

**DYNAMICS OF INDIGENOUS HEALTHCARE PRACTICES OF
MARAM NAGA TRIBE**

**A THESIS SUBMITTED TO NAGALAND UNIVERSITY IN
FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF
THE DEGREE OF DOCTOR OF PHILOSOPHY**

By

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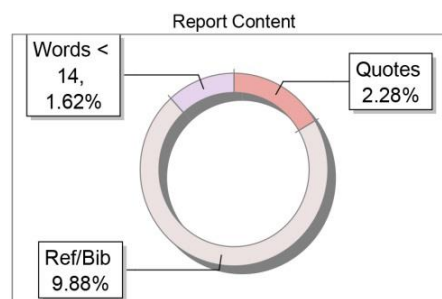
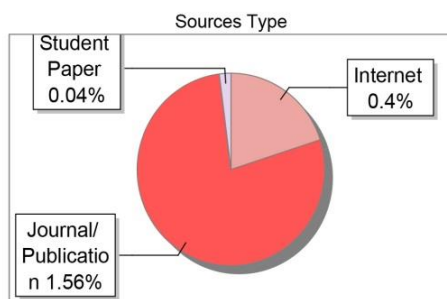
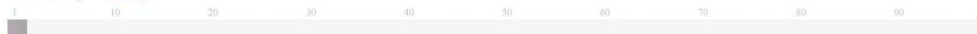
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Sincerely,

Judith Huidina

LIST OF ABBREVIATIONS

ADC	Autonomous District Council
AM	Allopathic Medicine
ANC	Ante-Natal Care
ASHA	Accredited Social Health Activist
CD	Communicable Diseases
CHC	Community Health Centre
FGD	Focus Group Discussion
HBM	The Health Belief Model
HIP	Health of Indigenous Peoples
HS	Household Survey
HSB	Health Seeking Behaviour
HUM	Healthcare Utilisation Model
IMFL	Indian Made Foreign Liquor
IUNC	International Union for Conservation of Nature
IWGIA	International Work Group for Indigenous Affairs
IWN	Indigenous Women Network
KAP	Knowledge Attitude and Practices
MDGS	Millennium Development Goals
MOTA	Ministry of Tribal Affairs

NCD	Non-Communicable Diseases
NH	National Highway
NSC	National Statistical Office
NSS	National Sample Survey
PHC	Primary Health Centre
PVTGS	Particularly Vulnerable Tribal Groups
RCC	Reinforced Cement Concrete
RNTCP	Revised National Tuberculosis Control Programme
SC	Sub-Centre
SDGS	Sustainable Development Goal
SEM	Socio-Ecological Model
TBA	Traditional Birth Attendant
TK	Traditional Knowledge
TM	Traditional Medicine
TMP	Traditional Medicine Practitioners
UN	United Nation
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organisation

LIST OF GLOSSARY

<i>Achii Marung</i>	a dog sacrificial ritual performed during endemic and natural calamities to appease gods and spirits for protection.
<i>Achiimalou</i>	an annual ritual to ward off all evil, misfortune and ill health.
<i>Ahii</i>	a medicine; a substance for treatment of diseases or injury.
<i>Ahiitalo</i>	to roast medicine. When a potential witch is asked to carry out a healing ritual in the evening, she would roast her fingernails on the heated clay pot until the victim senses the odour of burnt fingernails.
<i>Akirkot/Akirakot</i>	a house deity; a descendant of a particular house will prosper and have a good life.
<i>Amaleh</i>	a sacred object.
<i>Anagai</i>	a curry of fragrant meat cooked and distributed to neighbours and relatives to celebrate a newborn.
<i>Aragakiibi</i>	a state of being happy, healthy, chubby, and able to perform work; productive, capable of performing socio-cultural obligations, strong and vigorous.
<i>Arakalui</i>	a feast of merit to appease the gods for further blessings by feeding the village.
<i>Arakatii</i>	a ritualistic feast offered to the community by any family that wishes for good health and well-being.
<i>Arii</i>	most effective method is to flush out a bone stuck in the throat by consuming rhododendron flowers.
<i>Arrii</i>	rice winnowing basket/ Muram
<i>Fiihilampat</i>	a neonatal ritual to mark the newborn as a paternal lineage.
<i>Hangsü-ki/Rühang-ki</i>	a morung, a men's dormitory.
<i>Hiituimei</i>	a woman who practices black magic, one who casts an evil spell on others, causing illness and death.
<i>Kanat</i>	a ritual or a rite.
<i>Kanghi</i>	a post-harvest festival, the biggest traditional festival of the Maram.

<i>Karakimei</i>	a woman who inflicts ill on other people through greetings.
<i>Kataimei Rakak</i>	a day of formal farewell for the departed souls by offering prayers and performing rituals.
<i>Kedem katii</i>	a beginning of labour pain; a Braxton Hicks contraction.
<i>Kiiramba</i>	a piece of a large blood clot attached to Kiilam (Placenta) is considered a sign of a bond between the mother and the child.
<i>Maidama</i>	a practitioner of Indigenous religion
<i>Mala</i>	a ritual to appease <i>Akirkot/Akirakot</i> (the house deity) for <i>Sa'mhii Kabi</i> (healthy paddy plants), prosperity, good fortune, and health.
<i>Malem</i>	a toddler's rite of passage. A ritual for boy toddlers who have completed three years and have weaned to become full community members.
<i>Mangkang</i>	a festival of newly married women and young women.
<i>Mannai</i>	a genna; a non-working day.
<i>Marum-riit</i>	a ritual of purification who partake in <i>Malem</i> .
<i>M'bangkarii</i>	a neonatal ritual
<i>N'pamrah</i>	a ritual for toddlers below the age of two for purification and invoking blessings for good health and fortune.
<i>N'bungkatai</i>	a death during delivery; a maternal death.
<i>N'lou</i>	a ritual performed by the father for his newborn.
<i>Raliiki</i>	a women's morung/dormitory
<i>Ra-ngii Kasangnou</i>	a soulfully weak person with no invisible/unknowable power to protect oneself against malevolence.
<i>Ra-ngii Kasangting</i>	a soulfully strong person with invisible/unknowable power to win over malevolence.
<i>Siira kabi</i>	a God of benevolence
<i>Siira kasii</i>	a God of malevolence
<i>Takoukatuime</i>	a woman who inflicts/causes pneumonia.
<i>Tiikanii</i>	a taboo to perform
<i>Tingpui-Marumanai</i>	a ritualistic purification bath for men taken before dawn for successful hunting.

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Chapter 1

INTRODUCTION

Indigenous people are the custodians of traditional knowledge. Globally, there are an estimated 370 million Indigenous people, which make up nearly five per cent of the world's population. However, they inhabit 24 per cent of the world's surface land, protect 80 per cent of the world's biodiversity and make up 15 per cent of the world's poorest people (International Union for Conservation of Nature and Natural Resources [IUCN], 2019). Indigenous people are the original inhabitants of a particular geographical region; they live in accordance with unique cultural patterns, social institutions and legal systems (Struthers et al., 2004, p.142). They represent a rich diversity of cultures, religions, traditions, languages and histories yet continue to be among the world's most marginalised population groups. In India, the communities classified by the Indian government as "scheduled tribes" have often been categorised as being Indigenous (India Ministry of Tribal Affairs, 2004). As per the census of 2011, over 10.4 crores of people belonging to 730 Scheduled Tribes notified under Article 342 are identified as members of scheduled tribes, constituting 8.6 per cent of the total Indian population (India Ministry of Tribal Affairs, 2022). Being among the poorest and most marginalised groups in India, Indigenous people experience extreme levels of health deprivation. Nagas are a large ethnic group of nearly 70 Indigenous tribes inhabiting the northeastern states of India, in contiguous regions of Nagaland, parts of Manipur, Assam and Arunachal Pradesh, and the northwestern region of Myanmar (Tohring, 2010, pp. xv-xvii). They live primarily in hard-to-reach, harsh geographical regions with limited access to transport, communication and amenities for health, education and modern livelihoods.

Health is one of the key concerns affecting the Indigenous people compared to non-Indigenous people. The UN treatise on Indigenous health highlights that "extreme poverty is significantly more prevalent among Indigenous peoples than non-indigenous groups, and are rooted in other factors, such as a lack of access to education and social

services, destruction of Indigenous economies and socio-political structures, forced displacement, armed conflict, and the loss and degradation of their customary lands and resources”, it further elaborates that “structural racism and discrimination make Indigenous women and children particularly vulnerable to poor health. Because of these phenomena, Indigenous peoples experience high levels of maternal and infant mortality, malnutrition, cardiovascular illnesses, HIV/AIDS and other infectious diseases such as malaria and tuberculosis” (Inter-Agency Support Group on Indigenous Peoples Issues, 2014, p.2). Indigenous issues are the issues of all humanity. The violation of indigenous rights is a violation of human rights psychically, mentally, and socially.

Indigenous populations in India, often among the poorest and most marginalised groups, face significant health disparities and extreme levels of health deprivation. The tribal communities in India fall short of the national average on various critical public health indicators, with women and children being the most vulnerable populations. Furthermore, the indigenous communities are the most exploited and highly vulnerable to diseases with a high degree of malnutrition, morbidity, and mortality (Shrivastava et al., 2013, p.6). The key concerns about public health delivery to the Indigenous populations have been an inadequate outlay of the public healthcare infrastructure and personnel, remoteness, rugged and tough geographical terrain with limited transportation and communication facilities, cultural and traditional barriers in accessing modern healthcare services, as well as educational and socio-political problems faced by the communities. However, in pursuing the spirit of the SDGs, all stakeholders must be involved in exploring possibilities and opportunities to ensure the health and well-being of the Indigenous people.

Traditional knowledge is meticulously developed over the centuries through practical observations, spiritual learning and traditional teaching. The traditional healthcare knowledge systems approach health and well-being holistically. WHO estimated that 80 per cent of the population in developing countries relies on traditional

healing systems as their primary source of health care. WHO recommends “ensure the incorporation of Indigenous peoples’ perspectives into the attainment of the Millennium Development Goals and national health policies; develop strategic alliances with Indigenous peoples and other stakeholders to advance the health of the Indigenous peoples further; promote the training, education and leadership development of Indigenous healers, and their incorporation in the health system formally, where appropriate; promote the incorporation of the intercultural approach in the curricula of all training and degree programs in areas of health and related fields and its implementation in all health institutions” (Pan American Health Organization, [PAHO], 2006, p.2).

Indigenous healthcare practices are traditional methods of healing passed on from generation to generation through the practice of individuals, families, and communities. In 2019, the World Health Organisation (WHO) updated the definition of ‘Indigenous traditional medicine’ as “*the total of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental and social diseases. This knowledge or practice may rely exclusively on past experience and observation handed down orally or in writing from generation to generation*” (p.8). In this context, traditional medicine includes medicines derived from plants, animals, minerals, customs, rituals, and ways of life that the community practices. In Indigenous communities, health and disease management reflect the social solidarity of a community (Mishra, 2013, p.2). Traditional medicine is a holistic approach through which the body, mind, and spirit are connected to the individual, family, community, and universe (Struthers et al., 2004, p. 143). Therefore, in the changing world, traditional medicine is dynamic in health and healthcare (Dew & Liyanagunwardena, 2023, p.14).

There are several challenges to achieving the desired healthcare outcomes for the indigenous communities across India; “The challenges that tribal women and children face are intricately linked to the geographical isolation of tribal villages, the prevailing state of poverty, the dependence on traditional healing practices, insufficient nutrition, and the

demanding nature of both domestic and occupational work” (Madankar et al., 2024, p.10). Poor health sector, lack of education, absence of minimum health care and food insecurity continue to be major problems for the indigenous tribal people in India (Indigenous Women’s Network, INDIA, n.d, pp. 7-8). The Indigenous people fall behind in almost every social, economic or political indicator considered by the Sustainable Development Goals of the United Nations. Their health status severely affects their living conditions, employment and income levels, and access to food, water and sanitation services. The UN 2030 agenda for SDG that promises to “Leave No One Behind” is imperative that the indigenous people's concerns, priorities and rights be upheld in letter and spirit on the road to achieving the SDGs (Yumnam, 2024, pp. 20-21).

The current research is taken up in the context of the increasing global recognition and appreciation towards traditional healthcare systems and the unequal distribution of public healthcare among the Indigenous people who are marginalised people of the countries in the world. There have been many initiatives to understand the challenges the Indigenous people face in their natural environment and the scenario of ever-changing healthcare needs due to changes in their interaction with the modern industrialised world and the perils of overall human impact in the natural environment. The study is rooted in the premise that the Indigenous communities have had primary to advanced knowledge and skills to address the concerns that affect their lives. In most cases, Indigenous knowledge and skills are time-tested and valuable in a given natural environment, whereas some of them have become obsolete.

Conceptual Framework:

Throughout history, health and healthcare have been cornerstones of thriving societies. Humans have always strived to understand the causes and patterns of disease, disability, and death. According to the World Health Organization (1948), in its preamble, it defined health in its broader sense as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. This goes beyond

the usual idea of health as simply the lack of physical or mental problems but involves their emotional, social, cultural, economic, and environmental congruity. Park (2011) elaborated on the new philosophy of health as a fundamental human right, interdependent with the social environment for quality of life. It is a worldwide concern to take responsibility as an individual, community, nation, and internationally on humanitarian grounds. For good health, “one must establish a balanced relationship with oneself, with family, community, the land and the world. In other words, sickness is being perceived as an imbalance which may begin in the physical or the mental realm or in the emotional or the spiritual realm.” (Islam and Wiltshire, 1994, p 73).

The Oxford Dictionary defines well-being as ‘being comfortable, happy, and healthy’. According to Frey and Stutzer (2002), well-being encompasses mental and physical health, leading to more comprehensive disease prevention and promotion strategies. It is linked to various benefits across health, employment, family dynamics, and economic status. Enhanced well-being correlates with a reduced risk of disease, illness, and injury, improved immune function, faster recovery times, and increased longevity.

Healthcare encompasses all efforts to maintain or restore physical, mental, and emotional well-being. Early humans developed healthcare practices by observing patterns of illness, injury, disability, and death. Healthcare often refers to systems and processes designed to ensure citizen health. A modern healthcare system involves prevention, diagnosis, treatment, and rehabilitation, aiming to empower people to live healthy and fulfilling lives. This system traditionally revolves around Western (allopathic) medicine, which treats symptoms and diseases with medication, radiation, or surgery by trained professionals using specialised equipment.

Public health, being a multi-faceted interdisciplinary field, has many elements and practices, with scientific and technological advances and management of services at its

core. The infrastructure, human resources and preventive, curative and supportive medicine practices approved and promoted by a country's government or private practitioners are primarily considered the system's backbone. The outlay and utilisation of public health have been considered a critical indicator in assessing the developmental indices of a community. However, the knowledge, attitudes, and practices nurtured by the communities' inherent cultural traits and traditions are equally vital in evaluating the overarching impact of the systems in place.

The study sought to delve into the healthcare concerns of the Indigenous Maram community to explore the traditional healthcare practices and their relevance and efficacy in addressing modern healthcare challenges. The study provides a broad understanding of the evolving scenario in health and healthcare among the Indigenous people and recommends evidence-based action that would enhance healthcare delivery in hard-to-reach, resource-constrained Indigenous settings.

Theoretical Framework:

Symbolic Interactionism

The social interaction and behaviour of self with individual, group and community are influenced through symbols, language, and objects. Husin et al. (2021) in *The Symbolic Interaction Theory: A Systematic Literature Review of Current Research*, citing the work of Cooley (1902), Mead & Mind (1934), Blumer (1986), the perspectives and social behaviour of self and mind, society and environment are elements of culture, gender, race, religion, and health ... it is a social phenomenon (p.114). Hence, symbolic interactionism has advanced in a holistic approach to healthcare since it interfaces with the daily activities of the sick person (Cersosimo, 2022, p. 468). Health and healthcare are embedded in perceptions and social interactions with individuals, groups, and communities. In symbolic interactionism, *the Mind, Self and Society* of G.H Meads can be related to the present study on the dynamics of healthcare practices.

This theory is particularly relevant to this study as life, rituals, and customs assign symbolic meaning to plants, animals and natural elements used in various healing practices. These belief systems represent a deep connection to the natural world. The study further brings out the tribe's understanding of health and well-being, which are affected by spiritual, social, and environmental factors. This understanding has been the cornerstone of the individual's response to illness and death. How the community responds to its members' needs is also relevant. In Indigenous communities, healthcare response is a group effort limited to not only the families and friends but also the extended community members who pitch with support in terms of prayers, money or materials. This study seeks to understand the cultural, social and spiritual dimensions of healing among the Marams and contribute towards preserving and promoting traditional knowledge and practices. The study also fosters a more inclusive and culturally sensitive healthcare delivery approach.

Structural Functionalism

According to sociological functional perspectives on health, society has a similar system; all the organs in the human body function for growth and development; similarly, in society, if the social structure breaks, the total system suffers from displacement; in the work of Emile Durkheim (1951[1897]) *Suicide*, the disintegration in the society, the regulative aspects leading to religion and cultural changes resulted in suicides referring to the protestant and catholic church. Furthermore, Max Weber's (1958) *The Protestant Ethics and Spirit of Capitalism* reflected societal change and transition. The cultural beliefs of the religious group have resulted in a high rate of morbidity and mortality. Hence, health is a social phenomenon defined by Parson (1951). A *Sick Role* is "the state of the optimum capacity of an individual for the effective performance of the role and tasks for which s/he has been socialised" Therefore, dislocation of implication in the life of the Indigenous community is seen in the traditional way of living, belief system, religion, culture, traditions, and indigenous knowledge. Traditional healthcare practices are holistic, taking precautionary measures for preventive, curative, palliative care, and

rehabilitation, which aligns with the “Sick Role”. Parson describes, in like fashion, the dysfunctions of any parts of organs that affect the whole functioning of the body, for which the external environment (physician) is involved in repairing the body system where the patient should cooperate to get well. Similarly, Parson pointed out that the social system becomes dysfunctional when a person is sick; he said sickness is a “deviant”; the “Sick Role” is a social control. It is a social phenomenon in a social system. Parson has pointed out three primary criteria for the social role of being sick:

- First, sickness is a natural abnormality that is beyond the control of the sick person; therefore, victims and others should accept the sickness.
- Secondly, the sick person should be excused and exempted from social obligations and responsibilities. Although the social structure function is affected.
- Third, one should seek treatment and healthcare services to get well and restore normalcy

These theories are pertinent to the present study. The stakeholders involved in healthcare can be categorised into three groups: the patient, the caretaker (family members, relatives, and neighbours), and the practitioners (encompassing both traditional healers and modern medical professionals). All three groups must take responsibility for the patient's recovery, as this collaborative effort is vital for restoring equilibrium within the community's social system. Consequently, the current study investigates the social phenomena associated with the socio-cultural and economic factors influencing health and healthcare practices among the Indigenous Maram Tribe.

Review of Literature:

The literature review is organised into five thematic sections. It begins with health, well-being, and healthcare studies, highlighting various health and healthcare delivery models. Studies on the determinants of health and healthcare within indigenous communities follow this. The review then focuses on studies on traditional medicine, including the roles of traditional medicine practitioners and the ethnomedicine associated

with flora, fauna, and minerals. Finally, it concludes with studies on health-seeking behaviours among Indigenous populations.

Studies on the Concepts of Health and Wellbeing

Sonowal (2018) delineates the concept of health as encompassing physical, physiological, and social well-being, distinguishing between “diseases” and “illnesses” through the frameworks of “Etic” and “Emic.” The Etic perspective views disease as a biomedical condition linked to the individual, while the Emic perspective interprets illness as shaped by socio-cultural experiences of feeling unwell. Consequently, the author posits that disease and illness are interconnected aspects of health, suggesting that the healthcare system should adopt a holistic approach to address these complexities.

McKenzie et al. (2005) study on community health defines it as the collective actions of a specific group of individuals to promote, protect, and preserve their health needs. This encompasses researching and organising health education initiatives that serve the entire community. Additionally, community health is influenced by social factors that foster individual or group interactions in the context of both explicit and implicit cultural elements, thereby facilitating individuals’ integration into their respective societies.

Nettleton (2021) has clearly articulated that the health implications are significantly shaped by the child's upbringing, which is influenced by the social and cultural environment. Furthermore, the author states that living in an era of new technologies and healthcare institutions plays a crucial role throughout life.

Furthermore, Nagla (2014) discusses the sociology of health, emphasising the intricate relationship between health and illness. The author highlights the connections among healthcare personnel, patients, and the state within contemporary Indian society, addressing issues such as nutrition, health, illness, suffering, and reproductive healthcare.

Additionally, Nagla notes that various sociological phenomena, attitudes, and values are integral to understanding health and illness's complexities.

Sujatha (2017) emphasises the significance of understanding cultural predisposition and perception in health. The author highlights that health is beyond morbidity and mortality; it is the totality of health-seeking behaviour, cultural predisposition and perception, malnutrition, disability, mental health, and basic amenities, such as good infrastructure, roads and communication, water, hygiene, sanitation, and a healthy environment. The author affirms that the complementary factual statistical averages and ethnographic narratives about health in sociology are imperative.

Mishra (2013), in his review on public health, affirms that to perform the assigned social role in society or a group, the members of society should be in a healthy state or condition. Further, the author states that a healthy community may contribute to society's development.

Levesque et al. (2013) propose a five-stage perception linear framework that characterises public healthcare. The first is the desire for healthcare – the ability of the people to recognise the need for healthcare and the knowledge of service. Secondly, the ability to 'seek healthcare' is affected by social, cultural, and economic factors. The third stage concerns 'healthcare reaching,' the accessibility and approachability of services when needed. Fourth is the affordability of healthcare utilisation, the ability to pay, income, and social support. The fifth is appropriateness in meeting the client's satisfaction, expenditure, and curing of ailments.

Stacey and Homans (1978) have enlightened by reflecting upon describing health, illness, and treatment. Citing Parson's theory on the importance of medicine in society as a whole, which speaks of illness as a deviant, one must play the sick role and get better health for the smooth functioning of the social system. The author argues that in the social

approach to health, the focus is on health and illnesses, and hence, the stress on the intervention should be the health practices of the communities and the policies that facilitate the same. He further states that there is a need to strive for an integrative approach to healthcare.

In his 1981 review of social behaviour and medicine, Cockerham examines old and modern research trends related to health and medicine. He explored the key concepts - the sick role, the dynamics of the patient-doctor relationship, health-seeking behaviours, the social engagement of medical and nursing students, and issues of death and dying. In his review, he highlighted the evolving nature of healthcare delivery, social policies, stress, lifestyle factors, and the challenges associated with ageing and overall well-being. The author sums it up by stressing the importance of developing mutual understanding in simplifying the complex interaction between human behaviour, the mind and body, and the social and physical environments that influence the determinants and consequences of illness.

Mehta (1982) (Cited in Mohammad Akram, 2014) dissects the past studies conducted on themes related to health, disease, and medicine in India into two groups: (a) studies on providers of health and medical care and (b) studies on consumers of health and medical care.

Larkin (2011), one of the key proponents of the Sociology of Health, states that the concept of the sociology of health and illness has now achieved professional and academic recognition. Several developments have taken place in this field through continuous research. Now, it is concerned with all aspects of contemporary life that affect health and well-being throughout all phases of human life.

Studies on Health and Healthcare Models

Boruah (2012) describes Dalal and Ray's (2005) sectoral model of health. The author details the four sectors under the social dimension of health: socio-economic concomitants of health, health service system, healthcare practices, and health attitudes and perceptions.

Sonowal (2018) details the health models, that is, the Health Belief Model (HBM) and the Healthcare Utilisation Model (HUM). The health models detail the holistic approach to healthcare services, focusing on the demography profile, perception, social-cultural and economic aspects, health-seeking behaviour and alternative treatment perspectives. The author analysed the theories of HBM, which were formulated by Sheeran and Abraham (1995) and HUM by Andersen (1973), formulated by Kroegeer (1983).

Cáceres et al. (2023) present a socio-ecological model detailing the factors that determine health-seeking behaviour at the intrapersonal and interpersonal levels and at the community, organisation, and policy levels.

Studies on the Determinants of Health and Healthcare Among Indigenous Communities

Kleiman's (1978) analysis of the concepts and model for comparing medical systems to cultural systems has proven that the medical system is construed as a social and cultural system, with meaning and norms found by the social relationship and institutional setting. The author further describes the three sectors of the healthcare system, popular, professional, and folks, as an internal structure of indigenous healthcare practices.

Gyasi (2018) analysed the health and health-seeking behaviour of the ageing population in Ghana. The study reveals that traditional medicine usage has declined;

however, surprisingly, traditional medicine use in urban areas has increased compared to rural communities. The study also proved that ageing people with strong social networks with spouses, family, relatives, and friends who engage in social events are significantly healthier.

Armenakis and Kiefer's (2007) study on the social & cultural factors related to health Impact reveals that individuals' and communities' perceptions of health, illness and health care differ from community to community. The thoughts, beliefs and behaviours that integrate the culture and cultures within the society, like 'food, shelter, clothing, social justice and love' are the needs of humans, and these will impact health. 'Medicine is its own culture with socialised roles, beliefs, and practices'.

Dutta and Pant's (2003) analysis of the nutritional status of Indigenous people in the Garhwal Himalayas reveals that children with poor nutrition and undernourished are facing mental impairment and chronic diseases. As a result, infertility is common among adults. The authors argue that Cultural assimilation and changing lifestyles have adversely affected the traditional way of living, particularly in reducing the old dietary habits of organic leafy vegetables.

Chattopadhyay (2018) describes the politics of identities shaping women's experiences during childbirth in Northeast India. The author asserts that women from indigenous communities, Bengali Muslims, and Adivasi groups in Assam, particularly those from impoverished socio-economic backgrounds, experience discrimination and abuse. This includes physical, verbal, and sexual humiliation perpetrated by institutional systems and personnel during childbirth. The author contends that the community's preference for traditional midwives stems from a desire to avoid mistreatment by mainstream healthcare workers and the language barriers experienced by the various ethnic groups in the region.

Borah and Sengupta (2018), while examining the awareness concerning reproductive healthcare practices experience of Dibongiya Deoris of Assam, found that as a norm among the Deories, both the partners felt and shared equal responsibility for reproductive health care. It was further noticed that educated women have better knowledge and awareness of hygienic practices, especially during menstruation. On the other hand, couples from low educational backgrounds were found to be vulnerable to poor health. The author stated that the healthcare practices among the tribe are embedded in traditional beliefs and practices, which is evident from how the people approach healthcare services.

Raushan and Acharya (2019) examined the cross-sectional health-seeking behaviours among scheduled tribes in India, highlighting the intricate relationship between the tribal health profile and their distinct socio-cultural and economic contexts, shaped by their customs and traditions. Tribals are currently going through a transitional period, making them particularly vulnerable to malnutrition, morbidity, and mortality. This vulnerability can be observed by the rising incidence of chronic and lifestyle-related diseases among the indigenous people. The reliance on over-the-counter medications is increasing within these communities. The authors contend that there is a gross inadequacy of research on tribal healthcare systems compared to studies focusing on the general population. This would indicate a troubling neglect of tribal healthcare that threatens the prospects of achieving sustainable development goals.

Oré et al. (2024) examine the social and Indigenous determinants of health in the context of strengthening health systems. The authors highlight the significance of social capital, noting that increased socio-cultural activities among elderly individuals, particularly those that foster engagement and familial bonding, contribute positively to overall health. They emphasise that integrating traditional lifestyles and dietary habits correlates with a reduced risk of lifestyle diseases. Furthermore, the authors identify several factors contributing to the elevated risk of chronic and lifestyle diseases among

Indigenous populations, including low income, structural racism, limited access to healthcare and educational resources, and financial barriers to accessing necessary healthcare services. Consequently, the active involvement of stakeholders in healthcare facilities is essential to effectively address and mitigate the health disparities faced by Indigenous communities.

The socioeconomic factors exacerbate the challenges faced by tribal communities in mother and child healthcare; several studies highlight that Madankar et al. (2024) state that geographical isolation, poverty, and unhealthy traditional practices increase the vulnerability of tribal women and children. Das et al. (2023) note that indigenous populations suffer from higher rates of poor physical, mental, and emotional health, as well as higher mortality rates compared to the non-indigenous population, primarily due to socio-economic disadvantages. Singh et al. (2023) stress the importance of vigilant frontline healthcare workers to improve maternal and child healthcare among these communities. Barman et al. (2024) suggests that enhancing employment opportunities, improving transportation infrastructure, and providing health education could significantly benefit maternal health and well-being in poor socio-economic ST communities.

Browne et al. (2016) ethnographic study on enhancing healthcare equity of Indigenous populations unravels the impact of colonialism on healthcare practices. The authors analyse that it is the colonial attitude of inequalities, discrimination, and structural violence in accessing health care that continues to affect the health and well-being of the Indigenous people.

Horrill et al. (2018) picturise the healthcare among the Indigenous people of Canada, drawing the line between the two perspectives: in the biomedical perspective, the contributing factors to physical inaccessibility of services are geographical isolation, unavailability and poor retention of healthcare providers, long wait list, limited access to

screening and preventative services, inadequate education and health, financial barrier for treatment are the challenges faces by the indigenous people. On the other hand, the postcolonial perspective impacts social, historical, and political aspects. The negative experiences in healthcare include racism, discrimination, language barriers and fear of access to healthcare. The step-motherly treatment in healthcare benefits variations towards the Indigenous people who live in the rugged region. This applies to the Indigenous people across the globe.

Similarly, Chen et al. (2024) have reiterated the determinants of indigenous health disparity in Taiwan and revealed that the contributing factors of poor health among the indigenous people are genetic predispositions, sociodemographic marginalise, and lifestyle choices. Low birth rates, shorter life expectancy, substance abuse, and lifestyle diseases were highly associated with residents of rural and mountainous regions among the Indigenous people of Taiwan. Significantly, authors attributed the impact of colonialism to traumatic life among the Indigenous people. Therefore, the authors argue that understanding the socio-cultural and economic aspects of the life of Indigenous people is very crucial in addressing their mental health and well-being of the indigenous people.

Studies on Traditional Medicine

Lahon and Bage (2023) state the significance of a holistic approach in the healthcare system. Rich knowledge of herbal plants is essential to incorporate with modern medicine, and it is crucial to uphold the traditional practitioner's tactic knowledge and skills in healing illness and health problems. The authors highlighted the vital role of socio-cultural aspects, fostering the healing of emotion, mental, and social bonding and well-being of the indigenous communities across the globe. The authors point out the Indigenous people's resilience, surviving from colonialism with trauma. Therefore, it becomes crucial to integrate holistic healthcare, understand the nature of the socio-cultural

aspects of their life and that they deserve social justice in the amelioration of the transition era.

Sardesai (1996) highlights that Indigenous health care has historically evolved through colonial intervention; traditional medicine was labelled as Unscientific, irrational, and barbaric. However, the author argues that the community could sustain and practice the traditional treatment method, which has led to the rise of alternative and complementary medicine in modern society.

Morris et al. (2012) reiterate the WHO Code of the International Classification of Traditional Medicine (ICTM) since its inception in 1972. The authors' brief on the journey of traditional medicine emphasises the International Classification of Diseases (ICD) process of mainstreaming traditional medicine as alternative or complementary medicine. Highlighting the rational application of traditional medicine and its significance in the healthcare system, pointing out challenges such as inadequate information, lack of recognition and international harmonisation, lack of standardise and unification for efficiency, and digitalisation for growth and development opportunities that hinder the recognition of the traditional medicine. The author further argues that despite the wide gap in the knowledge of traditional medicine globally, the affordability and availability of traditional medicine have gained common consensus, paving the way for healthcare integration in the public healthcare system.

Sahoo and Pradhan (2021) surveyed the tribal communities in Odisha and Chhattisgarh Hill using the health belief model to understand beliefs and behaviours regarding the uses of traditional medicine among the displaced communities of Kharia, Kolha and Munda tribes. The study revealed that the community have a rich traditional knowledge with deep seen of attachment and dependency on traditional medicine practices in the reproductive healthcare practices in areas of pregnancy care, birthing and post-natal care. The study also found that respondent families with low literacy rates had

a low rate of institutional deliveries. They were found to be utilising both traditional and modern practitioners. Notably, in cases of severe health conditions, traditional medicine remained the preferred choice for treatment, reflecting a sense of safety among patients in the care of traditional practitioners. They attributed several factors to this preference, including superstitions regarding malevolent influences, trust in traditional remedies over allopathic treatments, and fear of injections and c-section deliveries. The lack of knowledge, cost, and language barriers were also key to the decisions made by the respondents. They further found that there are increasing incidents of people approaching modern medicines due to the scarcity of herbal plants and restricted access to forest resources. The authors conclude that socio-cultural beliefs, practices, education, and economy significantly influence health-seeking behaviours.

Traditional Medicine Practitioners (TMPs)

Kleinman and Sung (1979) in their analysis of the effectiveness of indigenous practitioners, noted that the ailments treated by these practitioners often include not only acute and chronic diseases but also common illnesses, self-limiting disorders, and minor psychological issues. The authors suggest that psycho-social and cultural factors play a more significant role in "healing" than in achieving a "cure," although this varies across different cultures. They argue that the efficacy of healing is rooted in the values and beliefs present within various sectors of the healthcare system, including professional, popular, and folk medicine.

Anyinam (1989) describes the traditional medicine practitioner in contemporary Ghana as a dying or growing professional response to Akiakpor. The author emphasises the importance of traditional practitioners, assessing the impact of migration, mortality, and abandonment of traditional medicine practitioners. The study found that for traditional medicine practitioners, both in rural and urban areas, the reasons for the decline are old practitioners dying and practices turning to part-time work as they engage in other

activities to generate income. Therefore, the authors suggest promoting traditional medicine practitioners for alternative treatment in the healthcare system.

Anquandah (1997) in the study of African ethnomedicine in Ghana, the author defines ethnomedicine as comprised of beliefs and practices which are purely based on indigenous knowledge and cultural development. The author states that traditional medicine practitioners have a holistic approach to healing patients' mental, physical and spiritual well-being. The author categorises the types of practitioners: profound herbalists; herbalists merged with supernatural practices and spiritualistic priests. The traditional method of treatment by the practitioners consists of taboos, rituals, charms, deity propitiation, water-gazing and divination.

Aniah's (2015) study analysed the perception of the contribution of Indigenous healthcare providers to healthcare delivery in Rural Ghana. The author argues that the first preference for traditional medicine was more than half of the respondents, with literate and economically middle-income-level, preferred traditional medicine due to safety, efficacy, dissatisfaction and high cost of allopathic medicine, embeddedness with socio-cultural beliefs in the time-tested, orally passed-down knowledge. Moreover, traditional medicine practitioners are accessible, available and affordable. Therefore, the authors prove that the indigenous/ traditional healers/ practitioners have significantly contributed to primary health delivery.

Shankar (2007) described the traditional medicines practised by the tribes of Thakur, Mahadev Koli, and the Katkari people belonging to the Kaijat tribes. The tribes have been found to be using over 400 plants, animals, birds and reptiles for medicinal purposes. The author highlighted two types of healthcare practitioners: ordinary householders and specialised village healers. The socially recognised healers are called Baidu (healers) specialised in treating snakebites, broken bones, and veterinary problems. Most of the Baidus practice part time and free of cost for the people who approach them.

The author argues that, unfortunately, traditional knowledge and practices are gradually losing its importance among the tribes due to the increased access to modern medicines.

Ramashankar et al. (2015) detail the traditional medicine practitioner in northeast India using Ayurveda, Unani and other allied practices. The authors categorise the types of practitioners found to practice in Northeast India as herbalists, diviners, traditional birth attendants, veterinarians, bone setters, acupuncturists and breathing treatments. The authors reveal the ethics of the TMP as holistic treatment, which includes the natural method passed down over generations as God-gifted knowledge, principles to save a life, belief in supernatural relations, and balance internal and external environments which manifest disease. The traditional practitioners vary in terms of generating the source of livelihood, such as economic income generation where, as some render the service out of obligation and humanity as there are no other choices for treatment. The authors point out that the dependency on traditional practitioners in rural areas is greater than in urban areas due to poor income and lack of interest among the younger generation in taking up healing practices. The authors state that the significance of the traditional healing system is sustainable and self-reliant because it is acceptable, accessible, affordable, and available, as the natural resources are locally available, such as flora, fauna and minerals, as used for the treatment methods.

Singh and Srivastava (2010) present the ethnomedicine and traditional healer of biodiversity hotspots of northeast India, state that Arunachal state is marked as the richest in flora herbal used in food, nutrition and medicine in the country, and fauna bioresources treating both communicable and non-communicable diseases. The author presents 80 traditional healers from across Northeast India. The authors stress the knowledge of one herbal plant's potentiality in treating various ailments, 112 medicinal plants, sources of knowledge, diseases and disorders treated were highlighted. The authors emphasize that educating, advocating and supporting the traditional practitioners in Northeast India is crucial to ensure that practices conform to the norms.

Watienla (2019) in her study of indigenous health practices among the Nagas, stated that in some cases, traditional practitioners have demonstrated the capability to diagnose and effectively treat ailments without the use of any modern diagnostic tools. Whereas the modern medicine heavily relies on advance diagnostic machinery for the identifying the diseases and planning treatment.

Chiangmai and Chiangmai (2018) describe the role of folk medical practitioners among the Mishing tribe during and after floods frequently occurring in Dhemaji district, Assam. The study reveals that traditional practitioners play a vital role in treating illnesses such as diarrhoea, respiratory infection, tonsils, and seasonal flu, delivery, skin diseases and snake bites.

Ethnomedicinal Practices

Agarwal (2014) describes the health perception and cultural practices among the Murias of Bastar. The author reveals that traditional healing medicines are easily accessible and affordable, strongly rooted that people prefer traditional over modern medicine systems. The youth sings folk songs or traditional religious songs (Ramayana) to please local gods and deities for good fortune. Murias believes that the illnesses are caused by sorcery and witchcraft; the suspected individuals are punished and ostracised, and as a consequence, interpersonal rivalries and intra-conflict in the community occur. Therefore, the author's critics of such beliefs and practices are unrealistic and illogical practices.

Rouhier-Willoughby (2003) a study on the Birth customs of ancient traditions in the modern guise in Russia, reveals that pregnancy and childbirth have been associated with several folk and ritualistic practices and traditions. The author details the beliefs and practices and the vulnerability that dwelt on pregnant women and newborns as victims of the 'evil eye', causing death, disability, or distress.

Dove (2010) details traditional Health Care Practices in Ghana. The author highlighted that the Ghanaian mothers, to sustain traditional medicine in the upbringing of children, young boys and girls are encouraged to acquire knowledge and carry forward the ancestors' legacy. The author states Ghanaian pregnant mothers still believe and practice food taboos and avoid visiting restricted places like funeral rites, markets, forests, and rivers to protect from malevolence. The author observed the strong practices and belief in traditional medicine in the community, however, the author suggests using alternative medicine as crucial.

Boruah's (2012) study on the socio-cultural practices of health care among the Ao Nagas reveals that there is a high dependency on traditional medicine, particularly in mother and child healthcare delivery, with 93.73 per cent at-home deliveries. The author argues that poor health literacy, the heavy burden of household work, and low socioeconomic status contribute to adverse health outcomes for mothers and children.

Boruah (2018) presents the traditional practices in mother and child health among the Mishings of Assam. The author explores the socio-cultural beliefs and practices associated with child care throughout various stages, starting with pregnancy care. The childcare practices include providing the infant with a hygienic first bath, pleasant toilet training, comfortable clothing, and proper sleep. Various home remedies utilizing different parts of herbal plants are used for preventing and treating childhood health problems. The author, states that the laid down norm for hygiene and individual care to infants is grounded in the traditional knowledge passed down through generations.

Goswami et al. (2009) examines the traditional medicinal plants used to heal different ailments among the Targin tribe of Arunachal Pradesh. The author claims that the Targin tribes promote herbal medicine systematically through oral practices, and it has been passed on from generation to generation. The author has detailed ten herbal plants and their uses. The parts of plants used are fruits, leaves, stems and tender leaves that treat

various ailments such as cuts and wounds, blood clotting, digestive problems, blood pressure, fever, diarrhoea, skin problems, toothache, burn injury, skin problems, jaundice, joint pain and arthritis. The author discusses that due to the availability and accessibility of natural resources, the state is one of the hot spots globally. Therefore, the author suggests that identifying the herbal plants and preserving and documenting them is crucial.

Sharma (2018) delves into the socio-cultural perspective on health and illness within the Minyongs tribes of Arunachal Pradesh. The Minyongs see a healthy life as one where individuals can perform their daily activities normally. If a child is unable to walk or play appropriately by the age of two, it raises serious concerns about potential disabilities. It was found that stomach problems, bone and muscle problems, infectious diseases and bites from animals and insects were the common ailments experienced by the people. The Minyongs attribute their health problems and ailments to the malevolent actions of supernatural forces and various spirits, leading them to seek help from local priests or shamans for healing. Most of the people also use various home remedies for treating the health problem. The author notes that for the tribesmen, rituals are an essential component of the healing process.

Bhattacharjee (2018) while exploring the utilization of natural resources and Indigenous knowledge system of the Karbi community in Assam states that the Karbis have a spiritual connection to various deities represented by mountains, hills, and rivers and it is integral to their health beliefs. The use of fish holds particular significance in their healing rituals. Specific resources employed in treating illness include wine, rice (measured by fistfuls), and fish (referred to as Toman), all of which play a crucial role in ritualistic practices. Furthermore, the author states that the traditional beliefs and practices surrounding pregnant women emphasize the invocation of nature for favourable outcomes.

Chanu & Arunkumar (2015) examine the interplay between environmental factors, socio-cultural dynamics, ethical considerations, and belief systems of women's reproductive healthcare. The study highlights the role of traditional knowledge, particularly regarding dietary practices and taboos related to reproductive health during pregnancy, the post-delivery period, and menstruation. Additionally, the research indicates a growing inclination among the younger generation toward modern medicine, attributed to its perceived benefits.

Singh (2018) cross-cultural analysis highlights the global recognition of traditional medicine, including plant, animal, and spiritual therapies, in treating various ailments. The study delves into the use of animal parts by different Northeast Indian ethnic groups, such as the Adis, Ao Nagas, Chakhesang, Khamtis, Meitieis, Muklom Tangsa, Mao Nagas, Nagaland Nagas, Nyishis, and Garos. It explores the types of animals, their parts used, preparation methods, and the conditions they treat. The author emphasizes the deep-rooted connection between traditional medicine and socio-cultural practices, often involving trial-and-error approaches. While validating the efficacy of these practices poses challenges for modern researchers, their importance in hard-to-reach and rural areas, where allopathic medicine may be inaccessible or unaffordable, cannot be overlooked. Therefore, preserving plants and animals used in traditional medicine is crucial.

Studies on Health-seeking Behaviour

Mackian et al. (2004) analysis of the underlying factors influencing health-seeking behaviour. The authors identify determinants such as social, cultural, economic, and geographical factors. They argue that the social capital networks formed through interactions and bonding among individuals, groups, and communities have a significantly positive impact on individual health. The authors recommend that formal healthcare institutions enhance the quality of care by integrating traditional healthcare systems and incorporating alternative medicine approaches.

Ghosal et al. (2024) examine the healthcare utilization of maternal, newborn, and child health services among all 13 particularly vulnerable tribal groups (PVTGs) in Odisha, India. Several factors were identified, contributing to the continued reliance on traditional medicine, including unaffordability, non-functioning health facilities, a lack of trust in modern healthcare systems, and the absence of female healthcare personnel.

Sahoo et al. (2023) investigated the health-seeking behaviour patterns of the Juang tribe, a particularly vulnerable tribal population in Odisha, India. The study describes the perspective of preferences in healthcare use. The author emphasised that traditional medicine is available at the beginning and early stages of treatment, together with the healer's faith and efficacy, magico-religion, and confidence in supernatural power. The author claims that the downfall of traditional medicine is due to the deaths of experienced practitioners and the poor performance of young healers. However, the author contends that the primary reasons for the preference for traditional medicine are inadequate infrastructure, remote accessibility, and the uncaring attitude of healthcare workers in public healthcare.

Gandhi et al. (2017) studied health-seeking behaviour among particularly vulnerable tribal groups (PVTGs) in the Nilgiris region of Tamil Nadu. The research identified several key factors contributing to significant disparities in healthcare access compared to the general population. These factors include cultural embeddedness, perceptions shaped by past experiences with modern healthcare services, and the challenges of long-distance travel due to the region's geographical terrain.

Kumar et al. (2020) analyzed the health and healthcare challenges faced by tribal communities, particularly in terms of health-seeking behaviour which were found to far from satisfactory. This resulted in untreated cases of various communicable and non-communicable diseases, malnutrition, mental health issues, and addictions. The authors propose involving traditional healthcare practitioners and local residents at the village

level to develop public health strategies to address the significant burden of health problems in these communities.

Negi and Azeez (2022) in their scoping review on the decline of traditional healthcare methods and the inaccessibility of modern healthcare services among tribal populations highlighted significant vulnerabilities, including low life expectancy, high rates of anaemia, reliance on home deliveries, elevated infant and maternal mortality rates, and a prevalence of genetic disorders such as sickle cell anaemia. Many tribes continue to rely on rudimentary traditional medicine. The authors argue that due to a shortage of healthcare personnel, inadequate sub-centres, primary health centres, and community health centres, as well as financial constraints are key factors affecting this healthcare behaviour.

Cáceres et al. (2023) investigated health-seeking behaviour (HSB) and the utilization of maternal and newborn health services within an Indigenous tribal community in Northeast India. Their study analyses the medical pluralism involving traditional healing practices, home remedies, community health initiatives, faith healing, and the biomedical system. The findings indicate a significant efficacy of traditional medicine, passed down through generations via folk wisdom and traditional knowledge. The authors conclude that socio-cultural beliefs, perceptions of both allopathic and traditional medicine, and the inaccessibility of allopathic care significantly influence health-seeking behaviour. To address the health-seeking challenges faced by the tribal community, the authors advocate for enhanced health education and collaboration among various stakeholders, including community members, traditional birth attendants (TBAs), and traditional medicine practitioners (TMPs). They also recommend support from national-level policy programs that adopt a holistic approach to reduce barriers to health-seeking behaviour in this region effectively.

Statement of the Problem:

The Indigenous communities are the most exploited and highly vulnerable to diseases with high degrees of malnutrition, morbidity and mortality (UN, 2014; Shrivastava et al., 2013, p.6). The “tribal communities in India lag behind the national average on several vital public health indicators, with women and children being the most vulnerable” (Madankar et al., 2024, p.10). The Maram Nagas, like the Indigenous communities elsewhere, face formidable challenges in healthcare in the context of the exposure to new diseases and health conditions due to changing lifestyle, environment, climatic conditions and overarching question of accessibility, availability and affordability of modern medicine.

The Maram Nagas, a Particularly Vulnerable Tribal Group (PVTG); has a rich cache of cultural and traditional knowledge and practices that define their unique identity. Most of the population reside in the hard-to-reach, difficult geographical region with limited access to modern healthcare services. The socio-cultural beliefs, language barrier, and economic constraints further hinder their utilization of modern medical services. However, the tribe have remained comparatively healthy through centuries, by following the traditional way of life and health care practices. In the changing context of increased exposure to the outside world, changing lifestyles, food habits and ever evolving nature of diseases, the Marams too experience discernible healthcare challenges. The Maram Nagas, despite their formidable Indigenous healthcare knowledge, face significant problems in addressing modern health challenges. Traditional healthcare practices, while valuable, do not always address emerging diseases or integrate seamlessly with modern medical practices. The modern healthcare providers often lack a comprehensive understanding of the community’s traditional healthcare practices and their significance.

This Research can help identify community-based solutions to health problems, empowering Indigenous people to take control of their health. Through this sociological study on health-seeking habits and traditional medicine among the Maram Nagas, the

researcher seeks to contribute to preserving cultural heritage, improving healthcare outcomes, and fostering a more equitable and inclusive society.

Significance of Study:

The study provides an understanding of the health-seeking habits in the context of accessibility and affordability of healthcare services among the Marams. The study explores indigenous healthcare practices and home remedies, traditional healers, and locally available herbs and medicinal plants in the region. The study aims at documenting and preserving traditional knowledge, understanding the effectiveness of these practices, and potential applications in modern healthcare. The study seeks to explain how modern healthcare initiatives can appreciate and integrate traditional medicine practices in order to enhance the affordability and accessibility to primary healthcare in the remote regions. This research seeks to contribute to the existing initiatives for a more comprehensive and culturally sensitive healthcare system that effectively caters to the well-being of the Maram Naga community in particular and Indigenous communities across the world in general.

Objectives of the study:

- To explore the health and illness profile in the community
- To describe the various socio-cultural practices and traditions associated with health and well-being.
- To document the Indigenous knowledge and ethnomedicinal practices in the community
- To explain healthcare and health-seeking behaviour in the community.

Methodology:

The study used exploratory and ethnographic approaches to comprehensively understand the indigenous healthcare practices of the Maram Nagas people in Senapati District, Manipur, India. The mixed-methods approach combined quantitative and

qualitative research techniques to gain a comprehensive understanding of behaviour, attitudes, and practices and a detailed picture of the existing healthcare landscape. The researcher gained insight by combining these three methods and cross-validate data from different sources and perspectives. The researcher also extensively reviewed existing literature on similar studies in the region and across the globe to collect relevant secondary data.

Study Area:

The study was conducted among the Maram Naga Tribe, which consists of approximately 6838 households, with a population of approximately 40, 658 people residing in 27 villages (revenue) as per the 2011 census. There are 36 established villages as per Maram Union record 2023 in the Tadubi Sub-division of the Senapati district and parts of Kangpokpi in Manipur. Maram households can also be found in the villages predominantly inhabited by other tribes in the region. However, they owe their ancestry and allegiance to their original villages among the established villages. The detailed list of villages is included in the next chapter.

Tools of Data Collection:

Primary Sources

Village Profiling:

Each of the 12 targeted villages was profiled with the help of an interview schedule prepared for the collection of data on various aspects, including:

- Population size and demographic characteristics (age, gender distribution)
- Infrastructure availability (access to roads, electricity, educational, water, health and sanitation facilities)
- Existing healthcare services (outlay of public healthcare system, availability of medical personnel)

The interview schedule was completed with the help of the community leaders, village secretary, and village headmen.

Household Survey

An interview schedule was administered to 225 households across the 12 selected villages. This survey gathered information on Household demographics and socio-economic status, utilisation of Indigenous healthcare practices within households, and Knowledge, attitudes, and practices regarding traditional medicine.

Interview Schedules for the Household Survey

The study employed an interview schedule to gather specific information from households within the target population. These interview schedules were carefully crafted to cover critical aspects relevant to the research objectives, such as demographic data, health practices, and traditional medicine usage. The interview schedules were carried out with the help of field notebook and voice recording devices. The respondent was encouraged to share their experiences and knowledge on the subject, which were recorded by note-taking or voice recording. Initial data entry was made using Microsoft Excel, and the compilation and quantitative analysis were carried out with the help of SPSS.

Interviews with Traditional Medicine Practitioners

One-on-one interviews were conducted with traditional medicine practitioners using a structured interview schedule. This method allowed for in-depth exploration of the practitioners' perspectives, knowledge, and practices regarding traditional medicine. The structured format ensured consistency in data collection while allowing flexibility for probing deeper into relevant topics. The practitioners were further encouraged to share their experiences and treatment methods, which were recorded with the help of note-taking and audio and video recording. The researcher also used the expertise of the practitioners to understand the different herbs used for treating illnesses. A field notebook, voice recorder and video recorder were the main tools used apart from the questionnaire. The records were manually transcribed and compiled in Excel sheets. SPSS was used to analyse the quantitative data.

Focus Group Discussions

Focus group discussions (FGDs) were organised with representatives of different groups in the community. These discussions provided a platform for participants to express their views, beliefs, and experiences related to traditional medicine in a group setting. FGDs facilitated the exchange of knowledge and practices, attitudes and aptitudes, opinions and collective experiences of the different sections of the community. The focus group discussions were carried out with a set of structured questions that encouraged individual and group responses. The questions were open-ended to encourage detailed responses. As situations demanded, follow-up questions were also asked to the individuals and groups. The discussions began with an introduction and thorough explanation of the research objectives and expected outcomes. The participants were divided into two or three groups according to the total number present for the discussion. Questions on knowledge, attitudes and practices regarding health and healthcare were discussed by the participants. The key points of the discussion and the information generated were written on chart papers and presented by each group. Observations and suggestions from other groups were encouraged during the presentations. The proceedings of the focus group discussions were audio recorded, and some key presentations were also video recorded. Photographs of the group and chart presentations were made. The researcher also maintained detailed notes on the proceedings of the discussions and the individual interactions that were held after the focus group discussions.

Secondary Sources

In addition to primary data collection methods, the study also utilised secondary sources of information. This included relevant literature, reports, and existing datasets related to traditional medicine, which provided valuable context, background information, and insights to complement the primary data.

Sampling Framework:

Multi-stage sampling drew the respondents – villages, households, and individual respondents.

Selection of Study Villages:

The villages were selected on the geographical, demographical and cultural characteristics. Twelve of the 36 villages were selected for the study, making it one third of the total number of villages inhabited by the Marams. Both accessible and hard to reach villages were included. Priority was given to the villages which were considered the ancient villages of the Marams since there would be more elderly people who understand the traditional systems. Villages which were established recently too were included in the study.

Selection of Households

Simple random sampling was used to carry out the structured household interviews. It was noticed during the data collection that the selected household did not adequately represent the different sections of the society. Hence, purposive sampling included households from various socio-economic backgrounds. Due consideration was also made to include extended families, joint families and nuclear families and those with high education and generally well off.

Respondents for Focus Group Discussions

Purposive random sampling was used to identify participants for focus group discussions such that every section of the community is being represented and their perspectives and experiences are recorded. Stakeholders from different sections of the society, such as community leaders, women, men, youth, and residents, were invited based on their knowledge and experience related to healthcare practices in the community. The traditional medicine practitioners were identified through purposive and snowball

sampling. The primary criteria were to ensure the practitioners were known for their expertise in traditional healing methods.

Sample Distribution:

Household Survey

The research involved a household survey conducted in 12 villages, with an average of about 6-10 per cent of each village's total population participating. This resulted in 225 household respondents. Due to the challenges posed by the COVID-19 epidemic, some villages had lower-than-average participation rates. Despite these limitations, the sample provides a representative overview of the target population. The overview of the sample for the household survey is below.

Table 1.1: Household Survey

Sl.no	Name of village	As per village records	Respondent HHs	Percentage (%)
1	Maram Bazar	486	30	6.17
2	Maram Centre	338	30	8.87
3	Maram Sagonbam	70	6	8.57
4	Lairoching	341	25	7.33
5	Maram Khulakpa Sagei	230	22	9.56
6	Maram Makha Sagei	170	15	8.82
7	Maram Mathak Sagei	463	32	6.91
8	New Maram	84	8	9.52
9	Rajamei	130	10	7.69
10	Sadim Naga	86	8	9.30
11	Shang Khumei	56	6	10.71
12	Willong Khullen	328	33	10.06
Total	Total	2782	225	100%

Source: Fieldwork

The number of households and families is counted based on the village's original inhabitants, irrespective of the people's current residences. However, the actual number of those who reside in the village might vary at any point of time as some would relocate to accessible locations for their children's education, employment, and livelihoods. They return to the villages only during common festivals and elections. It is also important to

note that joint families were counted as separate families in the census data, while in the village data, the families were considered one.

