Chapter VI
Conclusion

The present study unearthed the medical aspects of the colonial intervention in Arunachal Pradesh and the development of health care policies in post-Independence era. The object of medical policy during both the period was fundamentally not different from each other except their institutional sources, which in retrospective terms constituted two different ideological dichotomies. During the pre-1947 phase, medicine was distributed during tours and few dispensaries and hospitals were restricted to military outposts in the hills and administrative headquarters in the foothills. The scale of expansion of healthcare facilities tremendously increased in the post-1947 phase backed by an intelligent and sympathetic policy. Ethno-medical practice of the native population was reported since nineteenth century in the available historical records. Disease was an important socio-psychological reality of the peoples’ lives therefore, it has fiercely attached to their belief system, rituals and habits. It is observed that many of the indigenous healing system were influenced by modern medicine practice to some extent and other socio-magico and cultural forces.

The origin of western biomedicine in Arunachal Pradesh goes back to the period of colonial times. From the point of view of written ethnohistorical records, we do not have much information from the Ahom period on the beliefs and healing systems of the tribes of the state. Important records of the Ahom period like the Buranjis reflect some aspects of political and economic relations between
the hills peoples and the government of the plains. There is no detail explorations on the society and culture of the people from which healing systems then prevalent amongst the indigenous people of Arunachal Pradesh could be ascertained. This was because the general Ahom policy towards the frontier tribes was to maintain a tenuous balance of power in their favour and not penetrate into the hills. Even when the Ahom forces tried to penetrate into the hills, such attempts met with failures. In 1562, the earliest expedition of the Ahoms under *Laku Barpatra Bharali* against the Western Nyishi failed.¹ Throughout the period of the Ahom rule in the Brahmaputra Valley, conciliation rather than express subjugation guided their policy toward the tribes of Arunachal Pradesh. Thus, literature relating to frontier tribes of present day Arunachal Pradesh produced during the Ahom period focused on political questions of the day like raids, expeditions and treaty settlements.

The British commercial interest in North East India developed since the second half of eighteenth century when the Gurkha ruler Prithvi Narayan Shah usurped the Newar dynasty and disrupted the traditional trade between India and Tibet thereby necessitating the East India Company to explore a new trade route to Tibet through North East India.² This commercial interest of the British was facilitated by the weakening Ahom monarchy and political instability. In September 1792 the Governor-General Cornwallis sent Captain Thomas Welsh in response to appeal for help sought by the Ahom King Gaurinath Singha. However, it was after the First Anglo-Burmese War 1824-26 and the conclusion of the Treaty of Yandaboo that the real penetration of the British colonial state began

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in North East India. With the subsequent annexation of lower and upper Assam, the British colonial power replaced the Ahom monarchs and inherited the burden of the Ahom foreign relations with the frontier tribes.

One of the characteristic differences between the Ahom state and the British colonial administration based in Brahmaputra Valley was in the nature of ethnographical knowledge profiling. This difference was shaped by the respective political and strategic considerations. While the Ahom state was limited to quelling internal revolts and keeping raids from the hills regulated through payments of *posa*, the British colonial administration of the Brahmaputra Valley had strategic economic and political interest across the frontier to Tibet. Merely checking the raids from hills of Arunachal Pradesh and keeping the tribes at bay did not suit their interests. Knowing the topography, the peoples and their traditions became integral to the imperial project. Thus, we see that there was change in the nature of British exploratory missions into the hills of Arunachal Pradesh during the course of colonial interventions in the state.

