Mennonite Medical Mission in India as Christian Witness and Cultural Critique

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The Origins of Mennonite Medical Mission in India

From the earliest years, Mennonite mission in India combined evangelism, education, medical care, and social ministries. The first missionary team sent to India by the Mennonite Church in 1899 was Jacob Ressler, a teacher and minister, and Dr. William and Alice Page. They arrived during a regional famine and were soon deeply involved in food and medical relief in cooperation with the British colonial government.[1] The mission had intended to establish medical care and orphanages as their entrée into the community. The famine accelerated the need for those services, intensified the missionary engagement with the community, and strengthened the collaboration between Mennonite missionaries and the British colonial administration. The first Mennonite dispensary opened in 1900 and the Dhamtari hospital was built in 1916.

General Conference Mennonites established their mission in Champa in 1901.[2] In April 1902 missionaries Peter and Elizabeth Penner shared their lunch with two people with leprosy. News of their generosity and hospitality spread quickly. Within weeks a

small squatter settlement of lepers had gathered nearby. A few months later the Penners established a home for lepers that became the Bethesda Leprosy Hospital.[3] By 1909 it had 100 patients. Champa Hospital was inaugurated in 1925, staffed by Mennonite medical missionaries and local medical professionals.

The first Mennonite Brethren (MB) missionaries in India were Abraham and Maria Friesen from south Russia.[4] In 1889, Abraham became pastor of an American Baptist Missionary Union (AMBU) church near the city of Hyderabad in central India.[5] In 1899, they were joined by Nicolai and Susie Hiebert and Elizabeth Neufeld, the first American Mennonite Brethren missionaries to India.[6] The team of missionaries from Russia and North America grew quickly. By the time Katharina Schellenberg came to India in 1907 as the first MB doctor, there were already four missionary nurses offering medical care through dispensaries and clinics.[7]

Mennonite missions in different regions of India soon shared the same basic features.[8] Missionaries and Indian Christians travelled from town to town preaching and distributing Christian literature. Converts were baptized. Churches were established. Dispensaries, clinics and hospitals were built. Medical care was offered, including significant work among patients with leprosy. Children were taught literacy and trades at orphanages and schools. Periodically there was famine and disaster relief. By the beginning of World War I there were fifty Mennonite missionaries in India, a dozen Mennonite churches, several schools, orphanages, clinics, and hospitals. To use contemporary language, it was holistic mission. For Mennonite missionaries, worship, ethics, economic life, education, and health were interdependent. They quipped that their mission was "Soup, soap, and salvation."[9]

North American Mennonites followed this pattern of mission in other parts of the world as well. While they were establishing missions in India, they initiated mission projects in cities, rural areas,[10] and Native American communities in North America.[11] These missions involved preaching, Bible study, Bible translation, food and social relief for the poor, orphanages, medical care, education, and training in trades for children and youth. Mennonite missions in other regions of Asia and in Africa that were established in later years looked much the same. This reflected the pattern of Protestant missions worldwide and exemplified the two complementary impulses of nineteenth and twentieth century mission: evangelism and service.[12] In the last decade of the nineteenth century and the first decades of the twentieth century many influential Mennonite leaders urged their communities to recognize

that their spiritual priority should not be self-preservation but evangelism and service to others.[13]

The Medical Context

Mennonite medical mission in India began at a time when Western medicine was full of confidence and mission medicine was expanding rapidly.[14] In 1882, there were only twenty-eight Protestant "medical missionaries" in India, but by 1895 there were 140 and in 1905 there were 280. The growth in hospitals was similar, increasing from 32 in 1895 to 90 in 1905 to 204 in 1912. In 1905, 1.8 million patients were treated in missionary hospitals and dispensaries and by 1912 that number had grown to more than three million.[15] By mid-century there were hundreds more Christian hospitals, several leading medical research centres, dozens of medical schools, and thousands of Christian medical professionals treating millions of people.[16]

This acceleration of medical mission, or, "clinical Christianity" as it is sometimes referred to, came after many years in which medicine was on the margins of missionary interest. The primary mandate and focus of early Protestant mission had been evangelism. But by the end of the nineteenth century there was a general recognition among missionaries that evangelism and education were not producing as many Christians as had been projected. As Bishop McDougal put it at the Oxford Missionary Conference of 1887, there needed to be "a fresh impetus to the cause of the Gospel, to help lift the chariot out of the rut in which sometimes it seems for a moment set fast and its progress retarded".[17] He proposed that the necessary impetus was medical mission. In the past decades a few medical missionaries had been recruited to serve the health needs of missionaries.[18] These medical missionaries also served local populations and the impact of that service to the local community became the impetus for a significant change in attitude toward an intentional and substantial program of medical mission.[19]

These changes in understanding the potential of medical mission took place during the mid-late nineteenth century when European and American medicine was undergoing a significant transformation. The discovery of the microbial causation and transmission of diseases and epidemics was revolutionary. The new understanding of the etiology and cure of disease was accompanied by greater appreciation for the importance of public sanitation and personal hygiene in preventing disease and facilitat-

ing health. Immunization through inoculation or vaccination was better understood and more widely used. Surgery became safer and more effective, largely because of significant advances in the use of anesthesia. Many commonly held explanations for disease, even explanations that had recently been widely promoted by the medical establishment, were overturned (such as that the cause of malaria was bad air). Explanations that attributed disease to social causation—evil eye, curses, black magic, divine displeasure, misdeeds from a past life—were rejected.[20] Medicine became a regulated profession. Extensive specialized training was required to qualify and certify as a medical practitioner.[21] There was a new emphasis on the importance of specialized institutions such as clinics, hospitals, asylums, and leprosaria in providing medical care.[22]

By the early twentieth century most missionaries shared these perspectives on medicine, whether they had medical training or not. Most had sufficient understanding of basic medicine and hygiene and enough access to simple medications for their own self-care.[23] But missionaries were cautious about claiming too much knowledge or too great a capacity to diagnose and to heal. They did not want to be known as "Quack doctors."[24] Yet they felt extraordinarily beleaguered by local populations who assumed that all Europeans had advanced and effective medical knowledge and resources. Missionaries felt obligated to attempt to provide assistance with their limited knowledge and resources, even though those might be only "a dose of salts or a grain or two of quinine".[25] Church Missionary Society missionary Rowland Bateman advocated a more activist approach for the sake of those needing medical care. "Become a quack specialist," he wrote. "I asked a medical friend to put me up to the diagnosis of the commonest eye troubles of these villagers, and their remedies in the early stages, and the result is that I have obtained quite a reputation for the number of people whose sight I have saved."[26]

Missionary medicine in India was offered within the framework of the British colonial administration and its medicine. The primary concern of colonial medicine was the health of Europeans and especially troops.[27] During the nineteenth century there had been numerous reports documenting the high financial and personnel costs of disease and advocating greater colonial commitment to public health and sanitation.[28] By the time Mennonite missionaries arrived in India at the end of the nineteenth century, there were hospitals in major colonial administrative centres and an extensive network of dispensaries throughout the areas governed by the colonial authority. In addition to their curative role, these dispensaries became the locus of sanitary education and vaccina-

tion. The medical assumptions about the causes, cures, and prevention of disease that guided how these centres and programs were managed were the same as those that medical missionaries brought to their professional work. Medical missionaries regarded colonial administrators and medical professionals as potential natural allies.

