



Medical missionaries and health care in Sub-Himalayan Bengal, c. 1870s–1970s

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Received: 13 August 2025 / Accepted: 29 August 2025 / Published online: 26 September 2025
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Abstract

A parallel development akin to the spread of trade “western biomedicine” (as it came to be known later) too entered, accompanied by both diplomatic and military missions beyond the expanding boundaries of British India. It formally entered the Sub-Himalayan Bengal region in the 1870s after the annexation of the Bhutanese Duars and was subsequently developed under the aegis of imperial rule. Other prevalent forces too played a part in the spread of the new medical system into the mountainous tracts, of which a substantial involvement was that of the Christian missionaries, a discrete if loosely linked force. The contributions of the Church Mission of Scotland in this region were deemed significant by the colonial government. The enmeshing of the missionary and the medical with the political with special reference to the impact of new medical systems on the indigenous population of the region, medicine as a tool of proselytization by the missionaries, the contribution of women missionaries towards healthcare, advancement of dispensaries and hospitals, the impact of new medical systems on the indigenous population of the region, medicine as a tool of proselytization by the missionaries, the contribution of women missionaries towards healthcare, advancement of dispensaries and hospitals established in the process and the legacies they left behind for posterity coinciding with the formation of the Church of Northern India (CNI) constitute the crux of the investigation.

Keywords Scottish missionaries · Western medicine · Guild missions · Medical evangelism · Medical missionaries · Healthcare · Indigenous people

1 Introduction

An approach to contextualise the missionaries’ position in local society is to focus on the ethical context of healing and the construct of the ideal doctor in both cultures (Piryns, 1986, pp. 142–143). The medical missionaries’ charitable provision and (generally) high ethical and professional standards assign the epithet of religiosity to the profession, shorn of the medical or the political aspects (Dhavanony, 1987, p. 317). Considerable work remains to be done on the missionaries, including critical analysis of their writings, before we can hope to reach conclusions concerning such complex issues as their relationship to imperialism. One needs to¹ consider, for example, such diverse factors as

their shared interests in modernity and “progress” on the western model and the common projection of their casualties as martyrs (Jala, 2002). However, we may analyse the role of Christian medical missionaries (principally those associated with the Church of Scotland) in introducing and developing western medicine in geographically inaccessible regions (Pable, 2004, p. 35).

The missionaries were the initial force behind the introduction of Western medicine in places like Kalimpong and were also influential in southern Sikkim in the early period (Narjinari, 1970). They had provided educational and medical services in places where the government dithered to enter; they were sent as emissaries to Bhutan and Tibet, where several government diplomatic missions failed miserably.

While this was certainly in agreement with the wishes of those states, the missionaries could be forgiven for thinking that they had been effectively exploited by the imperial

¹ The project was accomplished under the sponsorship of the Indian National Commission for History of Science during the period between September 2022 and August 2023.

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Government (Hanlon, 1991, p. 10). The reports purport that the government took certain missions into their confidence, and the Scottish missionaries were no exception to this. In most cases, their *modus operandi* was in conjunction and in co-operation with the British Government regarding education and healthcare, and where the need of the hour was diplomatic help or political strategy, the government never hesitated to take missionary aid. This framework could be used to reread missionary activities in India or Southeast Asia.

During the latter half of the nineteenth century, health care in the Western world was radically transformed by a series of dramatic advances in the theory and practice of medicine. The emergence of this system in an era of European colonial rule, however, meant that its theory and practice were rapidly transmitted to colonial territories such as India, where the British had established a dominant presence in the eighteenth century, commonly known as “western medicine” in acknowledgement of its origins and in contrast to its indigenous counterparts. Akin to the spread of the tentacles of trade, “western biomedicine” (as it became known later) too entered accompanied by diplomatic and military missions beyond the expanding boundaries of British India. It formally entered the Sub-Himalayan Bengal region in the 1870s after the annexation of the Bhutanese Duars and was subsequently developed under the aegis of imperial rule. Other prevalent forces also played a part in the spread of the new medical system into the mountainous tracts, among which a substantial involvement was that of the Christian missionaries, a discrete, loosely linked force. The success of their evangelical efforts in India had hitherto been limited to the sphere of spreading Western education, but missionaries’ access to Western medicinal knowledge proved a powerful tool for increased intermingling with local society. Predicated on this, the project attempts to investigate missionary endeavours, indigenous responses, and imperial rule in sub-Himalayan Bengal.

2 Objectives

The project aims to unravel the (i) intertwining of the missionary and the medical with reference to the administrative and territorial changes in this region, (ii) inquiring about the medical centres that were established sporadically (b) the nature of government and missionary medical initiatives whether they worked in conjunction if not incessantly in co-operation; (iii) whether both missionary and government medical initiatives followed the dispensary model of small biomedical centres initially.

