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Colonial Bio-Politics and Medical Mission in NWFP: A Case of Dr. Pennell of Bannu Medical Mission

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This paper examines the colonial project of social control of the Pashtun body as seen through Foucauldian framework of biopower. This paper initiates debate into colonial health politics of NWFP and explores the biopolitical logic as to how the Pasthun subjectivities as medicalizable objects were constituted within the colonial missionary medicine discourses. It examines the ontological consequences of such constructions. It further aims to explore the co-constitution of colonial agents and the authority of the missionary doctor over the body. This paper delves into the myriad of strategies and sites of medical intervention, as hospital, medical camp, home, school, body, culture, race and gender. It takes up in-depth analysis of the works of Dr. Pennell i.e. Mission Hospital Bannu and *Life among Wild Tribes*. The study proposes that the relations of colonial power with the Pashtun body as embedded in the medical missionary discourse were biopolitical in nature.

Keywords: North Western Frontier region, medical missionaries, biopower, noso-politics, bio- other.

Colonial connection of medical missions is spread across the pages of a variety of colonial genres as much as Pennell's own work (Pennell, 1909; Vaughan,1991; Ranger, 1981;Fitzgerald, 1996; Lapinsky,1999; Hardiman, 2006; Jennings, 2008; Pati & Harrison, 2009).However, beyond a few primary sources we see a dearth of scholarly works on colonial medical mission in North Western Frontier Regions. Scholars have engaged into debates on whether the medical mission was part of colonial mission. Vaughan (1991) classifies the medical interventions of the empires in the colonies as colonial state medicine and mission medicine; the former being part of state medicine was secular and operated at the levels of collectives whereas the medical mission focused on the individual, as each individual patient was potential convert, a sick soul. Jennings (2008) however argues that the

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Contribution of Authors:

1. Tasleem Malik primarily focused on literature review, theoretical analysis of the data and overall writing of this research paper.
2. Faiz Ali initiated the research and collected data, including the primary works, and contributed in analysis of data and overall writhing of the manuscript.

medical mission did not operate in isolation with or in addition to the colonial medicine but in place of them. Mir (2017) argues that the decisive presence of missionary doctors long before the direct colonial intervention in Kashmir made this intervention 'blatantly possible'. Vashum (n.d) mentions that the "historically, the general assumption was that colonial expansion to the non-Christian world was believed to be God's providence" (p.1). Both the colonial powers and missions held the 'civilizing responsibility'. Colonial function is integrated with mission work when Pennell counts "Christianizing, civilizing and pacifying influence"(Pennel, 1909, p.311) of the medical mission. The writings by, and about Dr Pennell reproduced colonial desire, constructing a "frontier life with its danger and fascination" (A L, 1913, p.58). Colonial officer living the Christ was his ideal: Pennell cites many occasions when colonial Christian officers were able to either develop friendly attitude among native subordinates towards Christianity or finally convert them. The missionaries did receive help and in return contributed toward the colonial projects. Colonial condition provided for more than a 'level playing field' to missions by the 'secular' British government. Christian missionaries, besides official and informal philanthropic support, were also provided with active protection. The support to the missionaries was due to them being British, a privileged status than an ordinary native subject of British India, and to whom any harm was feared to bring the exceptional wrath of the colonial masters. Medical missions acted as the *dispositif* (Foucault, 2008) of British governmentality in colonial India and elsewhere and constructed the truth about the socio-political body of the colonial lands and people (Vaughan, 1991). These medical missions were the only source of knowledge for the colonial administration about the native of inaccessible regions of north western frontier regions. Missionaries were expected, and expected themselves, to be influential agents of empire" (Johnson, 2010). As dividing practices these mission were essentially euro-centric and racist premised upon superiority of western ideas and practices over the traditional beliefs and practices of the natives (Tuolor, 2014). Moreover, the prime responsibility of the 'colonial medicine' was the preservation of European health in the hostile new lands: Asiatic cholera reached England in 1831, and resurfaced in 1848 and 1854, as the disease travelled westward to Europe in 1871 (Pal-Lapinsky, 1993, 141).

Much has been written on the complex genealogies of colonial bio-politics. The available literature however, lacks in analyzing the role of medical missions in colonial bio- politics in NWFP. Using Foucault's insights on the biopower, this paper attempts to rectify this lacuna in bio-political analysis of colonial health politics in India. For the purpose Pennell's work and Bannu medical mission have been taken as case study. Given a limited scholarship on the topic, this paper will be the leading resource of research on the colonial medical mission and bio politics in NWFP.

