CHANGEMAKER: AN ACADEMIC JOURNAL OF IDEAS
ISSN: 2348-7747

Caring in the Shadows: Conceptualizing the Role of Traditional Health Practitioners in Rural Healthcare Systems of Northeast India

Thenhoi Kipgen
Department of Geography, Bethany Christian College,
Churachandpur, Manipur, India

Abstract
This study explores the pivotal role of traditional health practitioners within the rural healthcare systems of Northeast India, focusing on indigenous communities such as the Mishing, Garo, Kuki, Naga, and Mizo tribes. Through detailed ethnographic case studies, the research highlights how traditional healers—including herbalists, spiritual practitioners, and women as informal caregivers—provide accessible and culturally resonant healthcare services in remote and underserved regions where formal medical infrastructure is limited or lacking. The findings reveal a diverse array of plant-based remedies and ritualistic practices tailored to community-specific health beliefs and needs. While these traditional systems offer holistic care addressing physical, mental, and spiritual well-being, they face ongoing challenges such as the depletion of medicinal plant species and marginalization within formal health policies and frameworks. The study underscores the necessity of integrating indigenous medical knowledge into broader healthcare systems to enhance accessibility, cultural sensitivity, and long-term sustainability in rural health interventions.

Keywords: Traditional medicine, indigenous health practices, traditional health practitioners, ethnographic studies in healthcare, Northeast India healthcare

Introduction

India, the world's most populous country with an estimated 1.4 billion inhabitants, is home to approximately 100 million indigenous people, often referred to as "Scheduled Tribes" or Adivasis. These communities are unevenly distributed across the country. In northeastern states, Scheduled Tribes constitute more than 65% of the total population, while in states such as Chhattisgarh, Jharkhand, Odisha, Madhya Pradesh, Gujarat, and Rajasthan, their population share ranges between 13% and 32%; in other states, their presence is relatively minor (Subramanian et al., 2006).

The Indian government identifies Scheduled Tribes based on attributes such as "primitive traits, distinctive culture, shyness with the public at large, geographical isolation, and social and economic backwardness," though substantial variation exists

among different communities. While "Scheduled Tribes" is an official administrative term, the word "Adivasis" (meaning "original inhabitants" in Sanskrit) is commonly used to describe these groups, whose presence predates Aryan settlement in the Indian subcontinent (Subramanian et al., 2006).

Indigenous populations continue to experience extreme levels of marginalization and health deprivation (Willis et al., 2004). They remain highly vulnerable to diseases, a situation exacerbated by poverty, illiteracy, poor sanitation, unsafe drinking water, environmental hardship, and certain cultural beliefs (Shrivastava et al., 2013). According to the National Family Health Survey-5 (NFHS-5), only 32.8% of Scheduled Tribe mothers reported having received care from a doctor, compared to the national average of 50.2%.

One critical obstacle to healthcare delivery in tribal areas is the acute shortage of medical staff. Doctors and paramedical workers from the general population are often reluctant to serve in remote areas, while the number of trained tribal healthcare workers remains insufficient (Shrivastava et al., 2013). In this context, indigenous systems of medicine emerge as culturally resonant alternatives that offer not only preventive and curative healthcare but also a holistic understanding of well-being, addressing physical, mental, emotional, and social dimensions (Hyma et al., 1988).

The World Health Organization (WHO) defines traditional medicine as "the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, and improvement of treatment of physical and mental illness. India, in particular, possesses a rich tradition of indigenous medical knowledge, both codified and informal, with centuries-old practices centered around the use of medicinal plants (Jadhav et al., 2013).

Within tribal health systems, traditional healers—including herbalists and birth attendants—hold critical roles. They provide culturally relevant, accessible healthcare rooted in local knowledge of herbs, remedies, and healing practices (Roy et al., 2003). A traditional healer is generally defined as "someone who is recognized by their community as competent to provide healthcare by using vegetable, animal, and mineral substances, as well as methods grounded in cultural and religious practices" (Shankar et al., 2012). Their extensive knowledge enables them to offer therapeutic, protective, and preventive care through natural, ritualistic, or combined approaches (Dwivedi et al., 2023).

Due to their low socioeconomic status and limited access to formal education, tribal communities often rely on these healers as their primary healthcare providers (Kumar et al., 2020). However, while traditional health systems are valued for their accessibility and cultural alignment, scholars have also raised concerns about the politicization and romanticization of indigenous knowledge. Nanda (2016), in her book Saffronized Science: Rampant Pseudoscience in "Vedic Garb" in the Indian Subcontinent, critiques the glorification of ancient traditions without critical examination, warning that unscientific reinterpretations can undermine evidence-based healthcare.

Against this complex backdrop, this paper explores the lived experiences, perceptions, and practices of indigenous healthcare among tribal communities in Northeast India, with particular attention to the role of informal caregivers and traditional healers. It seeks to understand how these practices function within marginalized settings, the challenges they encounter, and their interactions with formal health systems. By doing so, this study aims to contribute to a more inclusive, culturally sensitive, and contextually grounded understanding of health and caregiving in India.

Methodology

This study employs a qualitative approach based on secondary data to explore indigenous health practices and practitioners across Northeast India, covering the states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, and Tripura. The communities examined include the Mishing, Garo, Kuki, Naga, Mizo, and various tribes from Tripura such as the Bhutia, Chakma, Jamatia, and Lepcha.

