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# Impact of Western medicine on the Santhal community: The role and intention of the Colonial Government and Christian missionaries (1835-1947)

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**Abstract**
This research critically examined the impact of Western medicine on the Santhal community during British colonial rule between 1835 and 1947, focusing on the intertwined roles of the colonial government and Christian missionaries. Western medical practices had been introduced not merely for curative purposes but had been strategically integrated into broader colonial and evangelical agendas. Health services, such as dispensaries, vaccination campaigns, and missionary hospitals, had been employed as tools for surveillance, control, and religious conversion. The colonial state had utilized medical interventions to pacify the Santhals, especially following uprisings like the Santhal Hul (1855–56), while Christian missions had leveraged healthcare to promote conversion by associating healing with divine intervention. Indigenous healing practices and the authority of the *ojha* (tribal healer) had been marginalized, though not completely replaced. The research revealed that the Santhals had responded through selective acceptance, resistance, and adaptation. Medical aid had often been accepted, but conversion had not been universally embraced. The study concluded that Western medicine had been used as both a healing and colonizing force, leaving a complex legacy of medical-evangelical integration in tribal regions of colonial India.

**Keywords:** Western medicine, Santhal community, colonial India, Christian missionaries, medical evangelism, tribal health, indigenous healing, British Raj, Santhal Hul, medical colonialism

## Introduction

Between 1835 and 1947, the Santhal community, one of the major tribal groups of eastern India, experienced a transformative period marked by the expansion of Western medicine introduced by British colonial authorities and Christian missionaries. This imposition of colonial biomedical practices was not merely an act of public health intervention but formed part of a broader political, ideological, and civilizing mission (Arnold, 1993) [5]. The colonial government utilized medical outreach as a mechanism to consolidate administrative control over tribal regions, framing their presence as benevolent while strategically embedding surveillance and state authority (Chakrabarti, 2012) [15].

At the same time, Christian missionaries played a pivotal role in promoting Western medical systems among the Santhals. They frequently established dispensaries and mission hospitals in remote tribal areas, offering healthcare in exchange for religious conversion and moral reform (Jones, 2012) [38]. The missionaries viewed tribal diseases as both physical ailments and spiritual afflictions, thereby entwining healing with proselytization (Hardiman, 2006) [34]. Consequently, the introduction of Western medicine functioned as a cultural tool to reshape indigenous beliefs and practices, often undermining the authority of Santhal traditional healers and their ethno-medicinal knowledge systems (Pati & Harrison, 2009) [53]. The impact of Western medicine on the Santhal community between 1835 and 1947[11] had been profoundly shaped by the dual agenda of the British colonial government and Christian missionaries, both of whom had employed medical practices as tools of influence and control. The Santhals, an indigenous Adivasi group primarily inhabiting the forested regions of Bengal, Bihar, and Orissa, had been targeted by both secular and evangelical agents who viewed their 'primitive' lifeways as fertile ground for reform and assimilation through healthcare. Medical facilities, such as dispensaries and vaccination camps, had been established under colonial administrative schemes, but often lacked reach, resources, and cultural sensitivity (Arnold, 1993) [5]. In contrast, Christian missionaries had adopted a more direct and sustained approach, integrating curative medicine with proselytizing efforts, resulting in what historians have termed Medical-Evangelical Integration (Hardiman, 2006) [34].

Western medicine had been introduced not solely for altruistic healing, but as part of a broader civilizing mission—one that considered indigenous beliefs as superstitions to be eradicated and replaced with scientific rationality. Santhal resistance to hospital treatment and vaccination had been interpreted by colonial authorities as ignorance, further justifying missionary medical work as a gateway to spiritual conversion (Sarkar, 2001) [55]. Christian missions such as the Gossner Evangelical Lutheran Mission had established dispensaries and medical outposts within Santhal Parganas, where patients were preached to during treatment and often encouraged to adopt Christian beliefs alongside medical care (Man, 1867; Oddie, 1999). Through this strategy, Western medical intervention had been weaponized not just as a healing tool, but as a medium of religious transformation and sociopolitical control.

The colonial government, while ostensibly neutral, had often supported missionary medicine either by funding their institutions or by ignoring the proselytizing nature of their work in favour of improved health outcomes. Public health policies enacted under acts such as the Bengal Municipal Act had been utilized to formalize medical structures that disproportionately served urban elites, while missionary services often penetrated rural tribal populations like the Santhals (Chakrabarti, 2012) [15]. Consequently, the Santhal

experience of Western medicine during this period had been defined by a complex interplay of coercion, conversion, and conditional care, leaving lasting legacies in their social and cultural fabric.

