Reforming Health Sector: Role and Impact of Missionaries in NWFP 1900–1947

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Abstract

The Christian medical missions operating within the North-West Frontier Province (NWFP) of British India between 1900 and 1947 constituted an indispensable and transformative source of accessible medical provision for the indigenous populace. This essay argues that despite the underlying evangelical and, at times, problematic narratives—which often framed local resistance and traditional practices through a lens of 'bio-othering'—the missionaries' healthcare activities fundamentally reformed the regional health sector through localized innovations in service delivery, superior organizational capacity, and specialized medical expertise. Tracing the missions' arrival to the mid-nineteenth century, this analysis details the widespread scope of their work, including patient volumes, surgical operations, and disease treatment statistics, thereby establishing the critical nature of their contribution relative to state-sponsored facilities. Furthermore, the study examines the cultural challenges faced, such as resistance to early hospitalization and the issue of providing care to *purdah-nishin* women. Ultimately, it demonstrates that the missions' systematic approach to nursing, specialized eye treatment, and culturally adaptive architectural strategies—such as the *caravanserai* model—facilitated vital social and medical transformation, simultaneously serving both humanitarian goals and, often implicitly, the colonial biopolitical agenda. (250 words)

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The North-West Frontier Province (NWFP) during the first half of the twentieth century was a critical zone of imperial control, characterized by accelerated socio-political and cultural dynamics unique to the Anglo-Afghan interface (Malik and Ali, 4). Into this malleable and strategically vital environment, Christian medical missions arrived, establishing institutions that provided a Western biomedical alternative to entrenched indigenous healing practices (Ebrahimi, 73–74). Their presence, initially viewed sceptically by many, gradually evolved into a fundamental feature of the regional landscape, carrying immense historical significance that warrants thorough socio-scientific investigation (Stock, 1917).

This research paper contends that the medical missions in the NWFP were an indispensable source of localized and transformative healthcare provision for a largely reluctant local population. This indispensable role stemmed from two core areas: the sheer volume and quality of medical services provided, which often surpassed state capacity (Dennys, 1908; Irvine, 1914), and the introduction of transformative, systemized practices in nursing, hospitalization, and specialized treatment (Ebrahimi, 2022). While acknowledging these positive advancements, the argument maintains a critical perspective, investigating the problematic narratives of 'civilizing' and 'bio-othering' that underpinned the evangelical motivation and, by extension, inadvertently advanced the colonial biopolitical regime (Malik and Ali, 7).

The research will proceed by first establishing the complex interplay between traditional Pashtun healing practices and the imposed colonial medical hierarchy. It will then quantitatively establish the indispensable scope of the missions' work, followed by a critical assessment of the local resistance encountered. Finally, the paper will analyse the specific transformative reforms introduced and contextualize the missions' narratives within Michel Foucault's framework of biopower, ultimately substantiating the dual nature of their impact—both humanitarian and politically charged—on the health sector of the NWFP from 1900 to 1947. This multi-layered approach aims to fill a significant gap in the historiography, which often lacks a compiled, critically analysed dataset specific to this region and period.

The existing scholarship on Christian missions in the Indian subcontinent is rich, yet material focusing specifically on the medical activities within the NWFP during the late-colonial era remains scarce (Ebrahimi, 2022). General studies, such as those by Richter and Frykenberg, provide the necessary historical evolution, tracing Christianity's path from early proselytization to the formation of distinct Christian communities amidst Hindu and Muslim contexts (Richter, 1908; Frykenberg, 2008). These works highlight how transcultural interactions shaped Indian Christianity and detail the roles of native 'go-betweens' who facilitated the flow of Western ideas (Frykenberg, 2010). Critically, historians like Cox, Stanley, and Sanneh diverge on the nature of the relationship between missionary and imperial motives, with some viewing missions as religiously driven and others, such as Comaroffs and Beidelman, pointing to their embeddedness within imperial systems (Cox, 2002; Stanley, 1990; Comaroff and Comaroff, 1991).

