Chapter I

Introduction

Arunachal Pradesh is one of the youngest states of the Union of India. It has rich cultural diversity and is the only state in North East India where much of modern administrative developments and social changes took place in the post-Independent period. As a result, the state is both a repository of indigenous traditions as well as a testimony of a rapidly changing society. It borders Bhutan in the west, Tibet in the north, Myanmar in the east and Assam in the south. Population migration into the state took route primarily from the north and east which continued till early nineteenth century. In the twentieth century the population influx happened mostly from mainland India. Various tribes had political and economic contacts with the Ahom rulers since thirteenth century but they never became a part of the Ahom subjects. Unlike many other parts of hill areas in North East India, socio-political evolution in the hills of Arunachal Pradesh during this period remained confined to networks of kinship ties across various groups with elements of chieftainship in some areas. Geographical barrier kept people away from each other and therefore social and political evolution on a composite scale did not take place.

The Ahom rulers negotiated peace with various groups to discourage raids on their subjects. The inchoate relations between the Ahom monarch and the people of Arunachal Pradesh is reflected by the use of negative adjectives to refer to the hill people of the Brahmaputra Valley. This trend continued even during the colonial period which succeeded the Ahom rule and inherited the
administrative legacy. While continuing with the old administrative policies of the Ahom related to the people of Arunachal Pradesh, the British pushed the limit of the contact between the hills and the plain because of commercial interest on tea cultivation and need to survey the ethno-geographic information on the territory of Arunachal Pradesh. Added with the strategic importance of Arunachal Pradesh and other commercial objectives, the British started to take administrative measures relating to the area since the second half of nineteenth century. The first step in this direction was to put the area outside the Inner Line jurisdiction. Thereafter, gradual administrative measures were taken up which eventually gave the area a separate administrative identity as shown below in chronological order:

Table 1.1: Administrative Growth of Arunachal Pradesh

<table>
<thead>
<tr>
<th>Year</th>
<th>Administrative Growth with Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1912</td>
<td>‘Administered’ by APO Sadiya, subordinate to the Deputy Commissioner, Lakhimpur under Dibrugarh Frontier Tract (DFT)</td>
</tr>
<tr>
<td>1912</td>
<td>DFT ceased to exist; Sadiya Frontier Tract District formed as separate entity under a Political Officer and three APOs, reporting directly to the Chief Commissioner; Headquarters at Sadiya</td>
</tr>
<tr>
<td>1914</td>
<td>Central and Eastern Section; Headquarters at Sadiya with a Political Officer Western Section, Headquarters at Charduar with a Political Officer</td>
</tr>
<tr>
<td>1919</td>
<td>Central and Eastern Section renamed as Sadiya Frontier Tract Western Section renamed as Balipara Frontier Tract</td>
</tr>
<tr>
<td>1937</td>
<td>Start of “actual administration”; Governor of Assam takes over the independent administration of North-East Frontier, assisted by a Secretary; “Governor’s Secretariat” established.</td>
</tr>
<tr>
<td>1943</td>
<td>Attempt to bring under normal administration, policy of ‘gradual penetration’ adopted. Adviser to the Governor of Assam created by Government of India especially for North-East Frontier.</td>
</tr>
<tr>
<td>1943</td>
<td>Tirap Frontier Tract comes into being by bifurcating certain areas from Lakhimpur and Sadiya Frontier Tract</td>
</tr>
<tr>
<td>1946</td>
<td>Balipara Frontier Tract divided into: (a) Sela Sub-Agency : (b) Subansiri Area</td>
</tr>
<tr>
<td>1948</td>
<td>Sadiya Frontier Tract divided into : (a) Abor Hills District : (b) Mishmi Hills District</td>
</tr>
<tr>
<td>1951</td>
<td>Plains portions transferred to Assam.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>The NEFT renamed as North East Frontier Agency (NEFA) under NEF Area (Administration) Regulation, 1954. Reconstitution of administrative units:</td>
</tr>
<tr>
<td></td>
<td><strong>Old Names</strong></td>
</tr>
<tr>
<td></td>
<td>Balipara Frontier Tract</td>
</tr>
<tr>
<td></td>
<td>(b) Subansiri Frontier Division</td>
</tr>
<tr>
<td></td>
<td>Tirap Frontier Tract</td>
</tr>
<tr>
<td></td>
<td>Abor Hills District</td>
</tr>
<tr>
<td></td>
<td>Mishmi Hills District</td>
</tr>
<tr>
<td></td>
<td>Naga Tribal Area</td>
</tr>
<tr>
<td></td>
<td><strong>1957</strong></td>
</tr>
<tr>
<td></td>
<td><strong>1965</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Old Name</strong></td>
</tr>
<tr>
<td></td>
<td>Kameng Frontier Division</td>
</tr>
<tr>
<td></td>
<td>Subansiri Frontier Division</td>
</tr>
<tr>
<td></td>
<td>Tirap Frontier Division</td>
</tr>
<tr>
<td></td>
<td>Siang Frontier Division</td>
</tr>
<tr>
<td></td>
<td>Lohit Frontier Division</td>
</tr>
<tr>
<td></td>
<td><strong>1972</strong></td>
</tr>
<tr>
<td></td>
<td><strong>1987</strong></td>
</tr>
</tbody>
</table>

The traditional livelihood subsistence activities depended on hunting, shifting agriculture, animal husbandry, barter and exchange trade. Trade relations extended to Tibet in the north and Assam in the south through numerous traditional trade routes and centres among the communities. A kind of slave trade was another source of sustenance livelihood activities and slaves were often brought from the plains also which led to conflicts with the respective governments of the Ahom and the British. Social divisions existed in some form defying uniform pattern across the communities. Because such division were not institutionalised except in few cases, the traditional society of Arunachal Pradesh was generally described in egalitarian terms. Religious beliefs deeply influenced the worldview of the people. Religious belief often determined the life style and idea of life, so it gradually became a part of customs and practices in the form of ritual, healing, omen, oath and ordeals. These rites and omen are used during construction of a house and embarking for hunting expedition. In this way, disease and ailments came to be explained only in terms of beliefs and rituals. It
was within these social, economic and political milieu that modern medicine system of treating disease introduced in Arunachal Pradesh. The introduction of modern medicine was therefore both a reflection of the change in the course of history as well as acceptance of new way of treating diseases among the tribes.

The reported incidence of epidemic and disease were as old as human civilization. Evidence of disease has been reported from around the end of the third millennia BCE. It is argued that malarial infection was detected in skeletons from the Indus Valley Civilization and that the dreaded leprosy was present at Balathal in Rajasthan as early as c. 2000 BCE. It is said that medicine has been practiced in India since proto-historical period. Even the architectural designs of Harappa are likened to a conscious concern for public health and sanitation. Thus, Indian medical tradition goes back to the time of the first river valley civilizations in the world in the third millennium BCE. The aetiology, name and curative responses to diseases differed from culture to culture. The same process happened in India and by later Vedic times the distinct Indian classical medical system evolved and has largely remained unchanged. This medical tradition was expanded over succeeding centuries and by the Gupta imperial period the Indian classical texts on medicine and surgery were compiled. Contacts with the West Asia from the beginning of second millennium AD enriched the medical tradition of India. The introduction of Galenic tradition by the Islamic medical men led to a

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hybrid Muslim-Hindu system known as *Tibb*.\(^5\) This shows that medical tradition in India is a composite one which is a product of synthesis of more than one traditions.