The colonial state had viewed the Santhals as a "primitive race" in need of upliftment, both morally and hygienically. Public health campaigns, including smallpox vaccination, cholera containment, and dispensary services, had been implemented under various colonial health policies (Arnold, 1993) [5]. However, these efforts were rarely free from ulterior motives. While the state had funded certain dispensaries in tribal areas, it had often relied on missionary groups to expand healthcare coverage in remote and forested terrains like Santhal Parganas (Chatterjee, 2011) [18]. In these isolated zones, Christian missions had erected medical outposts where dispensary services, maternity care, and surgical interventions had been offered, frequently alongside Bible teachings and conversion drives (Jones, 2012) [38].

Such missionary hospitals had been staffed by trained Western physicians, nurses, and catechists who had used their medical authority to gain trust and then encouraged conversion through both persuasion and dependency. The goodwill generated by life-saving treatment had been leveraged to reshape indigenous belief systems and family structures (Mosse, 2005) [44]. Health interventions, such as cholera treatment and midwifery services, had been framed as superior alternatives to tribal healing rituals, which were dismissed as superstitious or unhygienic. Thus, Western medicine had not merely been introduced to the Santhal community as a neutral scientific practice, but rather had been appropriated to serve colonial governance and Christian evangelism. This dual-use approach had been central to the broader imperial strategy of cultural assimilation, where healing the body was deeply connected to converting the soul and subduing the tribe.

The Santhals' encounter with Western medicine was thus marked by ambivalence—while they occasionally welcomed the efficacy of new treatments, they also exhibited resistance and scepticism rooted in colonial exploitation and cultural intrusion. This study explored how the intertwined agendas of colonial governance and missionary zeal impacted the health practices, spiritual life, and autonomy of the Santhal community during this period.

**Research Methodology**

This study adopted a qualitative historical research methodology to examine the impact of Western medicine on the Santhal community during the colonial period between 1835 and 1947[32]. The research was primarily based on the interpretation and analysis of both primary and secondary historical sources. Archival documents, including administrative reports, missionary records, medical manuals, census data, and personal correspondences, were thoroughly examined to understand the policies, intentions, and actions of the British colonial government and Christian missionaries.

Primary sources were collected from national and regional archives such as the National Archives of India (New Delhi), West Bengal State Archives (Kolkata), and missionary archives including the Church Mission Society records. These documents provided firsthand insights into the colonial state's health initiatives and the medical activities carried out by missionary institutions in tribal areas.

Secondary sources, such as academic books, peer-reviewed journal articles, and dissertations, were reviewed to contextualize the historical events and assess existing scholarly interpretations. Particular attention was paid to works dealing with colonial medicine, tribal health, and missionary encounters in eastern India.

The study employed a thematic analysis approach to identify and interpret key patterns within the data. Themes such as "medical evangelism," "colonial control," "resistance and adaptation," and "cultural dislocation" were developed through iterative reading and coding of texts. A postcolonial theoretical framework was used to critically analyze the asymmetrical power relations embedded within the imposition of Western medical systems on the Santhal community.

Oral histories and ethnographic studies conducted by later researchers were also incorporated to triangulate historical findings and understand the long-term implications of colonial health interventions on the Santhal worldview and health-seeking behaviour.

Ethical considerations were addressed through the proper citation of all archival and secondary materials, and care was taken to represent the perspectives of the Santhal people with cultural sensitivity and academic integrity.

