Chapter III

Healing of Body and Soul: Female Medical Missionaries

"A female medical mission may be defined to be the practice of medicine by a lady for the purpose not merely of curing but of Christianizing her patients.... This is a key which may be said to fit every lock. She would find an entrance where the educational missionary would find it closed. She would soften bigotry, remove prejudice, dispel ignorance, drive away gloom, and unobtrusively but effectually deposit the all-pervading leaven of the gospel in numberless hearts and homes." 1

This was the opinion expressed by Dr. Elmslie, a Presbyterian medical missionary from Kashmir before the London Zenana committee in 1871, pleading for the need of female medical missionaries for India. In a way these words sum up the role of women medical missionaries in India. But a deeper probe into the entire missionary enterprise, especially of women medical missionaries, within larger discourse of western health care systems and social reform for betterment of Indian women in the colonial context, shows a very complex dynamics of relations between the church and state, church and the colonised, church and the native Christians, female missionaries status within the church, the western health care systems and the depictions of the native dais etc.

Christian missionaries along with colonial administrators, Indian social reformers and the nationalist played a very important role in the reform movement aiming at the general betterment in the condition of women in India during late eighteenth and nineteenth centuries. They were the pioneers who have strived for the introduction of western health care system for women in India. Female education and western health care system, especially maternal health care, was introduced and promoted greatly by the missionaries. After 1880, medical missionaries who were single women trained professionally in medicine, came in large numbers to India. In 1885, at the prompting of Queen Victoria, the Vicereine, Lady Dufferin, launched the National Association for

Supplying Medical Aid to the Women of India; known famously as the Dufferin Fund. The colonial administrators did not take the direct responsibility for women’s health care system and entrusted the same to this association. Though a philanthropic organisation, Dufferin Fund was inevitably tied institutionally and politically to the colonial power. Most of the doctors working in the Dufferin hospitals and dispensaries, which were usually located in the major towns and district headquarters, were medical missionaries. Dufferin Fund sought to recruit qualified white women doctors, nurses and midwives to work in India, to give medical relief through hospitals, wards and dispensaries exclusively for women and children. It also succeeded in creating opportunities for aspiring female physicians through educational scholarships, grants-in-aid and other forms of financial assistance and also to educate and train them for the medical profession. The Dufferin Fund, thus, effectively managed opportunities for systematic medical training and distributed patronage to qualified women doctors in the form of hospital posts and dispensary positions.

A very significant feature of the medical missionaries who were working through missionary establishments was that they worked at grass root levels, in the villages where others failed to reach. Secondly they went in search of patients house to house rather than the patients coming to the hospitals and dispensaries. Village visits and camps were the unique feature of the missionary doctors. Thus, missionary doctors, be it through the church or mission hospitals, Dufferin fund, or the state sponsored hospitals, have contributed immensely for the promotion of western medical systems for maternal health care in India.

Historian Jeffery Cox sums up various discussions on missionaries in colonial context into three narratives i.e. “the imperialist/nationalist with its presumption of marginality, the Saidian with its unmasking of imperial complicity and the providentialist with its difficulties in confronting the
imperial character of the missionary enterprise. She shows how most of the master narratives or the mainstream of imperial histories marginalize the religious point of view and thereby exclude various individuals associated with it. The nationalist, later the subalterns and even post colonialist carried on this presumption of the marginalisation of the missionaries in their narratives. Historians following the Saidian frame depicted missionaries as cultural imperialist and the role of missionaries is predetermined as foreigners. The providentialist tried at separating totally the religious and colonial agendas. These narratives of missions are usually written by missionaries themselves and they evade the anti-colonial critiques of Western religious expansion. Historians writing about missionaries usually write within one frame or spread across all the three narratives. Another major draw back of the missionary histories, as well as the other two streams, is the marginalisation and even exclusion of women missionaries and their contributions. Large number of unmarried women came as missionaries to India from 1880 onwards and by 1900 two third of missionaries in India were women. However these women missionaries appear as mere ‘adjuncts’ even in the published records and histories of various missions, finding mention usually in the end as ‘women’s work’. However, this issue has been taken up by some scholars in recent years like Rosemary Fitzgerald, Kumari Jayawardena, Ruth Brouwer, Leslie Flemming etc.

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The role of Indian Christians and their contribution in the promotion of Church in the colonial context is another issue which has not been explored much. This becomes more important from 1920 onwards as Indianization of churches has started by then. In earlier missionary record, Indian Christians exist only as loyal and nameless employees. Jeffery Cox tried to incorporate the contribution of the 'native' convert Christians and the women missionaries, which were greatly ignored in the missionary and colonial narratives. She tried to develop an alternative form of interpretation for studying Western Missionary work in India (her area of focus is Punjab),\textsuperscript{5} which includes both the religious convictions of the missionaries as well as the anti imperialist critique.

Modern Missionaries were not merely religious agents but were also cultural and social agents. These roles gain more significance when set in the colonial context. Cox tries to incorporate Homi Bhabha’s concept of ‘hybridity’ and Mary Louise Pratt’s transculturations\textsuperscript{6}. Thereby, she tries to analyse the dynamics of exchange between the missionaries and the indigenous people in terms of exchange, even though it was a skewed and asymmetrical exchange. Thus she says:

"Missionaries and Indian Christians were in many respects engaged in a common enterprise, creating something new that was neither European nor Indian but simultaneously indigenous, foreign, and hybrid. Furthermore, missionaries in India were important to Indians, and in some circumstances were, and remain, respected and admired figures in the Indian Christian community and in the collective memory of educational and medical institutions that they helped to build." Missionaries also found themselves in a zone of "transculturation."\textsuperscript{7}

The present chapter uses these alternative frames of analysis to assess the contributions of female medical missionaries in India. By 1920s medical missions have reached their zenith and major mission hospitals and educational institutions were established. Though medical missions worked for general


\textsuperscript{6} Ibid., pp. 14-15. Cox Discusses the ambiguities in the relations between the colonial and the colonized in the lines of Homi Bhabha and Mary Louise Pratt.

\textsuperscript{7} Ibid., p. 15.
health care and even ran sanatoriums, in this chapter the focus is on the female medical missionaries and their contribution to maternal health care systems. After briefly tracing the advent of missionaries in India and their agenda, this chapter tries to place the growth of single or professional medical missionaries in West; within the larger discourse of western feminist movements. It will also discuss questions like the motive behind the female medical missions, relation between the church and the colonial rulers, the attitude of missionaries towards Indians women and health systems, the response of the Indians, especially Indian Christians, success of missionaries at evangelisation, Indianization of church, and church institutions, etc. Besides this it will also attempt to trace the genesis and growth of two famous missionary medical institutes i.e. Christian Medical College (CMC) at Ludhiana and St. Stephen’s Hospital at Delhi. Both these institutes were started by efforts of missionary women who had no formal medical training and they gradually grew into huge medical institutions, which are surviving even to this day.

Advent, Spread and Strength of Modern Missionaries in India

Long before the advent of Christians in Western and Central Europe, Christians were present in India. These communities, dating back to the earliest centuries of Christian era, were known as the Thomas (or Syrian) Christians and they believed themselves to be descendants of the converts of Apostle Thomas. Fifteenth century saw the advent of European colonizers in India and raiding this colonial wave, came the modern missionaries. Roman Catholic priests and missionaries set out from Lisbon each year in the fleets of ships for evangelising enterprises in heathen lands. They fanned out across different parts of India, seeking converts and establishing monastic institutions. After the British conquest of India a new wave of missionary activity started in eighteenth and nineteenth century which had important consequences for local women. Anglo-Saxon Protestants consider William Carey as the “Father of the Modern Missionary Movement” and he started a voluntarist movement by
appealing directly to grass-root believers whose Christian faith had been revived during the Evangelical Awakening (or Great Awakening in America).⁸

The modern missionary movement i.e. from late eighteenth century onwards was very different from the earlier missionaries, which were formal state sponsored enterprises, especially of Spain and Portugal. Most of these missionaries came from England, Germany, United States and they were all based around Missionary Societies, which were private and voluntary, run with private contributions and recruitments. The other very important distinct feature of the modern missionaries was that they were not itinerant preachers looking for converts but institution builders running hospitals, schools, churches etc. Even though evangelisation was the main activity, they were also cultural and social missionaries. Though Conversion to Christianity was the main objective of the women medical missionaries, they also strived to bring about some social changes, which they believed would follow from religious change.⁹ It is in this context that modern missionaries sought to reform the conditions of women in India and thereby promoted female education and health care systems.

Women missionaries, single and professional, were another distinct feature of modern missionary movement. From early nineteenth century onwards these single, independent women missionaries and nuns began travelling to Asia and Africa in their own right unlike their predecessors who were mere adjuncts to their male relations. They came in response to a belief that they had been 'called' to this work and they started women's groups, girls' schools, orphanages and convents. Through these they were able to enter the homes of married or secluded women to teach languages and other skills and also spread the gospel. On the other hand the pattern of mission work itself gradually altered. Evangelism had been by now taken up by the local priests; and

expatriates were recruited for their special skill and services in education, health and medicine and 'development' work. Unlike their predecessors these foreign missionaries no more spent their life time in the field, but went on short tours of 2-4 years duration.¹⁰

While Christian mission activity has often been presented as a single-purpose proselytising movement in league with the colonial powers, there were various denominations of Christian church. In colonial Indian context, the church of the colonisers i.e. the Church of England (Anglican) was the established one. The Raj needed to appear impartial and non-religious and thus had tolerated, with some reservation, other denominations like the Roman Catholic who had the largest local following and the non-conformist “low church” Methodists and Baptists who could irritate the British rulers by their emphasis on social reform. However, in the present study, all denominations are put in as a unitary church. By 1920 there was strong movement in India for the unification of Church, which strived for unifying all church denominations, despite their opinion and practice differences, into a single church.

Prior to nineteenth century in North India (consisting of broadly the two provinces of the Punjab including Delhi and the United Provinces) there was not much of the presence of Church. Some Jesuits had been invited to Akbar's court who established churches in major urban centres of the Mughal Empire for those Christians who had migrated. However, from eighteenth century onwards there were various other missionary societies working in North India, which had great impact not only on the religious front but also in the social arena, especially on women. The missionary activity had two main components i.e. the church or the ecclesiastical establishment and the missionary societies. For example, the Church of England had several ecclesiastical establishments and missionary societies working throughout North India. The Anglican chaplains for the Europeans in the East India Company's civil and military services constituted the ecclesiastical part of the Church of England. Church

Missionary Society (CMS), the Society for the Propagation of the Gospel in Foreign Parts (SPG.), the Church of England Zenana Missionary Society (CEZMS), the Zenana Bible and Medical Mission, the Society of St. Hilda, and the Cambridge Mission to Delhi (which was closely related to the SPG) were different missionary societies associated with the Church of England. Local committees of Europeans, who were eager to spread the Christian faith among the Indian population, generally invited and supported financially missionary societies into the cities of United Provinces and the Punjab. Various societies associated with different denominations were established in North India during eighteenth and nineteenth centuries. The chaplains, missionaries and Indian converts in North India were, thus, placed under the authority of the Bishop of Calcutta first and then with the establishment of new dioceses, of the Bishops of Lahore (1877) and Lucknow (1893). While some organisations like CMS and SPG worked with large establishments spread in various towns and villages, the activities of some societies like LMS were confined to very small area -some times just one town. By the turn of the century the missionaries were well spread in major towns and cities of North India.

In 1912, there were 136 missionary societies at work of which 41 were American and 41 British. There were 5,200 Protestant missionaries working under the aegis of Protestant church—which is nearly one thousand more than the missionaries working in China, which comes next in the number of Missionaries. (Annexure -I shows some of the missions working in north India by 1920) Of this, 1,867 were Americans and 2,470 were from Great Britain. These two countries alone sent four-fifths of all the missionaries to India at that time.