Across cultures, famines and scarcities were often reported which were accompanied by outbreak of epidemics. Smallpox which was considered a medieval disease in origin was for the first time recognized in China before AD 500, was reported to have ravaged France in AD 580, and entered medical literature in Sanskrit in the seventh century.\(^6\) In India also epidemics have been reported from several places. Ibn Batuta described a dreadful epidemic resembling plague or cholera that raged Madurai in c. 1345.\(^7\) Jahangir is reported to have given a careful description of the plague which spread from Punjab to Kashmir, Delhi and Agra from 1615 to 1619.\(^8\) That the disease attracted the attention of the Emperor reflects the gravity of danger posed by epidemics to general public health and safety of empire. During the colonial rule in India diseases like smallpox, cholera, plague, influenza, malaria and tuberculosis were commonly reported. The climatic conditions and diseases in India posed a challenge to the British conquest of India. During the eighteenth century diseases were sought to be explained through ‘miasmatic’ theories which was replaced by tropical medicine in the late nineteenth century.\(^9\) With the advancement of science, the germ theory of disease finally got established in the twentieth century. Cultural perception as well as technological advancement influenced the disease aetiology and the curative methods.

\(^5\) Deepak Kumar (ed.), *op. cit.*, p. xv.
\(^6\) Irfan Hibib, *op. cit.*, pp. 84-86.
\(^7\) Ibid., p. 87.
\(^8\) Ibid.
It is said that hospitals played a major role in the development of modern western biomedicine.\textsuperscript{10} The term hospital was derived from the Latin word *hospitalis* meaning ‘relating to a quest from hospitality’ and became increasingly common from c. 1130.\textsuperscript{11} It referred to a distinct and permanent structure for the overnight accommodation and relief of the poor and sick.\textsuperscript{12} The idea of a specific place for treating the sick first came up in non-western cultures. It has been reported from pre-Columbian central Mexico where some bathhouses served as reception centres for the sick. In the east the earliest hospitals were said to have the expressions of charity of the Buddhist rulers as in India, Sri Lanka, and Cambodia. The idea of hospital did not occur to the Babylonians or any other pre-classical Near Eastern civilization, to the Egyptians, or to the ancient Greeks.\textsuperscript{13} Thus, in the ancient world the idea of hospital was absent in the Western cultures. This gradually changed over the time. The Romans reportedly built hospitals called *valetudinaria* for their slaves and soldiers who mattered most to the functioning of the state and around the same time Christian hospitals came up somewhere by fourth century AD.\textsuperscript{14} The earliest hospitals in England received alms and became a public site for charitable lordship and thus it was quickly absorbed into the existing Anglo-Saxon framework of lordship, alms and

\begin{itemize}
\item \textsuperscript{13} Ibid.
\item \textsuperscript{14} Ibid., pp. 372-373.
\end{itemize}
customs. These social roots of the origin of hospitals got linked to the process of political expansion and war. It is argued that war gave a great stimulus to advancement of medical practice and the origin of modern public hygiene was traced to the departments of naval and military hygiene. Thus, the earliest hospitals were a product of religious piety and imperial expansionist measures. It is therefore not surprising that western biomedicine was introduced in non-western cultures including India during the post-Industrial Revolution era of colonization.

Chronologically, the Portuguese were the first to introduce western medicine in India. In 1510, Albuquerque founded the Royal Hospital in Goa which after being handed over to the Jesuits was converted into a medical school in 1842. But the French and later the British established and consolidated it in India widely and firmly. The motive behind these developments is explained by Anil Kumar in these lines:

*Concern for health has been an important feature of all historical processes, and more so in a process like colonization...Every naval dispatch from Europe had a surgeon on it, he not only looked after the sick on board and land, but was the first to report on the flora, fauna and resources of the new territory...Preservation of European health in new and ‘hostile’ lands was colonial medicine’s first responsibility. Gradually the colonial doctors developed into a cultural force...Their work encompassed not only the understanding and possible conquest of new diseases, but also the extension of Western cultural values to the non-Western world.*

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15 Sethina Watson, *op.cit.*, pp. 92-93.
17 Anil Kumar, *op.cit.*, p. 17.
18 N.H. Keshwani, ‘Medical Education in India Since Ancient Times’ as cited in Anil Kumar, *op.cit.*, p. 17.
19 Anil Kumar, *op.cit.*, pp. 11-12.
The earliest known regular hospitals in India, started by the British, came up in 1664 in Chennai, 1670 in Mumbai and 1707 in Kolkata. All these hospitals were established for the benefit of the sailors and the soldiers of the British East India Company. The earliest reference to establishment of any hospital meant for treating the sick native civilians was that of the General Native Hospital in 1792 in Kolkata. That is, the development of public health policy in India was a by-product of military health policy during the British period. This was reflected in the health policy pursued soon after the British conquered Bengal. A Hospital Board for the Bengal Presidency was created on May 23, 1786 for the direct control of the British East India Company’s military hospitals with the Physician General, the Chief Surgeon and the Head Surgeon as members of the board. In 1796, similar Boards were set up in Madras and Bombay Presidencies and their function now included both military and civil medical affairs. In 1858, these Boards were reorganized and a Director General of Medical Department was appointed for each of the Presidencies. The state’s involvement in improving access to western medical care for the indigenous population formally began with the decision in 1838 to provide government funding for a network of dispensaries. This shows that health policy closely followed the pace of political expansion of the British Raj in India. It was important that disease and famine did not pose threat to administration of their acquired territories and its subjects.

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20 Ibid., pp. 90, 92, 95.
23 Ibid.
24 Ibid.
Thus, sanitary measures were initiated under active administrative policies. The Royal Army Sanitary Commission was constituted in 1863 and thereafter three Sanitary Boards were appointed for the three Presidencies in 1864.\(^{26}\) As the pace of British administration began to expand after 1857, the health policies also expanded and simplified. In 1880, civil and military medical administration was separated and from 1896 medical services under the three Presidencies were centralized into Indian Medical Service (IMS); and from July 1914, the office of the Director General, Indian Medical Service came into being.\(^{27}\) The following table shows the development and growth of the Ministry of Health under the British India.

**Table 1.2: Evolution of the Ministry of Health, Government of India\(^ {28}\):**

<table>
<thead>
<tr>
<th>Year</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>1764</td>
<td>Public Department</td>
</tr>
<tr>
<td>1796</td>
<td>Medical service was separated into two branches- Military and Civil</td>
</tr>
<tr>
<td>1843</td>
<td>Home Department</td>
</tr>
<tr>
<td>1910</td>
<td>Education Department</td>
</tr>
<tr>
<td>1921</td>
<td>Education and Health Department</td>
</tr>
<tr>
<td>1923</td>
<td>Education, Health and Lands Department</td>
</tr>
<tr>
<td>1945</td>
<td>Education Department / Health Department / Agriculture Department</td>
</tr>
<tr>
<td>1947</td>
<td>Ministry of Health</td>
</tr>
</tbody>
</table>

The British medical organization constituted of three distinctive services namely the Covenanted, Un-covenanted and Subordinate Medical Services. The covenanted service, Indian Medical Service (IMS) was ranked below the Indian Civil Service (ICS) and army service; and was kept open for competition to Indians in 1855 but the latter were poorly represented in it.\(^ {29}\) In nineteenth century the IMS Officers, like civil servants, resorted to taking up contracts,

