CHAPTER V
Health Care Policy and Patterns of Change

The massive expansion of health care system in Arunachal Pradesh within a period of forty years after Independence was backed by an intelligent policy pursued by the government. The specific policy of using medicine to establish friendly relations with the people of the state in the preceding phase has already been discussed earlier. It is now important to analyse the general character of medical administration and factors which influenced the health care policy. A diachronic analysis of indigenous healing system is attempted with this historical background using some trans-disciplinary approaches in the study.

Medical Service and Racial Bias

It is observed that during the period of colonial interventions people welcomed medicine and dispensaries whenever they were offered so. This happened from the time of Father Nicholas Krick in 1853 to J.P. Mills in 1948. There was no divergence of opinions amongst the officials of the then British administration in the Brahmaputra Valley as to the importance of medicine in frontier policy. Gradually, as the importance of medicine in establishing friendly ties with the neighbouring hill tribes of erstwhile Hill Districts or Areas (i.e., present day Arunachal Pradesh, Nagaland, Manipur, Meghalaya and Mizoram) was realized the question of the racial composition of medical personnel in these areas became a matter of debate. The question as to whether European doctors or Indian doctors who were usually either Assamese or Bengali should be employed for what was by then considered medical mission began to guide the prospect of a long term hill-plains relations in North East India.
To understand this debate it is necessary to briefly consider the administrative background of medical services in Assam and parts of North East India as it existed then. The Indian Medical Service (IMS) was thrown open for competition from 1905 onwards. Following were the various service groups of medical personnel posted in North East India in both the military and civil establishments; Indian Medical Service (IMS), Indian Medical Department (IMD), Civil Assistant Surgeons (CAS), Military Assistant Surgeons (MAS) and Sub-Assistant Surgeons (SAS). The officers in Indian Medical Service and Military Assistant Surgeons were military in training and Europeans by race who usually served on deputation in the vital and important position under the Government of British India. Such important posts were generally those of Hill Districts or Areas. The Military Assistant Surgeons were inferior to the Sub-Assistant Surgeons who belonged to the Assam Provincial Cadre both in term of qualifications and training, but were placed in far superior positions with better pay and allowances an anomaly which was resented by Assam Medical Service officers. It is with regard to this anomaly in service conditions the question of competency and dedication to medical service, especially in the hills, took a racial turn.

When the Civil Surgeoncies of the hill districts held by the European officers was proposed to be thrown open to Civil Assistant Surgeons which was opposed by the Commissioners and Deputy Commissioners of the concerned districts, who were also the European officers. This happened in the early 1920s, a

1 Anil Kumar, *op.cit.*, p. 133.
2 Assam Secretariat, Education Department, Medical-A, March 1924, Nos. 1-12, SAGAP, Itanagar.
3 P.C. Dutta’s Note dated 17th July 1923, Assam Secretariat, Education Department, Medical-A, March 1924, Nos. 1-12, SAGAP, Itanagar.
period when dispensaries and hospitals were extended in some parts of Arunachal Pradesh as discussed earlier. G.E. Soames, Second Secretary to the Government of Assam expressed apprehension and accused the Civil Assistant Surgeons and Sub-Assistant Surgeons of inefficiency, of disliking hill posting and not getting in touch with the hill people and secure their confidence. Soames accusation incited the Minister of Medical Department in the Provincial Government of Assam, Shri P.C. Dutta who in return filed an extended response touching upon larger political aspects like the future of Assam and Hill Tribes in the wake of 1919 Reforms as quoted below:

Times have changed and old ideas have to be revised...If an Indian is not respected by the Naga or other Hill tribes, it is because he has always been seen in subordinate positions... It is the business of Indians to mix up and make friends with the Hill Tribes, take interest in their welfare...If an Indian is so unpatriotic as to disregard these interests to avoid a little personal discomfort, he deserves no consideration...\(^\text{5}\)

The duel between European officers like Soames and emerging political class of Assam like Dutta showed the inherent tussle between European officers and Assamese policy makers regarding the future of hill-plains relations. This was amply reflected in the case of medical policy also.

These perceptions did not limit itself to the particular case mentioned above but got accelerated and widened in the subsequent decades which affected the policy matters relating to medical administration of erstwhile North East Frontier Tract (the present Arunachal Pradesh). The European officers did not consider the doctors and medical staffs from the plains as competent to serve in

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\(^4\) Soames to Minister, Medical dated 3\(^\text{rd}\) October, 1923, Assam Secretariat, Education Department, Medical-A, March 1924, Nos. 1-12, SAGAP, Itanagar.

\(^5\) P.C. Dutta’s Note dated 11\(^\text{th}\) October 1923, Assam Secretariat, Medical-A, Education Department, March 1924, Nos. 1-12, SAGAP, Itanagar.
the hills and win people’s confidence in return. Their opinions on the doctors from the plains reflected the paternalistic ideology and distrust of plains people as evident from the argument given below:

*The Abor is still very prejudiced against the ‘Doctor Babu’ as a class. It is due to the lack of real sympathy so frequently shown by S.A.S. and which the Abor is quick to sense. That class of Government servant so often instinctively despises ‘junglis’ for a variety of reasons, and cannot always disguise it. There was a big deputation asking for European Medical Officer here as there used to be.*

In this racial and ideological battle in the medical administration of Arunachal Pradesh, the alleged lack of professional ethics was also accused on the Indian doctors from the plains. This appeared to have continued till the time the British left India as highlighted by another view on the matter:

*There being very little sense of social obligation in India, the Bengali and Assamese doctor, with some exceptions, is not interested in medicine as a science, but merely as a means of financial gain. They are therefore unwilling to work in the hills where opportunities for private practice are nil, and social service is of necessity the sustaining interest.*

Thus, while health care constituted an important tool of colonial diplomacy in Arunachal Pradesh and other hill areas of North East India, the respective views of the European officers and Assamese political class on the medical administration of the hills reflected their larger paternalistic ideological divide. This aspect of health care offers a window to assess the role of perception and racial prejudice in larger policy making of the region including Arunachal Pradesh.