The National Christian Council for the India and Ceylon Mission Fields conducted a survey about the distribution of the missionary forces and

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11 Between 1809-1825, CMS began work at Chunar, Agra, Benaras, Meerut and Gorakhpur in United Provinces, at Simla and Kotgarh in 1840, and at Amritsar in Punjab in 1852.


missionary institutions in India at the beginning of 1920s. Out of the total 44,319 Indian Christian workers there were 30,385 men and 13,934 women. Total foreign workers, including wives, were 5330 (wives-1458). One important point to be noted is the number of Indian Christian male workers working with the church. There were 8.1 Indian workers per 1 foreign worker. In Punjab it was 6.8, UP 6.5 and Delhi 3.3. On the whole there were 98 foreign men doctors, 164 women doctors and 650 nurses. Of these, 262 qualified doctors were in charge of 670 hospitals, asylums, sanitariums and dispensaries. Besides these medical missionaries there were 584 qualified Indian male doctors and 233 female doctors.\(^\text{14}\)

In Delhi there were four missions working and there were 15 male missionaries, 32 female missionaries and 164 Indian Christian workers. There were 2 medical institutions and 47 educational institutions of all grades. In Punjab (Punjab at that time had a population about 25 millions and 20 missions were working) there were 15.4 foreign workers per million of population working in 30 districts and 17 native states. There were 10 foreign male doctors, 28 foreign female doctors, 28 Indian male doctors, 19 Indian women doctors and 115 nurses working in 52 hospitals and dispensaries. There were also 501 missionary educational institutions. In United Provinces with a population of 46.5 million, there were 14 foreign workers per million population and 29 missions were working in 51 districts. However, there were only 7 foreign male doctors and 32 Indian helpers of all grades; besides 16 female doctors, 41 Indian women doctors and 67 nurses.\(^\text{15}\) By 1920 this was the distribution and strength of missionaries in North India.

**Missionary Objectives**

The ultimate aim of Christian missionaries was evangelisation or spread of Christianity. They sought to preach and spread the gospel of God in the heathen lands and convert people following the heathen religions into Christians.


\(^\text{15}\) Ibid., pp. 211-213.
Integral to their process of evangelisation was the social work like spread of education, medicine, running of orphanages, old age homes etc. (Annexure II and III show various Missions working in Punjab and North India and the activities they were involved in.) However, in the colonial context the missionaries had performed a dual role of ‘conversion’ and ‘modernisation’.

“In the first role, missionaries claimed that they were bringing salvation and the light of true faith to people steeped in the darkness of the devil. In the second role, missionaries contributed to the breakdown of traditional beliefs and social structures, imposing Western system and values on local societies.”16 In the modern missionary discourse Christianity and western values were corollary to each other and were considered much superior to other belief systems. Thus, integral to these two agendas was attacking the local religion, cultural practices, social customs and values by equating them with superstition, immorality, dirt etc. Western progress and enlightenment were provided as ideological and institutional alternatives. The Evangelicals, thus, advocated not just conversion of the ‘heathens’ to Christianity but also to reform them of their ‘barbaric’ and ‘savage’ ways by introducing them to western concepts of the rights of man, better material life and modern education. A similar view (without religious content) was also held by the British Utilitarians of the time like Adam Smith, Jeremy Bentham, James Mill etc. Basing on this particular vision of civilizing and modernising; almost all missionaries, especially the Baptists, Methodists, Unitarians and other non-conformists, worked for social reform and women’s rights in the colonies. The missionaries also realized quite early that the massive task before them was not purely religious.17


17 John P Jones of Madura mission wrote about 100 years of American missionary enterprise in India in an article titled ‘The American Enterprise in India’, in Missionary Herald, Vol. CVIII, no. 9, September 1912 and in it he commented “.....there is vast amount of real culture among the classes in India; and it should be always be kept in mind that while the Chinese may be the more practical and better endowed with common sense and physical force, and while the Japanese may be the more enterprising and aggressive and artistic tastes, India still maintains and continue to maintain its preeminence as the Eastern land of thought. Its religious thinking: its theosophies and its philosophies have for millenniums furnished the strongest pabulum to all the peoples in the Far East. The people of India may be dreamy, but they are the profoundly thoughtful. They may be wildly mystic, but they are
Wherever missionaries went they observed and took notes on all issues which caught their interest. They commented on almost all major issues of social concern raised and discussed in India during that period. Though the main focus of the missionaries was on the question of the relation between the native religions and the social system, they also discussed about the nature of Indian social life and social conditions. "These issues include many overlapping matters such as caste and caste conflict, sati, early marriage and widowhood, temple prostitution, hook-swinging, the plight of the untouchables, slavery (especially in Travancore), land systems and landlord oppression, the use of coercion in the recruitment and management of labour, racism and oppression by European indigo planters, the suffering of the peasantry, the partiality of the police and corruption in the courts, the spread of drunkenness, opium cultivation and consumption, famines in south India and elsewhere, epidemics and disease." Though of a particular point of view missionary comment of nineteenth century covering an impressive array of topics. As these records were meant for the western audience, sometimes the description of non-Christian religions was intended to inspire horror and loathing mixed with a sense of pity. Men were often depicted as evil and barbaric, while the women were even more degraded and in need of salvation. As a result, from the early years of British rule in India Christianity began to assume an additional role in

the most religious people in the world. Thought and faith will dominate in Asia, no less in the future than in the past" p. 395.


19 As most of these records are written from a particular point of view, it is necessary for historians to study them with a bit of caution. John Spencer Carman was a medical missionary who worked in Hyderabad state and he wrote a book ‘Rats, Plague, and Religion: Stories of Medical Mission work in India’ in 1935. In this book he warns the readers about the conclusions drawn about India. "Sweeping generalization about the character of whole people are not justified on the basis of brief and partial pictures, even though the pictures, as far as they go, are true and deeply moving. If the people of India were all denigrates, as some touring scribes would have us believe, where would hope lie? With such sweeping conclusions we cannot agree. It is our high privilege to share in a sincere admiration for many things Indian, past and present, and in the bright hope for a greater India in the future. How can we blame the more unfortunate citizens of a country for not applying and enjoying the benefits of knowledge which we have but imperfectly and incompletely shared with them, while yet we have been enjoying the fruits of their toil and labour and of our exploitation of their physical resources?" (p. 3)
challenging prevalent social customs and family structures that affected the status of women.

Colonial Administrators and Missionaries

The East India Company in their commercial interest had found it easier to go along with local religious customs than to antagonize the natives, so it did not hesitate to expel any missionary, whose activities they believed would create disorder or provoke social unrest. However, this changed with the passing of Charter Act of 1813. After considerable pressure from missionary groups in Britain, particularly the Evangelicals led by the Clapham Sect, Parliament and the Company agreed to include a clause in the Charter Act 1813 allowing Christian missionaries to enter India. In 1858 the Queen’s proclamation extended her jurisdiction and protection over her Indian subjects, after the British government had taken control of India after the mutiny. With regard to the religious faiths of India, the queen’s proclamation stated:

“We disclaim alike the right and the desire to impose Our convictions on any of Our subjects. We declare it to be Our royal will and pleasure that none be in anywise favoured, none molested or disquieted, by reason of their religious faith or observances, but that all shall alike enjoy the equal and impartial protection of the law........Firmly relying ourselves on the truth of Christianity, and acknowledging with gratitude the solace of religion”

Although the policy of the British administration in India was non-interference in religious matters, yet the Christian principles continued to be the foundation and guiding principles of the government.

Some historians like Robert Frykenberg felt that the government of India had little reason for enthusiasm toward missionaries, especially foreign missionaries. He says, “At no time in the history of India did anything like a majority of missionaries in India, whether British or non-British, show a

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predisposition in favour of colonialism." Frykenberg gives the reasons for official ambivalence towards missionaries as there was great strength of non-British missionaries who were opposed to colonial ideology and increase in the number of free, non-denominational and unfettered forms of voluntarism. These missionaries were beyond the control of the mainline denominations and beyond the established systems of ecclesiastical control that such denominations, or that state-church possessed. However there was undeniable relation between the missionaries and the colonial administrators.

Besides the official scepticism towards foreign missionaries the British administration was itself divided in its attitude towards missionaries as such. While some believed that encouraging and supporting missionaries was against the policy of non-interference in religious matters, others believed that the Christian principles were not tyrannical impositions but tools for betterment of life of the colonised. The social reform activities of the missionaries invariably found sympathisers in the British administration and got help in the government’s own regulations. For instance, missions began to take advantage of a pre-mutiny education dispatch of 1854 that offered grants to schools administered by voluntary efforts so long as they accepted government inspection and guidance in respect to the secular part of the curriculum. Thus, official attitude and responses to missionaries in India remained ambivalent.

The gradual softening of official attitude towards missionaries and the contrast between the time is reflected in the words of the World’s Christian Endeavour Convention (1909, Agra) President Herbart Anderson of India. He said that “nearly a century ago when one of the early English Baptist missionaries was

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22 The official attitude can be summed up in the words of Sir W. Mackworth Young, formerly lieutenant governor of Punjab. On his return to England he said “English officials are compelled by their position to maintain an attitude of impartiality in religious matters......As a business man speaks to a business man, I am prepared to say that the work which has been done by the missionary agency in India exceeds in importance all that has been done (and much has been done) by the British government in India since its commencement. Let me take the province, which I know the best. I ask myself what has been the most potent influence which has been working among the people since annexation fifty years ago, and that question I feel there is but one answer- Christianity, as set forth in the lives and teaching of Christian missionaries.” Cited from Missionary Herald, Vol. CXVII, no. 2, February 192, p.50.
marched out of Agra under the orders of the Earl of Minto: the Viceroy of that time and, the present, when this great convention met in tents furnished by another Earl of Minto and Viceroy."

Missionaries obviously did have different motives from other imperialists. Even those Anglican missionaries, who were politically the most enthusiastically pro-imperial in their politics, regarded the British Empire as ephemeral and the Kingdom of God as eternal. However, with the dual duties of ‘Conversion’ and ‘Modernization’ missionaries often combined religion and civilization, making it difficult to separate their tasks as a missionary and as a citizen. A large majority of missionaries were incapable of disentangling Christianity from Western culture, and those who tried usually failed. Colonial administrators and missionaries discovered common interests of social reform or imposition of western values and this convergence of interests often looked like an identity of interests to outsiders. Speaking in the same spirit, C.F. Andrews commented on the state-church relation in the following words:

"As the nineteenth century advanced missionary movement gradually intermingled with that of economic and political imperialism. Since territorial aggression in East emanated from the same countries as the missionary enterprises, it became almost impossible to disassociate the two.... Many of them were ready to accept liberal growth from the ruling foreign powers in order to promote by material means their spiritual work. Thus there grew up an imposing framework of buildings, which to the outward eye of non-Christian observers appeared to be outposts of foreign rule. Schools, hospitals, dispensaries and large mission compounds often bore this appearance."

Women's Work for Women

Women played a crucial role in almost all areas of Protestant and Catholic missionary endeavour. Although women had done missionary work for years, they had done so in subordinate capacity as assistants to officially church-designated missionaries. In this period missionary service was deemed to be a realm of male endeavour; the candidacy of women for missionary office was

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scarcely accepted by the main mission boards. Women were denied ordination and thereby, were excluded from the foremost missionary ranks. They had only the peripheral role in the missionary agenda and were relegated to the lowly rank of the clerical missionary’s lay assistant. Marriage and motherhood were believed to be woman’s natural calling and the home was considered as woman’s realm. So, traditionally, the female presence at a mission would be that of a wife or sister of a missionary, unless the mission was Roman Catholic in which case there might be nuns. In the home country these women were fund-raisers and recruiters for mission work abroad and while in the field they continued in the traditional roles of home-builders for male missionaries. Women were present in the mission fields of this period as members of the male missionary’s family, wives, daughters, sisters, even occasionally mothers and aunts. Their presence in the field was not only an indicator of peaceful intentions and thus ensured of friendly reception by the local people but also served as role model of female behaviour. “In effect, missionary wives were not only ‘married to the job’ but they were often married for the job.”

Although these women’s primary duty was to take care of home and family, many of them did much more than act as passive exemplars of Christian domestic life. They were rarely allowed to claim the missionary title, yet, ‘silently and unassumingly’; they pioneered mission work among the women and children of other lands. From 1860s onwards there was a change of attitude towards the role of women in the missions and there was a realisation that the women missionaries were needed to approach women.