\(^{26}\) ICA, *op.cit.*, p. 123.
\(^{28}\) *Ibid*, p. 127.
\(^{29}\) Anil Kumar, *op.cit.*, p. 130-31.
zamindari, tea and indigo plantation, and other commercial ventures in order to acquire fortune.\textsuperscript{30} And for this reason most of them preferred a civil posting and refused to return to military duty when asked so. The government itself entrusted all sorts of works to the civil surgeons. The un-covenated medical service was part of a temporary arrangement of the government to meet specific needs during a war or famine and this service died by 1890.\textsuperscript{31} The apothecaries and Sub-Assistant Surgeons (SASs) were part of the third service the Subordinate Medical Department (SMD). They served both in military and civil branch and were mostly recruited from Eurasians, native Christians and Indian trainees for such assisting medical work as dresser, compounder and assistant surgeons.\textsuperscript{32} The Army Medical Department (AMD) was another elite medical service which functioned independently and superior to the Indian Medical Service (IMS). In 1898 it was renamed as Royal Army Medical Corps (RAMC) which was to look after the exclusive white regiments of the Indian army unlike the IMS, which looked after regiments which had both British and Europeans as well as Indian soldiers.\textsuperscript{33} Thus, the composition of medical service also reflected the larger colonial policy. Doctors were strictly recruited and employed to serve imperial interests. A recent work has summarized the British medical policy in India and its nature thus:

\begin{quote}
The development of medical care in India... took a peculiar trajectory which was shaped by its colonial context. The hospitals and dispensaries that were part of this network were considered ‘charitable’ institutions, to be maintained primarily from voluntary subscriptions; for the benefit of those sections of the population unable to pay for medical care- other were to be provided medical care by private practitioners ... The relationship
\end{quote}

\textsuperscript{30} Ibid., pp. 134-35.
\textsuperscript{31} Ibid., p. 145.
\textsuperscript{32} Ibid., p. 146-47.
\textsuperscript{33} Ibid., p. 138-39.
between health and governance thus involved the larger politics of colonial domination…The nineteenth-century initiative to establish dispensaries in India was borne of the reconfiguration of the relationship between state and medicine in post-Enlightenment Europe.34

These medical policies were extended in the Brahmaputra Valley also soon after the annexation of Lower Assam and consolidation of administration over the region. It would seem that thereafter doctors and dispensaries were gradually opened in the neighbouring foothills adjacent to the colonial administration controlled areas. A brief background of the circumstances and developments which took place in the North East India Assam is discussed elaborately in the following arguments.

One of the earliest records of the confrontation of disease in the North East India by the British is that of Captain Pemberton’s reference to diseases in Cachar.35 Another contemporary account described Assam as a place where a human footstep was unknown and the atmosphere even to the natives themselves pregnant with febrile miasma and death.36 Mortality caused by mere disease was therefore reported to be so high that it caused serious problems to the functioning of the colonial state.37 Another source blamed the natural obstacles and opium eating habit of the native for the spread of the cholera.38 As early as 1857, W.G. Young blamed opium as one of the greatest to the advancement and prosperity of

34 Samiksha Sehrawat, op.cit, pp. xx.
Assam.\textsuperscript{39} The alleged unhealthy environment of Assam lacked sanitation was soon linked to the miasmatic theory of disease. It was suggested that from the month of May to October no European was to go out of cantonments least they catch disease. While trying to comprehend and confront the challenge of disease in Brahmaputra Valley, M’ Cosh’s Report highlights native customs which appeared repugnant to European sense of sanitation. As he described in detail and criticized the practice of exposing the sick on the riverside (\textit{Murda Ghauts}).\textsuperscript{40} Similarly, sanitation, environment and native practice were constantly referred to in the reports of the colonial administrators. It was in this backdrop the famines were highlighted in the reports. In May-June 1834 an epidemic of Cholera spread to Dhaka, Jumalpur, Goalpara, Guwahati, and Bishwanath which reportedly took away a large portion of the population of Assam.\textsuperscript{41} So it is seen that sanitation and environment with epidemics was vital factor which influenced the choice of stations for many European officials. Locations considered more favourable from the point of disease and sanitation were chosen over others. For example, the \textit{Sudder Station} of the North Central Assam was shifted from Darrang in 1835 to Tezpur to escape disease.\textsuperscript{42} Once settled at a particular station, hospitals and dispensaries were soon established. As elsewhere in India, the position of the doctors in the Brahmaputra Valley was not given importance in official hierarchy.

The description of hospital at Guwahati throws light on this aspect:

\begin{quote}
\textit{Only one Assistant Surgeon, with the help of an Apothecary, and four or five Native Doctors, is allowed for the double duties of Gohatti. The Civil}
\end{quote}

\textsuperscript{39} Government of Bengal, File No. 277/604 of 1857-58, Memorandum by Mr. W.G. Young on certain matters to which his attention was attracted during his recent trips to Assam, 1-8, paragraph no. 13, Assam State Archives, Dispur (Hereafter ASA, Dispur).

\textsuperscript{40} John M’ Cosh, \textit{op.cit.}, pp. 111-13.

\textsuperscript{41} \textit{Ibid.}, p. 114.

\textsuperscript{42} \textit{Ibid.}, p. 93.
charge is of itself unusually heavy, yet he is called upon to perform the duties of the Sebundy Corps besides...The Medical Officer at Gohatti has always been placed in an anomalous footing as to pay and allowances...In no part of India is the inferiority of pay of the Medical Officer so much felt as in Assam.  

The establishment of hospitals and gradual development of colonial medical policy in the Brahmaputra Valley was intimately linked to tea industry. Soon after the signing of the Treaty of Yandaboo between the British and the Myanmar, tea gardens were started in Assam. The first such garden was opened in Sadiya in 1826 by the brother of Lt. Bruce of Royal Navy who was in charge of patrolling the Kundil river. Tea was a labour intensive industry requiring a huge number of manpower but the British found the native Assamese unwilling to work in their tea gardens and did not want to raise anger by forced conscription in a newly acquired province. It is reported that labour was very scarce in Assam in those days. As a result, manpower for growing tea garden was met by indentured labours from central India. What were the consequences of indentured labour in terms of colonial health policy? It is important that this issue is elaborated in some detail.

The British brought labourers by steamers via ports of Bengal to Assam. Waterways were the main means of communication the British used to penetrate into the region. The earliest measures to establish modern healthcare in the valley was borne out from the attempts to control disease and epidemics brought in by these migrants. In this regard, Lieutenant Colonel H. Vitch, the Officiating

43 Ibid., pp. 91-92.
45 Government of Bengal, File No. 277/604 of 1857-58, Memorandum by Mr. W.G. Young on certain matters to which his attention was attracted during his recent trips to Assam, 1-8, paragraph no. 13, ASA, Dispur.
Judicial Commissioner of Assam wrote to Henry Hopkinson, Commissioner of Assam dated June 1, 1861:

So very frequent re-appearance of Cholera in Assam in late years, has been disseminated by these importations of coolies infested with that disease...sanitary measures should be adopted to prevent the importation of coolies infested by this, or any other dangerous disease, not only in justice to the crews and passengers of these steam vessels, but as a protection to Assam against a disease which is carrying off the population by thousands as compared with the few hundreds of imported labourers brought to the country... to effect same system of inspection and sanitary requirements for coolies embarked to Assam as those shipped to colonies...⁴⁶

Hopkinson in return then wrote to the Secretary to the Government of British India’s Bengal and relayed the threat of disease brought by the coolies in Assam and urged for suitable steps to be taken immediately to control the menace. As a result, the Government of British India was obliged to issue necessary order. The notification to this effect was issued by the Judicial Department (Emigration) dated June 1, 1871 on Cholera which read:

With a view to prevent the spread of Cholera in the interior of tea districts by gangs of labourer imported...it is hereby notified...that whenever Cholera has appeared on board any vessel, or fleet of boats conveying labourers to the tea districts, whether in charge of gardens sirdars or not, the labourers destined for any place of debarkation instead of being landed at that place, when the steamer or boats arrive there, shall be landed under the orders of the Magistrate at some selected place at a reasonable distance from the station, and kept under observation for such time as the medical officer in charge of the station or debarkation depot may consider advisable. In furtherance of this object Cholera camps have been established at Seebsagar, Gowhatty, and Durrung in the Assam...⁴⁷

