

Indigenous Medicinal Substances and Health Care: A Study Among Paite Tribe of Manipur, India

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ABSTRACT People living in tribal areas often obstacles in accessing basic health care services due to remoteness and backwardness of the areas in which they live. Understanding the health care needs of tribal people in these difficult circumstances with special focus on utilization of tribal indigenous medicinal substances is significant for devising comprehensive programs. Data on socio-economic status, knowledge on indigenous medicine, beliefs, practices, and health seeking behaviors were collected from traditional healers and service providers in the primary health centres in two villages- Mualnuam and Thuangtam in Manipur, India. The methods of data collection include survey, group discussions and social mapping. The health care services as part of the larger public health domain, is in a very poor state both in terms of infrastructure and service providers. Nearly all the women respondents indicated their preference towards indigenous medicine or home made remedies and traditional healers at the primary stage of their illness. Thus, scope of indigenous medicine becomes important. Peoples' belief in indigenous medicine can play a vital role in implementing Government programmes on improving and promoting Indian system of medicine in rural areas and at the same time recognizing the local tribal medicine.

INTRODUCTION

Indigenous medicine has sustained itself through processes deeply rooted in a society's socio-cultural complexes. Indigenous medicinal substances, their nature, axioms and practices varies from one country to another, or more precisely, from one culture to another. Even names, practices and products, vary from one place to another depending upon the socio-cultural heritage, religion and political identity. The term "indigenous medicine" or "indigenous systems of health care" refers to the long-standing indigenous systems of health care found in the developing countries particularly among indigenous populations. The paradigms of these indigenous medical systems view humanity as being intimately linked with the wider dimensions of nature. 'Indigenous medicine is a set of concepts of health and illness that reflect certain values, traditions and beliefs based on the people's way of life, or culture' (Segesmundo, 1994) and its relevance to people's lives even as it only primarily responds to people's health problems. There is wisdom in indigenous medicine that may help in developing health system that can be appropriate even at this time.

In India, we have both the documented and non-documented form of indigenous medicine¹

For a health care system² to be relevant to the people it serves, it must be suited to economic and socio-cultural conditions of the nation and fit in people's psyche or consciousness. Necessary, therefore, is a new conceptual framework that recognizes the interconnectedness of health with other aspect of the environment and that will lead to the development of a holistic approach and attitude towards health. The World Health Organization laid this down as the 'new holistic concept' of health in the late 70's. Most developing nations realized that progress in the area of overall economic development is intricately related to the general health status of the population. They now understand that funds allocated for health programs do indeed constitute in economic terms not only a sound but also an essential investment. Further more, the need for services is as large in scope as it is urgent. Estimates indicate that 70 to 80 percent of the population of developing countries has little or no access to basic health services. At the same time the masses of rural inhabitants are becoming increasingly aware of what is achievable through modern medical care and governments are

increasingly pressured to provide medical health services. However these countries find it impossible to expand the health services network or even to improve the existing health service network using expensively staffed hospitals and health centres, as the world inflation mounts and the financial situation of countries with low production worsens (Bannerman, 1983). Given this scenario, the idea of effective low-cost health care delivery systems was introduced, as it became inevitable and emerged as an obvious alternative.

The establishment of indigenous medicine program as part of attaining primary health care at the World Health Organization in 1978 should be regarded as an important milestone in the resurgence of interest in indigenous medicine³. In part, this resurgence of interest is also simply an acceptance of reality. The indigenous system of health care is low-cost, locally available treatments which according to WHO are utilized as source of primary health care by 80 percent of the world's population in many developing countries. Government could hardly continue to ignore this reality. On the other hand, the priority for this government was to create a legal framework for standardizing and regulating diverse traditional medical practices within their borders.