Research Objectives and Research Method

This paper broadly attempts to explore the construction of Pashtun subjectivities within the discourses of colonial missionary medicine and the ontological consequences of such constructions. It further aims to explore the co-constitution of colonial agents and the authority of the missionary doctor over the body. Here we propose that the relations of colonial power with the Pashtun body as embedded in the medical missionary discourse were biopolitical in nature. For this qualitative study we have used primary and secondary sources of data.

Production of Bio Other

Foucault (1980) argues that in the modern societies the bios and wellbeing of individuals and populations are subject to intervention for surveillance, control and regulations. This has resulted into medicalization of 'bio' or life and penetration of medical authority into every aspect of human life. Every society practices some form of health politics (Foucault, 1980) but there has been shift in the modalities of this power. Foucault has analyzed these shifts in his work on medicine. He

introduces the concept of biopower in 1976 in *History of Sexuality* (Foucault, 1978) and describes that since 17th century, power which is traditionally considered as repressive and deductive, is productive in its relations with the objects (Rabinow, 1984). Power not only kills but has taken charge of life. In the relations of this new power to its objects, health and sickness were problematized through multiplicities of social instances. This problematization of health what Foucault calls *noso-politics,* led to state intervention at multitude of sites in social body. *Noso-politics did not* operate vertically from above. Multiplicities of distinct health policies, of religious groups, charitable organizations, academics, statistics societies took charge of the 'bodies' and the problematic of health / disease. These multiple loci of power produced a quantifiable knowledge of 'a source of collective danger', a morbid phenomenon and 'the 'bio other' (Foucault, 1980).The imperative of hygiene in the *nosopolitics* entailed an 'authoritarian medical intervention' by the medical expert in the figure of doctor who assumed a strategic role. The doctor became a significant expert if not in art of government but observing and correcting the mass populations; having direct and intimate access to the individual body and the social body, through the practices of examination, scrutiny, quarantine, hygiene, statistics, etc.

The discursive extension of medico– administration in the everyday of populations through permanence of medical gaze produces a particular subject as its 'bio other' (Rail & Jette, 2015). The healthy/docile subject of power is proactive, shows agency, and is a dream consumer of modern bio-medicines and medico- technology. The active bio subject is not only constituted from above, rather through self-observation, and self-treatment practices of 'care of the self' (Foucault, 1988).He strives to improve his physical and social environment in order to achieve a healthy lifestyle. With his 'therapeutic sensibility' he is responsible for the wellbeing of family and fellow citizens as well (Rail & Jette, 2015). Rose and Nova (2005) call this subject 'bio-citizen', for whom expert no longer is the sole authority as he takes responsibility for his own health. Contrary to the active bio-subject, the 'bio-other' lacks agency, empowerment, sensibility towards his physical and social hygiene, active self-monitoring and is reluctant to consume modern medicine and technologies. The lack of therapeutic sensibility entails a lack in spiritual care which further necessitates an expert in this field.

Following Foucault's argument on biopower, this paper contends that the Pashtun tribal subject of Dr Pennell becomes an excellent case of colonial bio political regime. The discussion below will deal with how the medical mission operated with a bio political logic. The colonial medical missionary penetrated into the very intimate crevices of the (social) body of Pashtun and through the medico administrative intervention established the truth about Pashtun as the 'bio other' who lacks rationality and care of the self, and thus poses a potential hazard of contagion to the imperial project at the very instance of contact. Thus the legitimacy of colonial control was established to the point of penetrating not only geographies but the bios of the said populations.

Medical Mission Arrives in Bannu:

Though as a matter of policy, initially the British colonial rule kept itself distanced from the Christian missionaries. However, later it was deemed pragmatic to involve missionaries in the colonial 'civilizing mission' for acculturation of the local people into more peaceful subject-hood (Hardiman, 2006). On arrival from USA in 1834, Rev. John C. Lowrie established first mission in Punjab at Ludhiana and later developed other mission stations in Punjab (Webster, 2009). The first missionary of Christian Missionary Society (CMS) was Robert Clark, who arrived in Amritsar in 1852 and later established missions at Peshawar, Bannu and Kashmir. CMS was established as an evangelical wing of the Church of England in 1799. Punjab mission was created not by a decision in London but at the initiative of evangelical British civil and military officers posted in the region (Webster, 2009).