After the foundation of Company’s rule in 1826, the larger part of the nineteenth century was spent by the British to expand and consolidate their rule in the Brahmaputra Valley. Expansion and annexation of the surrounding hill areas was part of this exercise. In Arunachal Pradesh, the entire nineteenth century was devoted to keep the tribes undisturbed and hence the policy of payment of *posa* was continued. Individual efforts by some American and French Missionaries discussed earlier as in the case of Nathan Brown and Father Nicholas Michael Krick did not result into proselytisation. The mission amongst the Singpho and the Nocte was also abandoned. The reported Chinese threat
coinciding with the murder of Noel Williamson, Assistant Political Officer, Sadiya changed the nature of colonial intervention and shaped the course of its relations with the tribes. Topographical and ethnographical surveys became part of political missions and military expeditions from the second decade of twentieth century. It is from this period we notice the use of modern medicine in both safeguarding the health of the colonial forces as well as a medium of diplomacy in frontier policy. This is amply manifested in the records of the four punitive, political and exploratory missions carried out in the second decade of twentieth century namely, the Adi Expedition (1911-12), the Mishmi Mission (1911-12), the Miri (Nyishi) Mission (1911-12), and Aka (Hrusso) Expedition (Promenade) (1913-14). Data on flora and fauna, topography as well as diseases in the hills formed part of the above missions in which doctors were involved. The missions formed part of both colonial epidemiology and knowledge profiling project.

Medicine box, dispensaries and hospitals were closely followed by the pace of colonial window-administration in the beginning. This is established from the creation of military outposts after the above four missions ended. In 1912, Civil Surgeon Mc Donald was appointed as 2nd class Civil Surgeon at Balek outpost and subsequently all the military outposts were served by health professionals. These health and sanitary measures were not solely meant for the military personnels but were also meant to establish friendly relations with the tribes by providing the latter with temporary and alleviative medical care. It is to be remembered that the reports of the above four missions had explicitly suggested use of medicine as the best method to win the confidence of the tribes. Successive political officers of the erstwhile different frontier tracts of the state continued to
underline this policy. While this policy was accepted across officials of the British colonial administration centred in the Brahmaputra Valley, we do not find a general push in this direction in the hills of Arunachal Pradesh with transformative effects of medicine on the social life of the indigenous peoples. Medical remained subservient to the larger political considerations of loosely administering the frontier tracts of the erstwhile North East Frontier Tracts. Hence, the three decades following the four missions witnessed a sort of lull in both administrative policy and medical policy. The period of lull roughly corresponds the inter-war period, a time when the British were busy handling Gandhi’s mass movements, the rising Communists and experimenting Reforms. From 1912 to 1940, health services remained tied to military outposts in the foothills and occasional touring into the hills by the political officer accompanied by the doctor. There was no basic change in this policy; the medicine box was kept inside the safety of military outposts and it was given to the tribes only when circumstances required so. No attempt was made to institutionalize the healthcare system or to separate it from the military. Pile of bullets and strips of medicine remained under the same roof. This happened from 1912 to 1940 and the World War II changed this scenario.

By the second half of the twentieth century, the colonial ethnographical and geographical mapping of Arunachal Pradesh was completed but at the same time, the importance of the area in strategic terms was realized as in the failure of Shimla Agreement. The outbreak of the War and the threat of the Japanese exacerbated the immediate necessity of overhauling the administration of the then North East Frontier Tract. While this change in policy in terms of general
administrative measure is well known, how medicine was considered integral to this policy is not. The policy of attaching doctors with the Assam Rifle outposts and touring of interior areas by the officers and doctors was continued to ensure the strategic requirements in the wake of World War II. In areas adjacent to the theatre of the War as in undivided Tirap Frontier Tract new dispensaries were opened during the War. More importantly, a planned expansion of healthcare system across the study areas was envisaged under the Post-War Five Year Plan. The experience gained in the preceding decades regarding the utility of medicine in frontier policy was sought to be beneficially used when administrative re-ordering of the erstwhile North East Frontier Tract was planned. And under the new scheme, medicine acquired a very important place. Thus, the post-war forward policy reflected investments made to secure the British Empire in the North East India border. In this way colonial political, commercial and strategic policy influenced the health care measures initiated towards Arunachal Pradesh during this period.

As discussed above, health care facilities first came up in the administrative headquarters located in the foothills where people from interior hills descended to avail the facilities. These administrative measures were backed by organising an annual trade fair in the various duars of adjoining hills. These fairs were organised largely to trade and sell the factory produced goods; and also to disburse the posa to various chiefs. During this month of long fair sometime a health camp was held to facilitate the visitors. To this routine was now added medical visits especially in the then important commercial and administrative town of Udalgiri, Doimara and Sadiya situated along the inter-state boundary of
present day Assam and Arunachal Pradesh. These embryonic medical facilities targeted the prospective subjects in the fringe of the Empire which also attracted international patients. The reported case of a long caravan of Tibetans that visited the Sadiya Hospital and Daporijo Dispensary and the prospective political ally Tashigong Dzongpen of Bhutan hurrying to Dirangzong Dispensary are testimonies of the potentiality of medicine as an instrument of imperial diplomacy.

