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# MISSIONARIES, GENDER AND HEALTHCARE IN COLONIAL ASSAM: AN ANALYTICAL STUDY

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## ABSTRACT

This article examines the intersection of gender, missionary activity, and healthcare in colonial Assam, with a particular focus on the American Baptist Mission (ABM) in the Brahmaputra Valley. It analyses how missionary discourse constructed Assamese women as subjects of reform and intervention, emphasizing their perceived oppression, lack of education, and inadequate access to healthcare. By situating medical missions within broader colonial and evangelical frameworks, the study highlights how healthcare functioned both as a humanitarian service and a strategic tool for religious conversion. The article also explores the role of female missionaries in accessing secluded domestic spaces such as zenanas, and the transformation of women's lives through education, institutional healthcare, and missionary-controlled environments. While missionary interventions contributed to expanding healthcare access, they simultaneously reinforced Victorian gender norms and colonial hierarchies. Thus, the article reveals the complex and contradictory nature of missionary engagement with gender and health in colonial Assam.

**Keywords**: British, Missionaries, Gender, Healthcare, Zenana

## INTRODUCTION

The expansion of missionary activity in colonial Assam during the nineteenth century must be understood within the broader framework of evangelical imperialism, where religion, social reform and healthcare intersected in complex ways. The American Baptist Mission (ABM), which established its presence in the Brahmaputra Valley in the early nineteenth century viewed its work not merely as religious propagation but as a civilizing mission aimed at transforming indigenous society. Central to this mission was a deeply gendered understanding of social reform, wherein women were constructed as both the most vulnerable and the most crucial agents of change within colonial society.[i] Missionary writings from Assam consistently emphasized the perceived degraded condition of women, portraying them as victims of ignorance, superstition and oppressive social customs. These representations were not incidental but formed a foundational component of missionary ideology. As Orrell Keeler famously asserted, "Christianity alone has the vital power" to elevate women from their supposed state of degradation.[ii] Such statements reflect the broader evangelical conviction that spiritual regeneration was inseparable from social transformation. Women as custodians of the household and primary caregivers were seen as central to this process. If women could be reformed through education, moral discipline and religious conversion the entire structure of indigenous society could be reshaped.

The 1886 Jubilee Conference of the Assam Mission, held in Nowgong, offers a crucial insight into how these ideas were articulated and institutionalized. The conference brought together missionaries from across the region to reflect on fifty years of missionary work and to strategize for the future. Papers presented during the conference not only documented the progress of missionary activity but also emphasized the need to expand efforts among women.[iii] The discussions made it clear that missionary success was increasingly tied to the ability to access and influence women who were otherwise largely excluded from public religious spaces due to prevailing cultural norms such as *purdah* and domestic seclusion. However, this emphasis on women also revealed a significant structural challenge within missionary work. Male missionaries, who dominated the early phases of the ABM, found

themselves unable to engage directly with women in the Brahmaputra Valley. Cultural restrictions prevented them from entering domestic spaces, particularly those of upper-caste or elite households.[iv] This limitation necessitated a reconfiguration of missionary strategies, leading to the gradual inclusion of female missionaries. Women missionaries were seen as uniquely positioned to penetrate the private sphere, particularly the zenana, where indigenous women lived and interacted. Their presence marked a significant shift in missionary practice, highlighting the importance of gender in shaping the dynamics of colonial evangelism.

The integration of healthcare into missionary work further reinforced this gendered approach. By the latter half of the nineteenth century, medical missions had become a central component of evangelical strategy. Missionaries increasingly recognized that providing medical care could serve as an effective means of gaining access to local communities and establishing trust. In this context, healthcare was not merely an act of charity but a strategic tool for evangelization. As missionary reports suggest, attending to bodily ailments functioned as an "entering wedge" that opened the door to spiritual instruction.[v] The treatment of illness created opportunities for interaction, allowing missionaries to introduce Christian teachings in contexts where direct preaching might have been resisted.

For women, the significance of medical missions was particularly pronounced. Indigenous women often had limited access to formal healthcare, especially in settings where cultural norms restricted their interaction with male practitioners. Female missionaries, particularly those with medical training, were able to fill this gap. By providing care in both institutional settings and domestic spaces, they established themselves as indispensable figures within local communities. Their work blurred the boundaries between care giving and evangelization, positioning them as both healers and spiritual guides.

