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HEALING BODIES, GOVERNING POPULATIONS: MEDICAL MISSIONS, COLONIAL POWER, AND THE TRANSFORMATION

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RESEARCH ARTICLE

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Abstract
The introduction of Western medicine in Kashmir during the late nineteenth century was closely associated with the activities of Christian medical missionaries. Operating through institutions such as the Church Missionary Society and the Church of England Zenana Missionary Society, these missionaries established hospitals, dispensaries, and itinerant medical services that transformed the region's health infrastructure. This article examines the emergence and expansion of missionary medicine in Kashmir between the 1860s and the early twentieth century. Delineating on the historiography of colonial medicine and theoretical insights from scholars such as David Arnold, Mark Harrison, and Warwick Anderson, as well as the concept of biopower developed by Michel Foucault, the paper analyses missionary medicine as both a humanitarian intervention and a mechanism of colonial knowledge production. It argues that missionary hospitals in Kashmir functioned simultaneously as sites of healing, evangelization, and epistemic authority.

Keywords: *Kashmir, Medicine, power, Knowledge, Missionary*

Introduction

Recent scholarship on colonial medicine has emphasized that medical institutions were not merely therapeutic spaces but also arenas where power, knowledge, and social control intersected. [1] Historians have shown that hospitals, vaccination campaigns, and sanitary regimes often functioned as mechanisms through which colonial authorities sought to regulate bodies and manage populations. [1] At the same time, missionary medicine introduced additional layers of complexity, combining evangelical goals with biomedical practice. In the case of Kashmir, a princely state formally ruled by the Dogra monarchy yet deeply embedded within British imperial networks, missionary medical institutions emerged as important intermediaries between colonial knowledge systems and local society.[2] Their activities illuminate how medicine could simultaneously alleviate suffering while reinforcing new hierarchies of scientific authority and cultural legitimacy. The history of medicine in Kashmir reflects a long and layered interaction between indigenous traditions, political authority, and external interventions. Prior to the nineteenth century, the region possessed a rich medical culture shaped by Sanskritic and Persianate intellectual traditions. [3] Classical Ayurvedic texts attributed to scholars such as Charaka circulated widely in South Asia, while Persianate medical knowledge associated with the Unani tradition also influenced medical practice in the valley. During the reign of Sultan Zain-ul-Abidin in the fifteenth century, medical learning reportedly flourished under royal patronage, with hakims and vaidyas receiving support from the court and hospitals being established for the treatment of the population.[4]

Despite this long-standing medical heritage, the nineteenth century witnessed profound transformations in the social and epidemiological landscape of Kashmir. Following the Treaty of Amritsar in 1846, the region came under the rule of the Dogra's, although it continued to operate within the wider orbit of British imperial influence. [6] The new political order was marked by heavy taxation, administrative centralization, and periodic ecological crises. Famines, floods, and epidemics repeatedly afflicted the valley, generating conditions of widespread poverty and disease.[7] Contemporary observers frequently described Kashmir as a region suffering from severe malnutrition, inadequate sanitation, and recurrent outbreaks of epidemic illness. It was in this context that Christian medical missionaries began to arrive in Kashmir during the mid-nineteenth century. Their activities marked the introduction of organized Western biomedical practice in the region. Through hospitals, dispensaries, and itinerant medical camps, missionary doctors treated thousands of patients and gradually established a network of medical institutions that would play a central role in the development of modern healthcare in Kashmir. Yet the expansion of missionary medicine cannot be understood solely as a humanitarian endeavor. Missionary hospitals were embedded within broader imperial networks linking Britain, India, and the princely states of the subcontinent. Medical practice became intertwined with evangelical ambitions,

colonial knowledge production, and the exercise of cultural authority. Understanding this history therefore requires situating missionary medicine within the wider historiography of colonial medicine and examining its relationship to structures of imperial power.

Medicine, Mission, and Colonial Power: Historiography and Theoretical Framework

The study of colonial medicine has undergone significant historiographical transformation over the past several decades. Early historical accounts tended to portray the introduction of Western medicine in colonial societies as a progressive and humanitarian enterprise. More recent scholarship, however, has demonstrated that medicine was deeply embedded in the structures and ideologies of empire. The work of David Arnold has been particularly influential in highlighting the relationship between medicine and colonial authority.[8] Arnold argues that Western medicine functioned not merely as a therapeutic system but also as a cultural and political instrument through which colonial regimes asserted scientific authority and legitimized imperial rule. Hospitals, vaccination campaigns, and sanitary regulations became sites where colonial states attempted to regulate bodies and manage populations.[9] imilarly, Mark Harrison has demonstrated that medical policy in colonial settings was closely linked to administrative and military priorities. Public health initiatives were often shaped by concerns about labour productivity, military health, and the maintenance of social order.[10]