A dedicated body of literature explores the dual role of medical missions as both healthcare providers and instruments of cultural influence. David Hardiman's seminal

work, *Healing Bodies, Saving Souls*, establishes how the rise of Western biomedical authority led missionaries to dismiss local practices, reinforcing notions of Western superiority and contributing to 'colonial medicine' (Hardiman, 2006, 14). This sentiment is echoed by Vaughan, who examines the moral mission adopted by white doctors, positioning them as heroic figures fighting disease and 'darkness' (Vaughan, 1991, 1–74). However, other scholars, including Fitzgerald and Shankar, offer a more cautious view, questioning the long-term success of medical missions in achieving high rates of religious conversion, suggesting that immediate needs for healthcare often outweighed spiritual motives for the locals (Fitzgerald, 1996; Shankar in Hardiman, 2006, 292).

The contribution of women missionaries to the healthcare sector forms another crucial strand of the literature. Robert, Brouwer, and Cox emphasize that the deployment of female physicians was essential for overcoming the cultural barrier of *purdah*, granting exclusive access to women's quarters (*Zenana*) and establishing critical institutions like the Duchess of Connaught Female Hospital in Peshawar (Robert, 1996; Brouwer, 2002; Cox, 2002). Furthermore, Sara Ebrahimi's investigation into the architectural adaptation of mission hospitals—specifically the transition to the *Serai* or *Caravanserai* model—is highly relevant, as it demonstrates a strategic, localized approach to architecture designed to accommodate patients' families and thus engender trust, contrasting sharply with the purely utilitarian pavilion plans favored by military and state institutions (Ebrahimi, 2022, 80). By synthesizing these strands—the political context, the dual evangelical/humanitarian function, the role of women, and the adaptive strategies—this essay builds upon the existing framework to address the specific, quantitative and discursive impact within the NWFP.

This investigation adopts a predominantly analytical and quantitative research methodology, necessitated by the nature of the available archival material, particularly the scattered and often disorganized statistical data from the colonial era (Coleborne, 2017). The quantitative approach is critical for empirically establishing the 'indispensability' of the medical missions' work, relying on official records such as the *Annual Reports of Dispensaries in the North-West Frontier Province* and various district gazetteers published between 1901 and 1933 (Sykes, 1902; Dennys, 1908). These primary sources are subjected to Michel de Certeau's approach of selective curation, culminating in a detailed, organized 'marginal collection' of data concerning patient volume, bed capacity, and surgical procedures across all mission facilities (Hannoum, 2017, 76).

For the deeper, critical interrogation of the mission and colonial narratives, the thesis employs a post-positivist theoretical lens, primarily focusing on Ann Laura Stoler's method of reading *along the archival grain* (Stoler, 2009, 18–33). This approach acknowledges the non-neutral, biased nature of colonial records—which often contain intentional omissions and misrepresentations formulated to serve the imperial power's interests—and treats the archive itself as a subject of inspection (Trouillot, 1995, 48). By adopting this critical stance, the research aims to expose the underlying 'colonial common sense' and the biopolitical discourses—such as the creation of the 'bio-other'—embedded within the missionary literature and official reports (Stoler, 2009, 232–34). Furthermore, cross-referencing

between official government reports and missionary-authored literature allows for the identification of inconsistencies and rhetorical maneuvers, particularly concerning local resistance and the classification of indigenous healing practices as 'quackery' (Hardiman, 2006).

Historical Background and Context

The history of Christian presence in the Indian subcontinent predates colonial expansion, with early movements tracing back to the first century A.D. near Taxila (Neill, 1970, 17–33). The subsequent Jesuit phases, notably Francis Xavier's arrival in 1542, focused primarily on converting Mughal rulers and establishing churches in major centres like Lahore, though facing fluctuating acceptance and periods of restriction under different emperors (Vander Werff, 1977, 27). The modern Protestant era, starting with William Carey in 1793, solidified the link between evangelism and institutional establishment through missionary societies (Webster, 2009, 35–56). However, in the strategically crucial NWFP, formalized mission activity began only after the British annexation of Punjab in 1849, with the Church Missionary Society (CMS) arriving in Peshawar by 1855 (Guenther, 2012).