Scenario in North East India

India's diverse agro-climatic zones make each region specific for its biological diversity. Depending on the availability of principal medicinal plants, the country has been divided into eight phyto-geographic regions. Different medicinal and aromatic plants are found in these regions. In this study, the focus is broadly on the Manipur State of the North Eastern region⁴. Manipur has its own unique position among the States in North East India. It is one of the 18-biodiversity hotspots of the world (Rawat and Karki 2004). Almost 67 percent of the total geographical area of Manipur is hills covered by different type of forests. There are several valuable plant and animal species, minerals and diverse mix of human societies exclusive to the region with unparalleled bio-cultural and natural diversity. People have rich local health traditions and traditional healers have been practicing indigenous medicine for hundred of years. As the region is recognized to be one of the treasure trove of biological and cultural diversity- the product of millions of years

of evolution- there is a need to protect indigenous knowledge and cultural diversity on an urgent basis.

The spatial health pattern of the North East shows both uniformity and diversity. Uniformity of pattern is seen in communicable diseases, which are strongly influenced by ecological factors, like acute diarrhoea, respiratory ailments, leprosy and malaria. These diseases are widespread throughout the area. Cultural parameters lead to diversities in health characteristics. This is portrayed in the incidence of cancers, and sexually transmitted diseases and AIDS. AIDS has secured a firm ground in Manipur, and to some extent in Nagaland. Cancer in Nagaland and Manipur is associated with the food and other cultural habits. The low population densities and the existence of alternative tribal or folk medicine compensate healthcare facilities though poor in the northeastern states of India (Bose, Nongbri and Kumar, 1990). However these tribal medicine needs protection and promotion on the part of the government otherwise it may not compensate the health care services any longer.

In North East India, the majority of the medicinal plant species (70 percent) occur in the forest areas and the remaining 30 percent are found in non-forest lands including lands under cultivation (Hazra, 2002). The tribal people and the forest dwellers collect a variety of leaves, fruits, seeds, nuts, roots, barks, tubers and rhizomes which have medicinal value. However, marketing of medicinal plants faces serious problems. Trade in medicinal herbs suffers from market imperfections. Such imperfections are apparent both on supply side, and, on the demand side. Factors contributing to such market imperfections are: absence of a system of defining property rights; problems in arriving at a convincing patenting policy; unique characters of medicinal plants and uncertainty of their availability; knowledge of medicinal plants being restricted to a limited people; absence of organized market; interplay of middlemen etc.

Study Area

The present study has been done in the two village of district Churachandpur of Thanlon sub-division. Churachandpur is a developed district in the state and the sub division lies low on the development scale based on sex ratio and literacy.

The villages, namely Mualnuam and Thuangtam were selected because Mualnuam has almost all the basic amenities while, Thuangtam, on the other hand, lacked basic amenities, even primary school. Thuangtam has small population size and ranks low in the amenities index. The two villages at two ends to amenities scale were selected to examine if economic propensity made any difference in accessing a given type of health care. The 'Paite' tribe is the predominant tribe in the two villages as well as the district and thus becomes relevant to be examined⁶

Purpose of the Study

The present research was carried out to understand the importance of indigenous medicine and people's belief system for sound health care. The study also explores the traditional concepts of health and healing. An attempt was also made to find a meaningful collaboration between indigenous and modern health systems. Thus, the focus of the study was to identify and examine the changes in health seeking behavior of the people within the overall socio-economic milieu. The following are the specific objectives-

1. To examine the utilization pattern of indigenous medicinal substances among rural population of 'Paite tribe' and identify the various factors that impede their use.
2. To capture the dynamics of the interaction and changes that has occurred in relations to utilization of indigenous medicinal substances and tribal medical practitioners.
3. To explore the changes in tribal medicine with introduction of allopathic/modern medicine.
4. To examine the changes in structure of provisioning and how it had influenced the health seeking behavior of the community.