Traditional Medicine Practitioners (TMPs)

The Traditional Medicine Practitioners were identified from the region inhabited by the Marams. All the TMPs identified were Marams, except one who is also (half Maram). The researcher sought to maintain equal representation of gender. Selection of the samples based on field of expertise or skill was also considered in the course of the data collection. There was a limitation regarding the selection of the TMPs as most were part-time practitioners and often engaged in agriculture and allied activities.

Table 1.2: Traditional Practitioners

Aged Group	Male	Female	Frequency
21-40 years	-	3	3
41-60 years	5	2	7
61 years above	2	4	6
Total	7	9	16

Source: Fieldwork

The 16 traditional healers were interviewed individually to gain deeper insights into their specific knowledge and practices of traditional medicine, the cultural and spiritual context of these practices and their experiences with treating various ailments.

Focus Group Discussions

The focus group discussion aimed to elicit the participants' collective knowledge and attitudes regarding health, healthcare, and traditional medicine. Elders, ladies, young people, and children were all present during the conversation. In different villages, the groups were all of the same gender. The table that follows presents a breakdown of the individuals who took part in the discussion that took place within the focus group.

Table 1.3: Focus group discussion (FGDs)

Sl. no	Name of village	Gender		Total	Nature of participants
		Male	Female		
1	Maram Bazar	3	5	8	Old and young Married people
2	Maram Centre	8	9	17	Married women and youths
3	Maram Sagonbam	8	0	8	Village male elders
4	Lairoching	0	10	10	Youth female
5	Maram Khulakpa Sagei	6	4	10	Men and women Elders
6	New Maram	8	0	8	Men elder
7	Sadim Naga	0	8	8	Women
8	Shang Khumei	8	0	8	Youth male
9	Willong Khullen	10	0	10	Men
10	Willong Khullen	0	15	15	Women
Total		51	51	102	

Source: Fieldwork

Data Analysis:

Quantitative Data: Data collected through the village profiles and household surveys was analysed using the statistical software SPSS. This analysis helped to identify trends and patterns in healthcare access, utilisation of traditional practices, and demographic factors.

Qualitative Data: Data from FGDs and interviews were audio-recorded, transcribed, and analysed thematically. This involved identifying non-recurring and recurring themes, compiling and assessing them for validity; and developing a comprehensive picture of the practices and perspectives on healthcare.

Data Verification: The collected data underwent a rigorous verification process. Data triangulation was used to ensure data accuracy and trustworthiness. Findings from different data sources were compared, and inconsistencies were revisited. This involved revisiting some households to clarify responses and to ensure data accuracy. Key respondents of FGDs and TMP interviews were also contacted several times to ensure the accuracy of the observations and opinions.

Ethical Considerations:

In the course of the study, the researcher endeavoured to uphold the commitment to ethical practices. All the participants in the different modes of data collection were assured of their privacy. The research does not disclose the names and details of any of the persons who have been part of this study unless they have given explicit permission to do so. The direct engagement with the respondents was mainly carried out in their community's homes and surroundings; hence, there was no undue strain caused to the people during the study. The scholar has endeavoured to maintain the utmost integrity in processing data and validating it for analysis and interpretation.

Chapterisation:

Chapter one deals with the *Introduction* of Indigenous profiles across the globe, their health concerns and traditional knowledge and medicine. Conceptual Framework – concept of health, healthcare practices, and the public health system. The theoretical framework of Symbolic Interactionism and Structural Functionalism. Literature Review, Statement of the Problem, Objectives, Methodology and Chapterisation.

Chapter two briefs the *Ethnographic Profile of the Maram Naga Tribe*. Introducing the Manipur state, Senapati district. The Geopolitical Profile of the Marams, the Origin of Marams, Folklores related to the origin of Marams, Geographical distribution of Marams, Social aspects- family and marriage, kinships, clans and Morung. Religion – the Maram Pantheon, totemism. Cultural features – ritual and observation of Genna, festivals, and the impact of Christianity. Economy and occupation, and Traditional administrative system. General profile of the study area: basic amenities, economic profile, transport and communication. Demographic profile of the respondents and family.

Chapter three explores the *Health, Illness and Hygiene* profile of the Maram Nagas. Health and well-being, perception of family health status. Major healthcare concerns and incidents of the families: Communicable Diseases (CD), non-communicable

diseases (NCD), Substance/alcohol abuse and Disabilities. Nutrition concerns include nutritional diet, shelter, water, and sanitation. Access to healthcare and resources for treatment. Health screening and healthcare services. Family priorities: ethnic identity, health, education, employment and livelihood and public and infrastructure.

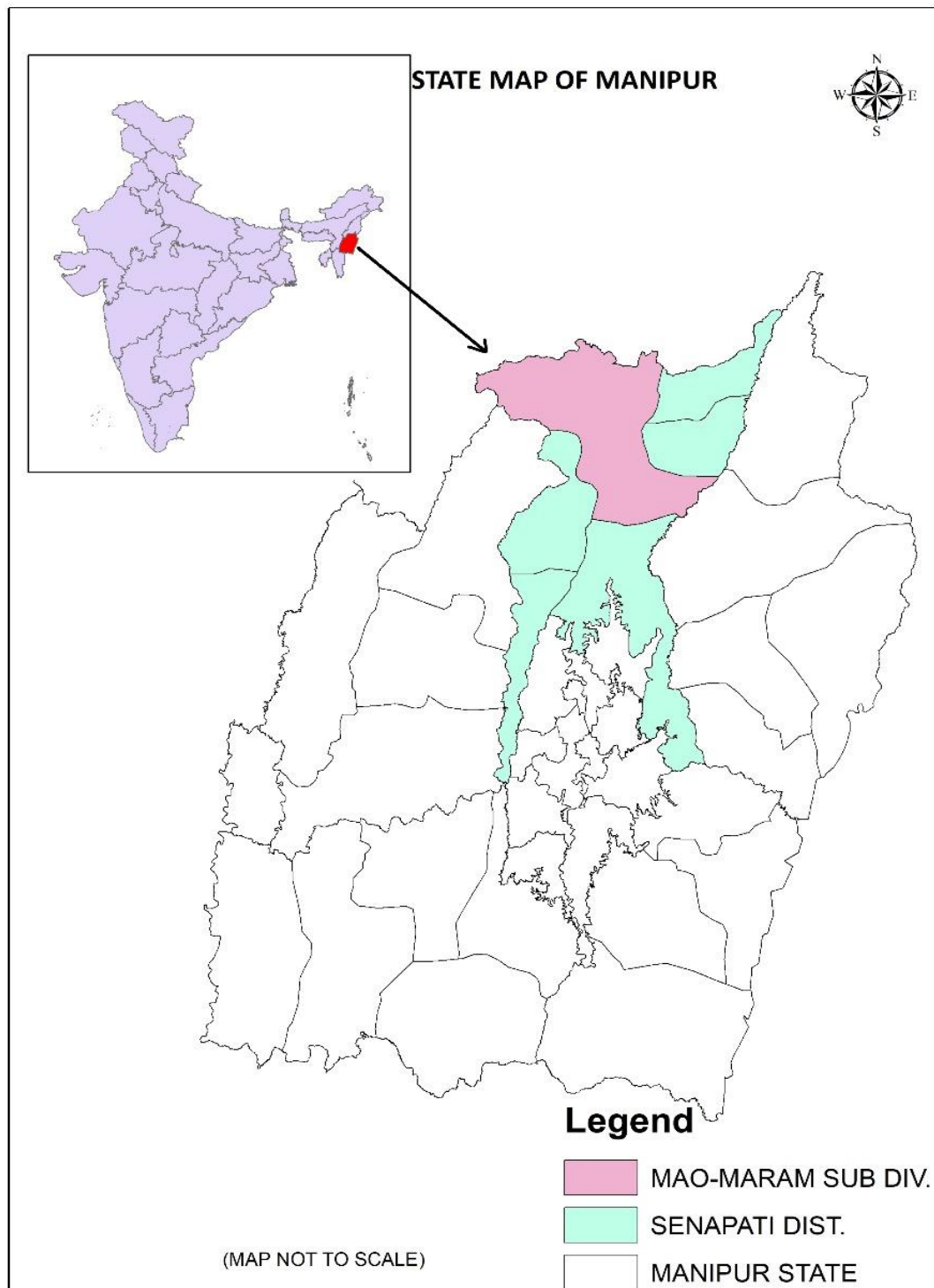
Chapter four describes the *Health and Culture* associated with maintaining good health and preventing diseases among the Maram tribe. The Concept of Health, The Concept of Illness and Disease: Genna and health – *Mannai, Tiikanii and Kanet*. Beliefs on Health. Festivals and Health: *Malem, Kanghi and Kataimei Rakak*. Rituals and Health: *Mala, Tingpui Maru-Manai, Achyi-marung, Achiimalou, Arakatii and Arakalui*. Mother and Child Healthcare Practices: Pregnancy, Pregnancy care – taboos and belief, nutrition and health. Delivery Care-Placenta delivery, *N'bungkatai* and the role of Traditional midwives. Neonatal Care and Practices-*M'bangkilang karii*, Naming ceremony, new hearth, *Fiikilampat and N'lou* rite. Post-natal care – Care for the mother, the health of the breastfeeding mothers, birth celebration meal, rituals and practices for infant care and *N'pamrah*. Cultural element in health and well-being: Perception on the role of customs, traditions, rituals, and beliefs in health.

Chapter five documents the *Ethnomedicinal Practices Among the Marams* concerning knowledge, attitude and practices (KAP) treatment among Maram Nagas. Traditional knowledge systems, role of ethnomedicine in tribal communities, ethnomedicinal practices among the Nagas. Knowledge and utilisation of ethnomedicine among the Marams: knowledge and capacity to identify medicinal plants, cultivation and maintenance of medicinal plants, families growing medicinal plants and use of naturally growing medicinal plants, use of plants in a regular diet, skills in the family to prepare home remedies and the common ailments treated with home remedies. Ethnomedicinal practices: home remedies for general common ailments. Common medicinal plants and their uses: Vernacular and common names, parts used, mode of preparation, and image of the plants.

Chapter six explores the *Healthcare and Health Seeking Behaviour* of the Maram Nagas. It examines the socio-cultural and economic factors affecting health-seeking behaviour in the present time. Public health care delivery: Health infrastructure and healthcare facilities. Healthcare personnel. Traditional medicine practitioners: profile of the traditional medicine practitioners, expertise of practitioners, experience of the practitioner, treatment efficacy and referrals, treatment profile of the traditional practitioners, patient intake, remuneration for the treatment, mother and child health choices case study of a popular TBA, general perception of the effectiveness of traditional medicine. Preferences in choices of treatment: first preference in the treatment of a minor illness, comparison of choice of treatment for children and adults, choice of healthcare for a major health concern, illnesses and choice of treatment and healthcare expenditure. Reasons for choice of traditional medicine over allopathic medicine. Analysis of the determinants choices of healthcare: accessibility and choices of healthcare, education of the respondent and choice of healthcare, family income and choice of healthcare, occupation and choice of healthcare. Factors affecting healthcare utilisation: acceptability, availability, accessibility, affordability, and conclusion.

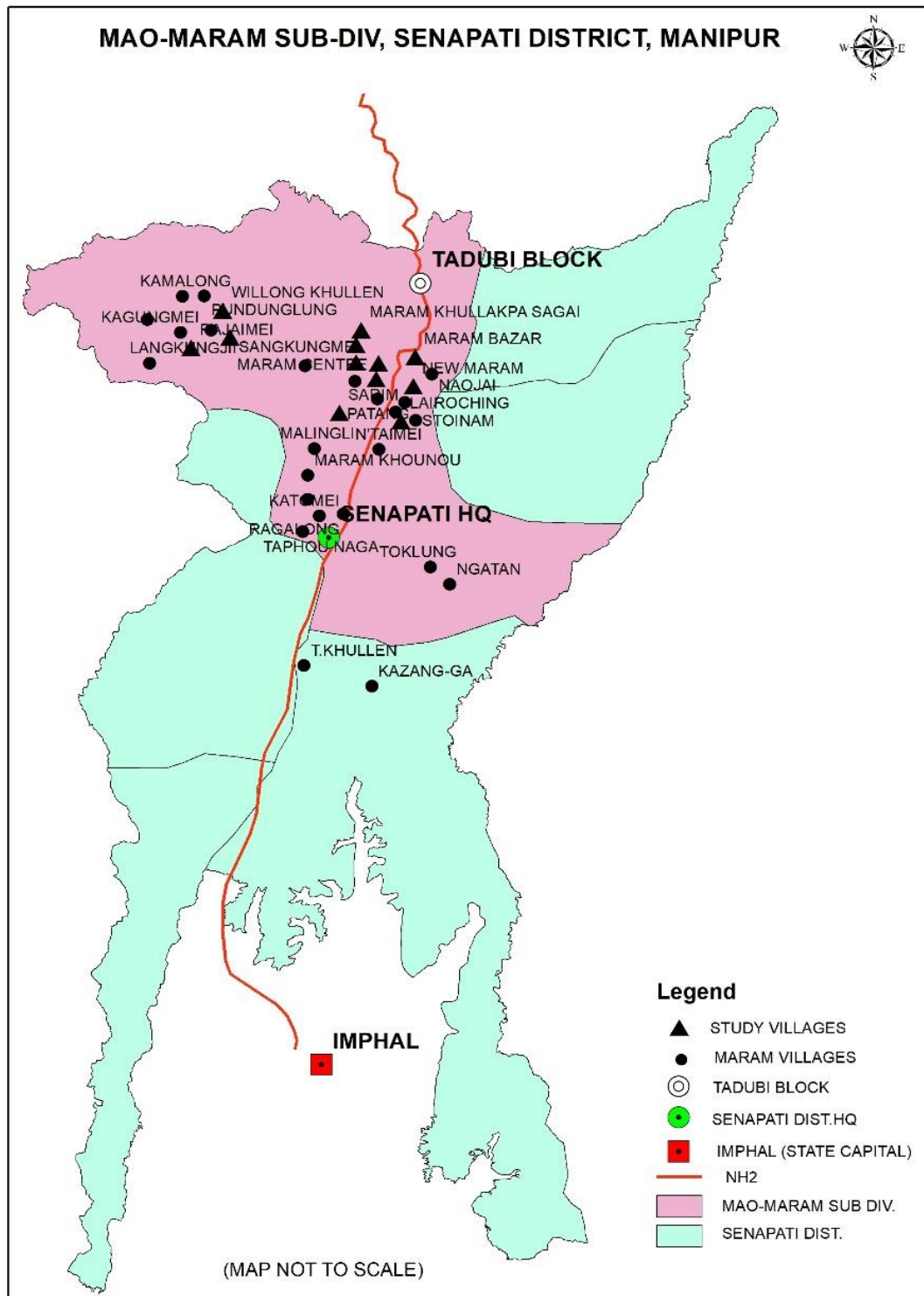
Chapter seven summarises the key major findings, conclusion and recommendation.

Map 1: Map of Manipur State



Source: Fieldwork

Map 2: Study Villages



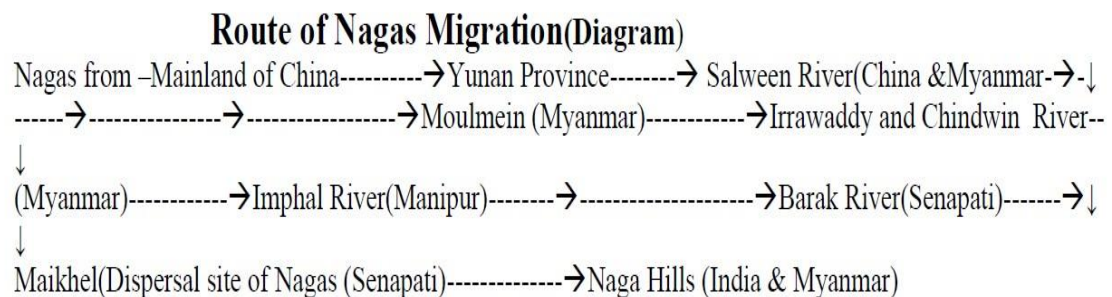
Sources: Fieldwork

Chapter 2

ETHNOGRAPHIC PROFILE OF MARAM NAGAS

India's Northeast has the largest concentration of Indigenous ethnic identities with unique cultures, traditions, and languages. Nagas are one of the major Indigenous identities in the region inhabiting the states of Nagaland, parts of Manipur, Assam, and Arunachal Pradesh, and northwestern parts of Myanmar with a total population of about 30 lakh persons in over 70 tribal identities with unique languages, customs, and traditions. In the past, the word 'Naga' was used as an exonym to collectively address several ethnic tribal groups with linguistic and cultural similarities residing in the foothills of the eastern Himalayas. However, the collective identity of Nagas is well accepted and appreciated among the constituent tribal groups across the region. With over 89 languages and dialects actively in use, Nagas have more language diversity than other ethnic groups or states in India (Tohring, 2010, pp. xv-xvii). Genealogically, the Naga tribes are considered to be of the mongoloid stock with their strong resemblance to Mongols, however, with discernible Caucasian features.

Figure 2.1: Origin of Nagas



Source: Gogoi, 2020, p. 1143

Figure 2.1 depicts the route of the Nagas' migration, as Gogoi (2020) details. The origin and history of Nagas are embedded in folklore, primarily handed down through oral

traditions. Only limited information on the origins of the Nagas is available, as the first forays of the outside world into the Naga realm happened only in the early 19th century, when the British expanded their colonial intentions to this region, albeit with very little success (Luithui, 2001, p.2). Historians and academicians agree that the Nagas originated in China (Irene, 2020, p. 215; Gogoi, 2020, p. 1141; Watt, 1887, p. 356). Luithui (2001) states, “Most Nagas believe their ancestors came from far North, in present-day China. They first migrated to the village of *Makhrail-Rabu* (also known as *Makheli*), from where they dispersed to the various directions they live now. *Makhrail-Rabu* is located in the land of the Mao tribe in present-day Manipur state. Several historic symbols associated with the dispersal of the Nagas still exist: a big stone called *Tamratu*, which means ‘stone of dispersal’; an ancient wild pear tree called *Chutebu*, planted at the time of dispersal by the Naga elders” (p.5). In India, the Nagas were known for their tradition of head-hunting/head-taking, Indigenous religion, distinct physical features, food habits, and socio-religious practices.

Manipur:

Manipur, often known as the Land of Gems and the birthplace of Polo, shares a boundary with Myanmar in the southeast. Moreh is the hub of commercial exchange between the two countries, serving as an international corridor to Southeast Asian countries. Manipur also neighbours Nagaland in the North, Assam in the West and Mizoram in the Southwest. The state covers a geographical stretch of 22,327 sq km; demographically, 10 per cent of the land is inhabited by more than 50 per cent of the Meiteis, a dominating community politically and socio-economically in the fertile plain valley. On the other hand, 90 per cent of the state's geographical area is covered by undulating hills. It is home to 40 per cent of the population comprising two major ethnic communities, i.e., Nagas and Kukis (Behera, 2023, p.5). There are about 29 ethnic tribes in Manipur (Serto, 2000, p.74).

According to the Census of India (2011), Manipur has a total population of 28.56 lakhs, which comprises 14,38,586 males and 14,17,208 females. Children between the ages of 0-6 are 13.14 per cent of the population. The state literacy rate is 77 per cent, with 84 per cent male and 70.26 per cent female literacy (Directorate of Economics & Statistics Government of Manipur, 2017, p.6). Though the *Meiteilon* is the state's official language, English is mainly the medium of education; Hindi and other regional languages are spoken and taught at schools. The major religions in the state are Hinduism, Christianity, Islam, Buddhism, Sikhism, and Jainism

Rice serves as the staple food in the state, and consequently, rice cultivation is the primary occupation of the local population, who also engage in fisheries and cottage industries. In the valley, permanent cultivation is practised, while terrace and jhum (shifting) cultivation are common in the hilly regions. Electrification and mobile network connectivity have been extended to every village, although residents experience intermittent electricity and weak signal strength. Manipur Airport facilitates both domestic and international flights. The national highways connecting Manipur include NH-02, which runs from Dimapur to Imphal; NH-37, linking Karimganj to Imphal via Jiribam; and NH-102, which connects Imphal to Moreh. Maram-Peren NH-129A is another highway under construction connecting Dimapur from the north end, ending at Maram Centre on the southern end and merging with NH-02.

The triangle ethnic communities (the Meiteis, the Nagas, and the Kukis) harmoniously co-exist with intermittent conflicts and near-violent outbursts. Socio-cultural interaction through finding common goals in education, healthcare, livelihoods, employment, and sports has increased rapidly in recent years. An uneven distribution of power and resources contributes to the conspicuous disparity between the people in the hills and the valley. The tribal communities feel excluded, neglected, and to an extent vulnerable in the state in all aspects of growth and development. Therefore, the underlying distinction between the valley and the hills continues to affect the socio-economic and

political narrative. Shimray pointed out that the ethnic tension is enhanced by the superiority complex of the Meiteis over the tribal communities (Shimray, 2001, p.3677).

Senapati district:

Senapati district, situated at an altitude of 1,500 meters, encompasses an area of 3,271 square kilometers. The district headquarters is located 62 kilometers from the state capital, Imphal, and is traversed by National Highways 2 and 129A, which connect the villages and towns within the district to Dimapur and Imphal. According to the 2011 census, Senapati district has a population of 479,148, making it the fourth most populous district in the state. The demographic breakdown includes 247,323 males and 231,825 females, resulting in a sex ratio of 937, which is lower than the state average of 985. The literacy rate stands at 63.60 per cent, with male literacy at 69.2 per cent and female literacy at 57.67 per cent, both figures falling short of the state's overall literacy rate of 77 per cent (District Census Handbook, 2011). Agriculture is the principal occupation of the residents, encompassing both terrace and Jhum cultivation. Approximately 30 per cent of the land is dedicated to the cultivation of rice, maize, potatoes, cabbage, and various cereals, while 66 per cent of the land is covered by deciduous forests (District Census Handbook, 2011).

As per the census (2011), Mao, Maram, Thangal, Khoirao, and Thadou are the major (80 per cent) ethnic inhabitants of the Senapati district, and other ethnic communities are Paomai, Zeme, Liangmai, Rongmei, Tangkhul, Meitei, Kuki, Nepalese, Vaiphei, Chothe, Chiru and Maring. Senapati district is in the north of the state, bordering Ukhrul in the east, Tamenglong in the west, and Imphal in the south. The enchanting Dzuko valley, which spreads into the state of Nagaland, is north of the district. The district, formerly known as Manipur North District, existed on 14 November 1969, consisting of six sub-divisions and headquarters, namely: Mao-Maram (Tadubi), Paomata (Paomata), Pural (Purul), Sadar Hills West (Kangpokpi), Saitu Gamphazol (Gamnom-Sapermeina), Sadar Hills East (Saikul) (District Census Handbook, 2011 p.19). The Senapati district is governed by the Manipur North Autonomous District Council (ADC), implemented in

1971 under an act of parliament, which is elected by the different tribes to represent the district under the direction of the state legislature to ensure increased financial autonomy, empowerment of local representatives, conflict solution mechanisms and monitoring and evaluation of ADCs (Indian Express, 2023) it is to bridge the gap and bring equal economic development between the hills and the Valley (Chanambam, 2022).

The Geopolitical Profile of the Marams:

The Maram villages have been traditionally set up on the hills of the Senapati district, which has a cool, salubrious climate and falls under the Subtropical monsoon climatic zone (District Census Handbook, Senapati, 2011). On the geographical location of Maram, M. Horam, in his foreword, says,

“Geographically and ethnically, Maram is an old land, and ancient people have lived in the comity of the Naga society for centuries. Sitting on a hilltop and looking out over the hills and mountains of a landscape in Naga country, one cannot fail to be impressed by both the picturesque country and the colourful people of Maram. Here was the place where the ancient Naga warriors departed from Meikhel, the departing place to seek fortunes and new lands and homes; here was the place where the King of Manipur fought with equal dignity and bravery; here was the place where the Japanese soldiers were halted in 1944 during the Great Second World War” (as cited in Athickal 1992, p.vii).

The Marams share a boundary with the Angami and the Mao Naga tribes to the North, the Paomai Naga tribe to the east, the Thangal Naga Tribe to the south and the Zeliangrong to the west. The routes to Maram are NH-02, which plies from Dimapur to Imphal and NH-129A, Maram Paren Road, which links Dimapur and Imphal. The highest concentration of Maram tribe can be found in nearly 40 villages between 93.15° and 94.0° E Latitude and 24.0° and 24.3° N latitude. According to the District Census Handbook, 2011, Maram people inhabit around 27 villages with a total population of 43,577, of which

22,796 are males and 20,781 are females, with a literacy ratio of 50.87 per cent (District Census Handbook, 2011). The Maram language is considered one of the endangered languages by UNESCO. Maram has been recognised under the "Particularly Vulnerable Tribe Group (PVTG)" as the only Naga tribe and second in North East India after Reangs from Tripura. The Government of India has identified 75 PVTG based on the pre-agricultural level of technology, low literacy rate, economically backward and stagnant population. Like any Naga tribe, the Marams are of Mongoloid origin with a remarkable strain of Caucasoid features and speak the Maram language, which falls under the Tibeto-Burman language. New villages have been established along National Highway-02 and National Highway-129 A for better communication and livelihood opportunities.

The Origin of Marams:

The origin of the Marams is vague, though a few British scholars like G. Grierson and Elwin (as cited in Athickal, 1992 pp.21-22) attributed and tried to link the origin of Marams with the neighbouring tribes such as the Maos and the Angamis. Watt (1887) recorded that Mao and Maram are believed to be descended from Angami; similarly, in Angami folktales, the three tribes are descendants of the three men who came out of the lake, of which to the south lies Mao and Maram, to the west lies the Kacha Naga, and third remains a native called Angami (p. 358). Another exciting version that Athickal (1992) records is the origin of the Marams based on his interview with Rev. Emmanuel Shangpliang, a Maram Khasi missionary who stated that there is a group called Marams among the Khasis of Meghalaya. According to him, the Marams were originally Khasis and settled in Meghalaya. However, since they were a huge group, they moved eastwards, looking for greener pastures, and they crossed the hill and settled at Maram Khullen (p. 23), with around 1000 households (Watt, 1887, p. 358). It is also believed that there is a group of Marams in Burma. However, no record suggests that all the Maram people in different regions spoke the same language or had the same culture and traditions.

Folklores Related to the Origin of Marams:

The origin and the more significant part of the history of the Maram Nagas are largely obscure due to a lack of written documents. However, a formidable and unique cultural history is passed down through the generations orally. Maram is rich in folktales, folklore, and folksongs, and they complement each other in trying to comprehend and knit together the social matrix, given the fact that these tales are orally handed down from one generation to another and are often interwoven with history and social norms. According to Maram folktales as recorded by Kanga, the first man, grandfather *Madungkashi*, was created out of *N'set* (beetle/wood larvae), and the first woman, grandmother *S'mutingdangpui* was created out of *Atingpui* (water scorpion). Kanga argues that in most primitive myths, life in nature is believed to have preceded the creation of human beings; therefore, it becomes appropriate that a man be created out of a creature of the earth and a woman out of a water creature. 'Since *N'set* bored into a tree, it becomes symbolic of the male principle and *Atingpui*, being a water creature, represents fertility and regeneration and is, therefore, symbolic of the female principle'.¹

Geographical Distribution of Marams:

The Maram inhabited area is divided into three major circles/zones based on geo-cultural aspects. Though not divided into different dialects, the language has variations in tones, tunes, certain terminology, etc.; however, people could communicate using their own accents of each village and region. Willong Circle, or the Western Maram People Organisation; Maram Khullen Circle or the Northern Maram People Organisation; and Senapati Circle or the Southern Maram People Organisation, comprises Tamuilong (Tumuyon Khullen) and its neighbouring villages and Katomei Maram Khunou, etc and its neighbouring villages (Tiba, 2006, pp. 119-120). Also, the nomenclature of the circle is based on the village's prominent identity. The zones under which the villages are distributed:

¹ <https://infomaram.wordpress.com/culture>

Table 2.1: Zone-wise distribution of the Maram villages

Sl. No	Maram Khullen Circle	Sl. No	Willong Circle	Sl. No	Senapati Circle
	(Revenue Villages)		(Revenue Villages)		(Revenue Villages)
1	Lairoching	18	Kamalong	27	Katomei
2	Maram Bazar	19	Kagungmei	28	Katomei Centre
3	Maram Centre	20	Pungdunglung	29	Malingli
4	Maram Kavanam	21	Rajaimei	30	Maram Khunou
5	Maram Khullakpa Sagai	22	Sangkunglung	31	Nagatan/Toklung
6	Maram Makha Sagai	23	Sang khunmei	32	Ragaalong
7	Maram Mathak Sagai	24	Willong Khullen	33	Sadim
8	Maram Sagonbam	25	Willong Khunou	34	Taphou Naga
9	New Magaimei			35	Tumuyon Khullen
10	New Maram		(Non-Revenue Village)		
11	N'taimei (Maram Khongnem)	26	Langkungjii	36	(Non-Revenue Village)
12	Maram Ramlong				Kazang-ga
	(Non-Revenue Villages)				
13	Kabinam				
14	Karingnam				
15	Naojai				
16	Patang/Kabaduikung				
17	Stoinam				

Source: Maram Union Record, 2022.

As per Maram Union (2022), there are 36 total villages in the three circles of which Maram Khullen Circle have the most number of villages compared to the other two circles. Twelve villages were selected for the current study: eight from the Maram Khullen Circle, three from the Willong Circle, and one from the Senapati Circle. Each circle will be briefly introduced in the following section, highlighting the socio-cultural practices and unique characteristics that have drawn the attention of numerous researchers, anthropologists, and tourists.

Maram Khullen Circle

Maram Khullen, also known as *Maramei Namdi*, is one of the oldest and largest villages in the district. It is from this village that the Maram people either migrated or relocated to establish other communities. Maram Khullen is significant for its dedication to preserving Maram traditions, culture, and customary festivals. The residents passionately uphold folk rituals, songs, and stories, reflecting a deep connection to their heritage. Additionally, the

village is home to the king's residence, the legendary tomb of *Apou Rangtaiba*, and various megaliths, all of which attract tourists and researchers, particularly those in the social sciences and humanities. Consequently, Maram Khullen serves as a vital custodian of Maram heritage.

Willong Circle

Located in the Willong Circle, Willong Khullen is the second-largest Maram village, following Maram Khullen. It is renowned for its Stonehenge-like structure at the village entrance, with megaliths reaching heights of up to seven meters and thicknesses of one meter, serving as a prominent attraction. Additionally, Willong village is known for its distinctive community fishing tradition called *Kajui*, which has been practiced for centuries and is considered one of the major customary celebrations in the area.

Senapati Circle

Senapati (*Tahamzam*) Circle includes villages in and around the district headquarters. *Tahamzam* is translated as 'the hill of the butterflies', and 17 kilometres from *Tahamzam* is the enchanting *Lizai* Lake, situated at the top of the hill near Sadim village. *Lizai* Lake is a hot tourist and picnic spot, and it is said that if the lake appears in a dream before one sees it in reality, it augurs good fortune.

Social System:

Family and Marriage

The family systems among Marams include nuclear, joint, and extended families. However, the nuclear family system is gradually increasing with cultural assimilation, modernisation, and changes in socio-cultural and economic domains. The Marams follow monogamy and exogamous marriage. Maram disapproves of even the consanguineous marriage, fearing misfortunes like attacks from wild animals (Athickal, 1992, p. 71). Marams, like other Nagas, is a patriarchal society. Traditionally, the family and social life of the Marams are bound by a cycle of rituals involving community and individual

participation and commitment. Observing these rituals and customs, the individual and the family accept society's norms and obligations, proclaiming one's tribal identity.

Kinship

The Maram Naga tribe is a simple society regulated by customs, traditional norms, oral knowledge, and kinship relations. The consanguinity and affinity relation of the people are referred to as Kinship. Thus, the “gens” united into a socially organised association are known as Moieties, either patrilineal or matrilineal and are exogamous practices (Athickal, 1992, p. 71). Maram Naga's concept of kinship is based on patrilineal lineage. Kin groups are distinguished through the cluster of *Pfiitat* (sub-clan) and *Siidung* (clan), where descendants are always traced to the father, and primogeniture is strictly followed (Tiba, 2006, p.60). Therefore, clans are morphologically intermediate between moieties and lineage (Athickal, 1992, p.55).

Clans

Among the Marams, *Siidung* (Clan) play a crucial role in the identity of the families and individuals. The social life of the Maram society is casteless and classless, with no social stratification, unlike the Verna system of Indian society (Stephan, 2020, p. 32). However, the tribals in India have been in a transition era ever since the colonial period. Therefore, the shift from communalism to individualism is gradually visible with the change and mobility resulting from globalisation. A list of dynamic social structures of moieties, clans and sub-clans of the Maram tribe is presented in the following tables.

Table 2.2: Maram Khullen (Moieties-Clans-Subclans)

<i>Nkukui (Kagamna)</i> (Moietie)	<i>Dikakuinah (Lamkahna)</i> (Moietie)	<i>Rangbung (Raigynahmei)</i> (Moietie)
<i>Kishiime (Clan):</i> <i>Rangsunahmei (Subclans)</i> <i>Lemnahmei</i> <i>Pungnahmei</i> <i>Tahangkime</i> <i>Majangmei (Clan):</i> <i>Peidumpukime (Subclans)</i> <i>Peisiinahme</i> <i>Puinahmei (Clan):</i> <i>Pungsiinahmei (Subclans)</i> <i>Kangkinalunei</i> <i>Baputahmei</i> <i>Painahmei</i> <i>Hingkungnahmei</i> <i>Hangkuipangbakimai</i>	<i>Pfusunahmei (Clan):</i> <i>Magunahmei (Subclans)</i> <i>Kateinahmei</i> <i>Rasaranahmei</i> <i>Hourapfukime</i> <i>Rangnahmei</i> <i>Sagongkime</i> <i>Huilamakime</i> <i>Kuilungmei</i> <i>Haomei</i>	<i>Magaibungnahmei (Clan):</i> <i>Shuikungnalime (Subclans)</i> <i>Shingnahmei</i> <i>Bishiingnahmei (Clan):</i> <i>Huibinahmei (Subclans)</i> <i>Bishunahmei</i> <i>Reigynahmei</i>

Sources: Tiba, 2006, pp.61-3; Athickal, 1992, p.54

Table 2.2 details three moieties under which there are six types of clans and 26 subclans under 17 villages within the Maram Khullen circle.

Table 2.3: Willong Khullen (Clans-Subclans)

<i>Kapsiilamei:</i> (Clan)	<i>Kangkuinahmei:</i> (Clan)	<i>Haomei-Hangnahmei:</i> (Clan)
<i>Lungdinahmei (Subclans)</i> <i>Kahiikime</i> <i>Puilingpuinahmei</i> <i>Hushangkime</i> <i>Mapoingnahmei</i> <i>Rangpfuinahmei</i> <i>Boishingnahmei</i> <i>Raidipfusungnahmei</i> <i>Namkangtahmei</i> <i>Lungdisoinahmei</i> <i>Sagongkime</i>	<i>Dirangnahmei (Subclans)</i> <i>Kangkuinahmei</i> <i>Siingngaibatamei</i> <i>Ranggingnahmei</i> <i>Rangtahmei</i>	<i>Haomarongmei (Subclans)</i> <i>Haomasangmei</i> <i>Kemdirangnahmei</i> <i>Muilungtahmei</i> <i>Shingtahmei</i> <i>Shoingtahmei</i> <i>Kabangbatalime</i> <i>Sambatalime</i> <i>Thiingingtahmei</i> <i>Haidoihingamei</i>

Sources: Tiba, 2006, pp.62-63; Athickal, 1992, p.55

Table 2.3 presents three clans under which 26 subclans are covered by 10 villages within the Willong Khullen circle.

Table 2.4: Tumuyon Khullen (Moieties-Clans-Subclans)

<i>Tungpangmei</i> (Moietie)	<i>Zangpzunahmei</i> (Moietie)
<i>Teinahmei</i> (Clan)	<i>Kampuinahmei</i> (Clan)
<i>Teinahmei Ninukasang</i> (Subclans)	<i>Kninahmei</i> (Subclans)
<i>Teinahmei N-naikasang</i>	<i>Rangnahmei</i>
<i>Teinahmei N-tiimkasang</i>	<i>Rangnahmei N-naikasang</i>

Sources: Tiba, 2006, p.62

Table 2.4 shows that there are only two moieties, two clans, and each of them has three subclans in the Tumuyon Khullen circle with villages.

Morung

Like any other Nagas, Maram too has the institution of Morung called “*Hangsü-ki*”/ “*Rühang-ki*” (men's dormitory) and “*Raliiki*” (women's dormitory) (Athickal, 1992, p.65). In the past, *Rahangki* was the centre for acquiring the art of warfare, hunting, merry-making, singing, dancing, playing games, etc., where the older men would educate the younger men or boys. Similarly, *Raliiki* served the purpose of learning the art of stitching, embroidery, weaving and women’s way of life. Thus, *Rahangki* and *Raliiki* served as institutions for acquiring indigenous knowledge. With the introduction of governmental administration and Christianity, a modern formal form of education has completely replaced the old, leaving the traditional form almost obsolete. The institution of formal education has created a transit point to a new dimension in the socio-cultural-economic way of life.

Religion:

Religion is defined in different ways; to philosophers, it is “a superstitious structure of incoherent metaphysical notions”; to sociologists, it is the “collective expression of human values”; to followers of Karl Marx, it is “the opiate of the people”, to psychologists, it is “the mythical complex surrounding a projected superego”, and to Anthropologists it is “to help unite people in a shared experience and explanation of life” (as cited in Athickal, 1992, p. 108).

The characteristics to define religion are as follows:

- a. The Sacred of mysterious potency, a sense of controlling Man's environment.
- b. Gods and God of higher degree of intellectualisation, clan Gods, specialised gods, the single god and wrathful Gods.
- c. The practice of Worship and power beyond Man's control.
- d. The beliefs of Myth and its cosmology.
- e. The presence of the Soul within oneself.

Similarly, general characteristics of Naga religions are belief in supreme God, world of spirits, myths and rituals, necessity of propitiation and sacrifice, ancestor worship and totemism (Athickal, 1992, pp.110-120). According to Kishimoto (1961) "Religion is an aspect of a culture centred upon activities which are taken by those who participate in them to elucidate the ultimate meaning of life and to be related to the ultimate solution of its problems. Many religious systems contain the notion of deity and/or holiness in relation to such activities" (p. 240).

The Maram Pantheon

In Maram, individuals who adhere to the indigenous religion are referred to as *Maidama*. According to Tiba (2006), Maram's cosmology is populated by a multitude of spirits and deities that practitioners must engage with. This belief system encompasses both malevolent and benevolent spirits; rituals involving animal sacrifices are directed towards these spirits or ancestral entities, rather than the chief God. Worship and sacrifice predominantly occur during agricultural activities, in response to illness, and during significant life events such as births, marriages, and funerals (pp. 155-163). These various forms of worship are deeply intertwined with nature, stones, ancestors, and a pantheon of deities. Research conducted on Maram by Athickal (1992, pp. 20-25) and Tiba (2006, p. 161) outlines the native religious practices, revealing that the Maram community believes in four gods: a chief God and several minor deities, each playing a distinct role in human destiny.

1. The Supreme God, known as *Paramhaba*, is revered as the creator of the heavens, the earth, and all living beings. He is believed to have formed *Tasiing* (the three stars that constitute the Belt of Orion) and *Thali* (the seven stars known as the Seven Sisters). It is commonly held that the appearance of *Tasiing* signals impending rain, and its disappearance heralds rain once more. As the creator of *Tasiing*, *Paramhaba* is regarded as the divine source of rainfall. Additionally, *Paramhaba* is credited with creating the first ancestors of humanity: *Madungkashi* (man) and *Samotingdungpui* (woman), fashioned in His own image.
2. *Akirakot* is the deity revered for protecting the home. The Marams hold the belief that houses should be constructed facing east to honour *Akirakot*. Additionally, it is believed that the spirits of the deceased journey toward the West. When this deity is pleased by a household, that household is thought to experience prosperity.
3. *Sara Kachinii* is regarded as the deity of justice, serving as the guardian of oaths and the enforcer of punishment for wrongdoers. He is particularly associated with individuals who occupy the middle ground between wealth and poverty. Those who fall under his protection are believed to enjoy longevity and a fulfilling life.
4. *Powmungba* is the deity responsible for controlling the weather. During cloudy, windy, rainy, or thundering conditions, children are advised to remain indoors, as it is believed that God is on the move. According to local belief, he resides on a mountain known as *Poukizang* (Grandfather's Hill), which is identified with *Koubu* Mountain. It is said that those under his protection experience a life that is rich yet brief.

Totemism

The classical definition of totem by Frazer “is an intimate relation which is supposed to exist between a group of kindred people on the one side and a species of natural or artificial objects on the other side, which objects are called the totems of the human group” (as cited in Malinowski, 1948, p. 4). In the narratives of Maram folktales, the cat is the first to see the sun from all living creatures; therefore, the cat is considered

older than man. Hence, when a cat dies, a proper burial is given; it is necessary to make a child cry during the cat's burial or before killing the cat for meat.

The relationship between rats and humans is illustrated in the folktale of the Maram. In this narrative, a rat ingeniously employed a ginger leaf as a vessel to retrieve a bundle of paddy grain from the depths of a lake, a task beyond human reach. This grain was then presented by *Samungtingdangpui*, the progenitor of humanity, to a crying child, thereby marking the beginning of mankind's agricultural practice of paddy cultivation. Consequently, humans and rats share the bounty of granaries, and ginger leaves play a significant role in various culinary rituals. Furthermore, when a group of rats is observed moving in a line, it is interpreted as a positive omen of prosperity.

The dog is a significant animal for the Marams. The animal plays an important role in sacrificial rituals and rites. During epidemics or misfortunes in the community, *Achii Marung*, a dog sacrificial ritual, is performed to appease the divine for protection. The rites involve killing a dog when a person dies, with the belief that the dog's spirit will protect and accompany the deceased. Dog meat is considered medicinal; it is believed to be beneficial for health. Especially after an accident or when someone is beaten, the sick person is given soup and meat. During *Kanghi* festival, dog meat is an important part of the feast where everyone in the Morung takes dishes made of dog meat. It is important to note that these beliefs and practices align with “Totemic reverence,” where animals and plants are consumed or used ornamentally during rites and ceremonies (Malinowski, 1948, p.4).

In *Maidama*, the original religion of the Marams; the consumption of pork is considered taboo and is classified as forbidden meat. This prohibition extends to the act of carrying pork through certain locations, such as the *Sagong ki-jang* (the King's compound) and other specific sites. One rationale for refraining from eating pork stems from a dream experienced by the *Sagong* (King), in which he envisioned himself as a blind

man. He feared that if individuals consumed pork, they too would risk becoming blind. Additionally, some adherents hold a narrative of reverence for pigs, recalling a story of an orphan who was once nourished by a pig.

The *Marambung* (Banyan tree) is under the protection of the *Rangnamai* clan, and even its branches must not be cut. Should any branches fall, it is believed that people will suffer from diseases and ailments (Athickal, 1992, p. 141). Furthermore, if anyone dreams of the *Marambung* falling, it is interpreted as a forewarning of the death of a distinguished individual. This belief aligns with Malinowski's theory of totemism, which suggests a "blend of utilitarian anxiety about the most essential objects in one's environment, with an interest in those which captivate the imagination, such as beautiful birds, reptiles, and dangerous animals." Malinowski (1948) posits that totemism is grounded more in the reality of the knowledge, attitudes, and practices of primitive religion than in the "animistic" focus emphasized by anthropologists (p. 4).

Cultural Features:

The Maram culture is resplendent with its uniqueness. Colourful traditional attire and ornaments are mostly worn on festivals and rituals. Dances such as *Psiiha Katii* is performed by women to express peace, joy and happiness. *Bang Katii* is performed by men on big occasions and festivals. *Sarii Katii* is a war dance performed only by men. Folk songs are sung in solo and group, it is the expression of emotions of love, sadness, the sacrifices and the chivalry of great personalities from the ancestry (Athickal, 1992, pp.91-105). Traditionally, the Marams build houses according to social standing and wealth in eight different types. However, only a few types are found today² which are also

² Monica, (2021, pp. 45-50) highlighted the striking impact on the indigenous Maram culture, heritage and tradition. In 1891 war between Manipur and the British adversely affected Maram. British came into control of the Maram, and as a result, the retaliated Marams faced a punitive measurement; the beautiful Maram villages were totally gutted to ash and dust. Thereafter, the Maram people never recovered from this fire.

on the verge of extinction. The Marams have a unique art of making weapons and tools, such as spears and shields, which are used during war dances.

Rice is the staple food of the people, and it comes in different varieties: white and red, sticky and non-sticky, which are used for making tea, bread/cake, and brewing rice wine apart from cooking and eating them as part of meals. Cooked rice is often eaten with various leafy vegetables, fish, and meat from different animals, including insects and water snails. The pork was not part of Maram cuisine in the past, but with the advent of Christianity, pork has become an integral part. Local brewed rice wine/beer called *Roshii* and *Jousang* are part of every meal. Tribal dances, sacrifices, celebrations of various kinds like *Mangkang*, *Kanghi* and *Ponghi*, construction of houses, use of Morungs, etc., were slowly condemned as sinful and not worthy of the Baptist religion. Rice wine was replaced with tea. However, people brought up from centuries of local brewed wine as the *sine qua non-food* item were told that drinking was a sin when actually getting drunk was the real weakness.

Rituals and observations of Genna

Table 2.5: Genna, Rituals, Customs and Celebrations of Lunar Calendar

Vernacular	Month	Genna and rituals	Custom and celebration
<i>Kapok-Kii</i>	January	<i>Achot- Kuitupai-ba</i> (genna)	
<i>Lung 'n 'rou-Kii</i>	February	<i>Achot- Kiipokramanai</i> (genna)	
<i>Fiibui-Kii</i>	March	<i>Mala, Kalirasa</i> <i>Kaliramanai/Gungdi kipouting</i> (genna to restrain from work)	
<i>Tingpui-Kii</i>	April	<i>Mala, Tingpui Maru-Manai</i> (ritual of purification)	<i>Mangkang</i> festival, <i>N'pamrah</i> (female purification)
<i>Kapokmatai-Kii</i>	May	<i>Mala, Rangtaiba/ Bunnamei</i> <i>Pouting</i> (genna to restrain from work)	
<i>Pokzing-Kii</i>	June		" <i>Sagong Kashumbanai</i> ", <i>Tupung</i>
<i>Pung 'ngi-Kii</i>	July		<i>Pung 'ngi</i> festival
<i>Lamshang-Kii</i>	August	<i>Mala, rite of Community</i> purification	<i>N'pamrah</i> (customary blessing of child)
<i>Taraou-Kii</i>	September	<i>Mala</i>	<i>Siipflimei-matei</i> (Male purification)
<i>Matai-Kii</i>	October	<i>Mala, Achii-marung</i> (Dog sacrifice), <i>Gungdi kipouting/Tingba-tingkat</i> (genna to restrain from work)	<i>Atiim-matai</i> (observed as cow feast day) <i>Sapuime-matai</i> (female purification)
<i>Rakak-Kii</i>	November	<i>Achimalou</i> (annual purification rites)	<i>Karakak</i> (Soul's departure ritual), <i>N'pamrah</i> (customary blessing of child)
<i>Kanghi-Kii</i>	December	<i>Tingpui-Marumanai</i> (ritual of purification)	<i>Malem, Kanghi</i> festival

Source: Fieldwork

Table 2.5 details the people of Maram following the lunar calendar, and every festival, performance of rituals, observation of Genna, the cycle of cultivation, hunting and fishing, weaving, etc., revolve around the movement of the moon. Through the lunar calendar, the customs, traditions and rituals are expounded, including the dominant values and principles for the well-being of people.

Festivals

Mangkang is a festival for the newly married women and young women. She comes to her parent's home for the celebration and feasts with her brothers and sisters

with chicken meat. During the *Mangkang* festival, all the unmarried and the newly wedded girls in the village deck themselves up in traditional attire, including ornaments like brass bangles, beady necklaces, wool and bead earrings, and sing folk songs, walk in groups towards the particular place called *Psiiha Pung*, and dance the traditional girls dance until dusk. *Mangkang* is also treated as a time to showcase young girls' beauty and dance talent, giving the opposite sex a glance for future marital unions.

The *Pung'ngi* festival is observed as a form of thanksgiving for the completion of paddy transplantation and serves as a plea for an abundant harvest. During the celebration, a spotless cow/bull is slaughtered as a symbol of fertility, believed to invoke blessings for prosperous crops and fertility for newlyweds. The festival takes place in July.

Karakak is the feast of death, it is celebrated by offering prayers for the departed souls in the family. The Marams believe that the soul reincarnates six times apart from the physical death. On this day, the family members stay away from others, and a chicken is sacrificed and cooked outside the house.

Kanghi is a men's festival. *Kanghi* is celebrated for seven days. During *Kanghi*, men from different localities go around the village in groups in the wee hours of the morning, making war cries. The afternoons and evenings are spent feasting over various meats, brewing rice wine/beer, singing folk songs in their respective men's dormitory, and later assembling at the king's yard for wrestling and long jumps. Stark naked wrestling takes place in the evenings to ward off misfortune and injuries. The festival concludes with the entire village menfolk taking part in the traditional war dance where each one is handed a wooden tool prepared by the Kingsman, and they dance around the king's yard/ground only to wind up in a loud conclusive end note in an impressive unison.

Impact of Christianity

With the coming of Christianity, the culture of the Marams took a different turn. Christianity came to Maram in 1949 through the American Baptist preacher Rev. John S. Anderson, who established a church at Tumuyon Khullen Village (Athickal, 1992, pp.149-152)³. The India Census report, 1931, reflected Christian institutions' destruction of the culture; Haimendorf said, "It is a pity that the American Baptist mission had little sympathy with the aims of government and even less appreciation of the valuable element of Naga culture" (as cited in Athickal, 1992, p.163). Religious ceremonies and ritual practices also diminished as the Sagong (king/village chief) became the ex-officio chairman. The chief's power took a drastic turn with the introduction of the Village Authorities in Hill Areas Act 1956 (p.63). This was also the year Christianity reached Maram Khullen through the Catholic Salesian priests Aloysius Ravalico and Peter Bianchi. Today, 99 per cent of the Marams practice Christianity, and 1 per cent of the population upholds native religion. Maram is the only tribe in Manipur with a majority in the Roman Catholic denomination (p.163). The intricate rituals of the native religion are also one of the reasons for the mass conversion to Christianity. In Maram, Christianity made its route at the peak of suffering from starvation, sickness and suffering, and poverty.^{4,5} The Christian Missionaries used the method to converse with the people by

³ The Baptist missionaries came with their own culture and intended to destroy the native culture of the people. The gospel does not speak of the destruction of culture but integration

⁴ Kanga (2021 pp.45-54) highlighted the striking impact on the indigenous Maram culture, heritage and tradition. In 1891 war between Manipur and the British adversely affected Maram. British came into control of the Maram, and as a result, the retaliated Marams faced a punitive measurement; the beautiful Maram villages were totally gutted to ash and dust. Thereafter, the Maram people never recovered from this fire. Again, on 18th June 1944, another battle between the British and Japanese was fought in Maram. As the Marams and Japanese were starving for survival or die situation, the Japanese obtained service from the Maram as porters and guides with Rs. Fifty monthly. As a consequence, Shri. Raisung, who was recruited by the British after the arson and destruction by fire, was imprisoned and removed from the service.

⁵ Tiba (2006 pp. 176-177) On these times, after several attempts failed, in 1949, Rev. John Anderson, an American Baptist from Southern American Church, managed to make inroads and convert seven youths from Tumuyon Khullen. The missionaries colonised the indigenous socially, culturally, and religiously with the attitude of white divine superiority. Then, in 1956, Catholic Missionaries reached Maram Khullen and converted and baptised forty men and a group from Willong Khullen. Maram people were one of the last Naga tribes to accept Christianity.

introducing modern education, employment opportunities and livelihoods, awareness of health and hygiene, and preventive and curative measurement of diseases (Sitlhou, 2009, p. 66). These were also the methods to win over the indigenous people and transform the culture. Similarly, Athickal (1992) highlighted the cultural assimilation through the Christian missionaries. With the assimilation and globalisation, the lifestyle of the Maram people has been shifting steadily, resulting in changes in food habits, culture morph, and changes in the belief system where the old system is completely or partially left behind (pp.144-165). Many cultural practices have delved into oblivion, and not much has been done to either revive or record them. Given this background, the indigenous ways of treating ailments, too, have received a drawback, especially with the introduction of health centres and allopathy medicine being easily made available at pharmacies, which can be bought without a prescription from a doctor. Therefore, the need of the hour is to record and preserve the precious little that is still partially practised/remembered.

Economy and Occupation:

Among the Marams, traditionally, people depend on agriculture, hunting, and gathering what nature provides for their sustenance. The wealth was measured with rice; any family not able to make three meals a day was in poverty. Terrace cultivation is practised by the majority of the Maram tribe, and shifting cultivation is practised on a small scale, unlike the other Nagas. The cultivation of cotton and chillies was the means of economy (Tiba, 2006, p. 115).

The salubrious climate that Maram has is conducive to rich flora and fauna. Sadly, due to deforestation with the felling of trees, hunting of wildlife is on a steady deterioration, and Maram, too, is facing certain climatic changes where summers and winters are getting extreme. Most of these vegetables and fruits are grown in private gardens and orchards for personal consumption, though some sell to generate income. Maram Khullen is known for its unique cabbage, which is at its best in winter when the dew-turned-ice seasons the huge cabbage leaves. When cooked, it is super soft and sweet.

Like every household with a vegetable garden, most families have fish and animal husbandries and keep pigs, cattle, dogs and poultry. The rich and poor was measured in terms of the amount of paddy harvested and the number of domesticated animals like cows, bulls and buffaloes. The feast of merit is celebrated with the distribution of paddy, brewed rice wine, and meat.

The means of livelihood have tremendously changed from cultivation to semi-cultivation, blue-collar jobs and white-collar jobs. Weaving was one of the sources of income for women folk. Women themselves cultivate cotton using traditional methods of processing and weaving. However, today, only a few women can skilfully weave the original attire, like *Aping-pai*, *Asha-pai* (name of shawls) and *Sapuimei-paina li* (wrap-around). There is a shift from weaving to the innovative fusion of traditional attire in various styles that has become a trend in redefining and revolving the tradition and customs with an attachment to culture. Nevertheless, from a critic's point of view, one can argue that the self-reliance and sustainability of traditional methods are on the verge of extinction.