Initially, Protestant missions remained hesitant about medical work, viewing illness as a primarily spiritual concern and modern medicine as a fledgling field. This skepticism began to shift dramatically in the 1870s, as medical practice emerged as a pragmatic and influential tool for securing the 'friendship and trust' of the local populace, particularly in Muslim-majority regions like the NWFP (Ebrahimi, 2022, 73). Medical work was consciously perceived as the most effective means of initial contact, a form of 'bait' to attract individuals who were otherwise resistant to purely evangelical overtures (Musasiwa, 1996, 193). This strategic reorientation led to a rapid expansion of medical facilities, with the CMS establishing key hospitals in Dera Ismail Khan (1889), Bannu (1894), and Peshawar (1898), making them the primary—and often sole—providers of Western biomedical services in the frontier areas.

The arrival of Western medicine challenged, but did not immediately supplant, the two large, established medicinal systems in South Asia: Ayurveda and Unani. Ayurveda, or the 'Science of Life,' focuses on balancing the five elements and the three *Tridoshas* (Vata, Pitta, and Kapha), emphasizing holistic well-being and rigorous diet regulation (Berger, 2013, 23–37). Unani medicine, introduced around 1350 A.D. and advanced by Arab scholars, equally relies on balancing four elements and four humours (blood, phlegm, and two biles) to maintain health (Rais-ur-Rahman, 2016, 16–37). Despite facing hindrances during British rule, these traditional systems were actively reformed and standardized by local nationalist elites—such as Hakim Ajmal Khan—who sought to align indigenous medicine with modern standards to resist colonial cultural domination (Bala, 2012, 2).

In the NWFP specifically, Pashtun indigenous healing practices were deeply entrenched in cultural and spiritual beliefs, often bypassing professionalized systems entirely. Treatments frequently revolved around amulets, Quranic verses, or cabalistic charms blessed by *faqirs* or *mullahs*, who commanded immense trust regardless of the patient's social class (Pennell, 1909). The missionary physician Dr. T. L. Pennell extensively documented and criticized two common and often crude practices: *dzan*, which involved wrapping a feverish patient in

a freshly skinned animal hide to induce profuse sweating; and *dam*, a form of cauterization by burning oil-soaked cloth on the skin to treat various ailments (Pennell, 1909). These practices, along with crude surgeries performed by village barbers or blacksmiths, were frequently cited in missionary discourse as evidence of the local population's 'primitiveness' and 'ignorance,' thereby justifying the necessity and moral superiority of Western medical intervention (Malik and Ali, 7).

To impose order and control over the burgeoning and diverse medical landscape, the colonial government established a clear classification system for healthcare institutions based on funding source and target population (Dennys, 1907). Class I: State-Public institutions included the main state-run facilities and crucial travelling dispensaries, which sought to reach rural populations but suffered from understaffing and eventual closures (Irvine, 1920). Class II: State-Special hospitals catered exclusively to specific state-controlled groups, such as police, railway staff, and military militia units like the Khyber Rifles, ensuring the health of law enforcement and critical infrastructure personnel (Dennys, 1905).

Class III: Local Fund hospitals were maintained by local municipal and district revenues, providing general healthcare at the local level. Examples include the Egerton Hospital in Peshawar and the Bannu Female Hospital, with major developments like the Lady Reading Provincial Hospital later emerging to provide superior, specialized services, particularly to women (Anderson, 1922). Class VI: Railways hospitals were also dedicated to the railway employees, a vital sector of the colonial economy. The medical missions primarily occupied Class IV: Private Aided (receiving partial government and local body grants, such as the Danish Mission Zenana Hospital after 1931) and Class V: Private Non-Aided institutions (entirely privately funded, usually by mission societies), signifying their independence and reliance on external philanthropic and evangelical resources to deliver widespread and essential services across the frontier region (Brierley, 1932).

Indispensable Scope of Medical Missions

The operational sustainability of medical missions relied on a mixed financial model of private subscriptions, mission society grants, patient fees, and, occasionally, government aid (Dennys, 1908). For institutions like the Peshawar Medical Mission Hospital (PMM-PSH) and Bannu Mission Hospital (MH-BNU), private subscriptions from both Europeans and natives were crucial, with native contributions sometimes increasing even when European funding declined (Edwards, 1911). The classification into Private Aided (Class IV) often led to a decrease in reported overall attendance, as state grants were conditional, but it provided a vital financial lifeline. For instance, the small Lord Robert's Mission Hospital at Thal initially received a modest government grant of Rs. 15 per month, which quickly escalated to Rs. 55 per month, underscoring the state's tacit acknowledgment of their necessary service provision (Edwards, 1911).