In terms of the main aims behind opening of dispensaries and hospitals there was no fundamental difference between the pre- and post-Independence phases. Doctors were viewed as ambassadors of goodwill by the respective governments. They were expected to learn the native languages; respect customs while administering medical care and establish friendly relations with the people of Arunachal Pradesh. However, till 1947 the presence of doctor was usually confined to areas within and surrounding military outposts which were very few in number. Annual tours to neighbouring villages were done under military escort, a practice sought to be done away with in the post-World War II period.

There was exchange of negative views between the European officers and Assamese political class on the matter of medical service in Arunachal Pradesh and the debate exacerbated when the medical administration of the then North East Frontier Tract was sought to be standardized after the Second World War. The anomalous position of medical service in Arunachal Pradesh between the Provincial Government of Assam and the Imperial Government of British India came to highlight as a result of this ideological and racial divide. Their sparring even extended to who and how medicine was to be administered to the tribes.
The aborted Crown Colony scheme in the North East India, retrospectively known in totality now thanks to a recent publication\(^3\), only substantiate the paternalistic views each side advocated regarding medical administration and general policy matter on Arunachal Pradesh.

Soon after the war, medical service in Arunachal Pradesh was temporally amalgamated and attempts to standardize it in the name of ‘NEFA Medical Service’ could not be materialized because by the time this was done the constitutional position of the erstwhile North East Frontier Tract was awaited by officials under the Constitution of Independence India. The origin and basis of medical administration was therefore laid during pre-1950 phase.

In the post-1947 phase, the medical policy pursued under the Nehru-Elwin philosophy did not practically differ from their predecessors’ but the scope of medical work immensely got expanded. The European officers’ sympathy for tribes was based mostly on their bias against Assamese and Bengali who were accused of physical and professional incompetency and utter lack in medical ethics. Later, Elwin’s medical sociology was inspired by an anthropologist’s desire to protect and sustain indigenous healing traditions along with obligatory introduction of western biomedicine. This academically inspired paternalism was succinctly described by Elwin himself; ‘The “philosophy” of NEFA must be built on a contended stomach, a clean skin, healthy lungs and a fertile womb.’\(^4\)

Subsequently, this policy was expanded and linked to the long term national agenda of integration of the people of Arunachal Pradesh with the national

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mainstream. Doctors, like the European officers saw them earlier, were considered as potentially the most effective envoy towards this end. No wonder, the evolution of a philosophy for medical man was considered the most significant of all achievements during the first five years. The idea that modern health care measures should not contradict with the basic beliefs of the peoples but be seen as a complimentary effort to the indigenous beliefs about disease and systems of healing was of paramount importance. Doctors and health professionals were required to know this and exhibit it while administering medicine.

In the post-Independence era, development programmes in Arunachal Pradesh become part of the National Five Year Plans from the very outset. Health constituted a major budgetary head competing with infrastructure, agriculture and education. This showed that healthcare formed one of the important elements of a holistic development agenda in the state from the beginning of planning process in India, one that understood the close relations between roads, literacy, food and medicine. Thus, both curative and preventive aspects of medicine took shape from the early years in the post-1950 phase whereas in the preceding phase health care administration was alleviative in nature. Along with unprecedented expansion of hospitals and dispensaries across the state, massive vaccination programmes were carried out throughout the period. Topical diseases like malaria, goitre, skin diseases and venereal diseases attracted special attention in health care policy and national preventive healthcare measures were initiated as

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soon as they were launched countrywide viz., National Malaria Eradication Programme (NMEP), National Small-pox Eradication Programme (NSEP) and special drives for eradication of tuberculosis (TB).