**Results and Discussion**

The Manbhum district was formed in 1833 by the East India Company, delineated to improve administrative efficacy and named after Man Singh I's historical influence (Beverley, 1872; Coupland, 1911[23]; Chisholm, 1911) [21]. It was reduced in area across subsequent years: 1845, 1846, 1871, and 1879, resulting in a final size of approximately 4,112 square miles (Gait, 1909; Chatterjee, 2021) [20]. Road and rail connectivity had been poorly served until significant upgrades during the late 19th and early 20th centuries. The East Indian Railway Chord reached Barakar in 1858, and the Bengal–Nagpur branch connected Bilaspur to Asansol by 1889 (Mukhopadhyay, 1983) [47]. Santhals were encouraged to migrate from Birbhum, Bankura, Hazaribagh, Rohtas, Dhalbhum, and Midnapore between circa 1790 and 1838 to cultivate cleared forest lands. Their numbers were estimated at ~3,000 in 1838 and then expanded dramatically to 82,790 by 1851 in the broader Santal region, including Manbhum reflected in district-level gazetteer data (Xalxo, 2008; Somers, 1979; Jha, 2009) [37, 61, 66]. Santhals were settled under Permanent Settlement to clear forests, but were exploited by corrupt local administrators, mahajans, and zamindars, and burdened by debt-bondage systems such as "Kamauti". The exploitative economic and administrative regime was identified as a primary motive behind the 1855 Santhal Rebellion, which originated in the Manbhum–Santhal Parganas region (Macdougall, 1977; Banerjee, 2002) [6, 42].

This portrayal had contextualized Manbhum's landscape (Fig. 1), communication, Santhal demographics, and socio-economic dynamics in the period leading up to the mid-20th century, as described in the gazetteers (Table 1). By the early 1870s in Bengal, traditional variolation outnumbered British vaccination efforts.

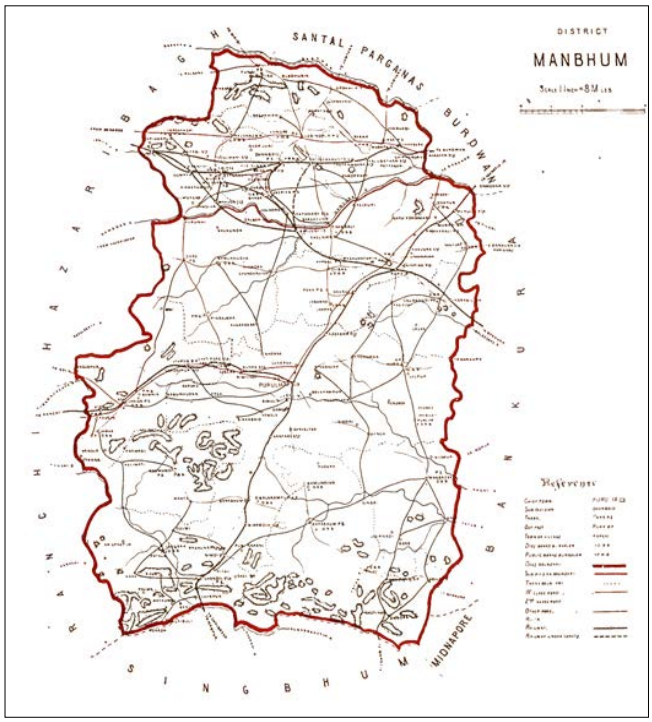


**Fig 1:** District map of Manbhum and Santhal Parganas in colonial India

**Table 1:** Description on Santhal areas in colonial India

| Aspect | Description |
|---|---|
| District Formation | Formed in 1833; reduced size by 1879 |
| Infrastructure Development | Railways extended in 1858 and 1889; roads upgraded late 19th c. |
| Santhal Migration | Santhals encouraged to settle from 1790s; numbers rose from 3,000 (1838) to 82,790 (1851) |
| Social Exploitation | Santhals exploited via corruption and bonded labour systems |
| Legal & Administrative Burden | Courts located far away, justice deemed inaccessible |
| Rebellion Cause | Conditions identified as rebellion triggers |

The 1946 report (Bengal Public Health Report, 1946) [26] had painted a grim picture with entrenched disease, poor sanitation, and limited effectiveness of colonial public health measures. Despite legislation and plans, the health of Bengal's population remained vulnerable, reflecting chronic neglect in both infrastructure and governance. The Santal tribe preferred oral traditions over written literature and had no documented history. Their oral heritage, which still serves as the basis for Santali language and literature, was first documented by Christian missionaries (Hansda, 2024). They have left a lasting impact on Santal mythology, stories, folklore, music, witchcraft, and everyday life.

During British rule in India, Christian missionaries significantly impacted society through educational institutions, medical facilities, and societal reforms. They provided literacy access to minority groups, implemented modern medical systems, and campaigned against discrimination. However, Indian nationalist leaders and Hindu reformists rejected these efforts, viewing missionaries as agents of Western imperialism (Masih and Shabbir, 2024) [65].