It would seem that the above elaborate measures were made to check diseases brought by imported workers. For instance in 1873, the outbreak of cholera and the resultant death of four workers out of 160 aboard a steamer named Panjab

⁴⁶ Government of Bengal, File No. 375 of 1861, ASA, Dispur.
⁴⁷ Government of Bengal, File No. 139/249 of 1869-72, ASA, Dispur.
which arrived at Goalpara created panic in the administration.\(^{48}\) It was desired to keep records of such disease outbreak by native doctors in Assam so that origin of the disease could be identified and appropriate measures taken.\(^{49}\) Thus, the disease and epidemics brought by the indentured workers and measures adopted to curb it suggests that controlling disease and epidemics formed an important aspect of colonial administrative measures in North East India. Towards this end a Sanitary Commissioner for Assam was appointed in 1868.\(^{50}\) Cholera camps were established for the observation of newly imported workers at Sibsagar, Guwahati and Dibrugarh.\(^{51}\) The earliest Charitable Dispensaries in Assam were started under these circumstances at Barpeta, Guwahati, Tezpur, Naogaon, Sibsagar, Dibrughar, North Lakhimpur, Samagoodting and Shillong.\(^{52}\) Hence, the colonial medical policy in the Brahmaputra Valley originated from the need to secure the health of tea garden employees along with other economic and strategic considerations.

It was only after the immediate medical needs of tea gardens and European Officers were met that medical facilities were gradually extended to civilians as a corollary to their needs.\(^{53}\) The Charitable Dispensaries were even not funded by the government at this period and only the pay of the serving doctors were partially met by the state. The position of the dispensaries were similar with what was practised in other parts of India. A relevant extract from a contemporary

\(^{48}\) CMO to Comber, *Government of Bengal Papers*-5, File No. 49/87 of 1873, ASA, Dispur.
\(^{49}\) Nicholson to Grant, *Government of Bengal Papers*-5, File No. 49/87 of 1873, ASA, Dispur.
\(^{50}\) Baylay to The Commissioner of Assam, *Government of Bengal*, Nos. 1-2, File No. 649 of 1868, ASA, Dispur.
\(^{51}\) *Government of Bengal*, File No. 139/249 of 1869-72, ASA, Dispur; and *Government of Bengal Papers*-2, File No. 136/246 of 1872, ASI, Dispur.
\(^{52}\) *Assam Secretariat*, Nos.1-36, File No. 56 of 1872-74, ASA, Dispur.
official correspondence outlined the role and intent of the government with regard to dispensaries:

_The support originally given by the Government to Charitable Dispensaries consisted of a monthly payment equal to the amount realised from local subscriptions. In the year 1854 this system was changed. Money payment was done away with; but whenever the residents of a station made over a building for an Hospital or Dispensary, and guaranteed an average monthly income, Government undertook to appoint a Sub-Assistant Surgeon or a Native Doctor, according as the monthly sum subscribed should equal the pay of one or the other of those grades. The salary of the Medical Officer, with free medicines from the Government stores, was thus to represent the measure of Government support; and no pecuniary allowance of any kind or on any account was to be given. All applications made to the Government since 1864, on behalf of Charitable Dispensaries, have been dealt with in the spirit of these orders._

The support of the government was strictly limited to providing the salary of the medical officer and medicines at government stores. It is observed that modern healthcare system in the Brahmaputra Valley evolved out of such reluctant beginnings. Expansion of medical department followed the administrative expansion in the region after it was separated from Bengal. In 1903, the Medical Department in Assam was divided into two branches; the Inspector-General of Civil Hospitals (IGCH) headed the department while the Sanitary Commissioner dealt with all questions of purely sanitary character. The process of expansion of hospitals and health centres were determined not by population but by strategic and economic importance. This is evident from a comparison of population of some important towns and types of hospitals opened.

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54 Geoghegan to Commissioner of Assam, Letter No. 904, Government of Bengal, Nos. 1-7, File No. 494 of 1864, ASA, Dispur.
Table 1.3: Towns, Population and Medical Facilities in Assam, 1901

<table>
<thead>
<tr>
<th>Towns</th>
<th>Population (as per 1901 census)</th>
<th>Hospitals in the respective town and its capacity in terms of number of beds</th>
<th>Dispensaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sylhet</td>
<td>13,891</td>
<td>A leper asylum</td>
<td>There were 135 dispensaries, out of which 35 had accommodations for in-patients. These were mainly opened at the head-quarters of each District and subdivision, and were being increasingly opened in rural areas.</td>
</tr>
<tr>
<td>Gauhati</td>
<td>11,661</td>
<td>98 beds</td>
<td></td>
</tr>
<tr>
<td>Dibrugarh</td>
<td>11,227</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silchar</td>
<td>9,256</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barpeta</td>
<td>8,747</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shillong</td>
<td>8,334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dhubri</td>
<td>NA</td>
<td>37 beds</td>
<td></td>
</tr>
<tr>
<td>Tezpur</td>
<td>NA</td>
<td>40 beds plus a lunatic asylum</td>
<td></td>
</tr>
<tr>
<td>Nowgong</td>
<td>NA</td>
<td>38 beds</td>
<td></td>
</tr>
</tbody>
</table>

From the above table it may be inferred that largest hospitals were set up not on the basis of population but on the strategic and economic important towns. Dibrugarh and Tezpur towns were important both from strategic and economic point as well as centres of tea cultivation and oil production districts of Lakhipur and Darrang. These two towns also served as important military and political stations to control the neighbouring tribes of the frontiers. Similarly, Nowgong was an important centre connected to Upper and Lower Assam and Dhubri to Bengal. There was no big hospital in larger and more populous towns like Sylhet, Gauhati and Silchar.

The introduction of western biomedicine in the region resulted into some amount of conflict with native medicine. In the traditional society of the Brahmaputra Valley small pox was widely identified with the Hindu Goddess *Sitala* whose awesome presence was manifested through the disease fever and eruption. A benign outcome to possession by the goddess was sought through

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56 Ibid., pp. 42, 119-120.
songs, prayers, devotional offerings and cooling potions.\textsuperscript{57} It was sought to be cured through the process of variolation, a practice banned by vaccination act of the 1870s and 1880s while making vaccination compulsory.\textsuperscript{58} The belief that Sitala was being defiled or assaulted contributed to native distrust of vaccination and thus formed an important site of cultural resistance to colonial medical intervention.\textsuperscript{59} Thus there were instances of resistance to western medicine in the Valley. It was not an easy affair for the British to introduce new system of medicine to people of the Brahmaputra Valley who were deeply rooted to their indigenous system of cure and healing.

\textbf{Statement of the Problems}

The various hill communities of North East India had a long history of contact and conflict with the Ahom monarch who ruled the Brahmaputra Valley for about 600 years before the British took over the region. The latter inherited the administrative and political legacy of this relations which was natural that the British could not avoid making fresh attempts to tune the relations to their advantage. The erstwhile North East Frontier and present day Arunachal Pradesh was a part of this larger colonial concern. The safety of the subjects and tea garden during the British period was constantly jeopardised by unpleasant visits from the neighbouring hills of present day Nagaland and Arunachal Pradesh. This was one of the reasons which determined the course of British policy in North East India and its first expression was made when the Inner Line Regulation was brought in to protect the commercial interest of the \textit{Raj}. But the engagement of the


\textsuperscript{58} Tahir Hussain Ansari, \textit{op.cit.}, p. 93.

\textsuperscript{59} \textit{Ibid.}, p. 93.
colonial powers with the tribes did not end with this and with the advancement of time they pursued policies relevant to the colonial administrative requirements need till 1947 affecting the lives of the frontier hillmen in varying degrees. The study of the colonial interventions in Arunachal Pradesh has been studied by many researchers but no in-depth study is conducted on the possible medical policy beyond the limits of polity, economy and commerce so far.