Respect for local traditions was reflected in actual practice of health care administration. Patients in hospitals were allowed the consolation of the tribal priests in conformity with the indigenous faith of the people and altars were allowed to be erected; and charms to drive away the deities of disease were displayed in the compounds of hospitals and dispensaries.

Health and sanitation formed important part of educative propaganda. Health posters with a local background were circulated, displayed and explained to children in the elementary schools; and to outdoor patients in the health centre. In Siang, 138 potential village yame rotung (leaders) were trained in elementary hygiene and sanitation. As a result of these measures, the earlier fear of vaccination and injection was gradually discarded by the people themselves.

The social stigma attached to patients of certain diseases like hansen’s disease (HD) and tuberculosis (TB) were thus removed and treated patients were rehabilitated. For example, in early 1970s twenty seven lepers medically declared non-infective were sent off from the Aalo Sanatorium in the present day West Siang District to their respective villages. Attempts were made to either locate sanatoria to places where land for cultivation was available or integrate surrounding land for the same purpose so that inmates could cultivate and lead a lifestyle similar to their

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6 Ibid., p. 85.
7 Ibid., p. 87.
village life. To facilitate this, even standard sanatoria rules followed elsewhere were relaxed in deference to the local customs.

Apart from some social customs, the main challenge that confronted the medical and other governmental staff were lack of transportation, harsh physical environment and climatic conditions of the hills apart from the professional requirement under medical sociology to respect the local customs. Doctors toured the interior villages for a period ranging from 40 to 115 days,\(^\text{10}\) roughly a quarter of the year in average. The obstacle they faced has a personal side to it as they had to endure prolonged isolation from their families and lead a life devoid of proper food and familiar social environment. As a result, a couple of suicide cases were reported. Some developed liking for local women and had to be secretly hurried away by the administration in order to avoid unwanted fallouts while many others got along with zestful tribal life, married local girls and happily served in the hills throughout their careers.

The acceptance of modern medicine in Arunachal Pradesh has sociological reasons behind it. Disease and famine were two of the most recurring concern affecting the life of people in the hills. Many of the rituals and organised group activities like hunting, migration, barter trade, raid, etc., were social manoeuvres undertaken to counter these adversities. And when amenities from outside the traditional socio-economic set up presented itself those were therefore, eagerly welcomed. Posa, political gifts by touring officials and explorers and medicine were such amenities in the social history of Arunachal Pradesh. The two major views on posa see it either as a blackmail, an argument that originated in the days

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\(^{10}\) *Annual Administrative Report of the Sela Sub-Agency for the Year 1951-52*, pp. 5-6, SAGAP, Itanagar.
of the Ahom rulers and subscribed to by many historians or that it was offered to
the tribes as their rightful claim, a view proposed by Colonel Shakeapeare11 and
pledging oral narratives, by many native ethno historians. These debates apart,
from the point of view of those who received it posa complemented the primeval
needs of food and clothing in times of general scarcity in the days of yore. Hence,
posa was given in kind by the Ahom which was later converted to cash by the
British. This is not argued as a general statement on the grant or receipt of posa
throughout the entire study area but to provide as an example to show the
necessity of basic amenities in the hills of Arunachal Pradesh. Medicine was also
part of this reciprocal exchange of interest. As such the medicine was invariably
presented as an allurement in colonial records relating to diseases in the state.

The study of indigenous healing systems of Arunachal Pradesh cannot be
isolated from the religious beliefs and cosmology of the people as ethno-aetiology
was rooted in the culture. In these aspects, priests were the primary institution of
rituals and healing practices of the societies. Shamanism in South Asia is classified
by Jones into two contradictory types.12 Relative to this classification, priests in
Arunachal Pradesh falls within the classic type where the priest achieves a state of
ecstasy, leaves their body, and travels to the underworld transcending further.
Jones argued that this kind of priest is almost absent amongst those who profess
some variation of Hinduism or Buddhism and that it was practiced in Arunachal
Pradesh apart from others cultures elsewhere. The other type of priest was
dominant and was followed by those who profess a belief in transmigration of
souls. It is observed that the institution of priest which are variously named

11 L.W. Shakeaspeare, History of Upper Assam, Upper Burmah and North-Eastern Frontier, McMillan
12 Rex L. Jones, op.cit., p. 333.
among different tribes as ritual healers in Arunachal Pradesh represents a classical form of priesthood practice. Historical and ethnographical accounts on the priests and their healing methods in the state from nineteenth century to contemporary research substantiate this position.