METHODS AND MATERIALS

The field study was conducted on a sample of 100 households selected so as to represent different socio-economic status, demographic composition and environmental conditions in the two villages. The sample of 100 households was drawn from the list provided by the village Chiefs. The households were classified on the basis of their house type, as it signify status symbol in both the villages. Houses are divided into three types-

1. Tin roof with wooden walls and floors. (High status)

2. Thatched roof with wooden walls and floors. (Medium status)
3. Thatched roof with bamboo walls and floors or mud floor. (Low status)

The number of respondents from the sample of 100 households varies between 100 and 200, which means that one household does not necessarily have only one respondent. Efforts were made to select purposively, traditional healers, health care providers to be part of the respondents. The study was done using both qualitative and quantitative methods. The field survey of about 100 respondents was used for the former and key informant interviews, in-depth interviews, case studies; focus group discussions were used for the qualitative analysis.

The following indicators have been used in the analysis of the utilization pattern of indigenous medicinal substances:

- Socio-economic conditions;
- Major health problems;
- Physical factors;
- Amenities available;
- Resort pattern for treatment;
- Preference for treatment;
- Perception of the causes of illness;
- Perception of the traditional healers and the health workers.

RESULTS AND FINDINGS

Sample Characteristics

1) Age Composition: The age composition of the two villages reflects that Mualnuam is 'younger' than Thuangtam. (Table 1). The age composition of the respondents suggests that almost half the respondent in Thuangtam are in the working/reproductive ages and almost one third in both the villages are aged 45 and above. As regards the respondents aged below 24 years, most of them (30%) are in Mualnuam than Thuangtam (20%). Age composition of the sample population suggests close similarities between the two villages. While the adolescent population in almost same, Mualnuam with 33.3%, less than 15 years as compared to 32% in Thuangtam, the working age group population is more in Thuangtam (59%) as compared to Mualnuam (57%). The share of 'old adults (46-60 years) are also more in Thuangtam (18%) than in Mualnuam (13.3%). However, the elderly (60+) are more in Mualnuam (11.1%) as compared to Thuangtam (8.3%).

Most elderly stay at home and take care of the grand children or make 'lenkha zial' local cigarettes.

Table 1: Age composition of the study population

<i>Thuangtam</i> % Persons Respondent	<i>Age Group</i>	<i>Mualnuam</i> % Persons Respondent
20	Below 24	30
50	24-44	40
30	45 and above	30
<i>Sample</i>		<i>Sample</i>
<i>Population</i>		<i>Population</i>
31.67	Below 15	33.3
20	16-30	22.2
21.67	31-45	20
18.35	46-60	13.3
8.34	60 and above	11.1

2) *Education*: As regards to educational level, Mualnuam appears to be more literate than Thuangtam. While in Mualnuam 30% of respondents and 11 % of family members are illiterate, in the other village 68% respondents and 55% family members are illiterate. Half of the respondents in Mualnuam as compared to 32% in Thuangtam have attained primary level education. In Mualnuam 16% respondents and 27% family members have studied till high school. It is interesting to note that 4% respondents in Mualnuam and only 0.03% family members in Thuangtam have studied till graduation. In Thuangtam village there is no educational institution. So there are more of illiterate populations than literate ones (Table 2).

Table 2: Education attainment of the study population

<i>Village/persons</i> <i>Mualnuam</i>	<i>Ill-</i> <i>iterate</i>	<i>Pri-</i> <i>mary</i>	<i>High</i> <i>School</i>	<i>Gra-</i> <i>duate</i>
Respondent	30	50	16	4
Sample Pop	11.1	61.1	26.6	—
<i>Thuangtam</i>				
Respondent	68	32	—	—
Sample Pop	55	40	4.7	0.3

3) *Family Structure*: It is a patriarchal society in both the villages. Generally, the parents stay with the eldest son. There is both nuclear and joint family. In Mualnuam village, 70% are nuclear family and 30% are joint family. While in Thuangtam village 60% are in nuclear family and the rest 40% are in joint family. Thus, nuclearisation of family is more in Mualnuam than Thuangtam.

4) *Land Holding Pattern*: Both the study village has the same land holding pattern. Village

land belongs to the Chief. Villagers can have houses and practice *jhum* cultivation on it. Chief with the help of his Councilors ('Upa's') and village authority, set apart every year certain portion of the land for *jhuming*. Chief, his councilors and village authority, just select *jhum* lands and then the general public follow suits through ticket system. Terrace cultivation at the foothills of the village is also done with the permission from the Chief of the village.

