Indigenous Medicine and Health Care Among Paite Tribe of Manipur

Nemthianngai Guite

This book pertains to research study in the field of indigenous medicinal substances and health care among the 'Paite' tribe of Manipur giving an overview of the evolution and history for the trade trends in indigenous medicine at the local, national and international level with its impact upon the health of people thereby making the same viable for economic sustainability. It also presents the methodology of the study describing the tools and techniques used in collecting data related to North Eastern region for population including their socio-demographic and economic profiles besides utilisation pattern of health care services, types of diseases found and treatment there of by means of tables and figures proving beneficial for policy makers.

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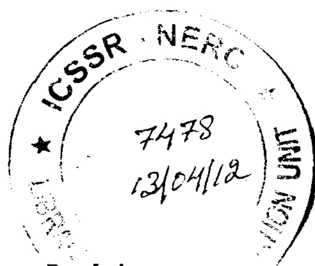

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1

Indigenous Medicine and Health Care

An Overview

Human life is inherently frail – from the inevitability of decay and death to that of disease and sickness. Alleviation of disease and preservation of health both conditioned by culture, have been a human pursuit since antiquity. Using drugs and diet as remedies for the disruptive episodes in life process, is not something new. It is as old as human existence. The pre-historic humans derived the therapeutic agents from nature without maligning the environment. The plant kingdom, since the beginning of human civilization, served as the reservoir of medicine – therapeutic agents to restore health. Overtime the need to cover a wider variety of disease patterns and to augment the therapeutic potential of the agents, mineral and animal constituents began to be incorporated into this plant based medicine. Needless to say, this used of natural resources as therapeutic agents was based on a unique belief system encompassing the concepts of health, physical or mental illness, diagnosis, treatment and of prevention. The accumulated knowledge of such health practices and products is a rich cultural heritage common to all human societies sometimes ignored or unrecognized in a formal or institutional sense.

INTERNATIONAL RESPONSE TO INDIGENOUS MEDICINE

In 1977, the Thirtieth World Health Assembly of the World Health

Organization (WHO) passed a resolution promoting development of training and research in traditional system of medicine. In the following year, in 1978, the International Conference on Primary Health Care held in Alma Ata under WHO and UNICEF sponsorship passed additional resolutions supporting the utilization of indigenous practitioners in government sponsored health care systems. This brought about the issue of improving and strengthening the public health infrastructure in all the signatories' countries including India.

As its declaration towards primary health care, WHO has taken up various activities and initiatives concerning indigenous medicine. In the progress report on indigenous medicine and modern health care presented by the Director General Dr. Nakajima at the 44th World Health Assembly in 1991, it was stated that WHO undertakes, in response to request from member states, are those that support member in their efforts to formulate national policies on indigenous medicine; to study the potential usefulness of indigenous medicine, including evaluation of practices and investigating of the safety and efficacy of remedies; to upgrade the knowledge and skills of traditional and modern health practices (Zhang, 1994).

At the international level, in 1988, the World Health Organization, the World Conservation Union, the World Wide Fund for Nature convened an international consultation on the conservation of medicinal plants in Chiang Mai, Thailand. This resulted, *inter alia*, in the issue of the Chiang Mai Declaration, calling for action to "save the plants that save lives" which helped in finalization of the guidelines on the Conservation of Medicinal Plants, published in 1993. Moreover, Resolution WHA41.19, taken at the Forty-first World Health Assembly (1988), drew attention to the Chiang Mai Declaration and endorsed the call for international cooperation and coordination to conserve medicinal plants, thereby placing their conservation firmly in the public health policy arena.