Geographically, the practice of female seclusion was far stronger and more widespread in the northern, north-western and eastern parts of the country where Mughal influence had taken deepest root. The missions gradually concluded that their failure to win converts from these classes and localities

was in large part due to the inaccessibility of women. The role of women missionaries gained greater significance in these areas where the women were secluded in the zenanas. Women missionaries had easy access to these zenanas where the male missionaries failed to enter. By the beginning of the nineteenth century almost all the missionary societies started forming the women's branches and women missionaries were commissioned to carry forward “women's work for women” started by the female relatives of the male missionaries. “Objections to women missionaries receded and were replaced by increasingly insistent pleas for “virtuous” and “valiant” women — “the more highly cultivated and refined the better”- to dedicate their lives to missionary service overseas.” These women missionaries not only sought the conversion of heathen women but also strived to bring some relief to these secluded women. The ‘mission of sisterhood’ also brought out a comparison between the ‘unfree’ zenana victim and the ‘free’ English counterpart, portrayed most starkly in the contrast between the confining zenana and the freedoms of the British home.

One of the earliest Ladies Auxiliaries to be established was of the Society for the Propagation of the Gospel in Foreign Parts. The ‘Ladies Association (sometimes called the Ladies Society) for the Promotion of Females Education among the Heathen’ was formally established in 1866. The stated objectives of this organization were: to provide female teachers for native girls, assist female schools with clothing and books, promote female education however possible, and assist in maintaining interest in the Society’s work. The women sent out as missionaries were attached to SPG missions in various places in India and their term of service was for three years. In 1904 the Ladies Association became an integral part of the SPG and was designated the Committee for Women’s Work under a standing committee of the Society. The function of this Committee was to find, train and send out women missionaries for the society. By 1915 there were 333 women engaged in education, medical work and evangelism. “Not

Xxviii Rosemary Fitzgerald, A Peculiar And Exceptional Measure: The Call For Women Medical Missionaries for India In the Late Nineteenth Century, p. 178.
violence, not emotion, but logic, led the SPG to pronounce in 1902 that as women’s work was a vital part of the missionary effort of the church, it should be organised and maintained by the society. The obvious corollary was that women should have a place in the administration of the Society which in fact came about in 1921.”

The following qualities were listed in an SPG pamphlet entitled *What Sort of Women do we Need?* (SPG Records 1915):

1. Women who are ‘mission hearted’.
2. While women of all classes may be suitable on grounds of character the special skill required mean in practice women from ‘higher’ social classes.
3. Women who have received a good general education.
4. Professional qualifications are desirable, especially in medicine, nursing and teaching.
5. In the work of evangelism women are needed abroad not only as district visitors, but as *friends* – the importance of friendship with educated women must be emphasized, especially in China, Japan, India, etc. All require imagination, sympathy and adaptability.
6. Candidates should be willing to go anywhere, and should readily accept preparatory training.

Temperamental suitability was one of the greatest considerations for recruiting single female missionaries. Church Missionary Society (CMS) was also very reluctant initially to engage single women as missionaries, although the work of women as “wives, sisters, daughters and female members of missionaries' families” was greatly valued, especially for the purpose of furthering female instruction. By 1880s a Ladies Committee was formed and a large number of single women were commissioned as CMS women missionaries. In 1890 the Society’s laws were further revised to cover cases of female candidates received by the Ladies Committee. Similarly London Missionary Society also saw the emergence of women’s auxiliary in the nineteenth century. ‘Women’s work’ in the LMS was progressively transformed from a ‘labour of love’ conducted by missionary wives to a professional employment carried out by

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single women missionaries.\textsuperscript{31} The formation of these church-oriented sisterhoods or female orders in other denominations did bring an increased female presence in missions, but these 'sisters', like Roman Catholic nuns and missionary wives were very much under male authorities. Yet they gained a recognized place in the missionary framework and began to come to India to fill designated positions when missionary activity began to expand in India both in volume and in kind.

With the creation of these Ladies' Auxiliary, the problems of the 'native' women also began to assume far greater importance and to merit systematic resolution. These problems were seen as enormous and thought to stem from two aspects of Indian culture i.e. Hinduism and Hindu patriarchal structure. Christianity and the accompanying smattering of Western 'practical' learning were supposed to give women the courage to break free of both these bonds.\textsuperscript{32} This sudden emergence of single women coming forward to work in distant lands is better understood in the background of the feminist movement witnessed in west during nineteenth century.

Recent feminist researches have shown that 19\textsuperscript{th} century had witnessed women's movements in Europe and United States. The Society of Friends, popularly known as the Quakers, a group originating in 17\textsuperscript{th} century radical Puritanism shared many of these beliefs. Quaker women have been called the 'mothers of feminism' because they were the first to have separate women's meetings.\textsuperscript{33} The movement also produced many of the women social reformers, including leaders of the anti-slavery agitation and women's rights movement of the 19\textsuperscript{th} century. During this period, a network of Christian women emerged proclaiming global sisterhood and they ventured out of their homes into the male world of work. They travelled alone to far off countries in the name of the

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\textsuperscript{32} Bose, For Our Native Sisters: The Wesleyan Ladies Auxiliary In India, p. 223.
\textsuperscript{33} Jayawardena, The White Woman's Other Burden: Western Women and South Asia During British Colonial Rule, p. 25.
\end{flushright}
'noble cause' to serve God and improve the condition of women. These middle-class single women were mostly professionally trained and they entered paid employment in large numbers. "Rather than a trope of domestication, it is a trope of emancipation, which organizes the representations of the 'mission of sisterhood' within the missionary texts."  

One of the outcomes of the bitter struggle for higher education in the west and also of the feminist movement of the early twentieth century was the emergence of women professional doctors. Some of these early women doctors like Clara Swain, Elizabeth Beilby, Edith Pechey, Fanny Butler etc worked in India and these doctors had the additional burden of social reform besides the day-to-day work in the hospitals and evangelisation. They brought many ideas of women’s rights into their work with Indian women. As these women doctors were more involved in saving lives rather than souls, the local non-Christian population often regarded them with great affection and respect. There were many secular women physicians along with missionary doctors who were working in India at that time. But the difference between the two is clear in the sense that the secular doctors were interested less in Christianity and more in institutional and social reforms especially in areas affecting women. These included female medical education, the training of midwives, nurses, apothecaries and the establishment of exclusive women’s hospitals. Some scholars felt that undeniably the missionary women were philanthropic yet there was an issue of 'opportunity'.  

The perception that foreign medical women were needed in India played an important role in opening medical schools to British women. This also provided job opportunities for first women doctors who found it difficult to practise at home countries. "The circle was a comfortable one; tasks of the zenana provided the raison d'etre for British women's medical training, trained women pursued lucrative careers in the Empire, and feminisms was

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34 Jane Haggis, 'Good Wives and Mothers' or 'Dedicated Workers?' Contradictions of Domesticity in the 'Mission of Sisterhood', Travancore, South India, p. 106.  
removed from 'home' and given free expression in India where it legitimized British rule. By sponsoring British medical women for women-only hospitals, the Raj posed as both human and sensitive to the needs of the zenana.\footnote{Geraldine Forbes, \textit{Women in Colonial India: Essays on Politics, Medicine and Historiography}, Chronicle Books, New Delhi, 2005, p. 110.}

Women in Victorian Britain campaigned for equal educational opportunities so that they could break in to the professions. The story of establishment of London School of Medicine for women in 1874 reflects the bitter struggle the women fought for entry into training of medicine. This began in 1865 when Elizabeth Garrett Anderson, having passed the examinations held by the society of Apothecaries, was refused admission to medical collages in England. In 1870, seven women were admitted as medical students to the University of Edinburgh, but after opposition from a section of the faculty and students (and a court case) they were expelled. In face of opposition and failure of bill in parliament, the women students who had been rejected by the Edinburgh University (led by Sophia Jex-Blake, Edith Pechey and others) formed the London School of Medicine for Women in 1874, which enrolled twenty-three students in the first year, with visiting male lecturers from other faculties.\footnote{Jayawardena, \textit{The White Woman's Other Burden: Western Women and South Asia During British Colonial Rule}, p. 76.} Parliament finally passed legislation (Enabling Bill) in 1876 that removed restrictions on medical education for women. London School of Medicine for Women (LSMW) played a very important role in promoting the work of female medical women in India. The LSMW predated the Dufferin Fund by a decade and established ideological and structural linkages between British women doctors and their Indian female clientele that the fund would use as the basis of its own network of female medical women for India.

The first generation of female physicians in Britain worried about the lack of proper medical training on part of women attached to religious missions. They felt that their claim to female professionalism for which they worked hard would be undermined. "Several of the most prominent of them wanted to use the resources in India to the maximum for which British medical women
needed to formulate and then police their own definition of ‘Women’s Work in the empire so that they could be taken seriously both as medical professionals and as workers indispensable to the imperial enterprise.”

The first task of the medical missionary women who came to India was community outreach. Contrary to the norms of medical practice in Western societies, women physicians in India had to reach out and make themselves available to those who were sick, wherever they were. House visits were important confidence-building measures, before patient could be expected to visit the dispensary. By 1920 the nature of medical mission had also changed. There are some factors, which led to the changes in the medical missions. “The increase in the number of qualified medical practitioners in the vicinity, the rapid decrease in the resources available from abroad, the development of transport facilities bringing formerly isolated institutions in to relative juxtaposition, the development of government health and medical services and the requirement of government registration involving the establishment of standards of hospital equipment and personnel.”

Many individual medical missionaries and in some case groups, struggled to make available the important advancements made at the base in the frontier medical mission services.

Women in the North India Missions were generally engaged in four spheres of activity i.e. education, medicine, zenana visiting and itineration. Many girls’ schools were established and some times boarding schools were run for the promotion of western education among the girls. For example the SPG and CMD in Delhi ran St. Mary’s School for girls and the North India Mission ran three boarding schools for Indian Christian girls, the Elizabeth Prentiss School.

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at Etah (1900), the Rakha Orphanage and School near Farrukhabad (1838), and Mary Wanamaker School at Allahabad.\textsuperscript{40}

A second sphere of activity was the provision of Western medical care to women and girls. In the years before medical mission, untrained women missionaries also tried to introduce new methods of tackling health problems. Using the home nursing skills most missionaries also ran ‘veranda dispensaries’ and dispensed simple medicines on their evangelical tours through the rural areas.\textsuperscript{41} Often this was the only medical facility available to women. These institutions, along with their conscious evangelism, provided a distinct and often life-saving service to Indian women and their families. Missionary women doctors were the pioneers in establishment of medical education for women in India. Missionary physicians ran, often with only a skeleton staff and provided medical services at smaller dispensaries in provincial towns and even in villages.

Zenana visiting was the third activity and was usually carried out by married women. Zenana visiting was aimed at reaching the secluded upper-class women confined to the women’s quarters of houses. In these visits they encouraged literacy and made the teaching and reading, albeit through religiously oriented texts, an essential part of their visits. Finally, despite the Presbyterian ban on women’s public preaching, women missionaries also engaged in itinerant evangelism. For the present study only one aspect of these four has been taken i.e. western medical care and medical education. Female Medical missionaries and their working in India is the main focus of the study.

**Medical Missionaries**

During the first half of the nineteenth century the medical missionary was regarded as a ‘rare curiosity’ in the mission field. Dr. Smith of Madras Service advocated the establishment of Medical Missions in India and he said that

\textsuperscript{40} Flemming, New Models, New Roles: U.S Presbyterian women Missionaries and Social Change In North India 1870-1910, p. 49.

every science, art or religious endowment should find its place in the system of religious agency, which is brought to bear on country like India. "The effects of science may thus be analogous to the influence exerted by miracles in the first generation of the Church. We have not now the gifts of healing anymore than we have the gifts of tongues: but if the modern missionary makes use of philological aids to remedy the latter defect, why should he not endeavour to supply the former by the study and practice of medicine?"  