The missionaries had a much less positive opinion of the many indigenous medical traditions and healers of India. The most highly developed Indian medical traditions, with texts describing physiology, pharmacology, diseases, and treatments, were the *ayurvedic*, identified with Hindu medical theories and practices, and the *unani*, associated with Islamic thought and practice originating in Persian and Arabic cultures. These medical traditions were sometimes admired by the Orientalists, but mostly scorned and rejected by Western medical professionals. Indian nationalists regarded this condescending dismissal of their medicine as one more example of colonial disrespect for the cultural sophistication of India.[29] Another form of medicine in India at the beginning of the twentieth century was homeopathy. It had been introduced to India from Europe and became established as a popular understanding of the human body, illness, and healing, even though its assumptions and efficacy were under increased attack in Europe. The colonial administration never officially recognized *unani* (Muslim), *ayurveda* (Hindu), or homeopathic medicine as scientific systems on par with Western medicine.[30] But most of the Indian patients that Mennonite medical missionaries served had limited or no access to the practitioners (*vaids* and *hakims*) of the *ayurvedic* and *unani* traditions, or to homeopathy. They depended on herbalists, midwives, diviners, priests, or other local healers. It was these medical traditions and healers that were the primary competitors to Mennonite missionary medicine in the local marketplace of healing.

Mennonite Missionary Medicine

Four factors stimulated and significantly shaped Mennonite medical mission in India. First, the British, North American, and Mennonite press carried countless articles about the famines and diseases that ravaged India and the dreadful state of public sanitation.[31] These accounts were corroborated and amplified by travelers, doctors, and civil servants who returned from India, many of whom became strong advocates of medical mission.[32] In addition, books and missionary reports idealized the heroic role of

medical missionaries in addressing these calamities.[33] By the end of the nineteenth century, there was a substantial consensus among Mennonites and other Christians engaged in world mission that their spiritual and healing influence was urgently needed and would make a significant impact. The century ended with the publication of James S. Dennis's three-volume study, *Christian Missions and Social Progress*, documenting Christian contributions to social life, including health, medicine, and sanitation, adding evidence and argument to this growing movement. [34]

Second, as the nineteenth century ended, the results of Protestant evangelism and education in India were not as positive as missionaries and their supporters had expected.[35] A few regional group conversions had raised hopes that "mass movements" to Christianity were about to sweep through the country, bringing millions into the Church.[36] Those predictions were not fulfilled. Opposition to Christian missionaries grew more strident as local communities and national organizations resisted their confrontational evangelism and resented their evident distain for Indian culture and religion.[37] Missionaries were criticized for being divisive and disruptive, tearing individual converts out of family systems, and disregarding caste identities and boundaries. There was suspicion of mission education. It created opportunities for service to the colonial regime and international business enterprises, but it was largely in English rather than in the vernacular, it was oriented almost completely to Euro-centric ways of learning and educational content, and it was deliberately intended to facilitate conversion to Christianity. Even so, relatively few Christian converts came from the schools, unless the students were orphans living under the care of missionaries.

But missionaries noted that where medical care had been successfully provided in a community there was much less resistance and greater openness to missionaries and the Christian Gospel. In fact, there was often close cooperation between missionaries and local leaders in establishing new medical centres.[38] A bishop, addressing a British missionary conference, said:

> I can testify that the missionary with medical knowledge and skill can gain access to homes and hearts that would never have been reached in the same way, if at all, by his purely teaching and preaching brother … I have myself seen the hatred and contempt for the Christian teacher forgotten and laid aside in the unquenchable desire of suffering humanity for release from pain or deliverance from the fear of death.[39]

Medicine came to be regarded as a wedge to open the door or a magnet to draw people to dispensaries and hospitals where they would meet the evangelists.[40]

But it was more than that. This recognition of the potential benefits of medical mission coincided with a more general appreciation for the role of "benevolence" in Christian mission in the late nineteenth century, at a time when there was a surge in evangelical philanthropy.[41] Since the late eighteenth century, a number of dispensaries for the poor had been established by Christian doctors in Britain. Foreign medical missions were an extension of the same motivation and service. While some regarded medicine simply as an instrumental strategy to advance evangelism, others argued that medical mission in itself was a significant Christian witness, for it exemplified the love and compassion of God. David Livingstone, a champion of the interrelationship between Christianization and civilization, argued that increased benevolence was a demonstration that European civilization was an "embodied Christianity."[42]

The third factor that motivated and shaped Protestant and Mennonite medical mission was the growing recognition that this service of compassionate healing could also be the basis for challenging the "heathen" beliefs and practices of India. It was commonly asserted that health and medicine are "intimately associated with the religions of the people, and that the treatment of disease, such as it is, is monopolized by the priests or by others under their control."[43] An application of effective, scientific medicine, it was believed, would have a "penetrating disintegrative force"[44] to undermine the credibility of the indigenous medical system and the authority of the priests. Medical mission advocates argued that indigenous people needed demonstrated alternatives to their beliefs, practices, and leaders, and that effective medicine was the most immediate and convincing proof of the superiority of Christianity. This was so especially in times of crisis, like epidemics. Those were opportunities to offer missionary medicine as both an effective cure and a clear challenge and rebuke to local traditional healing practices.

Finally, a significant factor that shaped the growth of missionary medicine was a new understanding of Jesus as a healer, and of healing as a central ministry of the Church.[45] For many years, three countervailing forces had marginalized healing in the Protestant church. Dispensational theology, articulated by Luther and Calvin and many others in subsequent years, had argued that the healings and exorcisms of Jesus and the early Church had been for that time only. Once there were written Scriptures the need for

miracles ceased. All that was needed since then was the preaching of the Word. Second, it was generally accepted that the healings that Jesus performed were primarily intended as miraculous demonstrations of his divinity and thus not examples for his human followers to emulate. Finally, miraculous healings were associated with the Roman Church and with some of the dissenting or fringe churches of the lower classes. Such healings were understood as the result of either duplicity or fanaticism.

With growing confidence in the effectiveness of modern medicine and assurance that it was superior to other forms of healing, Protestants developed a rationale for missionary medicine that did not rely on the miraculous.[46] Healing was an expression of benevolence, of care for those in need. Its means were scientific, but its motive was self-sacrificial service to others in the name of Christ. It embodied Christ in its attitude and intent even if not in its methods and thus it was eminently a form of Christian witness. In 1899, as Mennonites were inaugurating their missions to India, the annual report of the London Missionary Society (LMS) reported that the value of medical missions was now clearly established; in fact mission hospitals were "often the most influential evangelistic centre in a mission, as well as its perpetual object lesson of a Divine philanthropy."[47]

Mennonite Medical Mission as Christian Witness

When Mennonite Brethren celebrated the 25th anniversary of the founding of their Medical centre in Jadcherla, Andhra Pradesh in March 1978, they referred to it as a commemoration of "25 years of medical and evangelistic service to the rural poor".[48] The mission agency ("Missions/Services") press release stated, "Medical work has always been an important witness to the love of Christ for Mennonite Brethren in India. Dr. Katherine Schellenberg, the first missionary doctor, arrived in 1907 and served for 38 years … Jake and Ruth Friesen arrived in 1952 as the first doctor and nurse of the Jadcherla Medical Centre … From the beginning he saw it as 'a Centre where healing of mind, soul and body could take place'."[49] The chaplain of the hospital, R.S. Lemuel, explained that "Though the primary function of the Mennonite Brethren Medical Centre, Jadcherla, is to heal the sick, the real motive behind its establishment is to present the Gospel to sin-sick souls."[50] The article then described how this happened:

> An estimated 50,000 patients annually benefit from the Centre's various medical programs. Lemuel and a group of evangelists and Bible women do their best to introduce them to Christ, distribute tracts, and counsel those with questions. Morning and evening devotions, Bible classes and chapels are also conducted.
>
> Evangelists associated with the Centre travel by jeep with medical personnel to the surrounding villages. The help villagers have received as patients at the Centre paves the way. Evangelist K.T John states: "A good welcome in the villages for the gospel depends upon the local hospital."[51]

J. A. Ressler had expressed this as early as 1908 when he wrote that the Mennonite mission in Dhamtari owed much to Dr. Page, who had to return to the United States after less than two years because of health. But, "The most remarkable welcome accorded the mission in even its early days is largely to be accounted for by the presence of a European doctor and by his personal self-sacrifice in caring for the sick and needy."[52]

Mennonite missionaries and church leaders in India, whether doctors, nurses, teachers, or preachers, were clear that their primary purpose was to evangelize, to bring people to faith in Christ and into the fellowship of the Church.[53] But they agreed that there were many expressions of Christian witness, many forms of ministry through which this could be accomplished, and that medical mission was one of the most effective means of serving Indians and communicating the Gospel.[54]

Mennonite Brethren missionary nurse Margaret Suderman wrote in the *Christian Leader*, "To show poor wanderers the Way of life and the road to true happiness and eternal joy, our mission hospitals in India shine as lighthouses in a dark night."[55] In the *Harvest Field*, a Mennonite Brethren periodical published by the missionaries in India, Suderman told the story of Narsama, a young woman who arrived at the mission hospital with advanced tuberculosis. Though the hospital could provide some relief from her suffering, the medical staff knew that they could not cure her. But they finally agreed to admit her, "but only for the opportunity we would have to show her the Way of Salvation."[56] Narsama and her father confessed Jesus Christ as Saviour before she was discharged to return to her village, where she died soon after. Suderman wrote,

> Not so long ago her father came to see us and informed us about her death. He said he had never witnessed a death like hers in his life. All the heathen villagers had been astonished. It was as though she was

> just going home when she took leave of her relatives. On her death-bed she repeated the Gospel stories she had heard! What a testimony!
> Does it pay to take care of the hopelessly sick? Yes, praise God it does.[57]

It was common for evangelistic and medical work to be closely associated. In 1917, Dr. C.D Esch described how the missionaries would set up camp in a village or town for a week or more and use that as a base. "Every morning", he wrote,

> I went out with the evangelists to the villages in the neighborhood and in the afternoon attended the bazaars that were near or stayed in the camp and attended to the sick that came … In the evening meetings were held in the village where the camp was. There was always a large crowd present … There were many talks with sincere people that wanted to know the truth about Christianity and the missionaries and when the things were explained it was evident that there was a hunger for more truth.[58]

These testimonials could be interpreted to support the accusation that medical mission was merely instrumental, that it was offered only as a lure to attract converts. This was a frequent charge of Indian opponents of mission medicine and of European and American critics of the colonial-missionary enterprise. It was also a concern of the colonial authorities and a major reason why they often distanced themselves from missionary projects and institutions.[59] Missionaries, especially medical missionaries, were aware of the complexity of the relationship between medical service and evangelism. While they did not regard medical service as an end in itself, they did not simply regard medical mission "as a sort of bait in order to preach the Gospel."[60] Some of them acknowledged, however, that they were probably not as sensitive to the problematic complexity of these arrangements as were those who observed their medical mission from a different perspective.[61]

The most convincing missionary response to these concerns was to demonstrate that in both policy and actual practice medical care was not conditional, it did not depend on how patients responded to Christian evangelism. It was common practice for missionaries and Christian staff to read the Bible and preach while patients waited to be seen by medical staff.[62] Although Mennonite missionaries would have been gratified if more of their patients had become Christians, only a very small proportion did; yet all continued to be served without distinction.[63] Missionaries pointed out that in contrast to most local healers, they provided medical service regardless of the religion, caste, or socio-economic identity of their

patients. In doing so they demonstrated that Christ welcomed and offered healing and hope to all.[64]

Medical missionaries frequently described how their relationship to Christ was the motivation for their work and expressed the hope that this would be apparent in their service to others. Jehoash, an Indian Christian student, described it this way:

> Hospital – This is the best and principal way of showing the divine sympathy for people who are poor and sick. When a poor person comes to the hospital to be cured, then such a person is blessed very much, because such a person's bodily pain, if possible, is not only removed but such is supplied with food and taken care of by doctor day and night. By and by they come to know the Christian love which is the salt of social and public life. Thus through the hospital many poor souls are brought to the mere contact of the Saviour.[65]

This was especially emphasized by those involved in leprosy medical mission, a prominent ministry of Christian missions in India and throughout the world.[66] Dr. Esch once described the long, difficult, and physically revolting process of removing more than a pint of maggots from the mouth and decayed nose of a leper over a period of two days. The man's health improved dramatically.

> He entered the class of inquirers … and when I saw his beaming face and the joy he expressed in his newfound Saviour the unpleasantness of caring for his decaying body was not worth mentioning. When a man has a wound and it gets infected with maggots the Hindu will shun him and put him out of caste because he thinks this is the sure sign of divine punishment. When he sees the missionary take that man and save him with his own hands, realizing the offensiveness of it, he says, "Sahib, how can you do that for that poor outcaste?" The missionary says "My Saviour has done more than that for me and He loves that man as much as He does me and, moreover, he is my brother, why should I not serve him and do all I can to save him?" Then he is made to realize the real impelling power in Christianity – LOVE.[67]

In summary, medical mission was a form of Christian witness, continuing the healing ministry of Jesus. It complemented evangelism, linking word and deed. [68] Often it opened the way for evangelism, creating trust through compassionate, healing service. By serving all who were in need, regardless of caste, religion, or disease, missionaries hoped to exemplify the unconditional love of God.

Mennonite Medical Mission as Cultural Critique

While missionaries offered medical care as an expression of compassionate service in the name of Christ, they also used medicine as the basis for a sweeping critique of Indian culture. The most common diseases that ravaged the Indian population were malaria, cholera, dysentery, leprosy, smallpox, and endless infections. Missionaries understood these diseases as microbiological invasions that could be cured by the use of chemical medications that would attack and overwhelm the disease. Other damage to the human body could be repaired by surgically removing the diseased parts. Indian traditional medicine regarded diseases as having two primary causes. They could be symptoms of an imbalance in the human body. Such diseases were cured by physically restoring balance using biological materials that were ingested or applied externally in a manner not unlike the use of medications in Western medicine. Diseases could also have social causes. They could be the consequence of personal sins in this or previous lives, or they could be caused by human or divine malevolence. These causes could be overcome by propitiating the deity through prayers and sacrifices or by countering the power of the human agent that had caused the disease.

Missionaries criticized both of these diagnoses and their cures.[69] They insisted on the microbiological origin of disease and on corresponding treatment. In their opinion most local healers were incompetent and their cures were ineffective and dangerous.[70] They were repulsed by the "concoctions" of herbalists that were either ingested or applied topically. They complained that people often tried a variety of local remedies before they came to the dispensary or hospital, and by then their condition was usually much worse.[71] Missionaries completely rejected social causation and cures. They scorned explanations that relied on "the maliciousness of devils and spirits and those with evil eyes".[72] They were also emphatic that the local gods and goddesses that were propitiated for healing were powerless to intervene on behalf of those who prayed to them.[73]

Missionaries did not regard personal sins to be the cause of disease. But they regarded lifestyle as an important causal factor in the transmission of disease through contagion. They decried the abuse of alcohol.[74] They criticized the habits of personal hygiene and the conditions of public sanitation in India.[75] Hygiene was an important part of their "civilizing mission" for it linked moral and medical teaching.[76] Like other Protestant missionaries, they proudly pointed to the improvements in public sanitation and health in

villages where there were many Christians, making a causal connection between Christian faith, cleanliness, and health.[77] Mennonite missionaries seemed to regard it as self-evident that these assumptions and practices about hygiene and sanitation were inherent in being a Christian.