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7 G.E.D. Walker, Political Officer Sadiya to the Adviser to the Governor dated 20th Nov 1945, *Medical Department, NEFA Branch, F/No. 33/29 of 1946, SAGAP, Itanagar.*
Predicament in Implementation of Health Care Service

There was no reported incident of individual or organised resistance against the introduction of western biomedicine (WBM) in Arunachal Pradesh throughout the period of this study. Some minor instances of people at Sille area in the present day East Siang District refused to take vaccination and some villages in the Wancho and the Nocte area of Tirap District refused to give their correct names out of suspicious notion. Other than these there were no subsequent reports of similar incidents from other places. It was also reported that in the Borduria area under Tirap District where people had earlier looked upon the vaccinators as taboo demanded and welcomed the vaccinators when mass vaccination was carried out against small pox epidemics in 1951. Even in the areas like Tawang where indigenous medicine was well established there was no resistance to modern medicine. Thus, from a cultural point of view the introduction of western biomedicine in Arunachal Pradesh was a smooth one and faced no impediments from the people of the state.

The most important factor for this rapid acceptance and popularity of western medicine system amongst the people of Arunachal Pradesh was because of the consistent and intelligent policy pursued by the respective government from the early twentieth century to 1987. Emergency health relief measures were undertaken whenever an epidemic was reported from the interior places within the governments reach. The guidelines planned for medical staffs after the end of Second World War reflected the careful and friendly approach of health administration. The objective of using medicine for diplomatic ends during the

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8 Annual Administrative Report of Tribal Areas of Tirap Frontier Tract for the year ending June 1951, p. not available, SAGAP, Itanagar.
pre-Independent phase was expanded in the post-Independent phase to that of integration of the people of Arunachal Pradesh into national mainstream. Towards this end, an effective policy was pursued in administering health care service to the people and every care was taken to project modern medicine as a compliment to indigenous healing rituals and not against it. This policy was pursued right from the early 1950s under the then North East Frontier Administration up to 1972 and subsequently by Government of Union Territory of Arunachal Pradesh up to 1987.

The foundation of this policy was part of the Nehru-Elwin policy adopted soon after Independence with respect to Arunachal Pradesh and was clearly outlined in Elwin’s phrase; ‘Allies, not rivals in Medicine’.\(^9\) It was considered important that doctors and hospitals were not seen by the people as a rival to the priests and indigenous healing system. A medical sociology for health care administration in the state was outlined and it remained the guiding principles of medical department throughout the period under the study as stated that:

\begin{quote}
The doctors must cease to be antagonistic to the system of tribal diagnosis and cure…A wise doctor in NEFA will make friends with the local priests, invite them to visit his hospital and let them offer prayers and make sacrifices for his patients, explaining that his own way of treatment is supplementary to theirs…Whenever a hospital or dispensary is opened or when foundations of such buildings are laid…the local priest should be invited to perform rites of blessing and protection.\(^{10}\)
\end{quote}

This policy was followed and expanded in the later execution of programme. The need to instill a sense of pride amongst the people of Arunachal Pradesh as an inalienable part of India was probably accelerated by the Chinese invasion in 1962. While continuing with Elwin’s policy of medical sociology the question of

\(^9\) Verrier Elwin, 1957, op.cit., p. 177.
\(^{10}\) Ibid., pp. 178-179.
integration of the people of the state into national mainstream became a matter of medical policy from mid-1960s as revealed in these lines:

A sympathetic doctor will have to tell an ailing tribesman that the pills or the powder he is giving is not to bring down the temperature but to drive the spirit away from his body. It would be a good thing of his class his pills ‘spirit repellants’. This will create greater faith and confidence and the sick man will be more responsive to the modern treatment which will bring him closer to the culture of his developed neighbours. Doctors have better opportunities to be in closer contact with the tribal people and with a little sympathy, understanding and regard for the tribal values they will be better instruments in bringing about an effective integration of the tribal people.11

The passion with which this policy was propagated was reflected in one of the important public media. In 1976, the Government of the Union Territory of Arunachal Pradesh produced a feature film whose one of the major theme was vaccination.12 The film was shot in the early 1970s at Yazali in the present day Lower Subansiri District as part of the educative propaganda documentary film on health care and value of indigenous culture in the Nyishi villages. While the film raised other socio-cultural aspects, it has since acquired a cult status amongst the people of the state and therefore it may be seen as an enduring symbol of the sympathetic policy of the government in administering modern health care facilities in Arunachal Pradesh.