Hardiman (2006) describes that Christian missionaries were against medical missionaries. According to evangelicals, the sickness of mind and body was caused by paganism and poor hygiene. The inhabitants of European colonies were considered as suffering from moral and physical sickness. For such a disease expert doctor was not required. A missionary with adequate understanding of hygiene and gospel was suited for salvation of the mind and bodies of the sick. Another reason for unpopularity of medical mission for evangelicals was the inefficacious use of western medical practices in the colonies. It was only in 1830s that an American missionary EC Bridgman appreciated the strategic significance of the medical practitioner and the first protestant medical missionary was sent to China. Towards the end of 19th century medical missionaries started their work in India with a view to convert the locals and therefore heal their bodies and souls.

Of the colonial medical missions in rest of British India, Chota Nagpur mission, Mrs. Brikket's Bhil mission and Ranaghat mission were three important missions, which worked to preach and heal the Hindu populations in South India (Stock, 1917). The medical mission in the NWFP was of immense significance for colonial administrators (Stock, 1917). There were few medical missions in South Indian amongst Hindu populations, but it was the Muslims of the North West Frontier regions and the hill tribes where their importance was even greater because it was hard to reach and preach them through ordinary mission. The beginning of these missions was in Kashmir which Stock (1917) claims was famous for its beautiful places and for its vale.

The British military and civil bureaucracy was attracted towards Kashmir and Kabul in order to safeguard the British rule from Russia. First missionary came to Kashmir in 1854, long before the establishment of colonial rule there, which happened near the end of 19th century. The first medical missionary Robert Clarke in Srinagar came after ten years in 1864, appointed through CMS. Robert Clarke made tour of North Western Frontiers and gave the idea for establishing a chain of medical missions at strategic hilly posts in Kashmir. Dr Elmslie went there in 1865 and was successful in gaining a few converts. The maharaja's government in Kashmir was bitter towards these medical missionaries for fear of colonial intervention in Kashmir affairs (Mir, 2017). Gradually this bitterness turned into a favorable attitude. Thereafter, more mission hospitals and dispensaries were opened in frontier regions; at Bannu, Peshawar, Tank, DI Khan and Quetta (Stock, 1917). Of these missions this paper deals only with Bannu Mission of Dr. Pennell as a case of British bio politics in North Western Frontier regions.

About Dr Theodore Leighton Pennell of Bannu medical mission

Pennell was born in October, 1867 and died on March 23, 1912 owing to infection he caught through surgery of an infected Pashtun patient. Pennell's father was a doctor whose death left him orphan in early childhood. Pennell wrote about her mother that she took mission of developing her son in the service of God (AL, 1913). He took medical degree from London University with honors. His religious dedication in the Christian Association and London Medical Prayer Union won him religious acclaim. He offered his medical services to CMS. CMS was given the responsibility of the evangelization of the whole of the North-West Frontier. He had also spent a term at Islington College for theological study. CMS assigned him to Punjab Mission for the training the native medical missionary workers (AL, 1913). His mother, then fifty seven, joined him to his journey to India in October, 1892 and spent her rest of life there, mostly in Bannu. She remained a companion to his son's medical missionary work, providing the mission link of female medical practitioners at Bannu, before Pennell married his Parsi-convert wife, doctor Sarobji.

Pennell arrived at Bannu in 1893 and there he established a hospital inside mission house and church adjacent to the army unit. Soon he was not only heading the hospital, but also the mission school, a newspaper in four languages, dispensaries and churches in different areas such as Karak and Thal, besides frequent itinerant medical camps in 'fanatic and ferocious' frontier. He performed host of other mission related activities such as preaching openly in Bannu bazar, conversion, baptizing, etc. AL (1913) describes that "Pennell was rapid and skillful operator, and gained a reputation as a surgeon amongst Europeans as well as Indians throughout the Province" (p.28). AL (1913) also praised Pennell for his freedom and ability to work in the border hills (p.29). Dr. Pennell served at Bannu Hospital for more than two decades, with a very short visit to England, only once after sixteen years in 1908 and that too for promoting medical mission project in India.