Some aspects of ethno-aetiology reflect apparent gender bias. In 1855, E.T. Dalton reported about the feminine deity called *yapom* to be responsible for abduction of a kid in Mebo in present day East Siang.\(^{13}\) Once J. F. Needham also described the *yapom* as an evil genius bent on harming females, and so almost all the ailments which women suffer from, especially such mishaps as occur at the time of giving birth, or ailments during menstrual period, were attributed to it.\(^{14}\) Similar beliefs still exist in many parts of the study area, especially from Kameng to Siang. The name *yapom* itself bears a feminine prefix (*ya*) of the *Thanyi* language spoken in the aforementioned region and is represented in various folktales as an unfriendly feminine deity dwelling in the dark places of the earth. This singular depiction of a female deity appears exceptional considering the fact that most deities were generally indentified in duality of opposite genders as in the case of the *Donyi Polo* (Creator), the feminine the Sun (*Donyi*) and the masculine the Moon (*Polo*). Known also by other names the *yapom* was the reigning sylvan deity, dwelling in trees appropriate to the locale and event and was held responsible for any ailments related to women and childbirth. It may also be mentioned that extant literature on religion on the study area reveals the priest to be generally of masculine gender although priesthood as an institution is neither hereditary nor professionalized. Highlighting anything beyond this perceptible gender bias in

\(^{13}\) J. F. Needham, ‘A Sylvan Spirite’ in Verrier Elwin (ed.), *op. cit.*, p. 266.

ethno-aetiology is outside the scope and the competence of present study. It requires an exhaustive separate study.

Unlike many indigenous people who came into contact with the European and outside world, there is no concrete evidence of decrease in population in Arunachal Pradesh due to the diseases brought by the new migrants. Examples of indigenous population who experienced de-population due to the contact with outsiders and resultant epidemics have been documented as in the case of the Aleuts of North America. There were some reported cases of sickness carrying and import of disease from the plains as in the case of epidemic in Nyimte under the present day Sagalee Administrative Centre and malaria amongst the Monpa but any definite observation in this regard is obfuscated by lack of empirical data on population exchange as discussed earlier.

Sickness-carrying raid was an interesting phenomenon. It offers an alternative approach to understand indigenous aetiology, social customs, settlement pattern and political relations. The sickness-carrying raids reflected the relevance of beliefs and customs related to diseases and epidemics at a stage of social transition amongst the people of the state when settlement pattern was semi-migratory, habitation dispersed and economy more dependent on subsistence livelihood activities which were supplemented by hunting, fishing and gathering. Sickness-carrying raids were reported to be widespread but on the basis of data available, it would seem that the phenomena reflected indigenous

16 Notes from General Stafford’s Diary on Dafia Expedition of 1874-75 as cited in Tana Showren, op.cit., pp. 189-190.
social mores of survival against disease and epidemics within a particular family, clan and village context.

Introduction of western biomedicine or modern health care facilities in Arunachal Pradesh coincided with the larger process of modernization and therefore, indigenous healing systems were influenced by different forces from multiple directions. Amongst these forces, the onslaught of the Christianity affected the indigenous healing systems of the state more than others. The Christian healing accepted the indigenous cosmology of gods and spirit in relations to disease and offered a substitute mechanism of faith by proselytising process in place of traditional healing system. A process similar with the Bhils of Rajasthan happened in Arunachal Pradesh, under which after converts were gradually gained the new Christians were required by the missionaries to abandon their own old beliefs in the malign supernatural causation of illness and embrace the new English medicine wholeheartedly.17 This process of the Christian faith healing in Arunachal Pradesh happened in the post-1947 period as there was no significant missionary presence in the state prior to this phase. It posed a danger to indigenous faiths to counter which a protective religious law was legislated in 1978. In other words, the shortcomings in the health care delivery system became a major source of alternative faith healing among the indigenous population.