The establishment and growth of mission facilities were demonstrably strategic. New dispensaries, such as the one opened by Dr. Lankester at Akora in 1910, swiftly attracted significant attendance despite only operating once a week, confirming the local demand where state provision was minimal (Edwards, 1911). Conversely, the financial commitment required for mission operations was often

substantial, with mission hospitals consistently facing higher expenditures, including dedicated funds for training and hiring nurses—a capability frequently lacking in under-funded Local Fund facilities (Irvine, 1915). The closure of facilities, such as the Zenana Hospital in Hoti-Mardan after the 1918 murder of Dr. Starr, immediately impacted regional healthcare statistics, revealing the fragility of the entire system's dependence on these private entities (Grossle, 1919).

The quantitative data unequivocally establishes the sheer volume and critical nature of mission healthcare. In 1903, private dispensaries (almost all mission-operated) treated 2,122 indoor patients and nearly 59,000 outdoor patients, including a significant proportion of women (Harington, 1904). By 1910, institutions like PMM-PSH and MH-BNU were consistently leading in-patient attendance across the province, often surpassing even the primary civil facilities like Egerton Hospital in Peshawar (Edwards, 1911). PMM-PSH and MH-BNU maintained high daily average patient numbers, indicating their sustained importance over time (Irvine, 1912). For example, in 1915, MH-BNU treated a total of 25,577 patients, confirming its position as a central medical service hub (Irvine, 1916).

The fluctuating bed capacity also highlights the missions' responsiveness and adaptation. The addition of fifty beds to the female section of MH-BNU in 1915 was a significant increase in the province's overall capacity, specifically targeting the highly underserved female population (Irvine, 1916). However, reports consistently noted an underutilization of beds across both civil and mission hospitals, suggesting that while the demand for outdoor consultation was high, the deep-seated cultural resistance to prolonged hospitalization remained a pervasive challenge (Irvine, 1916). Despite setbacks, such as the 1930 Afridi invasion which temporarily disrupted PMM-PSH's operations, the institution, under Dr. Cox's guidance, quickly returned to the forefront of service provision by 1933, demonstrating the deep trust and reliance the local tribes placed in their specific expertise and personnel (Notes, 1934).

The mission hospitals served as critical points of defense against endemic and epidemic diseases. Malaria, a constant plague in the region, accounted for a significant portion of annual consultations, and missions' involvement in managing these cases was substantial (Irvine, 1917). Beyond fevers, missions addressed the full spectrum of disease, logging high case numbers for conditions like dysentery, tuberculosis, and, critically, eye diseases—a domain where they developed specialized, widely recognized expertise (Appendix B). For instance, in 1913, PMM-PSH treated over 5,000 cases of eye ailments, far exceeding their treatment numbers for other major conditions like pneumonia or tuberculosis, reflecting a purposeful specialization (Irvine, 1914).

In surgery, the mission hospitals consistently led the province, particularly in specialized procedures. In 1907, MH-BNU and PMM-PSH were the top performers in performing lens extraction operations, a clear indicator of their specialized training in ophthalmology, a skill often lacking in local *hakims* (Dennys, 1908). Similarly, for the removal of vesical calculi (bladder stones), PMM-PSH led the region with 84 operations in 1908 (Dennys, 1909). The commitment of individual doctors, such as Dr. T. L. Pennell and Mrs. A. M. Pennell, often determined the hospitals' output; Pennell's absence in 1910 immediately caused a drop in operations at

MH-BNU, while his return the following year saw a dramatic rise, including 405 cataract extractions in ten months (Edwards, 1911; Irvine, 1912). This statistical evidence solidifies the argument that, for both general disease management and specialized surgical interventions, the mission hospitals were an irreplaceable pillar of the NWFP healthcare system.