This project sought to construct a brief history of (i) diseases prevalent amongst the indigenous population in the sub-Himalayas, (ii) the church missions involved

in missionary endeavours and medicinal practices, (iii) impact of new medical systems on the indigenous population of the region, (iv) medicine as a tool of proselytization by the missionaries, (v) the contribution of women missionaries towards healthcare, (vi) advancement of dispensaries and hospitals and their political implications.

The study constitutes an integral part of medical and imperial history, and the methodology adopted includes an empirical study based on factual evidence. The study is based on both primary and secondary data collected from different repositories: (i) the collection of primary data from different archival sources (ii) local church records and missionary records have been perused in Jalpaiguri, Kalimpong, Cooch Behar and Alipurduar District (iii) correspondence letters between company officials and their superiors or private papers of health officials available in the libraries and archives in Kolkata, New Delhi, Assam, district records, archives and other repositories have been probed. (iv) Personal correspondences, including diaries and notebooks available in the missionary archives, (v) interviews with missionaries engaged in the Guild Mission Schools and the Presbyterian Church, (vi) the collection of secondary and published sources from various repositories, including local newspapers, vernacular dailies, and church periodicals. (vii) comparison of secondary sources with the data collated through fieldwork, including interviews with the indigenous people of the region, particularly the Christian population, (viii) analysis of sources for constructing a brief history of diseases of the indigenous people residing in the sub-Himalayan region and the healthcare provided by the medical missionaries.

The objectives of the project and methodology have been executed under the following heads:

1. Introduction
2. Chapter 1—The Geo-historical location of Sub-Himalayan Bengal, its demographic profile, and the diseases prevalent amongst the indigenous population.
3. Chapter 2—Church Missions and Medical Evangelism harps on the Scottish missionaries of the region and the impact on the indigenous population of the region.
4. Chapter 3—Missionaries and their Medicine incorporates the hospitals, dispensaries, and other charitable bodies contributing towards health care in the region. When the hospital administration left, the availability of doctors was the need of the hour. Dispensaries and Hospitals founded and the legacies they left behind for posterity.
5. Chapter 4—Women Missionary Medics and their contributions to healthcare in the region.
6. Concluding Remarks
7. Appendices – Photos, Statistics, Maps



3 Literature review

Several missionary groups from around the globe visited India frequently, but not all were British missions. Hence, they had to win the government's confidence to pursue their work in India. David Hardiman's book offers interesting insights into issues of imperial and missionary activity that are applicable to many other parts of India and elsewhere in the world (Hardiman, 2008). We are also given nuanced perspectives of how the Bhils responded to, resisted, or sought solace in these religious, medical, and imperial phenomena appearing in their area. This is achieved through a chequered journey which witnessed the emergence of nationalist resistance, the perils of the European war, the subsequent imperial waning, and the post-independence years. The Mission and its hospital are evident through the prism of indigenisation and dispersal. Early medical provisions were crude and knowledge was inadequate, but as professionalisation increased (along with the significant role of women), political and social weaknesses became more evident. Mark Harrison looks for the theoretical, professional, and administrative aspects of the development of public health in India and of course, the role of medical missionaries (Harrison, 1994). Kabita Ray engages with the medical missionaries in the Mission to Lepers, which played a significant role in providing refuge to them (Ray, 1998). Elizabeth Beilby reported the role of '*dhais*' (traditional rural obstetrician) for childbirth. Beilby referred to those '*dhais*' as being essentially needful despite lacking proper medical knowledge (Beilby, 1885, p. 176). So, a trained nursing system gradually developed in colonial India, guided by the medical missionaries (Singh, 2005). Sujata Mukherjee tells us the efforts of medical missionaries in the sphere of healthcare, especially for Indian women—medical assistance in childbirth, growth of medical education, involvement of British women in designing health care for women of India, etc. (Mukherjee, 2017, p.191). In this regard, it is to be mentioned that in the 1850s, the Zenana Bible and Medical Missions started sending women missionaries and lady doctors.