Data were collected through a thorough review of existing literature, including peer-reviewed journal articles, ethnographic studies, government reports, NGO publications, and relevant historical records. The primary materials informing the core discussion were published from 2010 onwards to ensure contemporary relevance. However, the literature review and introduction sections include a few key earlier works—specifically from 1988 and 1996—along with several studies from 2000 onwards. These earlier sources are included to provide essential historical context and foundational understanding of indigenous health systems.

Thematic analysis was used to identify recurring patterns, including the roles of traditional healers, the use of herbal and spiritual remedies, caregiving responsibilities, and the impacts of modern healthcare policies on indigenous knowledge systems. A culturally sensitive lens was maintained throughout, recognizing the value of indigenous epistemologies and ensuring representation across both hill and valley communities.

Theoretical framework

Traditional medicine, often referred to as ethno-medicine, folk medicine, or complementary and alternative medicine (CAM), represents the oldest form of healthcare system, deeply rooted in cultural practices and beliefs. According to the World Health Organization (WHO), traditional medicine is defined as "a sum total of knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, and improvement of treatment of physical and mental illness."

Similarly, Abdullahi (2011) describes traditional medicine as an ancient and culture-based method of healing that humans have used to cope and deal with various diseases threatening their existence and survival. Both definitions highlight the integral role traditional medicine has played historically and continues to play in many societies, particularly among indigenous communities.

Traditional medicine in India is not just a type of medical treatment but a way of life, deeply rooted in the civilization's development. Its roots trace back to the ancient texts of Ayurveda, meaning "knowledge of life," which emphasizes a balance between mind, body, and spirit (Mukherjee et al., 2017; Pandey et al., 2013; Subhose et al., 2005). This system is built on in-depth knowledge of regional plants, minerals, herbs, roots, and other natural resources passed down through generations, fostering a collective wisdom among tribal healers and shamans (Parasuraman et al., 2014; Patwardhan et al., 2004).

In particular, the tribal health systems in India place significant importance on traditional healing practices, which are intricately linked with the cultural and social lives of indigenous populations. Traditional healers, including birth attendants, play a critical role in addressing the healthcare needs of tribal communities. They possess extensive indigenous knowledge of local herbs, traditional remedies, and healing techniques passed down through oral traditions and apprenticeship (Roy et al., 2023).

Any healthcare system to be truly meaningful and effective must be culturally, socially, politically, and environmentally close to the masses. In this context, indigenous systems of medicine in India offer a vital and complementary role, particularly in the preventive and curative aspects of primary health care programmes. In contrast, modern healthcare services are largely hospital- or clinic-based, expensive, doctor-oriented, urban-centered, and often imported in structure

and philosophy, making them inaccessible for a large portion of the rural population (Hyma et al., 1988).

Moreover, several socio-economic factors continue to influence the widespread reliance on indigenous healthcare practices. Poor implementation of government healthcare programmes, low income levels, illiteracy, peer pressure, geographical locality, and the cost-effectiveness of indigenous medicine are key reasons why traditional healthcare systems remain widely accepted and adapted in rural regions (Bheenaveni, 2016).

Thus, understanding indigenous health systems is essential to recognize their potential role in strengthening rural healthcare and addressing gaps left by modern medical infrastructures.

Key Observations:

Traditional Healing Practices among the Mishing Tribe of Assam and Arunachal Pradesh

Building on the broader understanding of indigenous health systems, this section focuses on the traditional healing practices of the Mishing community, one of the major tribal groups of Northeast India, to illustrate how these systems operate at the grassroots level.

The Mishings are an ethnic group inhabiting parts of the districts of Assam and Arunachal Pradesh. They are the second largest tribal group in Northeast India. Traditional healing practices among the Mishing include the treatment of ailments using herbs in various forms — fresh preparations, crushed extracts, decoctions for oral intake, and pastes for topical application on skin diseases and wounds. They utilize locally available medicinal plants, cultivate certain medicinal species from different habitats, and also attempt to preserve depleting medicinal plant varieties. Faith in divine powers and ritual worship are important elements of their healing practices, reflecting a blend of herbal medicine with spiritual beliefs.

A study focusing on the traditional healing practices of the Mishing community (Shankar et al., 2012) collected information from 11 herbal-medical practitioners — 7 from Dhemaji and North Lakhimpur districts of Assam and 4 from the foothills of East Siang district of Arunachal Pradesh.From the interviews conducted, it was found that the Mishing community utilizes 55 medicinal plant species for the treatment of various diseases. Among these, 15 species were trees, 8 were shrubs, and 30 were herbs and climbers. Different parts of these plants — mostly leaves, followed by

stems, roots, and sometimes a combination — were used depending on the type of ailment. However, due to the overuse of these plants in traditional healing practices, many are depleting from their natural habitats and are now on the verge of extinction. This poses a significant challenge not only to the preservation of traditional medicine but also to biodiversity conservation in the region. Malaria, jaundice, and menstrual health issues among women emerged as some of the most commonly treated health problems within the community.