The early missionaries, though medically unqualified, had often provided some basic medical services to their converts and other locals. The Baptist missionaries like William Carey, Marshman or Ward had no professional medical training yet they were compelled to treat sick at Serampore. In 1810 William Jones, a Baptist doctor, came along with Miss Chaffin to whom belongs the honour of being the first missionary nurse. Mary Warburton Booth was stationed at Gorakhpur in the United Provinces. Though she came to work as a teacher, she was forced to do medical work because of lack of hospitals and doctors. The medical missionaries were welcomed by all strata of people, for medicine promised relief from pain and suffering. The effective role played by the medical missionaries was appreciated and the employment of medical work as a vehicle for missionary advance has become the new strategy of the missionary societies from 1860 onwards. Medicine came to be regarded as a supremely effective agency for 'breaking down the native wall of pride and prejudice, contempt and hatred' that commonly confronted ordinary missionary methods. Medical work became the most effective key to open up the heart of Indians by the missionaries. This situation called for an aggressive policy for medical missions in India, combining closely the task of the doctor and the evangelistic missionary. In 1864 at the Punjab Mission Conference, Robert

44 Fitzgerald, A Peculiar And Exceptional Measure: The Call For Women Medical Missionaries For India In the Late Nineteenth Century, p. 186.
Clark advocated the formation of a Punjab Medical Mission Association to cooperate with the Edinburgh Medical Missionary Society to provide trained doctors as missionaries.

From Britain, only men were available as medical missionaries until the late nineteenth century and CMS appointed William J. Elmslie, a Presbyterian Scottish medical missionary to Kashmir Mission in 1864. Dr. Elmslie approached the London Zenana Committee in 1871 to ask for female medical missionaries and put a startling suggestion that they should launch 'female medical mission' and it was not solely on humanitarian grounds. Since the establishment of medical college was still pending in England at that time it was decided to train women as private pupils to medical professors at hospitals. This new venture meant strain on funds of CMS, but in January 1872 Arthur Kinnaird convened such a well-chosen meeting of wealthy friends that 1,000 pounds was raised at once. The first women medical missionaries for India were Lucy Leighton, a sister at St. Thomas, and Mrs. Crawfurd, a Scots widow and they sailed to India in November 1873. Lucy Leighton who was already ill could not survive the long journey and passed away even before crossing the Gibraltar. Mrs. Crawfurd landed at Bombay and with in three months expired.45

It is through this fund that Elizabeth Bielby came to Lucknow in 1875 and it was she who carried the message of Maharani of Panna in a locket to the Queen in 1881, drawing her attention to the immediate need for health care of women in India. This eventually led to the establishment of the Dufferin Fund in 1885. These qualified physicians, among the earliest in their parent societies, worked for long years as gynaecologists, obstetricians and surgeons; heading full-fledged hospitals for Indian women.

Medical attention, it was also felt, would be an important means for missionaries to get access to females secluded in the zenanas, many of whom were reluctant to consult male physicians. Zenana missionaries, seeing the miseries of some of the women and children, would act as go-betweens, reporting to a doctor and bringing medicines. Missionaries began to equip

45 Pollock, Shadows Fall Apart: The Story of the Zenana Bible and Medical Mission, p. 35.
themselves with some medical knowledge, often using their vacations in the West to get hospital training. This was not very satisfactory; so some missionaries studied what medical books they could lay hands on, learned the use of simple remedies, and did what they could to relieve sickness among zenana women. On their first furlough itself some of them sought opportunities to increase their knowledge. For example Miss Rose Greenfield of the society for Female Education in the East came to teach in zenanas but seeing the need for medical aid she attended clinics conducted by her brother in the guise of a nurse. During this period when women had no access to medical education in Europe and the United States, some institutions in the West gave short courses in medicine and midwifery to missionaries. The medical work of missions started as secondary activity but later on became the central purpose of medical missions.

In the early stages western women physicians had to make a space for their work in indigenous society as local women mostly consulted practitioners of traditional medicine like hakims and vaidyas. The local dai (midwife) was the only help for women in childbirth conducted in the privacy of their homes. The physician, especially the woman physician, succeeded in entering the secluded zenanas, the most inaccessible stronghold of heathenism. Thus, they carried the Gospel of God into these dark areas. “Called to the inner most recesses of harem and zenana to take pity on mother or child, the woman Missionary doctor came ‘as the first streak of God’s pure sunlight which permeates those polluted prisons; as the lowly yet true herald of that Sun of Righteousness risen with healing on his wings.”

The emergence of the woman medical missionary was amongst the most striking of all developments in this new era of mission methods. She was said to possess unrivalled powers as a mission agent who can gain access to the

zenanas and thus spread the Gospel into the hearts and home of her patients. The unique feature of the female medical missionary was to enter the world of Indian women to apply the double cure of healing of both body and soul. Most missionaries came to India committed to bring about a change in the social norms effecting Indian women and often this commitment was couched in a rhetoric that stressed women’s low status in Indian society and urged conversion to Christianity as a means of raising women’s status. “Missionaries were equally critical of the lifestyles of high-caste Hindu and Muslim married women, who were almost completely secluded in their husband’s family’s houses, and in their writings they contrasted these women’s lives with what they considered to be their own enviable freedom of movement.”

In the early decades of the twentieth century the western women physician’s efforts led to the establishment of some of the great mission hospitals and medical educational institutes in India. The small-scale training classes for Indian girls were formalized to give certificates and diplomas that equipped them to launch their own dispensaries. Finally, by the middle of the twentieth century, these institutions were compelled to keep pace with the times and match the best standards of medical education and clinical facilities available in the general non-segregated hospitals in India.

In the middle of nineteenth century a medical college for women was opened in Philadelphia, chiefly through members of the Society of Friends, who have always recognized the equality of men and women. From this college came Clara Swain, an MD from Pennsylvania who belonged to the Methodist Women’s Foreign Missionary Society and was the first fully-qualified medical woman to come to India. She arrived at Bareilly, January 2, 1870. She trained a class of fourteen girls, opened a dispensary, then a hospital in 1874 on the land donated by the Nawab of Rampur. In 1871 the American Presbyterian


Mission sent Dr. Sara Seward to India and she worked at Allahabad till 1891 when she died of cholera. Zenana Missionary Society of the Church of England, in 1880 sent out its first qualified woman doctor, Fanny Butler, who worked in Jabalpur and in 1887 this mission pioneered medical work among Kashmiri women. The most important of the early British women medical missionaries was Elizabeth Bielby who arrived in India in 1875 with some basic medical training and opened a dispensary and a small hospital in Lucknow for the Zenana Missionary Society.

**Mission Hospitals**

India’s population had increased by about thirty-two millions in the decade 1921-31 and totalled over 351 millions. Some ninety per cent of these lived in the 750,000 villages— a mass of over 300 millions and the average size of a village was about 400 inhabitants.\(^{52}\) There were very few medical facilities available and missionaries were major providers of health care facilities. By 1927, there were just 181 hospitals which were headed by women. Of these 93 were headed by missionaries, 25 by members of the Women’s Medical Service and 63 by other medical women employed by the provincial government and local committees.\(^{53}\) Most of the medical institutions were built on the foundations laid by the non-professional missionary women working in India. There were 175 Mission hospitals spread all over India with Punjab, including Delhi, and United Provinces having 26 and 16 hospitals respectively. Besides these hospitals there were also many dispensaries run by the missionaries, where free treatment was provided. The following statistics give a brief overview of these hospitals in the Provinces of Punjab, Delhi and United provinces.\(^{54}\)

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\(^{52}\) Ibid., p.10.

\(^{53}\) Chawla Singh, *Gender, Medicine and Empire: Early Initiatives in Institution Building and Professionalisation (1890-1940s)*, pp. 93-94.

\(^{54}\) Ibid., p. 23.
By 1932 Punjab had a population of 28,490,856 and had twenty-six hospitals and a Union Mission Sanatorium at Sanawar, Simla Hills. The following table briefly shows the name of the Church and the place where they were running mission hospitals in Punjab:

<table>
<thead>
<tr>
<th>Church</th>
<th>Place</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church of England Zenana Mission</td>
<td>Amritsar and 4 near by places</td>
<td>St. Catherine Hospital</td>
</tr>
<tr>
<td>American United Presbyterian</td>
<td>Jhelum, Sialkot, Parsur and Sargodha</td>
<td>Women and children</td>
</tr>
<tr>
<td>American United Presbyterian</td>
<td>Taxila</td>
<td>General</td>
</tr>
<tr>
<td>Baptist Mission</td>
<td>South Bhiwani</td>
<td>Women and children</td>
</tr>
<tr>
<td>Baptist Mission</td>
<td>Palwal</td>
<td>General</td>
</tr>
<tr>
<td>Canadian branch of the Anglican Church</td>
<td>Palampur and Kangra</td>
<td>Women and children</td>
</tr>
<tr>
<td>Church of Scotland</td>
<td>Gujrat and Sialkot;</td>
<td>Women and children</td>
</tr>
<tr>
<td>Church Of Scotland</td>
<td>Chamba and Jalalpur Jattan</td>
<td>Men</td>
</tr>
<tr>
<td>American Presbyterian</td>
<td>Ferozepur and Ambala</td>
<td>Women and children</td>
</tr>
<tr>
<td>CMS</td>
<td>Multan</td>
<td>Women and children</td>
</tr>
<tr>
<td>SPG</td>
<td>Delhi</td>
<td>Women and children</td>
</tr>
<tr>
<td>American Reformed Presbyterian</td>
<td>Montgomery</td>
<td>Women and children</td>
</tr>
<tr>
<td>New Zealand Presbyterian Mission</td>
<td>Jagadhar</td>
<td>General</td>
</tr>
<tr>
<td>Seventh Day Adventist</td>
<td>Cheockokimullian</td>
<td>Women and children</td>
</tr>
<tr>
<td>Zenana Mission</td>
<td>Ludhiana</td>
<td>Christian Medical College</td>
</tr>
</tbody>
</table>

(Source: *The Ministry of Healing in India: Handbook of the Christian Medical Association of India, p. 34*)
The United Provinces with a population of 49,614,833 had fifteen hospitals and one sanatorium in 1932. Besides these there were many dispensaries also like Jumna dispensaries at Allahabad run by the American Presbyterian Mission. The hospitals at Benaras and Mahoba run by the Zenana Bible and Medical Mission and Christ Mission respectively may also be mentioned here which were closed down due to lack of funds.\textsuperscript{55} In United Provinces the United Presbyterian Church also contributed a lot for women’s health care. Missionary physicians ran, often with only a skeleton staff, the Sara Seward Hospital at Allahabad and a full dispensary at Fatehgarh. Some others provided outreach medical services at smaller dispensaries in provincial towns. Initially using the home nursing skills, typically possessed by nineteenth-century American women, most missionaries also ran ‘veranda dispensaries’ and dispensed simple medicines on their evangelical tours through the rural areas.\textsuperscript{56} The following table shows the name of the Church and the place where they were running mission hospitals in United Provinces:

<table>
<thead>
<tr>
<th>Church</th>
<th>Place</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Episcopal Church</td>
<td>Brindaban and Bareilly</td>
<td>Women and Children</td>
</tr>
<tr>
<td>American Presbyterian Mission</td>
<td>Fatehgarh and Kasganj</td>
<td>Women and Children</td>
</tr>
<tr>
<td>Zenana Bible and Medical Mission</td>
<td>Lucknow</td>
<td>Women and Children</td>
</tr>
<tr>
<td>Women’s Union Mission</td>
<td>Jhansi and Fathepur;</td>
<td>Women and Children</td>
</tr>
<tr>
<td>SPG</td>
<td>Cawnpore and Ummedpur</td>
<td>Women and Children</td>
</tr>
<tr>
<td>Wesleyans</td>
<td>Akbarpur</td>
<td>Women and Children</td>
</tr>
<tr>
<td>Australian Methodist Mission</td>
<td>Azamgarh</td>
<td>Women and Children</td>
</tr>
<tr>
<td>American Methodist Episcopal Church</td>
<td>Almora</td>
<td>Union Sanatorium for Women and Hospital</td>
</tr>
<tr>
<td>Bible Churchmen’s Missionary Society</td>
<td>Kachwa and Mirzapur</td>
<td>Women and Children</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>Moradabad</td>
<td>Women and Children</td>
</tr>
</tbody>
</table>

\textsuperscript{55} Ibid., p. 35.