For example, Dr. Clara Swain, the first female medical missionary, was sent to India in 1869. In 1880, another female medical missionary named Fanny Butler was sent to India. Fanny was taught at the London School of Medicine for Women (Arnold, 2000, p. 87). A few studies postulate that the nexus between missionaries and imperialism was profound. In their zeal for proselytization, they surreptitiously prepared the ground for the legitimization of imperial rule (Dutta, 2018). Scholars have also emphasized that medical work was recognized as an important means of evangelism from the early days of Mission. 'Clinical Christianity' was not a simple 'humanitarian gesture' capable of healing the sick; in missionary hands, medical interventions were designed to Christianize people of other cultures and faiths

by the end of the nineteenth century (Fitzerald, 2001). As Rosemary Fitzgerald has demonstrated, missionary endeavours were focused on preaching the Gospel until at least the mid-nineteenth century (Fitzerald, 2001, p. 89). But it became increasingly apparent that the evangelical approach was failing to produce significant numbers of converts, and there was a growing debate among missionary strategists over the most effective means of winning converts (Fitzerald, 2001, p. 90). Healing the sick had been an important part of Jesus's ministry, and service to the suffering was an established Christian ideal. Therefore, a tradition of healing associated with Christian Mission began to take on a particular context in light of this debate.

However, the medical missionaries failed to eliminate the 'heathen' ritual and practices which their Christian converts practised during times of illness (Hardiman, 2008, p. 28). Despite their success in some parts of South India, the medical missionaries hardly succeeded in their aims to be the catalysts of mass conversion, and their activities remained confined to the peripheries of Indian society (Basu, 2013). In a society like India, missionary women had an advantage over their male colleagues and were able to access women of the local communities, to whom male missionaries had no access (Basu, 2013, p.188). The early medical work for women in non-Western societies was initially of a tentative and experimental nature (Basu, 2013, p. 198). The missionary orientation towards the medical care of Indian women only became possible when women missionaries began to work beyond the Zenana. After 1880, medical missionaries who were single women trained professionally in medicine came in large numbers in India (Gourlay, 2017). At the prompting of Queen Victoria, the Vicereine, Lady Dufferin, launched the National Association for Supplying Medical Aid to the Women of India (Dufferin Fund). Most of the physicians working in the Dufferin hospitals and dispensaries, located in the major towns and district headquarters, were female medical missionaries. The colonial administrators did not take direct responsibility for women's healthcare and entrusted the same to the Dufferin Fund (Singh, 2000, p. 25).

Biomedical beginnings are also a part of imperial history in that the initial agents of change were mainly European colonial officials or Christian missionaries, and Alex McKay's work demonstrates an important point often neglected – the extent to which imperial power was fragmented at local levels (McKay, 2007, p. 18). The British lacked the personnel, the financial resources, and the desire to constantly enforce their will in the face of resistance. The application of force was thus reserved for extreme cases, while constant displays of symbolic power were designed to foster an impression of overwhelming imperial strength. This included the deliberate cultivation of British prestige, which was seen as a weapon in the struggle to convince the indigenous people that resistance was futile.



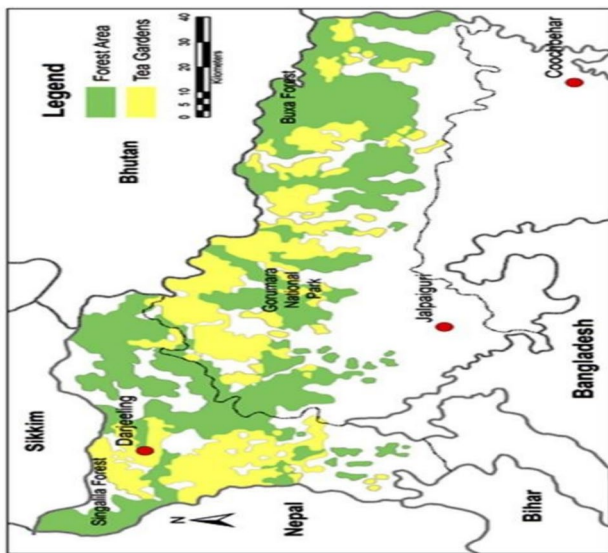


Fig. 1 Map showing the study area in Sub-Himalayan Bengal, India

4 Discussion

4.1 The Geo-historical location of Sub-Himalayan Bengal

A brief survey of the objectives, methodology, and importance of the study and published historical research on the medical missionaries and the impact of their activities and medicine in the region under the purview of this study and elsewhere in India has been taken cognisance of at the very onset. It explores the geographical features and demographic profile of sub-Himalayan Bengal (see Fig. 1). It shows that the sub-Himalayan Bengal, also known as Bengal Duars or Western Duars, is a part of the Terai lowland belt between the Himalayas and the plain. The average altitude varies between 600 and 1200 m and is not as high as other mountain ranges in the Himalayan range. The Himalayan foothills form the sub-Himalayan zone. The sub-Himalayan Bengal includes the northern part of West Bengal corresponding to the present districts of Darjeeling, Kalimpong, Jalpaiguri, Cooch Behar, Alipurduar, parts of Bhutan (Western Duars), Nepal (Terai region), Chinese-occupied Tibet, some provinces of Assam, and the North East. The indigenous groups residing in the region are the Mechs, the Rabhas/Bodos, the Totos, the Rajbanshis, the Bhutias, the Nepalese, the Lepchas, and Tibetans (Graham, 1897, p. 20).