Traditional Governance System:

The traditional system of governance and administration has been streamlined with the introduction of modern governance models. However, the traditional system of governance and decision-making processes is still practised and upheld in almost all social and administrative matters of the village communities. A patrilineal kinship is established in every community wherein the head of the clan typically represents the clan in all matters of dispute and decision-making. Kin groups are distinguished through the cluster of *Pfittat* (sub-clan) and *Siidung* (clan), where descendants are always traced to the father, and primogeniture is strictly followed (Tiba, 2006, p.55)

Any civil disputes and criminal cases are settled in the village court. The village council consists of male elders from each *Siidung*. Any disputes at the local level are

settled amicably by family, clan/kinship and village council. The punishment depends on the nature of the conflict and level of escalation, and the verdict passed is often accompanied by a fine paid either in kind or cash. The penalty for any committed crimes is paid off with a cow or bull as a price. Nepotism plays a big role in such matters, and there are times when winning the trial is based on the family's background, such as job status, social status, and financial status. A family with more male members can turn the tables in settling the issues through their capacity to manipulate discussions. According to customary law, only a male child can inherit properties like land, house, jungle, land, field, etc., which forefathers pass down (Athickal, 1992, p.73 and Tiba, 2006, pp. 81-82) such hereditary properties are called '*Sara Kiikat*' in Maram. This could be the reason behind the preference for a male child in the families.

Profile of the Villages:

Demographic Profile

The study covered 12 villages, mostly along the national highway 02 and adjacent areas. The villages were primarily selected based on their accessibility and the availability and willingness of people. The knowledge, attitudes and practices relating to health and socio-cultural and economic matters were also taken into consideration while selecting the villages.

Table 2.6 Infrastructure and Communication Facilities

Amenities	Number	Percentage (%)
Electricity	12	100
Mobile network	12	100
Landline	3	25
All weather roads approached in the village	10	83.33
All weather roads in the village	5	41.67
Community water supply	11	91.67
Public Toilets with water supply	1	8
Public Distribution System	12	100
Anganwadi	12	100
Primary Schools	11	100
Middle and High Schools	5	41
Hr Secondary Schools	2	16
Colleges	1	8

Source: Fieldwork

As indicated above in table 2.7 all the villages surveyed have electricity and mobile connections. However, the electricity supply is not regular and extra-ordinarily extended power shutdowns are experienced throughout the year. The mobile network strength is poor in most villages with only a couple of network providers. As shown in the above table only three villages were found to be connected with landline. The road infrastructure with rudimentary all-weather road approaches in nine out of the 12 villages and five villages with all-weather roads in the village. Though 11 villages are said to have community water supply, the lack of public regular water supply is a stark reality. Typically, the communities have established a collective system to bring water from the stream to a reservoir located within the village perimeter. The villagers, primarily women, transport this water using head loads. It was noted that only four villages possess public toilets, and among these, only one village has a public toilet equipped with piped water. As previously mentioned, all 12 villages have Anganwadi centres, and 11 villages have a primary school within their boundaries.

General Economic Profile

Table 2.7 Economic Profile of the Villages

Sl.no	Name of village	Number of HH	BPL Households	Percentage (%)
1	Maram Bazar	486	33	7
2	Maram Centre	338	25	7.40
3	Maram Sagonbam	70	50	71.42
4	Lairoching	341	38	11
5	Maram Khullakpa Sagei	230	200	87
6	Maram Makha Sagei	170	160	94
7	Maram Mathak Sagei	463	246	53
8	New Maram	84	38	45
9	Rajamei	130	80	61.53
10	Sadim Naga	86	86	100
11	Shang Khumei	56	55	98
12	Willong Khullen	328	200	61

Source: Fieldwork

As indicated table 2.8 only one village was found to be 100 per cent Below Poverty Line (BPL). Three villages with the majority (above 80 per cent) under BPL and four villages with more than 50 per cent of people below the poverty line and only three villages were found with less than half of its households under BPL.⁶

It is pertinent to note that cultivation is the major occupation, most of the community members are farmers. The men in the villages predominantly engage in hunting alongside their regular agricultural duties. Women primarily occupy themselves with household chores and weaving. Fetching water constitutes one of their major responsibilities, receiving minimal support from the men. Generally, village children assist with fieldwork, household tasks, and the care of younger siblings. In recent years, residents have begun participating in small-scale businesses, selling vegetables, clothes, and groceries. All 12 villages have established village councils, along with a public distribution system and the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS).

⁶ This is the information that has been collected from the village records.

Transport and Communication Facilities and Access to Services

Most Maram people, living in remote villages in the hilly region with rudimentary transport infrastructure and facilities. They face significant challenges in accessing essential services like healthcare, education, banking, and government services. This worsens existing inequalities in terms of economic, educational and healthcare opportunities available to them and hinders their overall development. Ensuring accessibility to these services is crucial for promoting social justice and economic empowerment of the Marams. The following table throws light on the status of the villages.

Table 2.8: Accessibility of Essential Services

Sl.no	Name of village	District HQ	NH -02	Banking Service	Market	Hospital	Ambulance Service
Distance in kilometres							
1	Maram Bazar	23	0	1	0	17	0
2	Maram Centre	22	0	3	0	16	1
3	Maram Sagonbam	23	0	2	0	16	1
4	Lairoching	17	0	1	0	14	6
5	Maram Khulakpa Sagei	27	5	6	6	20	6
6	Maram Makha Sagei	27	5	6	6	20	6
7	Maram Mathak Sagei	29	7	7	7	21	7
8	New Maram	20	2	5	5	15	5
9	Rajamei	55	55	55	55	55	55
10	Sadim Naga	17	17	17	17	18	17
11	Shang Khumei	58	34	37	56	52	24
12	Willong Khullen	62	39	42	39	57	19

Source: Fieldwork

Table 2.9 details the accessibility of essential services from the study villages to the district of Senapati. Most major government services, particularly healthcare, are centralized at the district headquarters. As a result, residents must frequently travel to these headquarters, especially during healthcare emergencies. Public transportation is available in the form of private taxis that operate along the national highway between the Senapati and Maram areas. However, for villages located further from the highway, reaching Senapati often necessitates the use of private vehicles. Despite the relatively short

distances involved, the cost of transportation can be very high for people, especially in the absence of public transport options in many villages.

Banking services remain out of reach for many indigenous people, as bank branch offices and ATMs are sparsely distributed. the lack of local language support in banking service is a significant obstacle for the common people. As a result, financial literacy levels are low, leaving them vulnerable to informal moneylenders. The Marams have traditionally relied on agriculture, forest produce, and handicrafts for their livelihoods. However, limited access to markets due to poor road connectivity, and lack of transportation facilities restricts their ability to sell their products. This leads to the exploitation by the middlemen who under-price the produce. This economic marginalization has prevented them from fully participating in the region's economic growth.

In this region, government healthcare centres are very few, and private healthcare facilities are often prohibitively expensive for many indigenous communities. According to a 2016 report from the Ministry of Health and Family Welfare, healthcare delivery in tribal areas faces significant challenges, including insufficient human resources, substandard service quality, and inadequate transportation options (p. 295). Consequently, maternal and child health indicators remain below the national average due to these accessibility issues.

Profile of the Respondents:

The primary source of information for this study is derived from interviews conducted with respondents selected from each village. The researcher personally administered the interview schedule to each participant. The first part of the interview schedule helped the researcher to develop the demographic profile of the respondents and their families as well as their concerns regarding socioeconomic status, education and livelihoods. A total of 225 households were interviewed in the targeted villages with

representation from different sections of the society. The detailed profile of the respondents and the household data is presented in this section.

Table 2.9: Village-Wise Distribution of the Respondents

Sl.no	Name of village	Gender		HHs
		Male	Female	
1	Maram Bazar	11	19	30
2	Maram Centre	12	16	28
3	Maram Sagonbam	4	6	10
4	Lairoching	6	16	22
5	Maram Khulakpa Sagei	16	8	24
6	Maram Makha Sagei	12	3	15
7	Maram Mathak Sagei	5	15	20
8	New Maram	5	5	10
9	Rajamei	5	5	10
10	Sadim Naga	4	4	8
11	Shang Khumei	5	5	10
12	Willong Khullen	10	28	38
Total		95	130	225
Percentage (%)		42.22	57.77	100

Source: Fieldwork

Table 2.10 indicates the village-wise distribution of the households interviewed. On an average, 10 per cent of the households from each village were interviewed as per the village record available. The first four villages in the table above are on the National Highway (NH)-02 while the remaining villages are away from the NH-02.

Socio-demographic Profile of the Respondents

Table 2.10: Age and Gender of the Respondents

Age Group	Male	Female	Total	Percentage (%)
15-29	14	26	40	17.78
30-44	29	53	82	36.44
45-59	34	30	64	28.44
60 and above	18	21	39	17.33
Total	95	130	225	100%
Percentage Gender	42.2.	57.8	100	

Source: Fieldwork.

As observable from table 2.11, nearly 58 per cent of respondents were females. The largest group of respondents were from 30-44 years old, with 36 per cent. This has been done intentionally in order to engage with respondents who are living with families and have young children. Similarly, the age group of 45-59 also have an adequate representation, with 28 per cent among the respondents. There has been an almost equal distribution of respondents from the lowermost and uppermost age groups.

Table 2.11: Marital Status of the Respondents

Age Group	Single		Married		Divorcee		Widow/ Widower		Total
	M	F	M	F	M	F	M	F	
15-29	9	13	5	13	0	0	0	0	40 (17.78)
30-44	3	6	24	39	1	2	1	6	82 (36.44)
45-59	1	0	28	17	2	2	3	11	64 (28.44)
60 and above	0	0	13	7	0	2	5	12	39(17.33)
Sub Total	13	19	70	76	3	6	9	29	225
Total	32		146		9		38		
Percentage	14.22		64.89		4		16.89		100%

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 2.12 presents the marital status of the respondents. As presented above, 65 per cent, were married and living with their families. It is observed that 17 per cent were widows/widowers of which 13 per cent are widows, from the age group of 60 and above.

Nearly 14 per cent were single and never married while around four per cent were found to be divorcees among the respondents.

Table 2.12: Education Profile of the Respondents

Age Group	Illiterate		Primary		High School		Hr. Sec		Graduate		P.G. and above		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
15-29	1	3	0	4	3	2	2	4	7	9	1	4	40 (17.78)
30-44	2	13	7	12	6	13	1	5	12	7	1	3	82 (36.44)
45-49	9	19	12	8	8	1	3	1	2	1	0	0	64 (28.44)
60 & above	9	17	3	3	5	1	0	0	1	0	0	0	39(17.33)
Sub-total	21	52	22	27	22	17	6	10	22	17	2	7	225(100)
Total	73		49		39		16		39		9		225
Percentage	32.44		21.78		17.33		7.11		17.33		4.00		100%

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 2.13 details the educational qualifications of the respondents. Whereas over 32 per cent were found to be illiterate, nearly 72 per cent of the illiterate were women. The largest group of respondents with some education belongs to the primary education level with 21 per cent. There are nearly 45 per cent of the respondents with education above high school level. Only nine per cent have postgraduate level education.

Table 2.13: Occupation Profile of the Respondents

Age Group	Student		Govt Ser		Pvt Ser		Business		Farmer		Unem ploye d		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
15-29	2	3	1	1	4	4	0	4	4	7	3	7	40 (17.78)
30-44	0	0	3	5	4	9	6	9	14	25	2	5	82 (36.44)
45-59	0	0	3	2	7	0	2	4	19	23	3	1	64 (28.44)
60 and above	0	0	3	2	1	0	1	1	13	15	0	3	39 (17.33)
Sub-total	2	3	10	10	16	13	9	18	50	70	8	16	225
Total	5		20		29		27		120		24		100%
Percentage	2.22		8.89		12.89		12.00		53.33		10.67		

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 2. 14 above details the occupation profile of the respondents. It is observed that 53 per cent, of the respondents are farmers, 13 per cent are engaged in private services, 12 per cent are engaged in business and 11 per cent are unemployed. Only nine per cent of the respondents are government-employed, and two per cent are students.

Wet rice agriculture is the primary occupation in the surveyed villages. Fruits and vegetables are cultivated on a small scale. The soil is suitable for cultivation, especially for cabbage, cauliflower and potatoes (Athickal, 1992, p.170). Maize is the secondary occupation, and cotton and chillies are the subsidiary crops that make up the economy (Tiba, 2006 p. 115). People were self-sufficient for their survival, though some engaged in generating income like the neighbouring tribe (Kabui) engage business in the plain and valley (Tiba, 2006 p. 117). That state has potential with vast mineral and forest resources, but due to poor infrastructure connectivity and communication, the state is ranked as one of the most industrially backward states in the country (Athickal, 1992 p.171).

Households profile:

The demographic profiles of the families were also compiled in order to gather adequate information about the nature of the families under the survey.

Table 2.14: Income Profile of Households

Annual Income	Frequency	Percentage (%)
Less than 24000	101	44.89
25000 to 60000	69	30.67
61000 to 120000	32	14.22
More than 120000	23	10.22
Total	225	100.00

Source: Fieldwork

Table 2.15 shows the annual income profile of the household surveyed. It has evidently shown that nearly 45 per cent families have annual income below ₹24000 which is just ₹2000 per month. Only 31 per cent of the families have an annual income of ₹25,000 to ₹60,000 which again is a meagre ₹5000 per month. In the lower income groups, dependence on the agricultural activities are very high. They do not have cash income. They meet their regular needs with the produce from the fields and by exchanging goods. The respondents with 14 per cent of the families' annual income are from 61000 to 120000, and only 10 per cent of the families with more than 120000 annual income. It is to be noted that the income is in line with the occupation, with more than half of the respondents being farmers. Also, families with more than 120000 are from where more than one person in the families holds government services from business families.

Table 2.15: Number of Family Members

Number of family members	Frequency	Percentage (%)
02-05	107	47.55
06-10	109	48.44
11 and above	9	4
Total	225	100.00

Source: Fieldwork

Table 2.16 shows the family no. members in the family who are residing at present. It is observed that 48 per cent of the respondents with 06-10 family members, and 48 per cent of the families with 02-05 family members, and only four per cent of the respondents with 11 and above family members.

Table 2.16: Types of Family

Types of family	Frequency	Percentage (%)
Nuclear family	179	78
Joint family	34	15
Extended family	17	7
Total	225	100.00

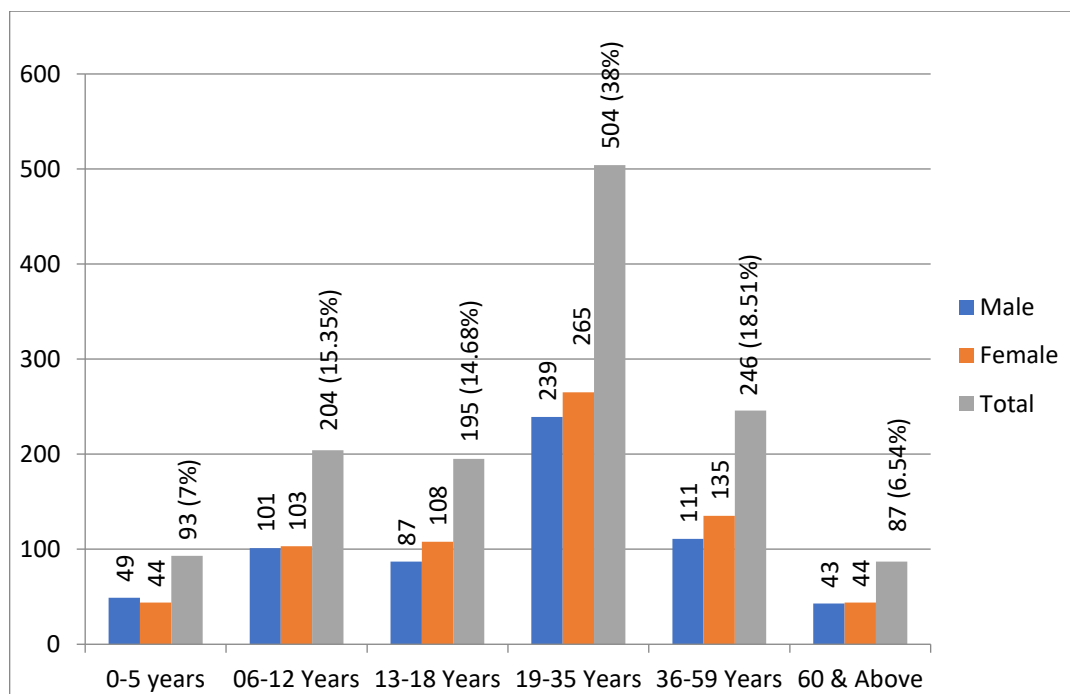
Source: Fieldwork

Table 2.17 depicts the types of family exist. It has clearly projected with 78 per cent of the respondents belong to nuclear family. While, 15 per cent of the respondents are from joint family and only seven per cent are from extended family.

Among the Marams too, family structures vary significantly, with three primary types of nuclear, joint, and extended families. A nuclear family typically consists of a married couple and their children living together. A joint family has multiple generations living under one roof, often including parents and their married children, who may share not only living space but also resources like a common kitchen. The extended family extends this concept further, where married children live in the same household as their parents but maintain a separate kitchen, allowing for more independence and privacy

while still fostering close familial ties. Each family structure offers distinct benefits and challenges, reflecting cultural norms, social dynamics, and individual preferences.

Figure 2.2: Age and Gender Profile of Households' Members Population



Source: Fieldwork

The figure above labelled 2.2, illustrates the total population involved in the study. This research encompassed 225 families, comprising 1,329 individuals, of whom 630 were male and 699 were female. The accompanying table outlines the age-gender distribution of the study population. The largest demographic, accounting for 38 per cent, falls within the age group of 19-35 years. This is followed by 19 per cent from the 36-59 age group, and 15 per cent from each of the 06-12 and 13-18 age groups. Lastly, only seven per cent of the population is represented in each of the age groups 0-5 and 60 years and older.

It is observed that the age group 19-35 were the highest population in the present study and the age groups of 60 and above present the least population in the present study. All age groups were included and enriched the data for the assessment of health and healthcare practices in the community. The traditional way of caring for children to elders is still practised and carried forward as a tradition in the community. For instance, rituals and traditions for the good health of children are still practised among the community, also as a tradition when dogs and other animals are butchered during the feast and ritual, the heart and brain are given to elderly people, since they cannot chew hard meat. Seeking blessings from elderly people is commonly practised, where the elders bless for good health, wealth and fertility.

The traditions and cultural practices of the community are deeply embedded within its social fabric. Demographic profiles of the villages and households serve as indicators for assessing the overall health and well-being of the community. It is important to recognize that colonialism has profoundly impacted the values, beliefs, customs, and practices of the Maram Indigenous community. There is undeniable evidence of cultural assimilation and acculturation, particularly through the embrace of Christianity and modernization. Currently, tribal communities find themselves in a transitional period, rendering them particularly vulnerable to malnutrition and morbidity. Their health outcomes are influenced by a combination of unique socio-cultural factors, traditional customs, and economic conditions (Raushan and Acharya, 2019). This transition has had a significant impact on the health and well-being of tribal populations, especially the Particularly Vulnerable Tribal Groups (PVTGs) (Sonowal and Konch, 2021, pp. 69-70).

Chapter 3

HEALTH, ILLNESS AND HYGIENE

Health and Wellbeing:

Health is an elusive phenomenon; it varies from culture to culture and is hard to understand comprehensively. Well, in Maram, the words *Ara* (diseases), *Araka-tii* (suffering, ill, sick or in pain), *Agangkatii* (physical pain), *Asuira* (psychological disturbances and imbalance) and *Tiirakarii* (insanity/madness), *Aluisyi* (thin and pale), *Kasangnou* (weak and unable) are used to describe the undesirable health status of individuals and families. Whereas the word *Aragakiibi*⁷ means healthy, happy, chubby, able to perform work, productive, capable of performing socio-cultural obligations, strong and vigorous. The state is also described as *Apum-kasangting* (physically strong and fit). As defined by the above words, the Maram understanding of good health corresponds with the World Health Organisation's (WHO) definition of health as a complete physical, mental, social, and cultural well-being, not merely an absence of disease or infirmity.

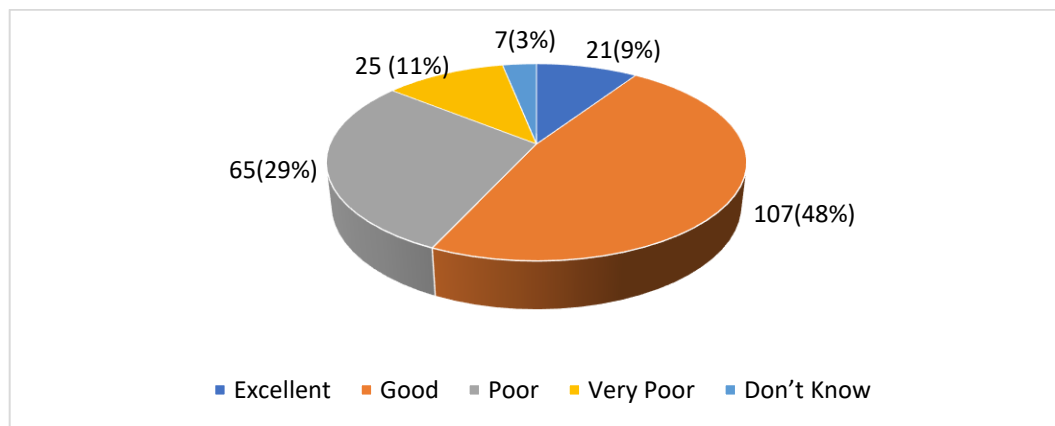
The researcher conducted an in-depth interaction with the respondents to gain insight into the various aspects of health, covering knowledge, perceptions, attitudes, experiences, and family practices. The information was collected through the interview schedule administered in person and completed by the respondents alone or in consultation with the family members. The focus group discussions (FDGs) were conducted to gather knowledge on the attitudes and practices and the general perception of the healthcare concerns affecting the community. The findings of the interviews and the interactions are analysed and discussed in this chapter, as well as the relevant sections of the following chapters. This section describes the general healthcare information of the families' knowledge, perceptions and experiences of the family.

⁷ It also implies in Identifying Atum (Cow) *Ara-ga-kabi* (healthy and spotless in black colour) is used for any sacrificial ritual.

Perception of Family Health Status:

The family's self-perception regarding their health status as experienced or perceived by the family members in the past year was gauged on a general scale from excellent to poor, considering their experiences. The respondents were asked to choose an option that best described their family health status.

Figure 3.1: Family Perception of Overall Health



Source: Fieldwork

Figure 3.1 reveals that more than half of the respondents' families (57 per cent) rated their health as good to excellent, with 48 per cent indicating "good" (107 respondents) and 9 per cent selecting "excellent" (21 respondents). This perception aligns with the broader assessment of health standards within the community. During focus group discussions with village elders, youth, and women, a consensus emerged that the community generally enjoys good health with few significant issues. However, 29 per cent of respondents reported their family health as poor, often citing communicable diseases, accidents, and injuries as prevalent concerns. Several families also identified alcohol and tobacco use as contributing factors to poor health.

Furthermore, 11 per cent of families described their health status as extremely poor, attributing this to the prevalence of diseases and disabilities. Conditions such as

cancer, diabetes, tuberculosis, high blood pressure, and major accidents were frequently mentioned as significant contributors to ill health. Approximately three per cent of family members expressed uncertainty regarding their health status, noting that it varies based on various factors and seasonal influences. Notably, respondents who reported excellent health among family members predominantly included farmers from remote villages

Major Healthcare Concerns of the Family:

The researcher delved into the family's key healthcare concerns through perception or experience. The respondents were assisted in selecting from the available options through a detailed explanation of each component of the question. In many instances, family members also contributed their perspectives. These observations are based on the incidence of the disease or condition within their families, as well as their perceived vulnerability to it.

Furthermore, during the FGDs, diseases prevailing in and concerning the community were discussed with the participants. The data is drawn from 10 FDGs. For various reasons, most diseases are not reported. Still, this exercise assessed people's awareness of the diseases around them and the community's health problems. This data is not verifiable because, in the bigger villages and villages along the national highway, the number of people suffering cannot be adequately ascertained. The participant's knowledge of the major illness, status of treatment, and fatality are presented.

Communicable Diseases (CD)

A communicable disease is any disease that passes between people or animals. According to Merriam-Webster, a CD is transmissible by contact with infected individuals or their bodily discharges or fluids, contaminated surfaces or objects, contaminated food or water, and contact with disease vectors.⁸ According to the International Classification

⁸ Communicable diseases (20 Jul 2024) <https://www.merriam-webster.com/dictionary/communicable%20disease#dictionary-entry-1>

of Diseases (ICD-10), CD are fever, cough, tuberculosis, tetanus, filariasis, HIV/AIDS, diarrhoea/dysentery/increased frequency of stools, worm infections, discomfort/pain in the eye, acute upper respiratory infections and skin infection (Swargiary and Lhungdim, 2021, p.42). The Indigenous people are burdened with high CD, and their life expectancy is relatively low. The infection drains the nutrients and energy from the body; therefore, it is crucial to emphasise the associated nutritional insufficiency and CD among the Indigenous people, especially children, as they have stunted growth (Valeggia and Snodgrass, 2015, pp. 121-122).

Perception of Communicable Diseases

Table 3.1: Communicable Diseases

Level of Importance	Frequency	Percentage (%)
Serious Concern	54	24.00
Important Concern	123	54.67
Not Important	33	14.67
Not concerned at all	15	6.67
Total	225	100 %

Source: Fieldwork

As reflected in Table 3.1, communicable diseases are a matter of discernible importance. Nearly half of the respondents (54 per cent) stated that they are a healthcare concern in the family, and 24 per cent said it is a severe concern that the family suffers from infectious diseases. While 15 per cent found it unimportant, only seven per cent are not concerned at all. Malaria, diarrhoea, jaundice, and viral fever are the main concerns due to their recurrent occurrence in communicable diseases.

Incidence of Communicable Diseases in Families

The prevalence of different CDs among people varies according to the seasons. In general, it was observed by the community leaders⁹ and the healthcare personnel¹⁰ that the incidence of malaria, jaundice and diarrhoea has had a discernible reduction in recent

⁹ Men Folk, Focus Group Discussion on 27/10/2020 at 11: 57 am, Maram Sagonbam.

¹⁰ Female, 40 yrs, respondent, interviewed on 20/09/2020 at 2.00 pm, Willong Khullen Village

years. None of the villages under the study has reported any deaths due to malaria in the past two years. However, the cases of non-infectious diseases and accidents are on the rise. The reporting of various diseases is also limited because, in most cases, treatment is done using traditional medicines. Table 3.2 depicts the incidence of different communicable diseases that affected the respondent families one year before the interview.

Table 3.2: Incidence of Communicable Diseases (CD)

Ailments	Yes	%	No	%	Total (%)
Cold and cough	208	92.44	17	7.56	225 (100)
Viral Fever	178	79.11	47	20.89	225 (100)
Diarrhoea	120	53.33	105	46.67	225 (100)
Malaria	19	8.44	206	91.56	225 (100)
Dengue	21	9.33	204	90.67	225 (100)
Tuberculosis (TB)	27	12.00	198	88	225 (100)
Jaundice	31	13.78	194	86.22	225 (100)
Skin Diseases	56	24.89	169	75.11	225 (100)
Measles	29	12.89	196	87.11	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

As indicated in Table 3.2, the prevalence of colds, coughs, and viral fevers is significant among the respondent families, with more than two individuals affected in over 75 per cent of these households. Additionally, the incidence of diarrhoea among both children and adults is noteworthy, as over 60 per cent of families reported occurrences involving two or more members within the past year. It is important to highlight that these conditions were predominantly managed with local remedies and over-the-counter medications, rather than through consultations with healthcare practitioners. Conversely, the prevalence of malaria, dengue, jaundice, and measles is minimal, with fewer than 10 per cent of families reporting cases of these diseases.

The prevalence of tuberculosis (TB) among the interviewed families is approximately 10 per cent. All TB cases are managed by Accredited Social Health Activist

(ASHA) workers and nurses who provide follow-up care under the Revised National Tuberculosis Control Programme (RNTCP). Additionally, the families reported utilizing various local medications for the treatment of TB and its associated complications. Over time, they also noted experiencing mild effects from measles. Isolation and local medications are effective in the treatment. As such, no fatalities due to measles were reported in the villages during the past two years¹¹.

During the FGDs, a discussion was held on the communicable diseases prevailing in the villages in the past year, as observed by the participants. The diseases observed by the participants in the villages are flu, cold and cough, fever, diarrhoea, typhoid, tuberculosis (TB), pneumonia, malaria, skin infection and HIV/AIDs. The participants of the FGDs believed that, currently, with the availability of medicines, malaria is no longer a big problem for us.¹² The occurrence of different diseases is not adequately reported within the village; the villagers learn of it only when a death occurs due to some complications. It may be noted that according to Kuar et al. (2022), ‘Causes of death in tribal districts’, Senapati district has zero per cent of deaths from malaria and other communicable diseases (Kuar et al., 2022, pp.257-258).

¹¹ Female, 40 yrs, Nurse, dispensary, interviewed on 20/09/2020 at 2.00 pm, Willong Khullen Village

¹² Youth (women), Focus Group Discussion on 06/12/2020 at 11.00 am, Lairoching.

Table 3.3: Major Communicable Diseases Reported in the Villages

CD	No. affected	Under Treatment	Cured	Died	Status not known	Percentage (%)
Diarrhoea	53	42 (79.24)	11(20.75)	-	-	100
Pneumonia	51	-	33(64.70)	2 (3.92)	16(31.37)	100
Jaundice/Hepatitis	47	2(4.25)	10(21.28)	9(19.15)	26(55.32)	100
Tuberculosis	15	6(40)	3(20)	2(13.33)	4(26.67)	100
HIV/AIDS	6	4(66.67)	-	2(33.33)	-	100
Malaria	5	3(60)	-	2(40)	-	100
Typhoid	5	1(20)	2(40)	2(40)	-	100

Source: Fieldwork

Table 3.3 details the knowledge and attitude of the participants about the major illnesses in the villages. During the FGDs, the communicable diseases prevailing in the villages in the past year, as observed by the participants, were 53 major cases of Diarrhoea, Pneumonia with 51 cases, 47 Jaundice/Hepatitis, 15 cases of tuberculosis, six cases of HIV/AIDS were observed to be prevailing and five cases of malaria and five cases of typhoid.

The diseases were also attributed to the change of climate and seasons, especially during the spring water season, when incidents of diarrhoea increase. It is learned that there was an infectious skin rash breakout in Willong Village, where everyone got infected. However, all got cured with simple home medication, using water and salt to clean up the rashes. According to the villager, a team of experts came to study the water and concluded it was contaminated.

Non-Communicable Diseases (NCD)

Non-communicable diseases are chronic health conditions that are not contagious. According to the International Classification of Diseases (ICD-10), non-communicable diseases are jaundice, cancer, anaemia, diabetes, under-nutrition, goitre, problems with the menstrual cycle, pregnancy complications, complicated childbirth, illness in newborns, hypertension, heart diseases, chest pain, breathlessness, stroke and cataract (Swargiary and Lhungdim, 2021, p.42). Chronic diseases such as diabetes and cardiovascular diseases

have a high rate of morbidity and mortality among the Indigenous community across the globe. The sociocultural risk factors and behaviours associated with acculturation, psychological stress, and hypertension manifest in food habits, diet and physical activity (Valeggia and Snodgrass, 2015, p. 124).

Perception of Non-Communicable Diseases (NCD)

Table 3.4: Non-Communicable Diseases (NCD)

Level of Importance	Frequency	Percentage (%)
Serious concern	43	19.11
Important concern	92	40.89
Not concerned	77	34.22
Not concerned at all	13	5.78
Total	225	100 %

Source: Fieldwork

Table 3.4 illustrates the healthcare concerns of respondents regarding non-communicable diseases within their families. More than half of the respondents expressed concern for their family members' health, with 41 per cent identifying it as a significant concern and 19 per cent categorizing it as a serious concern. Conversely, 34 per cent reported feeling unconcerned, while 6 per cent indicated that they were not concerned at all. Among the non-communicable diseases, the most prevalent health issues reported were high blood pressure, headaches, and gastrointestinal problems. Respondents who expressed concern regarding the first two conditions either had a family member or relative affected by these diseases or were aware of the rising number of reported cases within their community.

Incidence of Non-Communicable Diseases

The question of morbidity and mortality due to non-communicable diseases and conditions was assessed in terms of the occurrence in the family in the past year. It may be noted that, in general, the case reporting of different illnesses is not done adequately due to the dearth of healthcare services in the region. Herein, the cases that are reported are those which have sought treatment in the district headquarters, Senapati, or the state

capital, Imphal. There are no records at the community level or with ASHA workers, nurses or primary health centres (PHCs) about the occurrence of different diseases and the morbidity and mortality. Mortality due to unknown causes is a phenomenon for which the actual cause of death is not ascertained with the help of medical professionals.

Table 3.5: Incidence of Non-Communicable Diseases (NCD) in the Family

Ailments	Yes	%	No	%	Total (%)
Stomach Ailments	132	58.67	93	41.33	225 (100)
Migraine	127	56.44	98	43.56	225 (100)
Blood Pressure	102	45.33	123	54.67	225 (100)
Diabetes	44	19.56	181	80.44	225 (100)
Lung Disease	36	16.00	189	84	225 (100)
Liver and Kidney Disease	47	20.89	178	79.11	225 (100)
Arthritis	46	20.44	179	79.56	225 (100)
Cancer	11	4.89	214	95.11	225 (100)
Heart Disease	15	6.67	210	93.33	225 (100)
Stroke	6	2.67	219	97.33	225 (100)
Overweight	14	6.22	211	93.78	225 (100)
Addictions	58	25.78	167	74.22	225 (100)
Mental illness/disorders	6	2.67	219	97.33	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 3.5 illustrates a higher incidence of non-communicable diseases, including blood pressure issues, stomach ailments, and migraines, affecting at least one or two family members. While conditions such as diabetes, liver and kidney disorders, arthritis, and alcohol addiction are less prevalent, they still impact one or more individuals within the family. Conversely, the incidence rates for cancer, mental disorders, cardiovascular diseases, lung issues, strokes, and obesity are notably lower.

According to the findings of Kuar et al. (2022), the Senapati district reports the highest number of deaths due to diabetes and endocrine diseases among the twelve districts studied in India. This is followed by fatalities from cardiovascular diseases, infective gastroenteritis, and other common infectious diseases (pp. 257-258).

Additionally, the Maram community frequently experiences issues such as worm infestations, skin diseases, and hypertension, as noted by Athickal (1992, p. 187), a trend that is also observed in the present study.

Table 3.6: Major Non-Communicable Diseases Reported in the Villages

Ailments	No. affected	Under Treatment	Cured	Died	Status not known	Total (%)
Stroke/BP	75	58(77.33)	1(1.33)	5(6.67)	11(14.67)	100
Diabetes	70	14(20)	-	5(7.14)	51(72.86)	100
Heart disease	33	14(42.42)	-	7(21.21)	12(36.37)	100
Liver/kidney/ gallbladder stone	30	27(90)	-	3(10)	-	100
Cancer	15	5(33.33)	-	6(40)	4(26.67)	100
Pregnancy and child- related issues neonatal death	2	-	-	2(100)	-	100

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 3.6 presents the prevalence of non-communicable diseases (NCDs) reported by participants in the villages. During focus group discussions (FGDs), participants noted that diabetes is a significant concern, with 70 major and 170 minor health issues identified within their communities. In one village, there was a strong consensus that diabetes affects nearly every household, predominantly among men. The study area also revealed that 75 individuals were known to have hypertension, stroke, or paralysis, while 33 were identified with heart-related problems. Health issues concerning the lungs, liver, and heart were frequently linked to alcoholism. Additionally, there were 30 reported cases of liver or gallbladder issues and kidney stones, as well as 15 individuals diagnosed with lung or liver cancer. Furthermore, the FGDs recorded six instances of appendicitis and five cases of sinus-related issues. Participants expressed concerns that the actual number of individuals suffering from these diseases may be higher, as health screenings are not routinely conducted; individuals typically seek medical consultation only when their conditions reach advanced stages. Moreover, issues such as stillbirths and maternal mortality were attributed to the poor nutritional status of mothers, primarily due to poverty, lack of access to a healthy diet, and the burden of household responsibilities,

including fetching water, collecting firewood, working in the fields, and caring for other children.

Substance/Alcohol Abuse

Substance and alcohol abuse represent significant health concerns worldwide. In the United States, addiction is one of the most stigmatized diseases, comparable to HIV/AIDS, and remains highly prevalent in contemporary society (Richter and Foster, 2014, p. 60). Cultural changes, along with a loss of traditional roles within Indigenous communities, have been linked to increased rates of substance abuse, particularly among men (Valeggia and Snodgrass, 2015, p. 125). It is important to recognize that alcohol holds a deeper significance in Indigenous communities, intertwined with cultural customs and traditions that enhance social relations. In the Indigenous Sámi communities in America, alcohol plays a vital role in cultural and social life, marking various occasions. It is often offered as a gift, generously extended to visitors, and consumed socially during celebrations and funerals, thereby fostering connections among family and community members. In essence, alcohol is an integral aspect of their identity (Lakomäki et al., 2017, p. 6).

Similarly, the Indigenous brewed rice wine (*Ajou*) in Maram Naga is used as part of daily food (Meithuanlungpou and Singh, 2015, p. 15); no occasion is celebrated without brewed rice wine, especially in the ancient village Maram Khullen, the custodian of the Maram customs and tradition. Drinking alcohol symbolises different meanings on various occasions, such as during festivals, rituals, taking oaths, resolving conflict, offering to visitors, and also on mourning days. However, due to modernisation and acculturation, the consumption of alcohol is being misused and abused.

Perception of Substance/Alcohol Abuse

The perception of families and individuals on substance or alcohol abuse has been based on the impact of the use of substance/alcohol in the families or the extent to which it affected family life economically in the past. As a community that does not explicitly look down upon social drinking and the use of tobacco products, most of the recreational use of alcohol or tobacco products is condoned among adults. Only in cases where the abuse has caused illnesses, accidents or death, the people observe it to be a problem.

Table 3.7: Substance/Alcohol Abuse

Level of Importance	Frequency	Percentage (%)
Serious Concern	15	6.67
Important Concern	43	19.11
Not Important	127	56.44
Not concerned at all	40	17.78
Total	225	100%

Source: Fieldwork

Table 3.7 presents the concern about substance and alcohol abuse in the family; it is found that 56 per cent, said alcohol consumption in the family is not an important concern, 19 per cent said it is an important concern, seven per cent said it is a serious concern. The 18 per cent of families said no one in the family indulges or consumes substance/alcohol; therefore, they are not concerned at all.

The study found that drinking is perceived as associated with social drinking, age and work. Some of the respondents said smoking and drinking with friends, being elderly and cultivator, it is necessary to drink alcohol for energy. In the olden days, elders took a cup or two of brewed rice beer as part of their daily food. However, in the present time, drinks are being abused, especially by the younger generation. There is a discernible level of concern among the respondents on the use of tobacco and alcohol as detrimental to health and wellbeing. During FGDs, Alcoholism among men was observed to be a major concern. Seeking treatment only at the advanced stage of illness and not cooperating with treatment, such as continuing drinking, puts life at risk.

Incidence of Substance and Alcohol Abuse

It is generally recognised that the use of substances is a key healthcare challenge among Indigenous populations across the world. Both Indian Made Foreign Liquor (IMFL) and local brews are widely used by the people even though the local government, churches, and civil society organisations have imposed prohibitions. In this study, alcohol and substance abuse were measured as a key healthcare challenge due to their perceived percolation in almost all families. The respondents and the family members were asked to share the number of persons who used any substances as a habit.

Table 3.8: Incidence of Use of Substances in the Family

Use of substances	Yes	%	No	%	Total (%)
Alcohol	130	57.78	95	42.22	225 (100)
Brewed rice wine	133	59.11	92	40.89	225 (100)
Chewing Tobacco/pan	126	56	99	44	225 (100)
Smoking	61	27.11	164	72.89	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 3.8 depicts the habit of using substances in the family. It is observable that more than half of the families under the survey have expressed the problem of substance use evident with one or more persons using the same. It may be noted that the use of alcohol (IMFL), 58 per cent, was considered by the people in general as more problematic regarding health and financial implications to the family as against the use of local brews like rice wine. Nearly 40 per cent of the families report that they not use any substance in a manner that bothers them. The responses are consistent across the use of alcohol, rice beer and tobacco use.

It is essential to highlight that the general perception in the community about the use of substances is similar. In the focus group discussion with the women, it was explicitly stated that financing the substance use habits is one of the major expenditures

in the family.¹³ It is also noted that IMFL use is more common in well-to-do families with regular incomes. The people in remote villages depend mainly on brewed rice wine.¹⁴ Furthermore, it was also observed that the use of substances among the youth has been increasing in recent years.¹⁵

Table 3.9: Alcoholism and Accidents Major Incidents Reported in the Villages

Others major illness	Affected	Under Treatment	Cured	Died	Status not known	Total (%)
Alcoholism	97	40 (41.24)	-	17 (17.52)	40 (41.24)	100
Domestic Accidents – Serious Injury	66	27 (40.91)	4 (6.06)	-	35 (53.03)	100
Road Accidents – Serious injury	60	30 (50)	5 (8.33)	3(5)	22 (36.67)	100

Source: Fieldwork. Note: Figures in brackets are percentages.

In Table 3.9, there is a discernible level of concern among the respondents regarding the use of tobacco and alcohol as detrimental to health and well-being. During FGDs, 97 cases of Alcoholism were identified among men, especially unmarried men. Seeking treatment only at the advanced stage of illness and not cooperating with treatment, such as continuing drinking, puts life at risk.

In road accidents, several factors contribute to incidents, including vehicle collisions due to poor road conditions and hit-and-run scenarios, particularly on National Highway-02. Additionally, domestic injuries frequently occur from slips in gardens or during fieldwork, especially in the rainy season, leading to bone fractures and broken limbs. Some villagers have even lost limbs due to fishing and hunting accidents. It's important to note that in villages with 70 to 80 households, residents are generally aware of disease incidents, but in larger villages and those near National Highway-02, the prevalence of diseases and the status of treatment remain uncertain and inadequately assessed. During

¹³ Women, Focus Group Discussion on 23/02/2020 at 1.30 pm, Maram Centre Village.

¹⁴ Elders (men and women), Focus Group Discussion on 14/10/2020 at 11.50, Maram Khulakpa Sagei.

¹⁵ Youth (men), Focus Group Discussion on 15/12/2020 at 12 am, Shang Khumei.

FDG, elderly participants expressed their concerns regarding road accidents and alcohol abuse prevalent among youth and adolescents, which worry parents and elders who feel responsible for their future.

Incidence of Disability

According to the National Statistical Office (2018), “Person with a disability means a person with long-term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others. Barrier means any factor, including communicational, cultural, economic, environmental, institutional, political, social, attitudinal or structural factors, hampers the full and effective participation of persons with disabilities in society” (p.3).

The presence of disability in a family can have a profound impact on its dynamics and well-being. The effects of disability in the family depend on factors like the type of disability and its severity, whether the disability is congenital or acquired, as well as the age and gender of the differently abled. Along with economic status, the understanding and attitude of family members also play an essential role in the overall well-being of families with differently abled people. It is also essential that the communities have adequate knowledge and attitudes towards disability and persons affected by it. In the Indigenous communities, persons with disabilities are often on the margins with limited access to education, employment, and participation in community life, albeit not being ignored completely.

Table 3.10: Incidence of Disability in the Family

Type of Disability	Yes	%	No	%	Total (%)
Locomotor	9	4	216	96	225 (100)
Sight	20	8.89	205	91.11	225 (100)
Hearing	8	3.56	217	96.44	225 (100)
Speech	13	5.78	212	94.22	225 (100)
Intellectual impairment	6	2.67	219	97.33	225 (100)
Multiple impairment	7	3.11	218	96.89	225 (100)
Disfigurements & Dwarfism	11	4.89	214	95.11	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 3.10 presents the incidence of various types of disabilities among the surveyed families. Out of the 225 households interviewed, 17 per cent (38 households) reported having individuals with disabilities. Notably, five families had more than one member with a disability. It is important to highlight that among those reporting visual, auditory, and speech disabilities, a significant proportion—14 per cent (32 families)—were individuals of advanced age. The overall incidence of disability within the population is approximately six per cent, which aligns with the findings from the 76th round of the National Statistical Office (NSO) survey conducted between July and December 2018, indicating that the prevalence of disability in Manipur is around five per cent (p. 80).

Concerning the people's attitudes and approach towards disability, it was observed that the congenital disabilities in the family were considered a curse from God. Hence, there is a high prevalence of self-stigmatization and discrimination. Only two families stated they had undertaken the disability assessment and made the disability certificate. A considerable number of the five families said that they regularly visit the prayer centres and healers for healing persons with disability. Only 14 families have been undertaking visits to the hospitals for advice and treatment regarding their disability. Seven families were found to be seeking treatment from both the modern and traditional healers.

Nutrition:

Nutrition serves a fundamental role beyond merely supplying food; it encompasses the mechanisms necessary to maintain the body in optimal functioning condition. Foods that enhance physical efficiency and health include whole cereal grains, dairy products, eggs, green leafy vegetables, root vegetables, legumes, fruits, meat, and water (McCarrison, 1936, p. 611). The primary nutrients essential for health are carbohydrates, proteins, fats, vitamins, and minerals (Meithuanlungpou and Singh, 2015, p. 12). Insufficient or improper nutrition can adversely affect the digestive and endocrine systems (McCarrison, 1936, p. 612), leading to malnutrition (an unbalanced diet or overeating) and undernutrition (nutrient deficiencies).

Research by Meithuanlungpou and Singh (2015) indicates that Maram children are experiencing malnutrition and nutritional deficiencies, largely due to parental ignorance regarding child growth and development, compounded by family poverty. Children in hilly regions often face poverty, isolation, inadequate education, and poor health, highlighting the urgent need for intervention to safeguard their futures. Food is a fundamental human necessity, and nutrition is influenced by a multitude of factors, including dietary habits and behaviours, food beliefs, ethnic backgrounds, geographical contexts, religious practices, as well as social and psychological aspects. The manner in which food is consumed—whether raw or cooked—often depends on its perceived Flavors (pp. 12-18). Food culture is rich and varies significantly across different societies. Globally, Indigenous populations are undergoing a nutritional transition characterized by the assimilation of new dietary practices and changes in living standards, which include a decline in physical activity levels. The westernization of diets among Indigenous peoples is evident across various regions (Valeggia and Snodgrass, 2015, p. 123).

Perception of Nutrition among the Marams

The Marams' food habits are similar to those of the Nagas elsewhere. Rice is the staple diet, while a good variety of cultivated and naturally occurring leaves and vegetables are also included in the meals. The people also eat meat, fish, insects, and a wide variety of mushrooms. Fresh milk is not used widely, as very few households' rear cattle in the community.

Table 3.11: Nutrition

Level of Importance	Frequency	Percentage (%)
Serious Concern	41	18.22
Important Concern	136	60.44
Not Important	27	12.00
Not concerned	21	9.33
Total	225	100%

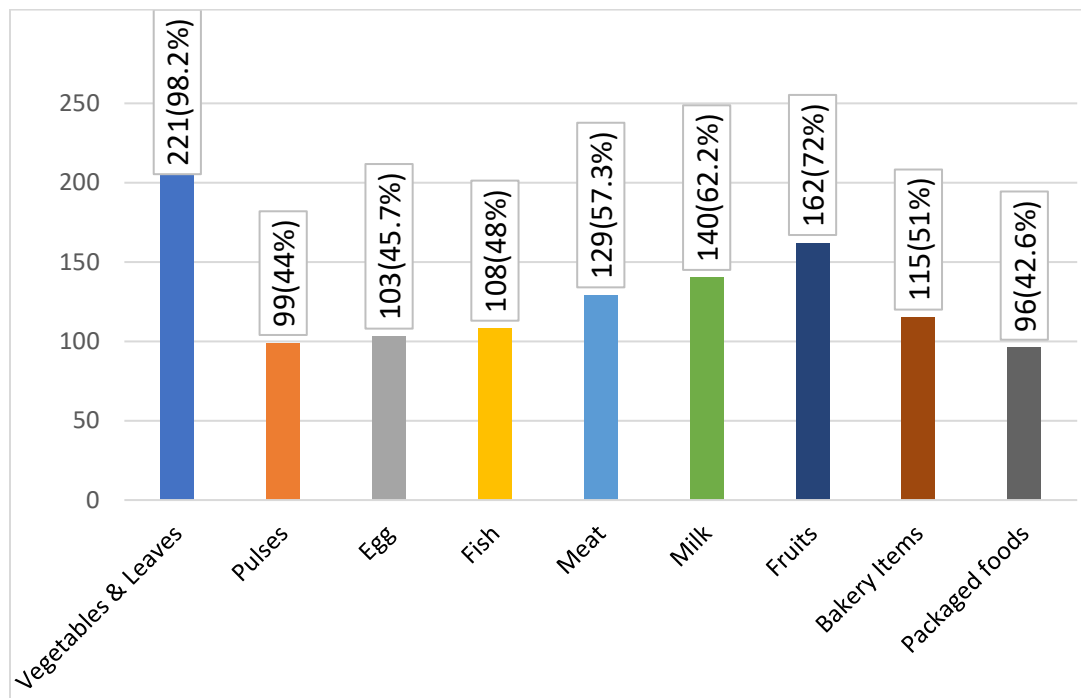
Source: Fieldwork

In the above table 3.11 it has shown that the nutritional concerns of diet are very much concerned in the respondents' families. The majority of the respondents were concerned with nutrition and diet with 60 per cent saying it is an important concern, and for 18 per cent it is a serious concern. While 12 per cent said that it is not important and only nine per cent of the respondents said not concerned.

The fundamental aspects of nutritional habits within the community reveal a concerning trend, as some respondents have never considered enhancing their dietary practices. A segment of the population, primarily farmers from remote villages, believes that the organic food they provide to their children suffices for a healthy diet. Conversely, other respondents express concern for their health and recognize the need to enrich their nutritional intake. Notably, it has been observed that many adults, particularly women, are increasingly turning to commercially available vitamin supplements. The essentials of nutritional dietary habits within the community reveal a divide in perceptions regarding nutrition improvement. Some respondents, particularly farmers from remote villages, believe that the organic food they cultivate is sufficient for a healthy diet, and they have

not considered the necessity of enhancing their nutritional practices. Conversely, other respondents express concern for their health and recognize the need to enrich their diets. Notably, it has been observed that adults, especially women, frequently rely on commercial vitamin supplements to address nutritional gaps.

Figure 3.2: Dietary Habits of Marams



Source: Fieldwork

Figure 3.2 depicts the general food habits of the families of the respondents. As it is obvious that more than the majority 98 per cent consume vegetables and leaves as part of the family's daily diet. Only 44 per cent of families reported consuming pulses on a daily basis. In contrast, 46 per cent, 48 per cent, and 57 per cent of families included eggs, fish, and meat, respectively, in their daily diet. It is noteworthy that non-vegetarian food items, including dried and fermented fish and meat, are integral components of every Naga family's diet. Meanwhile, 62 per cent of respondents indicated that they incorporate milk into their daily meals; however, most families primarily utilize milk powder. A significant

72 per cent of families consume fruits daily, with a variety of locally abundant fruits being widely enjoyed. Additionally, a notable 51 per cent of families regularly consume bakery items, while 42 per cent include packaged food in their daily diet. Various noodle products, sourced both from India and neighbouring Myanmar, are particularly popular among the younger generation.

The various kinds of vegetables like cabbage, potatoes, yam, beans, pumpkin, cucumber, maize, taro, sweet potato, Chinese chives, brinjal, bitter gourds and chillies, chow-chow and mustard and so on... are commonly consumed. Like every household with a vegetable garden, most families have fish and animal husbandries and keep pigs, cattle, dogs and poultry. The availability of fresh vegetables depends on the season. However, the seasonally grown vegetables are collected and stored by using various methods such as sun drying and fermenting. The fermentation of food for future use is an age-old skill of the Maram Nagas, the women folk spare time to preserve easily perishable seasonal food items by fermenting or drying. Bamboo shoots (*Kabiit badue*), Soya beans (*Lachiitimatang*) and mustered leaf juice (*Zangein diu*) are commonly fermented food items (Meithuanlungpou and Singh, 2015, p. 15). Also, commonly eaten fruits are plum, peach, guava, passionfruit and so on ... most of these vegetables and fruits are grown in private gardens and orchards for personal consumption, though some sell to generate some revenue (Tiba, 2006, pp. 114-115). The Maram also abounds in wild fruits like gooseberry, wild apples, hog plum, wild olives, autumn olives, chestnuts, cherry, raspberry, bayberry, which anybody can collect randomly (Kanga, 2022). Therefore, these locally available and affordable fruits should be given to Maram children to avoid Vitamin C deficiency (Meithuanlungpou and Singh, 2015, p.17).

Shelter, Water & Sanitation:

Type of Houses

Houses are typically constructed using traditional methods, though there has been a modern shift toward the extensive use of corrugated tin sheets for roofing and, in some cases, walls. Traditionally, roofs were crafted from grass, which required repairs every two to three years, while walls were commonly made of wood or bamboo, often coated with mud. The floors were typically plastered with clay. However, there is a noticeable trend in villages toward upgrading to tin-roofed houses. The durability of tin sheets is leading to a gradual replacement of grass roofs. Additionally, brick-and-mortar structures, along with reinforced cement concrete (RCC) buildings, are increasingly common in every village. Unlike in the past, there is now a greater investment in constructing houses and enhancing related amenities.

Table 3.12: Types of Houses

Categories	Frequency	Percentage (%)
Bamboo - wood and mud house with tin roof	111	49
Bricks house with tin roof	76	34
Reinforced cement concrete (RCC) house	38	17
Total	225	100

Source: Fieldwork

Table 3.12 details the distribution of the types of houses of the respondents. Nearly half of the respondents' houses in the region 49 per cent are built with bamboo and wood structures and mud houses with tin roofs. It is observed that 34 per cent of the respondent houses are built with brick walls and use tin sheets, and only 17 per cent are reinforced cement concrete (RCC) houses.

Water

The Maram Nagas primarily depends on perennial water sources or rain for all requirements during the year. Out of the 12 villages, only four had piped water connections, with limited supply during the dry season that stretches from November to

May. Perched on hilltops and valleys, the villages often depend on water sources almost 1-2 km downhill. In 40 per cent of the villages, their primary water source dries up for two months into winter, and water usage is drastically cut down through community orders. The availability of water and its use are greatly affected by the seasons. During the wet seasons, which run from the middle of May to November, the region receives a relatively good amount of rain, and perennial water sources are adequate. However, the winter and dry seasons bring acute water scarcity, with the streams and ponds drying up quickly.