5) *Housing pattern, Assets and Livestock*: In Mualnuam village, 66.3% of the respondents are living in Kuccha houses (house with thatched roof or bamboo walls and floors), and 33.7% are living in Pucca houses (house with tin roof and wooden walls and floors). Electric power supply doesn't reach both the village. Assets possess by the respondents excluding others, mention may be made of radio (listen by using battery), and two respondents have one truck each for business purpose, five rice mills in the village run by diesel generator. In Thuangtam village, 80% of the respondents are living in kuccha houses and the rest 20% in pucca houses. Radio is the only media that links them to outside world. There is only one rice mill in the village. In both the village, livestock comprises of cow, pig, goat, and horse, which serve their daily purposes whether it be for milk, oil, meat, ploughing and as a goods carrier or even as a source of income. Thus, Mualnuam appears to be more prosperous than Thuangtam. However, the overall economic status of the respondents from both the villages is low. They produce just enough for their own consumption and sometimes not even enough to last for one whole year. It is a patriarchal society but the women play a significant role in agriculture and animal husbandry, besides being actively involved in weaving (Table 3).

Table 3: Quality of life

<i>Quality of life</i>	<i>Mualnuam</i>	<i>Thuangtam</i>
Kuccha house	66	80
Pucca house	34	20
Electricity	—	—
Radio	Yes	Yes
Truck	(2) Yes	—
Rice Mills	(5) Yes diesel operated	-1

Perception of Disease Causation

Perception of disease causation included unhealthy food habits, poor diet, ignorance and lack of awareness; beliefs relating causation with

evil spirit; unsafe drinking water and sanitation; and poverty as a sign of economic insufficiency causing depression, loss of appetite leading to ill health. About 26.4% of the respondents mention poverty as one of the main cause of disease, due to which they are unable to afford good diet, work harder in the field and sometime have to spend the night in the field that exposed them to diseases like malaria. The other contributory causes of diseases mention are unhealthy food habits (20%), ignorance about preventive measures (18%), poor diet (12%), beliefs that disease are caused by evil spirit (5.8%), unsafe drinking water (12%), poor sanitation (5.8%) like *kuccha*/ open latrine that provides a breeding grounds for mosquitoes spreading malaria in the village.

Pattern of Diseases

The disease pattern can be divided as major and minor illnesses. Children are more prone to illnesses, which are seasonal and minor in nature. The women complain of reproductive health problems like constant white discharge, urinary tract infection, anemia, complication related to pregnancy. The men folk are more prone to malaria and tuberculosis. Their occupation demands them to stay back in the field for days or three since the distance between village and field is not feasible to communicate back and forth. There are also cases of mental illnesses, fits, epilepsy and polio in the villages.

Utilization Pattern of Different Systems of Medicine

Indigenous medicinal substances are usually utilized for minor illnesses. In Mualnuam village, 60% (30 out of 50 respondents) prefer to use indigenous medicinal substances for minor illnesses while 56% (28 out of 50 respondents) go to hospital (allopathic medicine) for major illnesses. 10% and 6% of them do not seek any treatment in minor illnesses and major illnesses respectively. On the other hand, the dependence on indigenous medicinal substances is high in Thuangtam village due to the absence of proper medical facilities. 80% and 30% of them utilized indigenous medicine for minor and major illnesses respectively. There is little awareness about Indian system of medicine (Ayurveda, Homeopathy, Unani, Siddha) and thus there is no question of utilizing it.

DISCUSSIONS

Since independence, a number of changes have taken place, which had an impact on the lives of the tribal. These include the nature of development itself. Specific interventions through State agencies, which have had its effect on the livelihood, work, cultural practices, which include health seeking behavior and this, have undergone change. Newer innovations and introduction of allopathic system of medicine have brought changes in the perception and practice not only in their various aspect of their life but also in their health seeking behavior. They have started using the newer inventions since they have more choices when it comes to structures of provisioning in health. It is observed that the change in the larger socio-economic system is bound to produce changes in the sub systems.