The environment also imposed a clinical frontier of distinct zones of disease as observed in the study. Approaching the Himalayas from the south, the traveller passed through the ‘fever-ridden terrai’, where malaria and kala-azar were endemic. As the Himalayas were ascended, the risk of these fevers diminished with the increased altitude; malaria was

not found above 5,000 feet, and kala-azar too reached only into the foothills. But new diseases appeared in the hills; goitre, for example, was endemic in many of the mountain valleys of the Himalayas, and tuberculosis became increasingly common (Narjinari, 1971, pp. 48–49; Worboys, 1997). Above 10,000 feet, travellers were liable to be afflicted by altitude sickness, snow blindness, and severe sunburn. Thus, a correlation between disease and location was demonstrated, although this was increasingly shown to be related to a variety of dietary, economic, and social conditions, as well as climatic and ecological factors (Brooks, 2001, p. 41). It is difficult to isolate Himalayan parallels to studies demonstrating the ‘fatal impact’ of European expansion on local populations in such places as the Pacific islands and the Americas. Nor are there obvious parallels to those showing how, in British India, the spread of diseases such as malaria was stimulated as a consequence of environmental and mental changes induced by canal-building. On the Indo-Tibetan frontier, a negative imperial impact on indigenous health patterns, while difficult to assess in the absence of any pre-colonial statistics, seems limited (May, 2017). There are no indications that new diseases developed in this region as a consequence of European contact. Although the influenza pandemic of 1918–19 affected the entire region, Tibet was crossed by trade routes that linked it into a wider economic world, and any or all of the trading groups could have been the causative agents of its introduction.²

4.2 Church missions and medical evangelism

It was observed that as a result of the revived interest in foreign missions created by the visit of Norman Macleod of the Barony and Dr. Watson of Dundee to the mission station of the Church of Scotland in, “The Mission to the Aborigines of Northern India” was founded in 1869. This Mission aimed at evangelising five aboriginal tribes of India, namely, the Lepcha, the Bhutia, the Nepali, the Mechi, and the Rajbanshi (Narjinari, 1920, p. 10; Bernard, 2000). Two German missionaries, Mr. Conrad Bechtold and Mr. Beutel offered their services to the Foreign Mission Committee of the Church of Scotland.³ The two young missionaries arrived at Darjeeling on 31st January 1870 and immediately moved out to live among the Mechs in Pankhabary near Siliguri and began to tour the Duars. Rev. Conrad Bechtold took pains to learn the Mechi language and subsequently translated three Gospels into the Mechi language (Manuel, 2014, p. 197). He was then transferred to Assam and the missionaries

² *External B, File Nos, 1–4, various correspondence Oct. 1907, pp. 1–7, National Archives of India, NAI.*

³ *Report of the Foreign Mission Committee, 1870, The Church of Scotland, Edinburgh p. 15.*





Fig. 2 Scottish University Institute (Photo courtesy: collection from field work)

amongst the Meches and was heard of only in Christian missionary records in 1897 when Dr Graham appealed to the members of the Church of Scotland for volunteers to accept the works as an itinerating Chaplain to the planters and as a missionary among the coolies. It was observed that it was primarily the services of the Scottish missionaries that contributed towards the development of Western biomedicine in this region. In 1829, the First Scottish Missionary to Bengal was Dr. Alexander Düff, headquartered in Kolkata. In 1859, Alexander Clark followed this with his headquarters in Gaya (Bihar).⁴ In 1865, Reverend William McFarlane joined Alexander Clark at Gaya. Again in 1870, this was followed by Dr. Norman McLeon and Dr Watson, who opened a new Mission Station, Darjeeling, under the supervision of Rev. William McFarlane.⁵ Rev. McFarlane became the pioneer missionary to the indigenous tribes, leading to the closure of the Gaya Mission.⁶ In 1888, Rev. John Anderson Graham was appointed as the first Guild Missionary or Scottish Missionary or the Young Men's Guild Mission to Kalimpong (Lepcha, 2017, p.72). Figure 2 is the image of the Scottish Missionary at Kalimpong, captured during the fieldwork. Again, Fig. 3 shows Dr. Graham and his students in front of the Graham's Homes. It was further observed that Christian missionaries attempted to build a complete social system in which converts embraced a new worldview imparted by their education and entered professions associated with

