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Healing the Zenana: The Role of Christian Medical Missionaries in Colonial Northern India (mid 19th century–1947)

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ABSTRACT

The Christian medical missionaries played an important role in promoting women's healthcare in Colonial Northern India between the mid-19th century and 1947. This study highlights various societal and cultural norms which prevented women from accessing different medical facilities. The British East India Company initially opposed missionaries but the Charter Act of 1813 officially authorized their entry into India. A major challenge for early missions was the *purdah* system, which prevented male doctors from entering the *zenanas* (women's quarters) and treating the Indian women. To solve this, missions began sending female medical missionaries and trained female nurses who could enter the private *zenanas*. This study examines the unique strategies adopted by the missionaries such as conducting door-to-door visits and organizing medical camps in villages. Through which their aim was to provide a "dual cure" viz. healing of the body and the soul. The paper specially discusses the role of institutions such as Dr. Clara Swain's hospital in Bareilly, CMC Ludhiana and St. Stephen's Hospital in Delhi which created a professional female medical cadre. It also explores the interaction between Western medical training and the traditional knowledge of birth attendants (*Dais*).

Keywords: Christian Medical Missions, Colonial North India, *Zenana* Missions, Female Healthcare, Traditional Midwives (*Dais*).

INTRODUCTION

Women's health is a broad term. It is about a woman's complete physical, mental, and social well-being but not just the absence of disease or infirmity. This comprehensive approach is different from men's health because it focuses on issues unique to a woman's body, such as menstruation, menopause, pregnancy and other reproductive issues. In the late nineteenth and early twentieth centuries, there was a growing debate on women's health in colonial Northern India. Women faced health issues like anaemia, tuberculosis, haemorrhage, eclampsia, puerperal sepsis, osteomalacia and malnutrition (Balfour, 1927; Guha, 1998).

Traditionally, women had to access only to practitioners like *dais*, *vaids*, and *hakims*. Factors such as the prevalence of *purdah*, child marriage, discrimination against women, poverty, and lack of time to travel long distances to reach urban medical institutions, severely restricted access to and reliance on formal medical care, often leading to maternal or infant deaths during childbirth (Lal, 1994). The practice of *'purdah'* was strictly followed by women in Northern

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India. They could neither be seen by male doctors nor receive medical treatment from them. This created a "medical vacuum," resulting in increase in maternal and infant mortality rates. Additionally, child marriage was also a particular cause of increasing mortality rates; as, it causes early pregnancies and complications related to it. Based on the census data of 1921 from various districts of Bihar and the United Provinces, Kripanath Mishra has shown that a large proportion of girls were married before the age of ten or even five, which in turn had directly affected their survival during childbirth (Mishra, 1926). Article such as *"Hamari Streeyon Ka Swasthya"* published in the Grihalakshmi's magazine criticised these societal and cultural factors in detail (Vaidya, 1915).

The British colonial health machinery focused primarily on the health of the army and urban centers. They largely neglected the health of Indian women, as they hesitated to interfere in the private lives of Indians, fearing religious opposition. Further, they do not have enough fund for the same. Christian missionaries viewed this as a double opportunity. The first was to spread the Gospel and second was to provide medical aid. They believed that by healing the body, they could win people over to Christianity. Between the mid-19th century and 1947, missionary women became the first providers of Western medicine to Indian women. They brought a new system of institutionalized care which challenged indigenous medical practices which paved the way for modern reproductive health services (Arnold, 2000).

The Charter Act of 1813

The arrival of these missionaries was not easy. In the early days of British rule, the British East India Company was firmly against missionary activities. The Company was a commercial entity and its directors feared that any attempt to interfere with the religion of Indians would lead to social unrest and damage their commercial profits. Thus, they followed a policy of religious neutrality, i.e., they would not interfere with Indian customs or faith. However, the Clapham sect led by William Wilberforce in Britain pressured the British Parliament to intervene. It led to the special clause in Charter Act of 1813 which allowed missionaries to enter India for "moral and religious improvement". Although the government continued to claim neutrality, its administration was highly influenced by Christian and Western principles. By the time medical missions became popular in the 1870s and 1880s, the legal path had already been cleared. Missionaries were no longer seen as a threat to commercial interests. But, as partners in "civilizing" the Indian population through education and healthcare.