Life among Wild Tribes of Afghan Frontier (1908) and *Things Seen in Northern India* (1912) are Pennell's two works. *Life among Wild Tribes of Afghan Frontier* is particularly focused on the themes of medical mission. *Things Seen in Northern India* is the observation based, behaviouralist, and traditional ethnographic colonial genre. *Pennell of the Afghan Frontier: The Life of TL Pennell* (1914) by Alice Pennell, *Pennell of Bannu* (1913) by AL and *Ministers of Mercy* (1919) by James H. Franklin are three major sources on Pennell written by his companions and contemporaries, besides his own works. Soon after Pennell's sudden death, AL in *Pennell of Bannu* (1913) wrote the life history of Pennell as a 'medical missionary hero'. Being his personal acquaintance and contemporary, he attempted to place Pennell's services within the conditions, circumstances and challenges which constituted the Pashtun frontier Pennell encountered. Of these works, this study only focuses on Pennell's book *Life among Wild Tribes* as primary text to examine the debate of colonial biopower in NWFP.

Bannu medical mission and the sites and strategies of medical interventions

This section deals with the strategies of intervention at multiple sites; physical geographies, individual Pashtun body, home with Pashtun women as special focus of colonial differentiating discourse, culture as a site of intervention, local practices and practitioners of diagnosis and treatment, hospital and school. It investigates how at these sites the colonial medical mission penetrated into the (social) body of Pashtun through the capillary actions of power (Foucault, 1995) to justify the regulation and control of those who posed a harm and were in need of civilizing and modernizing mission.

Physical geographies of Bannu medical mission

Dr. Pennell describes the medical topography or physical and human geography of his mission as "the most part composed of intricate and in many parts inaccessible mountain ranges" (Pennell, 1909, p.62). During his journey as a medical missionary he passed through four different territories. He described the first and last of these territories i.e. Afghanistan and British India as well defined geographies while the two intervening tribal areas as not easily comprehensible regions and habitats of 'lawless spirits'. In these regions two different policies were followed by British at various times (Pennell, 1909). The policy of masterly inactivity (British avoiding any involvement in trans-frontier politics) and the forward policy: active involvement in trans-frontier politics while the internal affairs remained in the hands of local chiefs who were guided by the political officers.

Of the position of medical missionary in these areas he writes that in British India missionaries had free hand till they acted within the law while in Afghanistan, they could not even enter. In the intervening tribal regions the missionaries well acquainted themselves with the language and customs of these regions. They were able to continue their mission with success by avoiding any

attack on the religion of the people in these tribal regions. Of these areas Kurram valley was described as the well administered and civilized area as it was under the control of British (Pennell, 1909).[1]

To express feelings of revulsion and alienation from the unfamiliar sub-cultures and to confirm the cultural superiority of the beholder the colonial travelers and merchants frequently constructed the physical and cultural topographies as a problematic of health (Newell, 2016). In Dr Pennell's text, the idea of the 'pathogenic space' (Foucault, 1980) of tribal *habitus* as a 'medicalizable object' (Foucault, 1980) has been frequently invoked. He narrates: "The streets are narrow and winding, and…very dark,…and at all times distinctly insanitary and malodorous" (Pennel, 1909, p.112). Perceived and narrated through the colonial gaze, the 'dirty familiars' (Newell, 2016) and figure of dirty native legitimatized the colonial and European expansion and control into the most intricate corners of the everyday, in order to enforce the regimes of sanitation and racial segregation. Across the geographies of colonial project, these regimes helped expansion of European markets in the name of health, hygiene and sanitation. Pennell was aware of this and aspired for extending western health practices even beyond frontiers.

Pennell integrates mission forward policy with military forward policy and sanitary border policy (Dutta, 2009, p.74). Starting with frontier mission outposts along north western border of the British Empire to the imperial desire for Central Asia, he is aiming at recovering old Christian lands through medical missions (Pennell, 1909, pp.305-306), with the purpose of "drawing nations together in bonds of service and sympathy, and diminishing the danger of racial conflict and devastating war" (p.312). It needs not be over-emphasized that by the time Pennell was sharing missionary imperialism, West has already occupied vast 'heathen lands' outside Europe; the only "conflict" and "war" he is referring to were from the savage natives colonized by the West who were resisting against the Western colonization.