Medical Relief Operation in Arunachal Pradesh

Another important factor in the acceptance of modern health care measure was because of the medical relief operations carried out at numerous occasions. Relief during individual and community distress carried important social value

12 Government of Arunachal Pradesh (Producer) & Bhupen Hazarika (Director), 1976, Meri Maa Mera Dharam, India, HMV; retrieved from: https://www.youtube.com/watch?v=gISClIYe378 on 7th February 2016 10:45 am.
amongst the people. Some epidemic relief operations were undertaken since 1920s in the foothill areas and in the post-Independence phase which formed a part of health care policy. One of the largest medical relief operation carried out in the history of Arunachal Pradesh was during the 1950 earthquake. It is stated that this was the ever worst natural disaster happened in the living memory of the people. The great earthquake took place in the evening of August 15, 1950 and caused floods with widespread disruption of roads, communications, buildings and huts, especially in the Lohit Valley. Sixty six deaths were reported in the Soilang group of villages in the Mishmi Hills. Seven houses and twenty three people were buried in Saru of Pailibo (Adi) village in northern Siang. Communication in the entire state was completely disrupted for months and people were brought to the verge of starvation. The destruction caused by the earthquake was so widespread that touring officials continued to report about destruction of river ecosystem and its affect on food supply (aquatic lives) and agriculture in the years following the disaster. Adverse effects on health and psychological impacts were also reported as:

*After the great earthquake, most of the people of the district have lost the power of resistance due to the acute shortage of food or for other reasons. Various kinds of diseases which were previously unknown to the tribals made their appearance in almost all the interior villages. As a result, the number of death has gone up and few thickly populated villages are now in a dwindling state.*

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15 Government of India, NEFA Administration, General Department, Political Branch, File No. P-58/51, Tour Diary of the Political Officer, Mishmi Hills, Sadiya, 1951, SAGAP, Itanagar.

16 Tour Diary of Shri B.C. Bhuyan, Political Officer, Abor Hills, Pasighat for the months of November and December, 1951, SAGAP, Itanagar.


In 1950, most of the interior villages of Arunachal Pradesh were beyond the reach of the officials and administration. The amount and extent of destruction might have been more than what was reported.

The earthquake happened at a time when the Government of India had just filled in the space vacated by the British administration based in Assam over the impending administrative re-organization of the then North East Frontier Agency. It was therefore important that a relief operation commensurate with the extent of devastation was immediately carried out in the frontier that was sought to be won through sympathetic means unlike other areas of North East India and elsewhere. Thus, it was reported that civil air dropping of essential commodities started in Arunachal Pradesh for the first time in the wake of the earthquake. A former Adviser to the Governor of Assam on Tribal Affairs made the following remarks on the earthquake and the extent of relief operation:

... the most extensive and elaborate civil air supply operation in the world, involving the dropping by air, annually, of 25 thousand tons of supplies... Earthquake brought NEFA to the notice of the country...we had to decline the services of volunteers on account of our inability to find accommodation.\(^\text{19}\)

The administration also engaged scores of local mostly serving in lower levels of administration in relief operations and who were later on rewarded for their services.\(^\text{20}\) The unprecedented relief operation carried out in the parts of Arunachal Pradesh in the aftermath of the devastating earthquake was a testimony of the humane approach of the administration in general policy as well

\(^{19}\) Nari Rustomji, \textit{op.cit}, pp. 116-117.

as in health care administration. As mentioned above, it was customary amongst the communities to be in gratitude for aid rendered in times of distress and it may therefore be concluded that the earthquake relief operation provided a good example before the people that modern health care under new administration stands to benefit them.

With this historical background of the policies and measures related to disease, epidemics and disaster the question of indigenous healing and patterns of change is attempted to analyse in the following arguments. In such study anthropologists generally include survey of environmental context and social patterns which affect health viz., food distribution, sexual practices, hygiene, population contact, urbanization, etc. This research work therefore briefly takes into account the above aspects in the context of traditional-modern dichotomy framework.

**Environmental and Socio-Cultural Dimensions**

The climatic, ecological and geographical conditions of Arunachal Pradesh is a subject studied in many colonial exploratory records, tour diaries, memoirs and research publications. The following description reflected the ecological impact on general health of the people of the state more accurately:

> The climate in most parts of NEFA is rigorous, the level of living low, the standards of hygiene primitive and medical facilities scarce. As a result the mortality rate is high, particularly among children. It is only the toughest among the progeny that survive and reach adulthood. The general appearance of good health compared with the other people in the country is somewhat misleading, because it is only the best element in the population that survives. Statistical info is not available but it appears that the population among the tribals is increasing, if at all, at a very low rate.

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It could be seen that the environmental, social and economic factors affected the prospect of health. Famine, diseases and death were not infrequent because of the harsh conditions of life. The government health care experts were aware of these environmental and economic constraints and attempts were made to incorporate these aspects in overall planning of government welfare schemes in the state. One study by the government agency classified the prevailing diseases in the state according to climatic conditions of which pulmonary diseases were common in the drier regions in the west and the north while goitre in the higher Himalayan ranges and skin and stomach disorders caused by worms in the wetter regions.23 Referring to the last category of disease the report underscored the prolonged period of low health conditions among the people which resulted in appearance of people of these areas as less healthy. The frequency and nature of disease however varied from region to region and depended on other factors also.