Local Resistance to Healthcare Activities

Despite the demonstrable need for modern medical care and the ample provision of beds by mission hospitals, there was a persistent and widespread pattern of underutilization for in-patient facilities (Irvine, 1915). Annual reports repeatedly documented that the daily average number of admitted patients rarely exceeded half the available bed capacity across the province, a phenomenon the authorities attributed to a deep-seated local reluctance to seek or accept prolonged hospital treatment (Irvine, 1916). This apathy was not born of ignorance of the facilities but rather a profound cultural tendency: patients often delayed seeking biomedical help until their condition had become extremely critical, thus bypassing opportunities for simple cures and contributing to high mortality rates (Anderson, 1922).

This cultural resistance was compounded by logistical and perception issues. The Chief Commissioner, in reviewing the data, suggested that the underutilization was partly due to inadequate funds for patient diets in state-run facilities, a deficiency that mission hospitals circumvented by offering free meals and very low admission fees (Anderson, 1922). More fundamentally, the perception of the hospital as a place of isolation, rather than healing, drove avoidance (Irvine, 1918). It took significant, culturally adaptive architectural and service reforms—discussed in Chapter 4—to chip away at this fear, reinforcing the view that medical outcomes were not merely a matter of scientific efficacy but of successful negotiation with social and familial norms.

One of the most significant cultural barriers was the near-total exclusion of *purdah-nishin* women from treatment by male doctors or nurses, severely limiting care for a large segment of the population (Brierley, 1924). The cultural taboo surrounding the unveiling or examination of women by non-relatives required a radical shift in staffing and infrastructure. This challenge, however, provided the specific niche that female medical missionaries and the institutions they ran, such as the Duchess of Connaught Female Hospital, were explicitly designed to fill (Dennys, 1908). Their presence was an initial step in breaking down this barrier, although resistance from both the women themselves and their male relatives persisted, highlighting the tenacity of entrenched social customs over medical necessity (Brierley, 1923).

Furthermore, the dual nature of the medical mission—simultaneously therapeutic and evangelical—posed an immediate hurdle to mass adoption. Mission authorities deliberately leveraged medical care as a precursor to spiritual conversion, often enforcing a compulsory evangelistic sermon by the mission physician before out-patients could receive treatment (Stock, 1917). Dr. Lankester himself noted that this mandatory address significantly reduced attendance for 'trivial complaints,' as patients were unwilling to invest a 'considerable time' in listening (Dennys, 1909). This structural impediment created a tension between the purely medical goal of serving the sick and the primary mission objective of saving souls,

acting as a measurable deterrent that selectively filtered the patient demographic.

The reluctance of the local populace was specifically concentrated in an active aversion to European treatments and biomedical institutional care. This was particularly evident in tribal regions like the Kurram and Tochi agencies, where cholera patients often refused medical intervention, even when offered in their homes (Anderson, 1922). The local *hakims* and traditional practitioners frequently met the introduction of Western medicine with hostility, interpreting the missionaries' frequent dismissal of indigenous practices as 'quackery' as a direct cultural affront (Hardiman, 2006, 14). This established a binary conflict that hindered widespread adoption of Western sanitary and preventative measures.

This resistance found political expression in the nationalist elite's active movement to revitalize indigenous medical traditions, notably Unani and Ayurveda, as a reaffirmation of Indian national identity against colonial cultural domination (Bala, 2012, 2). Influential figures like Hakim Ajmal Khan sought to amalgamate these traditional systems into a coherent national healing science, exemplified by the creation of the Ayurvedic and Unani Tibbia College (Gandhi, 1921). This 'nationalizing medicine' movement framed indigenous healing as an essential component of historical and cultural integrity, directly challenging the perceived superiority of colonial medicine. The occasional violent manifestations of hostility—such as the murder of Dr. V. H. Starr in 1918 and the Afridi invasion of PMM-PSH in 1930—further underscored the deep socio-political tension and resistance that underlay the seemingly benign provision of healthcare (Grossle, 1919; Brierley, 1931).

Transformative Reforms in the Health Sector

One of the most consequential reforms introduced by the medical missions was the implementation of a systematic and trained nursing system. Colonial reports frequently lamented the 'dearth of adequate nursing arrangements' and the 'insufficient nursing facilities' in government- and local-fund civil hospitals, which often led to preventable patient deaths (Anderson, 1922). Mission hospitals, in stark contrast, prioritized the hiring and training of personnel, ensuring that almost every mission facility in the province was staffed with trained nurses. This superior standard of systematized nursing was a primary factor in the enhanced efficacy and reputation of mission-provided care, positioning them as pioneers in establishing professional healthcare standards in the region (Irvine, 1916).

