Research Article

Youth, Ethnomedicine and The Access Gap: Health Care in Transition Among The Idu Mishimi and Adi Padam of Lower Dibang Valley, Arunachal Pradesh, India

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Abstract

Objective: To describe how younger and older members of two tribal communities in north-eastern India use traditional and modern health care, and to assess the health infrastructure available to their villages. Methods: Exploratory qualitative study in four villages of Lower Dibang Valley district, Arunachal Pradesh, India. Open-ended informal interviews were combined with village-level data from the Census of India 2011, state-level Rural Health Statistics 2019–20 and published literature. Results: Younger and older respondents alike preferred modern medical care and kept home-based medicinal plants for minor ailments. Respondents attributed the decline of traditional healing to the non-transmission of knowledge and to the shrinking number of ritual healers. Public facilities were described as poorly equipped and short of staff. No village with census data had a Primary Health Centre within 10 kilometres, and two had no Community Health Centre within 10 kilometres. Across Arunachal Pradesh, the shortfall of specialists in Community Health Centres rose from 124 in 2005 to 226 in 2020. Serious illness usually meant travel to Dibrugarh in Assam or private care, with high out-of-pocket costs. Conclusion: Young people in these villages grow up with modern care as the default, but it is distant, costly and thinly staffed, while the traditional system that once offset this gap is not being passed on. Strengthening peripheral facilities and documenting traditional knowledge with the participation of young people are complementary priorities.

Keywords: Health Services Accessibility; Rural Health Services; Medicine, Traditional; Indigenous Peoples; India.

1. Introduction

Arunachal Pradesh, in the far north-east of India, was a frontier region until it became a state in 1987. It is the least densely populated Indian state, its dispersed settlements place health facilities far from many dwellings, and it is home to 26 major tribes and many sub-tribes.

This article concerns two of these tribes in Lower Dibang Valley district: the Idu Mishimi[1] and the Adi Padam. Both are traditionally animist and agrarian. Illness has customarily been interpreted as disturbance caused by malevolent spirits and addressed through ritual and medicinal plants, mediated among the Idu Mishimi by a shaman, the Igu[2], and among the Adi by a shaman, the Miri. Modern biomedical services arrived late. The first hospital in the wider region was set up at Sadiya in 1914, largely for strategic and administrative reasons[3], and a functioning three-tier rural health system took shape only after the National Rural Health Mission of 2005.

Young people in these villages therefore grow up between two health systems: a traditional one whose knowledge is thinning, and a modern one that is formally present but practically distant. How they and their elders move between the two, and what the available infrastructure offers them, is poorly documented. This article reports the health component of a wider study of tradition and modernity. It has two aims: to describe how respondents, younger ones included, use and value traditional and modern care; and to assess the adequacy of the modern health infrastructure available to the study villages.

2. Methods

Design and setting. The study was exploratory and qualitative, with an ethnographic orientation. Lower Dibang Valley has an area of about 3,900 square kilometres and a population of about 54,000 (Census 2011). It has a subtropical climate with heavy rain from March to September, and mountainous terrain with plain land in the Roing, Koronu,

Parbuk, Dambuk and Paglam circles. Four villages were studied: Abali and Koronu (predominantly Idu Mishimi) and Balek and Tapat (Adi Padam). Their distances from the district headquarters, Roing, are given in Table 1.

Table 1. Study villages: community, distance from the district headquarters and nearest health centres (Census of India 2011).

Village	Community	Distance from Roing (km)	Nearest Primary Health Centre	Nearest Community Health Centre
Abali	Idu Mishimi	about 1	more than 10 km	none within 10 km
Balek	Adi Padam	about 11	more than 10 km	none within 10 km
Koronu	Idu Mishimi	about 23	not reported	not reported
Tapat	Adi Padam	about 48	more than 10 km	within 5 km

Primary data. Field visits were made to the four villages. Informal, mostly open-ended interviews were held with villagers on health, education and livelihoods. The field work was conducted in the months of January to March 2024. The number of respondents are 36 young and 18 elderly persons in Abali village, 30 young and 15 elderly persons in Balek village, 18 young and 9 elderly in Tapat village and 54 young and 27 elderly in Koronu village, taking the total number of respondents to 207. Youth refer to the age group between 15-29 and elderly corresponds to people above 60 years of age. The respondents were chosen using stratified random sampling method whereby the respondents were chosen randomly between the two age groups in proportion to their approximate population. The interviews were mostly conducted in Hindi and English based on the respondent's preference and linguistic skill. The interviews were conducted orally in the form of exploratory open-ended discussions.

Secondary data. Village-level availability of Community Health Centres and Primary Health Centres was taken from Census of India 2011 village statistics[4]. State-level infrastructure trends for 2005 to 2020 were taken from Rural Health Statistics 2019–20[5]. Ethnomedicinal and historical information came from the published literature cited below.
Ethics: The study was conducted as part of a field study under the supervision of Cotton University. Informed consent was obtained from the respondents orally in an informal format before interviews.

3. Results

Traditional medicine: use, valuation and loss

Elders described a long tradition of treating everyday ailments, and in some cases fractures, with medicinal plants. Both elderly and younger respondents named plants used for minor illness such as diarrhoea. The literature records, for the Adi of Lower Dibang Valley, a wide repertoire that includes treatments for diabetes, wounds, skin conditions and gastric disorders[6].

Respondents of all ages regretted the erosion of this knowledge and gave two reasons. First, knowledge holders were said not to have passed it on within families or to the wider community, which respondents contrasted with the community-based ethos of tribal life. Second, modernisation itself reduced reliance on traditional care. Respondents said that the number of Igu in the state has fallen to about 35, so that a typical Idu village has one or none, and that those remaining are mostly middle-aged. Respondents still expressed pride in the Igu heritage, while being dissatisfied with the healers' dwindling numbers and perceived limits in effectiveness.