Christian society and ideals – the church, education, and medicine.⁷ In an early example from the region under consideration, for instance, Dingbu, a local convert (probably Lepcha), was trained as a compounder at the Charteris hospital in Kalimpong with the support of the St Stephen's Guild in Edinburgh.⁸ He was later employed as both a compounder and a catechist at Nimbong and Peming in Kalimpong district. While these radical developments had begun earlier in the urban centres of colonial India, they were a late 19th-century phenomenon in the Himalayan regions under missionary influence, as indeed was the development of the category of 'medical missionaries.'⁹ It was further observed that missionaries posted in the remote areas had always been expected to treat themselves and their families when they fell ill, just as they were expected to educate their own children.¹⁰

4.3 Missionaries and their medicine

The impact of the new medical system on the indigenous population of the Himalayas constitutes the crux of the third chapter. It was observed that it was initially very limited, and its uptake was slow and notably selective. However, it increasingly gained popularity with the local populace, and aspects of biomedical practice were adapted to local conditions and cultures, and its structures and personnel were gradually indigenised in the later twentieth century.¹¹ It was further observed that the origins of the systematic transfer of Western medicine to the Himalayas are to be found in three factors that began to converge in the 1870s. Firstly, the conjunction of scientific and medical advances in the metropolis; secondly, the political circumstances in British India; and, finally, the increasing use of medicine as a conversion strategy by missionaries. In the twentieth century, the influence of the missionaries slowly faded, but the imperial government continued to use medicine as a political weapon in the region until the British withdrew from South Asia in the late 1940s.¹² Their role was then inherited by the new governments of India and China.¹³

⁴ External A, File Nos. 40–46, J.C. White to Government of India, p. 6. NAI.

⁵ Secret E, May 1906, File Nos. 47–76, Captain Steen's Shigatse diary entry, 26 February 1906, pp. 10–13. NAI.

⁶ Secret E, File Nos. 375–389, Dept. Political, Branch, Foreign. J.M. Holmes, Government of United Provinces to (Indian Foreign Minister) Sir Louis Dane, 25 April 1907; file note by R.E. Holland, 29 April 1907, pp. 10–15. NAI.

⁷ Minutes of the Church of Scotland Foreign Mission Committee [Edinburgh] 1898–1902, 1902, pp. 171, 304, 392.

⁸ *Ibid.*, p. 304.

⁹ *Ibid.*, p. 392.

¹⁰ Eastern Himalayan Church News, XI.3, October 1965, 43; in the 1930s, voluntary patient contributions to the 10th mile Tibetan dispensary in Kalimpong exceeded the costs of running the centre; Fader 2004, pp. 230–35.

¹¹ *Ibid.*, p. 230.

¹² *Ibid.*, p. 233.

¹³ Charteris hospital to Indian Government, 1 August 1972, letter in possession of the Rev Subha (Darjeeling); Darjeeling Diocesan Church News: October 1974, IV, pp. 11–12.



Fig. 3 a Dr. Graham with students of Graham’s Homes at Kalimpong, b Dr. Graham in front of the Graham’s Homes, and c Dr. Andrew Graham and his wife, Mrs. Katherine Graham at Graham’s Homes (courtesy: Dr. Graham’s Homes)



4.4 Women missionary medics

The Women’s Guild took up the medical part of the Mission in 1891, built the Charteris Hospital, and sent Dr. Ponder

in 1893 and Miss Ponder as nurse in 1895.¹⁴ Its members comprised of women, “Who are engaged in the service of Christ in connection with the Church, or desire to give help to any practical Christian work in the parish, as well as who are receiving Christian teaching and looking forward

¹⁴ Report of the Native News Papers for the Week ending the 15 March 22, 1900, pp. 4–5, NAI.



Table 1 Patient Statistics of Charteris Hospital (1895–1911)

Year	Out-Patients	In-Patients	Surgical Ops	Key Developments
1895	13,446	13–22/month	–	Dr. Ponder's Report; Pedong dispensary; compounder training
1910	15,944	327	187	Nurse Brodie appointed; veranda enlarged
1911	16,364	462	306	Govt. grant; demand for Lady Medical Missionary

(Data culled from archival sources)

to Christian service".¹⁵ The Women's Guild found in the Charteris Hospital an outlet for a small part of the missionary enthusiasm of its 380 branches with 26,401 members, but the work at Kalimpong gave, as in the case of the Young Men's Guild, an object for focusing its united interest and a stimulus to its wider diffusion.¹⁶

