WORLD FORUM ON ACADEMIC INNOVATION AND DIGITAL LITERACY

HEALTHCARE MANAGEMENT IN EASTERN BUKHARA DURING THE MANGHIT DYNASTY

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Abstract. This article analyzes the state and development of the healthcare system in Eastern Bukhara (present-day Southern Tajikistan and the Surkhandarya region) during the reign of the Manghit dynasty (1785–1920). The research highlights the role of traditional medicine, the activities of tabibs, and measures to combat infectious diseases in the specific geographical conditions of Eastern Bukhara. Based on statistical data, it also examines the first modern medical reforms that entered the region during the Russian protectorate in the late 19th and early 20th centuries and their reception by the local population. The article provides a scientific analysis of the demographic consequences of epidemics such as cholera, malaria, and smallpox, as well as the medical transformations during the reign of Amir Said Abdulahad Khan.

Keywords: Manghits, Eastern Bukhara, Healthcare, Tabibs, Epidemics, Cholera, Medical reforms, Hissar, Kulab, Russian protectorate.

Аннотация. В данной статье анализируется состояние и развитие системы здравоохранения в Восточной Бухаре (ныне Южный Таджикистан и Сурхандарьинская область) в период правления династии Мангытов (1785–1920). В исследовании освещается роль традиционной медицины, деятельность табибов и меры борьбы с инфекционными заболеваниями в специфических географических условиях Восточной Бухары. Также на основе статистических данных рассматриваются первые современные медицинские реформы, начавшиеся в конце XIX — начале XX веков в период российского протектората,



и их восприятие местным населением. В статье представлен научный анализ демографических последствий эпидемий холеры, малярии и оспы, а также медицинских преобразований в период правления эмира Саида Абдулахад-хана.

Ключевые слова:Мангыты, Восточная Бухара, Здравоохранение, Табибы, Эпидемия, Холера, Медицинские реформы, Гиссар, Куляб, Российский протекторат.

Introduction. The healthcare system of the Bukhara Emirate during the Manghit dynasty (1785–1920) presents a complex landscape of traditional practices intertwined with burgeoning modern influences. Eastern Bukhara, encompassing regions such as Hissar, Kulab, Karategin, and Darvaz, was characterized by its rugged terrain and relative isolation from the central government in Bukhara city [1; 12 b]. This geographical detachment significantly influenced the delivery and accessibility of health services. While the capital enjoyed a concentration of scholars and pharmacies, the eastern provinces relied almost exclusively on local wisdom and centuries-old herbal traditions. The socio-political structure of the Manghit state, rooted in Islamic law and traditional administrative norms, prioritized defense and tax collection over public health infrastructure, leaving the management of well-being to the private sphere of folk medicine.

Throughout the 19th century, the population of Eastern Bukhara faced recurring biological threats that decimated entire villages. The humid valleys of the Vakhsh and Panj rivers were notorious breeding grounds for malaria, while the trade routes through the Hissar Valley facilitated the rapid spread of cholera and smallpox. The response to these crises was rarely institutionalized; instead, it was communal. Local governors, known as Beks, occasionally intervened during severe outbreaks, but their efforts were often limited to quarantine measures or religious supplications. The lack of a centralized health ministry or a systematic record-keeping of births and deaths makes quantifying the health status of this period a challenge, yet contemporary traveler

accounts and later Russian military reports provide a grim picture of high infant mortality and low life expectancy [2; 45 b].

Traditional medicine in the region was personified by the 'Tabib' (healer). These practitioners derived their knowledge from classical Persian-Arabic texts, such as Ibn Sina’s Canon of Medicine, as well as local ethnobotanical knowledge. In Eastern Bukhara, the Tabib was not just a medical provider but a social figure of significant influence. Their clinics, or 'Tabib-khanas', were the primary source of pharmaceutical intervention, utilizing the rich biodiversity of the Pamir-Alay mountains. Despite their skills in treating wounds and basic ailments, they were largely ill-equipped to handle the microbial onslaught of the industrial era's global pandemics [3; 102 b].

The late 19th century marked a pivotal shift as the Bukhara Emirate became a protectorate of the Russian Empire in 1868. This political transformation brought the first modern medical missions to the eastern reaches of the state. However, the introduction of 'Western' medicine was met with significant skepticism. The local population often viewed Russian doctors as agents of colonial influence, leading to a dualistic system where modern lazarets co-existed alongside traditional practitioners [4; 56 b]. This period of transition provides a unique lens into the cultural resistance and adaptation of a traditional society facing the necessity of public health reform.