So far, the incorporation of healthcare into missionary work must be understood within the broader ideological framework of colonialism. Missionaries did not simply introduce new forms of medical knowledge; they also sought to redefine indigenous understandings of health, disease and the body. Western medicine was presented as scientific, rational and superior, while indigenous practices were often dismissed as backward or ineffective.[vi] This dichotomy reinforced colonial hierarchies, positioning missionaries as bearers of modernity and indigenous communities as subjects in need of reform.

The gendered dimension of this process is particularly significant. While missionary work opened new opportunities for women through education, healthcare, and limited public engagement it simultaneously imposed new forms of discipline and control. Missionary ideals of womanhood were deeply rooted in Victorian norms, emphasizing domesticity, modesty and moral purity. Women were encouraged to become educated and healthy, but within a framework that reinforced their roles as wives, mothers and caretakers.[vii] Thus, the process of "upliftment" was not simply emancipatory but also regulatory, shaping women's identities in accordance with Western ideals.

Moreover, the role of female missionaries themselves was marked by contradiction. While they were instrumental in expanding missionary influence, their own positions within the mission structure were often subordinate. Missionary wives, for instance, were expected to prioritize domestic responsibilities over independent work, mirroring the very gender hierarchies they sought to challenge in indigenous society.[viii] Even single female missionaries, who enjoyed greater autonomy, operated within a framework that defined their work in terms of service and moral duty rather than professional recognition.

This duality underscores the need to critically examine missionary activity in colonial Assam. Rather than viewing it solely as a force of progress or oppression, it is more productive to understand it as a site of negotiation where multiple forces intersected. Missionary ideology, colonial power, gender norms, and indigenous agency all played a role in shaping the outcomes of missionary work. Women were not merely passive recipients of missionary intervention; they engaged with, adapted to, and sometimes resisted these efforts in ways that complicate simplistic narratives of transformation.

In this context, the study of missionary healthcare offers a particularly valuable lens through which to examine these dynamics. By focusing on the intersection of gender and medicine, it becomes possible to trace how everyday practices such as treating illness, teaching hygiene or providing childbirth assistance were embedded within broader ideological frameworks. These practices reveal how missionary work operated not only at the level of institutions and policies but also within the intimate spaces of daily life.

This article, therefore, seeks to analyse missionary healthcare in colonial Assam as a gendered and ideological project. It argues that while missionary interventions contributed to expanding access to education and healthcare, they were simultaneously shaped by colonial assumptions

and Victorian gender norms. By examining missionary narratives, institutional practices, and everyday interactions, the study highlights the complex and often contradictory nature of missionary engagement with women in the Brahmaputra Valley. In doing so, it contributes to a more nuanced understanding of the intersections between gender, healthcare, and colonialism in South Asia.

## CONSTRUCTION OF ASSAMESE WOMEN IN MISSIONARY NARRATIVES

Missionary representations of Assamese women formed a central component of evangelical discourse in colonial Assam. These narratives were not merely descriptive accounts of indigenous society but were deeply embedded in ideological frameworks that justified missionary intervention. By portraying women as oppressed, ignorant, and socially marginalized, missionaries constructed a moral imperative for their presence and activities in the Brahmaputra Valley.[ix]

One of the most recurring themes in missionary writings was the depiction of women's daily lives as labor-intensive and devoid of intellectual or moral development. Ella Marie Holmes, for instance, described the life of Assamese women as characterized by "a long day of labour and a short night of rest," emphasizing their constant engagement in domestic and agricultural work.[x] Such descriptions highlighted not only the physical burden placed upon women but also their perceived lack of opportunity for self-improvement. However, these portrayals often overlooked the socio-economic realities of rural life, where women's labor was integral to household survival. Instead, missionaries framed this labor as evidence of social backwardness, reinforcing the need for reform.