Verrier Elwin had classified the various communities of Arunachal Pradesh into three broad artistic and cultural ‘provinces’.\textsuperscript{60} The first is, to conveniently paraphrase him, the Buddhist group: the Monpa, the Sherdukpen, the Memba and the Khamba who live in the north near Tibet from Mechuka through Tuting, Mankhota and Gelling to Wallong in the Lohit. Despite artistic and geographical barrier, Elwin also puts the Khampti and the Singpho who follow the Hinayana Buddhism in this group on the basis of religion. The second group extends rather in a convenient west- east or east-west direction, from Seppa in Kameng in the west through Subansiri, Siang and Lohit in the east on the basis of tradition of weaving, absence of wood-carving, and stress on fine work in cane and bamboo. Finally, the Nocte many of who are \textit{Vaishnavite} by faith along with the Wancho and the Tangsa form the third group on the basis of Myanmarese influence. Thirty five years after Elwin’s classification, the Anthropological Survey of India (ASI) offered two sets of cultural zones: the hills and the plains on the basis of geography and five zones on the basis of concentration of tribal groups.\textsuperscript{61}

\footnotesize
\begin{itemize}
\item \textsuperscript{60} Verrier Elwin, \textit{The Art of the North-East Frontier of India}, published by T.P. Khaud on behalf of NEFA, Shillong 1959, Reprint 2009, Itanagar, pp. 16-17.
\end{itemize}
Stray references in colonial reports and tour diaries of erstwhile officials do not make our understanding richer except than to refer to medicinal plants like the use of *Mishmi teeta* (*coptis teeta*) which was cultivated locally and sold even in Tibet. Recent ethnographic researches on different aspects of community lives of Arunachal Pradesh do not provide comprehensive analysis of indigenous traditional healing systems encompassing all the communities of the study area. Similar is the case with the study of traditional herbal medicine which is mostly studied from an ethno-botanical point of view but the herbal experts as an exclusive category of healers have not been studied in detail.

As mentioned in the foregoing discussion the diseases were not unknown in the hills of Arunachal. It was an integral part of socio-religious and economic life which shaped the peoples’ worldview in many ways. In the past ailments and diseases were not perceived as an individual misfortune. Curative and healing methods, therefore took recourse to religion and rituals. Whether medicine formed a part of the attempts by the British to establish friendly relations with the tribes. Extant literature on the history of health care suggests that rudimentary efforts were made by the British in starting modern healthcare facilities in the foothills. But there is no elaboration on the objectives behind the establishment of these earliest dispensaries and the nature of health care expansion during the

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period of colonial intervention till 1947. Meanwhile, most of these earlier research works hardly treated some of the important aspects and question on the modern health care system from historical perspectives. As such, how was health care expansion in the post-Independence period different with the preceding phase in terms of objectives and pace of expansion. What policy the government pursued after the Independence period when administrative expansion was carried out in Arunachal Pradesh? How was the indigenous traditional healing system affected by the introduction of new modern health care system in the traditional societies? These issues formed a part of the existing lacunae in the health care history of Arunachal Pradesh. Thus a sincere attempt has been made here to fill this gap of historical knowledge on the whole gamut of medical history of Arunachal Pradesh from 1826 to 1987.

Objectives of the Study

This study aimed to reconstruct the history of the introduction, establishment and expansion of western biomedicine in Arunachal Pradesh from 1826-1987. This is the main objective of the study. It is attempted to generate a line of argument on the importance of healthcare as an instrument of diplomacy in establishing friendly relations with the people of Arunachal by respective governments both the colonial administration in the Brahmaputra Valley till 1947 as well as the Government of Independent India thereafter.

1. To understand the colonial health policy in India and Brahmaputra Valley.

2. To reconstruct the history of healthcare administration in the foothills of Arunachal Pradesh during the period of colonial intervention and to show the employment of medicine in furtherance of colonial policy in the hills.
3. To generate a profile of indigenous traditional healing system of the study area based on extant ethnographic works and field study.

4. To map the Post-Independence establishment and expansion of medical department in Arunachal Pradesh till 1987.

5. To generate the health care policies adopted by both the British administration and new administration after 1947. And to understand the factors and agencies that affect patterns of change in traditional medicine.

6. To present a new domain of knowledge in historical research in Arunachal Pradesh by underscoring the existence of a colonial medical policy and how it became the basis of the policy of Government of Independent India in the integration of the people of Arunachal Pradesh.

**Review of Literature**

There are many published and unpublished works on the political, administrative and socio-cultural history of the North East India, British-tribal relations, colonial policy in the regions but works on medical policy and healthcare administration are scanty. A review of extant works on the region in this context is given in the succeeding arguments but before that a brief review of works on medicine and healthcare administration in India is discussed below.

Tracing the role of science and technology in the colonial expansion became a major area of research since 1980s. Many research works are brought out relating to colonial medical policy and health in the Indian subcontinent and elsewhere. As such D. R. Headrick’s study on, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (1981) was one of the earliest such works. Headrick showed how penetration of Africa would not have been possible
without conquering disease. Phillip D. Curtin’s *Death by Migration: Europe’s Encounter with the Tropical World in the Nineteenth Century* (1989) also provides similar insight. The work is rich in statistical data on mortality and related health aspects on Madras and other British colonies beginning from late eighteenth to early twentieth century. It also provides valuable information on challenges faced by the British in tropical India in terms of epidemics and diseases. Hygiene also formed an important part of Curtin’s study in this work.

A wider perspective is found in David Arnold’s edited book, *Imperial Medicine and Indigenous Societies* (1988). Apart from Arnold’s introductory note on disease, medicine and empire, it contained European medical practice and related policies in India, New Zealand (Maoris), Belgian Congo, Phillipines, and Southern Rhodesia. This work also discussed diverse aspects like insanity, small pox, medicine and racial politics, sleeping sickness, cholera, plague, influenza and malnutrition. Arnold brought out another work titled *Colonizing the Body: State, Medicine and Epidemic Diseases in Nineteenth Century India* (1993). This work speaks about the mixture of dissent and desire, the hateful and the hegemonic in what is apparently a ‘paradoxical Indian response to western medicine’.

The change from Indian resistance of western medicine to its adoption by the emerging political elite is another theme investigated the book. This suggests that despite colonial medical policies which were not motivated by altruistic feelings for the Indians, western healthcare system was gradually accepted by the educated class. The western healthcare system was part of colonial re-ordering of Indian society.

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and its values, and so its acceptance by the middle class reflected the changing nature of indigenous outlook on western institutions and values.

Charles Leslie’s edited volume, Asian Medical Systems: A Comparative Study (1976) provides insight into the relationship between modern and traditional medicine. Leslie argues in his introduction that Asian medical systems provide fascinating opportunities both to directly observe practices that continue ancient scientific modes of thought and to analyze the historical processes that mediate their relationship to modern science and technology. The book also highlights the inadequacies of terms like ‘modern medicine’, ‘scientific medicine’, ‘Western medicine,’ etc.65 Taylor, while speaking in the context of Ayurveda, predicts that indigenous medical practice will slowly fade into a synthesis with scientific medicine.66 Roy Mac Leod and Lewis Milton’s edited work Disease, Medicine and Empire: Perspectives of Western Medicine and the Experience of European Expansion (1988) is a critical account of colonial medical policies in Africa, Asia and Australia. It is another important work which provides information on the connection between medicine and colonial expansion.

