that the turnout in the hospitals was not because of the interest of the patients in the religion they promoted, it was on the contrary, because of their

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skills as doctors. Yet conversions did occur but not so in the spaces of hospitals and schools – a fact that was accepted by the women missionaries who ran these institutions. Hence the medical women missionaries changed their ‘evangelical strategies’ and the nature of their work. For they personalised medical facilities in such a way that the Christian hospital was no longer a threat to the religious identities of Punjab, whether any community- Muslim, Hindu or Sikh pupils or patients attended it.

The end of the British rule saw the process of Christianisation change. After a brief period of pioneering work by foreign missionaries local people took over the preaching trend. However education and medicine lived right till the end of the colonial rule and way after. As observed by Webster, 4 medical perspective differed from evangelistic and educational perspective in being more socially inclusive. It touched women from all walks of life. Some responses of women from the higher class to those of dalits formed the line of patients. Even for the medical training, women from all religions and different social backgrounds opted the profession. Unlike the mission schools where parents favoured to send their daughters under a protected environment, the hospitals gained confidence of the indigenous people on the grounds of high moral values and discipline. The introduction of new institutions and the existence of Church activities led girls and women into new situations outside their homes.

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The process of missionary activity was crucial to the very formation of gender definition, ideology and rhetoric of the emerging work by not only the missionaries but also by the state. As stated by Doris Jakobsh, gender constructs are evolutionary, they emerge and develop with the shifting needs of the community which they unfold. They are also susceptible to the forces surrounding them, be these social or cultural.\footnote{Doris R. Jakobsh. \textit{Relocating Gender in Sikh History. Transformation, Meaning and Identity.} (New Delhi: O.U.P., 2003, p.238)} The rhetoric of the mission reformist discourse with regard to the women's question often provides insight into socially or culturally constructed meaning of gender. The missionary intervention developed by its own needs of expansion brought considerable changes among the lives of women it got involved, directly or indirectly with. Here, in the act of constructing themselves as agents or subjects in the discourse about Indian women that we can locate the response of indigenous women. Indian feminism emerged within the context of the challenge that these women took in the traditional set-up. The success of this challenge also strengthened the missionary activism.

As the missionaries endeavoured to define themselves as 'civilised', they had to make of the Indian women whatever they chose not to make of themselves. As Metcalf puts it there emerged a 'necessity to create an 'other' to describe oneself as 'modern' or as 'progressive', meant that those who were not included in that definition had to be described as 'primitive' or 'backward'. \footnote{Thomas R. Metcalf, \textit{The New Cambridge History of India. Ideologies of the Raj.} (p.7)} Gender was the major area of difference conceptualized by the British. Women were merely the sites on
which the competing views of tradition and modernity were debated. In this context not only was a ‘creation of the difference’ produced by the women missionaries but points of similarity were extended to include feminine as well as masculine constructions. Going back to Doris Jakobsh’s observation, the hyper masculine ethos pervading Sikh identity was in harmony with polarized British constructions of masculinity that led to the ‘politics of similarity’ between the Raj and the Sikhs.\(^7\) The Jat woman contributed in the agrarian milieu making her position similar to the rural women in Britain. In a way, seeing the similarity, the Jat woman could be far easily reached by the women missionaries and would be acceptable to what they had to offer. This assumption gave impetus to medical mission work. The end of the nineteenth century saw a boom of mission hospitals in Punjab. Looking at the hospitals one can answer the question as to how far western medicine had achieved the results desired primarily by the women missionaries and by the British government. According to Foucault, the medical gaze was also organized in a new way. It was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention.\(^8\) The power was that of the western women missionaries and so was the intervention. The predominant model for women’s health was hospital medicine, concentrating on symptoms and signs that togeher configured surveillance medicine. The medical women


missionaries moved their attention to each and every aspect that controlled matters of women’s and children’s health. The mission hospitals outshone government hospitals with regard to this direct intrusion of women’s health care, nursing and medical training.

Western missionaries were gaining popular acceptance due to the fact that the impact of their work was not limited to a certain periphery or time. Whatever progress western medicine had made for women came largely from the missionary end. Whether it was dispensing medical care or imparting medical education, the indigenous women soon started relying upon them. For the medical women missionaries it was a means of carrying ‘enlightenment’ to the ‘heathen’ women. Though never totally free from discrimination, the women missionaries offered ‘better’ professional opportunities for the indigenous women.

By the end of colonial era, colonised people were taking charge of their own country and missionaries were amalgamating with them in their own domain. As stated by Maina Singh Chawla, acculturation is a process that does not decline with a given period, hence the legacy of missionary women went way beyond my period of study. Along with other mission hospitals of Punjab, the principalship of the Christian Medical College and Hospital reflected a strong control of the indigenous Christians under the missionary patronage.

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I end up with an extract of a letter written by Raj Kumari Amrit Kaur on her observations of the medical missionary work in Punjab during the partition days,

*I have had the most marvelous offers of help from all Missions in this country, for one, will always welcome those medical missionaries who come here as servants of sick and suffering humanity.*

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10 Letter from the Minister of Health, Government of India. To Dr. Chesterman, From Amrit Kaur dt. 3rd October 1947. (CMS Archive .Sec.No.5. India Box no.509).