Another key element in missionary discourse was the construction of gender disparity between men and women. Missionaries frequently argued that men in Assamese society had begun to adopt aspects of modernity, while women remained confined to traditional practices. Holmes lamented that men had "advanced so far beyond the women that they cannot be comrades in many things," thereby positioning women as obstacles to social progress.[xi] This narrative served a dual purpose: it highlighted the supposed failure of indigenous society to uplift women, and it underscored the necessity of missionary intervention to bridge this gap.

Education emerged as a central focus within these narratives. Missionaries consistently emphasized the lack of educational opportunities for girls, presenting it as a primary cause of

women's marginalization. Accounts such as that of Mrs. P.H. Moore describe attempts to establish schools for girls, often encountering resistance from local communities.[xii] These stories were framed as struggles between enlightenment and ignorance, with missionaries depicted as persistent agents of progress. However, such representations tended to simplify complex social dynamics. Resistance to female education was not necessarily rooted in opposition to learning but often reflected economic considerations, as girls' labor was essential to household functioning. By ignoring these factors, missionary narratives reinforced a one dimensional view of indigenous society.

Healthcare constituted another critical aspect of the construction of Assamese women in missionary writings. Women were frequently portrayed as lacking access to proper medical care and relying on what missionaries considered ineffective traditional remedies. This portrayal was instrumental in legitimizing the introduction of Western medicine. A particularly striking example is found in missionary reports describing cases of neglect and suffering, such as the account of a woman who died without assistance due to caste-based restrictions.[xiii] Such narratives emphasized the moral and social deficiencies of indigenous practices, positioning missionaries as both medical and humanitarian saviors.

However, these accounts must be approached with caution. While they highlight genuine instances of hardship, they often exaggerate or selectively represent realities to serve ideological purposes. Indigenous healthcare systems, including herbal medicine and community-based care, were largely dismissed or undervalued. This dismissal reinforced the perceived superiority of Western medical knowledge and justified missionary intervention.[xiv]

The intersection of gender and caste further complicates these narratives. Missionary accounts frequently highlighted instances where caste restrictions exacerbated women's suffering, particularly in healthcare contexts. While such observations reveal important aspects of social inequality, they were often framed in ways that emphasized moral failure rather than structural complexity. By focusing on individual incidents of neglect, missionaries obscured the broader socio-economic and cultural factors that shaped these practices.

Moreover, missionary representations of Assamese women were shaped by Victorian ideals of femininity. Women were depicted as passive, dependent and in need of guidance, reflecting broader Western notions of gender roles. These ideals influenced not only how missionaries perceived indigenous women but also how they sought to transform them. Education,

healthcare, and domestic training were all framed within a vision of womanhood that emphasized discipline, morality, and domesticity.[xv]

Despite these limitations, missionary narratives provide valuable insights into the gendered dynamics of colonial Assam. They reveal how women's lives were interpreted through the lens of colonial ideology and how these interpretations shaped missionary strategies. At the same time, they highlight the agency of indigenous women, who navigated, resisted, and adapted to missionary interventions in diverse ways.

The construction of Assamese women in missionary narratives was a complex and contested process. While these narratives served to justify missionary work, they also reflected broader colonial assumptions about gender, culture, and progress. A critical reading of these sources is therefore essential to understanding both the realities of women's lives and the ideological frameworks that shaped their representation.

## GENDER BARRIERS AND THE RISE OF FEMALE MISSIONARIES

The expansion of missionary activity in colonial Assam was significantly shaped by gendered barriers that limited the reach of male evangelists. Cultural practices such as purdah and broader norms of female seclusion restricted interactions between indigenous women and unrelated men, particularly outsiders. This posed a fundamental challenge to the American Baptist Mission (ABM), whose early efforts were overwhelmingly led by male missionaries. While these men could engage with public spaces, markets, and male congregations, they remained largely excluded from the domestic sphere where most Assamese women lived.[xvi]

This exclusion was not merely a logistical obstacle but a structural limitation that exposed the gendered nature of missionary work. The inability to access women undermined the missionaries' broader objective of social transformation, as women were perceived as central to the moral and cultural fabric of society. As missionaries increasingly recognized that the success of their evangelical project depended on influencing women, the need to overcome these gender barriers became urgent.[xvii]

In the initial phases, missionary wives attempted to bridge this gap. Their gender allowed them limited access to indigenous households, particularly the zenanas, where they could interact with women and children. However, their participation in missionary work was constrained by their primary role as wives and homemakers. They were expected to maintain their own

households and support their husbands' work, reflecting the same domestic ideals that missionaries criticized in Assamese society.[xviii] As a result, their contributions, though significant, were often informal and undervalued within the mission structure.