INDIGENOUS MEDICINE IN INDIA

In the case of India, our government has encouraged the traditional

great medical systems such as Ayurveda, Unani, Siddha etc. However, a policy decision regarding the myriad culture-specific local medical systems is yet to be taken. India has perhaps the world's largest community supported living tradition of its own indigenous systems of medicine. Indian medical traditions function through two types of social streams, the folk stream and the classical stream. The folk medical stream is located in the villages of rural India; there is no tribal or rural community without a local health traditions, a system which is local resource based relying on locally available flora, fauna and minerals. So intense is the dependence on local resources that an ethno biological survey conducted by the All India Co-operative Research Project on Ethno Biology, covering 80 percent of the tribal areas, reported the use of 7500 wild plants for medicinal purposes by tribal groups alone. This amount to almost five percent of all the flowering plants in India (Mukhopadhaya, 1997). These medical traditions are generally undocumented and systematic attempts have not been made to evaluate their strengths and weaknesses. Who is competent enough to judge local health traditions and what methodology should be adopted to evaluate these traditions are questions, which have not been posed seriously. It is indeed remarkable that with over 10,00,000 practitioners as its carriers, the folk streams receives practically no state or organizational funding and is entirely supported by the community. Given its magnitude in terms of human power, natural resources and knowledge, folk traditions could be harnessed to achieve the goal of self—sufficiency in primary health care.

Scenario in North East India

The North East India, comprising the seven sister states, namely, Assam, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Meghalaya, Tripura, have remained relatively backward even after fifty years of independence. The reasons for this backwardness or the lack of development are many. First, its location which is in the north east corner and joined to mainland India through a narrow corridor, hardly 80 kilometre wide. The rest of its land locked territorial boundary is

shared by among Bangladesh, Myanmar, China and Bhutan, giving the North East a strategic position.

The ethnic composition of the North East is diverse comprising principally of Sino-Tibetan stock, who have migrated into India during different periods in history, mostly from Tibet and China through Myanmar and Thailand, and more recently after independence from Bangladesh. Migration from the plain areas of West Bengal, Bihar and Uttar Pradesh, though less significant is not totally absent.

The tribal population had been encouraged to pursue their tribal lifestyle and culture undisturbed following Nehru's Panch Sheel Policy. What he failed to recognize was the dynamics of tribal societies and the social changes that were taking place. This has been the source of discontent among the tribal people and has given rise to distinct political aspiration. Moreover, with low population densities the North East is poorly represented in the National Government (Hazra, 2002).

The real cause of the lack of development is the alienation of the North East and the failure to develop proper relationship between tribal and rest of India. Solving the problems of today's world requires a high degree of professionalism, openness and inter-disciplinary approach, the backwardness stemmed from geo-political realities. The planning and development did not take in consideration the real needs of the people. Lack of law and order has been blamed for the North East's underdevelopment. Technology has made little stride and foreign firms are reluctant to invest. Under such a situation it is required to evaluate the resources available and determine the needs of the people, so that a justified planning may be attempted.

Development and health are intricately related. The health status of the North East is perhaps related to backwardness and *vice versa*. Despite the stress on sanitation and preventive medicine in the pre-Independence period and the Bhore Committee recommendation of 1946, the post-Independence era has seen a virtual decline of preventive medicine and a major stress on curative medicine particularly in the North East India. Health planning has never been made an integral part of the overall planning for socio-economic development. Planners failed to realize the need to tackle unemployment, malnutrition, housing and

sanitation problems along with the integrated health services for the entire population as the prime requisite for health attainment. But a number of vertical programmes like family planning programmes, etc., became the main focus of the health care system. Health education and public health were denied a priority and the budget allotted to health care never exceeded the 3 percent mark (Hazra, 2001).

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 health care facilities though poor in the northeastern states of India. 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. For the purpose of this study the state of Manipur is selected to explore the nature and utilization pattern of indigenous medicinal substances for primary health care needs. The State has about 6.20 percent of North East India's population (Census of India, 2001) but does not have a matching share of medical facilities available at the National level. Besides medical facilities are unevenly distributed, big hospitals, equipments for specialized treatment, specialist's etc. are all located in urban centres.

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 (Datta, 2001). 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.