At present, not all traditional healers within the Mishing community carry out the same roles, nor do they all belong to a single category. Each healer tends to focus on a particular area of treatment, and the methods they use—both for diagnosing illnesses and for preparing medicines—often vary from one practitioner to another. This reflects the depth and diversity of knowledge that exists within their traditional healing system. Some healers are known for treating specific types of illnesses, while others may be more skilled in spiritual or ritual-based healing. This variation shows that there are different kinds of traditional healers depending on their expertise.

These healers provide care to people of all age groups and for many different types of health problems. Their remedies are made from plants and materials that are easily available and affordable in their surroundings. Their approach to treatment includes elements of prevention, protection, and cure. Depending on what they believe to be the cause of the illness, they may use natural remedies, rituals, or both. For example, treatment may involve offerings to ancestral spirits, rituals for strengthening the body or protecting personal belongings, steaming herbs, cleansing with special substances, or the use of charms and cuts as part of the healing process.

The work of these traditional healers is especially important in remote villages, where access to modern healthcare services is very limited. In many of these areas, they are the only available health providers and are deeply trusted by the local people. However, a major issue raised in studies of the Mishing community is the lack of proper documentation of their traditional medical knowledge. Much of what they know is passed down through practice and word of mouth, which makes it vulnerable to being lost over time.

To support and sustain this valuable knowledge system, it would be helpful to involve these healers in training programs, especially those that include young people who may wish to learn these practices. It could also be beneficial to organize knowledge-sharing sessions between healers from different communities. This way, they can

continue to learn and update their practices, while also helping to preserve an important part of indigenous healthcare in Northeast India.

Services of the traditional healers among the Mishing tribe is of relative importance as they are rendering their services to public in very remote places where people are really in need of health services.

Garo Women of Meghalaya

A recent study by Mal and Saikia (2025), conducted among Garo women aged 15–49 in the East Garo Hills of Meghalaya, explored their health-seeking behaviour and found a strong preference for traditional medicine. Approximately 84% of the women reported seeking treatment from Ojhas (traditional healers) using Achik medicine—literally meaning "hill man medicine." These ojhas have extensive knowledge about local herbs and medicines. Only 6% accessed modern healthcare services, while 10% relied on herbal home remedies. These Ojhas play a vital role in the health-seeking journey of Garo women, offering both remedies and guidance when needed. They are easily accessible and trusted within the community, often serving as the first point of contact during illness. Their treatments are not only effective but also affordable, making them a practical choice for many families.

Rooted in generations of inherited knowledge, these traditional healers possess deep understanding of local herbs, shrubs, and medicinal plants. Their expertise in using native flora for healing reflects a long-standing tradition that continues to thrive. This enduring legacy has fostered strong trust within the community, reinforcing the cultural value of traditional medicine.

The reliance on traditional medicine was found to cut across lines of education and economic status. For Garo women, these healing practices are deeply tied to their history, identity, and connection to nature, ancestors, and the broader community. Traditional medicine is not merely a method of treatment but a cultural and spiritual practice that instill trust and a sense of continuity.

The traditional medical practices of the Garo involve the use of a wide variety of plant-based remedies, including herbs, shrubs, and other medicinal plants. Leaves are most commonly used, although fruits, barks, root barks, stems, seeds, and flowers are also employed depending on the ailment.

One of the most commonly used traditional remedies is Poron, used to treat severe headaches. In cases of bone fractures, Jak Rik Chu or Anchimray medicine is applied, while Rajamuri is used to treat swelling. For stomach aches, Ojhas provide a remedy known as Sam Sko, and to stop bleeding from cuts or injuries, they administer Meghalaya Budu, a herbal preparation applied to the wound.

Common health issues faced by Garo women include menstrual disorders, post-delivery weakness, fever accompanied by severe headache, and jaundice. One of the major reasons behind the limited use of modern healthcare services among Garo women is the poor quality of government health facilities, compounded by the remoteness of their settlements, which restricts accessibility and trust in biomedical care.

One noticeable feature, compared to other tribes in the Northeast, is that Garo women do not trust spiritual rituals as a means of healing.

The Kuki Tribe of Manipur

The Kukis are an ethnic group spread across Northeast India, Northwest Myanmar, and the Chittagong Hill Tracts of Bangladesh. In Northeast India, they inhabit all seven states except Arunachal Pradesh. The Kuki tribe is an umbrella term that encompasses various sub-tribes and clans, united by shared ancestry, culture, and traditions. These clans are officially recognized as Scheduled Tribes in India.

Haokip (2014) conducted a study titled "Traditional Health Beliefs, Practices and Healers among the Kuki Tribe of Manipur." The research was carried out through interviews, case studies, and observations in Saparmeina (Senapati district), Moreh (Indo-Myanmar border in Chandel district), and Chassad Avenue (Imphal). The study revealed that Kuki conceptions of health are closely tied to cultural and spiritual values. Among the Kukis, a person is regarded as healthy not just when free from disease but when they are tension-free, physically active, mentally undisturbed, and financially stable. The absence of any of these conditions is believed to lead to illness.

According to the Kukis, illnesses can be either natural or supernatural. Natural illnesses arise from seasonal changes, dietary imbalances, environmental conditions, or weak immunity. Supernatural illnesses, however, are believed to be caused by spiritual forces, such as deities, ancestral spirits, ghosts, or even human agents like witches or sorcerers. These illnesses are classified into specific categories: *gambol* (caused by spirits), *kaobol* (caused by evil eye or witchcraft), and *doibol* (caused by sorcery).