It was Verrier Elwin, the Adviser of government policy in Arunachal Pradesh after Independence who raised the question of environmental and social determinants as regard to general welfare and health of the people. Various aspects relating to housing, dress, opium use and food habits, etc., were considered important in the successful implementation of health care measures.24 Elwin raised the concern on the issue because of slow pace of preventive healthcare that had begun after 1951. Other studies following Elwin’s observation highlighted the absence of concept of cleanliness, paucity of clothes, distant source of water from villages, absence of windows in house and resultant problem of smoke, lack of lavatory and the custom of using attached pigsty at the

23 Ibid., pp. 332-333.
backyard in its place, etc., as important environmental factors affecting hygiene.\textsuperscript{25} Accordingly, a renewed effort to address these socio-economic impediments in the goal of health care delivery was made in the beginning of 1970s. It was reported that one-third of the population of the state was living below 5,000 feet and was therefore prone to malarial disease. As such shifting cultivation was an impediment to Malaria Eradication Programme because the practice made families and villages migratory, and that the problem of flies, mosquitoes and other pests like \textit{dim-dam} fly and leeches added to the general danger posed by environment to health. Even daily habits of the people which affected health and hygiene became a matter of government health policy as stated in these lines:

\begin{quote}
A central fire-place in this damp and cold region is a most welcome and attractive thing, but it has a hypnosis. It does not allow people to move away easily form it. Thus, through centuries a habit has developed in these people to spit where they like and as they like. Lung diseases are consequently common among them. This is a very great problem both to the Tuberculosis worker and the health educator.\textsuperscript{26}
\end{quote}

Thus, the environmental and socio-economic factors affected the health of the people as much as it influenced the health care measures of the government in determining the elements of preventive health care efforts.

Within this environment of socio-economic dimension of health care system a disease reported from certain specific areas deserve separate mention. Venereal diseases (VD) were reported from regions where village community was more settled with higher density of population namely; Tawang area as reported

\textsuperscript{25} Techno-Economic Survey of NEFA, op.cit., p. 224.
by Kennedy and Siang region. In 1947-48 alone about 500 cases of venereal diseases were detected and treated which were reported from Siang region. Similar cases were reported from Noklak area of Tuensang in the present day Nagaland and the suggestion of communal bachelors’ barrack as the probable cause was rejected. A possible relation between the existence of young men and women barrack with spread of venereal disease was earlier suggested by a contemporary Political Officer. The underlying assumption was that bachelors’ barrack facilitated potential sexual promiscuity which helped in spread of the disease. Since no systemic study on venereal diseases was done in Arunachal Pradesh like in the case of the Hulis of Papua New Guinea, it would be extremely hazardous to guess to offer any plausible scientific explanation in this aspect.

Within the bounds of environmental and socio-cultural elements concerning health some positive aspects have been noted. Observance of various ritual taboos were reported from some places which was stated as beneficial custom to contain infectious disease. Any social anthropologist would liken the indigenous belief system attached with diseases like cholera, small pox, bacillary dysentery and leprosy under which patients were segregated in quickly done up

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28 Medical Department, NEFA Branch, File No. 11/39 of 1949, SAGAP, Itanagar.
29 Medical Department, NEFA, File No. M.91/51 of 1951, SAGAP, Itanagar.
hutments away from the village with modern system of quarantine.\textsuperscript{32} Rather than labelling such taboos as social stigma, this view offered a rational explanation of certain beliefs and customs related to disease. It is proved that there are scientific basis to some beliefs and customs related to disease and epidemics beyond what mere eye can observe.

Increasing population contact and growing urbanization are also considered as important elements in health care history. From historical point of view, population contact in Arunachal Pradesh happened in three different ways viz., within a particular group or community and between some communities and the outside world. Because of difficult geographical conditions contact within and between communities in the state were very limited which kept the people divided and short of what they needed.\textsuperscript{33} Intercourse with the outside world happened from three different directions viz., with Bhutan particularly in the west and Tibet in the north while Myanmar in the east and Assam in the south. Traditional migration pattern, trade and political relations with the respective rulers of the Brahmaputra Valley during the Ahom and the British period were broad elements of this intercourse. It is observed that statistical records of population growth in the state is not available for the period prior to the 1961 Census. Hence, population contact as a determinant for studying disease and health from the historical perspectives is extremely limited if one desired to do objective study on the health care system of this part of the country.

Given this shortcoming, the question of urbanization as another element in the analysis of health care history of the state till 1987 is also debatable. A recent


\textsuperscript{33} Verrier Elwin, 1957, \textit{op.cit.}, p. 8.
social anthropological research related to urbanization and the rise of mental
diseases amongst the Apatani of Ziro plateau found that the indigenous belief
system of deities possession is construed as schizophrenia by modernist
psychiatry.34 The Apatani live in the thickly populated plateau area which was
the administrative centre of undivided erstwhile Subansiri District since the
1940s which experienced a rapid urbanization and professional mobility. This
rapid change is reported to be the reason behind the prevalence of more mental
disorder among the Apatani than any other community in the state.35 The study
substantiates its finding by taking example of the Reru village which is
considered as the most advanced, having highest literacy rate, producing more
officers, professionals, politicians and businessmen. This village also having a
number of modified modern houses compared to other villages in the plateau
had most number of psychiatric patients.36 It would seem that urbanization is an
important factor in health care studies in states like Arunachal Pradesh which
did not experience such changes for centuries. Now the impact of urbanization
on general well being cannot be underestimated. To have an idea about the
population growth in the recent decades in the state since 1961 relevant data on
population are given below:

Table 5.1: Population Growth in Arunachal Pradesh37

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>ST</th>
<th>General</th>
<th>Total</th>
<th>ST</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>3,36,558</td>
<td>2,99,944</td>
<td>36,614</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1971</td>
<td>4,67,511</td>
<td>3,69,408</td>
<td>98,103</td>
<td>3.89</td>
<td>2.32</td>
<td>16.79</td>
</tr>
<tr>
<td>1981</td>
<td>6,31,839</td>
<td>4,41,167</td>
<td>1,90,672</td>
<td>3.51</td>
<td>1.94</td>
<td>9.44</td>
</tr>
<tr>
<td>1991</td>
<td>8,64,558</td>
<td>5,50,351</td>
<td>3,14,207</td>
<td>3.68</td>
<td>2.47</td>
<td>6.48</td>
</tr>
</tbody>
</table>