UNDERSTANDING INDIGENOUS MEDICINE

What separates this body of knowledge referred to as 'indigenous medicine' from 'moder n medicine' is the fact that the latter in anchored in science, while the former is practical experience. As long as science continued to be narrowly defined, traditional medicine remained largely unnoticed (Mukhopadhya, 1992). It took a sort of scientific resolution, a paradigm shift, to draw renewed interest in traditional medicine. Increasingly the very validity of this traditional-moder n dichotomy is being questioned. Indigenous medicine differs from the 'moder n' or 'western' medicine not in terms of goals and effects, but in terms of their underlying cultures and historical contexts. Viewed from this perspective all medicines are modern in so far as it is satisfactorily directed towards the common goal of providing healthcare, despite the setting in time, place and culture (WHO, 1977).

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. In India we have both the documented and non-documented form of traditional medicines. 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).

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. 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." The indigenous systems of health care are 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.

Emerging concern towards indigenous medicine

It is the feature of indigenous health systems that it intersects with areas of national economy than simply health. Environmental factors such as land degradation through erosion and/or development has contributed to the loss of natural habitats. Loss of natural habitats can affect the availability of medicinal plants and hence have an impact on local heath standards. In countries where this occurred, herb gatherers have to walk increasingly long distance to find herbs that previously grew nearby. Overtime medicinal plant resources deplete in those areas and the distance and time involved in gathering herbs increase. This is compounded in herbs where demand is great and cultivation is minimal. All this contributes to increasing cost, the availability and sustainability of naturally occurring sources of medicine (Bodekar, 1994).

Domestic finances as well as national economic development may

be linked to the cultivation and use of indigenous medicine. For instance, cultivation and use of wild harvesting of medicinal plants can bring in additional source of family income. It also saves expenditure on other medicine. However, over harvesting constitutes a threat to biodiversity. Over harvesting of medicinal plants, as is the case of India, where approximately 80 percent of the raw materials for indigenous medicine and cosmetic products come from the wild sources, raise the need for new policies which integrate health and environment and economic perspectives. Investments are needs for the development of appropriate cultivation and harvesting strategies, which will meet the demand for low cost and locally available medicines as well as for the conservation of biological resources (Helly and Cherla, 1999).

In recent years, there has been a growing interest in indigenous medicine among the international pharmaceutical industry as well as among the natural product industry in Europe and North America. Indigenous medicine is viewed by the pharmaceutical industry as a source of 'qualified leads' in the identification of bioactive agents, which can be synthetically modelled for the production of patented modern drugs. These trends have led to a situation where indigenous medicinal substances are viewed as a source for the production of other medicine rather than having intrinsic validity and value of its own right. For instance in the case of malaria the synthetic drugs are no more useful as the mosquitoes have developed resistances against the drug. However, the original drug, i.e., the cinchona bark—the natural source of quinine, on which the synthetic drugs (chloroquine and mefloquin) are modelled and developed, is still effective in resisting malaria (Shankar and Venugopal, 2000).

Resurgence of interest towards indigenous medicine

In the past decades there has been a resurgence of interest and activities in indigenous medicine both in developing and developed countries. A number of factors contributed to this resurgence of interest. In brief, it may be cultural, economic, national crisis like war and epidemic to conserve biodiversity.

Cultural

The most important factor is the nationalist spirit that engulfed the developing countries on their independence from the colonial rule. With political independence from the colonizers, most of the developing countries experienced a sense of cultural revival. Reviving one's own culture and taking pride in it beçome a nationalist goal. This cultural revival renewed interest in traditional health practices and products among the indigenous people.

Economic

More recently, hard economic realities also contributed to this renewed interest in indigenous medicine. For many developing countries, the Western health care system became economically burdensome. This system, in most cases is based on institutions (hospital) with a curative focus. In many developing countries, hospitals are primarily located in large urban centres while the bulk of population lives in rural villages. These hospitals with their modern technology often consume more than 90 per cent of the health budget, leaving little resources for other essential activities. Drugs, produced by multinationals and often imported from outside are also a cost burden that few developing countries can afford. Faced with such economic pressure, government in many developing countries have recently increased their support for the long standing traditional medical practice for their primary heath care needs in tune with the WHO declaration.