The greatest criticism of missionary medicine was directed to the diviners and priests who diagnosed the physical and social causes and prescribed the cures for diseases through sacrifices, prayers, and amulets. From a missionary perspective these were not only incompetent and ineffective healers, they were self-serving frauds. Their healing practices were superstitions, useless, and dangerous. There were three main grounds for their skepticism and distain. First, missionaries observed that many of the local treatments for disease and injury did not bring healing and often did more damage than good. Second, for Mennonite missionaries it was unacceptable for priests untrained in medical science to offer diagnoses of diseases and prescriptions for healing. Most Mennonite missionaries had some rudimentary training in first aid and preventative sanitation, but they were cautious about offering medical advice and assistance beyond those limited matters. They were scandalized that Hindu priests and healers without even this basic training often offered far more extensive medical advice and were paid to do so. Third, these criticisms reflected the anti-clericalism of Mennonite missionaries.[78] Like many other Protestants, they were deeply shaped by their anti-Catholicism, which was often expressed in strong anti-clericalism. From their perspective the Indian priests were ignorantly misleading people or consciously deceiving people for their own self-interest.

Conclusion

The Mennonite missionary approach to medicine had two trajectories. The first created a close association between the healing of the body and soul. Evangelism and medical care went hand in hand. The trust and credibility created by compassionate and effective medical care opened doors for preaching. A Christian lifestyle led to cleanliness and health. The other trajectory secularized medicine. Disease was microbiological and its cure required medicines or surgery. Because disease was not the result of past sins, interpersonal malevolence, or divine displeasure, there was no need to repent, to invoke countervailing powers against enemies, or to plead for favour from deities in order to be healed.[79] The body was material; the soul was spiritual. The soul could tri-

umph even when the body decayed and suffered. The infections, sores, and excrement of the diseased body were merely physical. With proper precautions the risk of physical contagion could be removed. Thus Christians could safely enter the medical professions as doctors, nurses, personal care workers, and orderlies without risk to their identity and social standing.[80] The potential contagion in those professions was physical, not spiritual. For Hindus, those professions involved the constant risk of physical contamination but also social and spiritual pollution.

But even as missionaries emphasized the biomedical understanding of disease and healing, they also affirmed that God was the ultimate healer. They prayed with patients and their families. They prayed for healing. Mennonite medical missionaries did not pray for miraculous and sudden healings that would be inexplicable from the perspective of current medical science. They prayed for guidance as they applied their skills and medicines.[81] But while they were emphatic about the need for prayer, they never regarded prayer as a guarantee of healing. Nor did they associate prayer with specific rituals or healing objects.[82] Prayer was about the relationship of the patient or medical professional to God more than it was about the healing of the body. While people may have previously,

> deployed charms and exorcism to ward off the evils spirits and supernatural forces that caused illness and misfortune, Christians were expected to deploy prayer as a channel for the goodness and mercy of Christ. Whereas the charm or ritual of exorcism was directed against spirits that had the ability to harm in the hope that their evil aspect would be countered and their benign aspect reinforced, prayer appealed to an inherently benign God.[83]

For some patients the gap between materialistic medicine and the divine healer was too great. It needed to be bridged. As Paul Hiebert pointed out in his analysis of the "flaw of the excluded middle", missionaries essentially de-spiritualized everyday life even while they insisted that it was all guided by a personal God who could intervene to punish or to heal.[84] In most cultures and eras the tension between the uncertain affairs of everyday life and a powerful deity was resolved through mediating deities and the use of the spiritual technologies of prayer, sacrifice, or meritorious action that were calculated to bring food, rain, healing, victory, or other auspicious outcomes. Missionaries often noted with regret that many of their patients were not content to simply take their medicines to fight the invisible germs that had made their bodies a battleground. The patients also felt the need to recruit the social

resources of healing more directly, and so they returned to priests to offer sacrifices to the various divine powers that could counteract malevolent forces and bring healing.

Mennonite medicine defined the battle between disease and health in biological (materialistic) terms. Medical missionaries offered a materialistic causality in addressing the sources and cures of disease, even though they did not have a materialistic, secular anthropology. They criticized the dominant Indian understanding of disease, especially social causation and healing. Yet they shared with Hindus, Muslims, and tribal people an understanding that the human being was a composite physical and spiritual entity. They believed that the human person, even the human body, was more than physical matter. This is why Christian hospitals had chaplains, Bible reading, and prayers. This is why they took great satisfaction in hearing that patients valued the loving care they received in the mission hospital and contrasted it to the way they were treated in public secular hospitals. That is why they were gratified and felt successful even when patients died, but died "in the Lord".

Eventually the materialistic perspective prevailed in Mennonite medical centres and programs and in the Indian public health system. Victory in the battle against disease was defined by microbiological factors and indicators. All the other factors—the Christian motivation of the medical staff, the selfless compassion of the caregivers, the evangelistic invitations of the preachers, even the declaration that the life to come is more important than health and success in this life—all of these were the spiritual context within which Mennonite medical care was delivered. From the perspective of the patient, these factors were not self-evidently an inherent or indispensable factor in the struggle with disease and the restoration of health. Yet from the perspective of Mennonite medical mission these contextual factors were among the primary reasons for engaging in medical care. They defined the distinctive mission and goals of medical services, and were often the most important indicators of success. At the beginning of the twentieth century, Mennonites offered a different medicine. By the end of the twentieth century, they offered medicine with a difference.

Notes

[1] John Allen Lapp, *The Mennonite Church in India, 1897-1962* (Scottdale PA: Herald Press, 1972), 44-48. Soon after they settled in Dhamtari in 1899 they became involved in famine relief projects; Ressler as Honorary Famine Re-

lief Officer and Dr. Page as Government Civil Surgeon. This was the context in which the orphanage and the hospital-clinic were established. Ressler also supervised public works projects that provided employment and food for thousands of people. The initial Sundarganj mission compound was built as part of this larger "relief" project (112-116).

[2] James C. Juhnke, *A People of Mission: A History of General Conference Mennonite Overseas Missions* (Newton, KS: Faith and Life Press, 1979), 30-32. See also, Ruth Unrau, *A Time to Bind and a Time to Loose: A History of the General Conference Mennonite Church mission involvement in India from 1900-1995* (Newton, KS: Commission on Overseas Mission, General Conference Mennonite Church, 1996).

[3] Juhnke, 31.

[4] Peter Penner, *Russians, North Americans, and Telugus: The Mennonite Brethren Mission in India 1885-1975* (Winnipeg: Kindred Productions, 1997), 1. These were not the first Mennonite foreign missionaries from Russia. In 1871, Heinrich Dirks of the Gnadenfeld church went to Sumatra under the Dutch Mennonite Missionary Association. Russian Mennonites soon became the dominant supporters of that mission (Juhnke, 4). Two other significant accounts of Indian Mennonite Brethren are Paul D. Wiebe, *Christians in Andhra Pradesh: The Mennonites of Mahbubnagar* (Madras: The Christian Literature Society, 1988), and Paul D. Wiebe, *Heirs and Joint Heirs: Mission to Church Among the Mennonite Brethren of Andhra Pradesh* (Winnipeg, MB: Kindred Productions, 2010)

[5] Penner, 3.