Dr. Ponder, the medical missionary in charge, was a tea planter in the district for many years before he studied medicine at Edinburgh University. As observed in the fourth chapter, his sister, Miss Ponder, was sent in 1895 by the Woman's Guild to help him as a missionary nurse. Miss Ponder was assisted by a Bengali nurse.¹⁷ Three native nurses were employed, and an endeavour had been made to teach them ward duties. They were also trained to work in the surgical wards.¹⁸ During 1899 Nurse Ponder's letters tell of many interesting cases, and of a beginning which she had made in training ayas or nurses for help in the hospital.¹⁹ Miss Pirrie, D.C.S., who had trained her in the Deaconess Hospital, wrote the beautiful memorial tribute which appeared in the *Woman's Guild Supplement to Life and Work* for December 1909 in appreciation of Nurse Campbell, who had succumbed to typhoid fever. To fill Nurse Campbell's place, Nurse Elizabeth Brodie was appointed and began work in 1910. Statistics for this year give the number of out-patients as 15,944, the number of in-patients 327, and the number of surgical operations as 187.²⁰ With the money raised in memory of Nurse Campbell, the veranda on the women's side of the hospital was enlarged. During 1911, efforts were made to secure the services of a Lady Medical Missionary, who would act as a colleague to Dr Digby Roberts, and help with the medical work required for the

St. Andrew's Colonial Homes.²¹ Towards her salary the St. Andrew's Homes' Committee agreed to give £100, while the Woman's Guild offered to supply the balance.

It was further observed that statistics for the year indicated out-patients as 16,364, in-patients as 462, and the surgical operations as 306, which was quite a substantial number.²² The fourth chapter also showcases the founding of a chain of dispensaries and hospitals that contributed to healthcare in this region. The government showed its confidence in the Mission by giving a large grant to build the hospital, and it had handed it over to Dr Ponder.²³ From Dr. Ponder's Report for the whole year, 1895, we learn that the number of out-patients, including those who attended the Catechists, has been 13,446, and that the number of in-patients has varied from 13 in one month to 22 in another.²⁴ In this Report, Dr. Ponder recounted his medical class, in which students are trained for the work of compounders and dispensers.²⁵ Three of his students had qualified for the government entrance examinations (Arnold, 1993). Among these one notices the names of some who were doing excellent work for the Mission at several stations. In the course of the year a new Dispensary was opened at Pedong, a station about thirteen miles from Kalimpong (Bray, 1992). A class was conducted in which the compounders were prepared for the government entrance examinations (Bray, 1992, p. 370). During Hospital hours they were employed in compounding and dispensing and out-patient dressing. They also had subordinate charge of patients in the male wards, attending to all the dressings and medicines (Bray, 2005). They conducted the ward services, and during the ordinary routine of ward work, they discussed with the patients what had been

¹⁵ Ibid., p. 25.

¹⁶ Ibid., p. 33.

¹⁷ Eastern Himalayan Church News, 1970, vol No.,16.2, p. 25.

¹⁸ Part A, External, Dept. Political, Branch, Foreign, various correspondence, May 1908, NAI pp. 46–49.

¹⁹ Evangelical Presbyterian Church, Sikkim: Millennium Celebration Year 2000 Souvenir, Evangelical Presbyterian Church, Sikkim, 2000, p. 8.

²⁰ Part—A, External, Dept. Home, Branch, Foreign, May 1908, J.C. White to Government of India, 14 October 1907. p. 46–49.

²¹ Proceedings, Dept. Home, Branch, Foreign, March 1905, Report of Captain H.J. Walton, 22 September 1904, pp. 1–7. NAI.

²² Minutes of the Church of Scotland Foreign Mission Committee 1903–06: 101, 'Regulations regarding medical missionary' [sic]. Dep 298, p. 13.

²³ Eastern Himalayan Church News, XI.3, in the 1930s. October 1965, p. 43.

²⁴ Charteris hospital to Indian Government, 1 August 1972, letter in possession of the Rev Subha (Darjeeling); Darjeeling Diocesan Church News: October 1974, IV.2: 11–12, p. 114.

²⁵ Personal diary of Dr. Ernst Schaefer, 1938–39, reference courtesy of Dr. Isrun Engelhardt; cf. the Tibetan proverb 'There is no answer to an order, there is no medicine for death'; O'Malley 1999, p. 41.



read in tracts or heard at the church services.²⁶ Of the three qualified in October, one was doing valuable work in Sikkim, vaccinating. In the course of his Report for 1900, Dr. Macdonald spoke of smallpox as raging in Sikkim, and of the excellent services rendered by the Rev. Mr. Macara in carrying out a vaccination campaign; also of an epidemic of cholera in the months of May and June, which carried off its victims in most cases in a few hours (Craig, 1984). It was also observed that the increase of Bhutia patients had been the most striking feature of the year, 1902 which clearly indicated that the indigenous people were seeking treatment in these hospitals (Craig, 1984, p. 12). Table 1 depicts the Patient Statistics of Charteris Hospital between 1895 and 1911.