\textsuperscript{56} Flemming, \textit{A New Humanity: American Missionary Ideals for Women in North India, 1870-1930}, p. 199.
Some of the ‘veranda’ dispensaries of the initial years eventually grew into hospitals. From these also emerged the first training classes and medical schools for Indian women. The early informal classes for midwives grew into the certified graduate training programmes of LMP (Licensed Medical Practitioners) and even university grade classes for degrees in medicines. For example, The North India School of Medicine for Christian Women, which began in 1894 with six pupils became CMC Ludhiana. Usually the only medical facilities available to women, these institutions along with their conscious evangelism; provided a distinct and often life-saving service to Indian women and their families. They also trained both men and women as nurses, dressers (of wounds), compounders (lay pharmacists) and hygiene instructors, encouraging them to live among village Christians to help them combat disease.\(^{57}\)

CMC Ludhiana and St. Stephen’s Hospital are two famous Missionary institutions established during this period. Interestingly enough, the female missionaries who had no medical training laid the seeds for the establishment of both. Later on the small dispensaries and training units were taken up by professional medical missionaries and made into huge establishments. The initial struggles and efforts to reach out the personal experiences of single female missionaries, the disappointments, success, etc. reflect the immense struggle carried out by these missionary women. For an in depth study two famous medical institutions i.e. CMC Ludhiana; a medical College and St. Stephen’s Hospital Delhi; a Hospital are taken in the present chapter.

**Christian Medical College, Ludhiana**

By 1931 there were twenty nine mission hospitals in the Province of Punjab which was more than any other Indian state or province except Madras. Sixteen of these hospitals were staffed by women missionaries. Christ Mission Society (CMS) started its work in Punjab in 1851 soon after the annexation of the

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Province by British. However, the work concerning women was carried out by ‘The Zenana Bible and Medical Missions’ and the CEZMS. The former looked after exclusively the medical work in Punjab and Sarah Hewlett was their first female medical missionary. In early 1880s she began a class for one hundred untouchable women (who were dais) in Amritsar and introduced new methods of maternal care and childbirth procedure. She also founded St. Catherine’s Hospital with six beds for women in Amritsar and began systematic training of Indian girls as assistants in mission hospitals midwives in 1884. By 1897 she was supervising eleven fellow workers, sixteen Bible Women and several Christian converts in training. Sarah Hewlett continued her services till her retirement in 1912.

Rose Greenfield, a Scottish Zenana missionary worker, arrived in India in 1874 supported by the Society for Promoting Female Education in the East. She established the Ludhiana Zenana Mission. Her work was to teach in zenanas and to organize schools for children, however seeing sickness around, she began almost at once to prescribe cleanliness and simple remedies. She had no medical training and on her first furlough she attended the dispensary conducted by her brother in the guise of a nurse to pick some medical knowledge. On her return besides schools she also set up a one room dispensary in 1881 and finally, the 10-bed Charlotte Hospital. This hospital was housed in the building of an erstwhile Presbyterian church. In time this hospital began attracting Indian women, although house visits remained an important trajectory of medical work. This in turn brought the much-needed revenue through visiting fees. Charlotte Hospital (Ludhiana) soon acquired recognition and received colonial subsidies. In 1893 Greenfield worked with Dr. Edith Brown to open a medical school for women in Ludhiana. She raised funds for a hospital in connection with the school which was named the Memorial Hospital after one of her sisters. Years later when Miss Greenfield was joined by her niece, Dr. C. Rose Greenfield, the latter said that many of the

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58 The Ministry of Healing in India: Handbook of the Christian Medical Association of India, Mysore, 1932, p. 27.
woman preferred to have her aunt examine and treat them. Miss Greenfield did forty-nine years of service in the Punjab before she retired. She died in 1930, at her cottage in Murree.

Women's Christian Medical College at Ludhiana was established mainly by the efforts of Dr. Edith Brown. Brown got her degree from Edinburgh (a Scottish Medical Diploma) and later M.D. from Brussels. For her services she was awarded silver Kaiser-a-Hind in 1910 and in 1922 gold Kaiser-a-Hind. George V granted her the title of 'Dame Commander of the British Empire'. Dr. Brown was briefly posted at Palwal where she saw that native women preferred the services of local hakim and there were no facilities to practice medicine. She was later posted at Ludhiana mission hospital. At Ludhiana she welcomed opportunities when called to attend complicated cases of childbirth, which the local midwife had given up. Her professional reputation increased with the success in these complicated cases. Brown when performed her first surgery had no trained help and had to perform it alone. She realized that major operations simply cannot be done by one pair of hands alone. Describing the great need for trained assistants in the field Dr. Brown wrote to her friends.

"You know the difficulties I have had, unable to leave the hospital to visit the sick in the villages; and how unable the sick girls have been to come in to me regularly. I feel how much better the work could be done if I could have some trained medical assistants. Then the thought came, why should we not have a Christian Medical School attached to one of our mission hospitals, and ourselves train suitable girls" ...... "We must also have .... an army of trained Indian girls, more year by year; girls who are nurses or midwives or dispensers, and all of whom mean to live and teach the Christian way of life. We must have enough to get them into all the villages where they are needed." 61

Dr. Brown visited the medical schools at Agra and Lahore in 1892 where some women students were studying along with men. She found the moral climate in the two schools was not satisfactory for the girls to study there and she also believed that the girls "do not get competent training in midwifery from their

59 Ibid., p. 23.
61 Ibid., p. 20.
men teacher and etiquette forbids them asking questions." Chawla Singh, *Gender, Medicine and Empire: Early Initiatives in Institution Building and Professionalisation (1890-1940s)*, p. 98.

When Dr. Brown tried to discuss with the head of the Baptist Mission in Delhi about the need of trained female medical assistants, the mission suggested her to start training them herself. Despite this discouraging response from her missionary superiors, Brown was determined to start a training programme for assistants. With some support from officials of the colonial medical establishment she organized a conference of women medical missionaries in December 1893. This three-day Conference of Women Medical Missionaries at Ludhiana, was attended by fourteen women (eight with M.D or MBBS) representing the seven missionary societies in Punjab, Delhi and Rajputana. In 1894 the CEZMS passed a resolution approving the establishment of an interdenominational College for the training of the girls and women taught by qualified medical women. They circulated an appeal, signed by all 14 medical missionary women, among the missionary societies appealing for financial support for interdenominational medical school to train female native assistants for female medical mission work: "We wish friends clearly to understand that

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62 Chawla Singh, *Gender, Medicine and Empire: Early Initiatives in Institution Building and Professionalisation (1890-1940s)*, p. 98.


64 Ibid., p. 296.
however humbly the School may begin its work, a full curriculum of five years and a Government Diploma such as is open to men are steadily contemplated. In 1894 North India School for Medicine for Christian Women came into being in an empty School at Ludhiana with the promise of fifty pounds from a friend in England and another fifty pounds in hand.

Ludhiana was the oldest scene of interdenominational Zenana work and was chosen as a site for the school. When the college started, besides Dr. Brown, who was its one full-time member, there were three part-time members, four Christian medical students, two dispenser students, five nursing students and four midwifery students. The 30-bed Charlotte Hospital became the nucleus for training. Five years later the first batch of 4 students went to Lahore to take the final exam & all of them passed. Staff in addition to Miss Brown, the principal, included Miss Balfour (FES), M.D., L.R.C.P.S., lecturer (who remained in charge of the Charlotte Hospital) and two women from the American Presbyterian mission, both with M.D degrees, Miss Allen and Miss Caldwell, who taught chemistry, osteology, and materia medica. Teaching was in English except in the midwifery course which was taught in Urdu.

Later a large hospital and dispensaries were built, two of which were outlying and the school itself was a large building in the Mission compound. Gradually special contributions came in from friends, some of whom were missionaries themselves. The London School of Medicine for Women provided the medical books and chemical apparatus including a skeleton. Since then the progress of the school has been very rapid, its success became the springboard on which a bid for colonial funding was sought and secured. In 1904 the government of Punjab offered a regular yearly grant.

In Missionary institutes education is blended with religion with great emphasis on ‘values’. At the medical school in Ludhiana students were not only thoroughly trained medically by a competent staff of fully-qualified lady physicians, but also had regular Bible study and were ‘prayerfully encouraged

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65 Jeffery Cox, Imperial Fault Lines: Christianity and Colonial powers in India 1818-1940. p. 182.
66 Ibid., p. 183.
to become earnest and wholehearted Missionaries, who will seek the salvation of their patients.’ The first Rule of Admission runs thus: ‘Candidates must be decided Christians, and those holding Scholarships must undertake to work in some Protestant Mission to the Heathen after the completion of their course of study’\(^{67}\)

Nursing had few takers then as it was considered impure job of the low caste women and initially there was lot of dissatisfaction over the low standard of the candidates who came for nurse training. However, missionary schools and colleges were able to instil certain ideals of service and Christian girls from the mission schools and orphanages often perceived nursing to be a convenient career option. This trend was responsible for producing a cadre of nursing staff crucial for the successful functioning of women’s hospitals. Miss Simmonds associated with CMS in Punjab writes, ‘Training young Indian Christian girls to be good nurses and true Christian is not easy work, but it is very important. Very few of them have any real love for nursing, or sense of vocation; it is good to watch them grow out of the irresponsible school girl stage into that of thoughtful, responsible women able to run a ward, theatre or out-patient department with very little supervision.’\(^{68}\)

Dr. Brown also evolved a two-pronged programme to reduce the hold of the dais: one, she offered them monetary incentives if they took her along when summoned to assist in childbirth. Second, she offered to train them in simple anatomy and obstetrics, for which she also offered small rewards. To train the dais she rented a bazaar room, advertised classes and timings. ‘I wonder how many will come;’ she mused, as she set off on a blazing June day with the thermometer at 115 degree F to take first class. Only one came out of curiosity. But after a while both were sitting side by side discussing their experiences.\(^{69}\)

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\(^{67}\) Barnes, *Between Life and Death: The Story of C.E.Z.M.S. Medical Missions in India, China and Ceylon*, p. 297.


The dai was given 4 annas for attending and listening. Next time tour turned up.

In 1912 the college was renamed as Women's Christian Medical College. In 1915 women medical students were transferred from Government College Lahore, to Ludhiana. With this the college was opened to non-Christians girls too and up to 35 per cent non-Christians were admitted. However, government did not control or interfere in the Christian teaching of the college. This transfer also brought an increase in annual grant of 2,226 pounds besides the generous gift of the necessary new buildings. In 1922, at Ludhiana there were 77 students, 16 dispensers, 40 nurses and 20 dais under training. By 1931 this increased to 210 medical diplomas (licentiates of the State Medical Faculty of the Punjab) and trained 122 compounders, 158 nurses and 329 nurse dais.

Matriculation was required for admission. On completion of four years course students were sent for the examination by the Punjab State Medical Faculty for the diploma of L.S.F.M.P., and after a year's post-graduate study, for the M.S.F.M.P. The institution was therefore classed as a medical school rather than a college. The total enrolment for 1929-30 was 106, representing all parts of India. A scholarship was also instituted that was given to the student who was recommended as likely to make a good medical missionary.

The school was not endowed and expenses were met from various grants and contributions. Growing institutions especially for women attracted notice and patronage, both of which were also necessary for recognition, funding and expansion. Networking was key to all this and it was common to invite dignitaries for inaugurations and graduation ceremonies. Once after a talk with Lady Willington, then Vicerine, during which Dr. Brown had commented on the lack of good social assembly point in the college. A grant was made to the college from the king George V Jubilee Fund, which paid for a new assembly point.

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71 The funds to run the school and hospital came from scholarships given by Missionary Societies and missionaries, Government Grants, scholarships from municipal committees and district boards, fees of students, medical fees, rents of private wards, charges made for medicines, donations etc. Some of these funds were received directly in India and sometimes they were coming through Auxiliary Committees in England, Canada and Australia.
Hall and also for an x-ray unit and radium.\textsuperscript{72} Despite colonial grants, institution documents reveal a constant pressure on resources.