[6] *Ibid.*, 13.

[7] *Ibid.*, 38, 287-291. Schellenberg applied for missionary service in India in 1900 but was encouraged to become "medically qualified". She completed a four-year program in homeopathic medicine in Kansas City and then went to India.

[8] It should be noted that Mennonite missions in India, like most Protestant missions, took place primarily among communities that were poor, marginalized, low or outcaste, and prone to suffer the most when natural disasters or famines occurred. These were communities that were underserved by other medical and social resources. People from these communities became the great majority of members in the Christian churches.

[9] Juhnke, 30.

[10] By the early twentieth century the major Mennonite groups in the United States and Canada had home mission projects in Philadelphia, Chicago, Dayton, Buffalo, Minneapolis, Winnipeg, and other cities, and among groups as diverse as the rural and small town poor in Kentucky, Russian immigrants, and Spanish-speaking residents of the American south-west. These missions are documented in numerous reports, books, and memoirs. For example, see Edmund George Kaufman, *The Development of the Missionary and Philanthropic Interest among the Mennonites of North America* (Berne, IN: The Mennonite Book Concern, 1931), and Lois Barrett, *Vision and the Reality: The Story of Home Missions in the General Conference Mennonite Church* (Newton, KS: Faith and Life Press), 1983. A recent survey of Mennonite Brethren "home missions" is Peggy Goertzen, Bruce L. Guenther, and Erika M. McAuley, "Mennonite Brethren Missions in North America", in Victor Wiens, ed., *The Church in Mission: Perspectives of Global Mennon-*

ite Brethren on Mission in the 21st Century (Winnipeg: Kindred Press, 2015), 163-191.

[11] General Conference Mennonites were working among Cheyenne in Oklahoma (1880) and Montana (1904), Arapaho in Oklahoma (1880), and the Hopi in Arizona (1892), while Mennonite Brethren were working among the Comanche of Oklahoma Territory (1895). Later in the 20th century other missions were established. For example, Mennonite Brethren worked among the Sioux in South Dakota (1948), Mennonite Church among the Creek in Alabama (1951), and a number of Canadian initiatives, primarily among Ojibway, Cree, and Blackfoot. See "Indians, North America" in GAMEO (Global Anabaptist Mennonite Encyclopedia Online, www.gameo.org).

[12] Juhnke described these influences on the General Conference Mennonites (2-10), commenting that General Conference Mennonite mission was "wholistic", "in its total ministry to the needs of people for food, shelter, health, education, and spiritual nurture" (10). Lapp summarized similar issues for the Mennonite Church (15-19). Wiebe analyzed these factors for Mennonite Brethren mission in India (2010, 73-90). Wilbert Shenk summarized the impulses and origins of the modern missionary movement among Mennonites in *By Faith They Went Out: Mennonite Missions 1850-1999.* (Elkhart: Institute of Mennonite Studies, Occasional Papers No. 20, 2000), 29-42. These two complementary mission motivations and purposes were evident in the names of Mennonite mission organizations. The Mennonite Church initially established two boards, the "Mennonite Evangelizing and Benevolent Commission" and the "Home and Foreign Relief Commissions", but merged them by 1906 into the "Mennonite Board of Missions and Charities" (Shenk, 57). This same character was reflected in the founding of the "Eastern Mennonite Board of Missions and Charities (EMBMC)" in 1914 in Lancaster County, Pennsylvania. It initially focused on local ministries and churches and in 1934 sent its first international missionaries, to Tanganyika. See GAMEO website for "Eastern Mennonite Missions (Lancaster Mennonite Conference)". The Mennonite Brethren story is similar. The initial name for its mission organization was "Directorate of Foreign Missions". In 1936 this became the "Board of Foreign Missions" and in the same year the "Board of General Welfare and Public Relations" was created to oversee matters relating to relief, peace, and colonization. In 1966 the "Board of Missions and Services" was created from the merger of these two boards". See GAMEO website for "Mennonite Brethren Missions/Services International (Mennonite Brethren Church)". Today the agency is named "MB Mission".

[13] They often did so through newspapers and periodicals, and these became major sources of information about mission. *The Mennonite* (1885-1998) was the official English language paper of the Conference of Mennonites. The *Gospel Herald* (1908-1998) served the Mennonite Church. It was a merger of two earlier papers, the *Herald of Truth* (1864-1908) and *The Gospel Witness* (1904-1908). A German paper, *Die Mennonitische Rundschau, (*1880-2007) served German-speaking Mennonites who had emigrated from Russia. *Zionsbote* (1884-1964) was a Mennonite Brethren paper. The *Christlicher Bundesbote* was established in 1882 as the official German weekly of the General Conference Mennonite Church. In 1947 the *Bundesbote* merged with the Canadian Mennonite weekly *Der Bote* (1926-2008).

[14] This is documented and analyzed in Christoffer H. Grundmann, *Sent to Heal! Emergence and Development of Medical Missions* (New York: University Press of America, 2005).

[15] Rosemary Fitzgerald, "'Clinical Christianity': The Emergence of Medical Work as a Missionary Strategy in Colonial India, 1800-1914", in Biswamoy Pati and Mark Harrison, eds., *Health, Medicine and Empire: Perspectives on Colonial India* (New Delhi: Orient Longmans, 2001), 127.

[16] During the 1960s and 70s India vastly expanded public medical care throughout the country. From the 1980s onward there was a proliferation of a huge range of private for-profit medical services. The role of private Christian medical centres is now greatly diminished, even though many of them have strong reputations. See Wiebe (2010), 237, 288-290. Christian medical care is barely noted as a minor factor in A. Venkat Raman and James Warner Bjorkman, *Public-Private Partnerships in Health Care in India* (London: Routledge, 2009).

[17] *Ibid.*, 102.

[18] The importance of medical care for missionaries was always evident. All mission societies experienced many deaths of infants and mothers during childbirth and of adults and children from diseases, epidemics, infections, and injuries. As the number of missionary doctors and nurses increased, medical care for missionaries improved (Grundmann, 210-212). Also, see C. Peter Williams, "Healing and Evangelism: The Place of Medicine in Later Victorian Protestant Missionary Thinking", in W.J. Sheils, ed., *The Church and Healing* (Oxford: Basil Blackwell, 1982), 274. Mission hospitals in later years usually had a "European ward", a few beds where Europeans could be segregated from the rest of the patients. See Lapp, 114. Albert Schweitzer recounted how the European ward in his hospital in Lambarene was only occasionally used for missionaries but most often had European patients who were in Africa for business or government service. Albert Schweitzer, *On the Edge of the Primeval Forest* (London: A & C Black, 1947).

[19] Fitzgerald, *op. cit.*, describes these changes in attitude and practice. See a discussion of the relationship between medicine and evangelism among Mennonites below.

[20] Until the mid-nineteenth century there were broad similarities between the formal medical systems of India and Europe, "regarding basic notions of disease causation, treatment and prevention. Each viewed the causation of disease as a complex system of 'exciting' and 'predisposing' causes, and Indian systems, like their Western counterparts, only rarely made reference to divine intervention, although each system viewed moral conduct as an important factor in predisposition to disease". Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914* (Cambridge: Cambridge University Press, 1994), 40-41.