The inclusion of European lady-nurses and qualified lady-doctors further amplified this transformative impact. These female medical professionals provided the only reliable access to modern medical and surgical aid for the *purdah-nishin* women, a population segment that, due to cultural restrictions, had been largely cut off from institutional healthcare (Dennys, 1908). The success of institutions like the Duchess of Connaught Female Hospital demonstrated the critical necessity of female medical staff in bridging the cultural gap and facilitating care where male doctors could not (Cox, 2002). This commitment to female staffing became a vital, localized innovation that directly addressed a major, long-standing deficit in regional healthcare provision.

To counteract the local apathy towards early hospitalization, the mission hospitals implemented deliberate, localized socio-

economic strategies that fundamentally altered the perception of institutional care (Anderson, 1922). Key among these strategies was the provision of free food and exceptionally low admission fees—such as a token one-rupee entrance fee—for in-patients, making prolonged medical care accessible to the poor and distant travelers (Anderson, 1922). While civil surgeons criticized this practice as potentially turning hospitals into 'poor-houses' and attracting unnecessary admissions, the policy was highly effective in overcoming the cultural fear of isolation and the logistical burden of patient upkeep (Irvine, 1916).

More profoundly transformative was the adoption of localized hospital architecture, departing from the Western pavilion plan in favor of the *caravanserai* model (Ebrahimi, 2022). The construction of the CMS Hospital in Peshawar included the 'James Serai,' a block featuring thirty rooms arranged around a courtyard, explicitly designed to allow patients to stay with their family and friends (Ebrahimi, 2022, 86). This architectural solution, inspired by the traditional travelers' inns (*caravanserai*), created a family-centered, communal environment that met the deep-seated Pashtun need for familial proximity during illness (Lankester, 1912). This integration of native architectural styles and family-centered care was not only a pragmatic strategy to attract patients but a crucial demonstration of cultural sensitivity that fostered profound trust among a highly resistant population (Ebrahimi, 2022, 90).

The mission hospitals developed specialized expertise in treating eye diseases, a major public health crisis in the region where instances of blindness were amplified by poverty, poor sanitation, and traditional healing practices (Nair, 2017, 182). With eye patients constituting a significant portion of those treated annually—as evidenced by the high numbers of lens extractions at MH-BNU and PMM-PSH—the missions became the foremost authorities in this medical field (Dennys, 1908). They utilized advanced surgical techniques and even branched out to establish institutions for the education and training of the visually impaired, demonstrating a holistic approach that went beyond mere clinical care (Nair, 2017, 197). This expertise offered undeniable, life-altering benefits that cemented their reputation and influence in the community.

Beyond direct patient care, the medical missions exerted significant influence on colonial and international drug policies, notably through their strong moral stance against opium and cannabis (Hardiman, 2006, 171). Missionaries such as Reverend Thomas Evans, whose views were founded on moral concerns and anecdotal evidence rather than robust science, were key figures in anti-cannabis campaigns (IHDC, 1894). Evans's critical descriptions of *charas* consumption in the North-Western region, where he attributed a high percentage of mental health cases to the drug, influenced British political discourse and led to the establishment of the Indian Hemp Drugs Commission (IHDC) in 1893 (Mills, 2000, 63–65). Although the IHDC sometimes denied the missionaries' most sensational claims, the consistent lobbying efforts demonstrate how the missions' medical knowledge, biased by Victorian morality, was actively absorbed and utilized by the British government to shape policy and justify imperial control.

Bio-Political Role of Medical Missions

The discourses propagated by both colonial administrators and medical mission authorities concerning the indigenous

populace of the NWFP often converged to frame the local Pashtuns as a 'bio-other,' an unhealthy and irrational subject in need of external control and 'civilizing' intervention (Rail and Jett, 2015, 327–36). Colonial narratives commonly attributed high rates of blindness and disease to the inherent 'primitiveness' and 'ignorance' of the Indian lifestyle—citing causes like the smoke from closed-out huts, poor hygiene, and 'superstitious' practices like the use of irritants in eyes by traditional healers (Nair, 2017, 181). This intellectual maneuver served to establish the civilizational inferiority of the colonized subject, thereby justifying the political presence of the British and the medical necessity of the missions.