34 Atsuka Ibata, Community Mental Health and Folk Psychiatry in Tribal India, unpublished Ph.D.
thesis submitted to the Department of Anthropology, University of Delhi, 2014, p. 37.
35 Ibid., p. 228.
36 Ibid., p. 230.
Ethnomedicine and Neo Religio-Magico Healing

What is imponderable in assessing factors affecting health care due to the paucity of empirical data are approached by abstract but compoundable social processes. One such area in the field of disease and healing in Arunachal Pradesh is the influence of non-indigenous religions on ethno-medical practices. The three established religious systems which have considerable influence on the study area are the Buddhism, the Hinduism and the Christianity. The influence of the first two religions are already noted in earlier chapters. For larger historical and conceptual concerns the Vaishnavism is considered indigenous religion as is the legal position\(^\text{38}\) though social anthropological view might differ on this. While discussing about the influence of the Hinduism amongst the native population, the study is confined to the Nocte and Aka (Hrusso) communities against whom the faith is recognized as indigenous under the quoted law.\(^\text{39}\) The Aka (Hrusso) connection with the Hindu religion reportedly goes back to nineteenth century. In 1868 C.H. Hesselmeyer, a Christian missionary writing about Aka (Hrusso) religion said that the concept of Hori Deo, a Hindu deity was introduced by Tagi Raja, the elusive Aka warlord, among the people after he was freed from imprisonment in the plains. As a captive Tagi became a disciple of a Hindu guru who in turn obliged Tagi by giving security of the new convert’s future good behavior before the government.\(^\text{40}\) Going by this account, it may be argued that a civilizing element was part of conversion of sections of the Aka into Vaishnavism.

\(^{38}\) *Arunachal Pradesh Freedom of Religion Act, 1978*, Section 2 (c), p. NA.

\(^{39}\) *Ibid.*

Some recent studies on the influence of the Hinduism on the Mishmi and Apatani speaks about sects like Jai-Guru and Gayatri cult being followed by sections of respective community members but these studies do not offer any chronology of this process. Some factors suggested for adoption of new faith included want of spiritual fulfillment within the indigenous religion and maintained that ‘if purification is done through practices of other communities, the result would be beneficial.’ Apart from these factors the onslaught of the Christianity is mentioned in these studies which is said to have introduced a spiritual healing system resembling to indigenous religious practice.

The spread of the Christianity in Arunachal Pradesh differs from other regions of North East India. After American Baptist and French Missionaries failed attempt in the first half of the nineteenth century, the next stage of attempted missionary penetration into the state is reported to have happened from the last decade of nineteenth century among the Adi, the Nyishi and the Mishing who lived in and around the foot hills of north bank of the Brahmaputra Valley. Citing successive records of the American Baptist Missionary Conferences from 1890 to 1950, one study reported that the attempt to proselytize the people of Arunachal Pradesh was not very successful as in the case of other hills of North East India. However, by 1950s some of the Adi, the Mishmi and the Nyishi youths were converted into Christianity. With the passage of time the Baptist Missionary could establish a few schools in the neighbouring towns of Assam like

42 Rajiv Miso, op.cit.
Sadiya, Jorhat and North Lakhimpur where prospective and new converts were provided with subsidised education. In the post 1950 period, the Christianity spreaded more rapidly amongst the native population which affected the age-old practices of indigenous religion and healing system. In order to check this sudden advent of an alien religion the then Government of Arunachal Pradesh enacted the *Arunachal Pradesh Freedom of Religion Act, 1978*. Within the purview of ongoing argument, it is significant to discuss on the dichotomy between the indigenous religions and the Christianity.

Medicine and education were the tool as well as benefits of the coming of the Christianity in North East India. In July 1947, the Bishop of Shillong offered the services of their Sisters in the running of the hospital being improvised at Pasighat and proposed on behalf of the Catholic Mission to open and run schools for the hill tribes of the then Sadiya and Balipara Frontier Tracts and to work earnestly for their intellectual, moral and social ‘uplift’. We heard nothing more on the proposal of the Bishop and since the Catholic Mission was not a part of managing the hospital in the course of time. Subsequently, it is presumed that the offer was either rejected or ignored by the concerned authority. The Bishop’s proposal shows that there was an attempt by the Church to make an entry into Arunachal Pradesh through medical and educational mission.