Perception on Water- Air Quality

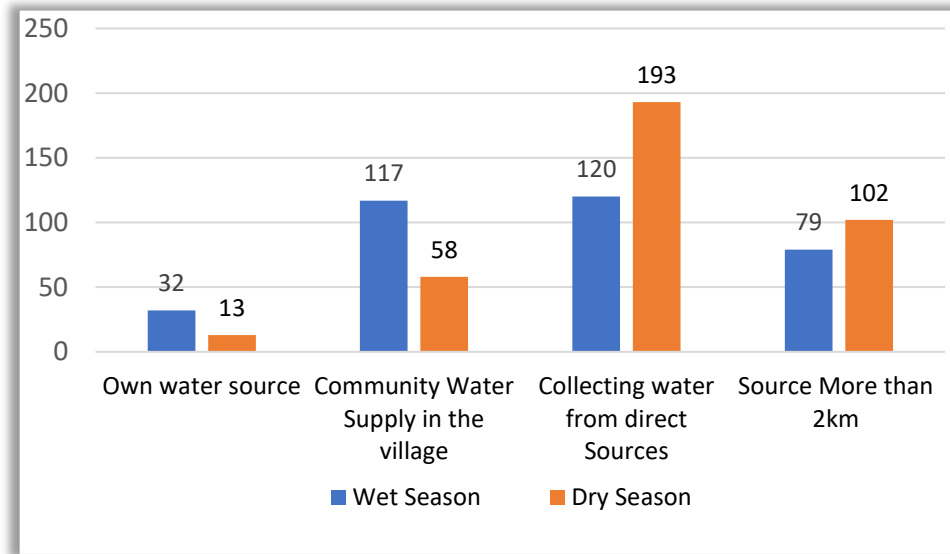
Table 3.13: Water-Air Quality

Level of Importance	Frequency	Percentage (%)
Serious Concern	52	23.11
Important Concern	101	44.89
Not Important	63	28.00
Not concerned at all	9	4.00
Total	225	100 %

Source: Fieldwork

The concern about the water and air quality in the study area was put it across the respondents in the above table 3.13. It was found that more than the majority were concerned about environmental changes, 45 per cent said important concerns and 23 per cent said serious concerns. Whereas 28 per cent are of not important concern and only four per cent are not concerned at all. The people in the region experience water shortage throughout the year as there are no established means for storing water. In the event of scarce rains during the year, almost every aspect of life is affected. It is observable that most of the families have adopted rainwater harvesting by using small tanks, but they are not adequate to last a long dry spell. In the absence of a public water supply system, resource-constrained families experience a severe shortage of water.

Figure 3.3: Availability and Accessibility to Water



Source: Fieldwork

As indicated in Figure 3.3 the water availability of the families differs according to the season. During the season, 88 per cent of the families depend on manual water collection from the source during the dry season. Again nearly 50 per cent of the families have to travel more than 2 kilometres to fetch water. Due to the geographical terrain and the conditions, rainwater harvesting by individual families is tedious and expensive.

The private and public water supply systems established in the villages primarily rely on perennial water sources, which frequently dry up during the winter and summer months. The basic supply systems managed by the villages and individuals become ineffective as soon as the nearby source is depleted. Families often resort to traditional water sources located farther from the villages, necessitating that women collect water in headloads. The study revealed that out of 225 surveyed households, 193 reported dependences on these traditional sources to meet their essential needs during the dry season. In all these households, the responsibility for water collection and transportation fell to women. Only 32 families indicated they had not faced significant water scarcity

throughout the year. Notably, none of the families interviewed possessed a rainwater harvesting system.

Water Management and its Impact

According to UN-Water (2006), women bear the primary responsibility for managing household water supply, sanitation, and health. Water is essential not only for drinking but also for food production and preparation, caring for domestic animals, personal hygiene, tending to the sick, and cleaning and waste disposal (p. 1). In Indigenous communities, gender roles tend to be more rigid, resulting in a greater burden on women compared to their counterparts in other regions. Many of the women interviewed expressed ongoing anxiety about securing adequate water for their families throughout the year. It has become their primary occupation, and hence, they are unable to focus on any other productive activities like weaving, knitting, gardening, etc. Furthermore, the women reported that they were compelled to postpone bathing or washing in the streams due to a lack of privacy. Several women expressed concerns about health complications arising from inadequate hygiene during their menstrual cycles.

The inadequate supply of water, along with insufficient sanitation and hygiene, significantly affects children, leading to poor nutrition and compromised care. Primary caregivers, typically women, are unable to instil proper hygiene practices in their children at home due to the lack of accessible water. According to UN Women (2017), the absence of adequate water and sanitation facilities has profound health implications. When household members fall ill, women bear a disproportionate burden of caregiving, which further exacerbates their own health challenges. In the context of childbirth, access to clean water and sanitation can be critical, often determining the survival of both mothers and infants (p. 6). Among the Indigenous people, the perception of the sociocultural relation of water and spirituality intimate bond plays a vital among the Indigenous women in relation to childbearing and birth. Women are the custodians of domestic water handling (Jiménez et al., 2014, p. 280). Therefore, women and girls are disproportionately, affected

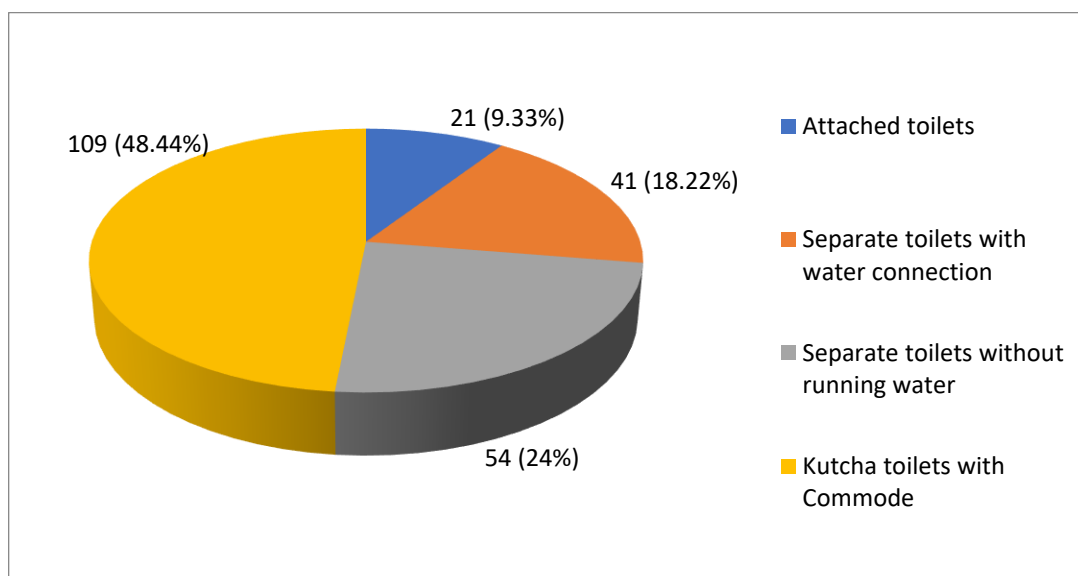
due to limited access to water, sanitation and hygiene (WASH) due both to biological and cultural factors (WaterAid, 2015, p.1).

Access to quality healthcare must remain a leading priority to improve Indigenous people's social and economic outcomes and bridge the wellness gap between Indigenous and non-Indigenous populations. With the effects of climate change being more visible and vicious globally, the need for comprehensive approaches to address the challenges faced by Indigenous communities has become more pronounced. The guarantee of water, sanitation, and hygiene is a frontier that requires urgent attention to resolve the healthcare challenges faced by the people. The introduction and nurturing of sustainable rainwater harvesting facilities is an urgent need. Watershed management programmes are essential to enhance groundwater levels. Natural dams and canal systems can be promoted at the community level to retain the water. The sanitation and hygiene practices would improve only subsequent to the resolution of the water availability challenges.

Sanitation and Hygiene

It is essential to acknowledge the existing perceptions regarding sanitation and personal hygiene standards prevalent in the communities. Perceptions have been built on environmental and climatic factors experienced by the people. Attitudes regarding open defecation, daily bathing, hand washing, and maintaining proper toilets or drainage are all affected by water availability and season. Douglas refers to sanitation and food hygiene rules as a universal human activity of classification. This implies that there is no universal specification of dirt itself; instead, what is considered dirty are items out of place in that society's classification system or hierarchies. Hence, dirt is referred to as "disorder" and exists only "in the eye of the beholder". Such values are essential for how sanitation can be organized and upheld in society (as cited in Jiménez et al., 2014, pp. 284- 285). Sanitation and hygiene of individuals are directly proportional to the availability of water.

Figure 3.4: Types of Toilets



Source: Fieldwork

As shown in Figure 3.4, all the 225 families interviewed in the 12 villages have toilet facilities in their vicinity. Although over 48.44 per cent of the families have kutcha toilets with commodes but no running water. Twenty-four per cent of the families have separate toilet without running water, 18 per cent of the households have separate toilet with water connection and only nine per cent of the households have attached toilets.

On the flip side, maintaining the toilets during the lean season is tedious and often used sparingly to save water. Open defecation is practised by adults in the jungles adjacent to or on the farmlands. Bathing, washing of clothes etc., have to be limited during the dry season. Certain communities have implemented strict warnings against using local water sources for bathing and washing during this season. This measure aims to prevent the contamination of the sole potable water supply for the entire village. A survey revealed that nearly 53 per cent of households reported instances of diarrhoea among one or more family members in the past year. Additionally, approximately 14 per cent of households reported cases of jaundice, and around eight per cent indicated occurrences of skin diseases in recent years, which appear to be linked to inadequate hygiene practices.

The availability and usage of toilets must be considered alongside access to water and sanitation facilities. As piped water supply is unavailable to most families, the necessity for women to collect and transport water for toilet use adds to their workload. This situation contributes, albeit minimally, to the prevalence of open defecation practices in the villages. Among the 109 households with toilets equipped with commodes, the lack of running water significantly diminishes their functionality and compromises overall hygiene conditions in the area.

Access to Healthcare:

Access to healthcare remains one of the key factors affecting the healthcare indicators of the Marams. Due to the inadequate outlay of infrastructure and human resources across the Maram inhabited areas coupled with difficult geographical conditions and poor roads; most of the people in the villages across the region do not have access to healthcare facilities or personnel throughout the year. Ensuring access to healthcare for Indigenous people is essential for several reasons. It can help reduce infant and maternal mortality rates, prevent the spread of infectious diseases, and improve overall health outcomes.

Table 3.14: Access to Hospitals and Medicines

Level of Importance	Frequency	Percentage (%)
Serious Concern	37	16.44
Important Concern	124	55.11
Not Important	41	18.22
Not concerned at all	23	10.22
Total	225	100

Source: Fieldwork

Table 3.14 shows the concern regarding the accessibility of modern medicine and hospital facilities in the community, it is found that 55 per cent said it is an important concern, 16 per cent of the respondents said it is a serious concern, 18 per cent of respondents said not important and 10 per cent were not concerned at all.

It is observed that respondents with not important concerns for the healthcare of the family were those who felt they were healthy and had not experienced serious health issues. The common response from them was, never go for treatment since there was no pain so, they never thought of a master checkup or health screening. However, respondents with serious and important concerns for healthcare in the family raised the issues of lack of accessibility due to poor healthcare facilities and lack of healthcare personnel. There is no doctor in the village, therefore no check-ups and doctors visit just once or twice a year.¹⁶ Moreover, due to financial constrain not able to visit hospitals.

Resources for Treatment

Largely subsistence agriculturists, the Marams, similar to Nagas elsewhere experience severe economic hardships in the event of a healthcare emergency. The choice of treatment for a disease or injury is generally affected by the family's capacity to bear the cost. This economic barrier often leads to delayed or forgone healthcare, resulting in worsening health conditions and increased morbidity and mortality.

Table 3.15: Resource for Treatment

Level of Importance	Frequency	Percentage (%)
Serious Concern	67	29.78
Important Concern	112	49.78
Not Important	34	15.11
Not concerned at all	12	5.33
Total	225	100 %

Source: Fieldwork

On the issue of resources for treatment, as depicted in the table above, nearly 30 per cent found the resource constraints a serious concern, while nearly 50 per cent of respondents found it an important concern. Hence, nearly 80 per cent of the respondents find resources as a key aspect that affects their treatment choices. The number of respondents who found the treatment resources as not important or not concerned at all

¹⁶ Women folk, Focus Group Discussion on 22/09/2020, 2.00 pm, Willong Khullen Village.

adds up to 20 per cent. The scarcity of resources for medical treatment leads to significant distress during times of illness and emergencies.

It is commonly observed that neighbours and relatives who have first aid supplies or stored medications often share these resources with those in need. The practice of using over-the-counter medications without a doctor's prescription is also prevalent within the community. In emergency situations or when faced with serious illness, individuals frequently resort to borrowing money from personal contacts or community associations, and many find themselves struggling to repay these debts for years. Some have even resorted to selling land, fields, forests, or rice paddies to finance medical treatments or settle outstanding debts. One respondent noted that their family continues to grapple with repaying the debt incurred from medical expenses, highlighting the financial burdens faced by 16 families engaged in this struggle.

Health Screening

Accessing healthcare services and health screenings is one of the key indicators of the health-seeking behaviours of people. Diagnostics and medical checkups play a crucial role in promoting health, especially among Indigenous people. By providing early detection of different diseases and timely treatment major healthcare problems can be averted. Regular checkups can identify potential health problems at an early stage, when they are often more treatable. This can prevent diseases from progressing and reduce the need for further treatment or care.¹⁷ Health screening and diagnostic checkups have become all the more important for the Marams, who are now at higher risk for chronic diseases like diabetes, heart disease, or cancer due to the changes in lifestyle, food and environment.

The question on health screening done by family members in the past year sought to measure the rate of families accessing modern healthcare services. Herein, most of the

¹⁷ <https://www.betterhealth.vic.gov.au/health/servicesandsupport/regular-health-checks>.

families who have reported health screening have undergone more than one diagnostics procedure at a time. Nevertheless, the data gives us an idea about the key concerns that the people in the region generally face and approach health care professionals. Health screening on common ailments in the families of the respondents was discussed with the respondents and family members. Table 3.16 picturizes the different tests and the number of families who reported that at least one person in the family has undergone the procedure one or more times during the past year.

Table 3.16: Health Screening Undergone in the Past 12 Months

Ailments	Yes	(%)	No	(%)	Total (%)
Blood Pressure	191	84.89	34	15.11	225(100)
Blood Sugar	124	55.11	101	44.89	225(100)
Malaria/Dengue/Typhoid	179	79.56	46	20.44	225(100)
Dental Exam	91	40.44	134	59.56	225(100)
Eye Screening	77	34.22	148	65.78	225(100)
Liver Function	61	27.11	164	72.89	225(100)
Kidney Function	59	26.22	166	73.78	225(100)
Pregnancy-related	59	26.22	166	73.78	225(100)
Cholesterol	26	11.56	199	88.44	225(100)
Cancer Screening	21	9.33	204	90.67	225(100)

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 3.16 shows that very few people go for different screening procedures. However, it is to be noted that the tests for blood pressure with 85 per cent and blood sugar with 55 have been quite high, and that has affected the total percentage of the people accessing the screening procedures. According to respondents in remote villages, only during health camps organised in the village do they get the chance to be screened. Also, those who live near or close to the NH-02 are found to get their blood pressure and diabetes checked from pharmacies, private clinics and Primary Health Centres (PHCs).

It was observed that there are several health problems being reported. However, very few people go for screening due to various reasons. Financial constraints are one of the key reasons for not accessing health screening services. The lack of screening facilities

in the localities are also another important factor. The government hospitals and centres do not have adequate screening facilities. There is a serious concern for medical expenditure. For instance, a respondent said, “*After consulting doctor from the PHC, the medicines have to be bought from pharmacies*”.¹⁸ Maram people are poor and mostly live in remote villages; in times of sickness, they commonly manage with home care and only at the advanced stage of the illness they go to the hospital (Athickal, 1992, p.187). Furthermore, in the tribal inhabited areas, there is poor infrastructure, inadequately trained healthcare personnel, and insufficient equipment and drugs, despite the high prevalence of non-communicable diseases such as hypertension, diabetes, and cancers (cervical, breast and oral) substance abuse and alcoholism among the tribal communities (Kuar et al., 2022, pp.263-266).

Use of Healthcare Services in the Past One Year

The actual use of the healthcare facilities and medication by the family members is another indicator in regard to the health-seeking behaviour of the family in the context where the Indigenous people access medicine or approach healthcare professionals only in emergency or serious situations. The healthcare infrastructure and the human resource outlay in the Maram inhabited region is inadequate. There is also a challenge of poor roads and lack of public transport. These factors affect the choices that are made by the people in accessing healthcare services during illness and healthcare problems. This section deals with the use of different healthcare providers by the respondent households during the past one year.

¹⁸ Female, 60 years, respondent, Maram Khulakpa Sagai

Table 3.17: Healthcare Services

Healthcare Provider	Once	%	More than once	%	Often	%	Total
Primary healthcare services – Medical shops, Sub centres, Nurses, and local practitioners	79	37.61	94	44.76	37	17.61	210 (93.33)
Public healthcare services with consultation with the doctor.	61	46.21	49	37.12	22	16.67	132 (58.67)
Specialists at the district level hospital or private facilities and hospitalization	42	45.65	37	40.21	13	14.13	92 (40.89)
Advanced treatment at the state level or outside the state medical facilities	33	60	14	25.45	8	14.54	55 (24.44)

Source: Fieldwork. Note: Figures in brackets are percentages.

As detailed in Table 3.17, it may be noted that out of the 225 respondent households, 93 per cent (210 households) have accessed primary healthcare facilities and pharmacies during the year. Most of the respondents indicated that their first recourse for medical needs was the nearest pharmacy. In villages lacking medical shops, families would rely on someone travelling to a distant pharmacy to procure necessary medications. Additionally, they would consult with ASHA workers and local nurses present in the villages. Notably, only 18 per cent of families reported frequent utilization of primary healthcare services, while approximately 45 per cent indicated using these services more than once a year. Furthermore, 38 per cent of respondents stated they had accessed local healthcare services only once in the past year.

Among the respondents, 59 per cent (132 households) out of a total of 225 households reported having directly consulted a modern medical practitioner for health-related issues within the past year. The need for medical attention arose primarily for families with children suffering from various illnesses, those who experienced accidents or injuries, and individuals dealing with chronic conditions. Most of these families have also sought further treatment at district and state hospitals. Of the 132 families that consulted a medical practitioner, 61 (46 per cent) indicated they had visited a doctor once during the year, excluding visits to medical camps organized by various agencies in some

villages. Additionally, 49 families (37 per cent) reported visiting doctors more than once, while 22 families (17 per cent) stated that they had sought medical care multiple times throughout the year.

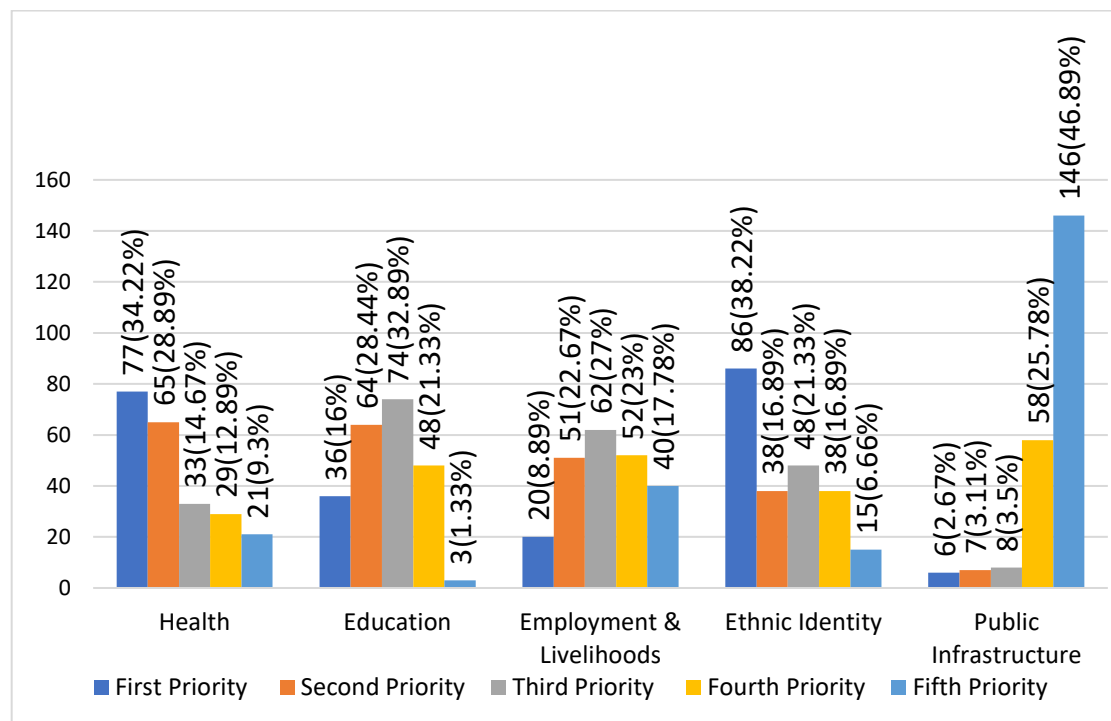
Considering the third variable of visiting district hospital of private facilities at the district, it may be noted that full-time doctors and some specialists are available in the district headquarters in Senapati. A few private clinics are also functional with diagnostic facilities. 41 per cent (92 households) out of 225 total respondents stated that they had visited district hospitals or private clinics at Senapati during the year. out of 92 households, among these, 46 per cent of the households have visited the district facilities at least once, 40 per cent of the households more than once, and 14 per cent of the households have been found to have used the services often. It was observed that the maternity visits to the hospital were more in the villages near the Senapati district headquarters and those along the National Highway leading to the district headquarters.

Imphal, which is the capital of the state is known for some of the best medical facilities in Northeast India. The people from other states also at times visit Imphal for treatment of major illness. The tribal people in the hills of Manipur are also predominantly dependent on hospitals in Imphal for treatment. In all, 24 per cent (55 households) out of the 225 respondent families stated that they had to access healthcare services at different hospitals in Imphal or elsewhere in the country. Normally, a situation which needs surgery or advanced diagnostics, specialist care or a life support system are taken to the state capital or elsewhere. Among the 55 families who had accessed services in the state capital, 60 per cent (33 families) had only one time visit, while 25 per cent (14 families) visited more than one time and 15 per cent (eight families) had visited several times during the year.

Family Priorities:

The family priorities are inherently subjective, however have a pattern and similarity among the families, sharing circumstances, values, customs, and traditions. The question of family priority was included in the interview to assess the key factors that affect the decision-making processes. Indeed, the priorities are not static but they invariably design the family's responses in the long run. In the process of rating the family priorities the available family members in the household were also encouraged to contribute and put in their opinions. Figure 3.5 details the finds of the rating made by the 225 families on five factors on a five-point scale.

Figure 3.5: Rating of Family Priorities



Source: Fieldwork

As illustrated in Figure 3.5, the priorities identified by families reveal significant insights. The foremost priority among those surveyed is ethnic identity and religion, with 86 families (38 per cent) indicating it as the most important factor. This is closely followed

by health, chosen by 34 per cent, and education, selected by 16 per cent. Employment and livelihood rank as the first priority for nine per cent of families, while only three per cent prioritize public infrastructure. In terms of second priorities, education and health each receive 28 per cent, followed by employment and livelihoods at 23 per cent, and ethnic identity at 17 per cent. Again, only three per cent prioritize public infrastructure in this category. The third priorities show a different trend, with 33 per cent selecting education, 27 per cent choosing employment and livelihoods, 21 per cent for ethnic identity, 15 per cent for health, and four per cent for public infrastructure. Overall, the first priority is ethnic identity at 38 per cent, followed closely by health and education, each at 28 per cent, while education again leads as the third priority with 33 per cent. Public infrastructure appears as the fourth and fifth priorities, with ratings of 26 per cent and 47 per cent, respectively. It is essential to note that the ratings by individual families vary significantly due to personal preferences and needs experienced at the time of the interview. Nonetheless, a generalized pattern emerges, indicating that communities place great importance on their ethnic identity, religious beliefs, customs, traditions, and way of life.

Fernandes (2017) highlights that in rural areas of the Northeast, education and healthcare are often inadequately maintained. The selling of land to cover educational and healthcare expenses exemplifies the challenges faced by rural families. He points out that these families invest significantly in their children's education and healthcare, yet the lack of adequate educational resources, healthcare, and transportation remains a major concern for enhancing the social and physical infrastructure necessary for growth and development in the region (p. 38).

Access to quality healthcare must remain a leading priority to improve Indigenous people's social and economic outcomes and bridge the wellness gap between Indigenous and non-Indigenous populations. With the effects of climate change being more visible and vicious globally, the need for comprehensive approaches to address the challenges

faced by Indigenous communities has become more pronounced. The guarantee of water, sanitation and hygiene is a frontier that requires urgent attention to resolve the healthcare challenges of the people. The introduction and nurturing of sustainable rainwater harvesting facilities is an urgent need. Watershed management programmes are essential to enhance groundwater levels. Natural dams and canal systems can be promoted at the community level to retain the water. The sanitation and hygiene practices would improve only subsequent to the resolution of the water availability challenges.

Chapter 4

HEALTH AND CULTURE

Indigenous groups possess distinct lifestyles and cultures characterised by knowledge, traditions, rituals, beliefs, and practices that shape their perspectives and behaviours throughout life. Traditional healthcare is a dynamic system that permeates all aspects of an individual's beliefs, experiences and practices to maintain good health in Indigenous communities. Traditional systems are holistic as they consider physical, mental, spiritual, social and ecological health dimensions. It involves promotive, preventative, diagnostic, curative, and rehabilitative measures and the management of incurable conditions involving continuous patient care and palliative care. Additionally, lifestyles, dietary preferences, art, music, dance, community festivals, and observances are integral to people's growth, development, and well-being. They are developed carefully and nurtured over centuries through empirical observation, spiritual insight, and traditional teaching orally passed down. These practices gradually evolve by adding and subtracting the elements of magic, rituals, religion, physical activity, plant and animal products, and even allopathic medicine. The traditional knowledge system in health in its present form exemplifies medical pluralism in its proper sense. There is minimal evidence on the impact or efficacy of traditional healthcare practices, traditional midwifery, traditions, and rituals on health outcomes. A formal evaluation of the traditional practices faces methodological challenges, including scarcity of epidemiological evidence, small size and remoteness of many indigenous groups, and lack of understanding by the larger population (Sarmiento et al., 2021, p.10). However, the local relevance and perceived benefits are not limited to the clinical health perspective.

This study delves into the existing and near-extinct healthcare knowledge systems, experiences, and practices of the Marams to gain insights. The findings from focus group discussions, one-to-one interviews with the elders, a review of the minimal literature available in this field, and personal observations make the crux of this chapter. The in-depth analysis of the key elements of cultural identity, the traditions, customs, and rituals

among the Marams seeks to establish the importance and relevance of their way of life. The analysis also aims to reveal the interconnectedness of every aspect of an individual's, the family's, the clan's and the community's well-being and progress.

Concept of Health:

The Maram community perceives health and happiness from multiple perspectives. Firstly, it encompasses an individual's personal perceptions and feelings regarding their own health. Secondly, it involves how others view and interpret that individual's appearance. Thirdly, it includes the observations and support provided by healthcare practitioners, both traditional and professional. Consequently, health is a collective effort involving the individual, family, and community in preventive, promotional, curative, and healing initiatives. In the Maram dialect, the term "Ara" signifies health. It is customary for individuals to greet one another with "*Aragalaimey*," which translates to "I hope you are in good health."). If a person is not well, the greetings would include *Arabimakle* (not keeping well); if a person is sick, then *Aranejale*. Sometimes, the observations made by others make the person realise they are unhealthy. If a person looks like *Aluisyi* (thin and pale) and *Kasangnou* (weak), then it is an undesirable health status. The word *Aragakiibi* means healthy *Apum-kasangting* (physically solid and fit) and happy, strong and vigorous, chubby, able to perform work, productive, and capable of socio-cultural obligations.

In the supernatural realm of the Marams, two kinds of powers affect and control the people's lives. The first is the *Siira kabi*, considered the God of benevolence, providing good health, bountiful harvest, weather, and victory over the enemy. The *Siira kabi* manifests as *Siira-pui* – the Mother God, and *Siira-fii* – the Father God. The second is the *Siira kasii* – the God of malevolence, which causes diseases, infirmity, misfortune, and natural calamities. The people believe that the good or bad days of life are the result of

the work of these spirits upon man¹⁹. There was a conviction that a few spirits enter into fellowship with a few individuals and show their control through those people by empowering them to anticipate others' prospects precisely²⁰. These spirits seem to recuperate ailments and donate plentiful harvests and to thrive to individuals; the only way to urge freed of fiendish spirits was to offer to give up and propitiate so that it is exorcised through supplication, an awfully casual compilation of words for that event, supplication and appeal. It was generally amid appeasement through arguing and asking the soul to free them from the ailment.²¹

A common belief is that a person with *Ra-ngii Kasangting* (strong soul) has the power to overcome malevolence and safeguard the village. On the other hand, *Ra-ngii Kasangnou* (weak soul) has no power to protect themselves against malevolence and, therefore, falls prey to diseases and misfortunes. There is also the belief in a supernatural being called *Kalung Riikot* (Home spirit), which protects the village against malevolence.

Illness and Disease:

Among the Marams, several aspects of health and well-being are significantly associated with rituals and magic. Although the original Maram belief system is on the verge of extinction, some beliefs and practices are fervently followed with or without explicit knowledge of their purpose and result.

Genna and Health

In the context of the Maram Nagas, the observation of "genna" in the Maram Nagas environment can be broadly divided into three categories. These are taboos, observations, and rituals performed to benefit people's physical, mental, emotional, social, and financial

¹⁹ Tiba (2006) introduces the spirits as *Rangii* - the benevolent is called *Rangii kabi*, and the malevolent is called *Rangii kushyii* (p.161).

²⁰ The good and bad spirits dwells on a particular grove, tree and mountain (Athickal, 1992 p.122).

²¹ The effective implies utilized amid satisfaction were offerings called '*KiiKat*,' which were eggs, chickens, and animals like dogs, cows, or any domestic animals (Tiba, 2006 p.161).

well-being and that of their communities. *Mannai* (a non-working day), *Tiikanii* (taboo) and *Kanat* (ritual). The ancient religion of the Maram tribe was a religion of taboos, and the spiritual world was peopled with both good and evil spirits in parallel existence with the natural world. The appeasement and mercy of the spirits determine the harmonious existence in the natural world.

Mannai, Tiikanii and Kanet

Mannai

To the Marams, *Mannai* (a non-working day) is diligently observed to appease the evil spirits, for they could harm humans and damage crops. *Mannai* sought to please and seek *Siira's* protection against natural disasters, bountiful harvests and a healthy life. Several of the diseases were attributed to the wrath of the Gods due to the man's misdeeds or flouting of *Mannai*. People pray '*Siirapui-Siirafii jumagelo*' (Mother god - Father god, have mercy) when natural calamities and epidemics occur. *Mannai* is also "not merely to abstain from work, but to instil a positive attitude towards their health and wellbeing" and re-energizing and renewing oneself (Tiba, 2003, p. 166). *Mannai* is also significantly associated with agriculture. It is observed to seek rain during a long dry spell and to be spared from hailstorms and windstorms that could damage the crops extensively. It is also observed when unnatural death occurs in the village, such as dying during childbirth, dying by drowning, fire, or being attacked by wild animals, etc. It is also observed when it is noticed that a permanent genna has been broken by any of the villagers.

Tiikanii

Tiikanii, meaning forbidden or prohibited, is associated with religious and social practices and environmental sacrilege, forming a guideline for life. According to Tiba (2006), the word 'taboo' is derived from the Polynesian word 'tab', meaning forbidden; the principle of taboo roots in communication is associated with ritualistic behaviour, the unwritten law of the primitive people (p.167). In Maram, *Kanii* stands for forbidden—for

instance, *Kavii Agiiba N'ki Niile* (taboo to bite ginger with naked teeth).²² Ginger is a fundamental ingredient in all the rituals of the Maram, and by extension, hygiene is stressed.

Taboos vary according to the events and occasions, for men, women, the king, family, clan, during the war, at the time of death, natural calamities, etc.... (Tiba, 2003 pp. 168-173) For example, it is taboo to disrespect parents, to marry within the same clan, to jump over a woman who's weaving, to mock an orphan and so on. Linguistically, there are certain taboos; for instance, a tiger is always referred to as a brother. The taboos set the tone for a harmonious existence with oneself, fellow human beings, and nature.

Kanat

Kanat is a rite to perform rituals like serving food to the house deity (*Akirakot*), observing *Mannai* and maintaining *Tiikanii*, other purification rituals like *Achi-N'lou* (Annual purification), animal sacrificial rites, bathing purifications, festivals, etc... The performance of various rituals at the family and individual level is called *Kanat* at childbirth, naming ceremony, sickness, etc. Individuals undergo temporary *Kanat* during marriage, pregnancy, important occasions, or accepting a social status, as well as in the past, before and after battles and head-hunting raids. *Kanat* (ritual) vary in duration. Some last for a month, while others are completed in two days. As a religious or magical rite, it is performed to prevent danger, establish and restore normal relations with potentially harmful powers, or require appeasement. The belief system of the Maram religious universe is quite karmic, for several of the diseases are attributed to the wrath of the Gods due to man's transgressions or infringement of the *Mannai*, *Kanii* and *Kanet*. With the advent of Christianity, the traditional Gods have lost their prominence in the life and rituals of the people in general; however, the customary practices that invoke blessings or ward off evil spirits are invariably practised during festivals and auspicious occasions.

²² No cutting with a knife. The ginger is covered with a piece of cloth, then bite with teeth or bare hands to smash on the stone or wood log.

It is pertinent to note the observation of Malinowski (1948) that in life, when certain situations are beyond man's control, the emotions of fear and difficulty make a man look for protection from supernatural forces and divinity, for which magic is performed with strict adherence and appeasing by an act of purification. As a result of consistent hard work, experience, and the rational thought process involved in the ultimate end of rudimentary science.

Indigenous health is best understood through a holistic lens perspective. In the present study, it is pertinent to relate Murdock's (1980) Ill-health theoretical model; he delineates the nature and supernatural belief of causative illness. The natural causes are infection, stress, organic deterioration, accidents, and overt human aggression. Supernatural causes include theories of mystical causation (i.e., fate, ominous sensation, contagion, and mystical retribution); theories of animistic causation (i.e., soul loss and spirit aggression); and theories of magical causation (i.e., sorcery and witchcraft) (Kearney, fall/winter 1984-85, p. 146; Kahissay et al., 2017, p. 2). However, various studies suggest Murdock's theory of absence of sociocultural perception of ill health, in reviewed work by Kearney (1984-85) points out that Murdock delineates more on the "parasitic" ideas and neglects to explain the cross-cultural variation of illness (p. 147). Furthermore, social elements associated with illness, such as the absence of trust, troubles brought on by the actions and experiences of family members and violation of some social taboos that were perceived as the determinants of ill health, were failed to explain in Murdock's theory of illness (Kahissay et al., 2017, P. 2) also diseases are caused by the close blood practice of marriage were not found in the ill health theory of Murdock (1980). Therefore, the perception of sociocultural causes of illness among the Nagas is crucial (Watienla, 2019, p. 63). Hence, the theory of illness model is categorised into three sections: nature, supernatural and socio-cultural causes of illness, with cross-cultural and social diversity backgrounds to delineate ill health and a holistic approach in healthcare. Malinowski (1948) states that illness and death are attributed to a "personal perspective". He said, "To the most rational of civilised men, health, disease, the threat of death, float

in a hazy emotional mist, which seems to become denser and more impenetrable as the fateful forms approach”. Thus, primitive man senses “nature and destiny” and recognises and utilises the “natural and the supernatural forces and agencies” for his benefit (p.15).

Several aspects of traditional medicine practices have a strong connection to the practice of black and white magic and rituals, which invariably underscores the “supernatural theory of diseases” that is prevalent in every indigenous community. K. Park (2011), in his book, *Textbook of Preventive and Social Medicine* (21st ed.), stated that ailments supposedly caused by the “Wrath of gods” and raid of “evil spirits” were treated by meditation, rituals, and sacrifices or by wearing amulets as primitive medicine. He further suggests that this is more prevalent among the Indigenous communities in the recent past or even now – the Indigenous culture of healing is based on superstitions and belief in the supernatural and practices controlled by magic and religious beliefs. (Jackson et al. 2022) described in their ethnographic work of diverse cultures to explore the destructive phenomena that occur in life, identifying that the belief of natural and social phenomena like diseases, natural hazards, etc., ... was called the “God of the gaps”, while, “The socially focused religious beliefs, including shaman and witches (with ability to help or harm) with magic and supernatural powers are also found to have great relevance in the beliefs and practices among the people” (p. 708). In the ill health theory of Murdock (1980), the supernatural causes theory and the spirit aggression are significantly associated with cultural intricacy (Kearney, fall/winter 1984-85, p. 146).

Beliefs on Health:

To the Maram, illness and diseases are deeply connected with the supernatural being, the sacred of perception toward treatment. In the past, home remedies were known only by the elders. Whenever asked about the herbs, elders usually say *Amaleh*.²³, but unmarried people are not eligible to know about medicinal herbs. During the interview, some older respondents said they did not realise because elders did not disclose the kind

²³ a sacred object

of herbs. Also, some say that if young people learn to prepare medicine, their fertility will be affected, and they will not be able to bear children, whereas some say if it is known to many, then the herb's effectiveness will be less. Therefore, there is a possibility that some of the good herbs might have been forgotten, or the herbs must be openly discussed and shared among the community.

There is still a significant connection between the supernatural and superstitious practices related to various signs, actions, words, and symbols among the Maram people. They are usually viewed as undesirable occurrences that are likely to happen. People who encounter these things, events, or actions take precautions by executing various rituals to fend off malevolence.

Pasai-goi/ Masaihoi / Apsyi-tii (Migraine/ headache)

A person suffering from migraine or any form of headache seeks the help of a head masseuse. The head massage involves a step-by-step procedure; therefore, only a few persons have the skill to perform it. In the first step, the whole head is massaged using the ten fingers, and then a pinch of hair is held between the tip of the thumb and the index finger and pulled using both hands; this is done for every side of the head. During the process of pulling, if a sound is produced, it indicates the onset of an acute migraine; on the other hand, in severe cases, no sound is produced, indicating a prolonged migraine called *Pasai-sizing-goi*, which takes time to heal. The second step is pulling the ears with both hands covered with a piece of cloth. Some experts use their hands or teeth on the stomach, back, hips, and forehead. The third step is to spit out saliva, eat a pinch of salt and drink water.

Ritually, when a person often gets headaches/ migraines, a sacrificial ritual of killing a chicken is performed. A small size (equal to a quarter of a kg) of country chicken is to be eaten by the sick person alone, and any leftovers are buried under the pillar of the house. This ritual is called *Aru Gikak*.

Rakchenii tat / Amoi katat (Stomach catch)

The literal meaning of *Rakchenii tat / Amoi karat* (stomach catch) is locked by a spoon. The remedy for it is to pick any twig and place it against the painful part of the stomach. Then, break it into pieces, spit saliva on it, and discard it to subside the pain.

Aka-rou-pai (Fishbone stuck in the throat)

There is a traditional belief that the person who managed to kill *Karam* (a river otter) has a remote power to flush down the bone just by calling out their name. Mr. Kangraidou, from Ramlung Village, is popularly known for this particular healing, and his name is invoked whenever a fishbone gets stuck in the throat. The healer is often informed about the timing of invoking his name. If not intimidated, only calling his name works in some cases.²⁴

Ameak Nemtiikanii (Eyelid dermatitis)

Eyelid dermatitis is treated by live burning firewood and performed by someone familiar with a specific rhyme used only to heal eyelid dermatitis. It is performed by pointing the firewood at the eye; the person recites *Tai Ka*, *Tai Na*, *Tai Tiim*, and *Madai Malailo* (one, two, three and fourth return). It is recited three times with utmost seriousness, for if mocked, laughed at, or made fun of, it will not heal and has a high chance of spreading to the performer.

Amang (Dreams)

The sharing and interpretation of dreams serve as an engaging start to the day. For example, dreams involving a pregnant woman or her partner, as well as those concerning others' perceptions of them, are often vividly imagined. It is believed that if a pregnant woman is envisioned holding weapons such as guns, knives, or axes, she is likely to give birth to a boy. Conversely, dreams featuring needles, weaving, or traditionally feminine items are interpreted as indicative of a girl. One respondent noted, "*I have given birth to*

²⁴ Focus Group Discussion on 23/02/2020 at 1.30 pm, Maram Centre Village.

seven children, three girls and four boys. During my pregnancies, dreams involving axes and knives consistently predicted boys, while dreams of needles and sewing were associated with girls. All my dreams followed this pattern and came true." This belief in the significance of dreams is reinforced by their repetitive nature, which fosters a strong conviction among individuals regarding their meanings.

Having bad dreams or visualising a specific sign or symbol during the dreams is considered to impact the person's life in the near future. They indicate unlucky experiences like shame, fights, sickness, deaths, etc. For instance, a respondent said, "*If I see eating rice in dreams, it is visualised as a conflict bound to happen. Also, if I see fish in a dream, it is visualised to get money.*"²⁵ Therefore, family elders often advise people with bad dreams to take the precautionary measure of facing eastward in the morning, spitting and cursing against the malevolent force. This would ward off any impending untoward incident.

Ziimakalak (Insomnia)

Being unable to sleep at night is believed to be the work of evil spirits. *N'kamramnok* leaf and *Hiipi* (sweet basil) are burned at the house's entrance. A respondent said, "*A piece of iron rod is cut into small pieces equal to the number of family members. The tip of each iron piece is tied with cotton and placed on the way to an isolated place to ward off evil and to get good sleep. Usually, the ritual is carried out after getting the soothsayer's interpretation*".²⁶

Witchcraft and black magic

Traditional witchcraft beliefs differ by culture, although there are some common themes. Witches are frequently feared and persecuted for their ability to use magic to hurt others. Witches are also said to be able to heal the ill, foresee the future, reverse misfortune

²⁵ Female, 47 yrs, respondent, Maram Centre

²⁶ Male, 70 yrs, respondent, Maram Bazar village

and converse with spirits in some societies. Aslam (2020) defines witchcraft as “A person, especially of the female gender, may be considered a witch who acquires supernatural power, is capable of performing black magic or sorcery, and of causing purported harm to human health” (p.156). Similarly, the Maram tribe too believes in the existence of diviners or soothsayers, “Black art or ‘*rtithei*’ was common in the northern villages like Maramei Namdi, Katomei and Willong” and witchcraft called “*raku-tchumei*” (Tiba, 2003 pp. 165-166). Women were being victimised in line with the various studies mentioned earlier. Maram, too, victimises women, as only women are found to be practising witchcraft.²⁷. The following are the three types of witchcraft according to the Maram people.

Karakime

Karakime a woman who inflicts ill on other people through greetings. The woman does not intend to cause pain, but it is considered that the person is evil by her innate nature. Her shadow, as much as her words, is considered destructive. Migraine and stomach pain are the result of a *Karakime* spell. To prevent the *Karakime* spell, one must eat something in the morning before leaving the house. In any case, if a person cannot eat anything before going out in the morning, they are advised to avoid contact with the *Karakime*.

Takoukatuime

Takoukatuime is a woman who inflicts/causes pneumonia. The literal meaning is a person who causes chest pain. It is said that a witch’s glance at the infant is enough to attack the child. Infants are vulnerable to this type of witchcraft. If the child suffers from pneumonia-like symptoms, including chest tightness, breathing problems, and chest swelling, it is thought to result from *Takoukatuime* spells. When a potential *Takoukatuime* visits the infant, the family members engage the *Takoukatuime* outside the

²⁷ The reason was, perhaps in the past men primarily engaged in war and hunting, therefore often equipped with weapons and if men folk are victimised, there will be fights and bloodsheds among themselves. Hence, women become a soft target to such beliefs and practices.

house in conversation on other matters. The remedy for *Karakimei* and *Takoukatuimei* for the victims is to eat the leftover food or even straw from the witch's residence without her approval. If she finds out, the remedy will not be effective.

Hiituimei

Hiituimei, a woman who practices black magic; one who casts an evil spell on others, causing illness and death. Only women can have this extraordinary power handed down through generations. The people believe that the person's power comes purportedly from a stone she possesses and carries around, wrapped with *Marangli* (a type of wrap-around for women). The stone is believed to give out a rainbow-like colour when it is taken out in the open. The stone was initially brought to the village to cast a spell on the enemy. It is believed that *Hiituimei* can harm only one whom she knows. She is not capable of harming strangers or enemies. Due to the vicious nature of the stone harming the people in the village, the person who has the stone hides it from others; in case someone suspects or comes to know about the person, it is passed on to others to avoid detection; it is said that the stone is usually kept in a box like *Tampak*,²⁸ *Huidibung*,²⁹ *Abai Tamspii*,³⁰ *Tampfii Rangboun*,³¹ She struggles to bear the urge to harm someone and experiences symptoms like pain in their private parts and fingertips and stomach aches until she uses her evil power on someone.

If the victim becomes aware of the imminent attack by the witch or escapes unhurt, a spell is made on other objects, and if the cursed object is thrown at the witch, the witch will die on the spot. The victims' symptoms are headache, stomach pain and swelling of the body. Confirmation of the witch's attack is done by pouring the victim's pee on the leaves of *M'bu* (Stinging nettle), *Rakuitak* (Angel's trumpet), and *Tiimpai* (Mugwort). The plant is observed for 30 minutes, and if the plant dries off or dies, the person is considered

²⁸ Bamboo-made baskets to preserve dried meat were placed on the hearth.

²⁹ A Claypot, where Puddy is being used for processing yeast for brewed rice beer etc.

³⁰ A bamboo-made container used for storing rice.

³¹ A bamboo box for storing clothes.

harm. The culprit's identity is not disclosed to the public, but the victim's family would approach the village elder about the matter. There will be a village announcement as *Ahiitalo* (roast the medicine) without naming the culprit. A potential witch is asked to carry out a healing ritual in the evening; she would roast her fingernails on the heated clay pot until the victim senses the odour of burnt fingernails. If the culprit refuses to do so since it is a painful process, her name will be known to everyone, and she will be excommunicated from the village and her family for the rest of her life.

According to Murdock (1980), the supernatural causes of illness by witchcraft have a significant association with patrilineal descent (as cited in Kearney, 1984-85, p. 146). Furthermore, Aslam (2021) pointed out that the beliefs of witchcraft are a socially structured phenomenon in a highly patriarchal society; women are victimised and accused. As a result, they get killed or ostracised, and entire families are victimised (pp. 156-156). It is pertinent to note that beliefs and practices of witchcraft are most likely found in rural areas with poor access to healthcare facilities, lack of educational institutions and economically underdeveloped areas (Aslam, 2020, p. 156); in the modern era, they are commonly found to be practice in North India, West Bengal and Northeast India (Malik, 2019, p. 200).

Malinowski (1948) said, "A sorcerer who learns a performance by which to cause a definite disease will at the same time learn the formula and the rite which can annul completely the effects of his evil magic" (p. 66). Today, such practices and beliefs are things of the past. Although there are no longer any incidents of this happening, some people still hold onto this concept, especially enter-marriages, which are not encouraged. The belief in witchcraft has lost most of its relevance and traction among ordinary people due to Christianity, education and contemporary engagement.

Festivals and Health:

The festivals are not just about merry-making; each has unique customary traditions and ritualistic components laid out meticulously. These festivals address the Physiological, Psychological, Mental, Emotional, Spiritual and Social well-being of the communities that celebrate them.

Malem

A toddler's rite of passage, a ritual for boy toddlers who have completed three years and have weaned to become full community members. A clear, unclouded sky that brings forth the bright sun approves and confirms *Malem*; it is celebrated in December. A successful *Malem* kicks off the month as a good sign of preparation for *Kanghi-Han'gni*, one of Maram's biggest and most prominent festivals. The month is also considered as the month of menfolk. The male members above the age of three would go into the jungle to catch live wild birds. The birds are tied to a bamboo pole and carried in front of the group in the *Sagong Ki* (King's house). The children partake in the purification ritual called *Marum-riit* before being recognised as community members. *Marum* leaves (tiger grass) are plucked to make garlands worn on the head, arms, hip and knees. The elders pronounce the children as purified and bless them to be protected from illness and misfortune.³² Food is prepared with water collected from the pond before the womenfolk start drawing water on a new fire, traditionally ignited with bamboo and dried shrubs. Food is cooked in an earthen pot and served in *arrii* (utensils made with bamboo for the entire gathering). All the males eat from the same *arrii* (rice winnowing basket/ Muram) to signify unity, bond, and strength. Brewed rice wine is served in cups made of banana leaves. Traditionally, the male child takes part in training for warfare and hunting after completing the ritual. *Tingpui-Marumanai* follows *Malem*, where a ritual bath purifies men folk before dawn and is carried out for successful hunting.

³² Father prays, "Let my child's sins be washed away", then *Sagong* (Kings) bestows his blessings: "Take your sons and be happy; may everything turn out to be alright for you" (Athickal,1992, p.88-89).

Kanghi

Kanghi is celebrated for seven days. As the festival begins, stones from the jungle are collected to make new hearth, signifying a fresh and new life. It means a fresh beginning of life with fresh wood and stone for cooking, indicating the preventive measurement of freshness and hygiene for a healthy mind, spirit and body. During *Kanghi*, men from different localities go around the village in groups in the wee hours of the morning, ululating and yodeling. The afternoons and evenings are spent feasting over various meat, brewed rice wine/beer and singing folksongs in their respective men's dormitory and later assembling at the king's yard for wrestling, long jump, and ululation. The event also serves as mental relief from stress, tension, and frustrations, providing calm and peace. Women folk, in particular, mobilise to watch and laugh, which can be deemed a healing festival. Stark naked wrestling takes place in the evenings to ward off misfortune and injuries. To win the wrestling, one should not get injured and abstain from sex to save energy for wrestling. Wrestling is considered masculine, and the most fit, strong and eligible in the community participates and wins. It also reflects a healthy, robust and well-built body. The festival concludes with the entire village menfolk taking part in the traditional war dance where each one is handed a wooden tool prepared by the king's men, and they dance around the king's yard/ground only to wind up in a loud conclusive end note in an impressive unison.

Kataimei Rakak

Kataimei Rakak is observed in the month of *Rakak-kii* (November), a day of formal farewell for the departed souls by offering prayers and performing rituals. The Marams believe that the soul reincarnates six times after the physical death. On *Kataimei Rakak* (deceased soul's day), the family members stay away from others in the event of a recent death in the family. Clan members also offer fowl to the family, sacrificed and cooked with country ginger outside the house. The family members consume the dish along with home-brewed rice wine. The leftover food is buried. The ritual is performed to please the

soul of the dead relative such that it does not disturb the family members. The rituals on this day ended the bonding with the deceased family member.

Rituals and Health:

Mala

Mala is a ritual of appealing to God for *Sa'mhii Kabi* (bountiful harvest), prosperity, good fortune, and health. An early morning offering of a fowl cooked with country ginger is made to the deity. Every home had a deity *Akirkot/Akirakot* – God of Good, “the descendant of a particular house will prosper and live a good life” (Athickal, 1992, p.121). The food is first offered to the deity in *Siirakok* (the plate on which the deity’s food is served) with *N'tec tii kang* (a piece of meat) from the right wing of the chicken mixed with the rice cooked separately, and this is done in a piece of clean and healthy banana leaf that had been prepared the previous night. The family’s youngsters are then given their meals. Generous families also feed children from poor households. Additionally, this rite is regarded as *Kanat kabi*, which translates to ‘good ritual.’ It is observed at the beginnings of the months- *Fiibui-Kii* (March), *Tingpui-Kii* (April), *Kapokmatai-Kii* (May), *Lamshang-Kii* (August), *Taraou-Kii* (September), and *Matai-Kii* (October). The observations coincide with seed preparation for sowing in March, sowing and transplanting in May, weeding and crop maintenance in August, and harvesting in October.

Tingpui Maru-Manai

It is a ritualistic bath of purification for men taken before dawn for successful hunting. Male members go to the village pond for a bath. Women, too, purify themselves from this ritual bath. The washing of weapons is considered a complete purification. For disabled persons, older people, and newborns, water is brought from the pond, and their hands and legs are cleaned. Then, the water is sprinkled in *Rahang-ki* (male dormitory) for purification. Bath symbolises the purification and filtering out of all sins in their lives. Every household performs the sacrificial rite by killing a chicken and offering it to the

deity; this is the fundamental act of *Marumanai*. Sacrificial chicken is cooked with country ginger and served in respective male dormitories and one's own homes. For the following five days, husbands and wives should abstain from sex. After five days until the male folk leave for hunting, women are not allowed to do work before the male folk leave the village. It is to avoid any accident or unfortunate event from household chores. The rite of spiritual bath purification is performed twice a year, following the days after the *Mangkang* and *Malem* feast celebration.

Achy-Marung

Achy-Marung (dog sacrifice) is observed when there is a fear of an epidemic or a natural disaster that might strike the community. This usually happens in October. Certain portions of dog flesh are placed at the *Akung-Karang*, a secluded place at the village entrance, to ward off or drive out malevolence and prevent epidemics and pandemics. *Atingba*,³³ a village crier, carries out the ritual and delivers information such as news of deaths, any decisions the village council takes, the timing of genna, etc. He is liberated from conventions and rituals and observes the genna, fearing punishment for engaging in specific rituals. He goes to the village entrance with another person and hangs a portion of a chopped-up dog. Life-threatening illnesses and natural disasters will be warded off and prevented by performing the ceremony, which also serves as a healing procedure. This ceremony is being practised even today because the villagers still see it as a protective precaution.

Achiimalou

Achiimalou is an annual ritual to ward off all evil, misfortune and ill health. It is performed by all, irrespective of age and gender, by pulling out a small piece of thread from a shawl, a cutting from a cloth, earrings, etc., executed early in the morning, and discarded it in a secluded place to be cleansed from evil, stroke of bad luck, adversity, misadventure, woe,

³³ He is regarded as the village medicine man (Athickal.1992, p.123), however, he is not a traditional medicinal practitioner.

disaster etc. When the ritual is accomplished, one returns home to a new start and is celebrated with chicken meat. This ritual is done in the month of *Riikak-kii* (November), the same as All Soul's Day, as observed by the Christians.

Children are prioritised in the health culture rooted in traditional practices, rituals, beliefs, and conventions. They are the most susceptible, and in the eyes of evil spirits, even unborn children are easy pickings. Kids should avoid walking on dogs, cows, or chicken excrement as it can cause illness or bad luck. Consequently, some customs are strictly observed to ward off evil and protect against malevolence. These customs include applying hearth ash to the forehead, wearing a necklace made of one's umbilical cord, and wearing *Ranok/Ralok* plant leaves as necklaces.