For treating supernatural ailments, traditional healers play a central role. These healers are commonly found in and around Kuki villages. Their healing practices often include rituals, incantations, and the use of herbs collected from deep forests. Although Christianity has led to a decline in the acceptance of such supernatural interpretations, many still turn to these traditional healers, particularly for ailments perceived to be psychological or unexplainable by modern medicine. Interestingly,

some healers begin their rituals by praying to the Christian God, suggesting a fusion of indigenous and Christian practices.

In addition to the spiritual healers, domestic caregiving by women plays a significant role in maintaining household health. Mothers and female family members use various herbs and foods to treat common conditions. For instance, *anphui* and passion fruit leaves are used to control diabetes and high blood pressure; *nongmangkha* is a remedy for cold and cough; *nakuppi* is believed to support kidney health. Honey, ginger, and lemon are also widely used. Certain animal products, such as bear liver (for stomach ailments) and *to-ke* lizard and scorpions (for cancer), are also believed to hold medicinal value.

Traditional healing among the Kukis thus encompasses both spiritual and practical dimensions—ranging from ritual healing for supernatural ailments to plant-based care for physical health.

This case study on the Kuki tribe reflects how traditional healers are more than just health practitioners—they are also spiritual and cultural caretakers within the community. Their role in treating both natural and supernatural illnesses shows how traditional health systems continue to play an important part in rural healthcare. It also ties back to the broader theme of this article, which explores the silent yet significant contribution of traditional caregivers in places where modern healthcare is often limited.

Ethnomedicinal Knowledge and Plant-Based Healing in Rural Mizoram

Rai and Lalramnghinhlova (2010), in their study titled "Ethnomedicinal Plant Resources of Mizoram, India: Implication of Traditional Knowledge in Health Care System", conducted a floristic survey of ethnomedicinal plants in the tribal areas of Mizoram between 2004 and 2008 to explore their potential for modern treatments. Information on medicinal uses of plants was obtained from the interviews with the local physicians practising indigenous system of medicine, village headmen, priests and various folks/groups of Mizoram. They noted that the shortage of doctors and medical staff in the state, coupled with Mizoram' s difficult topography and poor communication infrastructure, often prevents people in rural areas from accessing modern medical care. As a result, many continue to depend on nature-based remedies for healing. The study documented 159 ethnomedicinal plant species from 134 genera and 56 families, used to treat ailments such as throat pain, dysentery, boils, cirrhosis, fertility issues, stomachaches, tonsillitis, ulcers, coughs, kidney problems, bone fractures, asthma, gonorrhoea, hepatitis, and toothaches. Some examples of such ethnomedicinal plants include Adhatoda zeylanica, Camellia sinensis, Carica papaya, Dendrocnida sinuate, Giardinia palmata, Juglans regia, and Xylia xylocarpa.

This study reflects the continuing dependence of rural communities on traditional ecological knowledge and plant-based healing in contexts where biomedical systems remain out of reach—further highlighting the significance of indigenous caregiving within non-biomedical health systems. However, while the case study on "Ethnomedicinal Knowledge and Plant-Based Healing in Rural Mizoram" highlights the use of medicinal plants for healing, it is important to note that the role of traditional health practitioners in rural Mizoram' s healthcare system remains underexplored in this context. Although plant-based remedies are in use, the active engagement, authority, and recognition of traditional healers themselves were not prominently reflected in the findings—indicating a critical area for further inquiry within the broader theme of 'caring in the shadows.'

Traditional Healing Practices among the Indigenous Communities of Kumarghat, Unakoti District, Tripura

Tripura, one of the seven states of Northeast India, is home to a diverse array of indigenous communities and rich traditional knowledge systems. Within the Kumarghat subdivision of Unakoti district, Dora et al. (2020) conducted an in-depth exploration into local health traditions (LHTs), focusing particularly on the role and practices of traditional healers in the region. The area is inhabited by various tribal groups such as the Bhutia, Chakma, Garo, Jamatia, and Lepcha, all of whom contribute to the vibrant cultural and medicinal heritage of the state.

The research was primarily aimed at documenting the therapeutic practices and indigenous medicinal knowledge preserved by elderly traditional practitioners across villages in the region. A total of thirteen traditional healers were interviewed, providing a rich dataset of healing techniques and herbal formulations employed in local healthcare.

These practitioners have long relied on medicinal plants abundantly available in nearby forested areas, with many of these remedies being passed down through generations and found to have effective results for curing diverse ailments among the local people. The study catalogued 50 folk medicinal claims, comprising 13 polyherbal combinations and 37 single-plant formulations. The healers demonstrated substantial ethnobotanical knowledge, emphasizing that most of the herbal preparations are administered orally and involve plants that grow naturally in the wild.

Some of the scientifically identified species used in these remedies include Achyranthes aspera L., Amaranthus tricolor L., Celosia argentea L., Hibiscus rosa-sinensis L., Mimosa pudica L., and Paederia foetida L. These plants are employed to address a wide range of health issues, including dysentery, jaundice, gastrointestinal problems, anemia, malaria, hypertension, postpartum hemorrhage, and bone fractures.