The limitations faced by missionary wives highlighted the necessity of recruiting single female missionaries. Unlike married women, single women were not bound by domestic responsibilities and could dedicate themselves fully to missionary work. Their arrival marked a significant shift in the organization and scope of missionary activity in Assam. These women were specifically tasked with engaging with indigenous women, providing education, and addressing their physical and spiritual needs.[xix]

The emergence of female missionaries must also be understood within the broader ideological framework of nineteenth century evangelicalism. Missionaries believed that the transformation of society required the reform of women, who were seen as the primary transmitters of culture and values within the household. If women remained outside the influence of Christianity, the long term success of the mission would be uncertain.[xx] This belief led to repeated appeals to missionary headquarters in Boston referred to as "The Rooms" for the deployment of more female workers, particularly those with specialized skills.

Among these, medically trained female missionaries were considered especially valuable. By the late nineteenth century, the integration of healthcare into missionary work had become increasingly important. Female medical missionaries could provide treatment to women who were otherwise excluded from male dominated medical spaces. This not only addressed a critical gap in healthcare but also created opportunities for evangelization. As missionary reports indicate, medical care was seen as an effective means of gaining access to women's lives and establishing trust within communities.[xxi]

The strategic importance of female missionaries is further illustrated by the increasing demand for their presence in specific mission stations. Requests for women missionaries were repeatedly made during missionary conferences, emphasizing their role in "raising the standard" of womanhood in Assam.[xxii] This language reflects the deeply paternalistic assumptions underlying missionary work, where indigenous women were viewed as subjects in need of moral, intellectual, and physical upliftment.

However, the rise of female missionaries did not fundamentally challenge the gender hierarchies within missionary organizations. Despite their critical role, women were rarely

granted equal status with their male counterparts. Missionary wives, in particular, were not provided with separate financial support and their contributions were often framed as voluntary extensions of their domestic duties.[xxiii] Even single female missionaries, though more independent, were expected to embody ideals of service, humility and moral purity, reinforcing Victorian notions of femininity.

This contradiction reveals a broader tension within missionary work. On the one hand, female missionaries were essential agents of change, enabling the expansion of missionary influence into previously inaccessible spaces. On the other hand, their roles were shaped and constrained by the same gender norms that structured both colonial and missionary societies. The emphasis on women's work as nurturing and care giving further reinforced traditional gender roles, even as it expanded women's participation in public and professional domains.

Moreover, the work of female missionaries must be understood in relation to indigenous responses. While missionaries often portrayed Assamese women as passive recipients of intervention, the reality was far more complex. Women engaged with missionary initiatives in diverse ways, sometimes embracing education and healthcare opportunities, and at other times resisting or negotiating these interventions. The success of female missionaries, therefore, depended not only on their access to domestic spaces but also on their ability to navigate local cultural dynamics.

The rise of female missionaries in colonial Assam was both a response to practical challenges and a reflection of broader ideological shifts within missionary work. Gender barriers necessitated the inclusion of women in missionary activity, leading to the development of new strategies centered on education and healthcare. However, this inclusion was marked by significant contradictions, as female missionaries operated within structures that both empowered and constrained them. By examining these dynamics, it becomes clear that gender was not merely a peripheral aspect of missionary work but a central factor shaping its organization, strategies, and impact.