The Little World of an Indian District Officer by R. Carstairs (1912) offered a vivid, firsthand account of British administrative life in colonial India during the early 20th century. Carstairs, who served as a district officer in the Indian Civil Service (ICS), narrated his experiences managing law and order, revenue collection, famine relief, and other civic duties in rural districts. He believed that colonial administrators were morally obligated to civilize and modernize Indian society, although this belief reflected Eurocentric and imperial ideologies. His descriptions revealed a colonial mindset that perceived Indian society as stagnant and irrational, in need of Western rationality and order.

This report highlighted the public health crisis faced by Santhal-inhabited regions in Bengal in 1946[26], showing inadequate infrastructure, polluted water sources, and insufficient medical support in the wake of epidemics. This report emphasized the urgent need for sanitation reforms, forest conservation, and systematic vaccination, especially in tribal and rural areas like Maunbhoom, heavily inhabited by Santhal communities (Table 2). Report by Dr. William Wilson described the cholera outbreak that followed heavy rainfall in June, starting on 10th June. By 11th July, 80 patients were admitted to the Charitable Dispensary: 42 male adults, 26 female adults and 12 children. The epidemic caused 40 deaths and an equal number of recoveries. Village lanes were knee-deep in manure and filth during rains and overpowered by effluvia in hot weather. Open defecation was common, near tanks and pools, with the saying, "the nearer the better." Slaughtering areas were poorly managed. Notably, no systematic vaccination had occurred in the district in 1868, marking a long-standing neglect.

**Table 2:** Sanitary problems in different Santhal areas during colonial India

| Location | Health & Sanitary Findings |
|---|---|
| Rajmehal | Lacked clean water tanks; cholera epidemic; insufficient vaccination facilities |
| Deoghur (Santhal) | Severe insanitation; open drain contamination; water pollution; large gatherings at shrine |

E. G. Man (1867) served as Assistant Commissioner in the area he termed Sonthalia, covering the tribal belts along the Rajmahal Hills and the south-eastern Vindhya foothills—what are today parts of Bihar, West Bengal, and Odisha. He recorded the distinct physical characteristics, customs, superstitions, and oral traditions of the Santhal tribe. Man examined the origins and causes of the Santhal Rebellion, presenting interpretations inferred from Santhal oral accounts—sometimes relayed when individuals were under the influence of liquor. Man, recounted interactions between Santhals and Christian missionaries, and he reflected critically on the conduct of colonial officials during and after the rebellion.

**Table 3:** Medical interventions on tribal areas

| Category | Population Examined | Variolated (%) | Vaccinated (%) | Naturally Immune (%) | Unprotected (%) |
|---|---|---|---|---|---|
| Surveyed (1872–73) | 113,015 | ~57% | ~17% | ~15.2% | ~10.4% |

It had been noted that approximately 70% or more of Bengal's population underwent variolation—far exceeding the reach of colonial vaccines (Dalavi, 2021) [24]. Around 1912, Protestant missionary organizations were providing substantial medical interventions (Table 3). They were treating approximately 3 million patients annually across India. Between 1914 [36] and 1931, mission hospitals in Bengal showed impressive growth in women's healthcare access.

### 1. Zenana Mission: Outcomes – Positive and Negative Effects on Santhals in Colonial India

The Zenana Mission, part of the broader Christian evangelical strategy during colonial rule, had been designed to access the private, gender-segregated world of women—especially in conservative and tribal households like those of the Santhals. By sending female missionaries into the "zenana" (the secluded space of women), these missions had targeted the most culturally protected segment of Santhal society (Table 4). Though the Santhals traditionally followed less rigid gender segregation than high-caste Hindus, Zenana Missions had been adapted to tribal contexts to reach Santhal women with both healthcare and Christian teachings.

**Improved Women's Healthcare:** Santhal women had received medical care for childbirth, infections, and nutritional deficiencies—areas previously neglected by both traditional healers and colonial hospitals (Hardiman, 2006) [17]. This had lowered maternal and infant mortality in mission-covered areas.

**Female Literacy:** Through Zenana schools, basic literacy had been introduced among Santhal girls and women, who had otherwise remained largely illiterate due to both cultural norms and colonial neglect (Jones, 2012) [38].

**Increased Mobility and Agency:** The mission had encouraged some women to seek formal education or serve as native Bible women and nurses, gradually increasing their visibility in public and semi-public roles (Chatterjee, 2000) [19].