The missionaries mediated modernity through a religious worldview and social framework, which may have proved particularly appropriate for the outcaste and tribal groups that made up the overwhelming majority of Himalayan Christian converts.²⁷ These groups were able to advance their social status considerably as a result of their knowledge of Western systems, which qualified them for employment at the schools and dispensaries established by the missions and government.²⁸ Similarly, the education of women produced a new class of literate women who were to create new economic spaces in Himalayan society as nurses, teachers, and clerical workers (Gorai, 1996).²⁹ Existing gender relations were thus irrevocably altered by the new missionary strategies, with women able to enter (comparatively) powerful positions in biomedical structures (Maliekal, 2002). In conjunction with similar developments, predominantly in urban areas, where the colonial government introduced education and public health initiatives, the indigenous spheres of education and health were radically altered. While these radical developments had begun earlier in the urban centres of colonial India, they were late 19th-century phenomena in the Himalayan regions under missionary influence, as indeed was the development of the category of ‘medical missionaries’ (Alier, 1977). Missionaries posted in the remote areas had always been expected to treat themselves and their families when they fell ill, just as they were expected to educate their own children. The effectiveness of medicine – and education – as tools for gaining access to the indigenous peoples that alerted the missionaries to their use as a conversion strategy within Christian ideals of charitable service (Basumatary, 2017).

There was a widespread notion that Christian missions tended to denationalise their converts or rob them of their space. That could be an accompaniment in some cases, as the missionaries purported, and defensively claimed that it was not the consequence of Christianity (Basumatary, 2017, p. 15). Sir Charles Elliott, the lieutenant governor of Bengal, in a thanksgiving service address commemorating the twenty-fifth anniversary of Mr Macfarlane’s arrival in Darjeeling, was sanguine that Christianity had flourished in the Kalimpong district and that it had been fostered and furthered by the fact that the subdivision was a government property:

Here we have scattered over the district bodies of cultivators who have in no way altered from the manner of life of their forefathers, and who not only have livelihood independent of the Mission, but who also are themselves, in many cases, active Christian workers. It is a great satisfaction to know to what an extent Christianity has flourished in the Kalimpong district, and that it has been fostered and furthered by the fact that the sub-division is a Government property, and so no intermediary stands in the way of the social and moral improvement of the cultivators there (Basumatary, 2017, p. 16).

This optimistic statement further impetuses the mission activities and clearly indicates the symbiotic relationship that the government shares with the missionaries at certain junctures (Basumatary, 2017, p. 17). In educational, medical, and social matters, the Mission cooperated with the government and received the desired amount of support in return for its activities. On the other hand, the government maintained a significant amount of neutrality in religious matters. In this context, Sir Charles Elliott, during another address in Darjeeling, summarised the governmental proclivities on the matter in the following words:

As the head of the government, I feel that the missionaries are, so to speak, an unrecognised and unofficial branch of the great movement in which we are all engaged, and which alone justifies our presence in the country. They occupy a field that the government officers are unable to take up. We are doing great work in spreading the blessings of civilisation, securing life and property, teaching the rule of law, and encouraging the growth of education. Still, we cannot directly touch on religious subjects. By the orders of the Queen and the general fitness of things, we are prevented from proselytizing. In religious matters we must perforce treat all alike, and allow no more consideration for one faith than for another: and yet we know right well that the only hope for the realization of our dream, and for the true elevation and development of the people, lies in the evangelization of India, and we know that the people who are carrying on his work are the missionaries. They are filling up what is deficient in the efforts of government, by devoting their lives

²⁶ Ibid., p. 249.

²⁷ Ibid., p. 13.

²⁸ A Hundred Years of Missionary Life in Bengal. 1860–1960, Calcutta Orphan Press, Calcutta, 1961, pp. 35–40, NAI.

²⁹ Daddy Graham’s Homes, The Team, Union Press Pvt. Ltd., Kathmandu, 2000, p.25. Also see, Gorai, 1996, pp. 13–15.



Table 2 Treated patients in the Leprosy Hospital (1927–1928)

Year	Total Treated	Observations
1927	25	No significant observation
1928	57	20 patients came together from Bhutan; expansion to 17 wards

(Data culled from archival sources)

and labours to bringing the people of India to the knowledge of Christ (Piryns, 1986).