Pashtun as a medicalizable object, the Bio other of British colonial empire

Colonial construction of the Pashtuns can be divided into three broader phases of interaction. During the initial interaction with Pashtun, the British especially as foreign guest were well received which demonstrated the 'beneficence of the host' and passivity being the essence of the guest (Lindholm, 1996). Pashtun subjectivities constructed by British, particularly Elphinstone (1972) and Masson (1974) during these initial encounters were of 'good men', friendly, brave and positive. In the second phase of British domination, direct invasion and military expeditions, Pashtuns were resisting subordination through every possible means including betrayals, treachery and direct assaults. It was in this phase of interaction between the two, that Pashtun character gains negative description in British colonial discourses (Lindholm, 1996). In the third phase, the British under indirect rule came closer to the Pshtuns through the traditional mediating figure, as Warburton (1970) who distanced themselves from actual political maneuvering. During this phase positive images of Pashtun identity resurfaces in colonial imaginations such as Olaf Caroe's *The Pathans'*(1958). Lindholm (1996) mentions that, "these different images of Pashtun character which seemed so inconsistent to the western observer are not really inconsistent at all. Once the structural framework of the society is grasped, the contradictions are resolved and the diverse visions of the Pashtun fit together into a coherent whole" (p.15). Dr. Pennell's work (1909) can be positioned in the second phase of colonial discursive construction of the Pashtun. Although, the reader can feel that he

[1] Here the tone of Dr Pennel's text is similar to what Said (2001) refers to when he mentions James Balfour's lecture at the House of Commons rationalizing the Bristish colonial project in Egypt . Said refers here to the benefits which the colonizers assume to have given to races with whom they deal.For details see (Said, 2001).

has used positive descriptions of Pashtun at places, which reflects the ambivalence of his own character as a medical missionary and a member of a martial race.

Pennell's account abounds with the negative portrayal of Pashtuns which can be read intertextually along with the other colonial accounts of medical missionaries (see for instance Pont, 1991).

The text of Pennell's work opens with these lines:

> "*The east is the country of contradiction, and the Afghan character is a strange medley of contradictory qualities, in which courage blends with stealth, the basest treachery with the most touching fidelity, intense religious fanaticism, with an avarice which will even induce him to play false to his faith, and the lavish hospitality with an irresistible propensity for thieving*" (Pennell, 1909, p.17). He begins with a generalized construction of East and then immediately becomes specific and refers to Pashtuns/Afghans, the object of colonial power on whom the modalities of bio-politics will be exercised through gospel and modern medicine. In the opening paras, he as a colonial medical expert describes the symptom of the ailing Pashtun social body and justifies the role of mission medicine in the whole colonial project.

"*Vendetta, or blood feud, has eaten into the very core of …life, and the nation can never become healthily progressive till public opinion on the question of revenge alters"(p*.18).

The Pashtuns, are presented for a Western eye by Dr. Pennell (1909) as 'looters', 'plunderers', 'professional murderers', 'fanatics', 'wild', 'thieves', 'outlaws', 'superstitious', 'criminals', 'utter barbarians', 'villainous looking' ,'ruffians' 'rascals', 'disloyal', and having a 'proverbial enmity'. The symptoms of ailing body are as much physical as moral and spiritual. The Christian missionaries and medical missionaries had a common characteristic of attributing the spiritual and moral degeneration to the physical ailments. To the colonizer the moral sickness of the object of colonial medico – administrative power is rooted not only in their character flaws but due to practicing a faith which they know little about. They are superstitious by faith as instead of prayer and medicine they use charms, amulets and tomb visiting to cure their sick.

For the British colonial and medical missionary gaze, the indigenous populations were primitive, barbarians, followers of 'animistic religious beliefs' (Hardiman, 2006), diseased bodies devoid of any 'care of the self' and thus were in need of salvation through gospel and modern medicine. The accounts of the missionary doctors constructed the medical subject through the imperative of health and frequently reported the local people as sick, suffering from multitude of diseases, cholera, dysentery, malaria. Many suffered from eye disease which if left untreated or cured by the crude methods could cause permanent blindness (Pennel, 1909), the tribesmen also suffered from ulcers, itch and ringworm, 'diseases of the skin' and a host of other illnesses. The indigenous people were described as ignorant of and unwilling to resort to modern medical treatments which showed their resistance to modernity. Pennell has frequently referred to this revulsion on part of native Pashtuns towards the modern medicines. He also describes the inability of the natives to benefit from the modern allopathic medicines without the help of an expert figure of medical missionary. They would make the charms of the prescription and medicine given by Dr Pennel, in a belief that it would be more efficacious (Pennell, 1909; Lindholm,1996). This suggests the need of colonial control of the Pashtun's (social) body as the latter is incapable to make appropriate use and benefit from the modernity which its European counterpart has very successfully attained.