Soon after the passing of the Charter Act of 1813, Christian missionaries began actively working in the field of medicine in India. Initially, these missionary sent only males. But they soon realized they could not reach the female population. There was a strict prohibition against male entering the women's quarters and treating female patients. As a result, half the population left without care. Furthermore, these early male-led missions were frustrated because they were able to convert only a few people. As noted by the missions, they found that the wives and daughters of male missionaries were often the only ones allowed into Indian homes (Balfour & Young, 1929). These women saw the suffering of Indian mothers firsthand. It led the missions to a new realising that women missionaries were a far more "effective agency" for reaching the heart of Indian society. As a result, they shifted the strategy from male-led preaching to female-led medical service. After 1880, a large number of female medical missionaries came to India, and by 1900, two-thirds of all the Christian missionaries working in India were women.

Early Medical Missionary Efforts

Early missionaries were not trained doctors. For example, In 1790s men like William Carey and Joshua Marshman came to India; they had no medical degrees but they still felt they had to treat sick people in Serampore. Some of the

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key missionary societies active in Northern India after mid 19th century were the *Zenana* Bible and Medical Mission (ZBMM), the Church of England Zenana Missionary Society (CEZMS), the Society for the Propagation of the Gospel (SPG), the Methodist Women's Foreign Missionary Society, and the American Presbyterian Mission. All sections of society welcomed these missionaries. As a result, missionaries focused mainly on medical services by the 1860s.

The first women medical missionaries for India were Lucy Leighton and Mrs. Crawfurd. They sailed in 1873 but both succumbed to illness shortly after. Clara Swain, the first fully-qualified medical woman to come to Bareilly on 20 January 1870 (Swain, 1909). She was affiliated with the Methodist Women's Foreign Missionary Society. She opened a hospital in 1874. It was established on 40 acres of land and a large building donated by Nawab Kalb Ali Khan of Rampur. It was the first hospital for women in Asia, which still exists and is known as the 'Clara Swain Mission Hospital'. Further, she trained fourteen girls from an orphanage and three married women in anatomy, physiology, and materia medica– all through an interpreter (Swain, 1909). Three years later, these women were allowed to practice on their own after an examination conducted by the civil surgeon. The American Presbyterian Mission sent Dr. Sara Seward to Allahabad in 1871. She worked at Allahabad till 1891. Similarly, Mary Warburton Booth was a British missionary. She was affiliated with the *Zenana* Bible and Medical Mission (ZBMM). She was the appointed as a teacher at Gorakhpur in 1908. But she began medical work because there were no hospitals or doctors nearby (Basu, 1993). She spent over 35 years in India.

The first qualified female missionary from Britain was Fanny Butler sent by The *Zenana* Missionary Society of the Church of England. She came to India in 1880. Elizabeth Bielby came to Lucknow in 1875 and opened a dispensary followed by a small hospital. In 1881, she carried a message from the Maharani of Panna to Queen Victoria, drawing attention to the need for women's healthcare in India (Balfour & Young, 1929). As a result of this meeting, the Queen ordered Lady Dufferin to make efforts to improve the health facilities for Indian women, which eventually led to the establishment of the Dufferin Fund on 18 August 1885.

Reaching the Zenanas

The female missionaries act as the essential bridge between Western medical science and the secluded Indian home. The *zenana* was a strategic entry point for the missions (Forbes, 1996). Through the *zenana* missions, they brought primary medical care directly to women who were strictly reluctant to consult male physicians. They treated common diseases such as fever and skin diseases. Further, they provided the first forms of Western prenatal advice to expectant mothers. Missionary women used these home visits for medicine as well as to advocate for Western hygiene and sanitation. At the same time, they often criticized traditional domestic practices as "backward" and "superstitious." By the 1890s, the *zenana* missions in the United Provinces had successfully introduced the concept of western medical intervention to thousands of families.