In the beginning medical and education were the broad elements of activities of the Church to reach out to the native tribes of the state. With the advancing time, the church gradually appropriated some elements of indigenous cosmology and healing practices related to diseases and cure in their sacerdotal

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44 Rev. Dr. S. Ferrando to the Governor of Assam dated 29th July 1947, *Medical-B, NEFA Branch*, File No. 80/6(c) of 1947, SAGAP, Itanagar.
healing practices. Speaking about the Johane Masowe Church in Zimbabwe, Engelke mentioned three things in which the former paid emphasis on viz., spiritual healing, the eradication of witchcraft, and possession by the Holy Spirit. As discussed in the previous chapters, the concept of supernatural grace in healing from ailments and diseases was epistemologically rooted in indigenous belief system. Verrier Elwin spoke of effects of the missionary influence in the state on art. Contemporary studies on conversion into the Christianity in the state mostly focus on the reasons like the lack of spirituality in indigenous religion and an expensive ritual practices attached to it and its impact on culture. Many social anthropological studies focus on the investigations encompassing the indigenous theological aspects like the concept of soul, eschatology, perception of ghost, spirits, and priests. However, if we focus on societal factors like family and social structure, relationships, changing modes of life and psychoanalytic aspects it could reveal deeper academic insights into the relationship between indigenous healing system and Christian healing system. Among the Hehe traditional psychiatrist from Tanzania, the epistemology of mental illness is developed within a belief system that emphasizes witchcraft and moral magic but the treatment followed is in the nature of pragmatic psychopharmacology. A similar study on the role of urbanization in psychiatric

ailments vis-à-vis indigenous perception among the Apatani has already been discussed in the foregoing arguments.

It is to point out that the present research work is not a historical study of conversion and its effect on indigenous culture and ethnomedicine in Arunachal Pradesh. It is observed that the Christianity emphasized to offer a simpler form of healing system through prayers as an alternative to complex indigenous ritual healing. Thus, the Christian healing system accept the existence of malevolent deities who are believed to be the primary agent of ailments in ethno-aetiology and insists on ‘drive away’ by way of prayer in lieu of propitiation to malevolent deities. It is maintained that this method of pray system would get rid of the endless cycle of appeasement to malevolent deities.

**Relevance of Ethnomedicine**

The efficacy of a particular healing system is not viewed from one universal criterion but is to be appreciated culture and region specific. It is said that determining the efficacy of specific treatments in any medical system is problematic both conceptually and methodologically. The indigenous medicine and healing system of the study area is compounded by influences from multiple directions viz., Western biomedicine, ayurvedic, neo-religious healing and homeopathic systems. The outcome of this fusion may be described as what social anthropologists call ‘medical pluralism’, which is the simultaneous prevalence and practice of many systems of medicines.

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Medical pluralism has been documented in many cultures similar with those of Arunachal Pradesh. For example, within India the practice has been reported amongst the Muthuvans and Mannans of south India\(^50\) and the Sonowal Kacharis of Assam.\(^51\) The broad elements of the ethnomedicine of the Garifuna people of Honduras appear to be similar to the practice in Arunachal Pradesh. Their ritual specialist is called Buai\(a\) (priest) and they have a more evolved system of natural healers like Sovador (massager) and snakebite doctor.\(^52\) The Garifuna people welcome modern medicine but they exhibit sense of confidence in some aspects of their own medicine and do not entirely depend and rely on the modern medicine.\(^53\) That is why they adopted the best elements of the healing traditions of both indigenous and modern medicine while discarding respective irrelevant elements. It is said that among the Caboco community of Lower Amazon, traditional medicine is reported to be a salient marker of their ethnic identity which is similar to the Garifuna and they have a strong tradition of herbalist and midwives.\(^54\) In such culture, modern medicine and other forces are unlikely to have adverse impact on their ethnomedicine. Another example of medical pluralism is that of the Navajo people of the south western United States. The Navajo traditionally oriented themselves geographically within a territory


\(^{53}\) Ibid., p. 25.

defined by four sacred mountains aligned with the four cardinal points but today they are reported to orient themselves medically in a field of vital interaction amongst the four modes of healing viz., conventional biomedicine, traditional Navajo healing, Native American Church, and Navajo Christian faith healing.\textsuperscript{55} The contemporary ethnomedicine of the Navajo people reflects the absorption and re-alignment of Christian belief and healing with indigenous medicine. It is important to note that the Navajo are considered one of the most missionaried people in the world\textsuperscript{56} and live in a part of world where the impact of advancements in modern healthcare are relatively felt more.

It has been argued that access to health care facilities is a crucial variable in explaining why people choose one health care option than another.\textsuperscript{57} A situation opposite to this is particularly reflected in the case of Andean medicine in the rural communities of Peru and Bolivia where greater access to western biomedicine did not lead to less prevalence of Andean indigenous medical knowledge.\textsuperscript{58} This shows that the relevance of both ethnomedicine and adoption of modern medicine across cultures is not similar and is not dependent only on their accessibility.

In 1978, the World Health Organization (WHO) urged the member states to foster collaboration between traditional and allopathic systems of health care as a


\textsuperscript{57} Milton Cohen, \textit{op.cit.}

means to achieve the goals of the primary health care initiative. This reflected
the continued importance of indigenous medicine and healing system in the
contemporary world as the goal of healthcare is redefined in a holistic dimension
encompassing both physical and psychological well-being of traditional society.
In contemporary Western societies biomedicine is seen in terms of industrialized
therapy which exacerbated rather than solve public health problems. As a result,
popular dissatisfaction with biomedicine are reportedly increased and said to
have contributed greatly to secular expansion of folk therapies throughout
western society. It is worth to note that an instance of secularization of
traditional medicine is found in China where many aspects of traditional and
cosmopolitan medicine have been fruitfully integrated. Indigenous medicine
continues to provide succor to people as it is rooted in their belief system and
culture. The traditional Chinese medicine consider the ailing body as part of
indigenous cosmology and thus creates culturally relevant meanings to the
concept of well-being.