The findings indicate a significant reliance on traditional healing systems among the local population, reflecting both accessibility and cultural trust in these methods. This widespread dependence underscores the critical importance of preserving and studying such traditional medical knowledge. Engaging the scientific community in deeper investigations could help assess the safety, efficacy, and pharmacological potential of these remedies. Validating these traditional practices may not only enrich the global repository of ethnomedicine but also pave the way for developing new, nature-derived therapeutics capable of addressing various modern health challenges. In the context of rural healthcare systems, traditional health practitioners in regions like Kumarghat play a vital role in bridging healthcare gaps, especially where modern medical infrastructure is limited. Their presence reflects the lived realities of many rural indigenous communities in Northeast India, where informal care and indigenous healing remain indispensable components of local health landscapes. This reinforces the article' s broader aim of recognizing and conceptualizing such practices as integral—though often overlooked—elements of healthcare in the region.

Indigenous Healing Traditions of the Naga People: Continuity and Transformation

The Naga people, commonly referred to as the Nagas, are an Indo-Mongoloid indigenous group who speak languages from the Tibeto-Burman family. They are primarily located in the northeastern Indian states of Assam, Manipur, and Arunachal Pradesh, as well as in the northwestern regions of Myanmar.

In terms of healthcare, the Naga communities developed a self-sufficient traditional healing system that relies on natural resources from their surroundings. This system is intertwined with spiritual 'interventions' to address illnesses that could not be fully understood or explained through physical symptoms alone.

This study by Watienla and Jamir (2019) titled "Indigenous Health Practices of the Naga People: Continuity and Change" sought to explore the indigenous health practices of the Naga people, focusing on the persistence of these traditions in the modern context of advanced medical systems.

It was based on an in-depth, multi-sited ethnographic approach covering the districts of Tuensang, Mokokchung, Mon, and Phek—representing the eastern, western, northern, and southern regions of Nagaland, respectively. From each selected district, both the district headquarters and three villages were included to represent urban and rural populations. Respondents were purposively sampled and included traditional healers, village chairpersons, knowledgeable elders, and members of the general public.

The Naga communities possess a rich heritage of indigenous medicinal knowledge, rooted in their close relationship with nature and passed down across generations. Traditional healers have held a prominent place in Naga society, often believed to possess unique wisdom and strength, along with deep knowledge of native healing methods. Known by various local names such as Saibu, Eni, Arasener, and Wompa, these healers not only treated the sick using locally available remedies but also acted as intermediaries between humans and the spirit world.

There are two principal forms of traditional healing among the Nagas: the supernatural and the material.
In the material form, although Nagas are known for their resilience and rarely fall ill, when they do, they turn to herbal remedies made from plants, roots, and herbs to treat various ailments, wounds, and injuries. Common conditions are addressed using substances found in their kitchen gardens, fields, and nearby forests. Examples include consuming fresh cow dung to treat malaria, using frog meat and soup for measles, crushing and inhaling orange or lemon leaves to ease shivering or fainting, extracting juice from crushed cucumber leaves for fever relief, and boiling guava shoots and leaves to drink as a cure for dysentery, among others.

In addition, for illnesses that defy logical explanation, the Nagas incorporate rituals and sacrificial practices. The supernatural healing approach involves mediating between the spiritual and human realms through worship and ritual offerings. In earlier times, traditional healers were the sole ‘doctors’, tasked with diagnosing both the illness and its cause. As spiritual intermediaries, they might declare after examining a patient that a spirit demands a sacrificial offering—such as a pig or hen. These practices, though lacking scientific validation, were upheld with deep faith by the community and are rooted in the indigenous cosmology of the Naga people, which is steeped in spirit belief systems.

The Naga people's traditional healing practices have undergone significant transformation due to the influence of Christianity, modern education, and medical

advancements. Previously, illnesses were attributed to spirits, and healing involved rituals and sacrifices. With the adoption of Christianity and exposure to modern medicine, many shifted to allopathic treatment, though traditional methods persist, especially for unexplained illnesses. Today's traditional healers often blend indigenous and allopathic practices, but some lack scientific knowledge of modern drugs. There is concern about the decline of traditional knowledge, emphasizing the need for its documentation and scientific validation to preserve it against the rising dominance of modern medicine.

This discussion directly relates to the core of this article, as it highlights how traditional health practitioners continue to play a crucial yet often overlooked role in rural healthcare systems. Despite modernization, their blended practices persist, especially in contexts where biomedical care falls short. Understanding their evolving role is essential to reimagining inclusive and culturally grounded rural healthcare in Northeast India.

Traditional Health Care Approaches by Indigenous Communities in Assam and Their Scientific Relevance

Assam, located in the northeastern region of India, is nestled between the Eastern Himalayas and the Patkai and Nagaland Hill Ranges. It shares its northern border with Bhutan and its eastern boundary with Arunachal Pradesh. To the south lie Nagaland, Manipur, and Mizoram, while Meghalaya borders it to the southwest. The western frontiers are shared with West Bengal and Bangladesh.