Many *zenana* missionaries were not fully qualified doctors at first. They acted as messengers and report symptoms to male doctors outside the house and bringing medicines back inside. Further, to become more effective, many missionary women used their vacations in the West to receive basic hospital training or to study medical books on their own. For example, Miss Rose Greenfield originally came to India to teach, but she attended her brother's clinics while disguised as a nurse, to gain enough medical knowledge to help women in the *zenanas*.

The missionary work had three unique features: they worked at the grassroots level in villages, went house-to-house to find patients, and used medical camps to provide a "double cure"—healing both the body and the soul through conversion. However, it led to a direct conflict with traditional practitioners such as the *'Dais'*. In colonial India,

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childbirth was the domain of the traditional birth attendant or *'Dai'*. Missionaries, like the colonial state, viewed *'Dais'* as "unhygienic". To replace them, missionaries started midwifery training Classes. Because it was hard to recruit upper-caste women, they initially trained Christian converts and widows. Fitzgerald (2006) highlights that the goal was to remodel the Indian nurse into a medically skilled and morally disciplined. The training program created a long tension between traditional and Western childbirth methods.

The Growth of Women's Hospitals and Medical Training

As these missionaries grew, they established hospitals to provide professional care to women. Following the success of the first women's hospital in Bareilly, similar hospitals were opened in Agra, Lucknow and Delhi. These institutions were revolutionary because they were established by women for women. The establishment of hospitals gave Indian women the confidence to seek help for reproductive and "secret" health issues that they would have otherwise suffered through in silence. The true necessity of such institutions is reflected in the letters of Dr. Clara Swain. She noted that the benefit of a *zenana* dispensary and hospital is "readily apparent," as many women would "suffer in silence rather than have a native doctor called to them," even if he did not look upon their face; however, they were "glad to come to be treated by a lady doctor" (Swain, 1909).

There were 175 mission hospitals spread across colonial India, including the Punjab, Delhi and the United Provinces, which had 26 and 16 hospitals respectively (Gayathri, 2007). Along with these hospitals, missionaries established many dispensaries near the state headquarters and at the sub-divisional headquarters. These were mainly visited by people from the towns and those living close by. Some of the 'veranda' dispensaries of the initial years eventually grew into hospitals. From these, the first training classes and medical schools for Indian women also emerged. The early informal classes for midwives grew into the certified graduate training programs for Licensed Medical Practitioners (LMPs) and even university-level classes for degrees in medicine. For example, the North India School of Medicine for Christian Women, which began in 1894 by Dr. Edith Brown with six pupils, became CMC Ludhiana. It aimed to train Indian women as sub-assistant surgeons to serve in rural areas. On the other hand, St. Stephen's Hospital in Delhi began as a small dispensary in 1885. Later on, it developed into a full-fledged women's hospital. Both of these institutions not only provided medical training to women but also made them professionals in nursing and midwifery. It reduced the dependency on traditional *'Dais'* and created a "trained female medical cadre" which perfectly suited to the social structure of Northern India. Further, these institutions gave confidence to Indian women to seek help for reproductive issues (Ray, 2015).

CONCLUSION

The role of Christian missionaries in Northern India female healthcare was foundational in nature. It started with the passing of the Charter Act of 1813, which opened the doors for missionaries. The failure of male missionaries to reach Indian homes led to the arrival of female medical missionaries. These women were the only ones who could cross the social barriers of the *purdah* system and enter the *zenana*. By establishing hospitals such as Dr. Clara Swain's hospital in Bareilly, CMC Ludhiana, and St. Stephen's Hospital in Delhi, missionaries shifted women health from home to hospitals. They were successful because they worked at the grassroots level, going house-to-house and using medical camps to reach rural women. However, their work also created a major conflict with traditional birth-attendants, i.e., *'Dais'*. Their objective was to replace indigenous methods with Western medical methods. So, they trained a new "female medical cadre" of nurses and midwives. Although the ultimate goal of these missionaries was often religious conversion but their impact on reproductive health cannot be ignored. They provided the first professional medical space for women in Northern India. Even today, the hospitals and nursing schools founded by them remain an

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important part of India's healthcare system. Their historical contribution remains highly significant for the history of women's health.

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