The epistemological dimensions of colonial medicine have been further explored by Warwick Anderson, who emphasizes the role of medicine in producing colonial knowledge about bodies, disease, and environment.[11] Medical institutions served as laboratories where racial and environmental theories of disease were constructed and circulated within imperial networks. This article also draws upon the theoretical insights of Michel Foucault, particularly his concept of biopower. [12] According to Foucault, modern forms of governance increasingly operate through the regulation of life itself—through systems that monitor health, discipline bodies, and manage populations. In colonial contexts, medicine often functioned as a key technology of such biopolitical control.[13] Missionary hospitals, in this sense, were not only sites of healing but also spaces where new regimes of medical surveillance and discipline emerged. Patients entering hospitals were subjected to processes of observation, classification, and treatment that reflected the epistemic authority of Western science.

At the same time, historians of South Asia have emphasized the negotiated character of medical encounters in colonial societies. Scholars such as David Hardiman have shown that local communities actively interpreted and responded to colonial medical interventions rather than passively accepting them. [14] Similarly, Pratik Chakrabarti has highlighted the circulation of medical knowledge across imperial and local contexts, demonstrating that colonial medicine often emerged through processes of adaptation and exchange.[15] The gendered dimensions of colonial medicine have been explored by Samiksha Sehrawat, whose work on Zenana missions reveals how female medical missionaries expanded the reach of colonial medicine into domestic and gender-segregated spaces.[16] These historiographical perspectives provide an important framework for analyzing the development of missionary medicine in Kashmir, a princely state that occupied a unique position within the British imperial world.

The Emergence of Medical Missionary Work in Kashmir

The earliest organized missionary medical work in Kashmir can be traced to the efforts of Reverend Robert Clark and his wife Elizabeth, who opened the first allopathic dispensary in Srinagar in 1864.[17] Operating initially under difficult circumstances and facing resistance from sections of the local population as well as administrative restrictions imposed by the state, the Clarks nevertheless laid the foundations of a new medical culture in the valley. [18] Their work soon attracted further missionary involvement. One of the most significant early figures was Dr William Elmslie, a Scottish physician associated with the Church Missionary Society. Arriving in Srinagar in 1865, Elmslie established a dispensary that quickly drew patients from across the region.[19] Within a single season the number of patients treated reportedly exceeded two thousand, suggesting both the limited availability of organized medical care and the growing curiosity surrounding Western medicine. Elmslie's efforts extended beyond clinical practice: he studied local languages, including Kashmiri and Persian, and produced linguistic tools that aided subsequent missionaries.[20] His work also introduced surgical procedures previously unknown in the region, including operations performed under chloroform anesthesia. Such innovations gradually enhanced the reputation of missionary doctors among local communities. Yet the missionary enterprise was not without tension. Attempts to combine medical treatment with Christian evangelization occasionally provoked resentment.[21] Incidents such as Elmslie's controversial preaching near the Hazratbal shrine illustrate the delicate relationship between missionary activity and local religious sensitivities. Moreover, the death of patients during surgical operations an inevitable risk given the experimental nature of early modern medicine sometimes generated suspicion among the population. Despite these challenges, missionary medicine steadily expanded during the latter decades of the nineteenth century.[22]

A decisive phase in the development of missionary healthcare in Kashmir began with the establishment of a permanent mission hospital in Srinagar. Dr Theodore Maxwell, who arrived in 1874, secured support from the Dogra administration and obtained land for the construction of a hospital on the hill known as Rustum Ghaddi [23]. Although Maxwell's tenure was short due to ill health, the hospital became a crucial institutional base for future medical work.[24] The consolidation of this institution occurred under Dr Edmund Downes and later the Neve brothers, Arthur and Ernest, who played a central role in expanding the scale and scope of medical missions in Kashmir.[25] Downes arrived in the valley during a period of extreme distress. The devastating famine of the late nineteenth century reduced the population dramatically and was accompanied by epidemics of cholera and other diseases. Missionary doctors not only provided medical treatment but also organized relief activities, distributed food, and established temporary shelters for the destitute [26]. Their hospital became a focal point of humanitarian assistance during these

crises. When Arthur Neve joined the mission in 1882, he inherited an institution already respected by the local population. Over the next decades, the Neve brothers transformed the hospital into a major centre of medical care. Surgical operations increased dramatically, and new facilities-including laboratories, operating theatres, and expanded wards were gradually added. By the early twentieth century the hospital had become one of the most prominent medical institutions in the region [27]. The Neve brothers also extended medical services beyond Srinagar through itinerant camps in rural areas such as Anantnag, Baramulla, and the Pir Panjal region. These expeditions were particularly significant in a landscape characterised by difficult terrain and limited transportation networks. Their work during natural disasters, including the devastating earthquake of 1885, further enhanced the reputation of missionary doctors.[28]