What is said in the above, it is observed that further investigations both at micro and macro levels are required to unearth the different facets of

ethnomedicine. Indigenous religion, its changing nature of relations to diseases, taboos and customs like sickness-carrying, influence of other religion in healing, etc., would be some aspects of further investigation. An example is the concept of ‘afterlife’. The Idu Mishmi were reported to have no notions of a future state that is to say after-life and the deities they propitiate are considered mortal like human being and therefore, the custom of placing at the grave food and belonging of the dead is done as a mark of affection to their departed relatives.\textsuperscript{18} This view is different from the belief of the Adi, the Nyishi and many other communities of the state that the departing soul requires these things on the journey towards the nether world. Eschatology is closely related to healing rites and rituals in shamanistic religion and hence such concepts need more incisive and comparative empirical analysis. Another example is the concept of the supreme creator the Sun and the Moon. Why is the same only a distant symbol of human’s more compassionate aspirations and source of ideal notions? As back as mid-nineteenth century they were reportedly invoked to emphasize sincerity of words\textsuperscript{19} which is the case today also but they were never propitiated unlike countless other deities. And why are most of the spirits and deities indentified with dual names? Is the duality only a way of speaking or do they have a form of their own suggesting a fundamental male-female binary? Such studies would help in understanding the process of adoption of neo-faith healing and conversion to non-indigenous faiths in more academic ways than bickering about indigenous-alien dichotomy.

Consociation of social anthropological and ethnohistorical perspectives is of paramount importance in studying the past of the tribes of Arunachal Pradesh.

\textsuperscript{19} E.T. Dalton, ‘Captain Dalton’s visit to Membu’ in Verrier Elwin (ed.), \textit{op.cit.}, p. 251.
Edward Evans-Pritchard once pointed out that anthropologists write contemporaneous history.\textsuperscript{20} Whereas Haimendorf argued that the traditions of synchronic studies established by Malinowski and Radcliffe-Brown did not favour a sustained interest in historical processes, and the time-scale of the average type of fieldwork has set limits to the anthropologist's ability to observe social processes over extended periods of time.\textsuperscript{21} To complement these lacunae, Haimendorf suggested an expanded time-span for anthropological field work from twenty to more than thirty years to enable the evaluation of processes of change and transformation of a society experienced under the impact of the contact with materially more advanced populations or of environmental change. Viewing indigenous healing traditions \textit{vis-à-vis} other religious healing practices only through the prism of cultural invasion limits the scope of sound academic understanding of such processes and the tendency is not dissimilar in the case of Arunachal Pradesh. Commenting on the tendency to view western biomedicine as another face of capitalism Lynn M. Morgan says that medicine under capitalism is one thing, but medicine as capitalism is problematic.\textsuperscript{22} It could be argued whether a political economy of healthcare system in Arunachal Pradesh is a viable concept. Morgan urged for a complete political economy of health approach to include historical perspective, conflict of dialectical models of social change, and a theory of disease causation that is multifactorial and encompasses social aetiology.\textsuperscript{23} It will also include anthropological concepts like historical trauma and help expand

\textsuperscript{20} As quoted in Christoph von Furer Haimendorf, ‘The Presidential Address-1976’, \textit{op.cit.}, p.6
\textsuperscript{21} Ibid.
\textsuperscript{23} Ibid., p.132.
the scope of traditional epidemiological studies by drawing on factors from the past to explain the social and spatial distribution of contemporary health problems. Hence, a fertile ground for such studies exists in the case of Arunachal Pradesh encompassing studies on food habits, indigenous midwifery, bonesetters, chiropractors and herbal experts as also the ritual healers who are dwindling in number.

The present study is the reconstruction of the medical aspect of colonial interventions in Arunachal Pradesh and the establishment and development of health care administration in the post-Independence period up to 1987. In this study an attempt has been made to fill the gap in the existing knowledge on the origin and development of modern health care system in Arunachal Pradesh during the pre- and post-colonial period. The study further made an attempt to treat healthcare history taking into account the British frontier policy and the subsequent policy of the Government of Independence India. It also made an attempt to present a profile of ethno-medical practices of the indigenous people and raise methodical concerns relating to the study.