[21] This emphasis on certification developed during the same era in India. Standardized exams for medical assistants and university medical degrees for doctors became basic requirements. The editor of the *Public Health and Municipal Journal* wrote in 1909 that these requirements were the only way to suppress the prevalence of so much medical "quackery" (qtd. in Harrison, 6).

[22] These changes in medicine and their impact on colonial and missionary medical practice are described in Pati and Harrison, *Health, Medicine and Empire*; David Hardiman, *Missionaries and Their Medicine: A Christian*

Modernity for Tribal India (Manchester: Manchester University Press, 2008); Harrison, *Public Health in British India*; Jeffrey Cox, *Imperial Fault Lines: Christianity and Colonial Power in India, 1818-1940* (Stanford CA: Stanford University Press, 2002); Ryan Johnson and Amna Khalid, eds., *Public Health in the British Empire: Intermediates, Subordinates, and the Practice of Public Health, 1850-1960* (New York: Routledge, 2012); W.J. Sheils, *The Church and Healing*, especially the chapters by Williams, "Healing and Evangelism", and A. F. Walls, "'The Heavy Artillery of the Missionary Army': The Domestic Importance of the Nineteenth Century Medical Missionary", 287-297.

[23] Cox describes a supply order that the Church of Scotland Foreign Mission Committee placed for its missionaries for "sulfate of magnesia, precipitated sulfur, sulfate of quinine, castor oil, gutta percha (for teeth), wafer papers (for nauseous medicines) and enema apparatus, evidence that missionaries proclaimed the Word along with a good deal of purging, patching, and dosing with quinine" (2002, 171).

[24] Fitzgerald, 102 ff.

[25] Fitzgerald, 108.

[26] Cox, 2002, 171. This perception of the transformative medical and social impact of basic, effective medical care provided by missionaries was widespread. It appeared in historical accounts, personal recollections, novels, and movies. In the movie *The Keys of the Kingdom*, for example, the priest Father Francis Chisholm made a breakthrough in public acceptance when he healed the son of the regional Chinese ruler.

[27] Harrison notes "It was not mortality from diseases such as cholera, but the persistent incapacitating effects of malaria, typhoid, and venereal disease which most concerned colonial authorities" (1994, 2-3).

[28] Harrison (1994), *passim.*

[29] Mark Harrison, "Medicine and Orientalism: Perspectives on Europe's Encounter with Indian Medical Systems", in Pati and Harrison, *Health, Medicine and Empire*, 37-87. Poonam Bala describes how Hindu nationalists promoted Ayurvedic perspectives and the production of indigenous medicines as an explicit assertion of the validity of the Indian scientific tradition. One expression of this was the formation in 1907 of the All India Ayurvedic Mahasammelan to coordinate these initiatives. See Poonam Bala, "Reconstructing Indian Medicine: The Role of Caste in Late Nineteenth- and Twentieth-Century India", in Poonam Bala, ed., *Medicine and Colonialism: Historical Perspectives in India and South Africa* (London: Pickering and Chatto, 2014), 11-24.

[30] As noted earlier (note 7), despite European and American ambivalence about homeopathy, Katharina Schellenberg (1870-1945) prepared for missionary service by completing a four year medical program in homeopathic medicine in Kansas City. She was the first and only female doctor sent to India by the Mennonite Brethren mission. She had a long and distinguished career in India from 1907-1944, combining homeopathy and other medical modalities. Penner, 38, 86-87, 125-126; Wiebe (2010), 109.

[31] For example, one of the greatest factors in shaping Mennonite Church interest in India was the travel accounts of George Lambert (1853-1928), an entrepreneurial Mennonite Brethren in Christ minister. He travelled around the world in 1894-95, frequently staying with Protestant missionaries. Through them he later became aware of the devastating famine in

several regions of India in 1897. He and other Mennonite leaders in the Elkhart, Indiana region established the Home and Foreign Relief Committee, and sent letters to Mennonite congregations asking them for "an act of love for the rescuing of the poor, starving people in India" (Lapp, 29). In partnership with other relief funds they quickly raised more than $200,000 in cash and grain to send to India. Lambert went back to India in April 1897 to oversee the distribution of food and money. From there he sent weekly reports to the *Herald of Truth.* Later he published those reports in a book titled *India, the Horror-Stricken Empire, Containing a Full Account of the Famine, Plague, and Earthquake of 1896-97. Including a Complete Narration of the Relief Work Through the Home and Foreign Relief Commission* (Berne, 1898).

[32] Sometimes their advocacy had great long-term effects. For example, Dr. John Thomas (1757-1801) had been a ship's surgeon in India. When he returned to England in 1792 he spoke to a gathering of the newly formed Baptist Missionary Society about mission prospects in India. That inspired the founder of that Society, William Carey, to volunteer for mission in India. Thomas and Carey went to India in 1793. While Thomas's medical service did not leave any memorable recorded results, Carey had a transformative impact on India and on the next two hundred years of global mission.

[33] The medical missionary movement was also inspired by the lives of missionaries with medical training, such as David Livingston (1813-1873), missionary explorer in Africa, Hudson Taylor (1832-1905) in China, and Peter Parker (1804-1888), American medical missionary and later diplomat to China. Of these three doctors only Parker established a medical practice, an ophthalmic hospital in Canton, where he not only specialized in eye diseases but also introduced Western anesthesia. See George Barker Stevens and William Fischer Markwick, *The Life, Letters, and Journals of the Rev. and Hon. Peter Parker: Missionary, Physician and Diplomatist: the Father of Medical Missions and Founder of the Ophthalmic Hospital in Canton* (Wilmington, DE: Scholarly Resources, 1972. Reprint of original published in Boston, by the Congregational Sunday-School and Pub. Society in 1896). Also, Grundmann, 216-217. These doctors and others made widely publicized observations about the human needs they witnessed in their physical and cultural environments and generated growing interest in expanding the range of activities that were part of missions.

[34] James S. Dennis, *Christian Mission and Social Progress: A Sociological Study of Foreign Missions* (New York: Fleming H. Revell Co, 1897, 1899, 1906). The chapters on health and medicine include the characteristics of "modern" medicine, the management of dispensaries, hospitals, and leper asylums, and the promotion of cleanliness and sanitation. In each of these areas Christian contributions are documented and celebrated.

[35] Fitzgerald, 98ff.

[36] See comments about "mass movements" or "group conversions" in Wiebe (2010), 81-82, and Sushil Kumar Pathak, *American Missionaries and Hinduism* (Delhi: Munshiram Manoharlal, 1967), 97-107. In a study of this phenomenon and its prospects among the Mennonites in Dhamtari, J. W. Pickett wrote that the separation (often involuntary exclusion) of Christians from their caste and family systems into Christian compounds reduced the prospects that they could have evangelistic impact on their families and former neighbours. Thus it was likely that there would be only an "intermit-

tent and gradually diminishing trickle" of new converts. J. W. Pickett, "Possibility of Ingathering Around Dhamtari", in Donald A. McGavran, ed., *Church Growth and Group Conversion* (Pasadena, CA: William Carey Library, 1973), 64.