The coming of western biomedicine in Arunachal Pradesh was a part of
larger process of introduction and rapid expansion of administration,
communication, education, monetization of economy, increasing population
contact and powerful cultural influences. All these changes were novel social


experiences and the degree of this process was described by a noted social anthropologist as creating the puzzle of the impact of the atomic age on a Stone Age.\textsuperscript{62} It is argued that despite of these profound influences the relevance of ethnomedicine is not dimmed. However, these aspects require a thorough and critical in-depth investigation ranging from religion, socio-economic, cultural and political changes of the people from historical perspectives. Pending such a thorough investigation, two case studies of traditional priests and indigenous healing system as being practiced in most parts of central Arunachal Pradesh are being presented in the following paragraphs in order to substantiate the relevance of ethnomedicine in the societies. Cultural and historical backgrounds of the priests and indigenous healing system in Arunachal Pradesh have already been briefly discussed in chapter three.

Tama Mindo (Romin) is a renowned nyibb (priest) and a propagator of indigenous Donyi Polo faith. He was born in c.1940 at Bipi village in Liromoba Administrative Circle of West Siang District.\textsuperscript{63} Early in childhood he was lifted by the Yapoms (forest deity) from his bed and later recovered by village folks from a stone platform in the nearby stream. The Yapoms are sylvan deities who are believed to be capable of carrying away men, women and children. Would-be priests are also liable to be lifted by the Yapoms which is considered an omen to a career of priesthood. Young Tama Mindo did not want to become a priest, so he left his ancestral village and started doing petty contract works in places he could find such opportunities. In 1969, he was in Gandhigram in Vijaynagar area of the

\textsuperscript{62} Verrier Elwin as quoted in Ramachandra Guha, \textit{Savaging the Civilized: Verrier Elwin, His Tribals, and India}, OUP, New Delhi, 2000, p. 260.

\textsuperscript{63} Information about Tama Mindo was gathered through personal interview with the priest at his residence at A-Sector, Naharlagun, Arunachal Pradesh on January 6, 2017.
present Changlang District where he came into contact with Catholic Missionaries and got converted to Christianity. In 1974, when he was working in Pasighat in the present East Siang District, he had another *Yapom lifting* experience. One afternoon, at around two pm in the day he paid a visit to Shiva Mandir at Raneghat in the outskirt of the town. The temple premise had a huge banyan tree (locally called *sirek/hirek*) which is believed to be one of the abode of the *Yapom* and from there Tama had ecstatic experience of running across rivers and beyond mountains. By four pm the same day he was in Aalo, the neighbouring town and present district headquarters of the West Siang district. He had covered an impossible distance in just two hours (even today the distance between Pasighat and Aalo takes 4-5 hours by motor vehicle). He was convinced that this was the final call to priesthood and Tama Mindo finally decided to take up priesthood full-time despite his baptism in Catholic Christianity.

From 1975 onwards Tama started his career as a full-time *nyibb* (priest). Under the indigenous faith system of the Thanyi tribes, the *nyibb* are divided into different categories on the basis of their occult power, knowledge and kind of rituals they perform. Tama belonged to the highest category of *gumin nyibb* or *nyibb-buut*'. He is a teetotaler since childhood and do not partake beef because of allergy. In 1987, he helped organise the Abotani Priest Association as its first General Secretary. He is presently the President of the ecclesiastical wing of the Indigenous Faith and Cultural Society of Arunachal Pradesh (IFCSAP). In his long career as a priest Tama Mindo had cured many patients who did not get relief from modern medical treatment. Two examples were narrated by the priests during the interview.

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One dysenteric fellow from Likabali (the foothill entry-town to the West Siang District) was shifted to General Hospital, Naharlagun (now upgraded and renamed as Tomo Riba State Hospital, Naharlagun) after treatment in the Aalo District Hospital, West Siang District failed. Five days of medical attention in the General Hospital, Naharlagun also did not bring any succour to the dying patient when anxious relatives called for the priest’s help. Omen was taken and Nyibb Tama\textsuperscript{64} identified the disease as takw\textsuperscript{w} (local name of dysentery), prepared some herbal medicine, mixed it with goat-meat, and chanted the necessary priestly invocations to the takw\textsuperscript{w} deities before the potion was given to the patient. To the surprise of the doctor and nurses who were earlier reluctant to allow a treatment considered dangerous from medical point of view, the patient was cured within a couple of days. The latter left the medical without officially being discharged. The surprised medical officer Dr. Moji Jini\textsuperscript{65} (he is now the serving Director of Health Services, Government of Arunachal Pradesh) enquired Tama the method of cure upon which the above details were narrated to the overwhelmed doctor. On another occasion, Tama Mindo’s maternal uncle Mr. Jumtum Tato (a serving engineer with the Government of Arunachal Pradesh) sought the former’s help in treating a long-suffering colleague. The patient was a Sikh by faith and had been experiencing acute headache for years. Medical checkups in New Delhi and prayers in Gurudwaras were of no relief. Tama consulted the omen and found that the Sikh engineer had unknowingly incurred the ill-will of the Yapom at Bene Village near Aalo in West Siang District years back when the latter was posted

\textsuperscript{64} In the Galo speaking areas of central Arunachal Pradesh, it is common to speak of or address the priests by prefixing the term Nyibb before their personal name without using their surname. Tama Mindo’s mother tongue is a northern variant of Galo language.

\textsuperscript{65} The names of witnesses have been mentioned with the permission of the interviewee. Names of patients have not been mentioned in respect of their privacy to personal health.
there. An appropriate rituals were performed and a goat and five hens were sacrificed as *yudum* (sacrificial offerings) and the disease was cured. The engineer continues to pay thank you-visit to the priest.