While the present study outlines the development of healthcare system in Arunachal Pradesh, it encountered other issues related to the theme of the study which could not be addressed in detail. In a way these are the limitations of the present study which might incite separate research and they include the following. The first limitation is the unequal treatment over different periods covered under the study. The period of study covers roughly 150 years, that is from 1826-1987. It has not been able to show the presence of colonial medical

24 Miller, Barbara D., *op. cit.*, p.177.
policy till 1910s. Except individual efforts by a few Christian Missionaries, no extensive data on colonial medical policy, proselytisation and faith healing by missionaries could be established till after the said decade. Further studies at micro level might unearth a different category of data (both archival and field) and be able to bring out a complementary or even a divergent view from those proposed in this study. But it is emphasized here that the broad outline of the development of modern health care system in the study area remained contextual to the historical developments of the times. Colonial narratives on health and unhealthy conditions in the context of Brahmaputra Valley as mentioned in archival and secondary literature have been hence provided at length in the beginning of this study. These narratives have been then contextualized to give a background to the colonial health policy in the North East India.

The second limitation is the singular emphasis on unearthing development of healthcare systems and motives behind them from 1910 onwards. Much of the time during this research study was devoted to locate relevant records and join the dots that hitherto marked the health care history of Arunachal Pradesh. This limitation came in the way of taking up serious study on social history of medicine in the state. To explore social history of medicine would have first required understanding the different healing systems of the various tribes of the state properly and putting them in proper historical context. No compendium on healing systems of the tribes of the state exists and thus much effort was invested in generating a profile of ethnomedical practices of the people of the state. This required focus on a completely different set of data with different methodical approaches. Some field based studies were done as part of this to understand the
past and current ethnomedical practices. As discussed in the preceding paragraphs, proper assessment of ethnomedical practices of the different tribes of the state would require serious scientific and detail study at micro level with focus on a particular system at a time. Data and interpretations generated from such studies will make possible reconstruction of social history of medicine amongst the tribes.

The final limitation of the study is the lack of theoretical insights into the working of colonial medicine outside the limits of a colony. The present study describes the nature of use of medicine in the context of colonial interventions in Arunachal Pradesh but it is difficult to define the entire process in theoretical framework or to assign it within known forms of commodity exchange between the colonizers and the colonized since studies in similarly placed societies and regions is lacking. The nature of British-tribal relations when viewed through healthcare history as revealed by this study is a one way traffic. That is, in general the tribes appear to have eagerly received modern medicine. Was there an opposite position to this? The present study could not trace out any significant events to suggest so except the initial reluctance against vaccination in some places. To suppose an indigenous healing system versus western medicine scenario would require at least two known determinants- that of penetration of modern medicine extensively into the hills, and the presence of medical mission by the Christian church. In the assessment of the present study both these factors were weak. As stated elsewhere, unless investigated through research at micro levels and demonstrated otherwise, the result of the present study yields only the political, institutional, ideological and statistical aspects of the development of
modern healthcare system in Arunachal Pradesh not its social side and probable theoretical assumptions.

In so far as the affairs of the erstwhile North East Frontier Agency was managed under a different kind of administrative control (or absence of it) during the British colonial rule in the Brahmaputra Valley, it can safely be argued that the use of medicine in British colonial policy was not bound by the territorial and legal limits of the Empire. This study emphasises that there cannot be a singular view of colonial medical policy just as there cannot be a monolithic view of colonialism. A region and groups of indigenous societies outside the colonial administrative limits might become a part of colonial policies and influences due to reasons specific to the place and time. Healthcare provisions in Arunachal Pradesh during the period of colonial interventions were meagre by our standard. But the circumstances under which small beginnings were made and the fact that the basis of the philosophy of modern healthcare system and its broad structure followed in the post-Independence period was devised under the Post-War Reconstruction Plan begets a positive view of British paternalism on the tribes of the state. The history of modern healthcare system in Arunachal Pradesh is borne from this confluence of circumstances which continued to guide government healthcare policy till the end of the period of this study.