Arakatii

Arakatii is a family's ritualistic purification. A ritualistic feast offered to the community by any family that wishes for good health and well-being. *Aratii* is the rites of *Arakatii* to fulfil the advice given by forefathers or the fortune teller to purify the sins committed by forefathers. It is believed that the karma of wrongdoing falls onto the next generation by the wrath of God.

The dying traditional healing feast *Aratii* is a ritualistic celebration feast offered to the community by any family wishing for good health and well-being. This ritual is carried out based on the family's economic status. The sacrificed cow/dog/chicken, at the expense of the family, is cooked into a curry for dinner on this day, and freshly brewed rice wine is also taken along. Before the sun sets, everyone is expected to eat dinner and wash their dishes or before daybreak on the following day. If a cow is sacrificed, a piece of the meat is distributed to the community members. If a dog/chicken is sacrificed, only the family members have a common meal. In some cases, a dog is killed as a preventive and curative measure for the misfortune that happens in the family, like deaths, illness, incidents, etc. Traditionally, it is believed that the healing feast brings five benefits. They include, first,

longer life expectancy; second, calling back the good spirit; third, good health of children; fourth, good health for the whole family; and fifth, for the sick person in a family.

A chicken sacrifice is believed to extend life by one year, and a cow sacrifice extends life by three years. The chicken sacrifices were often confined to family members. During the ritual, all the family members were to maintain abstinence from visiting neighbours, and no visitors would be entertained. This is known as *Kanii-jale*. A piece of wood is placed at the doorstep to indicate that the family is carrying out the ritual and abstinence.

Arakalui

The feast of merit, an affluent family offers cattle, wine, rice and chutney to appease the gods for further blessings by feeding the village. The family sacrifices cows, is celebrated in three stages at the cost of family convenience time. The first stage is called *Arakalui*; before killing the cows, all the family members touch the cow's tail to maintain good health. On this day, depending on the family's affordability, 7 to 20 cows are killed and then distributed to the whole community. Each household gets a piece of meat equivalent to more than a kilogram. The second stage is *Haijoutou*, a brewed rice wine called *Jousang* (brewed rice wine) is prepared. Once the brewed rice wine is ready, villagers are invited to feast, make merry-making, and sing folk songs seated by a bond fireside. The last stage is carried out by distributing paddy to the community; a basket full of paddy is distributed to every household to mark the end of the feast. Any family who can carry out this ritual is eligible to build a house called *Aka-zaliki*, designed on the rooftop; it indicates wealth, pleases God and attains better status within the village. Hence, foods that are considered unhygienic are forbidden, such as mushrooms, stinging nettle leaves, chicken, pork, etc.

Mother and Child Healthcare Practices:

The question of mother and child health is central to every study on health care indicators for any group of people. Every indigenous community has a considerable body of traditional knowledge and practices on mother and child health. While one of the desirable results among women is to bring forth a healthy, bouncing child (Abasili, 2011, p.555), childbirth is a biological event; the pregnancy and birth experiences surrounding it are primarily social constructs shaped by cultural perceptions and practices (Withers et al., 2017). Among the Indigenous communities, several continuous and consistent ritualistic processes involving family members, relatives and the community were followed by Indigenous communities for the health and welfare of the mother and child. There are taboos, customs, rituals, practices of labour and leisure, food intake, and condiments meticulously followed to ensure healthy pregnancy and delivery. The birth of a new member is considered sacred and celebrated with rituals and customs. This section explores the beliefs, rituals, and traditional practices integral to the Maram Nagas that promote the health and wellness of the mother and child during the pre-natal and post-natal periods.

The journey of procreation begins at marriage, which includes specific rituals involving the parents, elders, and the newly married couple. Even in modern times, through folk songs and subtle rituals, the newly wedded couple is blessed by the well-wishers to have progeny as much as the stars in the sky or stone pebbles on the river bank and to be fertile like a spider. Common blessings are given by the elders on special occasions like births, naming ceremonies, weddings, and so on.

Oh, uta una maigo ina satoi psijjele (My grandchildren and children, I am giving you the blessing)

Mainamei lamka tatcha, Nang ramrii tatlo, (When others take the lowland road, may you take the highland road)

Uni gangto aluihing atak tiisa lunglo, meilui meirek patlo, (Through you, may your generation be fecund and prosper, surplus population)

Hingsa hangsa lunglo (Live a fertile and prosperous life)

Uniigangto Agana kumpa Mareckna kumpa Meilui meirek lung-N'tulo, (May you procreate like the crab and the spider)

Atii ana lungtuchii (As you start to have children).

Pregnancy:

Identification of Pregnancy

In the Maram community, the older women in the family, extended families, and neighbourhood have purported abilities to identify pregnancy accurately. Midwives and old wives could easily observe a change in body shape, gait, pigmentation on the face and general paleness of the skin as chances of pregnancy for married women. At times, headaches, body pain and weird dreams are supposed to be indicators of the onset of pregnancy. Interestingly, in some cases, the husband experiences morning sickness like nausea and loss of appetite.³⁴ An experienced traditional practitioner could determine pregnancy by placing a hand on the naval of a pregnant lady; if the lady feels the hand placed on her belly heavy and she becomes weak, she would be considered pregnant.³⁵

Pregnancy Care

Pregnancy care involves several food practices, taboos and beliefs in every indigenous community. A pregnant woman must maintain restrictions during pregnancy to avoid misfortunes like miscarriages and ensure the normal delivery and well-being of the mother's and child's life.

³⁴ When a husband experiences morning sickness leading to psychological and physiological changes, it is known as Couvade syndrome (Vermeulen et al., 2023, p.262).

³⁵ In ancient Egypt, a woman's pregnancy is tested by urinating on barley or wheat seeds. If the seeds quickly sprout, it indicates pregnancy. While this may sound like pseudoscience, several modern studies have shown that it works well, correctly identifying 70-85% of pregnancies (Tyssowski, 2018).

Taboos and Beliefs

A pregnant woman is advised to cover her stomach with a piece of cloth/shawl to be protected from evil eyes, as it is believed that evil spirits love to attack the foetus in the womb. A Maram pregnant woman is advised not to go to secluded places and forests alone, especially places believed to be the abode of evil spirits, and not to stay out late into the night for any purpose.³⁶ It is forbidden, and she should be “kept away from *Sazii* (earth), *Ating* (tree), *Atu* (stone), and *Karani* (spell of evil spirits)” (Jose, 2008, p.87). She should not venture out of the home after sunset for fear that something terrible will befall the baby. She is forbidden to kill a snake; it is believed that the child will posture out the tongue, resulting in the disability of the baby³⁷. During pregnancy, if an earthquake occurs, the husband burns the *Makhamranok* (Pleasant Himalayan Mint) leaf to ward off evil and protect the baby (Athickal, 1992, p. 67; Tiba, 2013, p.64).

Nutrition and Health

According to Maram, the restriction of eating certain foods during pregnancy is a precautionary measure to improve a woman’s general health, avoid miscarriage and facilitate normal delivery. Consequently, people practicing these pregnancy-related taboos believe breaking them may harm the unborn baby or threaten the mother’s health; other reasons to avoid certain foods are primarily focused on preventing possible miscarriages and difficulties during delivery. Among the Maram women, to avoid miscarriages, consumption of *Gatui* (black crab) is prohibited. Overeating food is also discouraged lest the fetus becomes too healthy and causes complications during delivery. Eating spiders is believed to cause web-like formation in the womb and cause complications during birthing. Animals trapped by string should not be eaten, as it would lead to drowsiness

³⁶ Other taboos include not attending funerals during pregnancy which is quite similar to the Thadou community of Manipur where pregnant women are restricted from attending funerals, fearing that it would cause miscarriage (Chanu & Arunkumar, 2018, p.199).

³⁷ Similarly, the Adyghes, pregnant women practice taboo not to visit cemeteries, walk outside after dusk for fear that an evil spirit will harm her, and should not kill snakes because the child will be born dumb (Djandar, 2008, p.256).

during birthing or labour pain. Eating hornet bees and walnuts is also prohibited as it is believed to lead to complications during delivery.³⁸

On the physical front, pregnant women are to avoid heavy labour and a sedentary lifestyle of sleeping or resting all the time. Weaving was discouraged as it could affect the child's position in the womb. Pregnant women approach traditional midwives to check the fetus's position and take necessary advice and treatment if required. The women were encouraged to walk and do some household chores. As the due date approaches, the pregnant woman is encouraged to carry out household chores such as drying paddy, pounding and cleaning rice, collecting firewood from the jungle, preparing brewed rice wine, fetching water, etc. The respondents mentioned superstitious beliefs of not going to certain places, not coming home late, not walking alone in the jungle, etc.

Delivery Care:

Modern healthcare services are inaccessible to most Naga villages perched on hilltops and valleys with limited transport and communication facilities. This is one of the reasons why the percentage of home deliveries in the Naga inhabited areas is on the higher side. According to Mishra et al. (2021), unequal maternal healthcare services between hills and valley regions of Manipur state have brought out less than 40 per cent with institutional delivery in the hill districts like Chandel, Senapati, Tamenglong and Ukhrul. Furthermore, only 19 per cent have access to 4+ Antenatal care (ANC) visits, 22 per cent to institutional delivery, and 21 per cent to Postnatal care (PNC) visits (p.1).

Among the Maram, traditionally, the family, relatives and neighbours shared various responsibilities during the birthing process. "The birth of the child was much awaited with great expectation where women folks and friends assist and extend help to the woman in labour" (Tiba, 2006, pp.64-65). The birthing process begins with *Kedem*

³⁸ Food taboos significantly influence pregnant women as many generations have followed them, forming part of their culture (Otoo et al., 2015, p.44).

katii- the beginning of labour pain (Braxton Hicks contractions). When the labour pain sets in, the bed is prepared on the kitchen floor or the adjacent room. As labour pain is felt intermittently, the expecting woman is made to kneel to prevent the woman from sleeping when there is no pain. Traditionally, this position of kneeling for delivery ensured speedy delivery with little effort from the woman. *Ami* (fire) is kept alive to protect and drive out evil spirits. During the labour, the woman is given warm *Hiipi tagou* (Sweet basil porridge), chicken soup or tender rice beer to rejuvenate, keep evil spirits away and facilitate an easy delivery. During the focus group discussions and one-to-one interviews, several older women informed us that the traditional birthing processes in the past mostly took place with the husband being present and supporting his wife as she kneeled. He takes position behind the wife and hugs her from the back, supporting her to push for a speedy delivery process.³⁹ Womenfolk in the room constantly check the child's status and position and encourage the pregnant woman to push. Soon after the birth, the *Pula ring* (umbilical cord) is tied up with *N'nanpuinaring* (herbal plant). A piece of sharp bamboo split called *Ralec-tai* is used to cut the *Pula ring* (umbilical cord) by an experienced person, preferably the eldest woman present.

Placenta Delivery

The crucial process during delivery is the *Kiilam* (placenta) delivery, which is also waited upon after the child's birth. The old wives wait for the *Kiilam* to be delivered; if there is any delay, an experienced person or a doctor is called. The handling of the *Kiilam* is also carried out with utmost care and formal procedures. The placenta is wrapped in a cloth and safely buried in the house's backyard, lest dogs or other animals eat it. Traditionally, the placenta from different births of the same mother is not buried in one place as it is believed that if done so, the siblings may die together on the same day.⁴⁰ If *Kiilam* comes out with a piece of a large blood clot, it is called *Kiiramba*. *Kiiramba* is

³⁹ Similarly, the father's presence during birthing is significant among the Ao community (Athickal, 1992, p.67).

⁴⁰ Similarly, the Poumai and the Zeliangrong tribes bury the placenta inside the house for a sense of attachment in future (Kamei & Singh, 2016, p.222).

a sign of a bond between the mother and the child. The bond is often manifested in the death of both the mother and the child on the same day, especially if one attends the funeral of the other. Traditionally, the occurrence of *Kiiramba* is made known to the mother and the child so that they can take necessary precautions.

If a child dies before the naming ceremony, the body is placed in a clay pot and buried under the house near *Kaching / Siimtung Chingdi* (central pillar). A person, preferably an older adult, is hired to bury; crying is forbidden, fearing that the next child will die in like fashion if they grieve.

N'bungkatai

A death during delivery is called *N'bungkatai*, considered a misfortune and a bad omen for the family and the community. They are not given proper burial ceremonies.⁴¹ In the past, when it was apparent that the woman would not survive the delivery, she would be tied with a rope and dragged out of the house, left to die outside the house. In such a situation, only a few women would manage to survive. *N'bungkatai* is considered abominable and only her family members quietly mourn her death. The dead body is untouchable by the family and community members. Hence, a person is hired from a neighbouring community for burial. The body is dragged with a rope and thrown inside the grave unceremoniously. All her belongings are discarded in a secluded place; if she dies inside the house, all the household belongings are discarded, too. The deceased's family cannot fetch or bathe from the common water source. If the rituals are not followed, it is believed that more such deaths will happen during delivery. However, this practice is abolished by the then Maram queen, Apai Hinga bearing in mind the immense pain it causes to the family members and the loss of resources to the people.

⁴¹ The same practices can be found among other tribes like Paites, and "*Nagikate*" in Mao (Athical, 1992, p.67).

The Role of Traditional Birth Attendants (TBA)

Iyengar (2008) notes that “in India, pregnant women favour home deliveries presided over by TBA. With home deliveries, a team of birth attendants led by a TBA and an elder female relative of the pregnant woman preside over the birthing process and are also tasked with making decisions regarding the birthing process” (pp.24-25). TBA are consulted from conception to pregnancy care, delivery, and post-natal care. The traditional healers and birth attendants are the first point of reference when a couple does not get a child within 1-2 years. One of the respondents said, “I have been trying to get pregnant and consulting physicians, but it has not worked out. One of my relatives suggested I talk to a traditional midwife. She claimed it is possible to become pregnant only after the womb’s position was altered by massaging the abdomen”.⁴² The respondent followed the advice, and the TBA carried out a massage. The woman was able to conceive soon after. Traditional practitioners were asked about the adequate steps to ensure easy and safe delivery. A TMP said, *“I treat clients with reproductive health-related problems before pregnancy, during pregnancy, post-delivery and urinary tract infections. I do not attend to delivery; however, when a client comes, I refer them to the other traditional experts.”*⁴³ A TBA said, *“I refer the clients for delivery to modern healthcare facilities only when the Ana ki (birth canal) is too narrow. I do not attend client because I know it is risky for the mother and child.”*⁴⁴ A certified midwife said, *“I could attend the birth if the baby arrived in a position with a head/buttock or leg. However, in cases like a too-narrow birth canal, too big/ healthy baby like above 4 kilograms, the baby’s delivery position starting with hands, exceeding due date, placenta delivery before the baby, is referred to modern doctors, usually such cases are delivered through c-section.”*⁴⁵ When asked during the focus group discussion, women folks said if it is “*Ana ki latmakle*” (literally means the baby house is not open yet) as during labour pain, the woman’s health deteriorates then in most cases she dies, this death is called *N'bungkatai*.

⁴² Female, 35 yrs, respondent, Maram Centre Village.

⁴³ Female, 36 yrs, TMP, interviewed on 03/09/2021 at 12. am Lairoucing Village.

⁴⁴ Female, 47 yrs, TMP, interviewed on 11/12/2020 at 2.15 pm, Maram Centre Village.

⁴⁵ Female, 63 yrs, TMP, interviews on 22/09/2023 at 5.19 pm, Senapati Dist. HQ.

Neonatal Care and Practices:

The first step of neonatal care for the infant is giving a first bath. *Ramnok* leaf (Pleasant Himalayan Mint) and salt are added to the hot water prepared to bathe the child as it is strongly believed that the scent of *Ramnok* can ward off evil spirits. The child's naval is massaged gently with warm water during the bath. Breastfeeding starts as soon as the mother is ready after the baby's bath; the mother's breasts are washed with water before feeding. The first few drops of milk are not given to the baby, believing it will cause or lead to stomach upset in the infant.⁴⁶ It is usual to kill a fowl to mark the birth of a child, a rooster for a boy child, and a hen for a girl child. According to the child's gender, the relatives also gift a rooster or hen to the family. When a male child is born, the celebration is even more enthusiastic, and the mother receives more respect in the community and family. *Makhamranok* leaf (fresh or dried) collected from the forest is placed; thus, if the infant cries at night, it should be placed on the wall close to the bed.

M'bangkilang Karii

The ritual *M'bangkilang Karii* starts on the evening of the baby's birth. A thanksgiving offering is made with rice and ginger on a banana leaf to *Aki-rakot* (a household deity). In the past, the ritual was observed for *Jangrii* (ten days). Of late, the number of days has been progressively brought down to five to three days due to complications related to the mother's health. In most cases, the rituals are no longer practiced today; however, keeping distance from strangers and random visitors is still maintained. A piece of wood is placed to signify a newborn in the family.⁴⁷ During the ritual, both the child's father and mother are forbidden to talk and touch others, and in the past, no visitors apart from immediate family members were allowed to enter the house. Conversation between family members, too, is limited to the basics; however, the mother's needs are all met. The mother and child are expected to use water fetched by the father

⁴⁶ Similarly, Dibongiya Deoris of Assam believes the child will face weird faces if given the first milk (Borah and Sengupta, 2018 p. 144).

⁴⁷ To protect the mother and child from the malevolence of humans and evil spirits, for the baby's good health due to the high child mortality rate (Tiba, 2006, p. 65).

while carrying a *Ramnok* leaf-tipped spear. During the observation of birth *Kanat*, father and mother are fed mainly fish (fresh or dried) or snails cooked with ginger and lentils.⁴⁸ *M'bangkarii*, also called *Kanat Kabi*, is a ritual followed diligently by the people prior to the arrival of Christianity. *M'bangkarii* last for a period of ten days in past but has been progressively brought down to five to three days due to the intricacy and deterioration of the mother's health. With the advent of Christianity, the birth rituals are almost a thing of the past. Nowadays, only a few aspects of the practices are found, albeit subdued or subtly.

Naming Ceremony

During the naming genna (*kanat*), the mother and the child sleep on the floor for three days until the naming ceremony is completed. The naming ceremony is generally carried out on the third day. The infant is carried on the back by a sibling or an immediate relative corresponding to the gender of the firstborn child; he/she is not allowed contact with others and stays till dinner. The father of the child calls out the name of the child while the infant is held by the person facing east. A healthy chicken, respective to the child's gender, is sacrificed, signifying becoming a healthy person. After dinner, when everyone retires to bed, the father performs a ritual called *N'lou*. The father performs the *N'lou* rite in the morning or during the day. He goes to the jungle or woodland and gathers a twig of the pre-marked chestnut tree (*Katha-Tarai*). Fresh spring water fetched with the leaves of *Katha-Tarai* is sprinkled on the chin of the infant, wishing him/her strong and healthy person.

New Hearth

The significant change that is done to the house during this ceremony is the making of a new hearth, implying a fresh and renewal day. The old hearth is cleared, and a new fire is lit with the live coal collected by the father from the neighbour's house, whose

⁴⁸ Similarly, the Zeliangrong tribe observes the mother eating plain food for three months for the firstborn and five days for the others; however, the father for five days for the wellbeing of the progeny (Kamei & Singh, 2016 p.222).

firstborn child is still alive. It is taboo to drop Lochia (postpartum blood) in the hearth fire; it is considered unhealthy and harmful.

Fiikilampat

A neonatal ritual to mark the newborn as a paternal lineage. The birth ritual ends on the third/fifth day with the *Fiikilampat*, literally meaning it belongs on the father's side. Mother recites "*Afiilam patsaragatale*" (now belonging to father's side, for the best thing in life, healthy and strong). Then, the father holds the baby and whispers his blessing, "*Laimak ngousa-ragalo*" (see the sun, have the best life, and stay healthy). The sickle and sweet basil leaves are then tied with a creeper plant (*Maniiring*), and placing the child to stand, the mother and father bless the child, saying, "*Sating kaba ngousaragalo*" (see the brightest sky and have a healthy and robust life) (Jose, 2008, p.90).

N'lou Rite

In the morning or during the course of the ritual days, the father collects a twig of the *Katha-Tarai* (a chestnut tree) from the forest. After dinner, when everyone is reposed to bed, the father performs a ritual called *N'lou* to mark the completion of *M'bangkarii*. *Katha-Tarai* twigs into three pieces, throws them under the bed, and prays.

Post Natal Care:

Care of the Mother

The first bath of the mother is the day after the completion of *M'bangkarii*. *She does so by* going to a stream accompanied by a small boy. The boy is made to collect *Mahamgai* (water celery), a perennial wild plant used to treat stomach aches and period cramps. The *Mahamgai* is boiled and eaten to ease the pain and prevent constipation. Nowadays, the woman takes a warm bath with *Ramnok* (Pleasant Himalayan Mint) or *Karananii* (castor leaves), depending on her health condition. The new mother is fed with steak and soup, but her diet depends on her family's monetary status. If the mother becomes weak, she is frequently given warm food; to help her recover, she is given

country eggs with chilli powder. The young mother is also given delicately brewed rice wine, chicken soup, dog meat, and fish to help her regain and garner strength. It is also suggested that the woman serving the new mother's food has a positive history of giving birth to healthy children.⁴⁹

The Health of the Breastfeeding Mothers

The lactating mother is recommended to consume *Samarati* (horse gram); the cooked horse grams and soup are eaten with brewed rice beer for quality and quantity milk. *Gainam* (chives), *Kuraigai* (Indian Pennywort) and *Ramchi* (taro) are famous salads among lactating mothers for milk quantity taken as a salad, with *Toktui* (sweet and tender brewed rice wine) and *Abaicha* (sticky rice tea). Banana stem for good skin of the child, Chicken soup, warm fresh cooked rice, local egg with taipan (rock salt/ horse salt) as an energy drink, wrap in banana leaves and heat in the ash from the hearth overnight. Bitter guard and salted soup. Supplementary feeding starts only when the mother does not have adequate milk three months before. Cooked rice is chewed into a paste by the mother and fed to the child. Generally, additional feeding starts three months after the child's birth.

Birth Celebration Meal

The birth of a child is marked by a celebratory meal, a traditional mandate by killing a chicken. A rooster for a boy and a hen for a girl. According to the newborn's gender, the relatives also gift a rooster or a hen to the family. When a male child is born, the celebration is even more enthusiastic, and the mother receives more respect from the community and family. The practice of distributing *Anagai* (infant curry), usually a bowl of fragrant meat, to neighbours and relatives is followed by the Maram people even to date.

⁴⁹ Among the Thadou tribe of Manipur, a woman is given a hot bath consecutively for a week after the delivery and served chicken soup or a quick recovery (Chanu and Arunkumar 2018 p. 199).

Rituals and Practices for Infant Care

For the first two to three months, certain plants, such as bamboo, sensitive plants, creepers, etc., are to be avoided by both parents since it is believed that touching them could cause allergies and harm the child's health. The abnormal faeces of the child indicate that either parent has contact with the plants. Only an expert on child faeces can identify the exact plant in such cases. Then, parents recollect where and which plant they touched, either from the garden, field, or jungle. Once the plant is identified, parents or family members destroy it by uprooting and burning it. Sometimes, it takes the whole village to search for the plant, whether in the thick jungle or far off field. A lactating mother only performs household chores, farming, or gardening for three months.⁵⁰ To ward off the evil and protect the baby, *Makhamranok* leaf (fresh or dried) collected from the forest is placed on the wall close to the bed if the infant cries at night.

N'pamrah

The infant ritual ends with *N'pamrah*, a ritual for children below two years for purification and invoking blessings for good health and fortune. The elders in the clan and immediate neighbours are invited to bless the child, and they are offered a hearty meal and home-brewed rice wine as part of the ritual. This ritual is carried out four times during the year in specific months, i.e., *Tingpuikii* (April), *Lamsangkii* (August), and *Rakakkii* (November). The initial ritual for a child commences in a designated month following their birth. This ritual must be performed once in each designated month, concluding with the observance in the month it was first celebrated. The month chosen for the initial observance is believed to have significant implications for the child's personality and character. For instance, if the observance occurs in April, the child is thought to possess a more feminine nature, while an observance in August is associated with a more masculine disposition. At dawn, men participate in the tradition of catching the *Tampai-Ruina*

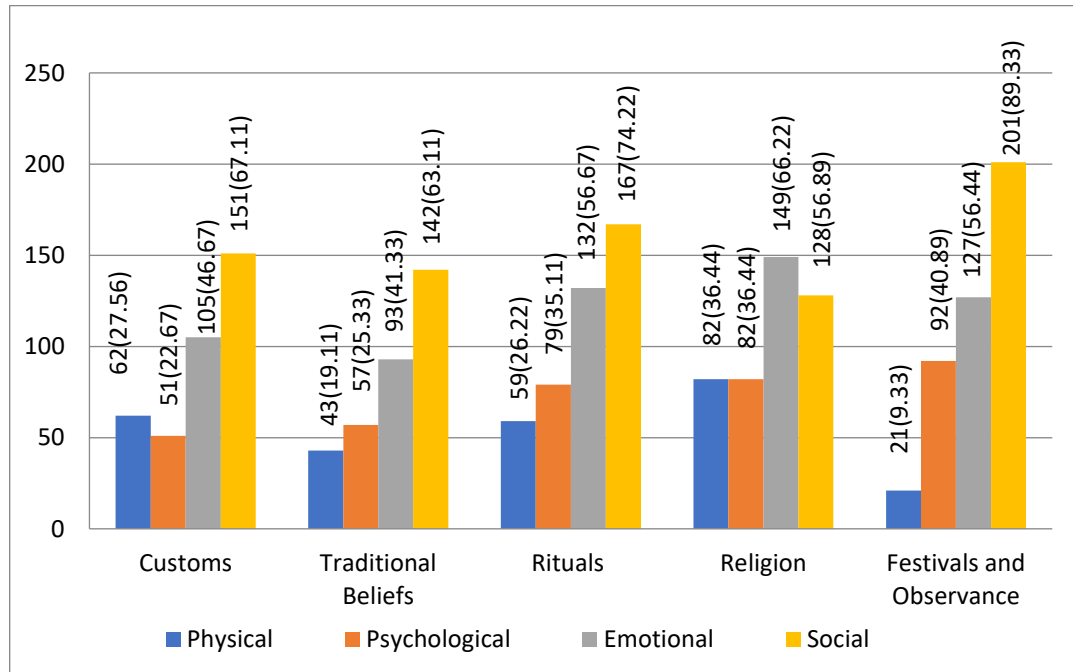
⁵⁰ During a time of "war/feud, the man with children below three months should not carry weapons but a branch to signify that the child will be brought up with due care, the enemies cannot kill him, and he cannot kill the enemies" (Jose, 2008, p.93).

(flycatcher) using bare hands or a stick. The catch is then displayed in front of the Morung, followed by a feast featuring chicken prepared with local ginger. The most important rituals and practices regarding a person's health are performed during infancy *kanat*. The rest of the rituals pertaining from childhood to teenage to adulthood take place alongside festivals and taboos.

Cultural Element in Health and Well-Being:

The perceptions of customs, traditions, rituals, and beliefs play a complex and multifaceted role in the health and well-being of communities. Their impact can vary significantly based on specific contexts and practices; however, there is a noticeable reliance on and appreciation for the observance of traditional customs and rituals in relation to health and well-being. Figure 4.1 illustrates the general outlook of respondents regarding the significance of these customs and traditions in their lives.

Figure 4.1: Cultural Factors in Health and Wellbeing



Source: Fieldwork

Figure 4.1 depicts the respondents' perspective on the value of different cultural factors in the health and well-being of individuals in other realms. It is evident that various cultural elements significantly influence an individual's physical, psychological, emotional, and social health. Rituals and beliefs can instill meaning and purpose in life, particularly in the face of illness or adversity, providing comfort, hope, and a sense of control over challenging circumstances. Among the respondents surveyed, 24 per cent (54 individuals) reported experiencing physical benefits from these cultural factors, while 32 per cent (72 respondents) acknowledged psychological advantages. In contrast, 54 per cent (121 respondents) emphasized the emotional benefits. Notably, 70 per cent (157 respondents) indicated that customs, traditions, rituals, religious practices, festivals, and observances positively impacted their social well-being and relationships. Shared customs and traditions can strengthen community social bonds, fostering a sense of belonging, identity, and mutual support. This can be crucial for mental health and well-being, especially during challenging times.

Decline of Traditional Practices

It is important to note that the knowledge, attitude and practices of socio-cultural perspectives, such as customs, rituals, beliefs and traditional practices passed down over the generations, are still upheld by the Marams to a considerable extent. It has benefited the growth, development and well-being of the community as well as supports in nurturing the unique identity of the tribe. However, there has been a steady decline in the practices and belief systems among the Maram due to various reasons.

The British Rule

The British onslaught into the Naga-inhabited regions brought along several different cultures and religions along with them. The Marams experienced their initial direct contact and sustained engagement with the broader external world, leading to significant shifts in their knowledge and attitudes. As a result, unwavering faith in traditional beliefs began to gradually diminish.

Impact of Christianity

Christianity made significant inroads into the Naga region during the British colonial era, largely facilitated by the support of local rulers. Many communities converted to Christianity, driven by collective actions that reinforced their social fabric. As a result, Christianity largely supplanted traditional religions, overshadowing existing practices and belief systems. Although many foundational beliefs and rituals persisted in their original forms, the prominence of traditional customs gradually diminished in the lives of the people. Additionally, the complexities observed in *Maidamei* (the indigenous religion) practices contributed to the adoption of Christianity by numerous communities.

Modernization

Modernization, education, and changing livelihoods have had a profound impact on indigenous communities worldwide, including the Maram Nagas. While these developments have ushered in certain benefits, they have concurrently contributed to the

erosion of traditional knowledge and practices. As younger generations increasingly engage with Western culture and education, their interest in traditional skills and beliefs wanes. Consequently, there has been a noticeable decline in the use of herbal medicines, traditional healing methods, and cultural rituals. However, it is essential to recognize that traditional knowledge and practices can effectively complement modern healthcare and promote sustainable livelihoods. By integrating traditional wisdom with contemporary scientific knowledge, we can develop innovative solutions to address the challenges of the 21st century.

The ancient village of *Maramei Namdi* (Maram Khullen) is regarded as the guardian of Maram heritage. Comprising three administrative villages-Khullakpa Sagai, Mathak Sagai, and Makha Sagai-Maram Khullen continues to uphold traditional practices, including the observance of genna, cultural festivals, and purification rituals. Agricultural activities are conducted in accordance with the lunar calendar, reflecting the community's belief that adherence to genna will appease supernatural beings, ensuring timely rainfall, crop protection, and a bountiful harvest.

The practices on the *N'bungkatai* (still birth) are completely discontinued due to the inhumanness as well as the psycho-social, emotional and mental trauma the entire practice evoked in the family. Discarding of the entire household items were also felt to be not economically viable. Similarly, the practices of *Aratii* and *Arakalui* caused economic distress to the family in feeding the community by killing cows and distributing the meat along with grains and serving brewed rice wine to the community.

It can be observed that culture and emotional well-being are linked to the economic status of individuals, families, and communities. Cultural practices that remain vibrant are often tied to emotions and require minimal spending, while those that emphasize expenditure as a central element are gradually fading away, leading to a loss of knowledge and practices.

Chapter 5

ETHNOMEDICINAL PRACTICES AMONG THE MARAMS

Indigenous communities deeply understand their environment, forming a close relationship with the natural world and its resources. This connection is reflected in their cultural practices, beliefs, and way of life (Bhattacharjee, 2023, p.182). Over generations, they have acquired and preserved knowledge critical to survival and well-being. This includes skills in hunting, gathering, agriculture, traditional medicine, and other aspects of daily life. These knowledge systems are not merely practical; they are fundamental to the identities of Indigenous peoples.

Traditional knowledge have been crucial in maintaining the health and wellbeing of people in the context wherein modern medicine was out of reach of most people until the latter part of the last century. The Indian system was an amalgamative evolution of Indigenous practices across different communities and groups. The evolution of Indian medicinal systems, such as Ayurveda, Siddha, and Unani, emerged from integrating ancient knowledge systems practised since immemorial. The system heavily relies on plants, minerals, and animal products, and it has few side effects due to a concentration on gut cleaning therapy concepts (Parveen et al., 2022, p.157). The traditional system is a ‘holism’, an integrated discipline of biological beings with social, cultural, and environmental dimensions. It is through the traditional healthcare system that the field of medical anthropology emerged (Bhattacharjee and Rongpi, 2022, p.131; Sharma B V., 2019, pp.396-397). Herbal medicine is one of the traditional healthcare practices used by the tribes and rural people, passed down for generations through oral narrative, and they are integral to primary healthcare among the Indigenous people (Dutta and Sengupta, 2018, p.93).

India’s reliance on traditional medicine stems from several social and economic factors ingrained in its cultural landscape. Several studies highlight that traditional

medicine is favoured for its accessibility, affordability, and widespread availability within the healthcare system to the millions in the resource-constrained settings of the rural economy (Patra et al., 2023, p. 1-13; Prasad, 2022, p.826; Sahoo et al., 2023, p.699; Sonowal and Puja, 2021, p.63) Furthermore, India has rich biodiversity; wild plants are estimated at around 45,000 species, with 7,500 plants medicinally used by Indigenous healthcare practices (Vedavathy, 2002, p.25). In northeast India alone, the tribes use 1963 odd ethnomedicinal plants (Bhuyan, 2015, p. 27).

India's Northeast has the largest concentration of Indigenous ethnic identities with unique cultures, traditions, and languages. Northeast India is also a haven of biodiversity, offering immense resources in traditional knowledge and practices. It is home to more than 200 ethnic communities with a tremendous wealth of orally passed-down traditional knowledge systems as their identity (Chakraborty et al., 2012, p.145). The northeast region is home to diverse cultivable flora. The region is called “the paradise for ethnobotanists and anthropologists”, considering the immense quantity of knowledge and resources available in the comparatively small geographical region. On evaluating 470 publications in northeast India, 243 were ethnomedicinal research, highlighting the enormous body of knowledge held by the local people (Mao & Roy, 2016, pp.99-100). For example, for a disease like malaria, the tribes in the Northeast use 64 plants as a treatment (Bora et al., 2016, p.8).

Traditional medicine practice is a holistic approach to addressing physical, mental, emotional, spiritual and lifestyle anomalies that affect the individual's normal functioning. Ethnomedicine, however, has a more focused interpretation of being the study of how different communities view diseases and the steps they take to treat or prevent them.⁵¹ The Naga tribes have developed unique Indigenous knowledge and practices that enabled them to survive and prosper in rugged geographical terrain with limited access to modern

⁵¹ <https://www.merriam-webster.com/dictionary/ethnomedicine>

amenities. Traditionally, the Nagas, like the Indigenous communities elsewhere, have developed several preventive, curative, palliative and promotive medicines, procedures, and practices, along with supplementary customs and rituals. These knowledge and skills were orally passed on. There have been concerted efforts by scientists and scholars to research and document the ethnomedicinal practices among the Nagas. These studies have contributed significantly to creating a verifiable database and developing an appreciation towards the practices among the communities themselves. Some of the significant research carried out in the region that light on the rich knowledge of the Nagas on traditional herbal plants include (Lokho, 2012; Singh et al., 2015; Shimray & Lungleng, 2017; Sumi & Shohe, 2018; Temsutola et al., 2019; Ozukum et al., 2019; Konyak & Swuro, 2021; Walling et al., 2021; Vemai et al., 2022)

This chapter explores the rich tradition of healthcare knowledge and practices within the Maram tribe. It highlights their impressive knowledge base and potential to address current healthcare challenges. The chapter also discusses some readily available herbs used by the Marams for various ailments. Traditionally, Maram communities prioritise using plant-based remedies at home for any health issues. Depending on the severity and nature of the illness, they might then consult a traditional herbalist or a spiritual healer. Modern medicine is often seen as a last resort in these rural villages. Interestingly, the study suggests that people with chronic conditions may return to traditional practices for long-term management of pain, trauma, and overall well-being.

Knowledge, Attitudes and Practices of Home Remedies:

This section focuses on the capacities of the Maram community regarding home remedies, which are mainly based on locally available plants and animals. The information was gathered through one-to-one interviews with family members, group discussions, and in-depth interviews with elders. The quantitative data presented in the charts and tables is directly tabulated from the family interviews. Additional qualitative information derived

from the FGDs and in-depth interviews is included in the discussion below the charts and figures.

In rural settings, the knowledge and capacity to identify herbal plants, prepare different medicines, and use them correctly to treat undesired health conditions are of great importance. This knowledge runs in the family and is handed over through generations. The study reveals that most families who live in the villages have a fair understanding of the medicinal properties of different plants. It is found that people who know the medicinal properties of local plant species mainly developed knowledge from observation and instructions from elders in the family.

Source of Knowledge of Home Remedies

From the earlier sections, it is obvious that households are heavily dependent on traditional medicines. Every household has knowledge of the different medicinal concoctions and their perceived benefits. Figure 5.1 highlights the distribution of knowledge of home remedies among the households or respondents.

Table 5.1: Source of Knowledge

Source of knowledge	Frequency	Percentage (%)
Family elders	149	66
Friends and neighbours	37	16
Training programmes	26	12
Don't know/can't say	13	6
Total	225	100

Source: Fieldwork

It is evident from Table 5.1 that 66 per cent of the respondents' primary source of knowledge of traditional medicines is the elders in the family. People generally learn the medicinal values of different plants and animals and the concoctions they prepare from them through observation of their elders in the family. Sixteen per cent of the respondents learned most of the remedies from their neighbours, relatives or friends who came to help them during healthcare distress. It is also important to note that there have been training

programmes organized from time to time on alternate medicines by NGOs and agencies/groups in the region, where 12 per cent learned some advanced knowledge on different home-based medicines through such training. However, they do not practice as traditional healer or practitioner. Only six per cent either do not have any knowledge of home remedies or have not really thought about the different remedies they practice.

Capacity to Identify Herbal Plants

Table 5.2: Family Capacity to Identify Herbal Plants

Identification of plants	Frequency	Percentage (%)
0-2	6	2.67
3-5	43	19.11
6-8	77	34.22
9-11	77	34.22
12 & above	22	9.78
Total	225	100

Source: Fieldwork

As depicted in Table 5.2, the capacity of at least one family member of the surveyed families to identify plants and prepare different medications was also gauged. The observations suggest that more than half, 68 per cent, of the family can identify more than 6-11 herbal plants in their surroundings. This capacity greatly contributes to the use of traditional medicines in times of emergencies.

In the discussions held with the communities and family members, it was noted that very few had advanced knowledge on the preparation of different medicines, although they knew a particular plant to have medicinal value. It was also observed that most of this knowledge was handed down from the elders to the younger ones in the family. They have also learned simple medicinal preparations from the elders. A respondent said, “*I learned from my parents; they sent me to collect the plants from our garden and backyards. I also help them to dry the plants after harvesting, like Hiipi (Sweet basil), Kangainii (bitter gourd), and Kabihiila/Tamtunii (Elsholtzia Griffithii), which are used during flu,*

*fever, migraine/ headache and stomach upset.”*⁵² An elderly respondent said, “*I learn from neighbours and relatives and also from training. Plants like Aloe vera and Hibiscus are both good for gastritis.*”⁵³

Cultivation and Maintenance of Herbal Plants

Most of the herbal plants used by the community are naturally available in the surroundings, especially in the jungles nearby. It was noted during the focus group discussions that there needs to be more effort, individually or collectively, to promote organized cultivation or maintenance of the herbal plants. There were families who could identify the herbs growing around their house and some who made an effort to ensure that the plants were maintained regularly. Figure 5.3 elaborates on the responses of the families who were growing different herbal plants in their garden and using them in times of need.

Table 5.3: Families Growing Herbal Plants and Uses

Knowledge of Plants	Frequency	Percentage (%)
10-15	22	9.78
5- 9	39	17.33
1-4	123	54.67
Don't know/ can't say	41	18.22
Total	225	100

Source: Fieldwork

Table 5.3 illustrates that 82 per cent are into the practice of growing herbal plants at home and in their surroundings. They are aware of their use and regularly use them when needed. Only 18 per cent of households reported that they are not practising or are not aware of the herbs that they are growing in their gardens. It is pertinent to note that most of the plants grown around the household often naturally occur in the environment and climatic conditions of the region. The medicinal properties were gradually appreciated, and people started maintaining these plants in flower and vegetable gardens. The growing of *Apourangtiiti/Kanemti* (Cape gooseberry), *Kang-gai* (Bitter

⁵² Female, 27 yrs, respondent, Sagongbam Village

⁵³ Female, 60 yrs, respondent, Maram Centre

melon/Guard/ Karela), *Hiipi/ Mahiila* (Sweet basil) *Kavii* (Ginger), *Lungsiihii /Modina/ Takpa* (Spearmint), *Ramchi* (Taro), *Rangdigai* (Trichodesma Kumareum), *Kabihiila/Tamtunii* (Elsholtzia griffithii Hook. F.), *Ramnok* (Pleasant Himalayan Mint), *Rangkananhii* (Phlogacanthus pubinervius T.Anderson), *Karananii* (Castor plant), *Gainam* (Chives), *Saroutpot-ti* (Passion fruit), *Burakamti* (Poison berry), *Sataigobi* (Cabbage) and *Kafiiti/ kafii-rangbungti* (Pomegranate), and so on ... indicated the discernment espoused by some of the families for growing common herbs with medicinal properties.

Use of Naturally Growing Herbal Plants

In pursuance of the above findings, it was also felt relevant to look at the number of people who actually sought out herbal plants from their surroundings and jungles. Seeking out herbal plants in the open needed much more knowledge and skill than using what is available at hand. Moreover, the plant leaves would often look and smell strikingly similar. These are further explained in Table 5.4.

Table 5.4: Using Naturally Growing Plants in their Surroundings

Categories	Frequency	Percentage (%)
7-9 medicines	13	5.78
4-6 medicines	92	40.89
1-3 medicines	111	49.33
Do not know/ cannot say	9	4
Total	225	100

Source: Fieldwork

Table 5.4 shows that four per cent said that they could not identify and take the plants from the open spaces because they were not very confident about the plants. Most (96 per cent) of the respondents said at least one member in the family is capable of going out to the jungle and getting some of the herbal plants. Therefore, it can be safely said that using different plants for medicinal purposes is very prevalent among the community surveyed. The natural incidence of plant growth in inhabited areas is reducing rapidly due to the development works and plastic waste, especially in the villages along the national

highway.⁵⁴ Nowadays, plants, fruits, and flowers are largely collected from the jungles of the community for food and medicine. One of the key concerns is that only the elders in the family take the initiative to collect the plants and products from the jungle. The youth either need more time or interest in the same, especially because they are either too busy with their studies or spend most of their time on mobiles and social media, providing them very little time to explore and learn from their environment.⁵⁵ The dependence on plants available locally is reducing rapidly among the youth due to the increasing number of packaged products that are in the market claiming several medicinal properties.

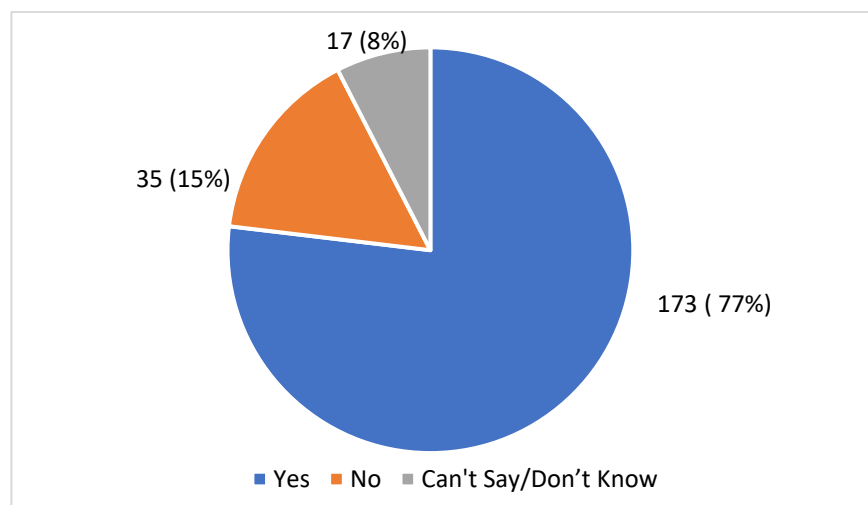
Use of Plants in Regular Diet

The Nagas, in general, are known for their extensive use of various types of plants, animals, and insects as part of their regular diet. The calorific, proteinous and medicinal value of these foods has been acknowledged and appreciated by the people locally. However, detailed scientific studies are yet to be undertaken in this regard. The researcher sought to understand the extent of use of various naturally available plants and animals by the experienced and/or perceived understanding of the medicinal properties they possessed. The respondents were asked whether they include any ingredient in their food because they know that it has medicinal properties.

⁵⁴ Women, Focus Group Discussion on 23/02/2020 at 1.30 pm, Maram Centre Village.

⁵⁵ Elders (men and women), Focus Group Discussion on 14/10/2020 at 11.50, Khullakpa Sagai Village.

Figure 5.1: Knowledge of Medicinal Values of Different Food Items



Source: Fieldwork

It is evident from figure 5.1 that the majority of the 77 per cent of the respondents reported the use of different plants or animals (especially insects) in their diet with the perception and knowledge of their medicinal properties. It is to be noted that out of the 23 per cent of the respondents who said that they are not aware about the medicinal values of the food they eat, also reported that they are regularly consuming the different food items like the others. The use of these food items is recommended during seasons, during certain health conditions or illnesses, during pregnancy and lactation, etc. People also consume several of these as part of their regular meals due to the taste and liking they have developed over the years. It has been noted that through sensitization campaigns run by the Department of Health and Family Welfare and non-governmental organizations, the public has learned a little bit about the medical benefits of many herbs and vegetables that have been used for generations. Many people took on knowledge from social media.

Skills in the Family to Prepare Home Remedies

Table 5.5: Family Knowledge in Preparing Home Remedies

Identification of plants	Frequency	Percentage (%)
0-2	9	4
3-5	34	15
6-8	66	29
9-11	73	33
12-14	43	19
Total	225	100

Source: Fieldwork

Table 5.5 details the extent of knowledge of traditional medicine preparation within the families surveyed. The families surveyed regarding the knowledge of different home remedies that they were using the locally available herbs and plant derivatives brought about the fact that 62 per cent said the family had knowledge of 6-11 herbal plants that grew around the surroundings that can be used for preparing medications for different health conditions. Respondents, with 19 per cent have knowledge of more than 12 traditional medicines for various ailments. Only 19 per cent have reported knowledge of herbal preparations for less than five health conditions or needs. The efficacy is the reason why some family uses home remedies. A respondent said, *“My family prefer to use home remedies because there are no side effects, and as long as we have the herbal plants in our backyard and gardens, we make use of them in the case of minor illness.”*⁵⁶ Another respondent stated that *“For health issues like viral fever, flu, headache and migraine, and gastritis, I treat them by taking care of my food habits and using home remedies which are effective.”*⁵⁷

⁵⁶ Female, 35 yrs, respondent, Lairoching villages

⁵⁷ Male, 70 yrs, respondent, Maram Bazar

Ailments Treated with Home Remedies in the Family:

Table 5.6: Ailments Treated with Home Remedies

Ailments	Yes	%	No	%	Total (%)
Viral fever	200	88.89	25	11.11	225 (100)
Cold and cough	207	92	18	8	225 (100)
Headaches and migraines	203	90.22	22	9.78	225 (100)
Gastrointestinal problem	177	78.67	48	21.33	225 (100)
Food poisoning	46	20.44	179	79.56	225 (100)
Cuts or bruises	211	93.78	14	6.22	225 (100)
Sprains/ muscle cramps	178	79.11	47	20.89	225 (100)
Skin problems	72	32	153	68	225 (100)
Snake or insect bites	79	35.11	146	64.89	225 (100)
Menstrual care	20	8.89	205	91.11	225 (100)
Pregnancy care	99	44	126	56	225 (100)
Delivery care	100	44.44	125	55.56	225 (100)
Care for newborn	96	42.67	129	57.33	225 (100)
Postnatal care	130	57.78	95	42.22	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

Table 5.6 presents the set of 14 ailments and healthcare needs of the family during the household interview to assess the knowledge in the family to use local medicine without the help of a practitioner. As the finding reveals, 89 per cent are treated with home remedies for ailments such as viral fever, cold and cough, migraines and headaches, cuts and bruises. It is to be noted that, on average, each family is aware of at least 6-11 medications using local plants and herbs. This indicates a formidable dependence on traditional knowledge in healthcare among the households in the Maram Tribe. It is to be noted that the families which reported limited knowledge of medicinal plants and their uses consisted of young nuclear families living in the villages along the national highway.

Ethnomedicinal Treatment Methods:

Home remedies for general ailments are used through various methods. The usage of herbal plants is categorised into three. Firstly, some of the plants are consumed as cooked/ boiled; secondly, certain plants are taken raw in the form of juice or salad; and thirdly, certain plants are used externally by applying the paste, extracting juice to apply or used during massage and warm bath.

Treatment for *Kararii* / *Mairihiim-gui* (Viral Fever):

It is commonly called *Mairihiim-gui*, which means Human flu.

The recipes and modes of use are as follows:

- a) *A handful of Hiipi/Mahiila* (Sweet basil), ginger, and three to four cloves of garlic are crushed or ground, then they are cooked along with mashed rice, chilli and salt. The soup is then consumed when it is steaming hot. If a person sweats after eating, it is a good sign to lower the body temperature.
- b) A handful of *Bura-kamn'ti* (Indian nightshade), egg yolk, and two or three spoons of honey are mixed and taken to lower the body temperature; similarly, *Bura-kamn'ti* (Indian nightshade), *Tamchii-chiiciina* (Carpet grass sp.) local/country eggs are consumed.
- c) Two to three tender and clean leaves of *Agaiti-nhii* (Cucumber) are crushed, then the extracted juice is consumed to lower the body temperature.
- d) *Apourangtiiti/Kanemti* (Cape gooseberry), a handful of leaves are crushed, and the extracted juice is consumed. Also, placing the crushed leaves on the forehead and feet lowers down the body temperature.
- e) *Bodonti / Ponding-ti* (Guava), a handful of tender leaves are crushed, then mixed with water and taken.
- f) *Kafiiti/ kafii-rangbungti* (Pomegranate), a handful of tender aerial leaves are crushed, then mixed with water and taken for sedation.
- g) *Mahingai* (roselle), a handful of leaves is crushed, then mixed with half a glass of water and drunk.
- h) *Saroutpot-ti-nii* (Passion fruit), a handful of tender leaves are crushed, and then the extracted juice is consumed to lower the body temperature. To reduce the bitterness, one may mix with half a glass of water.
- i) *Tuiniiti* (Raspberry) fruits are eaten to lower the body temperature.

The following *herbs are consumed in boiled or cooked form*:

- j) *Kang-gai* (Bitter melon/gourd/karela) involves boiling a handful of the entire plant along with a pinch of salt. Once prepared, serve it in a bowl and allow it to cool, then consume the entire amount in one sitting. Both fresh and dried leaves may be utilized. This herb is among the most commonly used by the community.
- k) *Mahamgai* (Water dropwort), a handful of tender aerial part of the plant is boiled, and both the leaves and soup are consumed.
- l) One or two tablespoons of *Siimiiti* (Wild sumac berry) fruit, boiled with a glass of water is consumed.
- m) *Tiirat-bang/Rangsai-pa* (Lantana), a handful of leaves are boiled with half a glass of water; to adults, half a glass of boiled water is given, whereas to children, only one spoon. It is given in the morning and evening for fever and cough after food.
- n) *N'chiijana* (Muskrat) is mostly given to children. The cooked meat and soup are taken to lower the body temperature.
- o) *Ma'ngati* (Prickly ash), a handful of boiled leaves is consumed. Both leaves and fruits are consumed to treat fever, common flu, cold and cough, toothache, and throat problems; seeds are used in tea and eaten along with meals to control blood pressure (BP).
- p) *Rangkananhii* (*Phlogacanthus pubinervius* T.Anderson), *Karananhii* (Castor plant) brought to boil in water with some salt and a hot water massage is given to relieve pain.
- q) The leaves of *Apoukihiipa* (Thickhead weed) are crushed and two to three drops of the juice are applied on the forehead to aid reduce body temperature and gives relief.

Treatment for *N'kiira* (Cold and Cough)

Similar to viral fever, it is called *Mairihiim-gui*, which means human flu.

The following are the traditional treatment methods:

- a) A handful of *Hiipi/Mahiila* (Sweet basil), ginger, and three to four cloves of garlic, salt and chilli are cooked with mashed rice. The hot soup is taken to relieve cold and cough.
- b) A handful of *Bura-kamn'ti* (Indian nightshade), egg yolk, and two or three spoons of honey are mixed and taken to control the cold and cough.
- c) A handful of *Bura-kamn'ti* (Indian nightshade) and *Tamchii-chiiciina* (Carpet grass sp.) are crushed and then mixed with local egg is taken to control cough.
- d) *Masok* (Turmeric) mixed with *Kabihiila/Tamtunii* (*Elsholtzia griffithii* Hook. F), ginger and a spoon of honey are blended, then mixed with half a glass of water and consumed.
- e) A handful of *Tiimpai-permit* (Wormwort) extracted juice from the leaves is mixed with a glass of water and drank to relieve cough and cold.
- f) *Gainam-namna/ namching* (Chinese chives / garlic chives) salad is eaten; it helps to clear the runny nose and sore throat and helps relieve cough and cold.
- g) Water collected from the bamboo stems is drunk to relieve colds and coughs.
- h) *Rangkananhii* (*Phlogacanthus pubinervius* T.Anderson) the aerial part of the plant and tender leaves are boiled and used for warm bath massage.
- i) *Kalaolao-nati* (Indian gooseberry) is eaten for digestion and to relieve colds and coughs.
- j) *N'kuna Kouziiunii* (Skink) is eaten either raw/roasted to treat the cough.
- k) *N'chijana* (Muskrat) meat and soup are taken for cold and cough. It is commonly used for children's overall health care.
- l) *Siihe* (Porcupine) bitter intestine meat and soup are taken with a meal and soup to treat cold and cough.
- m) *Masii Kagang* (Red earthworm) usually found in wetlands and banana stems, is consumed either raw or boiled to treat cold and cough.
- n) Mustard oil and garlic are roasted, and then the warm oil is applied to the throat and chest to control the cough.

- o) *Rangkananhii* (*Phlogacanthus pubinervius* T.Anderson): A handful of leaves, are used for steaming to relieve cough and cold. The same is done with the *Ramnok* (pleasant Himalayan mint).