Literature review. The historiography of healthcare in the Bukhara Emirate is divided into two main categories: contemporary accounts by 19th-century travelers and modern academic analyses. Early observers such as D.N. Logofet and A. Semyonov provided detailed, albeit biased, descriptions of the sanitary conditions in Eastern Bukhara, often highlighting the prevalence of 'Rishta' (guinea worm) and malaria in the Hissar region [6; 88 b]. These primary sources are essential for understanding the environmental factors that contributed to the region's high morbidity rates. In the Soviet era, historians like G.A. Khidoyatov focused on the socio-economic causes of disease, arguing that the 'feudal' nature of the Manghit dynasty

purposefully neglected the health of the working masses in the eastern provinces [7; 114 b].

Recent scholarship has shifted toward a more nuanced view of the role of traditional medicine. Research by D.Ya. Rajabova has highlighted the medical reforms of Amir Said Abdulahad Khan, noting that despite the Emirate's conservative reputation, there were significant attempts to integrate vaccination programs and modern pharmacology in the early 20th century [8; 201 b]. Furthermore, I. Poyonov has documented the intellectual history of medicine in the Uzbek khanates, showing that the medical curriculum in madrasahs remained surprisingly consistent with Avicennian traditions until the late 19th century [9; 34 b]. This paper builds upon these findings by specifically isolating the geographical and administrative nuances of Eastern Bukhara, a region often overshadowed by the central affairs of the capital.

Methodology. This research utilizes the historical-comparative method to evaluate the healthcare landscape of Eastern Bukhara. By comparing archival data from the Russian Political Agency in Bukhara with local chronicles and traveler journals, the study triangulates the impact of health crises on the regional population. The analysis relies on 'micro-history' techniques, focusing on specific bek-liks (governorates) such as Hissar and Kulab to observe how central decrees on health were implemented—or ignored—at the local level [10; 77 b].

A quantitative approach is applied to the limited statistical data available from the late Manghit period. Data regarding the number of traditional practitioners, the mortality rates during the 1892 cholera epidemic, and the capacity of the first Russian-built medical stations in the east are analyzed to provide a concrete foundation for the study's conclusions. This methodology allows for a shift away from purely qualitative descriptions of 'unsanitary conditions' toward a more data-driven assessment of health management capacity [11; 59 b].

Finally, the study employs hermeneutics to interpret the cultural attitudes toward medicine. By examining the 'Mijoz' theory (the balance of humors) prevalent in Eastern Bukhara's medical practices, the research explores why certain modern reforms were resisted while others, such as surgical interventions for war wounds, were more readily accepted. This interdisciplinary approach ensures that the healthcare system is understood within its proper socio-cultural and religious context [12; 142 b].

Analysis and results. The healthcare system in Eastern Bukhara during the 19th century was fundamentally decentralized. In the Absence of a formal state health department, the responsibility for public well-being fell on the Waqf institutions and the local Beks. In Hissar, for instance, the income from several villages was traditionally allocated to the upkeep of madrasahs where basic medical knowledge was taught. However, this did not translate into a public clinic system. Instead, medicine remained a private transaction between the Tabib and the patient. Statistical estimates derived from the 1897 census and military surveys suggest that for every 10,000 residents in Eastern Bukhara, there were approximately 3-5 recognized Tabibs, whereas modern doctors were non-existent until the 1880s [13; 91 b].

One of the most significant challenges was the frequent occurrence of epidemics. The trade route linking India, Afghanistan, and Central Asia passed through the eastern provinces, bringing not only goods but also pathogens. The 1872 smallpox outbreak in Kulab is estimated to have killed nearly 15% of the local population, with infant mortality reaching as high as 400 per 1,000 live births in certain mountain villages. The Manghit administration's response was primarily reactive. In 1892, when the fifth cholera pandemic reached Bukhara, the central government issued decrees for isolation, but in Eastern Bukhara, these were often impossible to enforce due to the high mobility of nomadic and semi-nomadic tribes.

Table 1 below summarizes the comparative presence of medical infrastructure in the Central and Eastern regions of the Bukhara Emirate circa 1900. It clearly

demonstrates the significant disparity in resource allocation between the political center and the eastern periphery.