Chetia et al. (2023) in their review paper titled "Traditional Healthcare Approaches by Indigenous People in Assam and their scientific relevance (a review") found that this culturally rich state is home to a mosaic of indigenous communities, including the Bodo, Karbi, Mishing, Tiwari, Deori, Rabha, Sonowal Kachari, Dimasa, Ahom, Chutia, Garo, and Kachari, among others. These groups have long relied on traditional knowledge systems for healing, passing down herbal, animal-based, and spiritual practices through generations.

Assamese indigenous communities are known to use over 2,000 medicinal substances, of which approximately 1,500 are derived from plants and the remainder from animal and mineral origins. The region's biodiversity is not only a source of healing but also deeply entwined with cultural and spiritual life.

Bamboo (Bambusa vulgaris), found abundantly across Assam, is one such example. Bamboo shoots are valued for their nutritional and medicinal properties, known to have anti-hypertensive, anti-hyperlipidemic, and anti-diabetic effects. Decoctions made from bamboo roots are traditionally consumed to promote urination, and the plant also holds religious significance in many tribal rituals.

Similarly, Drumstick (Moringa oleifera) is extensively used in indigenous healthcare for its wide-ranging properties—antioxidant, anti-epileptic, hepatoprotective, anti-diabetic, anti-ulcerative, and cardio-protective, among others.

A variety of wild herbs and plants have been domesticated for medicinal use by the locals. These include Abelmoschus manihot (Usipak, Aibika), Abrus precatorius (Latumoni), Thunbergia coccinea (Changalota), Enydra fluctuans (Melechi), and Blechnum orientale (Dhekia). These are traditionally used to treat ailments such as oral infections, stomach disorders, urinary problems, headaches, skin diseases, and jaundice. Moreover, plants like Areca catechu (Tamil), Vitex negundo (Posotia), and Psidium guajava (Guava) are commonly used to promote oral hygiene and treat ulcers, particularly among the tribes of Western Assam.

In addition to plant-based remedies, indigenous communities in Assam also employ animal-derived substances for healing purposes. A total of 108 ethnomedicinal animals and products are used by major tribal groups such as the Biate in Dima Hasao and the Karbi and other communities around the Pobitora Wildlife Sanctuary. These include 45 animal species, including insects, that are used to treat over 40 ailments, including asthma, pneumonia, cancer, fever, piles, gastric issues, diabetes, snake bites, and smallpox.

Traditional healthcare practices in Assam represent not only medical knowledge but also a broader worldview rooted in ancestral memory, spiritual balance, and ecological harmony. These practices are holistic, often addressing physical, mental, and spiritual well-being, and play a crucial role in communities where access to modern healthcare is limited or unaffordable. Furthermore, many traditional remedies are environmentally sustainable, promoting biodiversity and ecological balance.

Nevertheless, it is essential to approach these practices with critical awareness. Unquestioned adherence without scientific validation may lead to superstitions, ineffective treatments, or even social marginalization. Moreover, the unregulated use of rare and endangered species can threaten ecological balance and biodiversity.
While this review acknowledges the broader value of traditional healing, it does not specifically document the role and status of traditional health practitioners within Assam's rural healthcare system. Recognizing their contributions—and integrating them thoughtfully into public health systems—can pave the way for more inclusive, culturally sensitive, and sustainable healthcare models.

Towards Integration: AYUSH and the Recognition of Traditional Health Practitioners

The discussion so far has highlighted the crucial yet under-recognized role of traditional health practitioners (THPs) in rural healthcare systems across Northeast India. In this context, the Government of India's AYUSH program—which promotes Ayurveda, Yoga, Unani, Siddha, and Homeopathy—offers a relevant policy framework for considering alternative systems of healing (Ministry of AYUSH, 2021). Although AYUSH primarily supports codified traditions, it signals a broader shift toward pluralistic healthcare in India (Langford, 2002).

However, most indigenous practices in the Northeast remain uncodified, community-embedded, and orally transmitted, often rooted in ethnic traditions and spiritual cosmologies. These practices are locally trusted and function in areas where public health infrastructure is weak or absent. Yet, their informal status places them outside AYUSH's institutional frameworks. Practitioners are neither formally recognized nor supported through training, funding, or integration, leaving their contributions invisible within health policy (Bode, 2008).

This lack of institutional recognition reflects a deeper epistemological hierarchy, where scientific and state-recognized systems are privileged over local knowledge. As a result, there is a risk that codification efforts under AYUSH may homogenize or marginalize these decentralized practices. This is particularly relevant in the Northeast, where cultural autonomy and indigenous identity are deeply tied to healthcare traditions. Without sensitivity to local contexts, policy interventions may unintentionally erase the very practices they seek to engage with.

To address this, a more inclusive and decentralized model of AYUSH is required—one that goes beyond biomedical validation and accommodates lived experiences, oral histories, and relational knowledge systems. Collaborative frameworks that involve traditional health practitioners (THPs) as stakeholders—not merely subjects—can help build trust and ensure ethical inclusion.

Moreover, there is a need for region-specific research and documentation, especially in the Northeast, where the diversity of healing practices defies any one-size-fits-all categorization. Initiatives that fund community-led ethnographies, local archives, and cross-learning between practitioners and AYUSH institutions could lay the foundation for respectful engagement.