Treatment for *Apsyi-tii/ Masaigoi/Pasaigoi* (Headaches/ Migraines)

The following are the treatment methods:

- a) *Kabihiila/Tamtunii* (*Elsholtzia griffithii* Hook. F) and *Kavii* (Ginger) *salad* are eaten for a relief from headaches.
- b) *Siimiiti* (Wild sumac berry) tea boosts energy and helps relieve headaches.
- c) *Lungsiihii /Modina/ Takpa* (*Spearmint*) is chewed raw or taken with meals to relieve headaches.
- d) *Ramnok* (Pleasant Himalayan mint) is chewed raw to relieve headaches and migraines.
- e) *Gainam-namna/ Gainam-namching* (Chives) is eaten as a salad to relieve headache and migraine.

The following *herbs are consumed boiled or cooked*:

- f) *Hiipi/ Mahiila* (Sweet basil) soup or porridge is commonly taken for headache and migraine.
- g) *Kabihiila/Tamtunii* (*Elsholtzia griffithii* Hook. F) soup is taken for relief.
- h) *Kang-gai* (Bitter melon/gourd/ karela) leaves or whole plants, either fresh or dried, are boiled, and the warm soup is consumed to relieve headache.

Treatment for *Amoi-Katii* (Stomach Aches), *Amoi Tingkai-Lai* (Bloating), *N'gana-Karai* (Dysentery), *Mazii* (Diarrhoea and Loose Motion):

The following are the ingredients consumed raw:

- a) *Tiimpai* (Mugwort): A handful of tender leaves are crushed, and extract juice is taken; for children, one spoon and two spoons for adults are given to control dysentery.

- b) *Tiimpai-paimii* (Wormwood): A handful of tender leaves are crushed, and then the extracted juice is given to relieve stomach pain.
- c) *Japanhiinii* (Crofton weed): A handful of clean leaves are crushed, and then the extracted juice is taken to treat stomach pain, which is especially effective for dysentery.
- d) *Tiilemti* (Autumn olive) fruit is eaten to control dysentery and relieve stomach aches.
- e) *Apoukihiipa* (Thickhead weed): A handful of aerial leaves are boiled and eaten for stomach aches and bloatings.
- f) *Bodonti / Ponding-ti* (Guava): A handful of the aerial part of the plant and tender leaves and fruits are consumed for dysentery, diarrhoea and loose motion.
- g) *Kafiti/ kafii-rangbungti* (Pomegranate), both tender leaf and fruit, effectively treat dysentery.
- h) *Ka-naati* (palm): A handful of fruit is crushed, and the juice is consumed to control diarrhoea.
- i) *Ramnok* (Pleasant Himalayan mint): A hand full of leaves are crushed, and the juice treats stomach aches and bloating.
- j) *Lungsiihii /Modina/ Takpa* (Spearmint) is eaten raw for any stomach aches and gastric. It is used as an anti-parasitic intestinal worm/tapeworm for children.
- k) *A piece of charcoal is added* to lukewarm water and drank to reduce the burning sensation in the stomach, especially after consuming chilli.

The following *herbs are consumed as boiled or cooked*:

- l) *Cocraigai/Kuraigai* (Indian pennywort), the whole plant is boiled, and the soup is consumed to treat constipation, stomach problems and high blood pressure. It is also used as a purgative and sedative.
- m) *Gailugainii* (Stingvine), the aerial tender shoot is cooked as porridge and used to treat stomach disorders, piles, and dysentery.

- n) N'Dang-gai-(Knotweed), the aerial shoots and tender leaves are cooked and consumed with a meal, and the rhizomes are eaten raw. It treats stomach and gastritis problems. It is good for diabetes.
- o) *Saramarati* (Horse gram), the soup and grams are taken to treat dysentery and diarrhoea.
- p) *Saroutpot-tinii* (*Passion fruit*): *A handful of tender leaves and aerial shoots are crushed, then the juice is drunk to control loose motion and dysentery.* It is also cooked and eaten for stomach problems and gastric.
- q) *Kalaolao-nati* (Indian gooseberry/ amla), the fruit is eaten raw or taken in the form of tea for digestion, and cold, the root is boiled and drank to control diarrhoea.
- r) *Siimiiti* (Wild sumac berry): A handful of sumacs, is boiled with a cup of water and then drunk for any stomach discomfort, ache, bloating, loose motion, dysentery and diarrhoea.
- s) *Rangdigai* (*Trichodesma khasianum* C.B. Clarke), is cooked and eaten with meals. The leaves and soup are effective for loose motion, dysentery, diarrhoea, piles and constipation problems.
- t) *Mahingai* (Roselle): A handful of leaves is boiled with a glass of water and drunk to treat stomach upset.
- u) *Kang-gai* (Bitter melon/guard/ karela): A handful of the whole plant is boiled, and a pinch of salt is added and then drank for stomach aches and bloating.
- v) *Ramchi* (Indo-Malayan taro), the tuber, is cooked and taken for any stomach problems.
- w) *Hiipi/ Mahiila* (Sweet basil) is boiled, and then the soup is drunk for stomach aches and bloating.
- x) *Tingkhuinii* (*Gynura nepalensis*) is used for better digestion and gastritis problems. The aerial shoot is cooked and consumed along with the meal.
- y) *N'Kakunanii* (*Buddleja asiatic*): It is used for body aches and diabetes; a handful of aerial shoots and leaves are boiled and consumed.

- z) *N'chijana* (Muskrat): The cooked meat and soup are used to treat dysentery in children.
- aa) For other stomach aches and bloating, kerosene is applied to the stomach, and a pinch of tobacco (*kaini*) is placed on the naval button it helps to reduce stomach aches and bloating.

Treatment for *Amatiikama* (Food Poisoning):

The following items are used as anti-poison to treat food poisoning, any food allergy and wrong medicine consumed.

- a) A tablespoon of salt and sugar is mixed into the water and drank to vomit it out.
- b) Ginger is used in curry, especially wild mushrooms, as an anti-poison. Raw ginger is eaten as well.
- c) Raw maize or corn is eaten as an anti-poison for food poisoning; if the wrong medicine is taken, it is believed to absorb the medicine's effect.
- d) Popcorn, lemon, and ginger are also taken as remedies.
- e) The leaves of *Bodonti* / *Ponding-ti* (Guava), *Lungsiihii* / *Modina* / *Takpa* (Mint), and *Kafii-Rangbounhti* (Pomegranate) with local/country egg are also eaten.
- f) Honey and ginger mixed with warm water is taken.
- g) Boil one or two tablespoons of *Samiiti* (Wild sumac berry) with half a glass of water and then drink.
- h) Papaya leaves boiled water is taken.
- i) *Taksiinii* (fiddlehead fern) is cooked and consumed.

Treatment for *Rijam-Kapung* (Cuts, Bruises, Wounds):

To control bleeding from cuts and bruises. The following plants are used to control the bleeding, quickly heal, and prevent infection.

- a) *Japanhii* (Crofton weed): A handful of leaves are crushed, then a few drops of extracted juice are applied to the wounded area to control bleeding, then the wounds are covered with crushed leaves to avoid infection.

- b) *Apoukihiipa* (Thickhead weed): A handful of leaves are crushed, and extracted juice of a few drops is applied to control bleeding and for fast healing of wounds.
- c) *Saliimhii* (False daisy): A handful of aerial parts are crushed and pasted on the wounded area to control bleeding and for fast healing of wounds.
- d) *Cocraigai/Kuraigai*- (Indian pennywort): A handful of leaves are either chewed or crushed, then placed on the wounded area to control bleeding.
- e) *N'tingnanhii/pidounii* (*Bidens pilosa* leaves): A handful of leaves are crushed, and then the juice is extracted to the wounded area to control bleeding.
- f) *Tiimpai-paimii* (Wormwood): A handful of leaves, is crushed and then inserted in the nose to block and control bleeding.
- g) *Sung-gai* (Thatch grass): A handful of leaves are crushed and then placed on the wounded area to control bleeding.
- h) A piece of cabbage leaf is crushed and applied to the wounded area to control bleeding and for quick healing.
- i) *Ramnok* (Pleasant Himalayan mint): A handful of leaves are crushed and applied on the wounded area to control bleeding and for quick healing.
- j) A sticky gum from the pink orchid rhizome is applied to control bleeding and fast healing of the wounds.
- k) Tree moss is placed on the wounded area to control the bleeding.
- l) *Katbakhii* (Prickly chaff): A handful of leaves are crushed and then applied to the cuts and bruises to control bleeding from injuries and quick healing.
- a) *Lamsalaima/ Ramsalai* (*Chameleon plant/fish mint*): The leaves are crushed and applied on cuts and wounds for speedy healing.
- b) *Kungsanghii* (Quick weed): A handful of leaves are crushed, and then the paste is applied to the wounded area.
- c) *Gainam-namna* (Chives): A handful of leaves are heated on the fire, then crushed and pasted on the wounded area for fast healing and recovery.

For quick healing of wounds:

- d) *Nakung* (Water snail) curry and *Agouna* (frog) soup are consumed to heal wounds quickly.
- e) In some wounds, leeches are placed to suck out the blood clots and heal quicker.
- f) Boil salt and king chilli, and let the water get into the wounds. Though it has a strong burning sensation, it is the fastest mode of healing wounds.

Treatment for *Aroupat* (Bone Dislocation), *Kaniit* (Sprains), *Agangmalai* & *Atiitak* (Muscle Cramps or Dislocation), *Agang beak* (Fixing or Body Massage):

- a) *Abaringnii/ N'nampunaring* (Skunk/stink vine) is boiled in water and given a warm bath massage. It is commonly used for people with paralysis. The leaves are heated on fire, crushed, and pasted on the painful area.
- b) *Karananii* (Castor) is boiled in water. A hot bath massage relieves pain. The leaves are heated on the fire, crushed, and pasted on the sore area.
- c) *Rangkananii* (*Phlogacanthus pubinervius* T.Anderson) are boiled in water, and the leaves are used to massage the pain area. A whole-body massage is also given to reduce the pain.
- d) *Rakuitak* (Angel's trumpet) leaves are soaked in hot water, and then a warm bath massage is performed on the injured area. The leaves are heated on the fire, crushed, and pasted on the pain area.
- e) *Cocraigai/Kuraigai* (Indian pennywort), the whole plant is boiled, and a warm bath massage is given to reduce the pain.
- f) Sweet potato leaves are boiled, and a warm bath massage is given to reduce the pain.
- g) *Ramnok* (Pleasant Himalayan mint) leaves are added to the boiled water, and a warm bath massage reduces the pain. The fresh leaves are crushed and massaged in the pain area.
- h) *Saliimhii* (False daisy), the leaves are crushed and massaged on the area.
- i) *Rangdigainii* (*Trichodesma khasianum* C.B. Clarke) leaves are boiled, and a warm bath massage is given.

To reduce the swelling, bone fractures and sprains:

- j) The bone marrow (*Kalung king*) of *Kalung* (Stag/antelope) is mixed with salt, then applied and massaged to reduce swelling.
- k) *Karananhii* (Castor leaves) rice and charcoal are mixed and then pasted on the injured area.
- l) Termite soil and *Piitak-gainhii* (Broadleaf plantain) are mixed, pasted, and bandaged with cloths.
- m) *Masok* (Turmeric) and *Abai* (rice) are mixed, and then the paste is applied and bandaged with a cloth.
- n) In some cases, the blood clots in the swollen area are treated with *Kalung-ka siikung* (stag horn), wrapped the stag horn with *Koitiinii* (Indian tobacco leaf) on the tip of the horn to suck out the blood clot and pus.
- o) Swollen ankles are treated by letting out the blood clot by pricking a broken glass on the swollen ankle.

Treatment for *Staira/ Tijera* (Skin Ailment) and *Atakra* (Skin Allergy):

For scabies and skin rashes, the following home remedies are used:

- a) *Peseri* (Garlic) paste is applied to the affected area.
- b) *Masok* (Turmeric) paste is applied to the affected area.
- a) *Kavii* (Ginger) is chewed, and then the paste is applied to treat scabies, skin rashes, and allergies.
- c) A handful of ganja leaves are crushed and applied to the affected area.
- d) *Ramnok* (Pleasant Himalayan mint): A handful of leaves are crushed and applied to the affected area.
- e) *N'chiikum* (Culantro/ sawtooth), a handful of leaves and roots are crushed and applied to the affected area.
- f) *Japankihinii* (Crofton weed): A handful of leaves are crushed, and the extracted juice is applied to the affected area.

- g) *Tiimpai* (Mugwort): A handful of leaves are crushed, and the extracted juice is applied to the affected area.
- h) *Cocraigai/Kuraigai* (Indian pennywort): A handful of the whole plant is chewed and then applied to the affected area.
- i) *Bura-kamti* (Indian nightshade): A handful of fruits are crushed and applied to the affected area.
- j) *Rakuitat* (Angel's trumpet): A handful of leaves are crushed, and the extracted juice is applied to the affected area.
- k) *Koitiinii* (Indian tobacco leaves) two or three pieces of leaves are heated over the fire, then crushed and applied to the area.
- l) *Kabihiila/ Tamtunii (Elsholtzia griffithii* Hook. F.): A handful of aerial parts of the plant are crushed and then applied to the area.
- m) *Siiramgaiti-nii/ Kataime-gaitinhii* (Creeping woodsorrel): A handful of the whole plant is crushed, and the extracted juice is applied to the affected area.
- n) Sugar cane juice is applied to the affected area. It is commonly used during winter for dry skin and to treat cracked skin.
- o) *Agaiti* (Cucumber), the leaves are crushed and then applied to treat skin rashes, scabies, and allergies.
- p) *Neemnii* (Neem leaves): A handful of leaves are crushed, and then the paste is applied to the affected area.
- b) Foams of fresh firewood are applied to the affected area. Also, warm ash powder from the hearth is used to treat skin allergies.
- q) A fresh crab is made into a paste and then applied to the affected area.
- r) The muskrat's fur is burned, and the ashes are applied to the affected area.
- s) Bear fat is also applied to the affected area.
- t) *Chiiraquinii* (herbs) is crushed, and the juice is extracted and applied to the *Tijii riitat* (Ringworm) infected area.
- u) *Katbakihi* (Prickly chaff): A handful of leaves is crushed, and then the extracted juice is applied to the ringworm and blisters on the skin affected area.

- v) *Tiiti/Tiiti- tiiranii* (King chilli) is boiled in water, and then a few drops of pungent water are applied to the ringworm-affected area.
- w) For skin allergy, maize/corn is eaten raw to control the allergy.
- x) Potato and salt paste is applied to the allergy area.
- y) *Rangtamrii* (Water pepper): A handful of leaves are crushed, and the extracted juice is applied to the affected area.
- z) *Salamhii* (False daisy): A handful of leaves are crushed, and the extracted juice is applied to the allergic area.
- aa) *Gainam-namna/ Gainam-namching* (Chives): A handful of leaves are heated on the fire, then crushed, and applied to the allergic area.
- bb) *Agouna* (Frog) frog skin is placed on the wound to quickly dry and avoid infection.
- cc) *Samararati* (Horse gram) is cooked and then consumed to treat chickenpox. The soup of the horse gram is taken very generously.
- dd) *Satai-gopi* (Cabbage) green leaf paste treats pimples.
- ee) *Kudanii* (Wart) on feet and hands are treated by tying a piece of long hair to the main/ mother wart until it gets cut off.
- ff) *Miruhii* (Jatrupa), the white liquid from the tree, is tapped and applied to the burnt area.
- gg) *Salok* (Flying squirrel), the fur is burned, and the ash is applied to the area.
- hh) *Sanii* (Snake) fats are applied to the burned area.

Treatment for *Süniina-kamashou* (Snake Bites) and *Akounanii-maki* (Insect Bites):

- a) *Masii kagang* (Red earthworm) are collected from banana stems, and wetlands are crushed, then the paste is applied to the infected area. It is also consumed raw or soup as it is effective for anti-venom and anti-infection.
- b) *Gainam - namrang* (Scorpion) is crushed and applied on the bitten area; it is anti-venom.
- c) A handful of leaves is crushed in *Katbakihi* (Prickly chaff), and the extracted juice is applied to the insect-bitten area.

- d) *Tingkuinii* or *Kavii* (Ginger) are crushed and applied to the affected area.
- e) *Gainam-namna* / *Gainam-namching* (Chives) warm up and place on the area.
- f) *Samiiti* (Wild sumac berry) of one or two tablespoons is boiled with a glass of water, and then the water is taken.
- g) *Rakuitat* (Angel's trumpet): A handful of leaves are crushed and applied to the bitten area to avoid infection.
- h) *Mahingai* (Roselle): A handful of leaves is boiled and consumed as anti-poison.
- i) Treatment for *Akiiu-nii-karou* (Bee sting), *Tiiti* (King chilli) is applied on the stung area as a painkiller, and yum is applied to avoid swelling and prevent further complications.
- j) To treat moth and caterpillar allergies, salt and saliva are mixed to avoid the intensity of allergy. *Sung-ngai* (Thatch grass) or hair is used to remove the fur of the caterpillar.

Treatment for *Aka-rou-pai* (a Fishbone Stuck in the Throat):

When a fish bone gets stuck in the throat, *Madaipa* (Rhododendron) dried flower is *arii* (most effective) in removing the fishbone. The petals are boiled in water and then drank to flush down the fishbone. Even the leaves are used as an alternative to flower petals.

Treatment for *Amaek-katii* (Any Eye Pain):

- a) Water extracted from *Nakung* (Water snail) is used for eye pain. It is effective, especially for conjunctivitis, eye stye and red eye infections.
- b) The perennial herb *Gainam-namna/Gainam-namching* (Chives) is eaten to treat eye pain.

Treatment for Sinuses:

- a) *N'tingnanhii/Pidounii/Pokjounhii* (Spanish needle), a handful of leaves are used for steaming to treat sinus.

- b) *Taksiinii*- (Fiddlehead fern): A handful of ferns are used to treat sinuses by steaming.

Treatment for *Katang-kama* (Mumps):

To treat mumps, a type of sticky rice called *Makirii* is made into a paste and applied to the swollen jaw area to absorb and reduce swelling. Also, the leaves of *N'Kamranok* and ashes of sack burn are made into a paste and applied to treat.

Treatment for *Ajai-pung/ Ajaitat/Amapung* (Menstrual Problems):

- a) *Gainam-namna* (Chives) salad is consumed for proper blood flow.
- b) *Mahamgainii* (Water dropwort), a handful of whole plants is cooked and consumed for proper blood flow.
- c) *Tiimpai-paimii* (Wormwood): A handful of leaves are crushed and then the extracted juice is mixed with half a glass of water and taken to relieve from cramps.

Pregnancy Care:

Table 5.7: Beneficial Food during Pregnancy

Vernacular Name	Common Name	Usage and Purpose
<i>Bodonti</i>	Guava	It is used for relief from constipation and morning sickness during pregnancy.
<i>Gumblati</i>	Orange	It helps to keep pregnant women's foetal skin healthy.
<i>Kafiiti</i>	Pomegranate	The fruit is beneficial for relief from morning sickness and the baby's health.
<i>Kalaolaonati</i>	Gooseberry	It is eaten to help relieve morning sickness.
<i>Kaloulounati</i>	<i>Amla</i>	Consumption of fruit is found to be helpful to control morning sickness.
<i>N'jang-gai</i>	Mustard leaves	Consuming boiled leaves during pregnancy is considered suitable for the foetus's health.
<i>Sataigobi</i>	Cabbage	It is considered as beneficial for the overall health of the foetus.
<i>Siimati</i>	Pumpkin	Curry is made, and seeds are consumed for a healthy baby.
<i>Tiiti</i>	<i>Chilli</i>	It is considered to be one of the easy remedies for morning sickness. It is consumed in various ways.
<i>Tumpoiti</i>	Chayote squash	Consumption of the fruit and the leaves during pregnancy is considered beneficial in ensuring the foetus's health.

Source: Fieldwork

Table 5.7 details the medicinal plants and fruits, vegetable and leafy vegetables used during the pregnancy. During the households' survey and FGDs, it is observed that women, were more aware and knowledgeable about various kinds of plants and uses that helps during pregnancy care.

Delivery Care:

Table 5.8: Traditional Plants Used in the Delivery Process

Vernacular Name	Common Name	Usage and Purpose
<i>Abgiina</i>	Yam	Consumption of yam on the due date on the belief that slippery curry would make delivery faster.
<i>N'gi-lalati/Benty</i>	Ladies finger/okra	This curry is fed to the women in labour, believing that the slippery curry would aid delivery.
<i>Hiipi</i>	Sweet basil	Porridge is made and served to the women in labour to facilitate an easy delivery.
<i>Kadet-ti</i>	Fig fruit	The fruit is eaten as an energy-giving food during delivery.
<i>Plirang/Ranhiidui</i>	-	The bark is crushed, and the slippery form is extracted and mixed with water for easy delivery.
<i>Tiimpai paimii</i>	Wormwood	A handful of leaves are soaked in warm water and consumed to help speed delivery.

Source: Fieldwork

Table 5.8 outlines various plants that can facilitate a smoother delivery process. The details highlighted how these plants can enhance energy levels to promote quicker delivery. The perceptions of these plants and their uses are closely associated with their specific characteristics; notably, many of the plants exhibit a slippery texture. Moreover, the effectiveness of these plants can be examined along with the of psychosocial support, belief systems, and community involvement, all of which play a significant role in assisting the mother during the birthing process.

Neonatal Care:

Table 5.9: Herbal Plants Used During Neonatal Care

Vernacular Name	Common Name	Usage and Purpose
<i>Gumjyi</i>	Banana stem	Using the stem in food is considered beneficial for blood purification and the healthy skin of the infant.
<i>Mahamgai</i>	Water dropwort	Consumption of the plant with food is considered helpful in reducing cramps.
<i>Karananii</i>	<i>Castor plant</i>	The neonatal mother is bathed with water boiled with leaves to reduce body aches and cramps.
<i>Ramnok</i>	<i>Pleasant himalayan mint</i>	Bathing with the water boiled with the leaves helps reduce gas formation in the stomach after delivery.
<i>Rangkananii</i>	<i>Phlogacanthus pubinervius</i>	The plant leaves are used with a warm water bath to ease body aches and cramps.
<i>Neemnii</i>	Neem leave	The neem leaves are also used with hot baths to reduce pain and cramps.
<i>Tokligainii</i>	Plant endangered in the study area	Herbal Leaves are also used with hot baths to reduce pain and cramps.
<i>Kadigainii</i>	Plant endangered in the study area	To reduce pain and cramps, these herbal leaves are also used with hot baths.

Source: Fieldwork

Tabel 5.9 lists the plants that are used in neonatal continuous care to make sure the infant and mother healthy. The women report that, setting the sight on the baby after birth, all the pain are forgotten; however, the cramps and ache lingers, therefore consuming certain plants and taking a warm bath with the herbal plants help to reduce and relief the cramp and ache in the body.

Post-Natal Care:

Table 5.10: Herbal Plants Beneficial for Post-Natal Care

Vernacular Name	Common Name	Usage and Purpose
<i>Agaitinii</i>	Cucumber	The leaves are pasted on the mother's nipple to aid in the easy suckling of the milk.
<i>Cocraigai / Kuraigai</i>	Indian pennywort	Consuming the plant through salads or curry is beneficial in increasing the quantity of milk.
<i>Gainam</i>	Chives	It is eaten as salad and chutney to increase the quantity of milk.
<i>N'bu</i>	Stinging nettle	Consumed as porridge to increase the quality and quantity of milk.
<i>Ramchi</i>	Taro	Consumed as curry, soup or salad to enhance the quality of milk.
<i>Rangdigai</i>	<i>Phlogacanthus pubi nervius</i> T.Anderson	Consumed along with the daily food as curry or porridge for quality and quantity milk.
<i>Saramarati</i>	Horse gram	The soup is considered beneficial for the quality and quantity of milk.
<i>Sataigobi</i>	Cabbage	Various dishes are consumed to increase the quantity of milk.
<i>Siiron-n'ti</i>	Sweet potato	They are roasted in a fire and eaten as a snack to increase the quality and quantity of milk.

Source: Fieldwork

Table 5.10, the detail various plants used during post-natal care of the mother, especially for the lactating mothers for increase in the quantity and quality of the milk. These leaves and vegetables are used in soup, porridge, curry and salads. Also, they are eaten as snacks and during meals.

Common Herbal Plants and Their Uses:

The common medicinal plants used by Maram Nagas for more than two ailments and socio-cultural relations are described along with their properties and uses. Parallels are made with other communities to establish the universality of the medicinal values of the plants and derivatives for treating different ailments and health conditions. On the names of each of the medicinal in the local dialect, it is organized so that the person with knowledge of the language will easily be able to identify the medicinal plants by just hearing/reading the name. In Maram, *Ahii* means medicine; *a* substance for treatment of diseases or injury; a medicine. It can be in the form of plants, leaves or paste. In Maram parlance, all the names of plants with the suffix *hii* indicates that they have some medicinal properties.

***Abaringnii/N'gampuinar* - Skunkvine or Stinkvine**

Photo plate 5.1: *Abaringnii/N'gampuinar* (Skunkvine or Stinkvine)

Parts used: Leaves

Uses of the plant: The perennial herb vine is found in the open place. Used for cuts and bruises, the leaves are crushed and applied to the wounded area as antiseptic. It is used for joint pain and paralysis by giving a warm bath massage.



Source: Fieldwork

***Agaitii-nii* - Cucumber:**

Photo plate 5.2: *Agaitii-nii* (Cucumber)

Parts used: Leaves and fruit

Uses of the plant: The annual plant is grown in the gardens. The fruit is used for skin problems; a sliced piece is placed on the burn for coolant, and juice is applied to the pimples. It is eaten to treat liver and kidney problems. A handful of leaves are made into juice and drunk to treat dysentery and fever. It is used by first-time lactating mothers to let out the milk; the leaves paste is applied on the nipple. Once it dries, it is pulled out to suck out the breastmilk.



Source: Fieldwork

Apoukihiipa – Thickhead Weed:

Photo plate 5.3: *Apoukihiipa* (Thickhead weed)

Parts used: Leaves and aerial shoots

Uses of the plant: The annual herb grows in open places. It is a traditional culinary herb and has been found to have properties to control ailments like diabetes, jaundice, piles, common flu, fever, stomach problems, etc. A handful of aerial leaves cooked and consumed the leaves and the soup. A handful of leaves are crushed, and then two to three drops are applied on the forehead to reduce the body temperature. The herb is used to control bleeding of cuts, bruises, and wounds and is also an antiseptic.



Source: Fieldwork

Apourangtiiti/Kanemti – Cape Gooseberry:

Photo plate 5.4: *Apourangtiiti/Kanemti* (Cape gooseberry)

Parts used: Leaves and fruits

Use of the plant: The perennial herbaceous plant is grown in the backyard and open spaces. The Maram people use it to treat fever; a handful of leaves is squeezed into juice and consumed, and a handful of bundles of leaves is patted on the forehead, soles of the feet, and palms to reduce temperature. The leaves and fruit are consumed for diarrhoea, dysentery, and upset stomach.



Source: Fieldwork

Bodonti / Ponding-ti – Guava:

Photo plate 5.5: *Bodonti / Ponding-ti* (Guava)

Parts used: Leaves and fruits

Uses of the plant: The perennial plant is planted in the gardens and around the house. The leaves and fruit are used to treat fever, diarrhoea and stomach problems. A handful of leaves is crushed, and juice of two to three spoons is extracted. The fruit is also eaten for better digestion. The fruit is eaten by pregnant women to help relieve morning sickness.



Source: Fieldwork

Bura-kamn'ti – Indian Nightshade:

Photo plate 5.6: *Bura-kamn'ti* (Indian nightshade)

Parts used: Fruits

Uses of the plant: The perennial plant is one of the traditional culinary herbs in Maram cuisine. The fruit is crushed, then added to water and orally taken, or cooked as porridge for treating fever, cough and cold, dropsy, headache and migraine, and blood pressure for sedation. The fruit is dried, so it does not run empty in the kitchen.



Source: Fieldwork

Cocraigai /Kuraigai – Indian Pennywort:

Photo plate 5.7: *Cocraigai /Kuraigai* (Indian pennywort)

Parts used: Leaves and whole plant

Uses of the plant: The perennial Indian pennywort is a small creeper herb with shovel-shaped leaves in clusters. It is both cultivated and found in the open field. The leaves are often used to stop bleeding from cuts and bruises while working on the farm. It is also beneficial to stop bleeding due to the sucking of leeches. Raw leaves are crushed and placed on the affected region to arrest bleeding. The whole plant is boiled, and the soup is consumed to cure constipation, stomach problems and blood pressure. Consuming the plant through salads or curry is considered beneficial in increasing the quantity of milk. It is also used as a purgative and sedative.



Source: Fieldwork

Gainam-Namching / Gainam-Namna - Chives:

Photo plate 5.8: *Gainam-Namching / Gainam-Namna* (Chives)

Parts used: Whole plant

Uses of the Plant: The perennial aromatic plant is abundantly grown during summer in the kitchen garden, and the culinary herbaceous plant is eaten boiled, raw, and fermented. The herb treats various ailments such as colds and coughs, headaches and migraines, eye pain, body aches,



digestion problems, stomach discomforts, menstrual cramps and gastric. Roast a handful of leaves, crush them, and place them on the wounded area. It is also highly recommended for lactating mothers for quantity milk; it is also used for skin problems and snake/insect bites; the leaves are warmed up in the fire, then crushed and applied on the skin problem and bitten area to reduce the swelling used as a purgative. The aromatic scent herb is commonly eaten as a salad for snacks, eaten along with rice, porridge, tea or brewed rice beer by different stages of age groups, from young children to adults during leisure time as snacks, especially on Sundays. Maram is famous for the *Gainam* salad, especially among students from different states who learn the salivate salad.

Source: Fieldwork

Gumjyi – Banana:

Photo plate 5.9: *Gumjyi* (Banana)

Parts used: Stem and fruits

Uses of the plant: The perennial plants are grown in gardens. It is a traditional culinary. It is used for stomach problems, kidney stones, diarrhoea, and snake bites. The rhizome is cooked and eaten along with the meal for stomach and diarrhoea problems. The juice squeezed out from the stem is drank to treat kidney stones. The rhizome is placed on the bitten area to suck the venom. Using the stem in food is considered beneficial for blood purification and the healthy skin of the infant.



Source: Fieldwork

Hiipi/Mahila – Sweet Basil:

Photo plate 5.10: *Hiipi/Mahiila* (Sweet basil)

Parts used: Whole plant, aerial shoots and flower

Uses of the plant: This aromatic annual herb is commonly found in the Maram Naga inhabited areas and is grown along with vegetables. *Hiipi* or basil is dried under the sun soon after the harvest; the dried leaves are hung over in the corner of the traditional kitchen or packed in banana leaves and kept over the hearth. *Hiipi* is used as a ritualistic herb to ward off evil; the dried *Hiipi* is burned and placed at the house's main door to ward off evil. Fresh or dried leaves are used as cuisine, cooked with rice as porridge. It is an analgesic for fever, colds, coughs, migraines and headaches and a purgative for bloating and abdominal pain. It boasts energy and is served to the women in labour to facilitate an easy delivery.



Source: Fieldwork

Japanhiinii - Crofton Weed:

Photo plate 5.11: *Japanhiinii* (Crofton weed)

Parts used: Leaves

Uses of the plant: *Japanhiinii* means Japanese medicinal leave. The perennial herb is found in open places and is commonly used for cuts, wounds, and insect bites to stop bleeding from cuts, bruises and skin problems. As an antiseptic, the leaves are crushed along with saliva, and then extracted juice drops are pasted on the wounded area. Tender leaf juice is eaten for stomach disorders and blood pressure (BP) for sedatives.



Source: Fieldwork

Kabihiila/Tamtunii – Elsholtzia griffithii Hook. F:

Photo plate 5.12: *Kabihiila/Tamtunii (Elsholtzia griffithii Hook. F)*

Parts used: Leaves and flower

Uses of the plant: The aromatic annual herb grown in the kitchen garden. A handful of fresh or dried leaves and flowers are used for cough, sore throat, tonsils, migraine, and headache. Fresh leaves are eaten either raw or cooked. Leaf and ginger boiled in water are used for cough and sore throat. Fresh or dried leaves and flowers are also consumed as a salad for sedation of migraine and headaches.



Source: Fieldwork

Kafiti/ Kafii-Rangbungti – Pomegranate:

Photo plate 5.13: *Kafiti/ Kafii-Rangbungti (Pomegranate)*

Parts used: Leaves and fruits

Uses of the plant: The shrub/tree literal meaning of the name *Kafiti ti/ kafii-rangbungti* counting fruit/ counting box fruit. Traditionally grown in the field, it is grown in their kitchen garden and compound. The fruit and leaves are eaten to lower fever and control dysentery, diarrhoea, vomits. A handful of tender aerial leaves are crushed, mixed with water and taken for sedation. The herbal leaf is used as brew tea for any stomach upsets as a purgative.



Source: Fieldwork

Kalaolao-nati – Gooseberry:

Photo plate 5.14: *Kalaolao-nati* (Gooseberry)

Part used: Fruits, twigs and roots

Uses of the plant: The shrub/tree is found in the jungle and around the house's compound. The fruit is eaten raw for digestion, cold and cough. The root is boiled and drunk to control diarrhoea. Pregnant women commonly eat the fruit to help with morning sickness. A small twig is used to clean the teeth as a toothbrush.



Source: Fieldwork

Kang-gai/Kang-gai-ti – Bitter Melon/Bitter Gourd:

Photo plate 5.15: *Kang-gai/Kang-gai-ti* (Bitter melon/Bitter gourd)

Parts used: Whole plant, leaves and fruits.

Uses of the plant: The annual climber herb is cultivated in fields and kitchen gardens. The Marams used the plant's leaves and seeds as a vegetable and herb in cooking. Climber plant leaves are kept after being sun-dried. *Kang-gai* leaves treat bodily aches, fever, cold and cough, migraine and headache, and blood pressure. A handful of fresh or dried leaves are boiled and consumed with salt as a treatment. Farmers would use the climber herb daily as a tonic and energy drink before bed and when leaving for work on the farm.



Source: Fieldwork

Karananii – Castor Plant:

Photo plate 5.16 *Karananii* (Castor plant)

Parts used: Leaves

Uses of the plant: The shrub can be found both in open areas and in cultivation. The herb is used in postpartum treatment for mothers and their children. After birth, the mother receives a warm bath and massage in water heated by boiling four to five leaves. Boiling water is used for massage in cases of fever, fracture, dislocation, or sprain, and leaves pat the injured region to reduce pain and swelling.



Source: Fieldwork

Katbakhii – Prickly Chaff:

Photo plate 5.17: *Katbakhii* (Prickly chaff)

Parts use: Leaves

Uses of the plant: The perennial herb is found in open places. The leaves are used to treat skin problems like blisters, ringworms, and scabies. The leaves are crushed and then applied to the affected area. Use for treating cuts and bruises to control bleeding from injuries and quick healing.



Source: Fieldwork

Kataimei-gaiti-nii / Siiramgaiti-nii – Creeping Woodsorrel:

Photo plate 5.18: *Kataimei-gai-ti-nii / Siiramgaiti-nii* (Creeping woodsorrel)

Parts used: Whole plant

Uses of the plant: The perennial herb weed is found in gardens, agricultural fields and lawns. Maram people use the plant to treat jaundice and UTIs. The whole plant is eaten raw or crushed, and juice is drank. For skin problems like scabies and itching, crush the plant and apply a few extracted drops.



Source: Fieldwork

Kavii – Ginger:

Photo plate 5.19: *Kavii* (Ginger)

Parts used: Leaves and rhizomes

Uses of the plant: The perennial herb is grown in a garden and is extensively used by Nagas for various rituals, ceremonies, traditional culinary practices, and medicine. The leaves are eaten as vegetables and salad; the rhizome is used for ritual and treating ailments.

N'tek is a rite of offering food to a



deity; small pieces of ginger and chicken meat are put in a banana leaf in a sacred place in the house. The name *Siira Kafgii*'s literal meaning is gosh ginger. It is taboo to bite ginger with naked teeth or chop it with a knife; the ginger is wrapped with a

piece of cloth, then bitten into pieces, or smashed with bare hands. The rhizome treats fever, common flu, cold and cough, headache and migraine, digestion and anti-poison. It is eaten raw with salt or as a salad as sedation. Ginger is also used for skin allergies. Ginger is crushed, and the paste is applied to the affected area for sedation.

Source: Fieldwork

***Koitii-nii* – Indian Tobacco:**

Photo plate 5.20: *Koitii-nii* (Indian tobacco)

Parts used: Leaves

Uses of the plant: The annual herb is grown in open spaces. The leaves are dried and chewed for toothache as sedation. It is also used to treat boils and wounds; the leaves are placed in the area for quick eruption. Some experts used *Koitii-nii*, and Stag Horn wrapped with *Koitii-nii* (tobacco leaf) to suck



out the pus from the swollen area. For bone fracture/sprain/ muscle cramps, a handful of leaves are crushed and applied to the area for a mild sedative.

Source: Fieldwork

Lungsiihii /Modina/ Takpa – Spearmint:

Photo plate 5.21: *Lungsiihii /Modina/ Takpa* (Spearmint)

Parts used: Leaves and aerial shoot

Uses of the plant: The perennial herb is a spice or condiment in the traditional cuisine of Maram. It is grown in and around the compound and backyard of the house. The leaves and tender shoots are eaten raw along with meals as an appetiser. The leaves treat headache and migraine, stomach aches and gastritis. It is an anti-poison. It is given to children as antiparasitic for intestinal worms/tapeworms.



Source: Fieldwork

Mahamgainii- Water Dropwort:

Photo plate 5.22: *Mahamgainii* (Water dropwort)

Parts used: Whole plant

Uses of the plant: This perennial plant is found in the jungle and kitchen garden. It is used in traditional cooking. Cooked leaves and soup are consumed to reduce fever, relieve stomach aches and period cramps, and prevent constipation. It is deemed good for blood purification. Traditionally, in postnatal care, mothers eat a salad or boil.



Source: Fieldwork

Marouhii/ Maroughii- Sensitive Plant/ Touch Me Not Plant:

Photo plate 5.23: *Marouhii/ Maroughii* (Sensitive plant/ Touch me not plant)

Parts used: Roots

Uses of the plant: The perennial evergreen herb is a prickly shrub. *Marouhii/Maroughii* is a shy medicinal or sensitive plant in Maram commonly found in open places. The plant's root is boiled and drunk to treat ailments like swollen body, jaundice, urinary tract infection (UTI) and insect bites. The roots are boiled in water and consumed as a purgative. It is also an antiseptic for snake bites and other poisonous insect bites. The freshly crushed root paste is applied to the bitten area.



Source: Fieldwork

N'bu- Stinging Nettle:

Photo plate 5.24: *N'bu* (Stinging nettle)

Part used: Aerial shoots

Uses of the plant: The perennial wild plant is found in open places. It is consumed as a porridge delicacy. *M'bu* is one of the forbidden foods in the past for families who manage to give merit feasts. They are considered as achieved higher status and purified, and are forbidden to eat or cook inside the kitchen and using the same utensil is a taboo. The Marams use the plant to treat burns; leaves are roasted over the fire, crushed, and placed in the burnt area to heal. The boiled leaves are consumed to treat diabetes; the lactating mother consumes porridge for quantity and quality breast milk. The leaves stimulate blood circulation during extreme cold and faints by placing on the person.



Source: Fieldwork

N'Daipa - Rhododendron:

Photo plate 5.25: *N'Daipa* (Rhododendron)

Parts used: Sepals and leaves

Uses of the plant: The woody evergreen plant is found in the forest; the flower petals are eaten during outings in the jungle, and collected flowers and leaves are dried for medicinal purposes like aiding digestion and removing fish bone stuck in the throat; the flower is eaten or boiled to drink to flush out the bone it is called *arii*.



Source: Fieldwork

Piitak-gai/Tampanii-gai - Broadleaf Plantain:

Photo plate 5.26: *Piitak-gai/Tampanii-gai* (Broadleaf plantain)

Parts used: Whole plant

Uses of the plant: The perennial herb is a traditional Nagas cuisine. It is found in open spaces and agricultural fields. Maram people eat this tender plant as a vegetable to treat stomach upsets and disorders. Termite soil and *Patak-gai* (Broadleaf plantain) mixed are applied to treat muscle sprains.



Source: Fieldwork

Rakuitat/ Kuitak-Angel's Trumpet:

Photo plate 5.27: *Rakuitat/ Kuitak* (Angel's trumpet)

Parts used: Leaves

Uses of the plant: The common perennial shrub is often used as a hedge. The crushed fresh leaf juice is used as a sedative for Nettle stings. It is also used as an antiseptic for snake or insect bites. The leaves are crushed, and the juice and paste are applied to the bitten area. The leaves are boiled, and a warm body massage is given to reduce the swollen body.



Source: Fieldwork

Ramnok- Pleasant Himalayan mint:

Photo plate 5.28: *Ramnok* (Pleasant Himalayan mint)

Parts used: Leaves and whole plant

Uses of the plant: The perennial herb is grown in the garden and open spaces. A handful of leaves and the extracted juice of one spoon is given to the children, and two spoons to adults for treating body aches, colds and coughs, stomach problems, bloating, and dysentery. The crushed leaf is used to rub or to give mild massage for stomach aches. It is used during post-natal care; a handful of leaves is added to boiling water for a warm bath. Also, to protect the child from crying at night, the plant is placed on the wall to ward off malevolence.



Source: Fieldwork

Rangdigai- Trichodesma khasianum C.B.Clarke:

Photo plate 5.29: Rangdigai (*Trichodesma khasianum* C.B.Clarke)

Parts used: Leaves, aerial shoot and flower

Uses of the plant: The herbal shrub is found in jungles, forests, or roadsides. The aerial parts and leaves are consumed for vegetables, cuisines such as simple boiled or porridge, leaves, and flowers. People have started growing in the kitchen garden for availability. As it is used as a sedative for stomach disorders, gastric, dysentery and jaundice, People with piles and constipation problems are highly recommended to take this plant.



Source: Fieldwork

Rangkananii- Phlogacanthus pubinervius T.Anderson:

Photo plate 5.30: Rangkananii (*Phlogacanthus pubinervius* T.Anderson)

Part used: Leaves and flower

Uses of the plant: The perennial shrub is a common plant that is often used as hedges. Flowers are used in the cuisine as vegetables and also salad. It produces a strong aroma; boiled water is orally administered to treat various ailments and lower fever, as well as sedation for stomach problems, heartburn, chest pain, pneumonia, and body aches. Leaves are boiled, and a warm bath relieves body aches and pain. The flower is eaten in the form of fry or chutney.



Source: Fieldwork

Rangsai-pa /Tiirat-bang -Lantana:

Photo plate 5.31: *Rangsai-pa/ Tiirat-bang* (Lantana)

Parts used: Leaves and aerial shoot

Uses of the plant: The perennial shrub is a common plant that is often used as hedges. It is used for any skin allergy. Crush the leaf and apply it to the area for sedatives and healing. A handful of leaves is boiled, then a half cup is given to adults, and a spoon is given to children in the morning and evening for fever and cough.



Source: Fieldwork

Rubang-gaiti- Papaya:

Photo plate 5.32: *Rubang-gaiti* (Papaya)

Parts used: Leaves and fruits

Uses of the plant: The perennial plant is grown in the kitchen garden. The unripe fruit is used in cuisine. One or two tender leaves are made into juice and drank to treat fever and jaundice. It is used as an anti-rabbi for dog bites; the unripe papaya milk drops are applied to the bitten area to absorb the poison. The unripe is consumed as a contraceptive.



Source: Fieldwork

Saramarati-Horse Gram:

Photo plate 5.33: *Saramarati* (Horse gram)

Parts used: Grams

Uses of the plant: The annual herb is found in gardens, agricultural fields and lawns. The soup made with horse gram is taken to improve the quality and quantity of milk. The soup and gram are consumed to treat dysentery and diarrhoea. It is also taken as an energy drink.



Source: Fieldwork

Saroutpot-ti-Passion fruit:

Photo plate 5.34: *Saroutpot-ti* (Passion fruit)

Parts used: Leaves, aerial shoot and fruits

Uses of the plant: The perennial herb is grown in a kitchen garden. The tender leaves are boiled and eaten along with meals, or juice made out of fresh leaves is taken to lower fever and as sedation for liver, digestion problems, stomach problems, gastric, diarrhoea, blood pressure and menstrual cramps.



Source: Fieldwork

Sataigobi - Cabbage:

Photo plate 5.35: *Sataigobi* (Cabbage)

Parts used: Leaves and aerial shoot

Uses of the plant: The plant is a perennial herb grown in the kitchen garden. Maram Khullen is known for its unique cabbage, which is at its best in winter when the dew-turned-ice seasons the huge cabbage leaves. When cooked, it is super soft and sweet. The leaves are consumed for better digestion. They are eaten along with meals to prevent stomach ulcers.

The crushed leaf paste is applied to cure pimples.



Source: Fieldwork

Siilamhii- False Daisy:

Photo plate 5.36: *Siilamhii* (False daisy)

Parts used: Leaves

Uses of the plant: The perennial herb is found in open places and is used for treating skin problems, scabies, cuts, and bruises. The crushed leaves are applied to the area to stop bleeding, quickly heal and prevent infection.



Source: Fieldwork

Siimiiti - Wild Sumac Berry:

Photo plate 5.37: *Siimiiti* (Wild sumac berry)

Parts used: Fruits

Uses of the plant: The *Siimiiti* shrub/tree is widely and commonly found in almost every Indigenous community for various ailments. The fruit is widely used as medicine. Maram uses the plant parts to treat diarrhoea, dysentery, indigestion, stomach upset, headache and migraine. The herb is made into tea and consumed. The seed is ground, and the powder is eaten with a pinch of salt and chilly. The plant derivatives are also used to treat poultry and domestic animals.



Source: Fieldwork

Takiitirak-Yellow Fruit Nightshades:

Photo plate 5.38: *Takiitirak* (Yellow fruit nightshades)

Parts used: Fruits and seeds

Uses of the plant: The perennial plant is found in open spaces and jungles and is used for toothache. The ripe seed is dried/smoked, roasted, grinded, and then power is placed on the tooth. It is also used to treat animals; the ripened seeds are powdered, mixed with water, and flash in the nose to let out the leech from the cow's nose.



Source: Fieldwork

Tiimpai - Mugwort:

Photo plate 5.39: *Tiimpai* (Mugwort)

Parts used: Leaves and aerial shoot

Uses of the plant: The woody perennial plant is found along the roadside and in open spaces. The aromatic leaves are used to stop the bleeding of cuts and bruises, and the leaves are made into a paste with saliva and applied to the affected area. The leaves effectively control bleeding through the nose due to falls or accidents while playing games. A handful of leaves are crushed, juice is extracted from one spoon for children, and two



spoons for adults are given to treat dysentery. The aromatic plant is placed inside the nests or coops of the poultry to get rid of ticks and mites. The plant attracts the mites to it, and when it is filled with it, it is burned or discarded.

Source: Fieldwork

Tiimpai-paimii- Wormwood:

Photo plate 5.40: *Tiimpai-paimii* (Wormwood)

Parts used: Leaves

Uses of the plant: The perennial herb is a small, bushy shrub on barren land. It treats colds, coughs, diarrhoea, stomach aches, headaches, and menstrual cramps. A handful of extracted juice from the leaves is mixed with a cup of water and drunk to relieve and sedative. For cuts and bruises, a handful of leaves are crushed and applied to the wounded area to control bleeding and as an antiseptic. A handful of leaves is soaked in warm water and drunk as an energy boost for speed delivery.



Source: Fieldwork

Tiiti/Tiiranii - King Chilli:

Photo plate 5.41: *Tiiti/Tiiranii* (King chilli)

Parts used: Fruits

Uses of the plant: The perennial herb is grown and cultivated by the people of northeast India. Maram tribe uses it as a sedative for headaches, migraines, and digestion, and fruit is eaten with salad and cuisine. Applying the boiled water drops on the affected area is used for treating ringworm. For wounds, cuts and bruises, cooked or boiled chilly water is applied for quick healing; it causes an intense burning sensation; however, it is considered one of the best for fast healing.



Source: Fieldwork

Tuiniiti- Raspberry:

Photo plate 5.42: *Tuiniiti* (Raspberry)

Part used: Fruits and roots

Uses of the plant: The shrub is found in the jungle and open spaces. The seasonal fruit is eaten, and children especially enjoy it during leisure time. The plant roots are collected and used for treating dysentery, common flu, cold and cough, viral fever, and liver. The root is crushed, and the extracted juice of two to three spoons is consumed.



Source: Fieldwork

Traditional knowledge (TK) and healthcare practice are dynamic systems that permeate all aspects of an individual's beliefs, experiences, and practices to ensure good health in Indigenous communities. TK has a unique system of health maintenance among the Indigenous communities, meticulously developed over the centuries through practical observations, spiritual learning and traditional teaching. The knowledge systems are crucial due to their accessibility, availability, affordability, sociocultural beliefs and perceived treatment efficacy. Traditional healthcare knowledge systems approach health and wellbeing holistically, and the practices address the physical, mental, spiritual, social, and environmental dimensions of the person, the family, and the community. In an Indigenous setting, the preventive or curative action begins with using home remedies utilising concoctions made of plants, animals and minerals available locally, followed by seeking help from a traditional herbalist or the support of a traditional spiritual healer according to the severity and nature of the health condition. Herbal medicines are accessible, cost-effective and efficient in more ways than one for treating ailments, particularly in resource-constrained, hard-to-reach geographical settings of North East India. The socio-economic and geographic characteristics of the communities, families, and individuals also affect the treatment choices for various illnesses.

The Maram Nagas possesses a remarkable repository of knowledge and skills in traditional medicine, with this wisdom being passed down through generations. Many individuals and families engage in various Indigenous healing practices, often without fully recognizing or valuing this knowledge. This observation emerged from the discussions facilitated by the researcher during one-on-one and focus group interviews. Eliciting conclusive information proved to be a challenging task, as many respondents had not critically reflected on the knowledge and skills they naturally employed in response to illnesses or injuries.

Chapter 6

HEALTHCARE AND HEALTH-SEEKING BEHAVIOUR

Access to healthcare is widely acknowledged as a social determinant of health. Indigenous or traditional medicine has, since the 1970s, been widely regarded as a resource likely to facilitate reaching the health goal for all, especially in low-income countries. For Indigenous communities, the choice of treatment or prevention of the undesired state of health depends on their historical experiences, beliefs and understanding of the causative factors. The Maram Nagas face significant structural barriers to accessing healthcare, similar to many Indigenous populations globally. These obstacles include geographical isolation, inadequate transportation and communication infrastructure, and pervasive economic deprivation, hindering individuals' ability to access and obtain necessary treatment. Healthcare services involving infrastructure and personnel are critical to ensuring the delivery of modern healthcare services to the people.

The factors influencing the behaviour and practices of Indigenous populations include geographical isolation, inadequate transportation and communication infrastructure, and pervasive economic deprivation, all of which hinder individuals' ability to access treatment (Chen et al., 2024, p.18). Additionally, challenges such as insufficient amenities, limited accessibility and affordability of healthcare services, and a lack of health education further aggravate the situation (Sonowal & Puja, 2021, p.67). Access to modern healthcare is dependent on the physical accessibility of services. Physical accessibility relies on geographical distance, availability of infrastructure, facilities and personnel, and financial ability to overcome geographical distance to access services (Horrill et al., 2018, p.2). Indigenous people are currently navigating a transitional era, rendering them particularly vulnerable to malnutrition and diseases. Their health outcomes are influenced by unique socio-cultural factors, traditional customs, and economic conditions (Raushan and Acharya, 2019, p.12). However, the all-permeating evolution in the socio-political, economic and environmental factors have negatively

impacted the traditional lifestyles. This transition has profoundly affected the health and well-being of the PVTGs (Sonowal and Konch, 2021, pp. 69-70).

Traditional healthcare practices and home remedies hold a pivotal role in ensuring the health and well-being of the Indigenous people. Nevertheless, the Indigenous communities are in the process of accessing modern medicines due to the ever-changing nature of their lifestyles and the diseases they encounter. However, it is a well-accepted fact that Indigenous communities are often excluded and marginalised from mainstream health services for several reasons. This situation is evident in the limited investment in public healthcare infrastructure and workforce. Like other Naga-inhabited regions, the Maram area experiences significant deprivation of modern health services, resulting in a greater reliance on traditional medicine and healthcare practitioners. However, as infrastructure, workforce capacity, and public awareness gradually improve, the utilization of healthcare services is increasing.

Public Healthcare Delivery:

The public health system and its associated infrastructure are crucial indicators that influence the health-seeking behaviors of individuals. The researcher gathered data pertaining to the public healthcare system in the region from relevant departmental sources and community stakeholders. The findings are presented in the table below.

Health Infrastructure

Table 6.1: Healthcare Facilities

Name of village	SC	P H C	CH C	DH	SH	AS	ML	X- Ra y	P	PC	PH
Distance in kilometres											
Maram Bazar	6	1	23	17	84	0	23	23	3	2	84
Maram Centre	5	3	24	16	84	1	22	22	4	2	84
Maram Sagonbam	5	2	23	16	85	1	23	23	1	2	85
Lairoching	9	7	31	14	80	6	17	17	4	4	80
Maram Khulakpa Sagei	1	8	30	20	89	6	27	27	5	5	89
Maram Makha Sagei	1	8	29	20	89	6	27	27	5	5	89
Maram Mathak Sagei	2	10	31	21	91	7	31	31	7	7	91
New Maram	2	5	28	15	89	5	20	20	3	3	89
Rajamei	1	34	94	55	117	55	55	55	55	55	117
Sadim Naga	NI L	40	41	18	70	17	17	70	70	17	70
Shang Khumei	5	38	59	52	127	24	121	56	6	127	127
Willong Khullen	1	33	64	57	132	19	126	61	1	132	132

Source: Fieldwork. Note: SC-Sub Centre, PHC-Primary Health Centre, CHC-Community Health Centre, DH-District Hospital, SH-State Hospital, AS-Ambulance Service, ML-Medical Laboratory, X-Ray & ECG, P-Pharmacy, PC-Private Clinic, PH-Private Hospital

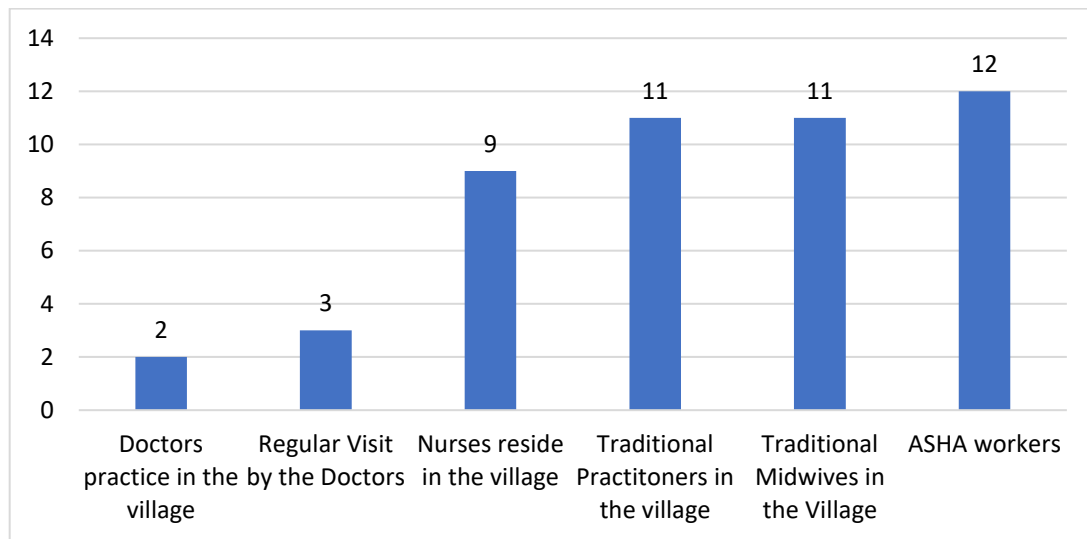
As evident in Table 6.1, the noticeable factor is the absence of a sub-centre in 10 of the 12 villages covered. Only one PHC covers the entire region in Maram Bazaar, while the nearest Community Health Centre is at Tadubi Block (Sub-division), an average distance of 25 km from villages under the study. The nearest district Hospital is at Senapati district headquarters, an average distance of 45 Km from the villages. Nondescript private clinics function in some villages, albeit mostly addressing basic healthcare needs. In any case, most people depend on the health facilities at Senapati or Imphal for modern healthcare support. Whereas there is a 50-bed government facility at Senapati, people often flock to the few private hospitals for emergency healthcare support. Most people directly go to Imphal for treatment as it is felt that the facilities and services at Senapati are inadequate.