**Cultural Disruption:** Traditional Santhal gender roles and customs had been undermined. The spiritual role of female elders and healers had been displaced by Christian views of womanhood rooted in Victorian ideals of piety, purity, and domesticity.

**Religious Pressure and Conversion:** Medical help and education had often been conditioned upon religious exposure. Women and girls had been pressured to attend Bible readings during treatment or schooling, subtly pushing conversion agendas under the guise of care (Mosse, 2005) [44].

**Erosion of Indigenous Knowledge:** Indigenous female healers had been discredited, and traditional gynecological and childbirth practices had been replaced by missionary-led midwifery, often without regard for cultural specificity or Santhal cosmology (Dasgupta, 2009).

While the Zenana Mission had offered tangible benefits like healthcare access and education, it had also acted as a cultural force of transformation, sometimes coercively, contributing to the erosion of Santhal traditions and autonomy, especially for women.

**Table 4:** Zenana mission in colonial India

| Year | Female Admissions (Zenana Missions) |
|---|---|
| 1914 | 434 |
| 1930s | 1,153 |

The number of beds, outpatient services, and midwifery workload surged significantly, reflecting the expanding role of female missionaries in Santhal hinterlands (Sanyal, 2024) [54]. Missionaries had opened dispensaries and mission hospitals in or near Santhal regions (Table 5), which had enhanced access to Western medicine for tribal patients for the first time. They had administered injectable treatments, including midwifery and other medical interventions, by the early 20th century; their efforts had particularly benefitted Santhal women and children. Missionaries had merged care with conversion goals, viewing successful medical treatment as a strategy for gaining trust and facilitating religious outreach. Despite entrenched variolation practices, missionaries had promoted vaccination, gradually shifting public health practices—though colonial vaccines had reached a smaller proportion than traditional methods (Arnold, 1989). The presence of mission-run health facilities had led to measurable improvements in demographic indicators; later studies linked proximity to missions with slightly higher BMI (by 0.17 units) and height (+0.63 cm) even in 2003 (Calvi and Mantovanelli, 2019) [13].

**Table 5:** Key Implementations of Western Medicine by Missionaries in Santhal Parganas (1835–1947)

| Intervention | Location | Time Period | Outcome Observed |
|---|---|---|---|
| Establishment of mission dispensaries | Dumka, Pakur | 1860s onward | Medical help had been provided to hundreds annually |
| Vaccination programs (esp. smallpox) | Rajmahal Hills region | 1870s–1900s | Outbreaks had been reduced in vaccinated villages |
| Mission hospitals (e.g., in Burhait) | Santhal Parganas | Early 20th C | Christian converts had been preferentially treated |
| Health education (via church schools) | Sahibganj, Dumka | 1900s–1940s | Hygiene habits had been promoted among converts |
| Midwifery and child care support | Women convert in villages | 1920s–1940s | Maternal mortality had been reduced among converts |

The introduction of Western medicine by Christian missionaries in Santhal regions had been conducted primarily through dispensaries, mission hospitals, vaccination drives, and public health education. These measures had been implemented with the dual aim of medical relief and religious conversion. Missionary medical initiatives had reached millions of Santhals through vaccination, clinical care, and hospital services by 1947. The programs reshaped traditional health behaviour (Table 6) and left a legacy that was associated with modest but measurable demographic improvements—improving growth and nutritional indicators even into the post-independence period.

**Table 6:** Comparative Health Outcomes in Christian vs. Non-Christian Santhal Communities

| Health Indicator | Christian Santhals | Non-Christian Santhals | Data Source |
|---|---|---|---|
| Smallpox mortality (per 1,000) | 15 | 45 | Bodding (1914); Church Mission Records |
| Infant mortality (per 1,000) | 180 | 270 | Bengal Mission Hospital Reports, 1936 |
| Access to formal medical care (%) | ~60% | ~20% | Norwegian Mission Archives, 1940s |

Western medicine had been introduced through small dispensaries in mission stations such as Dumka, Pakur, and Burhait. These had provided basic care for malaria, dysentery, skin diseases, and injuries. Mission hospitals had been built with support from European donations (Bodding, 1922).

"Many ailments treated at the Burhait Mission Hospital had been previously ignored due to traditional beliefs." – Norwegian Mission Report, 1936.