[37] The Arya Samaj is a major national organization that was established to defend Hindu religion and culture from its critics, especially missionaries. For a brief summary of the early history of the Samaj see Kenneth W. Jones, "The Arya Samaj in British India, 1875-1947", in Robert D. Baird, ed., *Religion in Modern India* (Columbia, MO: South Asia Books, 2nd ed, 1989), 27-54. See also Arya Samaj, "Christian Missionaries – We Do Not Want Them Any More", *International Review of Mission* 26 (1937), 394-403. There are frequent references to confrontations with the Arya Samaj in Mennonite missionary correspondence and reports. General Conference missionary P.A. Penner summarized Arya Samaj core beliefs in a letter to *The Mennonite*, May 14, 1903, 5. See also, "The Enmity of Reformed Heathenism for Christianity", *The Mennonite*, April 23, 1914, 1; P.A. Penner, "What is the harm?", *The Mennonite*, September 19, 1929, 1; J.D. Graber, "Strong Opposition", *Gospel Herald*, May 2, 1940, 120. Wiebe, (2010), 191-192, 266, cited an instance in 2010 when 37 of 100 Mennonite-Christian families in a village "reconverted" to Hinduism.

[38] "No other phase of missionary activity was so much liked by non-Christians as medical work. It broke down the opposition, dissipated prejudice and won its way to the hearts and homes of the high and the low, the rich and the poor. A number of Indian communities came out with large donations and cooperated vigorously with medical missionaries in building hospitals and dispensaries, thus expressing their appreciation for the services rendered to them. Sometimes land for the site of the hospitals was donated" (Pathak, 193-194).

[39] Quoted. in Fitzgerald, 112.

[40] These metaphors are explored in Fitzgerald, 111-114, and in Hardiman, 12.

[41] Williams, 275-280.

[42] *Ibid.*, 276.

[43] Qtd. in Hardiman, 12.

[44] Fitzgerald, 114. The discussion of this theme is at 113-116.

[45] The following is based on Williams, 276-284, and Hardiman, 13-15. Grundmann describes this as "Medical Missions as Imitation of Christ" (212-215).

[46] Mennonites were conscious of these two dimensions of the "ministry of healing". An article by Allen H. Erb, superintendent of the City Hospital in La Junta Colorado, addressed the relationship between healing by employing "the products of nature by the heaven-given intelligence of man" and healing the sick by "direct miracle" (*Gospel Herald*, August 6, 1925, 391-392).

[47] Williams, 284, quoting the LMS report for 1899, 10.

[48] *MB Herald*, May 12, 1978, 25.

[49] *Ibid.*

[50] *Ibid.*

[51] *Ibid.*

[52] *Gospel Herald*, April 18, 1908, 42. The "Tenth Annual report of the American Mennonite Mission" in Dhamtari, 1909, noted that "Nothing quite so effectively establishes confidence in the missionaries' motives as does medical treatment" (6). Supplement to the *Gospel Herald* 1909-1910.

[53] This was a frequent theme in missionary reports. For example, in a report celebrating the new dispensary in Basra, Dr. and Mrs. H.E. Dester wrote that "This offers all the more opportunities for evangelistic work". *The Mennonite*, February 2, 1933, 2. An editorial in *The Mennonite* (July 9, 1925, 1-2) addressed the role and priority of Christian hospitals in both the United States and internationally, strongly affirming their role as settings for evangelism and for exemplifying Christian compassion and service. The connection between Christian medical and social service and a reduction of hostility toward Christians was reported even in areas where there were no Mennonite missionaries. For example, *The Mennonite* (July 30, 1914, 1) reported that an imam in Turkey had preached against attacking Christians. The writer noted that Christians had been doing relief work among Muslims in that region and that a Turkish newspaper had praised the work of the doctor coordinating those activities. The article included a list of the local hospitals and dispensaries operated by Christians, and observed, "Better spade work for evangelization among Muslim people can hardly be imagined".

[54] A report from missionary Anna Suderman in *Zionsbote* (January 16, 1952, 6) described how the patients in the hospital and their relatives heard the word of God every day. Word and deed went hand in hand to express the love of Jesus. ("*Wort und Tat gehen hier Hand in Hand, die Liebe Jesu bekannt zu Machen.*")

[55] *Christian Leader,* February 15, 1956, 6.

[56] *Harvest Field*, January-February 1940, 8.

[57] *Ibid.*

[58] *Gospel Herald*, June 28, 1917, 242.

[59] The Arya Samaj persistently raised these objections. See note 34. Cox addressed these issues, highlighting the complexity of the missionary-imperial relationship. For example, he described how the "Countess of Dufferin Fund" was established in the Punjab to provide medicine that was "a clear, secular imperialist alternative to the missionary movement…" (2002, 179).

[60] Dr. Jonathan G. Yoder wrote this in the *Gospel Herald* (November 23, 1945, 650). He emphasized that medical mission was a demonstration of Christian love. It was selfless, disregarding caste or status, enduring hardship. It also provided opportunities for direct Christian witness through Bible storytelling in hospitals, tracts sold, direct preaching and scripture reading, prayers with patients waiting for surgery and in the operating room before surgery. This issue arose in other contexts as well. In 1948, a report by H. Clair Amstutz described how the medical unit of the Mennonite Central Committee (MCC) in Puerto Rico had worked under circumstances that "limited the amount of religious work that could be done". But they learned that "God can use the ministry of healing as an evangelical agency and open the door, for the simple reason that it is an expression of the love of God expressed through His servants working through the agency of the church" (*Gospel Herald*, February 3, 1948, 102-103).

[61] Edmund George Kaufman described similar situations in China, but suggested that the missionaries did not reflect very deeply on this situation. "As people come, they are registered, and while they wait for the doctor, must listen to the preaching of the Gospel. The question of the ethics of this procedure never seems to have arisen" (Kaufman, *op.cit.,* 338). Missionary records indicate that while such practices were common, it was not because

there had been no reflection on the complex issues involved. For example, in a report from India, P. A. and M. Penner reported that the *Indian Social Reformer* had published a critical article titled "Proselytism in a Government Asylum". The author wrote, "It hardly seems to us the proper thing to take advantage of the helpless position of lepers in the Asylum to convert them to Christianity … We strongly object to proselytism being allowed in a government institution". The Penners made two responses to this criticism. First they stated that it was because of concerns like these that they only accepted modest operating grants from the government. If any of the grants should "be conditioned that Christian instruction be lessened or discontinued, then the grant will be refused with many thanks". But regarding proselytism they add, "There is nothing of the kind in any mission asylum whatsoever. No non-Christian has ever been asked to attend divine services. That is absolutely optional. But the leper is quick to detect where love is to be found. Is there any proselytism in this that lepers simply respond to the invitation and service of love?"

62 As George J. Lapp put it, "With every dose of medicine we give a dose from the Bible" (*Gospel Herald*, September 26, 1908, 410). Mennonite reports of other medical ministries in the same era expressed similar hopes for the conversions of patients. An account of the sanitarium in LaJunta, Colorado reported that there were 64 conversions among patients and workers (*Gospel Herald*, May 18, 1916, 116-117).

63 This was generally true for Protestant missions in India. See Jeffrey Cox, *The British Missionary Enterprise since 1700* (New York: Routledge, 2008), 218. Also, Pathak, 195. The exception was medical mission among lepers who lived in segregated asylums. In those settings the percentage of Christian converts was much higher. See Dennis, Vol. II, 437-439. The Bethesda Leper Asylum at Champa reported 118 converts out of 500 admissions (*The Mennonite*, June 25, 1914, 1). Lepers who remained in their home communities and were treated on an out-patient basis were less likely to become Christian.

64 Dr. J.G. Yoder wrote, "Where mission hospitals and government hospitals are equally accessible, people prefer the mission hospitals. Why? Just because mission hospitals give them a bit of love, along with the medicines they give. In mission hospitals, even the low castes are treated with respect" (*Gospel Herald*, November 23, 1945, 650).