The second priest examined in this study has a similar but more interesting career. Late Tadar Nyajung\(^6\) was a renowned priest in the entire Papum Pare District and in the lower Nyishi belt. Son of late Tadar Langlum of Gangte Village under Sagalee Sub-Division of the undivided Subansiri District, Nyajung later on shifted and settled in Midpu I under Doimukh Administrative Circle town located near the state capital Itanagar. Like Tama Mindo, he was also ‘lifted’ by the *Yapoms* during his childhood and kept in ‘confinement’ for about a month in the jungle. Dreams and such other signs generally associated with would-be *nyubh* (priests) kept occurring at regular intervals till finally Nyajung became a full-time priest. He along with his priest-friend Chuku Topu acquired name and fame for their priestly powers and ritualistic healing capacity. They were *nyigre nyubhs* (priests of high order who could foresee or forecast). They could also transform themselves in any form including animals. Many a time both used this supernatural power to successfully take down pre-identified *sebbe* (*bos frontalis*), and also produce things kept hidden in a challenger’s granary through a quick incantation of magical words etc. in order to prove their priestly power to the common folks.

In 1969-70, late Nyajung’s wife converted to Christianity but he continued to practice his priestly duties. After two decades, in 1989-90 he also joined the church and remained so till his death. What is astonishing is that even after his

\(^6\) Information about Late Tadar Nyojung (who died some couple of years back) was gathered through personal interview with the priest’s son Mr. Tadar Nipo at the latter’s residence at Doimukh, Papum Pare District, Arunachal Pradesh on January 7, 2017.
conversion to Christianity, Nyajung’s role, name and fame as a priest and as a healer was not affected. He continued to perform rituals using indigenous hymns, narrate the myth-origin of man and universe, trace family lineage, invoke the migratory routes etc., in his ritual chants as priest usually do. The only symbol of his conversion to Christian faith was that he would conclude the rituals in the name of the Jesus Christ. Everything else in the rituals he performed was same as in the indigenous rites. In other words, Tadar Nyojung was an indigenous priest who converted to Christianity but continued to perform rituals and heal people through indigenous healing methods. His conversion did not affect his priestly powers of healing. He was much sought after for chiropractic cases (bone-fracture) as well as important personal and family rituals related to diseases and general wellness. Many patients of high educational background, the Christians, the followers of indigenous faith, the medicos and non-tribals alike approached him to seek redress for what they could not be cured though medical intervention. Nyojung continued his services this way and died as a nyubb Christian.

The two examples narrated above from field-investigation proved that the importance of the nyub (priest) in the indigenous religion and healing system is still relevant. Indigenous healing system occupies an important place in the era of medical pluralism. Priests play a very important role in indigenous healing system. However, the number of priests with healing and other ritual powers is declining these days. The number of tago-nyigre priests like late Kachi Yomcha67 and Late Tadar Nyojung are decreasing. Nyibb Tama laments that this was because of coming of new ways of life, non-observance of indigenous ways of life

and taboos, change in food habits, negligence of indigenous religion and its methods of healing, and adoption of new religious faiths. The progress of modernization has resulted in rapid change in the lives of the people of Arunachal Pradesh. This has resultantly affected the traditional ways of life and practice of indigenous rituals and healing system. Not only religion and rituals, many aspects of daily life is intimately related to indigenous culture. For example, speaking about the importance of food avoidance as an important element of tribal culture one study rightly suggested that ‘many abstentions may be interpreted as a type of primitive preventive medicine...Not only the individual, but also the whole community may derive psychological benefits from the avoidance of certain foods’. Indigenous healing system cannot be isolated from the larger indigenous religious practice and conventional habits associated with it. Indigenous healing system properly works in an environment where the traditional ways of life and values attached to it are respected and maintained.

When this ecosystem is disturbed, cracks occur as in the case of dwindling number of priests among the native communities. This affects not only the indigenous religion but also indigenous ways of healing and treating.

The Donyi Polo indigenous faith movement in the state may be understood as a step to restore and rehabilitate the fast eroding traditional values and indigenous religion and systems of healing in the traditional societies. A recent study calls this movement ‘reformist’ in the ‘contested domains of religious

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70 Interview with Tari (Gambari) Dabi, Gaon Bura (Nyikok) and propagator of Donyi Polo faith, Namey Village, Nari Sub-Division, East Siang District on December 31, 2016.
transformation…’71. Those who follow indigenous faith continue to seek cure and healing from diseases through indigenous rituals apart from availing modern healthcare system. Within medical pluralism, indigenous healing system is considered important by them. They believe that modern medicine cannot replace the rituals performed for general well being and prosperity of a family and the community. They see the maintenance and reform of indigenous religion as an important part of this exercise and accepted the institutionalized efforts of the Donyi Polo movement. Thus, on December 31, 2016 after avoiding the ongoing reformist movement for decades the followers of indigenous religion of Namey Village in East Siang District consecrated a Donyi Polo Ganggi.72 Ganggi is a prayer hall where indigenous faith believers meet weekly, offer prayers and seek cure of common ailments also. It can be argued that the future of the indigenous healing system in Arunachal Pradesh will also depend on the success of the Donyi Polo movement and other community based indigenous religious consciousness progression. With priests declining in numbers with each passing generation, and institutionalization of indigenous religion with the practice of cure and healing from diseases and ailments is likely to undergo some change while retaining the basic elements of indigenous rituals.

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72 Field visit to Namey Village, East Siang District, Arunachal Pradesh from December 26, 2016 to January 2, 2017.