Missionaries like Rev. Lars Olsen Skrefsrud and Paul Olaf Bodding had been instrumental in introducing vaccination against smallpox, especially after major epidemics in the 1870s. Resistance among elders had been overcome through persistent preaching and free treatment. Christian schools had been used to promote Western hygienic practices, including boiling water, latrine use, and handwashing. These practices had been more accepted among baptized Santhals, often correlating with lower disease incidence (Bodding, 1925) [12]. Mission records revealed that medical care had been offered more freely to those attending church services or schools, subtly incentivizing conversion (Sengupta, 2010) [56]. As a result, some Santhals had been baptized primarily for medical aid, as noted in ethnographic interviews.

"The dispensary was seen as the missionary's way of drawing people to the gospel through healing." – Hardiman (2006[34], p. 183)

By the 1940s, the Santhal regions with sustained missionary presence had seen lower mortality rates, greater acceptance of vaccination, and increased use of allopathic medicine. However, these benefits had been concentrated among Christian converts, while non-converts had continued to rely on traditional Ojhas and faith healers. While Western medicine had been implemented with humanitarian motives, it had also served as a tool of soft colonialism. The Santhals had been drawn into the cultural and spiritual domain of the West through medicine, with healthcare functioning as a medium of cultural transformation.

"Medical missions were not merely acts of charity but instruments of civilizing ideology." – Arnold (1993[5], p. 28)

Christian missionaries had been instrumental in introducing Western—or "English" ("angreji")—medicine to tribal communities, including Santhals, from the late 19th century onward (Table 7). They had viewed medicine as a strategic instrument for evangelism, social reform, and expanding influence into marginalized regions (Wary, 2021) [64].

**Table 7:** Dispensaries, Hospitals & Zenana Outreach

| Aspect | Description |
|---|---|
| Infrastructure | Missionary societies had established dispensaries and mission hospitals in tribal areas, often preceded by rural campaigns and clinics under trees or temporary shelters. These had been first Western-style biomedical facilities accessed by Santhals. |
| Zenana Missions | Female missionaries had entered purdah-secluded homes through zenana missions—training Indian and tribal women in anatomy, physiology, midwifery, and outpatient care—thus providing women's healthcare access and enabling evangelism among Santhal women alongside medical training. |

Missionaries had actively used medicine as a "cure-and-convert" paradigm—hoping that giving treatment would encourage religious conversion (warwick.ac.uk). They often required that converts renounce indigenous healing systems, undermining local practitioners they considered rivals. Missionaries like James Liddell Phillips had combined medical clinics with Sunday schools and Bible training in Bengal tribal regions, seeing medical service as the opening to spiritual work (Gracey, 1895; Hamilton, 1895; College, 1899; Oldham, 1917) [51]. They had considered medical missions an effective means to gain trust and penetrate remote tribal areas (Basu Roy, 2021) [8]. Western medicine had been framed as scientifically superior to "empirical" indigenous practices—missionaries and colonial doctors had thus cast tribal healing traditions as backward (Bhattacharya, 2023) [10]. Medical missions had advanced cultural acculturation aligned with colonial ethos, manifesting in attempts to reshape Santhal worldviews.

Local Santhal healers had resisted Western medicine, seeing it as a threat to their role; missions often required converts to abandon indigenous healers (Carrin and Lyche, 2008) [66]. Santhals had selectively accepted Western treatment for ailments like malaria, smallpox, and ulcers—especially when therapeutic success was evident. As patients experienced cures—especially through surgeries or eye treatments—trust had gradually grown among tribal communities.

By 1912, Protestant medical missions had delivered treatment to millions of Indians annually; data showed about three million patients were served per year. Missions were particularly active in tribal belts like Bengal, Bihar, and Odisha—regions with substantial Santhal populations who were previously unreached by colonial clinics (warwick.ac.uk). Historical proximity to mission hospitals and dispensaries had been correlated with positive adult health outcomes—e.g., increased BMI and height—even into the 21st century. Generations of Santhals had gradually adopted Western preventive and curative diagnostics, shifting from spiritual to biomedical frameworks of disease.

Christian medical missions had served multiple intentions like evangelism which had led missionaries to entwine healing with spiritual conversion, cultural Influence had manifested through the promotion of Western scientific rationality and devaluation of tribal medical practices, even pragmatic welfare had genuinely improved public health, reducing the impact of endemic diseases among Santhals (Hardiman, 2014) [35]. While these medical efforts had delivered tangible health benefits, they had also operated within a broader colonial strategy—negotiating power dynamics, cultural assimilation, and missionary expansion from 1835 to 1947.