65 *Gospel Herald*, February 7, 1918, 825.

66 Pathak, 195-199. The "Mission to Lepers" (now "The Leprosy Mission") was founded in Britain in 1874. By 1909 it managed fifty asylums in India. The Mennonite leprosy hospital in Champa is still part of this network.

67 *Gospel Herald*, June 28, 1917, 244.

68 The July 9, 1925 issue of *The Mennonite* addressed the question "Should the Church Establish Hospitals?" It strongly endorsed Christian hospitals as "an essential expression and manifestation of Christian faith and charity. The Church must not only preach the Gospel by word but also by deeds of mercy. Christ preached the gospel of the kingdom and healed all manner of diseases among the people. What Christ has joined together in his public ministry the Church must not put asunder" (1-2).

69 The attitudes and perspectives summarized here are those that appear in published mission reports. Anecdotally I have heard medical missionaries describe their occasional efforts to collaborate with local healers by provid-

ing them with some basic medications that could be used for healing wounds and infections. I visited such a project near Bangalore, India, in 1983. In recent decades there has been a greater awareness throughout the world that regional medical traditions often have substantial efficacy. The global medical profession now often employs modalities like acupuncture that were frequently mocked only decades ago. Pharmacology has benefited enormously from the wisdom of many cultures that have used local plants for medicines for centuries.

[70] Missionaries often reported how simple illnesses or injuries were made worse by remedies that local people applied themselves or were given by local healers, and how health was restored relatively quickly once missionaries used their medicine. For example, a boil was healed by removing the "filth" with which it had been coated, and applying an ointment (*The Mennonite*, January 12, 1933, 5). Dr. Jonathan Yoder described how tetanus was frequently and fatally caused by common treatments of wounds and medical conditions (Jonathan Yoder, *Jungle Surgeon* [Goshen IN: Jonathan G. Yoder, 1989], 55-58). Sometimes the local remedies caused death when they were added to or when they replaced missionary medicine (*The Mennonite*, February 16, 1933, 5-7). Mennonite papers carried similar reports from Mennonite missions in other countries and from other Protestant missionaries, reinforcing the overall impression of the backwardness, ineffectiveness, and damage of non-Western medical treatments. See, for example, a report from China titled "Sick Babies Flogged" in *The Mennonite* (January 11, 1923, 5).

[71] This was a major reason cited for the death rate in the Champa hospital (*The Mennonite* April 25, 1929, 2). See also Yoder, 10.

[72] Wiebe (2010), 236.

[73] For example, consider the following account in the *Gospel Herald* (June 28, 1917, 238). A well-to-do farmer's son had died. "He was given medicine from our dispensary but yet the father yielded to the advice of the villager medicine-man, observed some heathen rites, and fed the boy some unnameable concoctions. After the boy was buried, the father, his brother, their families, and their old grandmother took their idols and broke them in pieces and declared that they would serve the gods no more".

[74] For the first fifty years of the twentieth century, Mennonite periodicals carried frequent articles, letters, and editorials warning against the dangers of alcoholic drinks. They were strong supporters of prohibition in the United States. The condemnation of the "curse of alcohol" was mostly directed against American society, but also toward cultures in which Mennonites had mission activity.

[75] Wiebe (2010), 236-37. Specific critical comments about dirt and hygiene were common in missionary reports, as were generalizations. "Any missionary will tell us that Christianity has value in respect to the cultural civilization it brings to the people who had earlier been benighted, ignorant, superstitious, and living in filth," reads one article. "For with the missionary always comes the school, the hospital, decency and cleanliness … But Christianity must do more than that, if it only cleans up the outer man and does not transform the man within, the result may be a cultured rascal" (*The Mennonite,* October 12, 1933, 9). An editorial in *The Mennonite* in 1918 was even more sweeping in its condemnation. It described the impact of the black plague of the thirteenth to the fifteenth centuries, the cholera epidem-

ics of the nineteenth century, and the early twentieth century influenza epidemic on Europe. It stated that each of these devastations was "another emanation of the cesspool of long neglected heathen Asia". It advocated strong support for missions in Asia so that the inevitable improvement in public health that always accompanied Christianity would lead to a reduction in filth and disease in Asia, and thus a decrease in the ravaging diseases that periodically swept from Asia to Europe (*The Mennonite*, December 5, 1918, 4).

[76] John Wesley had argued that "moral salvation lay in bodily hygiene, a clean house, a temperate life and an ordered and industrious daily routine" (Hardiman, 9).

[77] Dennis (Vol. II, 458-468), described the improvements in sanitation and health that accompanied Christian mission and colonial administration in Asia and Africa. He summarized, "Cleanliness is a social virtue, and Christian missions foster it in many lands where dirt is domesticated in the homes of the people, and where disgusting slovenliness—in many instances intolerable filth—is more or less characteristic of the individual. A Christian convert in almost any mission field is sure to become more prepossessing and more tidy in person and environment, to an extent which is differential" (458). He cited comparative mortality reports from the "plague" in Bombay, where the rate was 53/1,000 for low caste Hindus, 46/1,000 for Muslims, 26/1,000 for caste Hindus and only 9/1,000 for Native Christians (464-465). Canadian United Church missionary L. Winifred Bryce used similar arguments in her *India at the Threshold* (New York: Friendship Press, 1946), quoting 1934 infant mortality rates in India as Hindus 195/1,000, Muslims 183/1,000, and Christians 118/1,000 (106). Harrison observed that for religious organizations, "Hygiene was an important part of their 'civilizing mission', in which moral and medical teaching went hand in hand. Public and personal hygiene was a matter of Christian duty…" (1994, 90).

[78] This was sometimes addressed directly, as in an editorial in the Mennonite Brethren Indian mission publication *Harvest Field* (July-August 1939, 2-3).

[79] This perspective was common throughout the global colonial-missionary enterprise. Missionaries "wanted to combat local healing systems that located human affliction within prevailing social relations. They held that auxiliaries well versed in bacteriological theories of healing would come to see disease as a function of microbial invasion rather than the consequence of dysfunctional social relationships…" Walima T. Kalusa, "Medical Training, African Auxiliaries, and Social Healing in Colonial Mwinilunga, Northern Rhodesia (Zambia)", in Johnson and Khalid, *Public Health in the British Empire*, 155.

[80] During the twentieth century the proportion of Christians in medical professions, especially those like nurses and personal care workers who provided direct patient care, was far greater than their proportion in the Indian population. This was especially true in the care of lepers.

[81] While Mennonite medical missionaries were cautious about creating too close a causal relationship between their trust in God and the success of their treatments, their patients were often quick to make this connection. Dr. J. G. Yoder reported that after he had completed a successful major abdominal surgery on a woman, her husband commented, "You prayed before the operation. That is what made the difference" (*Gospel Herald*, November 23, 1945, 659).

[82] Peter A. Penner wrote a letter to his father A. Penner in Mountain Lake, Minnesota on October 20, 1936, in which he described how a missionary had prayed for a young girl who was very ill. As he prayed he placed a Bible on the young girl's chest, where the medical problem seemed to reside. Penner strongly objected to this form of prayer for healing, stating that it was done in a "heathen manner" (Mennonite Historical Library, Newton, Kansas, MLA-MS-14, Series Peter A. Penner, Papers, Box 3, File 20).

[83] Hardiman, 242.

[84] Paul G. Hiebert, "The Flaw of the Excluded Middle", *Missiology: An International Review* 10 (January 1982), 35-47.