National Crisis

It has served to spur developments to evaluate their indigenous medical traditions as a means of providing affordable and available health care for their citizens. Two common crises have been influential. They are war and epidemic (Bodekar, 1993). In the case of war an acute shortage of pharmaceutical supplies necessitate the country to turn to its herbal tradition as a means of assisting with the country's medical needs. For

instance during the Vietnam war of independence, an official policy was articulated in 1954 by President Ho Chi Minh, which asserted the importance of preserving and developing indigenous medicine as a basic component of health care through out the country since modern medicine was not affordable for a significant proportion of the population of Vietnam. In the case of epidemic, example from Africa show that the government facing huge drug bills for the growing AIDS crises are looking to their indigenous medical traditions and medicinal substances to identify inexpensive and effective treatment for at least alleviating the suffering of AIDS victims. Also outbreak of chloroquine resistant malaria has also been a spur for a number of countries to re-examine traditional methods of treating malaria.

Conservation of biodiversity

International concern and pressure to conserve biodiversity is the latest source of influence on the promotion of indigenous medicine. Two other interrelated factors must also be noted: clinical tests on the efficacy of some indigenous medical practices (with positive outcome) and, consequently, a rush by some multinationals to patent and market those products. These latest development brought in various problems and issues.

HEALTH CARE SYSTEM AND STRUCTURE

Health care is just one of the inputs which determine the health of a given community. Health status is determined by a variety of socio-economic factors like income levels, education, nutrition, water supply, and sanitation. Therefore, WHO definition addresses health as 'a state of complete physical and mental well-being and not merely the absence of infirmity'. What is well recognized is that health care is not a mere technical input but is shaped by socio-political forces in the society. All societies have evolved means to alleviate pain and suffering caused by illnesses. Health care is at the very centre of concerns for an individual. Within the primary groups, for example the family, the

individual forming the group mutually shares this concern for health. This mutual concern gets, in practice, translated into the responsibility that the head of the family, who manages the affairs of the household, bears for attainment and maintenance of the health of each individual member. The individual concern is, in other words transformed into a family responsibility. Individual and families derive their identities from the community in which they live. So, at the next stage, the community becomes the guardian of the health of its members. This role of the community in the sphere of health, as in several other aspects of community life, derives justification from the fact that most determinants of the health of its individual members lie embedded in the environment within and surrounding that community. The community is in a sense a social organization that mediates between its members and environment in order to sustain life and promote healthy living conditions within its geographical bounds. It has been widely recognized that environmental factors play a much more important role than the individual specific genetic factors in determining the conditions of health and mortality in a population. Therefore, it is one of the basic functions of social organization to cater to the health needs for its members (Bose and Desai, 1983).

Communities do not exist in isolation; they form part of a larger society, the nation or the state. Accordingly, a part of their concern for health gets transferred to this larger, more inclusive whole. The individual, the family, the community and the state can thus be seen as partners sharing unavoidable responsibility of ensuring that the opportunity of leading a healthy life is available to all, without discrimination of any kind (Bose and Desai, 1983).

In the provisions of health care, primacy attaches to the role of the individual, the family and the community. Apart from the above conceptualization, this proposition rests on the historical experience of indigenous cultures, which have persisted for long in most of the so called developing countries from the Middle East to the Far East. It is within such a cultural framework that an appropriate indigenous system of health and medical care had been evolved on no less a scientific basis than the one on which the edifice of 'modern' medicine has been

built. Health care, thus, become an essential social service and the government provides free health care in government institutions.

As our proposed study is concerned with tribal societies, special attention was given to the utilization of indigenous medicine in dealing with health problems. 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 had have its effect on the livelihood, work, cultural practices, which includes health seeking behaviour and these have undergone change. Newer innovations and introduction of allopathic system of medicine have brought change in the perception and practice not only in the various aspects of their life but also in their health culture. It is observed that the change in the larger socio-economic system is bound to produce changes in the subsystems. Banerjee in his work on health culture observed that health culture is the subculture of the larger complex of culture (Banerjee, 1982). As a result the changes in the overall culture influence changes in the health culture of the community. Therefore, a study that proposes to look at the utilization pattern of indigenous medicine has necessarily to locate it within the changes that have taken place with intervention specifically related to health as well as the larger socio-economic sphere. Also there is a need to understand how the changes in larger socio-economic sphere and the health care system have brought about the changes in the practice of folk practitioners.