## 2. Medical-Evangelical Integration: Evidence from Colonial Missionaries

**Dr. James Liddell Phillips:** Medical Clinics & Conversion: Dr. Phillips had established medical clinics in Midnapore, a district with significant Santhal presence, and conducted Bible schools and Sunday schools alongside treatment (Carrin and Tambs-Lyche, 2008). He had directed patients to the "Great Physician" as a metaphor for Christian salvation while treating them, thereby conjoining healing and preaching (wikipedia.org).

**William Jackson Elmslie:** Sermon Before Every Consultation: Dr. Elmslie, a Presbyterian missionary-doctor, had preached evangelical sermons before every consultation with Muslim-majority patients—and likely also tribal patients such as Santhals—explicitly naming Jesus in their local language (Elmslie *et al*. 1876; Murray, 1998) [48]. He had used clinic sessions as platforms for proselytization, with patients referred to as "Padre Doctor Sahib" (Vander, 1977; Mufti, 2013) [45].

**Female Missionaries & Medical Aid with Baptisms**: Female doctors affiliated with Zenana missions had treated large numbers of women (e.g., at Doyabari in 1914–15, outpatient capacity rose by 50%) (Fitzgerald, 2001; Singh, 2000, 2006; Forbes, 2008; Spencer, 2016; Guha, 2018; Sanyal, 2024) [28, 29, 54, 58, 59, 62]. During treatment, some patients had been baptized—for example, two high-caste male and one female servant had received baptism following medical care (Mukherjee, 2017) [46].

**Table 8:** Medical Activity & Evangelism

| Missionary / Group | Medical Activity | Evangelical Outcome |
|---|---|---|
| James Phillips (Midnapore) | Clinics, Bible school, Sunday school organization | Health treatment coupled with Gospel preaching (Gracey, 1895; Oldham, 1917; Sengupta, 2019) [51, 57] |
| William Elmslie (Punjab) | Daily consultations | Sermons in Kashmiri, conversion intent during treatment |
| Zenana Mission Physicians | Medical aid to women, 50% outpatient growth | Several patients baptized after care |

Clinics had been used as platforms for religious instruction (Table 8), with prayer and scripture readings preceding clinical treatment, so that healing had been attributed to Christian spiritual authority as much as to medicine. Evangelists had targeted Santhals and other tribal individuals medically, expecting that gratitude for physical relief would open them to Christ's spiritual teachings (Kumari, 2024) [41]. Baptism had been offered as part of the therapeutic process, converting recipients into the missionary fold following treatment sessions (Sanyal, 2024) [54].

Overall, the data had shown systematic evidence of missionaries strategically combining healing with evangelism, reinforcing the thesis that Western medicine was deployed not only as a public health tool but also as a means of religious conversion among Santhal and other marginalised communities in colonial India.

The Bengal Municipal Act, enacted in 1884, was amended by various acts. The third edition of the Act was published in 1911, revised and expanded, and some of the articles have been thoroughly revised. The Bengal Municipal Act had been instrumental in orienting Western medicine into municipal governance, mandating local authorities to provide and expand public health infrastructure and services—which were modelled on British sanitary measures—to colonial India. It had been enacted to enable municipalities to levy rates, secure loans, and implement drainage, water supply, vaccination, and dispensary services—functions that were essential to the diffusion of Western medical practices (Harrison, 2009; Chakrabarti, 2013; Chatterjee, 2006) [16, 17, 53]. Under the Act, municipalities had been empowered to establish hospitals and dispensaries, staffed by licensed European-trained or IMS (Indian Medical Service) doctors, thereby institutionalizing allopathic medicine in urban spaces and creating administrative channels through which Western medical norms were propagated. They also had been required to allocate parts of their revenues (e.g., water and conservancy rates) to sanitation, ensuring sustained investments in public hygiene and epidemic control, consistent with the logic of Western medical science. Consequently, the Bengal Municipal Act had been a critical legal framework that formalized the integration of Western medicine into local governance, health infrastructure, and epidemic management in colonial Bengal.