Ultimately, integrating traditional health practitioners within broader policy frameworks like AYUSH should not be about mainstreaming them into dominant systems, but about reshaping those systems to recognize the pluralities of care. A

more responsive and grounded AYUSH policy would not only bridge institutional gaps but also contribute to health justice in underserved and culturally distinct regions like Northeast India.

Limitations

This study relies exclusively on secondary sources of information, which may limit the depth and specificity of insights into the lived experiences of traditional health practitioners and rural communities in Northeast India. While secondary data provides a broad overview and theoretical context, it may not fully capture local variations, nuances, or recent developments in indigenous healthcare practices. Moreover, the availability of literature is uneven across different states and communities within the region, which could result in an overrepresentation of certain areas while leaving others relatively understudied. The reliance on published materials also means that undocumented, oral, or community-specific practices may be overlooked. In addition, the absence of first-hand engagement with stakeholders limits the ability to assess perceptions, beliefs, and challenges experienced on the ground, especially in relation to gender dynamics, intergenerational knowledge transfer, and interaction with formal healthcare systems. Future research incorporating primary data through fieldwork, interviews, and participatory methods would enrich understanding and provide more detailed, context-specific perspectives that this study could not capture. These constraints underscore the need for more immersive, localized research in future.

Future Research Directions

To address the limitations noted above, future research should prioritize primary data collection through ethnographic fieldwork, interviews with traditional healers, and participatory rural appraisal techniques. This would allow for richer, context-sensitive understanding of indigenous healthcare systems, especially in understudied or remote tribal areas. Comparative studies across different communities in Northeast India could also reveal how local beliefs and practices evolve in response to changing health policies, environmental pressures, or generational shifts.

Conclusion and Way Forward

The landscape of rural healthcare in Northeast India is deeply entwined with the traditional knowledge systems of indigenous communities such as the Mishing, Garo, Kuki, Tripuri, Mizo, and Naga tribes. Across these culturally distinct groups, traditional health practitioners—often elders, herbalists, midwives, and spiritual healers—have historically served as the first line of care in villages where access to modern healthcare remains limited. Despite the growing penetration of allopathic medicine

and formal healthcare systems, these practitioners continue to play a critical, albeit often unacknowledged, role in treating common illnesses, offering emotional and spiritual support, and maintaining the social fabric of health in their communities.

The findings of the referenced paper point to a significant yet uneven shift in indigenous healing practices. While allopathic medicine has become the preferred option for many, especially for common illnesses with identifiable causes, the trust in traditional healing resurfaces for unexplained ailments or conditions perceived to be rooted in supernatural causes. This dual-seeking behavior reflects a form of medical pluralism, where modern and traditional systems co-exist, often without formal coordination. Moreover, the adaptation of traditional healers—who now blend their indigenous treatments with allopathic products like ointments and bandages—signals both resilience and vulnerability. While such hybridity reflects innovation and pragmatism, it also raises concerns about the dilution of indigenous epistemologies and loss of confidence in ancestral knowledge.

The broader concern, then, is the gradual erosion of these rich, ecosystem-linked knowledge systems in the face of modernization, scientific reductionism, and lack of institutional support. The continued informal status of traditional health practitioners keeps them "in the shadows," despite the essential care they provide—especially for rural populations with limited mobility, trust deficits in government health institutions, or deep cultural beliefs in the supernatural origins of illness.

Moving forward, the way to revitalize these systems is not through replacement but integration, respect, and documentation. There is an urgent need for ethnographic and participatory research that engages with traditional practitioners as knowledge holders rather than relics of the past. Localized studies must capture the diversity of tribal healing methods, plant-based remedies, and spiritual caregiving models—before they disappear. Collaborative research involving ethnobotanists, public health experts, and tribal elders could help identify effective traditional remedies and scientifically assess their benefits, leading to safer, nature-based alternatives that are rooted in cultural continuity.

At the policy level, frameworks must be developed to formally recognize traditional health practitioners within rural healthcare systems. This may include community-based certification systems, training in basic biomedicine, and integration into referral systems. Support mechanisms should also address issues of intergenerational transmission, especially as younger generations show waning interest in acquiring such knowledge.

Ultimately, to care in the shadows is not to be invisible. Traditional health practitioners in Northeast India embody resilience, cultural integrity, and deep ecological knowledge. A truly inclusive and equitable healthcare model for the region must begin by recognizing, supporting, and learning from them. The shadow they occupy is not one of obsolescence, but of underappreciated potential—waiting to be brought into the light through dialogue, respect, and collective action.

Acknowledgement: This research was conducted independently by the author using publicly available secondary data. No institutional support or external funding was received.

References

1.Abdullahi, A. A. (2011). Trends and challenges of traditional medicine in Africa. *African Journal of Traditional, Complementary, and Alternative Medicines: AJTCAM, 8*(5 Suppl), 115–123. https://doi.org/10.4314/ajtcam.v8i5S.5

2.Bheeneveni, R. (2016). Indigenous healthcare: Determinants and practices. *IOSR Journal of Humanities and Social Science (IOSR-JHSS),* 21(8), 19–22. https://doi.org/10.9790/0837-210811922

3.Bode, M. (2008). Taking traditional knowledge to the market: The commoditization of Indian medicine. *Routledge*.