System

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 service 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).

Structure

Health care institutions have structural division for better performance of duties. It should have good facilities with skilled staff. But quite often we find that they face difficulty in running institutions because of changing health care needs; rapid advances in technology; obsolescence of equipment; rapid turn over of staff. Besides this problem there are other emerging problems in health sector. They can be stated briefly as –

- Dual diseases burden of communicable and non-communicable diseases;
- Technological advances which widen the spectrum of possible interventions;
- Increasing awareness and expectations of the population regarding health care services; and
- Escalating costs of health care and ever-widening gaps between what is possible and what the individual, institutions or the country can afford.

With these perspectives the study basically attempts to gather essential information needed for health planning. Health planning, in

brief, needs to examine the following factors before implementing it. They can be –

- Current health status, health care needs and health care utilization pattern of the population;
- Available institutions/manpower/facilities;
- Quality assurance mechanism and cost of care data at primary, secondary, tertiary care levels;
- National and state level public goals; and
- Income and purchasing power of the people.

RATIONALE BEHIND SELECTING THE STUDY TRIBE

The study was undertaken to understand the utilization pattern of indigenous medicinal substances for health care needs in Manipur. It also tries to find out, if possible, a way for tackling the prevailing conditions characterizing the health scenario of Manipur. It is a multi-stage and purposive sampling. Manipur has nine districts, of which there are four plain districts and five hill districts. The hill districts are given more emphasis for the study because they constitute only the tribal population with no proper health facilities. Besides this, almost all the hill districts are overwhelmingly rural in character, few with the headquarters depicting a semi-urban nature. Out of the five hill districts, the district of Churachandpur was selected based on the area and size, population, sex ratio, literacy level, density of population etc. According to the census of Manipur 2001, Ukhrul, Tamenglong, Churachandpur, and Chandel are predominantly tribal districts having more than 90 per cent of the district's population as Scheduled Tribe (ST). Senapati district has recorded 78.5 per cent of its population as ST. These five districts together hold 92.4 per cent of the State's total ST population.

In Churachandpur district out of the many tribes, the 'Paite' tribe is selected due to the following reasons. Out of the many tribes residing in Churachandpur district, 'Paite' tribe holds the majority in terms of

population and land occupation. As per the Census of Manipur, 2001, the total population of 'Paite' was 49,271 which is the highest among the other tribes residing within Churachandpur. In terms of educational level 'Paite' tribe has recorded the second highest literate population[1] and also recorded the highest in attending schools and any other educational institutions[2].

Based on this data, the Paite tribe is selected for the study as this tribe is advanced in many fields as compared to the other tribes residing in Churachandpur district and this seems to be the most appropriate tribe to represent other tribes in the district.

CONCEPTUAL FRAMEWORK

From early days man started living in equilibrium with nature. As man realized that he has to depend heavily on nature and natural resources for his daily requirement, he automatically developed curiosity and instinctive interest towards various plants and animals. This knowledge comprises their use not only for food and medicine but also for their basic needs. Such indigenous knowledge about plant, animals, agricultural practices and other aspects that affect the human being are of important strategic value and got wide ranging economic, social and political repercussions. Hence the need to protect and improve the traditional knowledge associated with the biological diversity arose and also came to be debated all over the country.

Looking from the sociological perspective we find that, through time indigenous medicine has sustained itself through processes deeply rooted in a society's socio-cultural complexes. '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. Indigenous medicine is just but one of the manifestations of the people's would view, how they relate and interact with themselves as individuals, as part of the community and rest of the environment' (Segesmundo, 1994). Probably or maybe here lies the secret of its sustainability 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.