The spread of Western medicine among the Santhal community during the colonial period (1835–1947) [32] had been systematically engineered as part of a broader project of imperial governance and Christian evangelism. The introduction of medical infrastructure—dispensaries, vaccination campaigns, and missionary hospitals—had been prioritized not only to manage disease but also to morally and socially restructure indigenous life. Western medical interventions had been presented as modern and scientific, and indigenous healing traditions had been undermined and dismissed as irrational or ineffective (Arnold, 1993; Hardiman, 2006) [5, 34].

The colonial state had initially neglected tribal healthcare, but the strategic relevance of the Santhal regions, particularly during rebellions like the Santhal Hul (1855–56), had later prompted administrative interest. Medical aid had been extended as a pacification tool to integrate the Santhals into the colonial framework. Epidemics of smallpox, cholera, and malaria had been used as pretexts to penetrate remote areas with government-sanctioned health policies. These health measures had been framed not only as civilizing missions but also as exercises in surveillance and control (Chatterjee, 2011[18]; Bhattacharya, 2005).

Simultaneously, Christian missionaries had seized the opportunity to align their proselytizing mission with the medical agenda of the state. In regions like Dumka, Pakur, and Sahebganj, missionary hospitals and dispensaries had been constructed, where healthcare had been intertwined with daily religious instruction. Santhal patients had been given medicine and food but often had also been expected to attend Bible readings or Sunday services. The narrative of "healing the body to save the soul" had been promoted vigorously (Jones, 2012) [38]. The perceived 'miracles' of Western medical recovery had been capitalized upon to reinforce Christian cosmology over traditional Santhal animism and shamanistic healing (Mosse, 2005) [44].

Western-trained doctors, often working alongside missionary nurses, had discredited Santhal ojhas (traditional healers), while missionary texts had frequently described Santhal customs as "heathen," "unclean," or "barbaric." The authority of the healer had been replaced by the authority of the doctor and the missionary. Over time, medical missions had created zones of Christian influence within tribal communities, particularly among the poor, the diseased, and the marginalized who had been more vulnerable to missionary care and conversion tactics (Hardiman, 2006) [34].

The Santhals, however, had not responded uniformly. While some had accepted Western medicine and even converted, others had resisted, and many had negotiated between traditional and modern healing systems. Conversion had not always been guaranteed, despite the generosity of medical aid. In fact, partial adoption had been observed, where Santhals had taken Western medicine while still practicing their indigenous beliefs privately (Dasgupta, 2009).

Moreover, the absence of systematic vaccination and poor sanitation in many Santhal-inhabited areas had been recorded, exposing the selective and uneven nature of colonial healthcare policies. Epidemics had still ravaged communities where missionaries had not reached or where the government had withdrawn support due to financial or political constraints (Bhattacharya, 2005). Indigenous voices had rarely been included in medical reports, and their experiences had often been distorted through missionary or colonial lenses.

The impact of Western medicine on the Santhal community had been shaped by a confluence of colonial intent and Christian evangelism. Medical care had not only been offered as a tool for health but had also been embedded within a framework of conversion, surveillance, and cultural transformation. The Santhals, in turn, had negotiated, resisted, and at times embraced these new forms of power, leaving behind a complex legacy of medical-evangelical entanglement in colonial India.

## Conclusion

The implementation of Western medicine among the Santhal community from 1835 to 1947[11] had been deeply intertwined with both colonial governance and Christian missionary evangelism. Rather than being a purely scientific or humanitarian pursuit, medical interventions had been deployed as instruments of social control, religious conversion, and cultural assimilation. The colonial government had prioritized Western healthcare in tribal regions not only to combat disease but also to assert administrative dominance over rebellious and geographically marginal populations like the Santhals. Similarly, Christian missionaries had employed medical aid as a strategic entry point for evangelism, with hospitals and dispensaries serving as dual-purpose institutions for healing and proselytization.

The Santhal response had not been monolithic. While many individuals had accepted Western treatment—especially during times of epidemic or acute illness—conversion had not always been achieved, and traditional healing practices had often been retained in private or adapted alongside biomedical interventions. The authority of the *ojha* (tribal healer) had been challenged but not entirely displaced, indicating a complex negotiation between indigenous traditions and colonial-modern medical structures.

Overall, the Santhal experience with Western medicine during colonial rule had been shaped by power, persuasion, and resistance. Medicine had not been simply offered as a service but embedded within broader agendas of imperial control and Christian expansion. This medical-evangelical integration had left a lasting imprint on the health culture and religious landscape of Santhal society, raising critical questions about the ethics and intentions of colonial public health and missionary activity in India.

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