## HEALTHCARE AS EVANGELICAL STRATEGY

The incorporation of healthcare into missionary activity in colonial Assam marked a significant shift in evangelical strategy, transforming the nature of engagement between missionaries and indigenous communities. For the American Baptist Mission (ABM), medical

work was not simply an extension of humanitarian concern but a calculated approach to facilitate religious conversion. By addressing the physical ailments of the population, missionaries were able to create points of contact that transcended cultural resistance to direct evangelization. Healthcare thus emerged as a critical "entering wedge," enabling missionaries to establish trust and legitimacy within local communities.[xxiv]

This strategy was particularly effective in a context where access to formal medical care was limited, especially for women. Indigenous women, constrained by cultural norms such as purdah and domestic seclusion, often had little or no access to male practitioners. Female missionaries, particularly those with medical training, were therefore uniquely positioned to fill this gap. By providing treatment within both institutional settings and private domestic spaces, they gained access to women's lives in ways that male missionary could not.[xxv] This gendered dimension of medical work underscores the centrality of healthcare in expanding missionary influence.

Missionaries conceptualized illness not merely as a physical condition but as part of a broader moral and spiritual framework. Disease was often interpreted as a manifestation of moral decay or ignorance, reinforcing the belief that physical healing must be accompanied by spiritual transformation.[xxvi] In this sense, medical missions blurred the boundaries between religion and science, presenting Western medicine as both a practical remedy and a moral corrective. The act of healing the body was thus intrinsically linked to the goal of saving the soul.

The everyday practices of missionary healthcare further illustrate its dual function. Female missionaries frequently provided basic medical assistance during zenana visits, offering remedies, advice on hygiene, and care during childbirth. These interventions were often modest in scale, particularly in the absence of formally trained medical personnel, but they played a crucial role in establishing relationships of trust. As missionary accounts indicate, even limited medical knowledge could significantly enhance a missionary's ability to gain access to households and influence women's lives.[xxvii]

With the gradual arrival of trained medical professionals, healthcare provision became more institutionalized. The establishment of dispensaries, hospitals, and maternity services allowed missionaries to extend their reach beyond individual households. These institutions not only provided more systematic care but also created spaces where religious instruction could be

integrated into medical treatment. Patients were exposed to Christian teachings alongside medical care, reinforcing the connection between physical and spiritual well-being.[xxviii]

However, the use of healthcare as an evangelical strategy was not without its complexities. While it undeniably addressed real needs and alleviated suffering, it also reflected broader colonial assumptions about the superiority of Western knowledge systems. Indigenous medical practices, including herbal remedies and community based healing traditions, were often dismissed as ineffective or superstitious.[xxix] This dismissal served to legitimize missionary intervention while simultaneously undermining local systems of knowledge and care.

Moreover, the framing of healthcare as a tool for conversion raises important ethical considerations. The provision of medical care was frequently accompanied by explicit or implicit expectations of religious engagement. Patients were not simply recipients of treatment but potential converts, and their interactions with missionaries were shaped by this underlying objective. This dynamic complicates the notion of missionary healthcare as purely benevolent, highlighting its role within a broader project of cultural and religious transformation.

At the same time, it is important to recognize that indigenous responses to missionary healthcare were not uniform. While some individuals embraced these services, others approached them with caution or skepticism. Cultural beliefs, logistical challenges, and social hierarchies often influenced decisions about seeking medical care. Despite the establishment of hospitals and dispensaries, many women continued to rely on traditional practices, particularly in matters such as childbirth.[xxx] This suggests that missionary healthcare, while influential, did not entirely displace existing systems but instead operated alongside them in a complex and negotiated landscape.

Healthcare functioned as a central pillar of missionary strategy in colonial Assam, enabling missionaries to navigate cultural barriers and expand their influence. By linking physical healing with spiritual salvation, the ABM created a powerful framework that integrated medical practice with evangelical objectives. However, this strategy was deeply embedded in colonial ideologies and marked by significant ethical and cultural tensions. Understanding missionary healthcare in this context requires a critical examination of both its transformative impact and its role in reinforcing structures of power and control.

## ZENANA MISSIONS AND GENDERED SPACES

The zenana or the secluded domestic space reserved for women, occupied a central position in the missionary engagement with gender in colonial Assam. For the American Baptist Mission (ABM), the zenana represented both an opportunity and a constraint: it was the primary site where women could be reached, however it was also a space governed by strict cultural norms that limited external influence. The emergence of zenana missions was thus a strategic response to the gendered barriers that restricted access to women within indigenous society.[xxxi]

Female missionaries, including both missionary wives and single women, played a crucial role in this endeavor. Their gender allowed them entry into domestic spaces that were inaccessible to male missionaries. However, their interactions within the zenana were often carefully mediated by family members, particularly male heads of households and elder women such as mothers-in-law.[xxxii] These figures exercised significant control over the extent and nature of missionary engagement, ensuring that interactions did not disrupt established social and religious norms. As a result, zenana missions were characterized by negotiation rather than direct intervention.