Homes and Pashtun women as objects of medical discourse:

Home is the most intimate site of colonial contact with the Pashtun society. Pashtuns are said to have strict notions of *pardah*, particularly of women and home.These were the mysterious and exotic geographies for the colonial gaze and knowledge of these spaces made their management an easier task, 'a profitable dialectic of information and control' (Said, 2001). Writing about the home, Pennell (1909) mentions his visits to Pashtun homes as a guest and admires their hospitability. With the narration of these visits, he reifies the unclean social body and the imperial sensitivity towards the 'oriental odor' (Pennel, 1909; Sinclair, 1936). Pashtun homes in villages are described in colonial discourses as unclean, stinking with inhabitants both human and animals and their dung. It is shared by other colonial writers on frontiers: "…inside the place….smelled of cattle and dust heaps and dirty clothes" (Sinclair, 1936, p.75).

Pennell (1909) devotes one whole chapter to Pashtun woman, which offers ethnographic detail regarding her life. It reflected not only general practice of colonial writing about Indian people, but created difference through her as distinct medical object requiring special space in medical discourse, as has been developing in England with Church of England's Zenana Mission Society and Dufferin Fund calling for medical penetration of Indian women. Before Pennell's marriage to Alice Sarobji, his mother and other women at Bannu Hospital practiced alongside and in support of Pennell to attend Pashtun women patients whose husbands wouldn't let male practitioners touch their women. Besides mentioning the attitude of Pashtun men regarding unwillingness and resentment towards bringing their women for treatment to hospital Pennel offers a description of the differences in attitude towards health and treatment based on sub groups, regions and religion. Identity and difference is further embedded through women specific illnesses related with Pashtun environment and culture, such as nose cutting of wives, skin problems in Pashtun women owing to lack of culture of bathing in sweltering summers, unbearable responsibilities without power, resources and dignity. Pashtun women are constructed as facing incessant hostility, suspicion, threat to life and honour, segregation, unreciprocated love and sacrifice, and status like cattle. Here Pennell also creates racial/imperial difference by comparing her with her Christian counterparts for the latter's independence and care offered to her by her family. Pennell was not only furthering colonial discursive force field, he was also taking ideals of missionary women, who had in India greater freedom and love from their newly convert enthusiastic families, particularly his own mother; however, he recognizes that Pashtun women had greater independence and power within their homes (Pennell,1909). As Pennell wrote his book before his marriage with doctor Sorabji, he could not offer discursive depth of colonial zenana medical mission. However, he still seems successful in reproducing hierarchies of gender in terms of health and medicine.

Race and the cultural imperative:

Construction of the 'other' in cross cultural interaction in the19th and 20th centuries was mediated through negative connotations; the labeling of Jews by Nazis and anti-Semites as vermin, of Tutsis in Uganda as cockroaches, and homosexuals in Gambia as vermin (Newell, 2016). These discursive maneuvers are endured as permanent identity and return haunting the very existence of the 'condemned'. Fanon (1967) has argued in *Black Skin, White Masks* that blackness comes through the other and the Negro is locked permanently in his body. It is unimaginable how much adverse impact these images had on the 'total lives' of the post-colonial people. Even if they try, they can never resemble white men, for the 'other' scent was very strong (Fanon, 1967). As a colonial reporter of the "Toronto Star", Sinclair was shocked for being "anaesthetized by the (native) man's pungent bazaar perfume" (Sinclair, 2003). The body becomes the prison; identities assigned through colonial subjectivities are sticky and keep informing the knowledge about the 'other'. There is no simple way

to disentangle from colonialism and its memory. It is with the colonized in myriad forms of coloniality; demarcated borders, state bureaucracy, language, political system and particularly western ideals of development. Discursively, these imaginations are reinforced through 'the truth value of repetition'. In the colonial context, it was happening through the discourse of merchants, traders, travelers, explorers, scientists, artists, teachers, administrators, surveyors, reformers, etc. Said (2001) argues that "on the level of position of problematic, the European orientalist modes of seeing the 'other' not only create knowledge but a truth about the object, 'an essential character', 'stamped with an otherness'. This repetitious naming of the other by means of comparison, replaces the person with an essence, a metonym standing for the whole and takes over from it. While on the level of the thematic, what is being constructed is an essentialist notions of oriental people and nations, which is characterized by the ethnic typology and …will lead towards racism"(Said, 2001).