Preference for modern care among younger and older respondents

When asked about traditional practices, elderly and young respondents alike stressed the importance of modern medical facilities. Among the Idu Mishimi, the Igu is no longer seen as the sole protector of well-being: modern facilities are the first recourse in illness, and the Igu is called mainly to bless the individual or family for future well-being. Among the Adi Padam of Tapat, traditional care remains in use for minor ailments treated at home with plants, but serious illness is taken to modern facilities. In Balek, respondents described complete dependence on modern medicine. In Koronu, local practitioners of traditional medicine still treat everyday complaints, and respondents reported exposure to malaria and typhoid, which they gave as a reason for needing facilities nearby.

Infrastructure available to the villages

State level. The three-tier structure of sub-centres, Primary Health Centres and Community Health Centres was adopted in Arunachal Pradesh after the Bhore Committee (1946), but central funding began only in the 1970s, and the system received a boost with the National Rural Health Mission in 2005. Between 2005 and 2020, sub-centres fell from 379 to 356, while Community Health Centres rose from 31 to 60 and Primary Health Centres from 85 to 119[5]. Specialist posts did not keep pace: the number of sanctioned rose only from 4 to 14, and the shortfall against requirement rose from 124 to 226 (Table 2). Nursing staff increased about six-fold, leaving a surplus.

Table 2. Public health infrastructure in rural Arunachal Pradesh, 2005 and 2020 (Rural Health Statistics 2019–20).

Indicator	2005	2020
Sub-centres	379	356
Primary Health Centres	85	119
Community Health Centres	31	60
Specialist posts sanctioned in Community Health Centres	4	14
Specialist shortfall in Community Health Centres	124	226

District level. Lower Dibang Valley has about 14 sub-centres, 3 Primary Health Centres and 4 Community Health Centres, and a single district hospital at Roing, for about 54,000 people in a mountainous district with several hundred villages. (Ministry of Health and Family Welfare, Government of India, Rural Health Statistics 2019–20.)

Village level. According to Census 2011 village statistics[4], Abali, Balek and Tapat had no Primary Health Centre, and the nearest one to each was more than 10 kilometres away. Tapat had a Community Health Centre within 5 kilometres, whereas Abali and Balek had none within 10 kilometres (Table 1). Villagers described the district hospital at Roing as lacking equipment and staff.

Access, cost and self-medication

Because local facilities were seen as inadequate, people treated minor illness at home and took serious illness or accidents to private hospitals or to Assam Medical College in Dibrugarh. The Dr. Bhupen Hazarika Setu bridge has lowered travel costs and made the trip more feasible, but respondents still judged the distance too great for emergencies. A young man from Koronu said that unequipped local facilities force families to travel to Dibrugarh or pay for private care, raising out-of-pocket spending and risking delay for critically ill patients. He also described a protest over the absence of doctors at local health centres, which was partly successful: doctors are now available nearby, but only at fixed times on weekdays.

Respondents also bought commonly used medicines from private pharmacies on their own initiative, without a diagnosis. This is likely to raise costs and may lead to ineffective or inappropriate treatment.

4. Discussion

Three findings stand out. First, there is a near-consensus across generations that modern care is the preferred route in illness. The preference is not itself a problem; the difficulty lies in what the modern system can deliver locally. Peripheral facilities exist on paper but, as respondents and the state-level figures indicate, lack specialists and equipment, so the system depends on distant referral. Second, the traditional system is changing in a way that matters for the next generation. Respondents described knowledge that was not transmitted, healers who are few and ageing, and a repertoire reduced to minor ailments. Young people thus inherit neither a well-staffed modern system nor an intact traditional one. Third, the cost falls on households. This is consistent with the wider north-eastern pattern of high out-of-pocket spending and a heavy burden of communicable disease, which health insurance often covers poorly[7,8], and respondents themselves mentioned malaria and typhoid.

The findings agree with the historical account in which modern health services reached the region late and for strategic rather than welfare reasons[3]. They also suggest that policy should not treat traditional medicine and biomedicine as alternatives. Documenting traditional knowledge, with young people as participants, could preserve a low-cost first line of care for minor illness. Strengthening the Community Health Centres and the district hospital would address the serious illness that home remedies cannot.

Relevance to adolescent health. The study was not designed to examine adolescents specifically. The views of younger respondents are reported alongside those of elders, and the age range of the younger respondents is between 15-29 years of age. The findings bear on adolescents indirectly: distance to the nearest Primary or Community Health Centre, the cost of referral, and the loss of intergenerational knowledge of care all shape the setting in which adolescents in these villages obtain health care. Adolescent-specific issues such as reproductive and mental health, nutrition and school health services were not examined and are priorities for future work.

Limitations. This is a small, exploratory, qualitative study in four villages. It used informal interviews without a documented sampling frame or systematic analysis, so its findings cannot be generalised to other tribes or districts. Village-level facility data come from the 2011 Census and may be out of date, and state-level data end in 2020. Adolescents were not sampled or analysed as a separate group.

Conclusion

In Lower Dibang Valley, young and older members of the Idu Mishimi and Adi Padam prefer modern health care but find it distant, costly and thinly staffed, while traditional medicine is declining and is not being passed on. Health planning for these villages should prioritise specialist staffing and equipment in the Community Health Centres and the district hospital, and should support community-led documentation of traditional knowledge. Studies that focus on adolescents in these communities are needed.

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