One of the primary strategies employed by female missionaries to gain acceptance within the zenana was the introduction of seemingly non-threatening activities such as needlework, sewing, and embroidery. These practices were socially acceptable within the domestic sphere and allowed missionaries to establish rapport with women.[xxxiii] However, these activities were not ideologically neutral. They were imbued with Victorian notions of femininity, emphasizing discipline, patience, and domesticity. Through such practices, missionaries sought to reshape women's identities in accordance with Christian ideals, subtly reinforcing their broader agenda of moral and social reform.

Healthcare also played a significant role in facilitating access to zenana spaces. Women were often more receptive to missionaries who offered practical assistance for their bodily ailments. Even in the absence of formal medical training, female missionaries provided basic remedies, advice on hygiene, and care during childbirth. These interventions created opportunities for deeper engagement, allowing missionaries to move beyond superficial interactions and address more intimate aspects of women's lives.[xxxiv] As Keeler observed, the ability to

alleviate physical suffering often enabled missionaries to gain access to both the "homes and hearts" of women.[xxxv]

Despite these efforts, zenana missions were marked by persistent limitations. The controlled nature of the domestic sphere meant that missionary influence remained partial and contingent. Resistance to religious conversion was common, and women's responses were shaped by the authority of family members and the weight of cultural traditions.[xxxvi] Moreover, the zenana itself was not a space of complete autonomy for women; it was structured by internal hierarchies that often reinforced patriarchal norms. This further complicated missionary efforts, as they had to navigate not only male authority but also the influence of senior women within the household.

The challenges encountered in zenana work eventually led missionaries to expand their activities beyond the domestic sphere. The establishment of schools, boarding houses, and hospitals provided alternative spaces where women could be engaged more freely. These institutions allowed missionaries to exercise greater control over the environment and to integrate education, healthcare and religious instruction in a more systematic manner.[xxxvii]

## INSTITUTIONAL HEALTHCARE AND TRANSFORMATION OF GENDER ROLES

The gradual institutionalization of healthcare by the American Baptist Mission (ABM) in colonial Assam marked a decisive shift from informal, household-based interventions to more structured and sustained forms of engagement. While early missionary efforts were largely confined to zenana visits and rudimentary medical assistance, the establishment of schools, boarding houses, dispensaries, and hospitals created new spaces where healthcare and education could be systematically integrated. These institutions played a crucial role not only in expanding access to medical services but also in reshaping gender roles and social practices within the Brahmaputra Valley.[xxxviii]

One of the most significant contributions of missionary institutions was the creation of environments where women could receive care outside the confines of the domestic sphere. Traditionally, Assamese women's lives were largely restricted to the household, and their access to public spaces was limited by cultural norms. Missionary hospitals and dispensaries challenged these boundaries by encouraging women to seek treatment in institutional settings.

The movement of women from zenanas to hospitals represented a subtle but important shift in gendered spatial practices, gradually normalizing women's presence in public domains.[xxxix] Missionary schools and boarding houses further reinforced this transformation by integrating healthcare into everyday routines. These institutions functioned as controlled environments where young girls were not only educated in literacy and religion but also trained in hygiene, childcare, and basic medical practices.[xl] Missionaries believed that improving women's knowledge of health would lead to stronger families and, by extension, more stable Christian communities. This emphasis on health education reflected a broader understanding of women as custodians of domestic well-being, whose influence extended beyond their individual lives to the larger social structure.