In Pennell (1909) reference to the Jewish descent of Pashtun problematizes the subjectivity of Pashtun as a medicalizable object, as it alludes to the later eugenics against Jews in the west for being bio-other, a few decades after Pennell was writing this text under study. Pennell further finds villages as attractive sites of Indian life, being less sophisticated and reminding him of the Old Testament (Pennel, 1909, p.99). Thereby in his text a village being old fashioned, unsophisticated and oriental brings closer both Jewishness and ancientness. Race emerges "in unspoken assumptions about the needs of the Indian people, their liability to different forms of illness, and the role of their habits in the production of disease" (Pati & Mark, 2009, p.7). Medical manuals written by and for Europeans in the tropics constantly stressed the dangers posed by the habits of oriental peoples and often blamed them for their failure to make progress in matters of public health" (Pati & Mark, 2009). Pennell heavily relied on these discursive nodes constituted through medical training as well as colonial discourses regarding Pashtuns. His ethnographic 'thick description' of the region, its people, their customs and practices, political and military policies and their relation with the medicalizable condition of the Pashtun, situates missionary health discourse rightly inside the health politics that Foucault has found developing in Europe in the wake of development of capitalism during 18th century. Stoler (1995) has complicated this Foucauldian paradigm further in her extended critique of *The History of Sexuality*, arguing that 19th century European bourgeois' 'cultivation of self' and sexual identity were not only refracted through, but actually produced by racial/imperial configuration of 'healthy' and 'contaminated' bodies.

Disease, disability and death let modern medical practitioner examine every day practices, culture, history, racial and religious composition, and provides scope for medical interventions. In Pennell's text the culture of intoxicants and addictions as *bhung* or Indian hemp, *charas*, etc. is also implicated in this discourse. Pashtun culture is invoked as bio other: Pashtun being hot tempered and reckless (Pennell, 1909) violently pursued personal enmity, even on slight hurt, which continued as long time family and tribal feuds, etc. all leading to frequent deaths or fatal injuries. Most of the injury cases Pennell (1991) dealt with and invoked in his work, pertained to this class of cultural-criminal sources of conflict i.e. feud which has been enigma for most Westerners and has been explained aptly by Lindholm (1996). The discourse also incorporates the looting of Hindu families and cutting of their ears for removal of jewelry by raiding and plundering Pashtun gangs; it is considered by most of colonial texts as a profession and norm amongst wild tribes of the frontier (Pennell, 1909).Similarly medicalization is the response to other sources of such corporeal loss and lack such as "men … been crippled for life as a punishment for some crime" (Pennell, 1909) which also indicated 'primitivity' and irrationality of Islamic punishments.

Local practitioners / practices of health

Pennel (1909) refers to the absence of expert in Pashtun medical tradition. The sick was being treated by *hakim, mullah, faqir, jogi, sadhu* and herbalist through crude, primitive and savage modes of treatment. He particularly mentions and criticizes the two prevalent modes of treatment in native Afghan tribes —*Dzan* and *dam*. Those with fever and wounds were wrapped in fresh animal skin which used to rot the wound, being itself septic, infectious and unhygienic. Surgeries were performed by village barber, ashes were rubbed on wounds, splints were applied on fractures by village carpenter, cataract was treated by *hakeem* and tooth extraction was done by blacksmith. Alluding to these practices and practitioners in a repetitive fashion was part of 'truth production' about the patient having little or no knowledge of modernity. In the far flung, incomprehensible geographies medical mission was the sole source of introducing modern medicine to the natives. These accounts of local modes of treatment constructed the customary Pashtun ailing body / social body as a binary of modern bio- medicine and scientific modes of treatment. Mere introduction of modern medicine would not guarantee the appropriate use. As Dr Pennell writes " On more than one occasion, I have found my prescriptions made up into charms, the patient believing that this would be more efficacious than the hospital medicine" (p.36). Constant education and surveillance of the sick native body within the politico – medical regime is an imperative to suppress legitimacy of native health practitioners who exercise a considerable authority over everyday life of the local population. Contrary to the demands for, and traditions of, 'medical pluralism' in India, colonial medicine discourse was hegemonic (Pati & Mark, 2009). Pennell fights at lengths against the irrationality and hazards of alternative health practices and attempts to suppress the utility and relevance of indigenous medical traditions. He develops negative identities and subjectivities of indigenous medical practices, practitioners and patients alike. In stark opposition to the local traditions, the power of doctor as an agent of modernity and rationality, gains visibility and prominence in Pennell's discourse: "For the stories they have heard of the power of the Western skill lead them to believe that if the doctor does not cure them on the spot it must be that he is too busy or they are too poor" (Pennel, 1909, p.92).