Therefore in this perspective folk practitioners and the utilization of indigenous medicinal substances is not seen as static and unchanging but their contact with other systems of medicine and changing needs of the society produces changes in their role and practice in the society. Health culture is the sub culture of the larger complex of culture. As a result, the changes in the overall culture influence changes in the health culture of a community (Banerji, 1982). Therefore, a study that proposes to look at the utilization pattern of indigenous medicine has necessarily to locate it within the larger framework.

The prevailing health and medical system, the western system, has unfortunately failed to meet the need of the world's majority. The failure of the Alma Ata Declaration in fulfilling its objectives of achieving Health for all by the year 2000 gives more urgency for looking at an approach that is alternative of the existing medical system (Chandra, 2000a, 2000b). The government, which provided medicines free of cost to the PHCs, could not satisfy the growing demand for these drugs with its budget constraints and allocation to other aspects of health. Today there are no drugs available in several PHCs set up by the government, a very good example being the study villages itself.

Physical Factors Affecting Utilization of Indigenous Medicine

There are variations in resort pattern. One finds that in Thuangtam village dependence on

indigenous medicinal substances is much higher compared to Mualnuam village. This could probably be explained in terms of the availability and unavailability of health service infrastructure and that of accessibility and inaccessibility. It is extremely interesting to know that in Mualnuam village there is greater reliance in allopathic medicine. This kind of a trend reiterates the findings of Banerji and Anderson (1982) that while seeking relief from pain, people use services that are accessible and available to them.

Politico-economic Factors Affecting Utilization of Indigenous Medicine

Our study shows that structure of provisions changed overtime. With the introduction of allopathic medicine the tribal are not resistance to their need and plurality of provisions reflected in plurality in utilization. For quick relief from illness, our study shows that majority of the people have a plural resort pattern. They used both the allopathic and indigenous medicine. The role of traditional practitioners and their practices have undergone changes with the introduction of allopathy. However negligence by the government to provide medicine in the primary health center benefits the owner of small medical store while robbing the poor villagers of their hard earned money. With the unstable political situation and corrupt politician, the health services system is totally not functioning in the rural areas. The attitude of the workers and doctors employed in rural areas is that of serving their superiors rather than the community. The workers too are more responsible to the targets of a particular program than the welfare of the community.

The extent of focus on privatization of health services is also one of the reasons for decline use of government health facilities. It is understood that most of the curative services are provided by the private sector. But the idea of complete privatization of these services would, on the one hand deviate from the concept of providing integrated health care services through the PHC approach. Secondly, privatization also leads to emphasis on cost recovery, thus the burden gradually shifting from the government to the individual consumer.

Socio-Cultural and Economic Factors Affecting Utilization of Indigenous Medicine

1) Beliefs: Religion, serves the central and

crucial function in society of supporting what has been variously called social integration, social solidarity and social cohesion. Religion is an all-pervading supernatural phenomenon in man's life. For this reason perhaps it has been considered universal. Religion has exercised the most profound influence over man's thoughts and behavior from times beyond human recollection.

Conversion to Christianity after the coming of the British missionaries has brought about changes in the family, marriage, social life of the 'Paite's', their life styles, food habits and health seeking behavior. Before conversion to Christianity they believe in the existence of the spirits that move nature and guide human actions. They give different names to them and worship them in their own distinct way. The priests occupy a very important position and no ceremonies were performed without them. The priests also were considered as a great healer who heals people through his prayer and sacrifices of animals to Gods.

Among the tribal people, religion becomes all the more important for it is inter-woven in their entire social life and shapes most of their entire social behavior. Thus, we can see the changes in the social behavior encompassing the health culture or health seeking behavior of the people. They stop believing in the religious sacrifices and healing practices of the priest or healers. However, they continue to use indigenous medicinal substances for treating illnesses.