This rhetoric was deeply embedded in missionary literature. The short story "Andhi," for example, popularized by the missions, traces the journey of a blind girl named Andhi ('Blind') who is transformed through Christian faith and Western biomedicine into 'Roshni' ('Light') (Rutherford, 1900, 9). This transformation was not merely physical but, in the missionary interpretation, a metaphorical journey from spiritual darkness and ignorance to enlightenment and salvation. Such narratives reinforced the idea that physical health and spiritual redemption were codependent, attainable only through the adoption of Christian and European moral values, faith, and ways of life. By linking physical affliction to moral and religious failure, the missions successfully positioned themselves not merely as healers but as agents of total, necessary transformation.

The narratives disseminated by regional medical missionaries often reflected the dominant, negative colonial perceptions of the Pashtuns during the period of British domination. As Dr. Pennell's personal account reveals, the local Pashtuns were frequently characterized in missionary writings using terms like 'wild,' 'outlaws,' 'fanatics,' 'rascals,' 'thieves,' and 'utter barbarians' (Pennell, 1909; Malik and Ali, 7). Similarly, Zenana hospital publications painted local dwellings as 'dark, dirty, miserable dwellings, where fevers... breed unchecked' (Women's Medical Work, 1881). These consistent, generalized portrayals of moral and social degradation were essential rhetorical devices (Foucault, 1980, 166–67).

By documenting the local population's supposed lack of self-care and resistance to modern medicine—classifying them as lacking 'therapeutic sensibility'—the missionaries provided the cultural evidence necessary to label them as Foucault's 'bio-other' (Rose and Novas, 2005, 439–63). This classification justified widespread and intimate state and institutional intervention, arguing that the locals posed a 'collective danger' and were incapable of managing their own well-being without external expertise and direction (Foucault, 1980). The establishment of medical missions, therefore, operated as a critical extension of the colonial biopolitical regime, offering the British Crown an intimate, pervasive mechanism of surveillance and control over the personal and social bodies of the Pashtun populace, all under the guise of compassionate care and humanitarian aid.

Conclusion

This essay has argued that the Christian medical missions in the NWFP between 1900 and 1947 played a crucial and indispensable role in the regional health sector, driving transformative reforms despite operating within a context of persistent local resistance and problematic imperial narratives. The extensive quantitative evidence confirms the

indispensable nature of their work, with mission hospitals consistently leading in specialized surgical operations—such as lens extractions and vesical calculi removal—and maintaining high patient volumes that often eclipsed those of state-sponsored facilities (Dennys, 1909; Irvine, 1912). This was particularly vital for women, where female staff in *Zenana* missions provided the only means of care for *purdah-nishin* patients (Cox, 2002).

The 'transformative' aspect of their impact lay primarily in overcoming entrenched cultural barriers. This was achieved through localized, adaptive innovations: the provision of free meals and low admission fees countered the fear of hospitalization, while the unique *caravanserai* architectural model fostered trust by integrating familial support into the hospital environment (Ebrahimi, 2022). Furthermore, the missions established superior, systemized nursing faculties, a standard rarely met by financially constrained civil institutions (Anderson, 1922).

However, the analysis using the Foucaultian concept of bio-power reveals that these humanitarian efforts were interwoven with a political project. By generating narratives that pathologized the local populace—framing their traditional healing and cultural resistance as signs of ignorance, savagery, and spiritual blindness—missionary discourse effectively created the Pashtun 'bio-other' (Pennell, 1909; Malik and Ali, 7). This discourse provided the moral and empirical justification for the missions' intimate and pervasive intervention, thereby enhancing the colonial state's biopolitical regime of surveillance and control (Rose and Novas, 2005). The medical mission, therefore, stands as a complex historical phenomenon: a vital humanitarian agency that delivered life-saving care and enduring institutional reforms, yet one that simultaneously functioned as a critical arm of cultural and imperial power, ultimately shaping the health sector in the NWFP with both beneficence and control.