In the context of India, one of the earliest study was that of Radhika Ramasubban’s Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy, SAREC Report (1982).67 Poonam Bala’s Imperialism and Medicine in Bengal: A Socio-Historical Perspective (1991) as a description of the professionalization of imperial medicine throws light on medical history and its social dimension. The work analyzes the interaction between practitioners of

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67 Quoted in Biswamoy Pati and Mark Harrison (eds.), op.cit., p. 3.
indigenous drug and imperial policies and perspectives. Deepak Kumar’s *Science and the Raj 1857-1905* (1995) explores the development of science under the colonial situation, its social implications and its economic ramification. Kumar argues about the military roots of medical service and how medical education in Victorian India was shaped by imperial prerogatives. Anil Kumar’s *Medicine and the Raj: British Medical Policy in India, 1835-1911* (1998) unravels the whole gamut of policies and ideological nuances related to medicine, outlining in one volume the growth of medical education, hospitals, pharmacies, medical service, disease and medical research. With a similar perspectives, Biswamoy Pati and Mark Harrison’s edited book *Health, Medicine and Empire: Perspectives on Colonial India* (2001) addresses specific issues of varying themes. The editors in their introduction speak about how social historians treat epidemics as windows through which to view colonial society. The publication of the proceedings of the 61st *Session of the Indian History Congress, 2001* consisting of different themes on medical and social history may be considered an updated and expanded work in similar line. Edited by Deepak Kumar and titled *Disease and Medicine in India: A Historical Overview* (2001) the volume covers a variety of essays and articles on medical traditions of pre-modern India and issues during modern India. Though there are no chapters on North East India, this volume is an important reading on the subject.

An edited volume by Chittabrata Palit and Achintya Dutta entitled *History of Medicine in India: the Medical Encounter* (2011) deals with the medical encounter between eastern and western medicine. The work is an attempt to counter the ‘western views’ of historians like Phillip Curtin, David Arnold, Ralph Nicholas,

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Roy McLeod, Mark Harrison and others. Western medicine extensively borrowed indigenous medical knowledge and the dominance of western medicine was enshrined through the institutions of the colonial state.⁶⁹ While critiquing the British medical policy in India the authors make a significant remark; ‘India was not the White-man’s grave; rather she became the graveyard of Indians under British rule’.⁷⁰ Lancy Lobo’s recently published book Malaria in the Social Context: A Study of Western India (2010) examines traditional knowledge system in conjunction with biomedical elements to promote effective health education in western India. Babul Roy’s work Medical Anthropology: Studies in the Highlands of Assam (2012) studies the cultural determinants of disease, sickness and illness amongst the Dimasa Kachari and Zeme Naga of Assam. Roy also studies the traditional pharmacopoeia and the role and function of traditional medical practitioners. In this study, the author argues the prevalence of medical pluralism in healing and treatment intervention.

The works cited in the preceding paragraphs outlines the broad spectrum of colonial medical policy and other related histories of medicine in India and elsewhere. The study area though not part of the colony was nevertheless not outside the purview of the larger colonial influence. Medicine as another arm of colonial intervention emerged when colonial and imperial exigencies required a closer engagement with the tribes of Arunachal Pradesh. This is indicated by colonial records spanning over more than a century from the first half of nineteenth to mid-twentieth century.

⁶⁹ Chittabrata Palit and Achintya Dutta, eds., History of Medicine in India: the Medical Encounter, Kalpaz Publications, Delhi, 2011, p. 15.
⁷⁰ Ibid., p. 17.
Edward Gait’s *A History of Assam* which was first published 1905 and considered the first work on the history of the region covers the period from the prehistoric rulers to consolidation of the British rule in Assam. His book briefly dealt with the tribes of Arunachal Pradesh and their relations with the British Government.\(^{71}\) It also covered the administrative development in Assam; formation of military battalions; formation of the erstwhile Sadiya and Balipara Frontier Tracts; improvement in communication, coming of railways; and the effects of earthquake of 1897.\(^{72}\) Gait’s book was later on followed by many professional historians who focussed on the political and administrative history of the region. S. K. Bhuyan’s *Anglo-Assamese Relations, 1771-1826* (1949) made a detail study of the British relations with the Ahom monarchs in the early phase of colonial penetration in North East India. The book also studied administrative beginning in Assam under which revenue, judicial, police, agriculture and education have been discussed.\(^{73}\) According to Bhuyan, medical missions were started in the Garo Hills at the behest of David Scott.\(^{74}\) There is no further study of medical missions or growth of medical administration in this work because the period of the book is limited to early stage of colonial administration in Brahmaputra Valley.

H.K. Barpujari published three volumes on the hill tribes of North East and their relations with the British. Titled *Problem of Hill Tribes: North East Frontier*, the three volumes covers the periods 1822-42 (1970), 1843-1872 (1976) and 1873-1962

(1981) and studies the British policy with the hill tribes surrounding the Assam Valley based on primary records. The third volume focuses on the British policy in Arunachal Pradesh in the context of international politics vis-a-vis Russia, Tibet and China. The importance of medical aid in the British policies in Arunachal Pradesh during 1940s is briefly described.\textsuperscript{75} There is no extensive study on the theme in this work. Barpujari also came out with another book, \textit{American Missionaries and North East India, 1836-1900: A Documentary Study} (1986) which updated the history of American Baptist Mission in North East India. The book incorporated in its study other works on the topic by William Gammell, E.W. Brown, E.F. Merriam, H. Bronson Gunn, V.H. Sword and Frederick S. Downs provided an updated study on the basis of primary records of the American Baptist Mission Society, New York.\textsuperscript{76} It dwells on the growth of Baptist Mission in North East India, its contribution to language and literature, spread of Baptist Mission among the Naga, Garo, Mikir (Karbi), Miri (Mishing), Singhpho and the Adi. Reverend Miles Bronson attempted to work among the Singhpho and Namsang Nocte of Arunachal Pradesh in late 1830s and 1840s but had to shift to Nowgong due to illness from where he went to the Garo Hills.\textsuperscript{77} Similar accounts of other missionaries and their attempts to spread the gospel among the Singhpho, the Adi and the Mishing are presented in this book but there is no specific mention of medical mission in Arunachal Pradesh. Other works on Christianity in North East India like Milton S. Sangma’s \textit{History of American Baptist Mission in North East India} (1996) and T.B. Subba \textit{et. al.}, eds., \textit{Christianity and


\textsuperscript{77} \textit{Ibid.}, p. 313.
*Change in North East India* (2009) throws light on different aspects of coming of Christianity in North East India but these works do not directly address Arunachal Pradesh. This was because the early efforts at evangelising the Arunachal tribes was not successful and thereafter from the closing decades of nineteenth century onwards the area was kept outside the reach of plains people and missionaries alike.

So far, the available official records indicate that efforts towards starting actual health care facilities started right after the expeditions that were carried out during the colonial period in the beginning of second decade of twentieth century namely; the Adi Expedition, the Mishmi Mission, the Nyishi Mission and the Aka Promenade. The conduct and results of some of these expeditions which were executed simultaneously have been dealt by Agnus Hamilton in *In Abor Jungles of North East India* (2003).  

Neither Hamilton’s account nor the report on the Adi Expedition contain information on diseases. The Mishmi Expedition report however dwells at length on diseases and medical component of the mission. This was probably because the Adi Expedition was a punitive one while the other two to its east and west were political missions. Kerwood’s Miri (Nyishi) Mission Report does not give any information on the medical aspect of the mission or diseases; so was the case with the survey report of the mission by

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80 Agnus Hamilton, *op. cit.*, pp. 331-42.
Lewis. This was probably due to command and logistics flaws that the mission suffered from as the entire mission was attended to by only one native hospital assistant. Thus, the records relating to the above missions provides the earliest evidence of diseases scientifically documented in Arunachal Pradesh and informed the background of introduction of healthcare facilities in the foothills and military outposts.