Ludhiana medical college had 30 private wards that were patronised by the wealthier patients. This was an important source of revenue and Brown's own practice among the elite Punjabi families brought in valuable additional funds used for hospital maintenance. Brown's visits to women from neighbouring princely families were particularly lucrative. The 'Ranis' of Malerkotla (a princely state about an hour's journey from Ludhiana) and of Jind (about four hours away) often summoned her sending a car to drive the physician to palace.\textsuperscript{73} By late 1930s interdenominational co-operation became widespread and college got funds and help from other churches also. Of the 27 missionaries working in the college, there were women from England, Scotland, Wales, America, Canada and New Zealand representing 9 different denominations. Besides these there was the junior staff consisting of 28 Indian women who were all Ludhiana alumnae.

The organisation was revised in 1924 and was put under the control of an interdenominational governing body. The internal affairs of the college were managed by the faculty and there was one government representative in the executive body. The missionary staff was selected by the home auxiliary committees, but the final decision of their appointment to the college was decided by the governing body. Indian Christian staff with same qualifications as their European counter parts drew same salary, but the rest of the Indian staff with Indian qualification was assistant staff with lower salaries.\textsuperscript{74}

Like any other missionary educational institutions at CMC too there was strong emphasis on 'values'. These values like pride in the alma mater, commitment to the rural health, and dedication to broadly 'Christian ideals' of 'service' above material gains etc. were integrated into the curricular and extra-curricular

\textsuperscript{72} Dibble, \textit{Voice of a Stranger-Life Story of Dr. Edith Brown}, p. 31.

\textsuperscript{73} Chawla Singh, \textit{Gender, Medicine and Empire: Early Initiatives in Institution Building and Professionalisation (1890-1940s)}, p. 104.

\textsuperscript{74} \textit{The Ministry of Healing in India: Handbook of the Christian Medical Association of India}, p. 105
activities; and reiterated through the sustained efforts of the faculty. Although daily prayers were held for students, staff and ward patients, the school promoted a broad sense of ‘Christian fellowship’, rather than formal religious worship. Hostel accommodations were provided for all students and all were boarders. There were separate dining rooms for the Hindus and Sikhs. All attended morning prayers but other Christian instructions were optional.

Thus starting from humble beginnings CMC, Ludhiana grew into a major educational institute for girls. For a very long time it was the only all girls medical school and students came from all over India. Much later Lady Hardinge Medical College for girls was established at Delhi.

**St. Stephen’s Hospital, Delhi**

Society for the Preaching of the Gospel was started in 1852 and its associate organisation Cambridge Mission to Delhi was established in 1877. In 1867 the Society for the Propagation of the Gospel (SPG) established the first female medical mission in India, the Delhi Female Medical Mission. Ms. Priscilla Sandys came to Calcutta in 1858 at the age of 16 and got involved in female education work. After her marriage to Rev. Robert Winter she shifted to Delhi and started working for SPG and CMD. After her arrival to Delhi in 1863, Priscilla Winters found not a single zenana open for instruction in the Punjab and North West Provinces. It is said that she began to establish a system of zenana visitation and teaching\(^\text{75}\) and this gave her the opportunity to see the crying need of medical aid for women in the zenana. She started her medical work in 1864.\(^\text{76}\) Although she had ‘no further medical qualification than a medicine chest’, she began to hold an open-air dispensary at the women’s bathing ghats on the western bank of the holy river Jamuna. Here she distributed simple remedies and gave advice to all classes of Hindu women, the majority of whom would not go to male physician. Though these women lived secluded in Zenanas they would go down every morning to the river both to

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make their vows and dip in the sacred stream. This rudimentary dispensary and Mrs. Winter's home nursing of women during epidemics of fever and cholera formed the modest origin of what later became the Delhi Female Medical Mission as well as the St. Stephen's Hospital

Mrs. Winter worked hard to run the schools and spread the medical aid for women. She called in the help of others through what was known as 'White Ladies Association' to run a small dispensary in the city. In 1868, the Winters were visiting England and they began to collect subscriptions for the sending out and support of a lady medical worker, whose work was to attend native ladies in their Zenanas, to set on foot a dispensary for women only and to train native women as nurses. There are a great number of respectable but destitute women in Delhi, for whom the means of an honest livelihood will thus be provided.

The Civil Surgeon of Delhi heartily approved the scheme, promised his assistance in supervision and donated two gold mohuras (32 rupees). The Winters raised about 290 pounds and had the assurance of a body of friends interested in the scheme. The first medical missionary was Mrs. Browne who left England in September 1867, but she was dismissed in June 1868. In 1874 a house was rented where patients could be treated in dispensary hours and a woman worker was engaged to manage the dispensary to train nurses and to visit women in their houses. This dispensary evolved into a medical zenana work specializing in midwifery under Miss Engelman, a German. Ironically

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77 Rosemary Fitzgerald, 'A Peculiar And Exceptional Measure: The Call For Women Medical Missionaries For India In the Late Nineteenth Century', in Robert A Bickers and Rosemary Seton, (eds.), Missionary Encounters: Sources and Issues, Curzon Press, Surrey, 1996, p. 188.

78 Besides St. Stephen's at Delhi there were two more hospitals run by CMD at Karnal and Rewari. In 1871 St Elizabeth dispensary was opened at Karnal. Dr. J. Muller worked to build this hospital for seven years. In 1905 an earthquake completely destroyed the hospital and by '908 a new hospital was opened but it had to be closed in 1912 due to shortage of staff. All the staff of this hospital were transferred to Delhi hospital. Dr. Charlotte Hull of St. Stephen's opened Mary Hayes dispensary at Rewari in 1902. Due to shortage of staff even this was closed in 1940.

79 In one letter to Mrs. Winter wrote "I have to study the language, teach in schools and zenanans, nurse the sick, visit Indian Christians and write begging letters." Her husband once wrote "She has almost lost the use of her right hand writing begging letters" as quoted in Ruth Roseveare, 'Delhi- Community of St. Stephen's 1886-1986', 1986 p. 11.

80 Western, Early History of the Cambridge Mission to Delhi in Connection with SPG, p. 102.
Miss Engleman joined the Delhi Mission in 1871 essentially as a teacher-cum-evangelist. When she was posted at Karnal she picked up interest in medical work and had rudimentary medical training under Dr. Bose, a Christian Bengali doctor. Dr. Bose was also the visiting physician at Delhi dispensary in later years and Miss Engleman lived in the hospital, attending out-patients, teaching nursing students, responding to calls in zenanas, reading the bible and prayers with students and patients.  

With a passion for Christianity embodied in institutions, Miss Engelman and the Cambridge Brothers established St. Stephen’s Hospital for Women, in memory of Mrs. Winters who died in 1881 at the age of 39. In 1885 this new hospital with 50 bed capacity, over-looking Queen’s Gardens, also known as Company Bagh, was built at Chandni Chowk. The foundation stone was laid by the Duchess of Connaught on 18th January 1884 and the Hospital was formally opened by Lady Dufferin, the Vicerine, on 31st October 1885. The ground floor was used for the outpatient department; the first floor had rooms for two doctors, a sister, evangelist, a dispenser and 10 or 12 nurses. The top floor had a few small wards, which could with difficulty accommodate 20 to 30 patients. By 1888 she and her Anglo-Indian assistant Alice King lived in a new thirty-bed hospital overlooking the Queen’s Gardens in Delhi. In 1891 Mr. Winter died and in memory of both Robert and Priscilla Winter an extension was built to the hospital.

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82 In the same year the Zenana Mission Council was formed and 12 resolutions were passed.

1. To hold bible classes for Indian Christian women
2. To prepare female candidates for Baptism and confirmation
3. To hold prayer meetings in low-caste bastis and villages
4. To teach in Sunday school
5. To conduct a boarding school for Indian Christian girls
6. To run a training class for zenana missionaries
7. To run two-day schools for Anglo-Indian children
8. To run an Industrial School for poor Muslim women
9. To run a refuge for ‘Fallen Women’
10. To teach in two normal schools
11. To run day schools for Hindus and another for Muslim girls
12. To teach women and girls by house-to-house visiting


83 *DELHI*, Vol. XII, no.9, January 1930, p. 172.
Miss Englemann was put in charge of the training of the dais by the Delhi Municipality and the first women to be trained were Non-Christians, Mohammedans and low caste Hindus. At that time the Punjab Government was giving Rs. 410/- a year for medicines and the Delhi Municipality was contributing Rs. 75/- a month in scholarships for training women as nurses. Later on when Chamar Christian women, both wives and widows, entered training; Miss Englemann accompanied them to the patient’s houses and acted as a chaperon the whole time. 84 Dais in those days were the very lowest class of woman. Therefore when they first began to attend the sick an escort was essential. These pioneers of nursing profession in Delhi were illiterate and Miss. Englemann had to colour the ointments, oils and medicines in the dispensary to distinguish one from another. 85

The first full time doctor in St. Stephen's Hospital was Dr. Jenny Muller who took over as the head of St. Stephen’s Hospital in 1891 and worked till 1916. In fact Jenny Muller came to India to help in the Teacher’s training class run by Mrs. Winter but she got interested in medical work. She later on joined Calcutta Medical College and returned as a fully qualified licentiate doctor. It was during her time that the site on which St. Stephen’s Hospital now stands was acquired and the present Maternity Wing was built. On 3rd December 1906 the foundation stone of the old hospital was laid by the Countess of Minto at Tis Hazari, overlooking what was then a Police Parade Ground and now the Tis Hazari Courts. On 9th January 1909 the new hospital in Tis Hazari was formally opened. However, in 1908 itself the doctors’ house and out-patient block were finished and opened for work. The Indian staff, consisting of five dais (midwives), three dispensers and seven nurses, together with ten or twelve patients who had to be admitted, were housed, fed and cared for wherever there happened to be vacant spot in the dispensary building. 86

84 Ibid., p. 171.
85 Ibid., 171-72.
86 DELHI, Vol. XIV, no. 2, April 1934, p. 34.
For the first year or two the daily average in-patient figure was 25-40; the total for the year being 550-880 odd. The Intern Obstetrical work was low, 20-60 patients in the year; while the Extern figured at about 208, making a total of 230, of which about 75 needed operative assistance. Dr. Mildred Staley was the first MBBS doctor and she joined St. Stephen’s in 1893. She described a typical day of her life at St. Stephen’s in the following words “Woken at 5 am with chota hazari. ‘Out’ seeing patients by 5.45. Back to take prayers in Urdu by 6.45. Brief ward round, then Dispensary till 11 am. Breakfast. Ward round. Office job till 8 pm. Dinner and more Patients.”

Many issues of class, caste, gender and religion and the local preferences were to be considered and incorporated by the western women doctors in their efforts to build viable medical institutions. In this process these doctors had to clearly flout prescribed rules of patient care and hospital administration as they had been taught at medical schools in Britain and America. For example often the abnormal obstetric work was done in the patients homes as they refused to come to the hospitals and were in critical condition.

“A “band-gari” (a box with seats back and front on four wheels, with a pair of derelict horses, and the driver on the cool with ropes for reins) would proceed with a portable table, large sterilizers with instruments in them, another large box with trays and medicines tied on to the roof, the anesthetic apparatus and a few smaller bowls and trays carried inside on one’s knees, and two hurricane lanterns on the floor, for often the only light in the house would be a vile smoking wick in an earthen saucer of oil. The surgery on most occasions was antiseptic rather than aseptic, and at critical moments anxiety was hair-raising. Even in hospital on visiting days the relations would not hesitate to remove the dressings of a patient who had had a major operation.”

Baby welfare clinic was started in connection with Maternity department in 1933. In the second half of the 1930s school inspection work in Delhi was also taken up by the Hospital. In 1939 St. Stephen’s Hospital had three European and three Indian doctors, three European nursing sisters, one Indian nursing

87 Ibid., p. 35.
88 Roseveare, Delhi Community of St. Stephen’s 1886-1986, p. 36.
89 DELHI. Vol. XIV, April 1934, p. 35.
sister, one pharmacist, one Indian staff compounding, one Evangelist, two Indian bible women and one Secretary-housekeeper. All these were missionaries. Besides these there were four trained nurses who were native assistants. 44 nurses and 5 compounders were in training.\textsuperscript{90} The following table shows the number of patients treated at the St. Stephen's Hospital.