Therefore, for a health care system 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. This was laid down as the 'new holistic concept' of health by the World Health Organization in the late 1970s. 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 programes 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 services network using expensively staffed hospitals and health centres, as the world inflation mounts and the financial situation of countries with low production worsens. Given this scenario, the idea of effective low-cost health care delivery system was introduced, as it became inevitable and emerged as an obvious alternative.

The establishment of indigenous medicine programme 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 medicine. 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.

International concern and pressure to conserve biodiversity is the latest source of influence on the promotion of indigenous medicine. Two other interrelated factors must also be noted: clinical tests on the efficacy of some indigenous medical practices (with positive outcome) and consequently, a rush by some multinationals to patent and market those products. These latest developments brought forth a plethora of problems and issues, but at the same time ushered in a new era for indigenous medicine. This contemporary focus on indigenous medicine has also brought forward other related issues. These issues may be grouped under four broad categories:

- Preserving and promoting indigenous practices and products;
- Collaboration/cooperation of indigenous and modern systems of health care;
- Production/research and development of indigenous medicine with full attention to all the complex issues of intellectual property rights, patent rights, the role of multinationals, etc.; and
- National and international policies regarding indigenous medicine and biodiversity, and environmentally and culturally sustainable and equitable development.

These issues are complex and critical. Most of them transcend national boundaries and cannot be resolved without international efforts and agreements. It is time that we embark on a serious dialogue, both within and among nations, to address these fundamental issues for human health in all its dimensions. With this conceptual framework in mind, the research study is carried out in quest for better understanding of the importance of indigenous medicine and people's belief system for sound health care by drawing on the traditional concepts of health and healing as well as locally available modern facilities and also to find a more meaningful collaboration between indigenous and modern health systems.

OBJECTIVES 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 behaviour of the people within the overall socio-economic milieu. The following are the specific objectives –

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

ORGANISATION OF BOOK

This present book has been organized in the following chapters :

Chapter 1 - Indigenous Medicine and Health care : An Overview. This chapter introduces the research question and the perspective of the study. It explains the concept of the study. It also states the rationality behind choosing the study areas and the objectives of the study.

Chapter 2 - Evolution and Trade in Indigenous Medicine: Reviewing its Impact on Health. This chapter brings out the social, political, economic and cultural factors that affect the evolution of indigenous medicine. It

also discusses the roles played by international agencies of the developed countries in regard to promoting indigenous medicine for their own benefits and how trade trends in medicinal plants had an impact on the public health of developing countries.

Chapter 3 - Research Design. This chapter presents the methodology of the study. It discusses the scientific rationality on why the study area was selected. It also explains the tools and techniques used in collecting data, the research processes etc. and the limitation faced while conducting the study.

Chapter 4 - Profile of the study area. This chapter introduces the profile of the study area beginning from the State to the village.

Chapter 5 - Health, Disease and Care Utilization. This chapter discusses the profile of the study population, which includes their socio-demographic and economic profiles, utilization pattern of health care services, types of diseases found and their perception of disease causation. Their resort pattern for any treatment is also discuss using tables and figures.

Chapter 6 - Summary and Conclusion. This chapter summarises the whole studies and draws inferences from the findings of the field study and the review of literature. It also gives suggestions concluded from the inferences. Then it concludes the study by giving a few recommendations for policy makers.

NOTES

1. Census of Manipur, 2001, "Of the thirteen major STs, Hmar has recorded the highest literacy of 79.8 per cent, followed by Paite (79%), Any Mizo (Lushai) tribes (74%), Anal (73.9%), and Tangkhul (72.7%)".
2. Census of Manipur, 2001, 'In the age group of 5-14 years, 69.2 per cent of the ST population is attending schools or any other educational institutions. Of the thirteen major STs, Paite has recorded the highest 79.9 per cent, closely followed by Tangkhul (77.9%), Hmar (73.9%), Anal (71.9%), and Kom

(71.3%). Thadou (60.5%) has the lowest percentage attending school in the age group of 5-14 years.'

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