2) Education: A large number of respondents were illiterate or educated till the primary. Utilization of indigenous medicine has nothing much to do with education as the majority believe in it. However utilization of PHC facilities and medical store increased with levels of education. The illiterate's sometimes just believe in the prescription of medical storeowners, without doctors or the pharmacist prescriptions. Education led to awareness and realization that self-medication can be dangerous for health. High percentage of illiterate women utilized both the PHC facility and the indigenous medicine.

A visible trend among women is that they seek care, whether indigenous or modern after 2-3 days of illness while relatively few resort to earlier care from medical store/ PHC (if open) and indigenous medicinal substances. This lack of early response may be attributed to the lower priority that women give to their own health in

addition to less awareness, low literacy and work hours as most women work in (agricultural) fields.

3) Occupation: The occupation of most of the respondents is cultivators, they practice *jhum* on the land given by the chief of the village. However with the coming in of State highway some of the villagers prefer doing their own private business like running a medical store, hotel, variety store, rice mill etc. With this increasing trend of exposure with the outside world, most of the villagers prefer using modern medicine. Indigenous medicinal substances are considered inferior and slow in treatment as compared with the modern allopathic medicine.

4) Income of Household: Income level is very much related to occupation. The private health services located in the district headquarters are utilized by those with high socio-economic standard or high in income levels. The less privilege use the public health services like the district hospital in the district headquarter, PHC (when they can get free medicine) or utilized indigenous medicine.

Utilizers' Perspectives of Care Givers

The villagers' feel that the existence of indigenous practitioners should be there but not a healer who practices magico-spiritual, as it is against their religious faith. Their faith in the healing power of indigenous medicinal substances is still very strong as they see positive result. However they usually approach a modern health care facility in the first place and indigenous medicinal substances occupy an alternative position. The respondents also feel that the role of traditional healer/folk practitioners has undergone change because there are no such full time practitioners available in both the villages.

Regarding the health personnel of the PHC, the respondents are of the view that they are unresponsive and irresponsible towards their duties. People do not resort to care when they fall ill because there are no doctors available nearby, no money, no time, improper treatment given by government doctors and the belief that allopathy cannot cure some of the diseases. These reasons points out that the caregivers lack responsiveness to specific illness or to the villagers' problem, rather than any resistance from the community to seek care. These kind of

observations were made by Banerji and Anderson (1982) in the study of tuberculosis where they found that people do not go to the primary health center as they did not get relief from the suffering caused by tuberculosis since they were dismissed with 'a bottle of cough mixture'. Here it is amply clear that the fault did not lie with the people who sought care but with an unresponsive health care system.

Providers' Perspective

Perspective of Traditional Practitioner: The in depth interview with the only practitioner alive, shows that he stop practicing for the past one decade. His perception is that his role has undergone changes due to a number of factors, which are brought about by changes in the larger socio-economic milieu. These include resource depletion /over exploitation of the available resources that are plants and animals, the time taken in preparation of medicinal substances and besides this, the introduction of allopathic medicine together with Christianity. Beside this reasons, he also feels that the community's response toward traditional practices especially belief in magical-spiritual healing, is no more relevant for them after conversion to Christianity. With these changes, the people are more open to bring development in their villages. At the same time, they still utilized the indigenous medicinal substances available as an alternative to the allopathy medicine.

This mixed pattern of responses for both allopathy and indigenous medicine for both minor and major illnesses also contradicts much of the earlier anthropological works, which represent tribal as unaccepting of changes (in this case the introduction of allopathy medicine) since it does not share the same cultural world (Carstairs, 1955). It tends to represent them as people unwilling to change, therefore need to be "educated" about the importance of bio-medical world.

Perspective of Health Personnel in the PHC: The list of problems faced by the PHC in Mualnuam village is listed below-

- Shortage of medicine /quality of medicines at the PHC. Inadequate supply of medicine was a problem in many PHCs and SCs. Discussion also indicated that shortage of medicines was partly due to the fact that medicines were distributed from the district

panchayat to each PHC as per the population, rather than the performance of the OPD. At the same time the health personnel are least bothered of what happen to the supply, as no medicine means any work for them.