<table>
<thead>
<tr>
<th>Year</th>
<th>In-patient</th>
<th>Out-Patient</th>
<th>Maternity cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1919</td>
<td>1840</td>
<td>9527</td>
<td>284</td>
</tr>
<tr>
<td>1929</td>
<td>2040</td>
<td>37743</td>
<td>590</td>
</tr>
<tr>
<td>1939</td>
<td>3100</td>
<td>40748</td>
<td>1152</td>
</tr>
</tbody>
</table>

(Source: Annual Report of the SPG and CMD and South Punjab, 1939, p. 10.)

However, the external maternity work had decreased tremendously, partly due to the Municipal Welfare Centres which had trained midwives; but greatly due to antenatal clinic begun by Dr. Houlton in 1928. Many of the doctors who served at St. Stephen were in demand for other sister missions, IMS, colleges etc. Some of these doctors held very high posts yet continued to serve at the mission too. In 1913 Dr. Helen Franklin joined the staff and worked in St. Stephen's Hospital until 1920 when she became Vice-Principal and Professor of Surgery in the newly established Lady Hardinge Medical College. She continued to give part time services to St. Stephen's Hospital. In 1937 she left Lady Hardinge Hospital, took up full time work in Ranchi and later in St. Stephen's Hospital for a year till her retirement in 1945. Dr. Millicut Webb joined Women’s Medical Services three years after coming to India to become CMO. In 1917 Dr. Dorothy Scott joined St. Stephen’s succeeding her cousin, Dr. Agnes Scott. She was invited to start a tuberculosis sanatorium near Kasauli in 1927. The same year Dr. Charlotte Houlton came to India and she went on to become the principal of Lady Hardinge Medical College in 1933. She was a member of the SPG, and was involved in the planning of the All India Institute of Medical Sciences. In 1941 she was awarded the Kaiser-i-Hind for her services in India and on her retirement in 1961 was awarded the M.B.E by the British Government Between 1919-1929 no fewer than 17 new staff arrived from England.

\textsuperscript{90} Annual Report of the SPG and CMD and South Punjab, 1939, p. 12.
Besides trained doctors there were many nurses who came to serve at St. Stephen's hospital. In 1908 Sister Alice Wilkinson arrived in India from Britain. The nurses Training School of the hospital was started in her time. She became Nursing Superintendent and was responsible for raising the standard of nursing not only in St. Stephen's Hospital but also in whole of India. Being founder member of the 'Trained Nurse's Association of India' she worked as its Secretary until she left India in 1948. She continued working in the S.P.G. House in London until her 90th birthday when she retired and returned to India to spend her last days here. She worked to the last to bring together countless nurses in India and abroad and she died in St. Stephen's Hospital at the age of 92 on 15th May 1967.

Sister Wilkinson was the founder-member of the trained Nurses' Association. She was also involved in the founding of the College of Nursing at Delhi. In 1913 a Board of Missions was formed for examining nurses as several hospitals felt the need of a uniform syllabus and examination. In 1918 the name 'The United Board of Examiners for Mission Hospitals in North India' was adopted. Arrangements were also made for examinations to be held in different languages as its sphere extended from Quetta and Mardan on the North West Frontier to Hazaribagh and Mission hospitals beyond Calcutta. A definite course and examination for dispensers was added and later on even non-mission hospitals were affiliated. Sister Wilkinson writes frankly on the training of nurses in the following words:

"I do not think the general standard of the nurses work has been up to its usual mark, due in a great measure to they being new sisters not yet versed in the ways of an Indian hospital nor sufficiently conversant with the fact that Indian nurses are mostly very young and inexperienced girls who have come straight from the school room; and also due to the fact that they do not play the game, and instead of rising to the occasion will often let a sister down. At times I wonder is it worthwhile going on? But the promise shown by one or two senior nurses keep up the hope and preserve."^91

These trained nurses were not quite satisfied with the Indian nurses and often expressed their displeasure on the training of the native women as nurses.

^xci Annual Report of the SPG and CMD and South Punjab, 1924.
Sister Bury’s report of 1915 notes that, the nurses were sent to Karnal for six months to get varied training. They get more operation work, midwifery and nursing of European patients here in Delhi, and in Karnal they get out-patient work and the chance of more individual attention and training, which is the advantage of a smaller Hospital. However some times the performance of the nurses in the exams was not up to the mark and these nurses were disappointed. Sister E.M. Hughes involved with the nurse training felt it was tough to teach nurses even the basics and she was very upset with the poor performance of the nurses in Mission board Examinations. But she continues to say that “...three midwifery candidates we put in for examination are quite a way down in the list of marks, and yet I really do feel they knew their job better than I did when I sat for C.M.B; or any other nurse at that stage in England.” Sister Hughes following words show how daunting was the task of training Indian women as nurses.

“It is interesting teaching them, but also at times more than depressing and I thought instead of a thorough nursing training to fit you for work in St. Stephen’s it would be better to take a course of training in the metropolitan police force, for it does seem at times that there is no nursing to be done beyond constant hammering for cleanliness and order.”

The sister in charge of St. Stephen’s Hospital in 1934 in her annual report wrote “The nurses, very good while supervised, were incapable of assuming any responsibility and doctors and sister in turn sat up at night with any seriously ill patient. Lectures to nurses and dispensers were exceedingly simple. I well remember a hot hour in June spent in trying to get one of the latter to say “potassium permanganate” correctly, and when Sister was ill, endeavouring to teach a nurse of two years’ standing how to record a temperature chart.”

The other point of observation was about the kind of candidates who came for nurse training. Most of the nurses sought hospital as a refuge and means to support the family. Most of them were young women educated in mission

94 Ibid., p.23.
95 DELHI, Vol. XIV, no.2, April 1934, p. 35.
schools, married at an early age, widowed or deserted by their husbands. These nurses hardly had any idea of the 'love of nursing' and for most of them it meant just a job. Though there was gradual realization and recognition of nursing as a profession, there was still strong social taboo on nursing as a respectable or ideal profession for educated girls. The advent of an English trained sister began a new era in nursing and girls, on leaving school, began to think of training before being married. Most of these girls could read and write, so attempts were made at training them on English lines. Besides nursing these girls were also taught to dispense medicines with a very elementary knowledge of the pharmacopoeia.  

For very long time the nurses were not trusted with any sort of responsibilities. "A serious operation case or a very ill patient could not be left to the care of the night nurses, the Sister or Doctor had to be called at stated intervals to give a hypodermic injection, and often they had to watch, themselves, by the patient through the night." Gradually this attitude changed and the Indian staffs were given opportunities of handling responsibilities independently. The indianization of the hospital staff started at St. Stephen's in 1925 when an Indian nurse staff was put in-charge of an entire ward; doing full sister's duties. Sister Wilkinson writes "While some who are by no means brilliant make good reliable workers, it is essential to have intelligent well educated girls if they are to be trained to take full charge as sisters, which is the ultimate aim and object of our work of teaching them, so that they may be fitted for the task of helping and teaching their own country men." Most of the sisters had to reason out a lot while delegating the work to Indian nurses. Dr. Morris once wrote "I admit it is very difficult at times to stand by and see a nurse do badly what you feel you could do much better (one pines to do it but there it is, how shall they learn if we always do it for them and they look on? I do so hope that our venture of

96 *DELHI*, Vol. XII, no. 9, January 1930, pp. 172-173.
97 Ibid., p. 173.
faith in this direction will be blessed and that nurses will rise equal to their
great responsibility. 99

Miss Salmon of CMS writes that once she was discussing about the
responsibilities of church being handed over to Indians and an Indian doctor
said to her “Do you mean that this is our own, and that we can run it ourselves?
I do think it good of you all to stand on one side this way and let us do it”
Salmons reacting to this said “She was not being sarcastic. But the remark hurt
for I feel that some how in the past we had failed and that we had not got across
to them that the church was theirs; and that their service was both needed and
wanted. 100 Annexure-IV gives a list of the doctors and sisters who worked at St.
Stephen’s Hospital from 1886-1947.

Besides nurse training, native dais were also given training at St. Stephen’s
Hospital. Doctors took the help of the local dais to communicate with the
native women and often the doctors had to face lot of problems. Dr. Barnaby
once said that:

“"The Dais (midwives) have a really incredible faculty of understanding our halting Urdu,
and translating the patients’ story into English Urdu. They, the dais, do not speak English
but understand the peculiar language spoken by the newly arrived doctor. It is very tiring,
of course, when you have to struggle to express in your best Urdu for patient to say, “I do
not understand English.” 101

The illiterate dais were gradually replaced by younger women who could read
but who were not capable of passing the United Board of Missions
Examination. They were given a two-year’s training chiefly in the wards under
the sisters and then take the Punjab Central Midwives’ Board Examination for
Nurse Dais. 102

Mission hospitals were also pioneers in the training of girls as dispensers. In
the initial years when Dr. Englemann was running the small dispensary an
entirely untrained missionary helped to give out medicines. “The “doctor”

99 Annual Report of SPG and CMD and South Punjab 1929, p. 27.
heard the patient's list of complains, looked at her tongue, felt her pulse and called out to the "Dispenser" "Give so and so three fever pills for to-day," etc. The midwife would be told to "Wash the baby's eyes with pink lotion and to put green ointment on its wounds."

In 1919 a separate department was established for training of girls as dispensers. During the time of Miss. Fielding Smith the hospital dispensary was equipped and the first staffs were trained. In collaboration with colleagues else where she drew up a syllabus and organized examinations under the auspices of the North India United Board for the Training of Nurses and Dispensers. This enabled girls trained at St. Stephen's Hospital to take a certificate of efficiency and the Hospital came to be recognised for dispensers.

Village camps or visits were a very important part of the medical missionaries. Spasmodic attempts at village medical work have been made for long time for village visiting. It was possible only in January 1929 to set aside a doctor for itinerating work during the winter. There were a few centres where a room over the Indian Catechist's house or a mud walled room was used as the temporary dispensary by the visiting doctors. By living with the villagers these doctors won the confidence of the ignorant and frightened village women, so that when seriously ill and needing proper medical treatment the doctor could persuade them to come into hospital. Female Medical missionary doctors were objects of great curiosity, especially in the villages; the villagers crowded round them debating loudly with each other. There were instances like when an Indian passer by referred rudely to one missionary as a dancing girl and she jumped out of her carriage and thrashed him with her umbrella.

One of missionary doctors described about her first village visit as follows.

"It was my first visit to the village: my companion and I started after break fast in a 'baili' (ox cart) across 4 miles of rough road. The last half mile being more suitable for camel, we prepared to wade through the sand, the baili

103 Ibid., p. 172.
105 DELHI, Vol. XII, no. 9, January 1930, p. 174.
following......As we entered the village a Jatni friend invited us into her house and was anxious for me to hold the dispensary in her courtyard, but that would have absolutely shut out the low caste and sweepers so after a little conversation we moved on, and selected a shady tree to sit under. The usual inquisite crowd collected, some young men gathered round to jeer and make rude remarks. My colleague went off to let the people whom she visits to know of the arrival of the medicines. Sick folk came up very slowly. I had to remind myself that such is the case in some villages. The small crowd of jeering men who would not remove themselves, however politely asked, was largely the cause of women not coming up......we could not get away till the bottles and boxes are empty. Even a buffalo calf with a sore eye was brought for medicine. I am not quite certain of the numbers, but I think 3 patients came into hospital from that one visit."  

Dr. Bazely who served at St. Stephen’s Hospital was very famous for her village visiting and camping. She had a great sense of humour, loved village people and was often on loan to other hospitals. When in Delhi; she liked nothing better than camping in the villages. In later years she did this in her car known as ‘Yellow Biscuit’. She retired officially in 1941 but was still helping out at St. Stephen’s hospital and elsewhere even after 1946. She was, however, professionally dissatisfied with village visits. She writes “I will honestly confess that camping work does not satisfy me professionally; under the circumstances it is not possible to treat any with the least degree of satisfaction. After a 10 or 12 days tour, I yearn for hospital work. But the latter does, in some measure, depend on the former, and the result being so apparent, no hardships seem too much to endure when clear and insistent is the urgent cry to go out to find the sick and dying.”