The architectural design and infrastructure of missionary institutions also reveal the centrality of healthcare in their operations. Buildings were constructed with features aimed at improving ventilation, sanitation, and overall living conditions. High ceilings, multiple windows, and well-planned drainage systems were introduced to reduce the spread of disease.[xli] Such measures reflected the missionaries' belief in the importance of environmental factors in maintaining health, as well as their commitment to implementing Western standards of hygiene. The construction of wells, bathing areas, and water supply systems further underscores the integration of healthcare into institutional planning.[xlii]

However, the development of institutional healthcare was not without its challenges. Cultural resistance remained a significant barrier, particularly in relation to childbirth and women's mobility. Many families were reluctant to send women to hospitals, preferring traditional home-based care unless complications arose.[xliii] This hesitation highlights the persistence of indigenous practices and the limits of missionary influence, even as institutional healthcare expanded.

Despite these constraints, missionary institutions gradually gained acceptance, particularly in urban and semi-urban areas. The presence of female medical professionals, including doctors and nurses, played a crucial role in this process. Their ability to provide care in a culturally sensitive manner helped to bridge the gap between traditional practices and Western medicine. Moreover, their work reinforced the association between healthcare and missionary benevolence, enhancing the credibility of the mission.[xliv]

At the same time, these institutions functioned as sites of cultural transformation. By bringing women into structured environments where Christian values and Western norms were emphasized, missionaries sought to reshape gender identities. The training provided in schools and boarding houses promoted ideals of discipline, cleanliness, and domestic responsibility, aligning with Victorian notions of femininity.[xlv] While these initiatives expanded women's access to education and healthcare, they also reinforced specific models of womanhood that emphasized subordination and moral regulation.

The transformation of gender roles through institutional healthcare was therefore both enabling and restrictive. On one hand, it facilitated greater mobility for women, allowing them to access public spaces and professional care. It also provided opportunities for education and skill development, contributing to gradual social change. On the other hand, it imposed new forms of discipline and control, shaping women's identities in accordance with missionary ideals.

Furthermore, the institutionalization of healthcare must be understood within the broader context of colonial power. Missionary institutions operated as extensions of colonial authority, promoting Western knowledge systems and cultural values. By positioning themselves as providers of modern healthcare, missionaries reinforced their authority while marginalizing indigenous practices.[xlvi]

The development of institutional healthcare in colonial Assam played a pivotal role in transforming gender relations and social practices. By creating new spaces for interaction and care, missionary institutions challenged traditional boundaries and expanded opportunities for women. However, these changes were deeply embedded in colonial and ideological frameworks, resulting in a complex process of transformation that combined elements of empowerment and control. A critical examination of these institutions thus reveals the multifaceted nature of missionary engagement with gender and healthcare in the Brahmaputra Valley.

## CONCLUSION

The analysis of missionary activity in colonial Assam demonstrates that healthcare and gender were central to the functioning of the American Baptist Mission (ABM). Missionaries constructed Assamese women as subjects in need of reform, portraying them as oppressed and

lacking access to education and medical care. This representation justified intervention while positioning missionary work as both a moral and humanitarian necessity.[xlvii]

Gendered barriers played a decisive role in shaping missionary strategies. The inability of male missionaries to access women led to the increasing importance of female missionaries, who became crucial intermediaries within domestic spaces such as zenanas. Their work in education and healthcare enabled deeper engagement with women, although their roles remained constrained by patriarchal structures within the mission itself.[xlviii]

Healthcare functioned as a key instrument of evangelization. By addressing bodily suffering, missionaries established trust and created opportunities for religious instruction. The linkage between physical healing and spiritual salvation blurred the boundaries between medicine and religion, reinforcing the dual objectives of missionary work.[3] At the same time, the development of institutional spaces—schools, boarding houses, and hospitals—facilitated women's entry into public domains, subtly transforming patterns of seclusion and mobility.

However, these changes were marked by significant contradictions. While missionary initiatives expanded access to healthcare and education, they also imposed Victorian ideals of femininity, emphasizing domesticity and moral discipline.[4] Furthermore, missionary critiques of indigenous practices often ignored their complexity, reinforcing colonial hierarchies that privileged Western knowledge systems.[5]

In conclusion, missionary healthcare in colonial Assam was both transformative and regulatory. It created new opportunities for women while simultaneously shaping their roles within a framework of colonial and gendered control. A critical reading of these dynamics reveals the complexities of missionary engagement and its lasting impact on gender and healthcare in the region.

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