Gogoi et al. (2021) state that in India, the health infrastructure in rural areas is based on a three-tier system i.e. Sub-centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs), with SCs, and PCs as the prime healthcare service, In the rural area, Manipur has inadequate PCs, lack of laboratory technicians in the PHCs, on the positive note the states have a surplus of AYUSH medicine practitioners and radiographers in CHSs (pp. 184-187). While in Manipur, the public health services comprise two tertiary-level hospitals, seven District hospitals (DHs), 17 CHCs, 85 PHCs, and 421 SCs with 1400 doctors and 30 lakh population, Manipur state lagging when an estimated 3000 doctors are required, which is against the WHO's recommendation of one doctor per 1000 population (Yumnam, 2024, p.3). Similarly, this study found that the Maram inhabited region reflects gross inadequacy in healthcare infrastructural and human resource outlay, considering the difficult geographical conditions and poor road and communication infrastructure.

Healthcare Personnel

It is pertinent to note that the region's deployment of public healthcare infrastructure and personnel is scant due to the low population density. Whereas the personnel ratio vis-a-vis population is seemingly ideal considering mainland India, the situation in the hill districts is grossly inadequate. It discourages people from accessing the services on a timely basis. High dependence on over-the-counter medications bought in bulk by the persons travelling to the nearest townships is very characteristic of the communities under the study. The discernible morbidity and mortality rate due to accidents and injuries also indicate poor access to timely services.

Figure 6.1: Healthcare Personnel



Source: Fieldwork

Figure 6.1 highlights the distribution of healthcare personnel in the study villages. It should be noted that allopathic doctors could be found only in two of the 12 study villages. This too in the villages along the National Highway 02. Similar is the case with the nurses, such that although nine villages have a nurse staff in the village appointed by the government, most do not reside in the village and visit the village once in a while or on call from the people in times of need. ASHA and Anganwadi workers are present in all the villages, and traditional healers and midwives are present in almost all the villages.

Traditional Medicine Practitioners (TMPs):

Traditional medicine practitioners have a formidable role in rural Indigenous communities and are vital in ensuring timely treatment and cure. The TMPs range from elders in the family with inherited knowledge and skills focusing on a limited number of health conditions to full-time practitioners with advanced knowledge to address several health conditions and problems. The TMPs also play an important role in the lives of the Maram people, especially those in remote villages. The TMPs are often the only healthcare support person available for most rural folk; hence, their role as a first point of care is

crucial. It may be said that their training and engagement as the first point of care would significantly enhance the healthcare delivery system in the Maram inhabited areas.

A TMP is defined as a person who does not have any formal medical training but is considered by the local community as being competent to provide health care using animal, plant and mineral substances and certain other techniques based on social, cultural and religious background as well as the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of the disease and disability. Ayurveda, Unani and other allied practices are found in North East, India as herbalists, diviners, traditional birth attendants, Veterinary, bone setters, acupuncturists and breathing treatments (Ramashankar et al., 2015, p. 325-326). The sources of knowledge are intuition, dreams, folktales and methodological beliefs, which help select the plant to combat the diseases (Singh and Srivastava, 2010, p. 608). The ethics of the TMP as holistic treatment includes the natural method, principles to save a life, belief in supernatural relations, and balance internal and external environments which manifest disease (Ramashankar et al., 2015, p. 325). Traditional medicine practitioners have a holistic approach to healing patients' mental, physical and spiritual well-being. The author categorizes the types of practitioners, i.e. profound herbalists, herbalists merged with supernatural practices and spiritualistic priests. The traditional method of treatment by the practitioners consists of taboos, rituals, charms, deity propitiation, water-gazing and divination (Anquandah, 1997, p.289).

According to Kleinman and Sung (1979), the ailments treated by TMPs are “acute diseases, non-life-threatening chronic diseases and minor psychological disorders.” They opine that the psycho-social and cultural aspects contribute more to “healing” than the “cure” (p. 24). Intriguingly, the practitioners' understanding and perception of the various diseases they treat are in discernible contradiction with the understanding of modern medicine. However, the treatment is often effective and instantaneous. Traditional practitioners can sometimes diagnose and treat ailments, but modern medicine fails to

explain the ailment without using advanced diagnostic tools and methods (Watienla, 2019, p. 71). Therefore, understanding TMPs and their contributions is crucial for the overall health outcomes of the community. In urban areas, the use of traditional medicine has risen compared to rural settings.

With the multitude of Indigenous identities that flourished with limited contact with each other until recently, Northeast India is home to a diverse group of traditional medical practitioners who have been providing healthcare support to individuals and communities. It can well be said that most of them inherited their skills from their forefathers, while a few earned them through mere chance or hard work. The dependence on the TMPs has been consistent even today, mainly due to the advantages of accessibility and affordability. It has been not very long since the number of traditional medical practitioners or healers far outnumbered the practitioners of modern medicines.

The TMPs among the Maram tribe include traditional birth attendants, bone and muscle setters, diviners, ritual and spiritual healers, and herbalists. For various reasons, these practitioners have been the primary source of healthcare services to people with limited access to modern healthcare. Traditional medical practices and practitioners play a significant role in the healthcare system among the Maram Nagas, and all value their knowledge and expertise.

Profile of the TMPs

The research sought to assess the impact of the TMPs in the Maram region. Sixteen traditional practitioners were identified and studied through in-depth one-to-one interviews, and the community's opinions about the treatment's type, methods, and effectiveness were compiled.

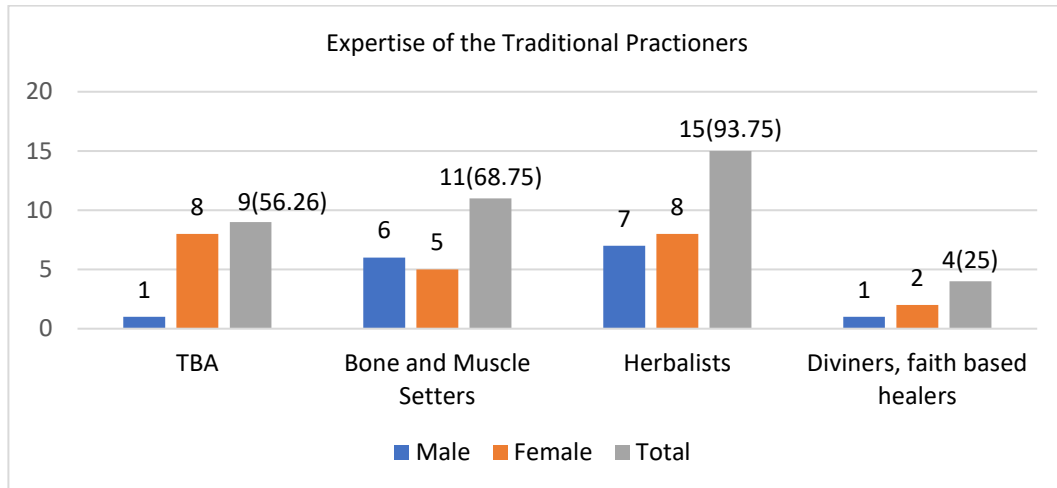
Table 6.2: Profile of the TMPs

Age Category	Literate		Semi-Literate		Illiterate		Frequency		Total Percentage (%)	
	M	F	M	F	M	F	M	F		
21-40 years	-	-	-	2	-	1	-	3	3	18.75
41-60 years	2	-	3	2	-	-	5	2	7	43.75
61 years above	-	1	1	1	1	2	2	4	6	37.5
Total	2	1	4	5	1	3	7 (43.75)	9 (56.25)	16	100

Source: Fieldwork. Note: Literate- able to read and write fluently in Roman script, semi-literate- able to understand the script without formal education, illiterate- cannot read nor write.

Table 6.2 elaborates on the basic profile of the TMPs in the study. The finding shows that 56 per cent are female TMPs and 44 per cent are male TMPs. People in the region approach the TMPs under study for different ailments and injuries. It is found that 81 per cent of the TMPs are from the age group 41 and 61 and above, and only 19 per cent of the TMPs are from the 21- 40 age group. All the TMPs are 100 per cent Christian and married. The healers mainly belong to the following categories according to the primary field of their expertise.

Figure 6.2: Expertise of TMPs



Source: Fieldwork

Figure 6.2 describes the distribution of TMPs based on their expertise. Among the total 16 TMPs in the study, 56 per cent are TBAs. All except one TBA are females. Around 69 per cent of the TMPs are also bone and muscle settlers; six are males, and five are females. An overwhelming 94 per cent of TMPs are herbalists, of which eight are females and seven are males. Only 25 per cent of TMPs are diviners and faith-based healers, one male and two females. It may be noted that the herbalists often double up as diviners and faith-based healers.

It has been observed that almost all the TMPs had more than one expertise and skill. Interestingly, while one or two skills were passed on from the forefathers or elders in the family, the TMPs picked up new knowledge and skills from others and sometimes on their own due to the constant demand for such services.

Experience of the TMPs:

Table 6.3: Number of Years in Practice

Years	Male	Female	Frequency	Percentage (%)
5-10 years	1	2	3	18.75
11-20 years	2	3	5	31.25
More than 21-30 years	4	4	8	50
Total	7	9	16	100

Source: Fieldwork

The experience of the TMPs is discussed in Table 6.3. It was observed that 19 per cent of Traditional Medicine Practitioners (TMPs) have been practicing for 5 to 10 years, while over 31 per cent have been engaged in their practice for 10 to 20 years. Additionally, 50 per cent of the TMPs possess over 21 to 30 years of experience. During the field visit, it became evident that very few young individuals are pursuing traditional medicinal practices. Some TMPs reported that they began treating patients out of necessity and compassion for those in distress, utilizing the limited skills they inherited from their parents.

Traditional Medicine Practitioners (TMPs) have faced scepticism regarding their methods and efficacy. However, the younger generation is increasingly turning towards modern medicine, as many individuals from the community have pursued careers as doctors and nurses, particularly in Naga-inhabited regions. It is, however, important to note that TMPs are still being consulted as the first point of reference in times of short-term illness or morbidity. This happens especially in households that live far away from modern healthcare facilities. It is important to recognise that the decline of TMPs can be attributed to the inadequate skills of younger generation healers and the loss of experienced practitioners (Sahoo et al., 2023, p.699). A similar trend is seen in the Maram community on the same observation.

Treatment Efficacy and Referrals

The TMPs interviewed were queried on the steps they took to ensure the effectiveness of the treatment.

Table 6.4: Treatment Efficacy and Referrals

Particulars	Frequency	Percentage (%)
Mostly manage the cases by oneself	5	31.25
Consult or refer to other traditional healthcare practitioners	3	18.75
Refers to modern healthcare services	8	50
Total	16	100

Source: Fieldwork

Table 6.4 highlights the responsibilities of Traditional Medicine Practitioners (TMPs) in providing effective treatment to their clients. The data indicates that 50 percent of respondents refer clients to modern healthcare facilities when they become unmanageable. One TMP stated, *“I refer clients to modern healthcare facilities only in cases such as delivery. If the birth canal is too narrow, I do not attend to the client, as it poses risks for both the mother and child.”*⁵⁸ Another TMP remarked, *“I advise patients to seek modern healthcare only after evaluating their condition. Not all ailments necessitate a visit to modern medicine; it largely depends on the client's willpower and their ability to work independently, coupled with faith in God for recovery.”*⁵⁹

The study further revealed that 19 per cent of respondents consult and collaborate with fellow TMPs. It was noted that TMPs within the same village often refer cases to one another. One respondent commented, *“I treat clients with reproductive health issues as well as urinary tract infections (UTIs), but I refer clients to another TMP for delivery.”*⁶⁰ Additionally, the findings indicate that 31 per cent of TMPs manage all cases independently and do not personally advise clients to consult other healthcare providers.

⁵⁸ Male, 70s yrs, TBA, interviewed on 20/04/2020 at 1.45 pm, Lairouching village.

⁵⁹ Female, 56 yrs, TMP, interviewed on 20/09/2020 at 6.35 am, Willong Khullen Village.

⁶⁰ Female, 36 yrs, TMP, interviewed on 03/09/2021 at 12. pm, Lairouching Village.

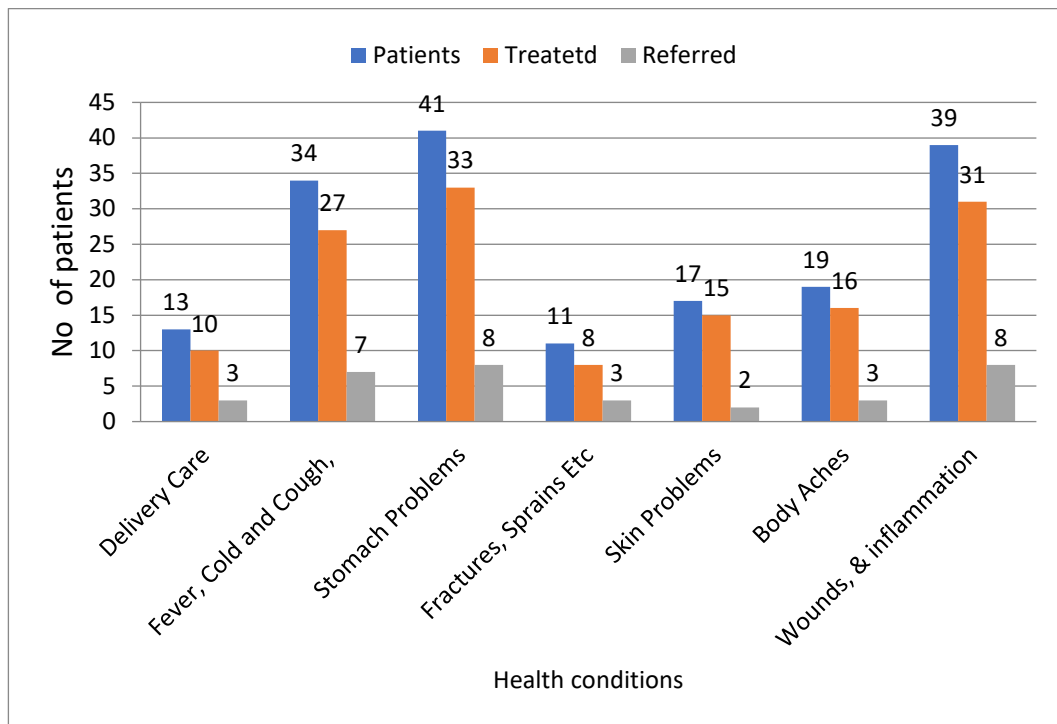
The Traditional Birth Attendants (TBA) are consulted from the time of conception for pregnancy care, delivery and post-natal care. The TMPs and TBA are the first point of reference when a couple does not get a child within 1-2 years of marriage. One of the respondents said, *“I have been trying to get pregnant and have been seeing physicians, but it has not worked out. One of my relatives suggested I talk to a traditional midwife. On approach, TBA claimed it is possible to become pregnant only after the womb's position was altered by massaging the abdomen.”*⁶¹ The respondent followed the advice, and the TBA carried out a massage, and the woman was able to conceive soon after. A respondent (pregnant, 30 yrs) said, *“I had pain in the abdomen, and the first point for consulting was TBA. There are a few practitioners suggested by relatives; among them, one of the TBAs massaged a pregnant woman and caused the fatal fetus in the womb. Learning from relatives approach the other one, where after being observed by the TBA, got relief from pain with no further pain complaints.”*

Treatment Profile of the TMPs

Common treatment approaches adopted by and the result of the treatment in the month before the interviews suggest that the treatments have been considerably effective in addressing the problem at hand. Figure 6.3 gives findings about the treatment carried out by the TMPs in the month preceding the interview. It can be observed that the TMPs are making considerable contributions to healthcare delivery in the region.

⁶¹ Female, 36 yrs, respondent, Maram Centre Village.

Figure 6.3: Treatment Profile of the TMPs



Source: Fieldwork

Figure 6.3 indicates that the TMPs can address all types of healthcare problems they are approached for. In almost all health conditions, the TMPs could care for more than 80 per cent of the patients that approached them. It can also be observed that people approach the practitioners for different kinds of illnesses and conditions. This is primarily because of the people's trust in the practitioner's expertise and the treatment's perceived efficacy. However, it may be said that the number of full-fledged practitioners is dwindling with the improved access to modern healthcare facilities and changes in attitudes and knowledge among the common people.

Patient Intake

All the TMPs are part-time practitioners, with most being farmers (11 persons). Even those who were reported to be housewives (four persons) were also engaged in vegetable cultivation and maintenance of livestock at their homes. As such, none of the

practitioners under the study had any professional setup/clinics. They are treated in the open space on the lawn or the kitchen. In the case of TBA, the deliveries were mainly taken at the pregnant woman's house, while day-to-day care and massage of the pregnant woman were sometimes carried out at the home of the TBA.

Table 6.5: Average Patients Attended by the TMPs

Patients attended	Frequency	Percentage (%)
Above 5 Patients/ per day	2	12.5
1-4 Patients per day	8	50
3-5 Patients in a week	4	25
Seasonal	2	12.5
Total	16	100

Source: Fieldwork

Table 6.5 elaborates on the number of patients the TMPs are attending to on an average basis. As the above table indicates, half of the practitioners (50 per cent) have an average of 1-4 patients daily. And four TMPs state that they attended to more than four persons daily. It was observed during the discussions that the birth attendants and bone and muscle setters had the most significant number of clients regularly. The number of clients for the diviners and faith-based healers was also seemingly regular. What needs to be highlighted is that all the TBAs (56 per cent) also had good knowledge of massage and some herbal preparations, so people approach them regularly.

As the TMPs had other engagements, there was no particular schedule for their work. One said, *"I usually go to the field daily during the sowing and harvesting season. Some days, people come to me early in the morning, and I have to stay back to take care of them. If I stay back for one or two hours, I often miss the entire day's work."*⁶² Another stated, *"Five to six clients come to me daily. I tell them not to come, but people come and request; some don't leave until I see the patient. Patients come not only from the Maram*

⁶² Female, 39 yrs, TMP, interviewed on 03/09/2021 at 7.35 am, Lairoucing village.

*tribe but also from different places; I came to know that patients from different states come after hearing from the students who have come to study at Don Bosco College Maram.”*⁶³

Traditional Medicine Practitioners (TMPs) do not engage in full-time practice as many of their global counterparts do. In resource-limited, sparsely populated areas primarily inhabited by Indigenous communities, treatment services often do not provide a sustainable livelihood. The patient population is smaller, and the financial resources available for treatment are restricted due to the economic challenges faced by these communities. Consequently, many TMPs supplement their income by participating in additional livelihood activities to fulfil their financial needs.

Remuneration for the Treatment:

The question of remuneration for treatment by TMPs is crucial, considering the socio-economic characteristics of the people. Traditional medicine's affordability quotient depends not only on how much individuals pay but also on how the practitioners render their services even when the individuals cannot afford the cost.

Table 6.6: Types of Remuneration for Services

Types of remuneration	Frequency	Percentage (%)
Free of cost	2	12.5
Cash	3	18.75
Rice, vegetables, livestock, etc.	2	12.5
Any of the above	9	56.25
Total	16	100

Source: Fieldwork

Table 6.6 discusses the cost of the consultation fees charged by the practitioners. More than half of the TMPs (56 per cent) take remuneration in either cash or kind or provide free services, while three per cent of the TMPs believe it to be God's gift to be able to heal people; if they charge or accept anything in return, God will be displeased and

⁶³ Female, 47 yrs, TMP, interviewed on 11/12/2020 at 2.15 pm, Maram Centre Village.

punish them. On the other hand, 19 per cent of the TMPs accept any amount offered by the client, commonly Rs. 10 to Rs.100, while 13 per cent of the TMPs said clients come in kinds like rice, vegetables, and livestock ... and 13 per cent of the TMPs told though it is not compulsory, clients offer either in cash or kind. One of the respondents said, *“I do not demand or insist on taking a fee for the services, but when the people insist on giving, I just accept, and I offer it in the church, giving back to God.”*⁶⁴

General Perception of the Effectiveness of Traditional Medicine:

The study also sought to understand the respondents' general perceptions regarding the effectiveness of traditional medicine. Dedicated questions were asked during the one-to-one interviews with the families and focus group discussions. Given increasing options for allopathic medicine, the general attitude towards traditional medicine, especially herbal medicine, was considered and discussed. The responses captured through the family survey questionnaire indicated a strong positive attitude towards traditional herbal medicines.

Table 6.7: Effectiveness of Traditional Medicine

Categories	Frequency	Percentage (%)
Very effective	146	64.89
Fairly effective	60	26.67
Not effective	6	2.67
Don't know/ can't say	13	5.78
Total	225	100

Source: Fieldwork

Table 6.7 shows the distribution of general perceptions of the family respondents on the effectiveness of traditional medicine. The general perception of the effectiveness of the medicines is derived from their experience, as most people use herbal medications on a day-to-day basis. More than half, i.e. 65 per cent, of the respondents said it is very effective. Usually, it can cure/contain the disease, and 27 per cent of the respondents said

⁶⁴ Female, 60 yrs, TMP, interviewed on 03/09/2021 at 10.00 am, Lairoucing Village.

it is fairly effective where they can initially contain it until further treatment from doctors is made. Only three per cent of the respondents said it was ineffective, and six per cent didn't know/ can't say. Nine per cent of the respondents said it was not effective and neutral, and some respondents use combined herbal treatments with prescribed medications, often reporting better health outcomes.

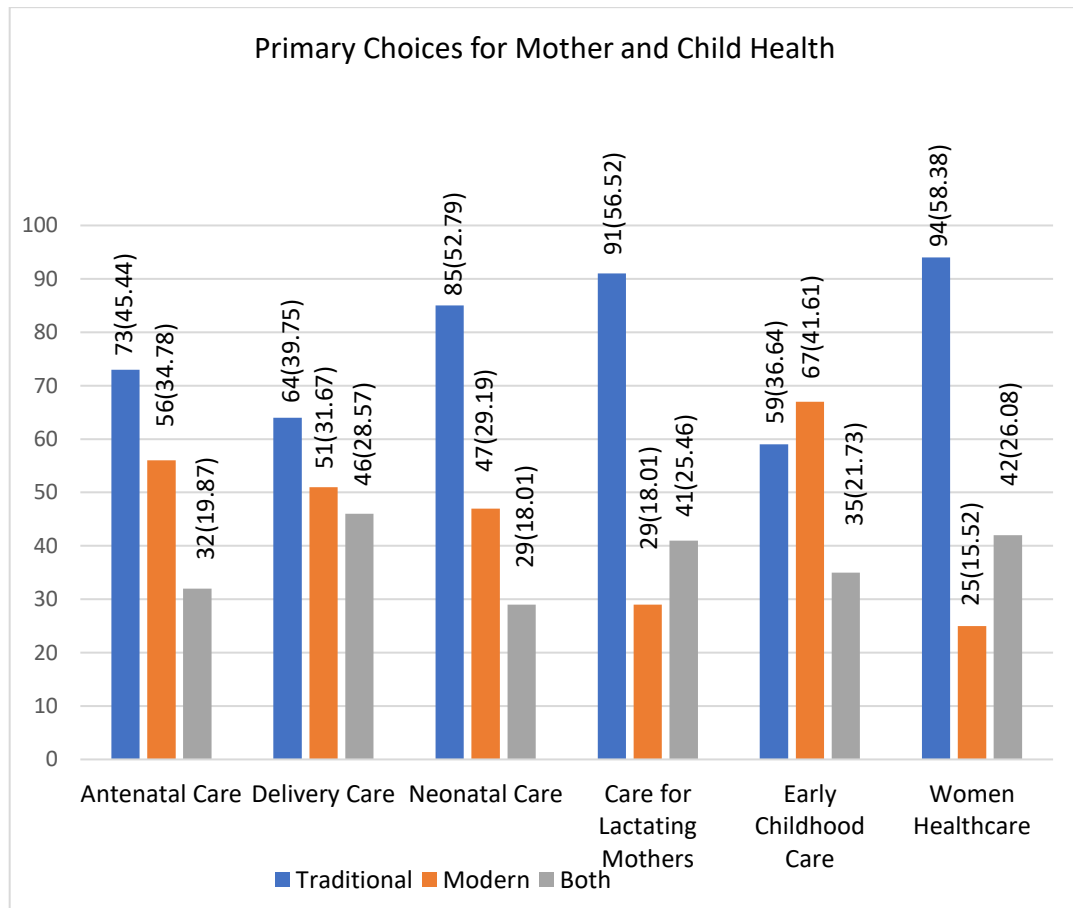
The perception of the effectiveness of traditional medicines is deeply rooted among the Indigenous people in their cultural practices, beliefs, and community experiences due to the perceived harshness and side effects of allopathic treatments. There are also incidents wherein people revert to traditional medicines while finding the allopathic treatment not adequately effective or too costly to maintain. (Sahoo et al., 2023, p.699). The general opinion of the respondents and participants of the focus group discussions in this study corroborates the above statement. Financial constraints are often cited as a significant reason individuals choose traditional medicine. Additionally, the adverse side effects associated with allopathic medications further discourage patients from relying on them consistently.

Mother and Child Health Choices:

Mother and child health is a key indicator of community health. The choices of mother and child healthcare services have seen significant improvement in recent years. It is essential to acknowledge that due to the focused interventions of the public healthcare programme; there is enhanced follow-up of pregnant women and discernible improvement in Antenatal care (ANC) visits, institutional delivery and immunization. However, a discernible dependence on traditional medicines can be found among the indigenous populations. Moreover, traditional practices resonate with cultural beliefs and lifestyles, thereby fostering greater acceptance and adherence among individuals. In this study, we conducted measurements of attitudes and practices among families with pregnant women or children under the age of ten, which ensured the information was pertinent to the current

context. A total of 161 respondents participated in one-on-one interviews, during which we inquired about their treatment preferences.

Figure 6.4: Healthcare Choices for Mother and Child Health



Source: Fieldwork

As shown in Figure 6.4, the preferences for mother and child health between traditional and modern healthcare were put forward to all 161 respondents on the practice they adopted during the last instance of pregnancy and birth in the family. In most cases, the choice of Indigenous method care was observed traditional methods to be higher than the modern medicine care methods, except in early childhood care modern medicine is higher than the traditional method care. However, the people who opted for traditional medicines are almost at par with modern medicines. It can also be observed that a sizable

number of respondents simultaneously used both the treatment and care. One of the characteristics that was very evident during the interviews was that, due to the recent improvements in the public healthcare system, primarily through the sub-centres and ASHA workers, Anganwadi workers in the region, as well as schemes like the Janani Suraksha Yojana, more pregnant women and children have been drawn to modern healthcare facilities.

It is noteworthy that ceremonial practices and reliance on traditional knowledge remain prevalent among households with older individuals and in geographically isolated villages. The study revealed that 92 per cent (148 women) of young mothers who had given birth in the past five years found traditional methods to be quite effective and heavily relied on them during pregnancy and early childhood care. In contrast, eight per cent (13 women) of the respondents reported limited knowledge of traditional maternity and childcare practices, primarily depending on clinics and government hospitals, even for minor health concerns.

Both traditional and modern healthcare systems play a vital role in promoting the health of mothers and children. An integrated approach that honours cultural practices while improving access to contemporary medical services can significantly enhance health outcomes. This comprehensive perspective is essential for achieving sustainable improvements in maternal and child health.

Case Study of a Popular TBA:

Mrs. Pungdila Cecilia, aged 63, lives in a village in the suburbs of Senapati district HQ. She is a widow with four children, cultivating her small farm for livelihood and meeting her children's education. She is also a traditional birth attendant. She received some formal training in midwifery during the 1990s from a church-run health facility in Dimapur, Nagaland. She underwent the training as no birth attendants were in her village then. She has also been engaged as an ASHA Worker (Accredited Social Health Activist)

under the NRHM in her village. She is a certified traditional birth attendant with three years (1991-94) of training from Holy Redeemer, Chumukedima, Nagaland. She has been recognised for her skills and commitment to her work, and she was awarded the best ASHA in the Senapati district in 2016. Again, she was also awarded the best local ANM in 2018. She speaks Hindi, Manipuri, Maram, Mao, Poumei, English, Zeme and Nagamese and attends to clients from all communities.

Mrs. Pungdila generally carries out her care activities from her own home. People come from villages far and near, mainly due to word of mouth, and she has excellent skills in observing anomalies in pregnancy and suggesting the best ways to overcome them. Currently, she attends to at least 6-7 patients a day. Most people come to seek advice during the early stages of pregnancy. She attends to issues relating to conception, pregnancy, delivery, post-natal care and menopause. However, being a midwife during the delivery is her primary area of expertise and commitment. As per the records, she has maintained that she has attended at least 2000 births in the past 30 years.

Mrs. Pungdila is contented that she has been attending to deliveries in some families for more than one generation. In some cases, she has been the midwife of all the births in the family. She said, *“There are about 20 families which I have been attending all the births for two generations.”* Sometimes, she takes care of all the births in the village. Only cases with perceived complications are referred to the hospital. She has garnered a reputation among those who hear of her ability to ensure a smooth pregnancy and delivery. Occasionally, she is invited to the homes of expectant mothers to stay overnight, where she monitors their progress and offers essential counselling, massage, or medication as needed. In instances where home delivery is not feasible, she often accompanies the pregnant woman to the hospital, providing support throughout the entire delivery process.

Mrs. Pungdila does not use or recommend injections for speeding up the labour and delivery either at home or in the hospital. She uses Asli oil and oils blessed by the priests, a glove, and Cervi prime 0.5mg Gel to carry out procedures during delivery. In the hospitals, she remains a keen observer and assistant to the doctors who attend to the delivery and provides clear information to the doctors about the condition of the pregnant woman and fetus. The doctors also appreciate her assistance and trust her knowledge and intuition. On taking pregnant women to the hospital, she said, *“I can attend the birth if the baby arrives in a position with head/buttock/leg first. But there are cases like a narrow birth canal, a very healthy fetus, wrong position of the fetus, undue delay in labour, and chances of pre-birth placenta delivery. When I know of these cases, I take them straightaway to the hospital. Often, the delivery is made through c-section surgery”*.

According to Mrs. Pungdila, home deliveries are a common practice in villages, even in those near Senapati with access to hospitals. In remote villages, families often resort to home deliveries due to the significant distance and inadequate transportation options during labour. For instance, in a village located 50 kilometres from the nearest hospital or Primary Health Centre, it can take two to three hours to transport a woman to medical facilities, primarily due to poor road conditions. Mrs. Pungdila recalls a particular case from Yangkhullen village, which is approximately 80 kilometres from the district hospital. In this instance, the family chose to conduct the delivery at home with the assistance of an elder. Complications arose when the placenta became lodged during delivery, prompting a call for her support after about two hours. On arrival, she noticed that the birth canal had swollen abnormally. She also saw the women had not used gloves or lubricants while attending to the delivery. She had to take the women to the district hospital by road to make safe delivery of the placenta. The women had to undergo further treatment for two days. The mother and child were healthy otherwise. She also stated that the doctors in the PHCs and CHCs request her to oversee deliveries in the villages where the women cannot come to the hospital. In most cases, normal deliveries take place.

The TBA is confident about her methods and her capacity to address the problems of pregnant women effectively and without fear. She has exceptional observation skills to identify the baby's body parts in the uterus when she examines the belly of the pregnant woman. She can locate the baby's head, hands, legs, and body through touch. In one instance with a client, she identified a lump that was not part of the fetus, which was later confirmed as a fibroid through an ultrasound examination. Her extensive experience allows her to accurately diagnose complications and implement appropriate measures. In cases where complications are anticipated, she typically refers the pregnant woman to a hospital. On occasion, she accompanies the patient to the doctor, sharing her observations with the medical staff. Additionally, women who have been advised to undergo a caesarean section often seek her for a second opinion. She only accepts cases after conducting a thorough examination and if she believes the woman is capable of a normal delivery. She has successfully managed several normal deliveries in such circumstances.

Since the onset of the COVID-19 pandemic, she has experienced a notable rise in the number of clients she serves. During this period, she managed nearly all the deliveries in her village and the surrounding areas. Additionally, during the strikes by nurses and various organizations, home deliveries became more frequent, further increasing the demand for her services.

Mrs. Pungdila has noted a significant rise in complications among women in recent times compared to previous years. Many of these issues appear to stem from lifestyle choices and dietary habits. Pregnant women who engage in minimal physical activity often face difficulties during delivery, necessitating hospitalization. Additionally, women who are weakened by labour and malnutrition require medical attention, as several factors must be monitored, particularly concerning the health of the newborn. One prevalent issue she has observed is the abnormal positioning of the uterus, particularly in women who have undergone caesarean sections. This condition is also common among those who frequently cough, engage in strenuous activities, or experience stress and tension at home.

Furthermore, women who have given birth more than three times may encounter a downward shift of the uterus during menopause, which can lead to sensations of numbness, as well as hip and joint pain.

Mrs. Pungdila is well-informed about various sexually transmitted diseases, including HIV/AIDS. She takes necessary precautions to prevent blood mixing during deliveries, consistently recommending the use of sterilized knives and gloves. If she suspects a patient may have an STD, she advises a referral to a hospital to ensure the safety of both the mother and child. Additionally, she participates in training programs organized by the health department, adhering to their guidelines with diligence. She emphasizes the importance of consulting knowledgeable medical professionals, highlighting that contemporary health challenges necessitate their expertise. "Ultimately, our focus is on the well-being of the mother and child, rather than merely demonstrating my knowledge and skills," she stated.

Mrs. Pungdila does not charge any fixed amount from the patients for her services. However, there are fixed charges for the materials used, which do not exceed Rs.100-150 per person, which may include gloves, blades, syringes, etc. She is paid in both cash and kind. People usually give any amount from Rs.100 to Rs.1000 based on capacity. They also give her local rice, vegetables, meat, and various local goods as a sign of gratitude. In the event of a home delivery at a different village, her transportation is taken care of by the patient's family. She says that the income she earns from her work helps her meet various family expenditures to be considered a professional.

Preferences in Choices of Treatment:

The preferred treatment choice among the people was measured to understand the existing practices among the people as normative behaviour in times of healthcare distress. The sample population was guided in expressing their responses on treatment for minor illnesses, mild to severe illnesses, and the eventual outcome, as well as their appreciation

of the effectiveness of treatment mode. Queries were put forward during one-to-one interviews and group discussions to understand the different dimensions of their choices regularly.

Table 6.8: First Preference in Treatment of a Minor Illness

Categories	Frequency	Percentage (%)
Traditional home-based medicine	209	92.89
Over counter medication	10	4.44
Consult a medical doctor	6	2.67
Total	225	100

Source: Fieldwork

Table 6.8 reveals that an overwhelming 93 per cent of respondents preferred treatment for minor illnesses over traditional homemade remedies. In contrast, the use of over-the-counter medications accounts for only four per cent, while consultations with medical practitioners represent a mere three per cent, indicating a significantly low tendency. A critical factor influencing these choices is the limited availability of pharmacies and clinics. Most respondents indicated that they favour traditional medicines due to their perceived effectiveness and accessibility as treatment options. The minor illnesses identified during interviews and discussions include colds, coughs, headaches, migraines, fevers, bruises and cuts, muscle cramps, sprains, and minor skin conditions.

Choice of Treatment for Children and Adults:

A separate assessment was conducted to evaluate treatment preferences for adults and children. As illustrated in Table 6.9, notable similarities exist in the selection of treatments and medications for children. Therefore, it is reasonable to conclude that there is a significant reliance on traditional medicines within the community.

Table 6.9: Healthcare for Minor Illnesses for Children and Adults

Treatment preference	Children		Adults	
	Frequency	%	Frequency	%
Home Remedies	135	60	200	88.89
Visit a Pharmacy	31	13.78	8	3.56
Consult a Nurse or an ASHA Worker	24	10.67	7	3.11
Use medicines available at home	9	4.00	6	2.67
Consult an allopathic doctor at the hospital or clinic	7	3.11	4	1.78
Not applicable	19	8.44	0	0
Total households	225	100	225	100

Source: Fieldwork.

As illustrated in Table 6.9, among the 225 family respondents, a significant majority—over 60 percent—expressed a preference for traditional medicines compared to other available treatment options within their communities. Notably, when it comes to children, there is a greater inclination to seek treatment in consultation with nurses, ASHA workers, and medical doctors. This trend is largely attributed to the improved follow-up mechanisms established by the public healthcare system. However, in remote villages situated slightly away from the National Highway, reliance on home remedies approaches nearly 100 per cent.

Healthcare Choice for Major Health Concerns:

Several factors influenced the decision to utilize healthcare facilities within the district or state during periods of serious illness or injury. The study revealed a growing trend among individuals and families opting for advanced treatment centres located in district headquarters and the state capital, despite the associated high costs. This shift can be attributed to the evolving nature of diseases, driven by environmental changes, lifestyle modifications, and enhanced knowledge resulting from education and awareness initiatives. To better understand the evolving landscape of healthcare utilization among the Maram community, family respondents were interviewed regarding their use of various services across different levels.

Table 6.10: Healthcare for Major Health Concerns

Choices of Treatment	Frequency	Percentage (%)
Approach a doctor in the district government hospital	48	21.33
Approach a doctor's private Clinic	42	18.67
Take the patient to Imphal at the government facility	33	14.67
Take the patient to Imphal at a private hospital	24	10.67
Take the patient outside Manipur to the private hospital	8	3.56
No major illness/Injury so far in the family	70	31.11
Total	225	100

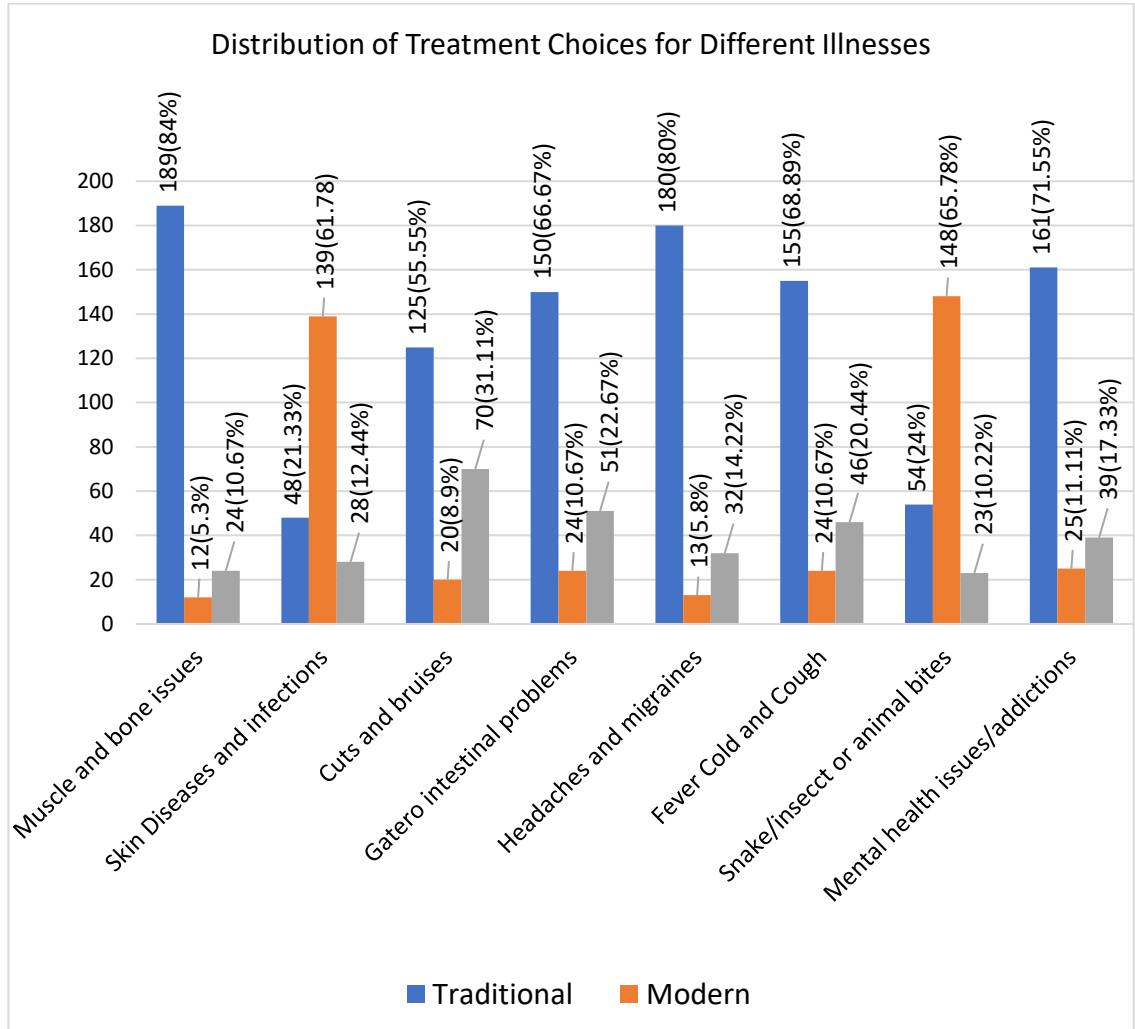
Source: Fieldwork

Table 6.10 indicates that over 31 per cent of respondents reported having no major illnesses in their families that required additional healthcare support, and they had never sought assistance from any facilities for such needs. Approximately 29 per cent of individuals are utilizing services at district hospitals and private clinics. Interviews and discussions revealed a trend toward increased utilization of private services for pregnancy care and delivery. Just over 24 per cent of the population accesses healthcare services in the state capital, utilizing both private and government facilities. A negligible four per cent of respondents reported seeking health services outside of Manipur. Nevertheless, some respondents travel to other states for better healthcare options, primarily due to ongoing ethnic conflicts, clashes, and bandhs within the state.

Illnesses and Choice of Treatment:

The choice of medications or treatment for minor illnesses for adults and children was also assessed based on the respondents' experience in the past two years. Figure 6.5 shows the people's preference while selecting the first option for treatment in the event of a minor ailment.

Figure 6.5: Choices for Different Illnesses



Source: Fieldwork

As it is evident from figure 6.5 traditional medicines are extensively used for treating various illnesses regularly. The study reveals that out of the eight diseases discussed, six were seen to be addressed with traditional medicines. The scope of traditional medicine usage permeates all different types of illnesses and conditions that the commonly found in the region. It was found that 84 per cent of the people suggested traditional treatment for bone and muscle issues. They were of the view that the treatment by the local practitioners is often much effective and cheap. Most of the bone setters do

not even use modern diagnostic techniques for identifying the problem and solving them. During the interviews and discussions, it was observed that most of the people who use the medicines as individuals or caregivers have some knowledge of the medicine. Another factor contributing to the widespread use is the easy availability of herbal plants region; in most cases, at least one to two medicinal plants could be identified from their backyards.

Healthcare Expenditure:

Expenditure on healthcare constitutes a primary financial burden for Indigenous families with limited income. Traditionally, payments to healers were made in the form of agricultural produce. However, accessing medications and consulting allopathic doctors now necessitates financial resources for fees, medications, and travel expenses. In instances of serious health concerns, families often prioritize medical expenditures above all other needs, reallocating resources to address treatment costs. Due to inadequate healthcare facilities in the region, residents of Maram-inhabited areas must seek treatment in Imphal, often at private clinics and hospitals. The resulting high healthcare costs can lead to debt, strain savings, and create challenges in fulfilling other essential family needs, such as nutrition, children's education, and care for other family members

Table 6.11: Healthcare Expenditure of the Families

Healthcare expenditure	Frequency	Percentage (%)
1000-3000	35	15.56
4000-6000	20	8.89
7000-10000	42	18.67
11000-20000	43	19.11
21000-50000	32	14.22
50000 & above	53	23.56
Total	225	100

Source: Fieldwork

Table 6.11 depicts the out-of-pocket expenditure on health by the respondent families during the past year. It is significant to note that 24 per cent of the households surveyed reported healthcare expenditure of more than Rs. 50000 during the past year.

The cumulative percentage of families that spend more than Rs. 10000 on healthcare in a year is 47 per cent.

The community's practice of coming to each other's aid in times of distress is one of the ways in which the families meet otherwise unimaginable healthcare expenditures. Every relative, clan and neighbour contribute whatever they can to the treatment. This timely help enables the families to tide over the financial distress. Reciprocatively, payments are expected as a duty from the family, which receives support when others are in distress. Increasing healthcare expenditures, not only in terms of the doctors' fees and the cost of medicines but also in terms of transportation and allied expenditures, rise every year, making modern medicines unaffordable for most of the people in the villages.

Reasons for Choice of Traditional Medicine:

Traditional medicine is deeply rooted in Indigenous cultures, passed down through generations. It's often seen as a vital part of their identity and heritage (Lahon and Bage, 2023, p.151). Accessibility and affordability are another key factor affecting the choices. In many remote areas, access to modern healthcare facilities is limited. Traditional healers may be the only option available (Norris, et al., 2016, p.). Among the Naga population, both of these contentions are very true as they live in remote, hard reach and difficult geographical conditions with limited access to modern healthcare services. Furthermore, the TMPs have often been trusted within their communities for generations. This trust and familiarity can make them more appealing to the people. It was also felt necessary to look at the perceived reasons for the choice of treatment by the family. The question had seven choices in which the respondents were asked to select all that applied to them.

Table 6.12: Reasons for Choices of Traditional Medicines

Reasons for choices	Yes	%	No	%	Total (%)
Cost-effective	189	84	36	16	225 (100)
Accessible and available	180	80	45	20	225 (100)
Have some knowledge	191	84.89	34	15.11	225 (100)
Traditional medicine is effective	164	72.89	61	27.11	225 (100)
Allopathic medicine is costly	151	67.11	74	32.89	225 (100)
Doctors are not easily available	74	32.89	151	67.11	225 (100)

Source: Fieldwork. Note: Figures in brackets are percentages.

As indicated in Table 6.12, individuals exhibit a preference for traditional treatments for various reasons. Notably, 85 per cent of respondents utilize traditional medicines, largely due to their existing knowledge of home remedies. Factors such as accessibility, availability, cost-effectiveness, and perceptions of efficacy play critical roles in their decision-making processes. However, 27 per cent of participants expressed scepticism regarding the effectiveness of traditional medicine. One respondent noted that they opt for modern medicine for quicker recovery, particularly during the busy farming season when fieldwork cannot be neglected.⁶⁵ Another respondent mentioned that the bitter taste of homemade herbal remedies deters children from consuming them.⁶⁶

Analysis of the Determinant Choices of Healthcare:

Accessibility

The survey was carried out in 12 villages, of which four were fairly accessible as they are located along the national highway. They have improved access to transport and communication. Eight of the targeted villages were considered inaccessible as they are around 20 or more kilometres away from the national highway. These villages do not have regular transportation services that connect to the towns and cities.

⁶⁵ Female, 42 yrs, respondent, Willong Khullen

⁶⁶ Male, 52 yrs, respondent, Maram Centre

Table 6.13: Accessibility and Choices of Healthcare

Accessibility	N-12	%	N-225	%	TM	%	AM	%	Total
Fairly Accessible Villages	4	33.33	90	40.00	79	87.78	11	12.22	100
Hard-to-reach villages	8	66.67	135	60.00	130	96.30	5	3.70	100
Total	12	100%	225	100%	209		16		225

Source: Fieldwork. Note: N-Total Number, Percentage, TM- Traditional Medicine, AM- Allopathic Medicine.

As illustrated in Table 6.13, nearly 70 per cent of the villages can be classified as remote, characterized by limited access to transportation and communication facilities. Simultaneously, 60 per cent of the family respondents reside in these hard-to-reach villages. Accessibility significantly influences their healthcare choices; over 96 per cent of individuals in remote villages prefer traditional medicine over modern alternatives. Even in inaccessible villages, traditional medicine remains the predominant choice, accounting for 88 per cent of responses. This trend underscores a substantial reliance on traditional medicine as the primary treatment option for healthcare issues in both remote and accessible villages. Consequently, it can be concluded that geographical location has a limited impact on the choice of medicinal practices among the Maram community.

Education

Education standards among the Maram community have seen significant advancement, with a majority of young individuals successfully completing their graduation. The youth are gaining substantial exposure to the broader world as they travel and reside in various regions of the country and abroad for educational and employment opportunities. In this context, these educated young people are swiftly adapting to contemporary lifestyles. Nevertheless, it is important to note that most remain deeply connected to their families as well as the traditions and customs of their communities. This strong attachment to cultural identity often heightens their appreciation and understanding of Indigenous medicine.

Table 6.14: Education of the Respondent and Choice of Healthcare

Education	N- 225	%	TM	%	AM	%	Total
Illiterate	73	32.44	73	100	0	0	100
Primary School	49	21.78	46	93.88	3	6.12	100
Middle & High school	55	24.44	48	87.27	7	12.72	100
College Education	48	21.33	42	87.5	6	12.5	100
Total	225	100	209		16		225

Source: Fieldwork. Note: N-Total Number, Percentage, TM- Traditional Medicine, AM- Allopathic Medicine.

Table 6.14 illustrates that the healthcare choices of both illiterate individuals and those with primary education show minimal significance. Notably, all of the illiterate respondents, who constitute 32 per cent of the total, indicated a preference for traditional medicine as their primary healthcare choice. Similarly, among respondents with primary school education, 94 per cent reported favouring traditional medicine. Furthermore, a significant overlap exists among high school and college-educated respondents, with 87 per cent and 88 per cent, respectively, also selecting traditional medicine as their primary healthcare option over modern medicine.

In both the one-to-one discussions and the focus group sessions, respondents indicated that their preference for traditional medicines primarily stems from their easy availability, accessibility, and affordability, along with a general perception of their effectiveness. It is important to note that educated Maram individuals residing in other parts of the country, or those with sufficient financial resources, may exhibit differing attitudes and practices regarding these remedies.

Family Income

As the majority of respondents belong to the subsistence agriculture category, a significant portion of the population falls below the poverty line. The demand for financial resources primarily arises in relation to education and healthcare, which are often financed through loans from extended family and friends. Calculating the annual income of the

respondents proved to be a challenging task, as most individuals lacked cash receipts to document their earnings. Consequently, income was estimated based on the total value of agricultural produce and livestock that they could sell.

Table 6.15: Family Income and Choice of Healthcare

Family Annual Income	N-225	%	TM	%	AM	%	Total (%)
Less than 24000	101	44.89	99	98	2	2	100
25000 to 60000	69	30.67	67	97	2	3	100
61000 to 120000	32	14.22	29	91	3	9	100
More than 120000	23	10.22	14	61	9	39	100
Total	225	100	209		16		225

Source: Fieldwork. Note: N-Total Number, Percentage, TM- Traditional Medicine, AM- Allopathic Medicine.

As depicted in Table 6.15 nearly 45 per cent of the respondents have income below 24000 annually. This results in a monthly income of INR 2,000. Notably, over 31 per cent of respondents live on approximately INR 5,000 a month, while an additional 14 per cent report a monthly income of INR 10,000. Across these income groups, healthcare choices are largely similar, with more than 90 per cent opting for traditional medicine as their primary form of healthcare. However, it is important to note that as income levels increase, reliance on traditional medicine tends to decline. For respondents with an annual income of INR 1.2 lakhs or more, dependence on traditional medicine significantly decreases to 61 per cent, although this group constitutes only 10 per cent of the total respondents.

Occupation

The majority of respondents identified agriculture as their primary occupation. Additionally, some individuals reported being engaged in business or were unemployed, yet their families were significantly involved in agricultural activities. Consequently, nearly 80 per cent of the respondent families relied on agriculture for their livelihoods. Approximately 10 per cent were employed as government servants, while around 12 per cent were engaged in the private sector.

Table 6.16: Occupation and Choice of Healthcare

Occupation	N-225	%	TM	%	AM	%	Total
Agriculture	120	55.33	120	100	0	0.00	100
Business	27	13.78	24	88.89	3	11.11	100
Unemployed	24	10.67	21	87.50	3	12.50	100
Govt Service	20	9.89	17	85.00	3	15.00	100
Private Service	29	12.89	24	82.76	5	17.24	100
Student	5	2.22	3	60.00	2	40.00	100
Total	225	100	209		16		225

Source: Fieldwork. Note: N-Total Number, Percentage, TM- Traditional Medicine, AM- Allopathic Medicine.

Table 6.16 details the cross-tabulation of the respondent with their occupation and choices of health treatment between traditional and modern medicine. The study revealed that all the respondents are found engaged in agricultural livelihoods utilized traditional medicine as their primary healthcare source. Over 80 per cent of respondents from other occupations also reported a preference for traditional medicine. This indicates a significant consistency in healthcare choices across different occupations within the Maram population. The reliance on traditional medicine is widespread, transcending variations in occupation, income levels, education, and geographical locations. Most respondents identified agriculture as their main occupation, although some reported being engaged in business or unemployed, with substantial family involvement in agriculture. Consequently, nearly 80 per cent of the respondent families relied on agriculture for their livelihoods. Additionally, approximately 10 per cent of respondents were government employees, while around 12 per cent were employed in the private sector.

Factors affecting healthcare utilization:

There are several factors that influence the utilization of modern healthcare services by the Maram people in the region.

Acceptability

Although the Maram community is embedded with cultural beliefs and practices and has a formidable knowledge of traditional healing practices and strong faith in its effectiveness; improved education and awareness have enhanced their trust in modern medicine. There is still a noticeable preference for traditional healers over biomedicine among the older generation. For them, often, illnesses are attributed to spiritual causes, leading to seeking help from spiritual healers instead of medical professionals. The attitudes of Indigenous people towards modern medicine are evolving. While traditional healing practices remain important, there is a growing recognition of the benefits of modern medicine, especially in situations requiring immediate and specialized care.