Bibliography

Primary Sources

Anderson, Lt. Col. W.M., I.M.S. 1923. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1922*. Peshawar: Government Press.

Brierley, C.I., Col., I.M.S. 1932. *Notes on the Annual Statements of the Hospitals and Dispensaries in the North-West Frontier Province for the Year 1931*. Peshawar: Government Printing and Stationary Office.

Dennys, Lieut-Colonel G. W. P., I.M.S. 1909. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1908*. Peshawar: Commercial Press.

Edwards, Lieut-Colonel W.R., C.M.G., M.D., I.M.S. 1911. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1910*. Peshawar: Commercial Press.

Grossle, Major H., M.D., D.P.H., Camb., D.T.M., I.M.S. 1919. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1918*. Peshawar: Government Press.

Harington, Lieut-Col. H. N. V., I.M.S. 1904. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1903*. Peshawar: Commercial Press.

Irvine, Lieut-Colonel T.W., M.B., C.M., F.R.C.S.E., D.P.H., I.M.S. 1915. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1914*. Peshawar: Government Press.

Pennell, T. L. 1909. *Among the Wild Tribes of the Afghan Frontier: A Record of Sixteen Years' Close Intercourse with the Natives of the Indian Marches*. London: n.p.

Report of the Indian Hemp Drugs Commission 1893/4. 1894. Simla.

Stock, E. 1917. *Beginnings in India*. London: Central Board of Missions and Society for Promoting Christian Knowledge.

Sykes, Lieut-Col. W. A., D.S.O., I.M.S. 1902. *Annual Report of Dispensaries in the North-West Frontier Province for the Year 1901.* Peshawar: Commercial Press.

Secondary Sources

Bala, Poonam. 2012. "'Nationalizing' Medicine: The Changing Paradigm of Ayurveda in British India". In *Contesting Colonial Authority: Medicine and Indigenous Responses in Nineteenth and Twentieth Century India*, edited by Poonam Bala. Lanham: Lexington Books.

Berger, Rachel. 2013. "Historicizing Ayurveda: Genealogies of the Biomoral." In *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India, 1900-1955*. New York: Palgrave Macmillan.

Brouwer, R.C. 2002. *Modern Women Modernizing Men: The Changing Missions of Three Professional Women in Asia and Africa, 1902-69*[27]. Vancouver: UBC Press.

Comaroff, Jean, and John Comaroff. 1991. *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa*. Chicago: University of Chicago Press.

Cox, Jeffrey. 2002. *Imperial Fault Lines: Christianity and Colonial Power in India, 1818-1940*. Stanford, California: Stanford University Press.

Ebrahimi, Sara. 2022. "Medical Missionaries and the Invention of the 'Serai Hospital' in Northwestern British India". *European Journal for the History of Medicine and Health* 79: 67-93.

Foucault, Michel. 1980. *Power/Knowledge*[35]. Edited by Colin Gordon. Translated by Colin Gordon et al. New York: Harvester Press.

Frykenberg, Robert Eric. 2010. *The Oxford History of Christian Church in India*[37]. Oxford: Oxford University Press.

Hardiman, David. 2006. *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*[39]. Amsterdam-New York: Rodopi.

Malik, Tasleem, and Faiz Ali. n.d. "Colonial Bio-Politics and Medical Mission in NWFP: A Case of Dr. Pennell of Bannu Medical Mission".

Mills, J. 2000. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900*[42]. Basingstoke: Palgrave.

Nair, Aparna. 2017. *'They Shall See His Face': Blindness in British India, 1850-1950*[44]. Cambridge University Press.

Neill, Stephen. 1970. *The Story of the Christian Church in India and Pakistan*. Grand Rapids: William B. Eerdmans Publishing Company.
Rose, Nikolas, and Carlos Novas. 2005. "Biological Citizenship". In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and Stephen Collier. Blackwell.
Stoler, Ann Laura. 2009. *Along the Archival Grain: Colonial Cultures and Their Affective States*[51]. Princeton: Princeton UniversityS Press.
Trouillot, Michel-Rolph. 1995. *Silencing the Past: Power and the Production of History*[53]. Boston: Beacon Press.
Vaughan, M. 1991. *Curing Their Ills: Colonial Power and African Illness*[55]. Cambridge: Polity Press.