As to the success of missionaries in terms of number of converts the medical missionaries often failed. There were very few converts. Dr. Agnes Scott working at St. Elizabeth Hospital at Karnal in her medical reports notes that “.....others have expressed a wish to become Christians, but there is generally some motive behind, an unkind husband or mother-in-law, blindness or

\[107\] Delhi, Vol. XII, no. 6, April 1929, p. 114.
\[108\] Roseveare, Delhi Community of St. Stephen’s 1886-1986, p. 69.
incurable lameness or inability to produce the necessary son and heir.” 110 The feelings of the missionaries on the issue of number of conversions can be summed up in the words of Dr. C.L. Houlton who headed St. Stephen’s Hospital. She said,

“Undoubtedly there have been many failures and many times when one has almost despaired and doubted whether from missionary point of view the work has been worthwhile. But on the other hand, there has been overwhelming evidence that God’s presence has been working in the hospital and has given healing of body and soul to many who were sick almost unto death. In our work in the hospital, which is chiefly among non-Christians, results cannot be gauged by the number of conversions that take place. Those are very few and far between; but from time to time evidence is forthcoming that, however faulty and unChrist like our work and lives may be, yet somehow God is working through us and the people we come in contact with do learn something of the love of our Lord and Master.” 111

Indianization of Church

The work of missionaries was not impository in nature and many Indians extended their co-operation for the endeavours of the Church. There were of Indian Christians by 1900s in India. James F Edwards an American Missionary who was in India for more 30 years noted, “Never was Indian charity so generous and open-handed; for there is far more money raised in India itself for the Christian work in India than all the money added together that comes to India from other lands.” 112

One important trend from the 1900 was the Indianization of church. The mid-Victorian Protestant missionary theorist Henry Venn attempted to prevent entanglement of Western religion and western civilization. He said some of the Churches became so dependent on the Colonial rule for spreading its activities in the colonies that they would not have survived the withdrawal of the colonial rule. He believed that missionary strategy should focus on the fostering of non-Western churches that were ‘self supporting, self-governing, and self-extending’. In order to prevent missionary clergymen from dominating these

110 Delhi Mission News, Vol. VII, no.10, April 1915, p. 120.
111 Annual Report of SPG and CMD and South Punjab, 1932
churches Venn advocated separate, racially based churches with episcopates overlapping those of the colonial white churches.\textsuperscript{113} There was questioning of the western religion and western culture as separate entities. Christianity was not considered corollary of western civilisation. A European Missionary who was held in high esteem by Indian students summed up the change in the religious outlook of the Hindu youth during the last few decades of the nineteenth century in the following words. “In the early days of the Christian Missionary enterprise, the opposition took its stand on the plea, ‘Christianity is not true’; gradually the attitude changed to ‘Christianity is not new. We have the law and the prophets-our sages have taught us all these truths in the past’ but the modern attitude of many enlightened Hindus is ‘Christianity is not YOU’.”\textsuperscript{114}

It was strongly urged by 1910 that missions should associate with them in their work Indian Christians who should have the same position in these missions as the missionaries sent out from western lands. The church establishments were run by Europeans and usually the lower staff were Indian Christians. Even well qualified Indian professionals were not given independent responsibilities and they served only in subordinate positions. For example in CMC Ludhiana, Indian Christians holding Indian qualification were on the assistant staff. The National Missionary Conference held in Calcutta in 1912 recommended missions ‘to place Indians on a footing of complete equality with Europeans’ and ‘to open for them the highest and most responsible positions in every department of missionary activity’.\textsuperscript{115}

Of roughly 622 foreign mission agents in northwest India in 1931, 43 were qualified female doctors and 11 were qualified male doctors. But these foreign practitioners were almost matched in number by Indian doctors, male and female, who numbered 59 by 1935. There were nearly 400 Indian nurses.


working in Christian medical institutions. Besides the nurses there were incalculable numbers of hospital and dispensary staff like Bible Women, compounders and dressers, cooks and laundresses, cleaners and sweepers, some of whom were not even Christians. However, missionaries’ objection to the total transfer to Indian Christian doctors was based on the grounds of lack of proper training, mistrust, lack of proselytising enthusiasm etc.

Dr. Walter F. Hume in his article ‘Indianization of Medical Missionary Work’ said that the devolution of the foreign medical missions depended not only on co-operation but on the development of leadership among Indian doctors. He further went on to say “Christian Medical Schools and Mission hospitals should equip Indian doctors for independent work by allowing them to carry responsibilities, to do operations, treat serious cases and gain confidence. Unfortunately, Mission hospitals are too much of ‘one-man’ show and the institutions is too often known by the name of the senior foreign medical missionary.”

Gradual change was later seen and one of the first real advancement made was the changing of the original ‘Medical Missionary Association of India’ where only foreign missionaries with few exception were members, to the ‘Christian Medical Association of India’ where Indian Christian doctors were equal members.

Hume said that Indian doctors’ taking over the Missionary hospitals was done through various steps.

1. Foreign doctor in the administrator and director of the hospital, while the Indian doctor is just an ‘assistant’ who carries out the orders without any responsibility
2. Minor responsibilities to Indian doctors
3. Real co-operation between Indian and foreign doctors in most cases is he head of the hospital
4. where entire hospital is made up of Indian doctors

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117 Ibid., p. 421.
However, from the point of view of an Indian Christian woman the mission continued to be an educational and professional bureaucracy, with all the hazards and opportunities of any such bureaucracy including upward mobility and the satisfaction of a profession worth doing. Europeans were doctors but Indians were ‘hospital assistants.’ Indian Christian women joined as nurses in large numbers. For example, mission hospitals provided the bulk of training for nurses throughout all India and the small Christian community supplied the overwhelming majority (by one estimate, 90 percent) of all trained nurses. The relationship was inevitably one of subordination. Similarly in 1928 when the government launched a scheme for village dispensaries with a sub-assistant surgeon and midwife nurse, most of the nurses hired were poor Christian widows of outcaste origins.

The imposition of Christian faith on non-Christians was a sore issue in these medical establishments. Mahatma Gandhi discussing with Christian missionaries once said “You have amazing self-sacrifice, you are great organisers. You are good men. I want to multiply occasions for your service. I want to work closer with you, but I do not want you to get India to change her faith.”

“...The idea of converting people to one’s faith by speech and writings, by appeal to reason and emotion and by suggesting that the faith of his forefathers is a bad faith, in my opinion, limits the possibility of serving humanity.”

Edith Brown’s attempt to impose an evangelical confession of faith on all Christian students and staff at Ludhiana failed ultimately because of the combined opposition of the government and the missionary societies.

**Missionary Contribution**

While the government doctors did something in medical lines it did not at all meet the situation and the medical missionaries were able to reach out to these untouched areas. “Careful estimate shows that over one-third of the population of India; that is 100,000,000 population-more than the population of the United

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119 Ibid., p. 103.
states- are wholly beyond the reach of government medical aid, with full appreciation of the government Taluka, or country dispensary and what it is able to offer, it appears that another third of the population which may reach these dispensaries find their aid only for the more simple diseases; government surgery can be secured only by the smallest handful of the people of India.\textsuperscript{120}

Foreign Medical missionaries and few exceptions came together and formed an association called the ‘Medical Association of India’. The greatest advancement was the changing of this association to ‘Christian Medical Association of India’ in 1930s and Indian Christian doctors were also members of this Association. This body was composed of both men and women medical professionals and was open also to private practitioners who were not connected to any mission hospital.\textsuperscript{121} At the Biennial Medical Missionaries Conference at Clifton Spring it was said “Medical missionaries do not go to the foreign lands to proselytize. Their immediate motive is not to convert to Christianity or even to disarm the doubting, opposing minds of the people. They go to cure and prevent and to save just as the Great Physician himself did on earth and would have them do as His disciples.”\textsuperscript{122} Some thing of the similar vein is stated by the President of Evangelical society for the Medical Missionaries (New York) in their Annual Report for 1937.\textsuperscript{123}

Mission hospitals became ‘one man-shows’ and the institution was often known by the name of the senior most foreign medical missionary. These mission hospitals came to be known as ‘American’, ‘English’, ‘Canadian’ or

\textsuperscript{120} \textit{Missionary Herald}, Vol. CIX, no. 3, March 1913, p. 132.
\textsuperscript{121} Walter, \textit{Indianization of Medical Missionary Work}, p. 424.
\textsuperscript{122} \textit{Missionary Herald}, Vol. CXXXII, no. 5, May 1935, p. 271.
\textsuperscript{123} “Four years ago, when we sent our first medical missionary to India, it was not done, because we wished to conform to other Foreign Mission enterprises, who had built hospitals and stationai physicians in every one of their mission fields. We did it not, because we desired to promote research into unknown tropical diseases, or to test modern hygiene and sanitation in their application to tropical conditions. We \textit{did} it not, because we wanted to offer our congregations at home something new, in order that through the added interest financial contributions might be increased. We \textit{did} it, because of the love of God, \textit{in dwelling} in the heart of every true Christian, constrained us to relieve the suffering of thousands of the disease-stricken people, who are camping on the threshold of our mission-station, that we might \textit{cure} the lepers, restore the sight of the blind and protect innocent childhood from ravages of disease and cruel ignorance. And because it was the love of God which constrained us to do so, God has blessed our work” (p. 4)
'Australian' depending on the nationality of the doctor-in-charge, but it was never Indian.124

The trained nurses were in great demand. "St.Luke's hospital in Vengurla some years was asked by one of the Bombay municipal Hospitals to supply some graduate nurses if possible. We were able to spare three. Shortly after their arrival the matron telegraphed “please send two dozen more.”125 "The infants we anxiously watched over through intense heat and severe illness are bringing their infants in turn to be treated, but there is this difference- they have learnt to come in time. No long is there a struggle to persuade people to be vaccinated or inoculated; our efforts of long ago find their reward in people refusing to be done except by aseptic technique!"126

"Instead of the patients arriving, as in old days, often in a moribund condition having been maltreated by the dirty and ignorant indigenous dais, large number now attend the Ante-Natal Clinic all through their pregnancy and come in for their confinements from choice, even if it is not absolutely necessary."127

Conclusion

Female medical missionaries who came to India had the double aim of healing the body and soul of the women. The study in the chapter shows that the work of female medical missionaries had many more related issues like the medical training for women in West, place of women missionaries in the church, indianization of church etc. The analysis shows that what started as 'veranda dispensaries' and 'medical chest' treatments have grown into great medical hospitals and medical schools. There was always a sense of mistrust and scepticism in delegation to Indians. Under British Rule, Women Missionaries found space in the public domain and opportunities for achievement denied then at home. However, they had to face continuous tussles and conflicts with

124 Walter, Indianization of Medical Missionary Work, p. 421.
their own male church hierarchies and their struggles for equal reorganization, equal remuneration, the rights of single women and for the autonomy of Christian women's organizations were important manifestations of resistance to patriarchal control. But their lasting contribution was the unintentional creation of a 'feminist' consciousness in local women. Besides these internal ecclesiastical administrative issues the female medical missionaries had to struggle in foreign countries, some times even for survival in the hot climates of eastern lands. Undeniably these missionary women had worked selflessly for the saving the lives of Indian women. However, the treatment given to Indian doctors was less than desired. Although the missionaries spoke of the contributions made by the Europeans and home societies, the Indian donations and contributions were underplayed. Many local rajas and wealthy men had given land and funds for construction of dispensaries and hospitals. At the grass root level it was the Indian Christians who worked as assistants and their contributions also need to be studied further.

There were several layers in the interaction of the medical missionaries in India. It was not merely a colonial or religious enterprise. It's a complex phenomenon expressed itself strongly even when they were living and learning in England. They realised that their education in medicine is incomplete without practicing it, so they took to the colonies as a place where they could experiment and learn. This was much more than their religion motive. Once they reached the colonies the dynamics took another shape. The colonised even though weak and diseased, were no tabula rasa which the foreign missionaries had to contend with.

Cultural contrast came much before nationalist feelings. Later when the indianization movement gathered strength the situation became even more complex. Indian doctors and nurses, even Christian among them, wanted their own autonomy. The British government has its own problems. Officially they could only sympathise, or they could grant the much needed land and grants. But they could not help beyond a point. The Raj had to look impartial and non-denominational.