One of the most important developments in missionary medicine was the establishment of specialized medical services for women. Social norms in many parts of South Asia limited women's access to male physicians, particularly in matters related to childbirth and reproductive health. Recognizing this barrier, missionary organizations established the Church of England Zenana Medical Society in 1880 with the specific aim of training and sending female doctors to colonial territories. In Kashmir, the arrival of Dr Fanny Butler in 1888 marked the beginning of organized medical work among women. [29] Assisted by other female missionaries and nurses, Butler established a dispensary in Srinagar that soon attracted large numbers of patients. The success of this initiative led to the creation of the John Bishop Memorial Zenana Hospital, funded in part by philanthropic donations from supporters in Britain.[30] The Zenana hospital represented a significant intervention in the gendered landscape of healthcare. For many Kashmiri women, it provided the first opportunity to receive professional medical treatment outside traditional networks of midwives and household remedies.[31] Over time similar facilities were established in other towns, including Anantnag, where another Zenana hospital began functioning in the early twentieth century. Female missionaries not only treated patients but also introduced new forms of nursing training and maternal healthcare. Their work gradually contributed to changes in attitudes toward women's medical care and encouraged the adoption of Western obstetric practices.[32]

Missionary hospitals often became centres of relief during moments of crisis. Kashmir experienced repeated outbreaks of cholera throughout the nineteenth century, as well as devastating famines that drastically reduced the population.[33] Missionary doctors treated thousands of patients during these epidemics and established temporary camps in affected villages. Similarly, the earthquake of 1885 caused widespread destruction across parts of the valley. Missionary staff organized rescue operations, transported the wounded to hospitals, and distributed medicines and supplies in remote areas. These interventions reinforced the perception of missionary institutions as centres of humanitarian assistance. Leprosy treatment also became a significant focus of missionary medicine.[34] With support from the Dogra administration, a leper hospital was established near Srinagar in the 1890s.[35] Missionaries supervised the institution, providing both medical care and shelter to patients who often faced social exclusion. While the humanitarian contributions of missionary medicine are undeniable, it is necessary to situate these developments within the wider framework of colonial power. Missionary institutions were closely connected to networks linking London, Calcutta, and other centres of imperial administration.[36] Their activities facilitated the dissemination of Western biomedical knowledge and reinforced the authority of European scientific paradigms. Medical missions also formed part of a broader strategy of evangelical engagement.[37] Hospitals and dispensaries created spaces in which religious instruction could accompany medical treatment. Although the number of conversions in Kashmir remained relatively small, the cultural influence of missionary institutions extended far beyond the sphere of religion. At the same time, the spread of Western medicine contributed to the gradual marginalization of indigenous medical traditions such as Unani and Ayurvedic.[36] These systems, once central to the region's medical culture, increasingly lost institutional support as colonial models of scientific medicine gained prestige. The relationship between the Dogra state and missionary medicine was similarly complex. Although the state initially maintained a cautious distance, it eventually provided land, financial assistance, and administrative support to certain missionary initiatives. In this sense, missionary medicine operated within a hybrid political environment shaped by both imperial and princely authority.

Conclusion

The history of medical missions in Kashmir reveals a complex interplay between humanitarian service, religious evangelism, and colonial influence. Missionary doctors introduced Western biomedical practices at a time when the region faced severe crises of disease, famine, and poverty. Through hospitals, dispensaries, and mobile camps, they provided treatment to thousands of patients and contributed to the establishment of a modern healthcare infrastructure. Their efforts were particularly significant in expanding access to medical care for women and in responding to public health emergencies such as cholera epidemics and natural disasters. The institutional legacy of missionary medicine, including hospitals that continue to function today-demonstrates the enduring impact of these initiatives. Yet this history must also be viewed critically. Medical missions were embedded within colonial circuits of power and knowledge that reshaped local medical traditions and introduced new cultural hierarchies. Western medicine was not merely a neutral scientific practice but also a vehicle through which imperial influence penetrated the social fabric of the region. Understanding the history of missionary medicine in Kashmir therefore requires moving beyond celebratory narratives of humanitarianism. It calls for recognizing the ambivalent nature of these interventions, simultaneously alleviating suffering while participating in broader processes of cultural and epistemic transformation.