The needs of Sub-Himalayan Bengal were very clearly efficient Hospitals and fully qualified doctors. It was scarcely surprising that the Women's Guild, in seeking to develop its life in missionary directions, should have been led to provide the necessary help which seemed to be so essential. Towards the building of the hospital, the Government of India had agreed to give one-half the cost. The Woman's Guild set itself to raise the other half and provide a lady doctor.³⁰ A Women's Guild tributary took up cudgels to fulfil the mission work.³¹ The Government gave grants, and the Government and the Mission worked in co-operation. Various dispensaries were also opened, like the one in Pedong, which was opened in 1897 and was placed under a native compounder cum catechist, trained by the Scottish missionary doctors. Since leprosy was also rampant at that time and since it was not right to keep the lepers in the hospital together with the other patients, a Leprosy hospital was also built later with its own church nearby. In connection with the leper wards, significant developments had occurred since they were initiated around 1914 (Perry, 1997, p. 48). The number treated during 1928 was 57, compared with 25 in 1927. The largest number in hospital at one time was 43 (Rai, 2011). Of the admissions, 20 came together in one party from Bhutan (Rai, 2011, p. 33) (Table 2). Although a considerable part of their journey was via Assam by train, the block was opened entirely free of debt, and towards its equipment, generous gifts of Rs. 1000 each were given by Lord Lytton, Kumar Tobgay Dorzi, and the Darjeeling Improvement Fund through the Deputy Commissioner.³² Another new building opened during the year was a dispensary in the marketplace. This was rendered possible by a legacy of Rs. 1750 left to the hospital by one of the local Indian Christians, and they used to travel for twenty days (Manuel, 1914, p. 133). There were then 17 wards for lepers, of which 9, and a workers' house, were erected during the previous year (Manuel, 1914, p. 169).

³⁰ "Women's Guild Supplement, Life and Work," November, 1906, p. 116.

³¹ Ibid., p117.

³² Life and Work", Magazine of the Church of Scotland, 1882–1905.

The last British doctor who served Charteris Hospital was Dr. Craig Duncan, but there are no doctors of foreign descent today. The hospital has served the local people for more than eighty years. In 1972, the hospital was demolished except for the surgical ward. In 1973, it was handed over to the Bengal Government and became known as the Kalimpong Sub-divisional hospital, and has now been rechristened the Kalimpong District Hospital.³³ The services of the Hospital and other healthcare measures of the Scottish Mission would be left for posterity to judge.

5 Concluding remarks

Conclusively, the Scottish Mission's advent in India initiated the foundations of missionary work in the Eastern Himalayan region and in Kalimpong in the Darjeeling district in particular. Its primary objective was to evangelize Tibet, but when it failed to do so, the Scottish missionaries had to confine their activities to the strategic towns of Kalimpong and Darjeeling (Graham, 1897, p. 10; Jain, 2021, p. 8; Graham, 2021). There were several failed attempts by diplomatic missions to woo the Tibetan Government into initiating bilateral trade relations (Jain & Piryns, 1986). Eventually, the Young Men's Guild was popularized, followed by the emergence of the Women's Guild in 1887 (Jain & Piryns, 1986, p. 166).³⁴ The former became a forthright and active force. The same conference proposed that the Guild should be allowed to delve into Foreign Mission work to realize its full potential (Jain & Piryns, 1986, p. 167). For twenty-five years, the Foreign Mission of the Young Men's Guild of the Church of Scotland had pursued its work among the Eastern Himalayas with missionary zeal.

The Christian medical men and their sojourns in the foothills and mountain tracts constituted an intriguing inquiry into the right to access to universal healthcare sanctioned by Christian piety, coupled with their myriad experiences peppered with the indigenous healthcare practices they encountered, some tantamount to 'heathen practices' and often impervious to change (Fitzgerald, 2006). Since Western medicine was attributed a higher status for being representative of a rational and progressive science, the missionaries

³³ Life and Work, September, 1895, pp. 25–33.

³⁴ The Church of Scotland Guild was a movement within the Church of Scotland which invited and encouraged both women and men to commit their lives to Jesus Christ and enabled them to express their faith in worship, prayer, action and fellowship. The Foreign Mission Committee was formed by the Church of Scotland in 1824. The first missionaries were commissioned to India in 1829 by the Church of Scotland. Professor Charteris and the Rev. William Robertson was appointed by the Guild Committee to present their reports before the Foreign Mission Committee.



donned this new identity of being the healers of both the body and the mind. The Scottish missionaries attempted a harmonious combination of the medical and theological for the sub-Himalayan Bengal region (Hardiman, 2008). This was a quest for achieving competence in both domains. The colonial state's attempt to regulate and erase many of the 'native' medical practices received unreserved support from the Christian medical missionaries. The missionaries defined the cultural terrain of India in terms of their own understanding of the 'cultured' and the 'uncivilized' (Kumar, 2001; Das & Dutta, 2021). The Christian missionaries worked with the colonial power to bring western biomedicine to the doorstep of the 'unfortunate natives' (Singh, 2000).

Acknowledgements I gratefully acknowledge the generous financial support of the Indian National Science Academy (INSA), New Delhi, for making this research possible. I am also thankful to my home institution, Rabindra Bharati University, for providing me with the institutional support and encouragement needed to pursue this work.

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