- Infrastructure facilities at the PHC. Observation of the PHC revealed that water supply/connection taken from the tanker, where spring water is stored, is not connected anymore. There is no power supply not only in the PHC but also in the whole village. There is no toilet facility. The PHC building lack maintenance and left unused and whenever a doctor or medical official came for carrying out family planning programs, they used the house of the village Chief. The official at the PHC complained of limited powers in their hand, whereby they could not make modification to suit them. For any sort of replacement or facility required, a written application had to be submitted to the health department, and only at their order, could the work proceed. The long and cumbersome procedures delayed their implementation.

Emerging Issues of Concern from the Study

Constraints of the Primary Health Care System: The people of Mualnuam village do not face the problem of physical proximity towards the health center. However, lack of physical proximity of the health center for Thuangtam village has been identified as a major constraint in utilization of the PHC. Dissatisfaction of the clients with the quality of medicines provided and the longer time taken to get cured, the unavailability of injections, the lesser timings for which the PHCs function, which is not suitable to their work timing in the field, all in contrast to the private outlets thwart the PHC's utilization. Lack of privacy during examination, the gender of the provider and the behavior of the staff with the patients is other identified factors.

The programme driven supply of medicines, the meager budget of the PHC for medicines and the excessive focus on achieving Family Planning and immunization targets further hamper the utilization of PHC for curative services (Bose and Desai, 1983). Women and children are considered important clientele for only these two services. Nevertheless, there is insensitivity to their overall health problems. Thus the entire system is geared towards target fulfillment of preventive and

promotive services, in the process, community involvement in identification of their health needs being neglected.

At the building level too, poor maintenance and unhygienic conditions, inefficiency in catering to emergency needs of deliveries, accidents and obstetric care become crucial in the rural population losing faith in the PHC system. The same issues at the providers' level such as lack of residential facility, poor maintenance in case of provision of residence, short of emergency skills at the PHC and SC level is an obstacle in providing good quality services. This further demotivates the doctors to work in rural areas.

The present system also fails to satisfy some other needs of its employees. Workers are not given salary in time due to the economic crisis in the State. Hence, they became more irregular than before in delivering services to the people. They are more involved in target programs and visit the village to implement the programs, rather than working towards a more sustainable and holistic system. In spite of a good institutional structure, the approach remains bureaucratic, without satisfactory involvement of the community because of the failure of the PHC to reach the rural population for curative services.

Scope of Indigenous Medicine: The study reveals that the community prefers cheap and free medicines. However, the constraints and inefficiencies of the Public health delivery system is a very sorry state with the needs of community looming large. In such a scenario the potentials and scope of the indigenous medicine and locally trained Dais become very important. The study also brings to light the preference of indigenous medicine or home made remedies and traditional healers by the respondents, especially the women, in the earlier stages of illness and also when they cannot pay for medicine. Their faith in this form of medicine can play a vital role in implementing the government's original plans of promoting Indian system of medicine in rural areas and at the same time recognizing the local tribal medicine. The potential of the trained dais, aanganwadi workers and traditional experts, if tapped can be instrumental in being a link between the community and health institution. Likewise, services of institutions from within the community i.e., school teachers, religious institutions, private practitioners, women if tapped, can lead to successful implementation of the Primary Health Care goal of providing health services through community participation.