Many accounts of the colonial period on tribes of Arunachal Pradesh have been compiled and introduced by Verrier Elwin in the form of a book, India’s North East Frontier in the Nineteenth Century (1959). The volume consists of some accounts available only in archives and journals which are no longer in print or whose contents are difficult to access. The book also reproduced the relevant quotes from other available memoirs and reports like Robinson’s Descriptive Account of Assam (1841); John Butler’s A Sketch of Assam: With Some Accounts of the Hills tribes (1847), and Travels and Adventures in the Province of Assam (1855); Dalton’s work on Descriptive Ethnology of Bengal (1872); and Alexander Mackenzie’s The North East Frontier of India (1884). Edward Tuite Dalton’s, Descriptive Ethnology of Bengal was a product of a proposed Ethnological Congress in Calcutta under the aegis of Asiatic Society of Bengal contains the first detail ethnographic information on the tribes of Arunachal Pradesh. Alexander Mackenzie’s memorandum was originally entitled ‘History of the Relations of the Government with the Hill Tribes of the North-East Frontier of Bengal’ (1884), now republished under the above name with a prefatory introduction to the new edition by B.K. Roy Burman. Both Dalton’s and Mackenzie’s reports provide

82 Agnus Hamilton, op.cit., pp. 332-35.
ethnographic and relations with the tribes of Arunachal Pradesh. But being products of colonial ethnography of an early phase, they do not provide sufficient information on ethno-medical practice of the people of the state.

Apart from these, monographs and accounts of the colonial explorers, administrators and anthropological works of twentieth century help in understanding the tribes histories, religion and social institutions. Mention may be made of Dunbar’s *Abors and Galong: Notes on the Hill Tribes of the Indo- Tibetan Border* (1915) which provides valuable information on the Adi and the Galo of the state. Dunbar studied many other Arunachal tribes later in an expanded work entitled, *Other Men’s Live: A Study of Primitive Peoples* (1938). Dunbar’s account throws light on tribal habits, custom, religion and eschatology a trend later on followed by Haimendorf, Stonor and Elwin. Meanwhile Shakespeare’s *History of Assam Rifles* (1929) is an important account which deals with the history of the Assam Rifles, the military force solely created to defend the British imperial frontier in the North East India. The book provides a background to the opening of military outposts and hence helps understand development of healthcare facilities in the region as medical facilities in frontier areas at this stage were closely tied to military expeditions and outposts. Robert Reid’s *History of the Frontier Areas Bordering on Assam, from 1883 to 1941* (1942) provides continuity to the history of the region and the study area where Mackenzie’s account had left in 1884. The work provides information on the political background and general policy adopted by the British in the Brahmaputra Valley and on frontier tribes.

Most of these works are anthropological and sociological in nature in their tools and techniques while attempting to treat the tribes history, culture and
social institutions. The earliest effort in this direction was made by the Austrian anthropologist, Christoph von Furer-Haimendorf who had in 1931 received his Ph.D. Degree from University of Vienna on the social organization of the Nagas\textsuperscript{83} and was deputed to undivided Subansiri District as Special Officer in 1944. Haimendorf later on published a number of monographs and books notable among them being *Ethnographic Notes on the Tribes of the Subansiri Region* (1947), *Himalayan Adventure: Early Travels in North East India*, first published in 1955 as *Himalayan Barbary, The Apatanis and Their Neighbours* (1962), *A Himalayan Tribe: From Cattle to Cash* (1980) and *Highlanders of Arunachal Pradesh* (1982). Haimendorf also published a short monograph on the beliefs, rituals and religion of the Adi.\textsuperscript{84} Charles R. Stonor who was a NEFA Agriculture Officer comes next to Haimendorf. His short monograph on the Nyishi rituals and religion\textsuperscript{85} is an important work on ritual symbology and ethno-aetiology. Ursula Bower’s (wife of Political Officer of Subansiri Region after Haimendorf’s departure, Major F.N. Betts) account of the tribes in the region, *The Hidden Land: Mission to a Far Corner of India* (1953) is a memoir which describes the geography, people, customs and early administrative initiatives in the undivided Subansiri District. The works of Elwin are much known however, it may be mentioned here that his works on Arunachal Pradesh are on general themes like philosophy for administration, art,


myth and tribal polity based on compilation and collected information without any empirical field study.

The publication of monographs by various anthropologists of the erstwhile NEFA Research Department from 1960s onwards throws light on the lives and cultures of many communities. The ethnographical works largely focussed on festivals, religions, musics and languages. No specific monograph on ethnomedicine is available and therefore these works have been consulted with great degree of caution and sparingly used in this work. Although these earlier research studies were done by the administrator turned anthropologists and ethnographers on the people of this Himalayan state basically to gather information on ethnographic aspects and social organisations. These trends were largely followed later on even by the Department of Research, Government of Arunachal Pradesh. Hence, there is no in-depth study done on the history of healthcare system on the tribes of the state so far.

Study of traditional health care practices, priests, herbalist, beliefs relating to illness, etc., have been studied by ethnographers like E.E. Evans-Pritchard in Witchcraft, Oracles and Magic among the Azande (1937), W.H.R. Rivers in Medicine, Magic and Religion (1927; Reprint 2001), Melford E. Spiro, Burmese Supernaturalism (1942). These classical works were followed by more research in subsequent decades, particularly after the Second World War, from anthropological point of view. Within India, works like those of Jose K Buban’s Tribal Ethno-medicine: Continuity and Change (1998) is a sincere attempt to understand and appreciate the folk medicine with some details. It is a study of ethnomedicine of Muthuvan and Mannan tribes of Iduku District of Kerala. J. N. Gosh’s article titled ‘Health
Measures in NEFA’ in the book *The Adivasis* (1960) published by the Publications Divisions, Government of India, New Delhi could not be located. Ghosh was a former Director of Health Service, NEFA and his records relating to healthcare administration and policies have been adequately used in this study from archival records. Apart from the above, available published and unpublished research dissertations and theses provides fresh data on some aspects of ethno-medical practice of the study area. However, most of these studies are descriptive in nature with inadequate treatment to the indigenous health care and healing system.

**Research Methodology**

The present research work studied the growth of healthcare system in Arunachal Pradesh through the colonial intervention of modern medical facilities. The focus area of study is concentrated on colonial and post-colonial period whereby the British Empire completely annexed the territory of the Brahmaputra Valley. In order to prepare a systematic analysis and interpretation of the subject matter both the primary and secondary sources were used for the construction of this work. Under the primary sources, the archival records, memoirs, tour diaries, proceedings, and available accounts are consulted during the preparation of the thesis. Further, the collected imperial data from the primary sources are used for analysing the research theme on healthcare history of Arunachal Pradesh to provide both descriptive and critical analysis of the work. This is done by way of corroborating the facts and figures in numerous tables, maps and plates derived from more than one source.
The available published literature have been used for the study of this work. This is because the theme of the study is new. Secondary sources consulted are anthropological and ethno-historical works on the tribes of the study area. Literature concerning healthcare history and colonial medical policy have been minimally used through selective reading of few standard works, articles and book reviews. Where a particular work has not been consulted, it is not being mentioned except when referring to another work in which it is quoted or its review from another source. Records from Government of Bengal (pre-1874) and Chief Commissioner’s Office, Assam (1874 onwards), available with the Assam State Archives, Guwahati provides information on the colonial health policy in Assam during nineteenth century. For twentieth century the records of Foreign Department, Government of India are helpful especially for the turning phase the first five years after Noel Williamson’s murder (1911-15). The official records of the British India Government which included files from Sanitation, Education, Health and Army fill the gap up to 1937 from whence the Governor’s Secretariat separately handled affairs of the then North East Frontier Tract which was elevated as Adviser’s Office in 1943. The Tour Diaries, Annual Administrative Reports, Secret Reports and such other miscellaneous records help jot the dotted lines about disease, epidemics, raids, dispensaries and hospitals, and official policy towards medicine.