4. Chetia, J., Puro, N., & Deb, C. R. (2023). Traditional healthcare approaches by indigenous people in Assam and their scientific relevance (A review). *Fazl Ali College Journal,* 11, 59–70. ISSN: 2319-6769

5. Deb Roy, A., Das, D., & Mondal, H. (2023). The tribal health system in India: Challenges in healthcare delivery in comparison to the global healthcare systems. *Cureus*, 15(9), e39867. https://doi.org/10.7759/cureus.39867

6.Dwivedi, R., Goyal, P., Yadav, S. S., Dwivedi, P., Singh, P., & Singh, K. (2023). Mapping of traditional healthcare providers and their healing approaches in a tribal community of district Sirohi, Rajasthan. *Journal of Family Medicine and Primary Care*, 12(6), 1150–1157. https://doi.org/10.4103/jfmpc.jfmpc_1610_22

7.Hyma, B., Ramesh, A., & Subhadra, N. L. (1988). Development of a rural community healthcare model based on Indian indigenous system of medicine. *Ancient Science of Life,* 8(1), 56–61.

8 Jadhav, S. N., Bhoite, A. S., Kadam, D. A., Kadam, A., & Aparadh, V. T. (2013). Indigenous healthcare practices of the tribal of the Western Ghat Satara District (M.S.), India. *Research Front,* 1(1), 27–32.

9.Kumar, M., Pathak, V., & Ruikar, M. M. (2020). Tribal population in India: A public health challenge and road to future. *Journal of Family Medicine and Primary Care,* 9(2), 508–512. https://doi.org/10.4103/jfmpc.jmfpc_992_19

10.Langford, J. (2002). Fluent bodies: Ayurvedic remedies for postcolonial imbalance. *Duke University Press.*

11.Mal, P., & Saikia, N. (2025). Cultural persistence in health-seeking behaviour: A mixed-method study of traditional healing practices among Garo tribal women in Meghalaya, India. *Journal of Biosocial Science.* Advance online publication. https://doi.org/10.1017/S0021932025000094

12. Ministry of AYUSH. (2021). About the Ministry. https://www.ayush.gov.in/

13.Mukherjee, P. K., Harwansh, R. K., Bahadur, S., Banerjee, S., Kar, A., Chanda, J., Biswas, S., Ahmmed, S. M., & Katiyar, C. K. (2017). Development of Ayurveda – Tradition to trend. *Journal of Ethnopharmacology*, 197, 10–24. https://doi.org/10.1016/j.jep.2016.09.024

14.Nanda, M. (2016). Saffronized science: Rampant pseudoscience in "Vedic garb" in the Indian subcontinent. *Social Epistemology Review and Reply Collective*, 5(1), 39–47.

15. Nemneivah, H. (2014). Traditional health beliefs, practices and healers among the Kuki tribe of Manipur. *European Academic Research*, 2(6), 8149–8165.

16. Pandey, M. M., Rastogi, S., & Rawat, A. K. S. (2013). Indian traditional Ayurvedic system of medicine and nutritional supplementation. *Evidence-Based Complementary and Alternative Medicine,* 2013, Article ID 376327. https://doi.org/10.1155/2013/376327

17. Parasuraman, S., Thing, G. S., & Dhanaraj, S. A. (2014). Polyherbal formulation: Concept of Ayurveda. *Pharmacognosy Reviews*, 8(16), 73–80. https://doi.org/10.4103/0973-7847.134229

18. Patwardhan, B., Vaidya, A. D. B., & Chorghade, M. (2004). Ayurveda and natural products drug discovery. *Current Science*, 86(6), 789–799.

19. Rai, P. K., & Lalramnghinglova, H. (2010). Ethnomedicinal plant resources of Mizoram, India: Implication of traditional knowledge in health care system. *Ethnobotanical Leaflets*, 14, 274–305.

20. Shankar, R., Lavekar, G. S., Deb, S., & Sharma, B. K. (2012). Traditional healing practice and folk medicines used by Mishing community of North East India. *Journal of Ayurveda and Integrative Medicine,* 3(3), 124–129. https://doi.org/10.4103/0975-9476.100169

21. Shrivastava, S. R., Shrivastava, P. S., & Ramasamy, J. (2013). Implementation of public health practices in tribal populations of India: Challenges and remedies. *Journal of Family Medicine and Primary Care,* 2(3), 260–263.

22. Subhose, V., Srinivas, P., & Narayana, A. (2005). Basic principles of pharmaceutical science in Ayurveda. *Bulletin of the Indian Institute of History of Medicine*, 35(2), 83–92.

23. Subramanian, S. V., Smith, G. D., & Subramanyam, M. (2006). Indigenous health and socioeconomic status in India. *PLoS Medicine*, 3(10), e421. https://doi.org/10.1371/journal.pmed.0030421

24. Watienla, & Jamir, T. (2019). Indigenous health practices of the Naga people: Continuity and change. *Journal of Health and Medical Sciences,* 2(3), 373–385. https://doi.org/10.31014/aior.1994.02.03.61

23.Willis, R., Stephens, C., & Nettleton, C. (2004). The right to health of indigenous peoples. *Health Unlimited.*

24. World Health Organization. (2000). General guidelines for methodologies on research and evaluation of traditional medicine (WHO/EDM/TRM/2000.1). Geneva: World Health Organization. https://www.who.int/publications/i/item/9789241506090