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Notes:

[1]Biswamoy Pati and Mark Harrison, Health, Medicine and Empire: Perspectives on Colonial India (New Delhi: Orient Longman, 2001), p. 2.
[2] The people of Kashmir adopted a range of purificatory and devotional practices in an attempt to mitigate diseases and physical afflictions. These practices commonly included visits to the shrines of saints, pīrs, and hereditary spiritual guardians associated with particular families, as well as the use of amulets and the organisation of Darood Shareef recitations and related ritual observances.
[3] Mohibbul Hassan, "Kashmir under Sultans" Ali Mohammad & Sons Srinagar, 2005, pp. 84- 90.
[4] Chitralekha Zutshi's, Languages of Belonging: Islam, Regional Identity and the Making of Kashmir (Delhi: Permanent Black, 2003), pp. 1-10.
[5] Ibid.
[6] David Arnold, "Medical Priorities and Practice in Nineteenth century British India" South Asia Research Vol. 5, no. 2 (1985), pp. 167-83.
[7] Ibid.
[8] Mark Harrison, Public Health in British India: Anglo Indian Preventive Medicine 1859-1914 (Cambridge University Press, 1994), p. 2-7.
[9] Warwick Anderson, "Where is the Post Colonial History of Medicine," Bulletin of the History of Medicine Vol. 17, No. 3 (1998), p. 523.
[10] Michael Focault, Psychiatric Power: Lectures at the College de France, 1973-74 (New York: Palgrave Macmillan, 2006); also, Discipline and Punish: the Birth of Prison (New York: Pantheon Books, 1977).
[11] Ibid.
[12] David Hardiman, Missionaries and their medicine: A Christian Modernity for Tribal India (Manchester and New York: Manchester University Press, 2008), p. 9.
[13] Pratik Chakrabarti, Medicine and Empire, 1600–1960 (London: Palgrave Macmillan, 2014), pp. 45–47.
[14] Samiksha Sehrawat, Colonial Medical Care in North India: Gender, State and Society, c.1840–1920 (New Delhi: Oxford University Press, 2018), pp. 72–75.
[15] Ishaq Khan, Historyof Srinagar 1846-1947: A Study in Socio Cultural Change (New Dehli: Cosmos Publications, 1999), p. 139.
[16] Ibid.
[17] Ernest F Neve, A Crusader in Kashmir (London: Seeley, Services and Co. Limited, 1928), p. 29. See also, Ernest F Neve, Beyond the pirpanjal, p. 260: M Elmslie and W. B.Thompson, Seed Time in Kashmir (London: James Nisbet& Co. Benners street, 1875), p. 85.
[18] Ishaq Khan, History of Srinagar, p. 142.
[19] Elmslie and Thompson, "Seed Time in Kashmir," p. 282
[20] Tyndale Biscoe, Kashmir in sunlight and shade (London: Seeley, Service & Co. limited, 1922), p. 240.
[21] Ibid.
[22] Neve, Beyond the Pir Panjal, p. 264.
[23] Ibid. Arthur Neve, Thirty Years in Kashmir (E Arnold, 1913), p. 21.
[24] Arthur Neve, Thirty Years in Kashmir (E Arnold, 1913), p. 21.
[25] Ibid.
[26] Neve, Beyond the Pir Panjal, p. 267.
[27] Hardiman, "Missinaries and their Medicine," p. 140: see also, Mrs J T Gracey, Eminent Missionary Women (New York: Eaton and Mains; Cincinnati: Curts and Jennings, 1898): Dawson, "Missionary Heroines in India," pp. 87-88.
[28] E M Tonge, Fanny Jane Butler: Pioneer Medical Missionary (London: Church of England, Zenana Missionary Society), p. 38.
[29] Ibid. p. 41.
[30] Stock, The History of the Church Missionary Society, p. 84.
[31] Dawson, "Missionary Heroines in India," p. 128.
[32] File No. 105, 1895, Old English Records, JKSA, Jammu Archive.
[33] Ibid.
[34] E C Dawson, Missionary Heroines in India : True Story of the Wonderful Bravery of Patient Endurance of Missionaries in India (London: Seeley Service and Co. Limited).
[35] Hardiman, Missionaries and their medicine, p. 142.
[36] Neshat Qaesar, "Unani Medical Culture: Memory Representation, and the Literate Critical Antcolonial Public Sphere," in Contesting Colonial Authority, ed. Poonam Bala, pp. 122-132:
[37] Poonam Bala, ed. Contesting Colonial Authority: Medicine and Indigenous Responses in nineteenth and Twentieth Century India (Lexington Books, 2012), p. 1.