SUGGESTIONS

From the issues that emerged from the study it is clear that indigenous medicine is preferred as an alternative and not the first priority. The first priority being allopathic medicine or modern scientific medicine, this has explanation for every cause and effect. At the same time, it does not mean that indigenous medicine is totally discarded. It is timeless and still close to people's heart. It is their indigenous knowledge linked to their culture, custom and tradition. However the impact of modern scientific medicine is quite tremendous that the belief in this system superseded the faith that people used to have in indigenous medicine. The outcome of this study shows that in the study villages the tribal people are hardly aware about government policy towards health care and also about the functions to be carried out by the primary health sub centre. The indigenous systems that the government promotes were Ayurvedic and Homeopathic, which is quite irrelevant for the tribal people and given a choice between their own tribal medicine and ISM they will go for their own tribal medicine. It means they have faith in only allopathy medicine when it comes to seeking treatment outside their indigenous medicine. In other words, what the government tries to promote as indigenous medicine in compliance with the declaration of WHO is not indigenous for many of the tribal living in India, if not for the entire tribal but it is for the tribe under this study. In the Annual Plan of Health Department of Manipur government (DCO,2002; GOM, 2004a, 2004b), it was stated that 'the scheme for establishment of homeopathic and ayurvedic clinics targeted during the 8th and 9th plan could not be achieved due to non creation of posts. Seven posts created during the seventh plan are still maintained under the plan'. It further states that 'but so far none of the clinics could be established due to financial constraints'. The scheme of ISM and Homeopathy has been covered under Prime Minister Gram Yogna (PMGY) w.e.f 2000-01. If this is the kind of promotion /attention being given to the Indian system of medicine recognized officially it is hard to imagine when the localized medicine will get recognition and promotion from the government.

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author and submitted to the Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi.)

NOTES

- 1 The Indian system of medicine recognized those originated in India as well as from other countries and got assimilated over the course of time. In this study the term 'indigenous medicinal substances in use are synonymous with 'traditional medicine' for wider coverage. Its main focus is on non-documented/unofficial/unrecognized system of medicine, which is easily available and accessible to the people. "Describing folk medicine as 'unofficial' health beliefs and practices, define it in contrast to 'official medicine' on the basis of authority. Something is official if it is authorized in a formal way. Folk health traditions are not given official standing by state agencies, and most lack formal authority structure of their own. There is no office among the folk herbalists in a region that can specify "standard procedure" or regulate practice" (Hufford, 1997).
- 2 The health care system of a society can be broadly defined as a set of ideas, practices and organizations, which have been developed to deal with problems of health and illness in the society. Numerous studies by medical anthropologists and sociologists in the past several decades have shown that the content of the health care system tends to vary from one society to another, depending upon social-historical and ecological circumstances (Lee, 1982). Health systems comprise the whole array of elements or components of the broader social system, which are related to the health, and physical, mental and social well being of the population. While the medical systems or the health services systems comprise for the organized array of human resources, technologies and services specifically designed for the development and practice of a medicine for individual or collective health care. In a more strict sense, medical systems are made up of a more or less uniform set of schools, hospitals, clinics, professional associations and agencies that train personnel, maintain an infrastructure for biomedical research and deploy a network of services for varying degrees of complexity for the prevention, curing, care and rehabilitation of the sick (Pedersen and Baruffati, 1989).
- 3 The World Health Organization has referred to these systems as "holistic"- i.e. that of viewing man in his totality within a wide ecological spectrum, and of emphasizing the view that ill health of disease is brought about by an imbalance or disequilibria, of man in his total ecological system and not only by the causative agent and pathogenic evolution."
- 4 Himalayas are spread over many States in India, viz. Jammu and Kashmir, Himachal Pradesh, Uttranchal, Sikkim and the North Eastern States comprising of Assam, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Meghalaya and Tripura.
- 5 According to the 1981 census there are 24 tribes residing in Manipur South District (that time Manipur

was not divided into nine districts as it is now). Out of these 24 tribes 'Paite' tribe holds the majority in terms of population and of land occupation. The total population of 'Paite' in the South district of Manipur in 1981 was 22,621, which is the highest among the other tribes. While the total population of all the 24 tribes combined together comes to 99,409. In terms of educational level 'Paites' has the highest literate population. Out of the total population of 6166 who studied till middle level the 'Paite' constitute 1432 (the highest as compared to other tribes), 593 at the matriculation/secondary level out of 2310 (the highest as compared to other tribes), 167 at the level of higher secondary out of 597 (highest), 141 at the level of graduation out of the total of 478 (highest). (Special Tables on Scheduled Castes and Scheduled Tribes, Census of Manipur, 1981)

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