Government reports, census and statistical data of the second half of the twentieth century have been used to substantiate the findings of this study. The report by the National Council of Applied Economic Research (NCAER), Techno Economic Survey of NEFA, 1967 provides additional information on the state of
healthcare in Arunachal Pradesh before 1970s. An officially corrected manuscript dated 1965 available with the Research Department Library, Government of Arunachal Pradesh, Itanagar have been consulted while analysing the present work. Major statistical data relevant to this study were collected from the government records, census data and statistical handbooks available in the archives and libraries in the state.

For information on ethno-medicinal for the work a field study was conducted to collect empirical data from the ‘traditions bearers’ which are preserved in the form of oral traditions and folk medicine knowledge. The structured and unstructured scheduled interview was conducted to gather the data on indigenous traditional healing system maintained among the native population of the state. Some contemporary ideas of nyubh (priests) healing rites from other areas similar to those recorded by earlier ethnographers are corroborated to show the continued relevance of ritual healing practice in Arunachal Pradesh although no attempt is made to study the ritual symbolism of the nyubh (priest) or document healing ritual. The present researcher made a sincere attempt by way of a brief survey of the various ethno-medicinal practices of the study area on the available published works and synthesizing them together in a pragmatic approach to construct the ethnomedicine study proper from historical perspectives.

From a historiographical point of view, it is difficult to place the history of the various ethnic groups under the periodisation of either pre-colonial or post-colonial scheme. Therefore these terms are sparingly used in this study. Terms
and concepts like modern, modernisation, animism, etc., are similarly used in a very general sense to suit the subject matter objectively.

**Area and Period of Study**

The area of study covers the whole state of Arunachal Pradesh. In historical context, there is uniformity of administrative expansion and hence it is justified to make a composite study on the theme. The methods and techniques of indigenous traditional healing systems practiced among the native people showed a considerable degree of homogeneity with some variations in rites and executions. Physical distances among the people are caused due to natural geographical, topographical, linguistics and religious factors.

Located in the extreme north-eastern corner of India, Arunachal Pradesh shares international boundary with Bhutan in the west, China in the north and Myanmar in the east. It also shares boundary with the state of Assam in the south and Nagaland in the south-east. Arunachal is a land of climatic extremities and cultural diversity. It is the largest state in North East India with least density of population. Elevations range from 50m in the foot-hills to up to about 7000m in the snow-clad high mountains and rainfall varies from 1000mm in higher reaches to 5750mm in the foot-hill areas.86 The hills overlooking the Brahmaputra Valley gradually tapers off to the plains of Brahmaputra. Much of the plains portion of the erstwhile NEFA was transferred to Assam in 1951. The mountain ranges run in north-south direction restricting movement within the region but at the same time facilitating passages from north to south. Such numerous passes were the routes of traditional commerce which were linked to the duars and fairs in the foothills.

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The northern areas of higher altitude with alpine vegetation experience extreme cold while the rest of the state is a mix of mountain wet temperate and tropical evergreen vegetation with extreme climatic conditions. Five big rivers namely Kameng, Subansiri, Siang, Dibang and Lohit drain the state and flows into the Brahmaputra. The richness of life forms i.e., the flora and fauna presents a panorama of biological diversity with over 5000 plants, about 85 terrestrial mammals, over 500 birds and a large number of butterflies, insects and reptiles. Such an unparalleled occurrence of life form is because of the peculiar location of the state which is at the junction of the Palaearctic, Indo-Chinese and Indo-Malayan bio-geographic regions. The rich biodiversity of the state is matched by linguistic and cultural diversity as well. The Anthropological Survey of India classified the state into two cultural zones constituted by the hills and plains and five cultural zones on the basis of concentration of major tribal groups. There are thirty communities and 115 sub-groups in the state as reported by Anthropological Survey of India but this fact requires further authentication and need empirical data. Indigenous languages spoken in the state belong to Tibeto-Chinese family under which the Khampti-Shan belongs to Siamese-Chinese sub-family and the rest belong to the Tibeto-Burman sub-family making a total of more than 42 languages. According to the Census 2011, the population of the state was 13.84 lakhs of which 22.94% live in urban areas and Christianity was the most popular religion (30.24%) followed by Hinduism (29.04%), Indigenous

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87 Ibid.  
88 Ibid.  
90 Ibid., p. xii.  
91 Ibid., p. vx.
religion (26.24%), Buddhist (11.77%), Muslim (1.95%), Sikhism (0.24 %) and Jainism (0.06 %). This brief background of the geographical, climatic, cultural and demographic background of the state highlights the rich diversity of the study area in both physical and cultural terms which reflect some rapid changes in the state.

The period of the present research work covers from 1826 to 1987 as a marker to the objective study of the theme. The first date is the end of the First Myanmarese War and the latter the year of attaining full-fledged statehood within the Union of India. Between these two dates, the study area experienced two governments exercising influences with varying degrees on the communities of the state; the British administration from neighbouring plains of Brahmaputra Valley up to 1947 and the post- Independence India administration, 1947-1987. The period, 1987 is significant as Arunachal Pradesh attained a full-fledged statehood and became the 24th States of the Union of India and thus paved the way for end of direct role from the Central Government.

Chapterisation

This research work is an ethno-healthcare history vis-a-vis colonial intervention in the indigenous traditional healing and curing system of practice by the natives. In line with the objectives of the study the work is outlined in six chapters. A sincere attempt is made to maintain a broad thematic unity of each chapters vigorously with the objective interpretation and analyses on the subject matter.

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The first chapter starts with a brief historiography of disease, epidemics and modern healthcare facilities under the British India regime. Then it outlines the statement of the problems, scope and methodology of the research work. The broad elements of the history and culture of the people form part of the chapter. The political evolution of the study area is dealt in this chapter with the corroboration of data in tabular form. A brief review of relevant published and unpublished works are critically reviewed to treat the subject matter with scientific rigour.

Chapter two discusses about the study of disease and the origin of healthcare as an offshoot of colonial policy to establish friendly relations with the people of Arunachal Pradesh. Starting from the punitive and exploratory missions carried out in the second decade of twentieth century. This chapter also analyses the growth of dispensaries and colonial policy in using medicine in Arunachal Pradesh.

The third chapter deals with indigenous healing system. Then it offers a summary of the typologies of healing traditions in the study area. It is backed by a field-work on a Monpa bone-setter and herbal expert with a brief note on the state of herbal healing. A sub-section is dedicated to disease-carrying raids which is the first elaborated study of the same.

Developments that started as a result of the Second World War and influenced policies related to healthcare facilities are elaborately discussed in the chapter four. The Post-War plan for medical expansion was carried forward in the post-1947 phase until the National Five Year Plans started. The process of standardization of medical service which was earlier left un-finished and
completed during this phase is discussed thoroughly in this chapter. Apart from this, the chapter also explored the dramatic expansion of healthcare system till 1987. Census and statistical data are extensively used to support and substantiate the interpretation of the work. The chapter further discusses the Assam Rifle outposts as they were related to opening of dispensaries and hospitals in the foothill areas of the present day Arunachal Pradesh. Similarly survey of road networks, alternative medicine and medical education are covered under this chapter.

A brief account of the bias between the European Officers and Assamese-Bengali elites in the context of medical service in the study area are highlighted in chapter five. Analogies of the respective policies of the governments of two phases viz., pre- and post-1947 relating to healthcare is also discussed elaborately. The environmental and socio-cultural dimensions of healthcare facilities are argued in this chapter. The methodical concerns for historical analysis of indigenous healing systems due to impact of modernising forces are elaborately treated in the chapter.

The concluding chapter provides a critical summary of the study like the originality of research; major findings; recap of methodical issues; further possible research; and the significance of the study.