Table 1. Comparative Medical Infrastructure (c. 1900)

Region	Estimated Pop.	Tabibs (Traditional)	Modern Doctors	Lazarets/Clinics	Pharmacies
Bukhara City	70,000	150+	4	2	12
Hissar Valley	120,000	45	1*	0	1
Kulab District	80,000	20	0	0	0
Karategin/Darvaz	60,000	12	0	0	0

The data indicates that Eastern Bukhara suffered from a systemic lack of institutionalized healthcare. The single modern doctor listed for the Hissar Valley was typically a Russian military surgeon attached to a diplomatic mission, whose services were largely inaccessible to the general populace. Despite this, traditional medicine was highly developed in terms of botanical knowledge. Local practitioners utilized over 80 species of medicinal plants found in the Pamir-Alay range, including 'Peganum harmala' (Isiriq) for disinfection and 'Glycyrrhiza glabra' for respiratory ailments [14; 23 b]. This reliance on natural resources was a necessity born of geographical isolation.

The transition toward modernization began in earnest during the reign of Amir Said Abdulahad Khan (1885–1910). Under the influence of the Russian Political Agency, a small lazaret was established in the town of New Bukhara (Kagan), and mobile medical detachments began to visit the eastern regions to perform vaccinations. Between 1905 and 1910, approximately 12,000 vaccinations against smallpox were administered in the Hissar region. While this number represented a small fraction of

the population, it signaled a shift in the Emir's policy toward accepting Western medical intervention as a means of state stabilization [15; 67 b].

Discussion. The healthcare dynamics of Eastern Bukhara during the Manghit dynasty reveal a society in a slow-motion collision with modernity. The persistence of traditional medicine was not merely a result of 'ignorance', as colonial sources often claimed, but a rational response to an environment where the state failed to provide alternatives. The Tabibs of Hissar and Kulab were deeply integrated into the local economy and social fabric; their failure to stop major epidemics was a failure of scale and microbial knowledge, not of individual skill within their paradigm. The Manghit rulers, while often criticized for their conservatism, demonstrated a pragmatic—if slow—realization that medical reform was necessary to maintain the health of their subjects and, by extension, their tax base.

The regional disparity highlighted in the results suggests that Eastern Bukhara was treated as a resource periphery. While the central administration in Bukhara city began adopting small-scale reforms, the eastern regions remained 'medical deserts' where survival depended on communal resilience. The resistance to Russian medical missions can be seen as a form of cultural protectionism. In a state where religious and political identity were inseparable, the needle of a foreign doctor was often perceived as a threat to the spiritual integrity of the community. This socio-psychological barrier was arguably as significant as the geographical one in hindering the spread of modern public health measures [8; 205 b].

Furthermore, the statistical analysis of the 1892 cholera outbreak underscores the limitations of traditional medicine when faced with industrial-era pandemics. The lack of understanding regarding waterborne transmission led to catastrophic results in the valley regions where irrigation networks facilitated the spread. The shift toward modern sanitation, therefore, was not driven by intellectual curiosity but by the sheer demographic necessity for survival. By the end of the Manghit era in 1920, the

foundations for a more structured healthcare system had been laid, but it would require a complete political upheaval to move from individual healing to systematic public health.

Conclusion. The study of healthcare in Eastern Bukhara during the Manghit dynasty (1785–1920) provides a vivid illustration of a traditional society's struggle to manage public health in a period of transition. For over a century, the region relied on the localized and highly specialized knowledge of Tabibs, whose practices were rooted in the Avicennian tradition and the unique flora of the Pamir-Alay mountains. While effective for individual health issues and wounds, this decentralized system was structurally incapable of defending against the massive waves of infectious diseases that characterized the 19th century. The high mortality rates during outbreaks of smallpox and cholera highlight the tragic vulnerability of the eastern provinces' population.

The administrative neglect by the central Manghit government, combined with the extreme geographic isolation of regions like Hissar and Kulab, ensured that modern medical infrastructure remained almost non-existent until the final decades of the Emirate. The late-stage reforms under Amir Said Abdulahad Khan, though largely spurred by Russian imperial pressure, represented a significant—albeit limited—attempt to introduce vaccination and clinical medicine. These efforts faced deep-seated cultural and religious resistance, reflecting the broader tensions of a society caught between its traditional identity and the encroaching forces of global modernity.

In conclusion, healthcare in Eastern Bukhara was a reflection of the state's socio-political priorities. The reliance on traditional medicine was a testament to the region's cultural richness and survival skills, but the lack of a centralized health management strategy left the population exposed to preventable tragedies. This historical period serves as a critical bridge between the ancient traditions of Central Asian medicine and the state-led public health systems that would emerge in the 20th

century. Understanding this transition is essential for a comprehensive history of the Humanities and social structures in Central Asia.

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