Availability & Accessibility

The gross inadequacy of the healthcare facilities and personnel are one of the key factors affecting general healthcare services utilization in the remote villages. As stated in Table 6.11, 10 out of 12 villages do not have a sub-centre; only one Public Health centre is available in the entire study region. In emergency situations or instances of serious injury or illness, individuals must travel a minimum of 45 to 50 kilometres to access necessary healthcare services. In contrast, traditional medicine and herbal remedies are readily available and routinely utilized by the Maram community. A respondent from Maram Bazar raised concerns about the deteriorating condition of the Primary Health Centre (PHC) located within the village. He pointed out that the number of doctors at the PHC has decreased, leaving only two- a dentist and a physician- on duty. Previously, the facility had more than two doctors and operated 24/7 since 2016. This decline in medical personnel coincided with the election of a new representative from a neighbouring tribe to the legislative assembly, suggesting that political factors significantly impact the public healthcare system. While surrounding villages have seen improvements to their Community Health Centres (CHCs), local residents and village authorities have sought assistance from the health director and district hospital, yet their efforts have been met with little success.

It is important to note that in Primary Health Centre (PHC) and Community Health Centres (CHC), doctors are not available on a 24/7 basis, despite being advertised as offering full-day service. Consequently, individuals may find themselves waiting until the following day to receive medical attention, particularly in the event of an emergency occurring in the evening. Sometimes people hire taxis to go to PHCs or private clinics but have to return home and go again the next day to meet the doctor again, which adds to the expenses, and delays in treatment.⁶⁷ People go to traditional practitioners for health issues with nerves, dislocation, fractures, and minor cases based on the expertise available within the village and neighbouring villages.⁶⁸ If the traditional practitioners are not available at home, people even go to the field to meet the practitioners, and in case of emergency, the practitioner is called back home.⁶⁹

Affordability

The Marams are primarily subsistence agriculturalists with very limited sources of additional income. As such there is an economic disadvantage in accessing healthcare services. Most of the cost in regard to healthcare services in the region is concentrated on the travel and transport. The general refrain is that, even for the pregnant woman to visit the doctor for ante-natal or post-natal check-ups – which is free in the PHCs and CHCs – it is unaffordable for most of the families due to the travel cost involved. The lack of public transport from the villages to the nearest towns is the main cause of escalated cost in hiring vehicles to go the clinics and hospitals. Families fall into deep economic distress whenever they have to access advanced medical support from Senapati, Imphal or elsewhere in the region. Not only they have to find means to pay for the medical services, medicines and tests, the cost for transportation together with financing accommodation and food for the bystanders. Most of the government hospitals specialist doctors and adequate medicines.⁷⁰

⁶⁷ Male, 30 yrs, respondent, Maram Mathak Sagai

⁶⁸ Women, Focus Group Discussion on 23/02/2020 at 1.30 pm, Maram Centre Village

⁶⁹ Women folk, Focus Group Discussion on 22/09/2020, 2.00 pm, Willong Khullen Village.

⁷⁰ Elders (men and women), Focus Group Discussion on 14/10/2020 at 11.50, Maram Khulakpa Sagei.

The study reveals that the choice and utilization of modern medical services among the Maram are significantly influenced by socio-economic factors. Traditional medicine remains prevalent among the Maram tribes, who reside primarily in remote and challenging hilly terrains. Their reliance on traditional medicine is often driven by necessity and limited access to modern healthcare. The inherent knowledge of local herbs, their easy availability, and the perceived effectiveness of traditional remedies contribute to their widespread use, especially in more accessible villages. The community has a rich understanding of various herbal concoctions, which are both affordable and serve as the primary healthcare option for the Marams. Moreover, traditional healthcare practices, alongside biomedicine, hold deep cultural significance and familiarity within the community, forming an integral part of their identity. Consequently, it is important to recognize that the shift in healthcare paradigms is primarily emerging from the Maram population.

Chapter 7

SUMMARY AND CONCLUSION

Health remains a primary concern for Indigenous populations, particularly when compared to non-Indigenous communities. The UN treatise on Indigenous health states that the Indigenous communities across the world are characterized by “the prevalence of extreme poverty is notably greater among Indigenous peoples compared to non-Indigenous groups. This disparity is driven by several factors, including limited access to education and social services, the dismantling of Indigenous economies and socio-political structures, forced displacement, armed conflict, and the loss and degradation of their traditional lands and resources.” It further elaborates that “structural racism and discrimination make Indigenous women and children particularly vulnerable to poor health. Because of these phenomena, Indigenous peoples experience high levels of maternal and infant mortality, malnutrition, cardiovascular illnesses, HIV/AIDS and other infectious diseases such as malaria and tuberculosis” (Inter-Agency Support Group on Indigenous Peoples Issues, 2014, p.2).

The tribal communities in India significantly trail the national average across various critical public health indicators, with women and children representing the most vulnerable segments of the population. The tribal communities in India consistently fall short of the national average across various critical public health indicators, with women and children representing the most vulnerable segments of these populations. Furthermore, the Indigenous communities are the most exploited and highly vulnerable to diseases with a high degree of malnutrition, morbidity, and mortality (Shrivastava et al., 2013, p.6). The key concerns with regard to public health delivery to the Indigenous populations in India have been the inadequate outlay of the public healthcare infrastructure and personnel, remoteness, rugged and tough geographical terrain with limited transportation and communication facilities, cultural and traditional barriers in accessing modern healthcare services as well as educational and socio-political problems faced by

the communities. However, in pursuing the spirit of the SDGs, it is important that all stakeholders be involved in exploring possibilities and opportunities to ensure the health and well-being of the Indigenous people.

Traditional medicines have a crucial role in maintaining the health and well-being of over 80 per cent of the Indigenous people. WHO recommends that it is vital to incorporate traditional knowledge, perspectives and practices in implementing healthcare programmes to address the challenges faced by the Indigenous peoples effectively. According to WHO, advancing healthcare indicators for Indigenous populations necessitates promoting training, education, and leadership development for Indigenous healers. It is essential to formally integrate these healers into the health system where appropriate. It is also essential to advocate for integrating an intercultural approach within the curricula of all training and degree programs related to health and allied fields, as well as its implementation across all healthcare institutions. (Pan American Health Organization, [RAHO], 2006, p.2).

This study attempted to explore the existing healthcare concerns and the role of traditional healthcare practices in the health and well-being of Maram Tribe inhabiting parts of Senapati district in Manipur, as a representative population of the Indigenous people in the North East India. Qualitative and quantitative data were collected and analysed to understand the health and healthcare concerns and the health-seeking habits of the Marams, focusing on traditional medicine practices. The study has revealed the characteristics of a cross-section of the Maram tribe, the only particularly vulnerable tribal group (PVTG) in Manipur. Personal interviews, field observations, focus group discussions and case studies were carried out in 12 of the 36 revenue villages inhabited primarily by the Maram tribe. The interview schedule covered 225 households. Ten FGDs were conducted with different community groups. In-depth interviews with 16 traditional practitioners and community elders were also part of the study's strategies to understand the attitudes and practices.

The study aimed to create a comprehensive narrative of the Maram community to better understand their healthcare concerns, knowledge, attitudes, practices, and available resources. The Marams primarily engage in subsistence agriculture, with most villages situated on hilltops. Only a select few villages along National Highway 02, which traverses the region, have reasonable access to modern amenities related to education, employment, livelihoods, and healthcare. In contrast, the more remote villages maintain traditional lifestyles, with many elders adhering to long-standing values and customs that define the community's unique identity. Notably, there has been significant progress in education among children, as evidenced by all the children's enrolment rates in schools. However, over 60 per cent of older individuals remain illiterate. Despite a relatively equitable distribution of healthcare infrastructure and personnel concerning the population, there are substantial deficiencies in healthcare delivery. Many villages encounter considerable challenges in accessing essential services due to their remoteness, difficult geographical terrain, and inadequate transportation and communication systems.

The overall perception of families and individuals regarding their health status is largely positive, with over 67 per cent reporting their family's health as good or excellent. This suggests that the Marams, as a community, generally enjoy good health, experiencing a limited incidence of serious illnesses and health-related issues.

This study showed that communicable diseases are a significant concern for families, with 79 per cent having encountered various illnesses in the past year. Families with children and older people are found to be more susceptible to minor diseases like cold and cough, viral fever, jaundice, diarrhoea, etc. It is also noticeable that there are fewer cases of vector-borne diseases like malaria and dengue and airborne diseases like tuberculosis, and no incidence of COVID-19 has been reported in the region.

Among the Maram Nagas, the incidence of non-communicable and lifestyle diseases is found to be increasing at a steady pace, with more than 60 per cent of the

families reporting one or more of the conditions like high blood pressure, migraines and chronic stomach problems. Diabetes is becoming more common among the Maram Nagas, with increased cases of high sugar being reported among the elderly. Kidney and liver problems are also found to be occurring among the people. It has been observed that at least one to two individuals were diagnosed with cancer or various types of ulcers in each village.

The study revealed that while narcotic substance abuse is not perceived as a significant issue, the consumption of alcohol and tobacco in various forms is widespread among families. Respondents expressed considerable concern regarding the detrimental effects of tobacco and alcohol on health and well-being. Over 60 per cent of families reported that at least one member regularly consumes some form of alcohol, whether it be Indian Made Foreign Liquor (IMFL) or locally brewed rice wine. Despite community efforts to mitigate alcohol consumption, including a ban on liquor sales, it is widely acknowledged that alcohol use remains prevalent, particularly among the youth. Additionally, there are annual reports of fatalities attributed to alcohol consumption, although these cases are often not substantiated by medical examinations or autopsies.

There were 74 cases of disability reported in the 12 villages as per the information available from the village leaders. The primary disabilities identified in the study were related to vision and hearing, with reports also noting locomotor disabilities. Additionally, only two cases of intellectual disabilities among children were observed.

In evaluating the nutritional standards of the population under study, it was observed that 78 per cent regard nutrition as the most critical factor in maintaining good health. The general consensus is that locally available traditional food items can provide adequate nutrition. Rice serves as the staple diet, with individuals typically consuming two full meals daily; those engaged in agricultural work often have an additional meal to sustain their energy levels. Vegetables and leafy greens, both cultivated and foraged from

the forest, are essential components of the daily diet. Efforts are made to incorporate protein sources, including various meats, insects, local fish, a selection of legumes, and numerous wild mushrooms. Furthermore, individuals recognize and value the medicinal properties of several food items they regularly consume.

The study found that the Maram tribe primarily depends on perennial water sources or rainfall for all requirements during the year. Access to clean drinking water is a significant concern for 68 per cent of families. While rainwater is collected for daily use during the rainy season, 88 per cent of families rely on manual water collection in the dry season. Alarming, nearly 50 per cent of these families must walk over 2 kilometres to collect water. Mostly, only women and children are engaged in water collection. The geographical terrain and prevailing conditions make rainwater harvesting for individual households both labour-intensive and costly. Furthermore, only a small percentage, specifically nine per cent, have access to water connections provided by the local government.

The sanitation and hygiene of individuals are directly correlated with the availability of water. The study indicates that 72 per cent of families lack running water in their toilets. Additionally, maintaining toilet facilities during the dry season presents challenges, leading to their infrequent use as families attempt to conserve water. Open defecation is practised by adults in the jungles adjacent to or on the farmlands. Bathing and washing of clothes have to be limited during the dry season. It is pertinent to note that cases of diarrhoea, jaundice and skin diseases were reported in the last year, apparently due to the lack of proper hygiene.

In this study, access to healthcare services has emerged as a significant concern for families in the surveyed villages. Seventy-two per cent of respondents reported challenges stemming from inadequate infrastructure and insufficient personnel. Most significant medical treatments are conducted at the district headquarters or the state capital.

Consequently, a substantial portion of healthcare expenses is attributed to travel and transportation costs. There is also the question of the language barrier for the people from villages, and hence, they must get additional help/translator to communicate with the medical personnel. There is an additional cost involved in the accommodation of translators and helpers. Nearly 80 per cent of the people who availed healthcare services in the cities had to borrow money to finance the treatment. It takes years to clear the loans taken for treatment purposes. It was found that 93 per cent (210 households) have accessed primary healthcare facilities and pharmacies during the last year. Most of the respondents said that the first point of medicine was always the nearest medical shop.

The study revealed a significant observation regarding the healthcare infrastructure: 10 out of the 12 villages examined lack a sub-centre. There is only one PHC covering the entire region in Maram Bazaar, while the nearest Community Health Centre is at Tadubi Block (Sub-division), which is at an average distance of 25 km from villages under the study. The nearest district hospital is at Senapati district headquarters, which is at an average distance of 45 Km from the villages. Multi-specialty hospitals are found only in Imphal, 70 kilometres from the study area.

This study delves into the existing and near-extinct healthcare knowledge systems, experiences, and practices of the Marams based on their traditional way of life. The study found that to date, the Maram Nagas tribe is replete with traditions, customs, and rituals that supposedly contribute to the health, well-being and happiness of the individuals, families and communities. The concept of health and happiness of the Marams can broadly be put into three categories, the first is the person's perception and feelings about their own health. The second is how other people see and interpret the person's appearance. The third is the observation and assistance provided by the healthcare practitioners (traditional and professional). It is to be noted that, in the supernatural realm of the Marams, two kinds of powers affect and control the people's lives. The first is the *Siira kabi*, who is considered the God of benevolence, providing good health, bountiful harvest,

good weather, and victory over the enemy, and the second is the *Siira kasii* – the God of malevolence, which causes diseases, infirmity, misfortune, and natural calamities.

The study reveals several aspects of health and wellbeing are significantly associated with rituals and magic. Albeit the original Maram belief system is on the verge of extinction, some of the beliefs and practices are fervently followed with or without explicit knowledge of the purpose and result of the same. The observation of “genna” in the Maram Nagas environment can be broadly divided into three categories. These are taboos, observations, and rituals performed for the benefit of people’s physical, mental, emotional, social, and financial well-being, as well as that of their communities. In local parlance, they are *Mannai* (a non-working day), *Tiikanii* (taboo) and *Kanat* (ritual).

The ancient religion of the Maram tribe was animism, a religion of taboos, and the spiritual world was peopled with both good and evil spirits in parallel existence with the natural world. The harmonious existence in the natural world is determined by the appeasement and mercy of the spirits. *Mannai* (a non-working day) is diligently observed to propitiate the malevolent spirits, for they could harm humans and damage crops. *Mannai* sought to please and seek *Siira’s* (God or spirit) protection against natural disasters, bountiful harvests and a healthy life. Several of the diseases were attributed to the wrath of the Gods due to man’s misdeeds or flouting of *Mannai*. *Tiikanii*, meaning forbidden or prohibited, is associated with religious and social practices and environmental sacrilege, forming a guideline for life. *Kanat* is a rite to perform rituals, animal sacrificial rites, and bathing purifications. The performance of various rituals at the family and community level, such as naming ceremonies, sickness, festivals, and hunting.

For the Maram Nagas, the concepts of illness and disease are seen as manifestations of God’s wrath. They believe that these health issues are intricately linked to the supernatural, which influences their approach to treatment. Traditionally, ritualistic

remedies were known primarily to the elders. There remains a strong connection between supernatural beliefs and superstitious practices, which revolve around various signs, actions, words, and symbols within the Maram community. Such occurrences are often regarded as unfortunate events that could arise. Individuals who experience these phenomena typically take precautions by performing various rituals to ward off negative influences.

In the Maram way of life, traditional festivals extend beyond mere celebration; each festival is intricately structured with customary traditions and ritualistic elements. These events play a vital role in addressing the physiological, psychological, mental, emotional, spiritual, and social well-being of the communities that observe them. Festivals dedicated to health, such as *Malem*, *Kanghi*, and *Kataimei Rakak*, continue to be fervently celebrated. The rituals performed during these festivals are intended to promote good health and overall well-being. Notably, the ritual known as *Tingpui Maru-Manai* emphasizes spiritual purification. At the same time, *Achy-marung* (dog sacrifice) is conducted in response to fear of epidemics or natural disasters that may threaten the community.

This study explored the traditional knowledge surrounding mother and child healthcare practices, which is deeply rooted in the cultural customs, taboos, beliefs, and rituals; still observed by the Maram people. In traditional settings, family elders, extended relatives, and neighbours possess a remarkable ability to accurately identify pregnancy. Pregnancy care includes a variety of food practices, taboos, and beliefs. It is crucial for pregnant women to observe specific restrictions to avert miscarriages and to ensure the health of both mother and child during childbirth. In the Maram Naga community, the birthing process is characterized by shared responsibilities among family members, relatives, and neighbours.

A key aspect of delivery is the *Kiilam* (placenta), which is an important focus after the child's birth. Traditional midwives are consulted throughout the journey from conception to pregnancy care, delivery, and post-natal support. In terms of neonatal care and practices, it is customary to sacrifice a fowl to celebrate the birth of a child; a rooster is offered for a boy and a hen for a girl. Additionally, relatives present a rooster or hen as gifts during the naming ceremony and *Kanghi* festivals, depending on the child's gender. The study indicates that during post-natal care, lactating mothers are encouraged to consume various leafy vegetables and non-vegetarian foods to enhance both the quality and quantity of breast milk. Celebratory meals, rituals, and practices surrounding infant care culminate in the *N'pamrah*, a purification ritual for children under two years of age intended to invoke blessings for health and prosperity.

The study found that among the Maram Nagas, customs, traditions, rituals, and beliefs play a complex and multifaceted role in the health and well-being of communities. The study evidently found that factors of different cultural elements are perceived to have some impact on the individual's physical, psychological, emotional, and social health. The people believe that rituals and beliefs can provide meaning and purpose in life, particularly when facing illness or adversity. These rituals, customs and traditional festivals offer comfort, hope, and a sense of control over challenging situations.

It was found that the ethnomedicinal treatment and home remedies are mainly based on the plants and animals that are found in the vicinity of Maram. The study found that nearly all the Maram families (98 per cent) have some knowledge of different home remedies and regularly use them. The knowledge is naturally acquired from the elders in the family. A sizeable section of the community (68 per cent) has the capacity to identify more than five medicinal plants and the method of using them for different illnesses. It may be noted that 89 per cent of the respondents were treated with home remedies for ailments such as viral fever, cold and cough, migraines and headaches, cuts and bruises. The use of home remedies could be broadly divided into three: firstly, some of the plants

are consumed as cooked/boiled; secondly, certain plants are taken raw in the form of juice or salad; and thirdly, certain plants are used externally by applying the paste, extracting juice to apply or used during massage and hot/warm baths.

As such, medicinal plants are found to grow naturally in their surroundings. Almost all the families reported using different naturally available herbal plants regularly and include several leaves, roots, seeds, insects and animals in their regular diet, purportedly for their health benefit. These food items are recommended during seasons, certain health conditions or illnesses, pregnancy and lactation, etc. People also consume several of these as part of their regular meals due to the taste and liking they have developed over the years.

The study found that 82 per cent of the respondents are into the practice of growing herbal plants at home and in their surroundings. The study found the commonly grown herbal plants are of *Apourangtiiti/Kanemti* (Cape gooseberry), *Kang-gai* (Bitter melon/Gourd/ Karela), *Hiipi/ Mahiila* (Sweet Basil) *Kavii* (Ginger), *Lungsiihii /Modina/ Takpa* (Spearmint), *Ramchi* (Taro), *Rangdigai* (Trichodesma Kumareum), *Kabihiila/Tamtunii* (*Elsholtzia Griffithii* Hook. F.), *Ramnok* (Pleasant Himalayan Mint), *Rangkananhii* (*Nongmangkha*), *Karananii* (Castor plant), *Gainam* (chives), *Saroutpot-ti* (*Passion fruit*), *Burakamti* (Indian Nightshade), *Ramchi* (Taro), *Sataigobi* (Cabbage) and *Kafiiti/ kafii-rangbungti* (Pomegranate), etc. This study has been able to identify the 42 most commonly used herbal plants and describe their uses as per the inputs from the respondents and traditional practitioners.

In Maram language, *Ahii* means medicine; all the plants with *Hii* in the plant's name indicate that they have some medicinal properties. The Marams utilize various parts of plants to address a range of ailments, including leaves, flowers, fruits, seeds, tubers, barks, rhizomes, stems, roots, twigs, tender shoots, and entire plants. Research indicates that leaves are the most frequently employed component for treatment. These plants are

typically harvested from open areas, agricultural fields, and forest regions, as well as cultivated in backyard gardens. Common ailments treated include influenza and fever, gastrointestinal issues, headaches and migraines, sprains and fractures, bodily aches and pains, skin conditions, insect bites, cuts and bruises, menstrual cramps, and maternal and child care.

Similar to other Indigenous communities, the Maram Nagas tribe faces significant limitations in accessing modern health services, resulting in a heightened reliance on traditional medicines and healthcare practitioners. Nevertheless, as infrastructure, manpower, and general awareness continue to improve, there is a noticeable increase in the utilization of modern healthcare services within the community.

The study revealed that allopathic doctors are present in only two of the twelve villages examined. While nurses are appointed in nine villages, the majority do not reside there, often due to various circumstances. They typically visit the villages sporadically, primarily during routine immunization programs and health screening camps. In contrast, ASHA workers and Anganwadi workers are available in all villages, while traditional midwives and practitioners play a pivotal role in healthcare delivery within the community.

Traditional Medicine Practitioners (TMPs) in the region primarily include Traditional Birth Attendants (TBAs), muscle and bone setters (masseurs), herbalists, diviners, and spiritual healers. The majority of TMPs are female TBAs, many of whom possess the capability to address various healthcare concerns. Notably, there is one male TBA who regularly assists with deliveries in the village. The TMP demographic is predominantly elderly, with very few young practitioners currently active in the region. Among the 16 TMPs interviewed, 13 (88 per cent) reported having knowledge of preparing a variety of herbal medicines. Furthermore, nearly all TMPs engage in farming and provide treatment services only when patients approach them.

On average, 1-4 patients are attended by most of the TMPs. The remuneration is either in cash or in kind. The TMPs generally treat their patients in their homes or at the agricultural fields where they work; occasionally, they visit the patients' homes at request. The TMPs often refer the patients to modern doctors if they find the case to be complicated. Traditional Medicine Practitioners (TMPs) frequently refer patients to modern medical doctors when they encounter complex cases. The most common conditions addressed by these practitioners include delivery care, viral infections, cold and cough, gastrointestinal issues, fractures, sprains, muscle aches, skin conditions, body aches, wounds, and inflammation. It is important to note that, similar to other regions in the country, TMPs in the Maram area have not established any permanent treatment centres, nor do they consider their practice a primary source of livelihood.

Research indicates that, despite improved access to allopathic medicine, approximately 93 per cent of respondents still prefer traditional practitioners and home remedies as their primary treatment option. Notably, among the Maram Nagas, there is an increasing tendency to utilize allopathic medical facilities for children's health needs. However, in cases involving cuts, bruises, or musculoskeletal issues, the guidance of traditional medicine practitioners is still frequently sought. In instances of serious illness within families, individuals typically turn to district or state-level hospitals and clinics for care. Traditional medicines are extensively used to treat various illnesses regularly. The scope of traditional medicine permeates all different types of illnesses and health conditions commonly found in the region. It was found that 84 per cent of the people suggested traditional treatment for bone and muscle issues. They believe that the treatment by the local practitioners is often much more effective and cheaper. Similarly, the dependence on traditional medicine for stomach ailments, migraines, and most pregnancy-related problems is discernible, with more than 60 per cent of the respondents opting for the same.

The study reveals the factors influencing healthcare choices, specifically analysing the interrelationship between accessibility, education, family income, and occupation. The findings reveal that accessibility significantly impacts healthcare preferences; over 96 per cent of individuals in remote villages opted for traditional medicine over modern alternatives. Even in more accessible villages, a substantial majority – 88 per cent – favoured traditional medicine. This trend underscores a notable reliance on traditional medicine as the primary treatment option for healthcare issues in families in remote and accessible areas. It can be concluded that geographical location has limited significance in shaping the medicinal choices among the Maram Nagas community.

It was found that all of the illiterate respondents, who constitute 32 per cent of the sample, selected traditional medicine as their primary healthcare choice. Additionally, there is no significant difference in the preferences of high school and college-educated respondents, with both groups overwhelmingly favouring traditional medicine—87 per cent and 88 per cent, respectively—over modern medicine. The healthcare choices of both illiterate and literate individuals (with only primary education) show minimal significance.

The study revealed that 90 per cent of respondents with an annual family income below ₹120,000 primarily chose traditional medicine. Notably, as income levels increase, reliance on traditional medicine significantly decreases. Among respondents with an annual income of ₹120,000 or more, dependence on traditional medicine drops substantially to 61 per cent. However, this higher-income group constitutes only 10 per cent of the respondents. The study revealed that all the respondents are engaged in agricultural livelihoods and use traditional medicines as their primary healthcare source. Moreover, over 80 per cent of respondents from various occupations expressed a preference for traditional medicine as their primary healthcare choice. This data suggests that there is little variation in healthcare preferences across different occupations within the Maram population.

The prevalent dependence on traditional medicine as a primary healthcare option transcends various factors, including occupation, income, education, and geographical location. Among the Maram community, several determinants influence the utilization of modern healthcare services. Key influences include the acceptance of cultural beliefs and practices, as well as socioeconomic factors that impact accessibility, availability, and affordability. Together, these elements significantly shape the health-seeking behaviours of the Maram Nagas.

The study on the dynamics of Indigenous healthcare practices among the Maram Nagas unveils a complex interplay between tradition and modernity. Geographic isolation and restricted access to modern healthcare facilities have compelled the Maram community to rely heavily on traditional medicine. This reliance transcends mere convenience; it is deeply rooted in their cultural and spiritual beliefs.

Findings indicate that traditional medicinal practices, particularly herbal remedies, serve as effective, accessible, and affordable healthcare alternatives for the Maram population. However, the efficacy of faith-based customs and rituals remains uncertain and necessitates further scientific investigation. Traditional herbal medicine presents a promising pathway for delivering primary healthcare, especially in resource-limited settings such as the hilly regions of northeast India. Thus, understanding and leveraging herbal medicine can enhance individual health outcomes and improve overall community well-being. An integrative approach to healthcare delivery is essential to safeguarding the health of the Maram people. This approach should harmonize the strengths of traditional and modern medicine, honouring the community's cultural heritage while incorporating scientific advancements. Future research should focus on evaluating the efficacy of traditional remedies, identifying potential risks and side effects, and exploring the development of standardized herbal formulations. By bridging the divide between tradition and modernity, we can empower the Maram people to make informed choices regarding their health and well-being.

Recommendations

This study highlights the importance of a collaborative approach to improve the health and well-being of the Maram Nagas tribe. By working together, policymakers, healthcare workers, academics, social workers, and the Maram Nagas community itself can ensure culturally sensitive, accessible, and effective healthcare for all.

- Healthcare infrastructure development in remote areas and better transportation are needed to facilitate access to primary healthcare facilities and ensure timely healthcare services.
- Furthermore, creating a culturally inclusive healthcare model is vital. This would involve integrating traditional Maram Nagas practices with modern medicine, allowing for care that is respectful and sensitive to the community's values and beliefs.
- Accommodating traditional medicine as an alternative medicine under one roof in the Primary Health Centre will enhance healthcare utilization. Asian countries like Sri Lanka, Indonesia and China have successfully paved the way, as several studies highlight.
- It is important that scientific research must be carried out on the efficacy and safety of herbal remedies. It is also relevant that a collaborative intervention with Maram Nagas elders and traditional healers to document their healthcare knowledge and practices. Academicians can further the cause of traditional medicines as viable alternatives in the primary care setting by creating educational materials for healthcare workers and the public on integrating traditional Maram Nagas practices with modern medicine.
- Social workers and community leaders need to work with the communities to address issues like poverty, unemployment, deprivation, and other vulnerabilities so that the factors affecting healthcare negatively are ameliorated. There should be a concerted effort towards developing an appreciative learning environment

among the younger generation such that beneficial traditional knowledge and practices are preserved and promoted for the welfare of the larger community.

- It is important that the community itself makes concerted efforts to document and preserve the traditional knowledge. It would be not only for the Maram Nagas alone but also for the Indigenous Nagas living contiguously in similar geographic and climatic conditions with limited access to modern medicine.
- It is important that government studies on the efficacy and safety of traditional medicines used by the Maram Nagas are carried out. This will provide scientific evidence to support its integration with modern healthcare. Facilitate integration and develop policies encouraging collaboration between traditional healers and modern healthcare providers. This could involve training programs and referral systems. It goes without saying that there is a need to increase access to modern healthcare in remote areas while considering the value of traditional practices. Mobile clinics, equipping local health workers with knowledge of traditional medicine, should be promoted in the hard-to-reach villages that lack regular healthcare personnel.
- It is necessary to understand traditional healing practices in the Maram Nagas community. This would foster trust and build partnerships with traditional healers to enhance access to treatment. It is important to develop a system where patients can be referred to traditional healers for conditions deemed suitable for their practices. It is also very crucial that people are educated about the potential benefits and limitations of both traditional and modern medicine.
- It is essential to enhance the collaboration between traditional and modern practitioners. They should work alongside healthcare providers to create safe and effective treatment plans that integrate both traditional and contemporary medical practices. Furthermore, it would be advantageous for traditional practitioners to contribute to the research and documentation of traditional medicines, thereby strengthening the overall knowledge base for future advancements.

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ANNEXURE-I

Nagaland University

Title of the Study: DYNAMICS OF INDIGENOUS HEALTHCARE PRACTICES OF MARAM

NAGA TRIBE

Name of the Scholar-Judith Huidina

Interview Schedule for Families

Family Healthcare Survey

I. RESPONDENT PROFILE:

a	Name:	
b	Gender:	
c	Age:	
d	Marital status:	
e	Education:	

f	Occupation:		
	(1) Cultivator	(2) Business	(3) Agriculture laborer
	(4) Govt. employed	(5) Private Employed	(6) Any (other specify)
g	Type of family:		
	(1) Joint Family	(2) Nuclear Family	(3) Extended Family
h	Religion/ Denomination:		
i	Village:		
j	Monthly income:		

II. FAMILY DATA: (In relationship to the respondent)

Code.	Relationship	Gender	Age	Education	Monthly income	Remarks

III. ASSESSMENT OF SHELTER, NUTRITION, WATER, SANITATION AND HYGIENE OF THE FAMILY

a. What best describe the house you are living in?

Code	Categories	Remarks	Code	Categories	Remarks
1	Own		2	Rented	
3	Leased		4	Ancestral Property shared by other families	
5	Any other				

b. What kind of house are you living in?

Code	Categories	Remarks	Code	Categories	Remarks
1	RCC Building		2	Brick wall with tin roof	
3	Bamboo walls with Tin Roof		4	Bamboo walls with traditional grass/palm leaves roof	
5	Mud Wall house		6	Wooden house	

c. Do you have livestock reared adjacent to your house?

Code	Categories	Remarks	Code	Categories	Remarks
1	Dogs		2	Cat	
3	Pigs		4	Poultry	
5	Cattle		6	Any other	

d. Do you have a toilet for your house?

Yes		No	
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e. If yes, What type of toilet do you have. Note: R=Remarks

Code	Categories	R	Code	Categories	R
1	Attached toilet within the house with running water		2	Attached toilet within the house without running water	
3	Pucca toilet in the compound with running water		4	Pucca toilet in the compound without running water	
5	Kachcha toilet with commode		6	Kachcha toilet without commode	
7	Any other				

f. What is your main water source?

Code	Categories	R	Code	Categories	R
1	Regular Government/Community Water supply (through Pipes)		2	Private water supply from open streams	
3	Open Well		4	Water collected during rains	
5	Tube Well		6	Community Water Supply	
7	Water purchased from private vendors.		8	No Water source – Carry/ fetch headloads from nearby wells or streams	

g. Do you have proper drainage system in and around your house?

Code	Categories	R	Code	Categories	R
1	Pucca built in drainage with no change of water logging near the house		2	No proper drainage, waste water does not accumulate near the house as it flows off naturally	
3	No proper drainage, water accumulates near the house		4	Community drainage system built by the government	
5	Any other				

h. What is your observation about the personal hygiene of the members in the family

Code	Categories	R	Code	Categories	R
1	Everyone takes bath at least once in a day		2	Only those who do work in the field take bath once a day during winter	
3	Takes bath 2 times a week		4	Frequency of Bathing depends on seasons and availability of water	
5	Any other				

i) How many full meals does your family have in a day?

Code	Categories	Remarks	Code	Categories	Remarks
1	Once in a day		3	Thrice in a Day	
2	Twice in a day		4	Any other	

i. What does your normal family meal consists of? (1=all meals in a day, 2=at least during one meal in a day, 3 = at least once in a week, 4 = very rarely, 5=never)

Rice		Meat	
Vegetables		Dried/Smoked Meat	
Leafy vegetables		Milk	
Pulses (Dal, Chana, Peas, etc		Fruits	
Eggs		Bakery Items	
Fish		Noodles, & other packed items	

IV. FAMILY HEALTH ASSESSMENT

- a. What do you think about health status of the individual family members? (Code description best fits)

Code	Parameter	Code /Remarks	Code	Parameter	Code/Remarks
1	Excellent		4	Very Poor	
2	Good		5	Poor	
3	Don't Know		6	Any other	

- b. Have any one in your family undergone any of the following tests in the past one year? (Put the Code description best fits them)

Categories	Code/ Remarks	Categories	Code/ Remarks
Blood Sugar Check		Eye Screening	
Blood Pressure Check		Bone Density Check	
Dental Examination		Kidney Function Test	
Cholesterol Screening		Liver Function Test	
Mammogram		Cancer Screening	
Pregnancy related tests		None of the above	

- c. Do you feel any of the following is affecting your family health now or is going to affect your family in the future?

Categories	Yes/No/ Remarks	Categories	Yes/No/ Remarks
Smoking		Family Predisposition	
Drinking Alcohol/Rice Beer		Poor Water Quality	
Chewing Pan/Tobacco		Poor Air quality	
Hard work in the farm		Lack of Medicines	
Overweight		Poor Nutrition	
Any Other			

- d. Do you/your family members suffer/have suffered from any of the following health conditions? (Put the Code description best fits them)

Categories	Code /Remarks	Categories	Code/ Remarks
High Blood Pressure		Mental Health Disorders	
Diabetes		Heart Disease	
Asthma		Lung Disease	
Liver and Kidney related illnesses		Stroke	
Arthritis		Alcoholism or any other addiction	

Cancer		Chronic Stomach Pain	
Overweight		Migraine	

- e. Have your family members been affected by any of the following communicable diseases in the past one year? (Put the Code description best fits them))

Categories	Code /Remarks	Categories	Code/ Remarks
Common Flu		Tuberculosis	
Viral Fever		Jaundice	
Diarrhea		Skin Diseases	
Malaria		Measles	
Dengue		Any Other	

- f. Are/have you or anyone in the family using or used any of the following substances? (Put the Code description best fits them)

Categories	Code/ Remarks	Categories	Code/ Remarks
Alcohol (Beer, Whiskey, Roksi etc)		PAN/Tamul	
Rice Beer		Smoking - Cigarette, Beedi etc	
Tobacco		Other Drugs	

- g. Do anyone in the family is affected by any congenital/acquired disability? (Put the Code description best fits them)

Categories	Code / Remarks	Categories	Code / Remarks
Locomotor Disability		Speech	
Sight		Intellectual disability	
Hearing		Mental disability	
Disfigurements of the body		Dwarfism	
Loss of limbs		Any other	

- h. Have any one in the family been seriously ill or deceased in the past one year?

Code	Deceased/seriously ill/injured	Relationship with the respondent	Cause of death/nature of the illness

- i. Have anyone undergone pregnancy or delivery in the family in the past one year? (Put the Code description best fits them)

Code	Home	Hospital		Pregnancy Continuing			Medical Terminal Pregnancy	Miscarriage
		Normal	C-Section	1 st	2 nd	3 rd		

- j. If there are children below the age of 10, what is the status of immunization of the children? (Reasons for not administering vaccines may be- (1) not available, (2) not aware, (3) not interested, (4) not affordable (5) Any other.

Vaccine	Time Given	Yes /No	Code/ Remarks
BCG	At birth or as early as possible till one year of age		
Hepatitis B Birth dose	At birth or as early as possible within 24 hours		
OPV Birth dose	At birth or as early as possible within the first 15 days		
OPV 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks		
IPV (Inactivated Polio Vaccine)	14 weeks		
Pentavalent 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks		
Rota Virus Vaccine	At 6 weeks, 10 weeks & 14 weeks		
Measles 1 st Dose	9 completed months-12 months. (give up to 5 years if not received at 9-12 months age)		
Vitamin A, 1 st Dose	At 9 months with measles		
DPT 1 st booster	16-24 months		
OPV Booster	16-24 months		
Measles 2 nd dose	16-24 Months		
Vitamin A (2 nd to 9 th dose)	16 months with DPT/OPV booster, then, one dose every 6 month up to the age of 5 years)		
DPT 2 nd Booster	5-6 years		
TT	10 years & 16 years how many times?		

k. Major Expenditure on Health in the past one Year

Code	Expenditure	Disease/ condition	Code	Expenditure	Disease/ condition
1	1000-3000		2	3000-6000	
3	6000-10000		4	10000-20000	
5	20000-50000		6	50000 and above	

l. Any indebtedness due to the medical expenditure?

V.ACCESS AND UTILIZATION OF HEALTHCARE SERVICES & PERSONNEL BY THE FAMILY

a. What you do/ whom do you approach when there is a case of minor illness or injury among adults in your family?

Code	Categories	R	Code	Categories	R
1	Treat them with local traditional medicines		2	Consult a nurse or Asha Worker nearby	
3	Obtain medicines from a medical shop		4	Use the medicines available at home	
5	Consult a medical doctor at the government hospital		6	Any other	

b. What you do/ whom do you approach for fever and minor illnesses of children in the family?

Code	Categories	R	Code	Categories	R
1	Treat them with local traditional medicines		2	Consult a nurse or Asha Worker nearby	
3	Obtain medicines from a medical shop		4	Use the medicines available at home	
5	Consult a medical doctor at the government hospital		6	Consult a medical doctor at the private hospital	
7	None of the above		8	Any Other	

c. What do you do/whom do you approach for a major illness or injury in the family?

Code	Categories	R	Code	Categories	R
1	Approach a doctor in the district government hospital		2	Take the patient to Imphal at the government facility	
3	Approach a doctor in the private hospital nearby		4	Take the patient to Imphal at a private hospital	
5	Take the patient outside Manipur, to private hospital		6	None of the above	

d. Do you know /consult a traditional herbalist or faith-based healer?

YES		No	
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e. If yes, for what kind of illnesses you approach a traditional practitioner? (Tick all that are relevant)

Code	Categories	√	R	Code	Categories	√	R
1	Sprains, Muscle Cramps			2	Different kinds of aches and pains		
3	Bone settings			4	Mental and psychological disorders		
5	Stomach related problems			6	Addictions		
7	Pregnancy/ delivery			8	Any Other		

f. If yes, for what kind of illnesses you approach a faith-based healer?

Code	Categories	√	R	Code	Categories	√	R
1	Sprains, Muscle Cramps			2	Different kinds of aches and pains		
3	Bone settings			4	Mental and psychological disorders		
5	Stomach related problems			6	Addictions		
7	Any other						

g. In case if any of your family members have any type of disability, which of the following have you done to address for alleviating the condition?

Code	Categories	√	R	Code	Categories	√	R
1	Visited regular doctors for treatment			2	Have done assessment of the disability and disability certifications obtained		
3	Visited specialist doctors for advice and treatment			4	Continuing with treatment with the herbal practitioners		
5	Regularly visits faith-based healing centres and traditional diviners			6	None of the above		
7	All of the above			8	Any other		

VI. KNOWLEDGE AND PRACTICE OF TRADITIONAL NATURAL MEDICINES IN THE FAMILY

a. What do you think health and well-being is?

b. Prioritize the following:

Code	Categories	R	Code	Categories	R
1	Education		2	Health	
3	Employment/Livelihood		4	Religion	
5	Public infrastructure		6	Ethnic identity	

c. Perception of cultural Elements in Health and Well-Being:
(1- Physical, 2-psychological, 3-emotional, 4-Social)

Code	Categories	Remarks	Code	Categories	Remarks
1	Custom		2	Ritual	
3	Tradition		4	Religion	
5	Festivals and observance				

d. Do you or anyone in the family are aware of any traditional medicines/local medicines for treatment of illnesses or injury?

Yes		No	
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e. Do you know any person who is practicing herbal/traditional medicine in your locality or region?

S. No	Name	Major Diseases Treated	Location & Contact Number	Remarks

f. Do you/anyone in the family know of any local medications for the following. (Tick all that are relevant)

Categories	✓/ Remarks	Categories	✓/ Remarks
Common Flu		Cold and cough	
Sprains/Muscle Cramps		Minor headaches to Migraines	
Skin rashes		Menstrual Cramps or discomforts	
Snake or insect bites		Pregnancy Care medications	
Food Poisoning		Easy Delivery	
Cuts or bruises		Care for the new born baby	
Stomach aches, bloating, Gastric etc		Care for the post-natal mothers	

Breastfeeding mothers for increasing breastmilk as well as health of the mothers		Any other	
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- g. How effective has treatment with the traditional medicines in preventing or treating illness or injury?

Code	Categories	v/ R	Code	Categories	v/ R
1	Very effective (Normally able to cure/contain the disease)		2	Fairly effective – initially able to contain until further treatment from doctors are made	
3	Not effective – the condition worsened even after use of traditional medicine		4	Any other	

- h. Do you grow medicinal plants or herbs around your house? Can you name some?

S. No	Name of the plant or herb	Use	Remarks

- i. What according to your understanding is the benefit of using traditional medicines

Code	Categories	v/ Remarks	Code	Categories	v/ Remarks
1	Effectiveness		2	Easy availability	
3	Low cost		4	They can be prepared at home	
5	No side effects		6	Any other	

- j. What is your first family preference in approaching a traditional healer or modern practitioner? (Grade from 1 to 5) Highly Preferred=1, Preferred=2, Neutral=3, No Preference=4, Never=5, (T= traditional & M = Modern) Why?

Categories	T	M	R	Categories	T	M	R
Common Flu				Cold and cough			
Sprains/Muscle Cramps				Minor headaches to Migraines			
Skin rashes				Menstrual Cramps or discomforts			
Snake or insect bites				Pregnancy Care medications			
Food Poisoning				Easy Delivery			
Cuts or bruises				Care for the newborn baby			
Stomachaches, bloating, Gastric etc				Care for the post-natal mothers			
Bone fractures				Any other			

ANNEXURE-II

Nagaland University

Title of the Study: DYNAMICS OF INDIGENOUS HEALTHCARE PRACTICES OF MARAM
NAGA TRIBE

Name of the Scholar-Judith Huidina
Interview Schedule for Focus Group Discussion
Role of Community in Health-Seeking Behaviour

Name of the Village:

Block:

District:

I. Demographic Information:

a. Population

Male	Female	Total
Literate	Literate	Total

b. Children (0-6)

Male		Female		Total
0-6	07-18	0-6	7-18	

c. Poverty line

BPL Households	APL Households	Total

d. Occupation

Occupation	Population	Occupation	Population
Farmers		Govt. Servants	
Doctors/nurses		Army/Police	
Teachers		Traders	
Laborers		Others	

II. Facilities:

a. Educational Infrastructure

A. Nursery Schools/ Anganwadi/ Creche (If None–How far is the nearest facility)(in km)	B. Primary Schools (If None – How far is the nearest facility?) (in km)	
C. Secondary Schools (If None – How far is the nearest facility) (in km)	D. Senior Secondary Schools (If None – How far is the nearest facility)(in km)	
E. Colleges (If None – How far is the nearest facility) (in km)	F. Other Educational institutions	

b. Health Infrastructure

A. Primary Health Centre (If None How far is the nearest facility) (in km)		B. Community Health Centre (If None – How far is the nearest facility) (in km)	
C. Private Clinics (If None – How far is the nearest facility) (in km)		D. Hospice/Hospital (If None – How far is the nearest facility)(in km)	
E. Pharmacy (If None – How far is the nearest facility) (in km)		Traditional Midwives	
E. Traditional Medicine Practitioners		Any Others	

c. Water

a) Is there Government/ Community Water Supply	YES / NO			
A1. Frequency of water supply	Daily		Weekly	
b) If No, what is most common source of Water for the villagers	Well	Pond	Stream	River
c) How far is this water source from the inhabited area (in Km)				
d) Do you think the water from these sources is free of pollutants?	YES/NO			
e) Is there a common water treatment/filtration mechanism?				

e. Transportation, Electricity & Communication

a) Is there a blacktopped approach road to the village?	YES/NO
b) Are there blacktopped roads within in the village?	YES/NO
c) Is there telephone connection in the village?	YES/NO

d) Is the village connected by mobile networks?	YES/NO
e) Is the village fully electrified?	YES/NO

f. Sanitation

a) Have all the households in the village toilets?	YES/NO
b) How many households in the village have toilets?	
c) Are there common toilets for the villagers maintained by the community?	YES/NO
d) If yes, how many such toilets are there in the village?	
e) Where do the people without toilets defecate?	
f) Is there a common drainage system in the village for management of waste water?	YES/NO

g. Health services-personnel

a) How many doctors reside and practice in the village?		
b) How many doctors visit the village daily basis?		
c) If a & b =0, How often does a doctor visit the village? (tick the relevant box below)		
Once/Twice a week	Once in a month	Rarely
d) How many Nurses reside in the village?		
e) How many Traditional practitioners reside in the village?		
f) How many midwives reside in the village?		
g) How many trained health workers/health assistants reside in the village? (ASHA Workers)		

h. Health services-2

a) Who takes care of childbirths in the villages	
b) What is his/her qualification?	
c) Has any pregnant lady die during childbirth in the previous year? (If Yes, How many?)	
d) Has any infant or child die last year? (If yes, How many? reason)	
e) What is the most common illness troubling the village?	
f) How many persons have died due to this disease during the past one year?	
g) How far is the nearest hospital/clinic the villagers visit during serious illnesses? (km)	
h) How long does it take to reach this Centre?	
i) What is transport facility do you use to reach this Centre?	

- i. General Views and Perspectives of healthcare concerns in the community.
 - a. Major diseases
 - b. Nutrition
 - c. Sanitation and hygiene
 - d. Quality of water
 - e. Lifestyle
- j. General Views and Perspectives on public healthcare delivery
 - a. Is the availability of public health care meeting the needs of the people? Yes/no?
If no, please explain why?
 - b. Is the service easily Accessible to the people of the villagers.
 - c. Are basic healthcare services affordable for the villagers?
 - d. What is your opinion on the healthcare services Quality for the villager?
 - e. What is your opinion on who is responsible for establishing the healthcare centres?

III. Ailments in the Village:

a. What were the serious illnesses reported in your village in the past one year

Sl	Name of the disease	No of persons affected	Under Treatment	Cured	Died	Remarks
1	Malaria					
2	Typhoid					
3	Pneumonia					
4	Jaundice/hepatitis					
5	Tuberculosis					
6	Diarrhea					
7	Cancer					
8	Diabetes					
9	HIV/AIDS					
10	Heart Disease					
11	Liver/Kidney Ailments					
12	Stroke/BP					
13	Road Accidents – Serious injury					
14	Domestic Accidents – Serious Injury					
15	Alcoholism/Drug Abuse					
16	Pregnancy and Child Birth related issues					

17	Unknown disease					
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IV. Traditions, Customs, Belief, practice and Health:

Pregnancy and Child Birth

1	Identification of pregnancy	
2	Early Pregnancy Care for the women	
3	Continuous Care for pregnant women	
4	Identification of gender of fetus	
5	Ensuring Normal Delivery	
6	Care for the New Born Child	
7	Post-delivery care for the Mother	
8	Improve quality and quantity of breast milk	

a. Health of Children

1	Food Items that are traditionally recommended for good health of the children	
2	Any special activities that are traditionally done to improve the health of the children	
3	Anything that is done to protect the children from serious illnesses	
4	Traditional treatments for the children for skin ailments, bruises, scars etc.	

b. Prevention of Communicable Diseases (Any traditional means for prevention of the communicable diseases generally known to the people)

1	Diarrhea	
2	Malaria	
3	Jaundice	
4	Typhoid	
5	Any other	

c. Commonly Practiced Traditional Remedies. (Home Remedies)

1	Diarrhea	
2	Malaria	
3	Jaundice	
4	Stomach Aches/ Gastric Etc.	
5	Skin Diseases	
6	Poisoning – Insect bites, Snakebites etc.	
7	Food Poisoning	

8	Head Aches, Migraines	
9	Arthritis, Joint pain Etc.	
10	Typhoid	
11	Pneumonia	

d. Food and Nutrition

1	No of full Meals in a day	
2	Most common food Items	
3	Is there any food items that are seasonal?	
4	Foods that are considered poisonous/bad for health (Seasonally or otherwise)	
5	Foods that are considered good for health and has capacity to cure illnesses	
6	Common traditional food items recommended for children	
7	Common food items recommended for pregnant women	
8	Common food items recommended for the aged.	

- e. General views and perspectives on traditional practices that are beneficial to the health of the community

V. RITUALS, FESTIVALS AND CUSTOMARY PRACTICES IMPACT ON HEALTH (Discussion on the relationship between rituals or customary practices and health- List the same

a.

Sl.No	Rituals, Festivals Customs, Art forms	Relationship/perceived impact on health

b. Traditional Natural Medicine Practitioners & Healers approached by the people in the community

Sl. No	Name of the Practitioner or Healer	Methodology (Natural medicine/Faith/Occult)	Diseases/ Conditions treated	Location	Remarks Fulltime/part-time

c. Medicinal plants or herbs grown around the village?

S. No	Name of the plant or herb	Use	Remarks

VI. Modern Healthcare Amenities Access and Utilization

a.

Sl.No	Healthcare Facilities	Location	Distance	Remarks
1	Sub Centre			
2	Public Health Centre			
3	Community Health Centre			
4	District Hospital			
5	Medical College			
6	Ambulance Service			
7	Medical Laboratory			
8	X-Ray, ECG			
9	Pharmacy			
10	Private Clinic (only OP)			
11	Private Hospital (IP)			

b. Healthcare Personnel

Sl.no	Personnel	Units	Location	Distance	Remarks
1	Anganwadi Workers				
2	Asha Workers				
3	General Nurse				
4	General Practitioner (Doctors)				
5	Gynecologist				
6	Pediatrician				
7	Orthopedic Doctor				
8	ENT				
9	Skin Specialist				
10	Cardiologist				
11	Neurologist				
12	Ophthalmologist				
13	Psychiatrist				
14	Physiotherapist				
15	Nephrologist				

c. Are there any diseases that were life threatening in the past?

- a. Have their incidence increased or decreased?
 - b. If increased, what are the preventive and curative measurements adopted?
 - c. If decreased, what do you think is the reason for the same?
- d. Is there any new diseases affecting the community?
- a. If yes, which are those diseases? Reason/ causes of the diseases.
 - b. What are the curative and preventive measures commonly adopted by the people?
- e. General views and perspectives of traditional practices and habits those are detrimental to health.
-
- f. General views and perspective on affordability, availability and accessibility of modern health facilities in village.
-

VII. a. Access to Treatment and Rehabilitation for Persons with Disabilities in The Village.

b.

Sl.no	Type of Disability	No of Persons	Disability certificate	Linked to Schemes	Under Treatment
1	Locomotor				
2	Blind-partially Blind				
3	Deaf/partially Deaf				
4	Amputees (hands/legs)				
5	Intellectual Disabilities				
6	Mental Disabilities				
7	Disfigurements				
8	Others				

General view and perception about the cause of disability (Chart Paper)

ANNEXURE-III

Nagaland University

Title of the Study: DYNAMICS OF INDIGENOUS HEALTHCARE PRACTICES OF MARAM NAGA TRIBE

Name of the Scholar-Judith Huidina

Interview Schedule for Traditional Medicine Practitioner

DATE: _____

Name of the Facility (Optional)		Registration – Facility (If available)	
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1. Demographic Data

Name of the Respondent		Profession/Position	
Professional Registration of the Respondent (if Any)		Gender	
Age		Marital Status	
Educational Qualification		No of years in Practice/Service	

2. Professional & Practice Details

Specialization – if any		No of years in practice	
Average number of clients/Patients per day		Average duration of consultation with the client/patient per visit	

3. Ailments or conditions Treated

(AC-Average cost, D-Duration, E-effectiveness, Ref.-referrals & R=remarks)

Sl.no	Diseases or conditions	Treatment (Yes/No)	A C	D	E	Ref.	R
1	Fevers, cold and cough						
2	Stomach – Diarrhea, Gastric issues, food poisoning						
3	Headaches, Migraines						
4	Jaundice						
5	Malaria						
6	Dengue, Bird Flu etc.						
7	Tuberculosis						

8	High Blood Pressure						
9	Cholesterol						
10	Diabetes						
11	Cancer						
12	Heart Conditions						
13	Fractures – Bone setting						
14	Sprains – Muscle and ligament						
15	Arthritis						
16	Rheumatism						
17	Skin Diseases/conditions						
18	Eye/Vision or sight problems						
19	Ear/hearing problems						
20	Cuts and Bruises						
21	Care for Pregnant Women						
22	Delivery – Midwifery						
23	Post-natal care for the mother and child						
24	Impotency, infertility						
25	Physiotherapy – Massages, occupational therapies etc.						
26	Treatment for substance abuse/addictions						

4. Do patients prefer traditional medicine as compared to modern medicine?

Yes [] No []

If yes, why do patients prefer traditional medicine?

Code	Category	Remarks	Code	Category	Remarks
1	Convenience		2	Affordability	
3	Efficiency		4	Accessibility	
5	Good taste		6	Lack of modern health centers	

5. How did you acquire those traditional medicinal treatment skills?

a. Relatives [] b. Self-Taught [] c. Formal Training []

d. Traditional Healer: Ancestral/ hereditary []

i. Do you share knowledge with others?

ii. If yes, with whom

iii. If no, why

e. Others specify.....

6. How do you ensure that your treatment is effective and safe for the patients who approach you?

- (a) Interactions and discussions with other traditional healthcare practitioners.
- (b) Attending training programme organized by different NGOs or Departments
- (c) Referrals and linkages with the modern healthcare services.
- (d) Others specify.....

7. What is the payment arrangement usually made by clients?

- (a) By cash []
- (b) Through livestock []
- (c) Rice, Vegetables etc. []
- (d) Installments []
- (e) Others specify.....

8. Do you recommend training of Traditional Medical Practitioners for their practice?

Yes	No	Remarks

9. Do you send the patients to modern health practitioners?

Yes	No	Remarks

10. Do you face any operational challenges?

Yes	No	Remarks

If yes, what are these challenges?

- (a) Financial challenges
- (b) Logistics
- (c) Personnel
- (d) Low educational level
- (e) Others specify.....

11. In your opinion how do you think these challenges can be solved?

12. Do you observe increased number of patients?

13. In your opinion, is there any new diseases affecting the people?

(a) If yes, which are those diseases?

15. Any remedies for emerging health challenges.