Mission hospital and school as site of medical intervention

Hospital emerges as a modern ensemble of medical discourses, techniques, practices, relations, and apparatuses aimed at for colonial and capitalist function. It is the center of modern pathogenic space, which includes home, school, asylum, and even borders. Hospital metonymically represents whole edifice of modern medical discursive field to which (Gougelet (2010) calls: '*The world is one great hospital*'. Bannu Mission hospital covered a variety of techniques and apparatuses: treatment practices, individual attention by medical staff on each patient, donated beds with stories of forgiveness as revenge of the Christian, prayers, gospels, education and disciplining healthy body of the natives.

In Pennell (1909), Bannu Mission Hospital found a unique combination of surgery, psychiatry and spirituality: not only the first two elements are essentially modern and medical, the third element is very deeply, rationally and intellectually modern as it diagnoses the illness of the social body of the Pashtun. Family feud was a source of pathogenizing and medicalizing Pashtuns, which is re-dressed only through modern, western, rational, scientific, and medically driven Christianity. People crowded hospital and medical camps in Pennell, like masses seeking salvation. Missionary Christianity has transformed itself into a scientific and medical discourse, integrated into health

politics, and performing colonial function in absence of governmental capacity and/or willingness for broad based health care services in regions like north western frontiers.

Mission School also provided a similar template of corporal discipline and docility of the interns as was provided within the mission hospital— both being sites and sources of biopower. The format of daily disciplinary activities such as studying modern subjects, class activities, examinations, sports, educational tours besides daily prayers, scriptures readings, hymns,etc. was the *dispositif* of colonial power. Pennell (1909) insists that very early on, the students conducted these all religious, educational and sport activities, with broad consensus and what Gramsci (1971) calls consent. "On the Sunday evening, the boarders come to my house to sing hymns from '*Sacred Songs and Solos*' and vernacular collections, and if I omit to offer the usual prayer at the close, they remind me of the omission; they do not wish to go away without it" (Pennell, 1909, p.148). Recognizing amenability of an Indian for colonial corporal discipline inside the mission school, Pennell affirms that an Indian "is … much more readily subjected to discipline than his English counterpart" (p.143). The discipline of mission school is claimed to have transforming effects on the new generations of the natives (p.156). Discipline becomes productive of Pashtun social body eventually.

Pennell thus exhorts that "…these frontier tribes form some of the finest fighting material from which the Indian Army is recruited" (p.64). More so was the pacification function of medical mission as these were considered more fruitful than establishment of police posts among the 'lawless spirits' of the frontier (p.68). They functioned to pacify the resistance of the wild and savage natives. With the 'power of healing', doctor was considered confidant of colonialism in its operations over the pathogenic and medicalizable body of native.

Conclusion

The study opens up debate on colonial health discourses through critically examining the work of Dr. Pennell's Bannu Medical Mission. Medical mission in NWFP has performed colonial function of biopower, in constituting and reproducing the identity and subjectivity of Pashtun individual and social body. Missionary medicine performs this role by and through colonial condition. Though Foucault identified regimes of accumulation as source of transformation in biopower and health politics in 18th century Europe, the biopower of medical mission reproduces the colonial utility of the Pashtun for colonial and hegemonic expansion into the farthest lands.

Colonial biopower has ever since reproduced the identities and subjectivities of the colonized natives providing the moral imperative for 'civilizing mission' of the west and the right to rule the savage and sick populations of the erstwhile colonized world. Further research would provide greater elaboration into the colonial discursive practices of health and medicine in the colonial frontier regions. It would provide insights into the histories that constitute our 'present': while local politics of polio, municipal waste and wasted refugee lives is significant reconstruction of colonial discourses, global struggles around health and sickness offer equally critical discursive force field. Finally, the study thus opens up opportunities not only for research but for policy debates as well in governmentality of health.

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