ROLE OF MISSIONARIES IN MEDICAL CARE IN MANIPUR: AN EXPLORATORY STUDY

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CERTIFICATE

This dissertation entitled "Role of Missionaries in Medical Care in Manipur: An Exploratory Study" is submitted in partial fulfillment of six credits for the award of the Degree of MASTER OF PHILOSOPHY of Jawaharlal Nehru University. This dissertation has not been submitted for the award of any other degree of this university or any other university and is my original work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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This dissertation is dedicated to:

My Grandfather, Haipou Jadonang a great leader for Zeliangrong Nagas and inspiration for Nagas as a whole

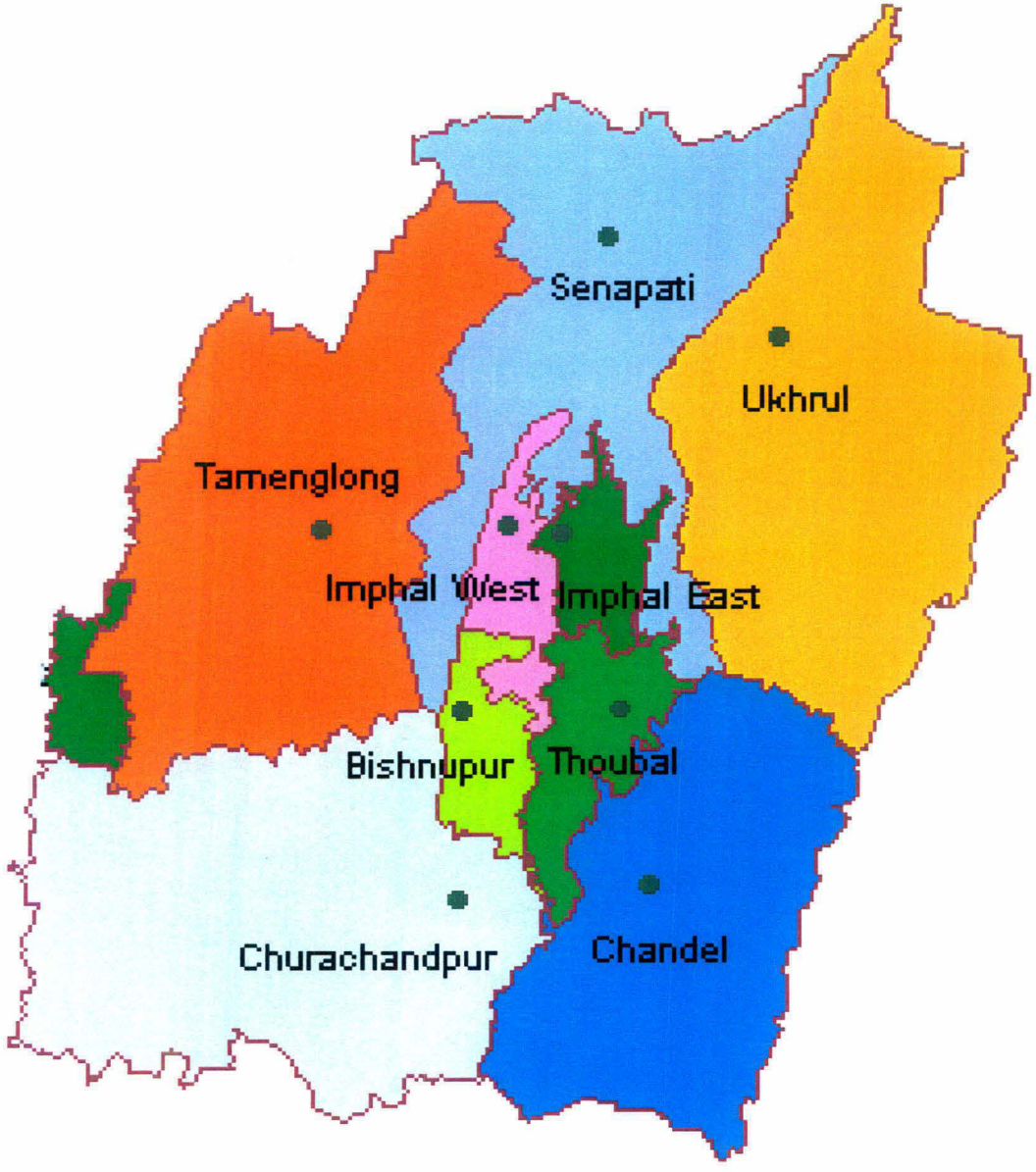
My Parents who have been taken lots of pain to bring me up at this very level

My Brother-In-Law who supported my studies in Delhi

My Niece who is physically challenged due to the lack of medical care

Map of Manipur

(Not to scale)



Source: http://manipur.nic.in/census_map_man.htm

Contents

Abbreviations

AFSPA	:	Armed Forces Special Powers Act
AIDS	:	Acquired Immune Deficiency Syndrome
AR	:	Assam Rifles
CBCNEI	:	Council of Baptist Churches in North East India
CHAI	:	Catholic Health Association of India
CHC	:	Community Health Centre
CMAI	:	Christian Medical Association of India
CMC	:	Catholic Medical Centre
ECCI	:	Evangelical Congregation Church of India
Ed.	:	Edited or Edition
EFCI	:	Evangelical Free Church of India
FAME	:	Fellowship Associates of Medical Evangelism
FCRA	:	Foreign Contribution Regulation Act 1976
GoI	:	Government of India
GoM	:	Government of Manipur
HIV	:	Human Immunodeficiency Virus
IBPM	:	Indo-Burma Pioneer Mission
IDU	:	Injecting Drug User
IMR	:	Infant Mortality Rate
ISPCK	:	Indian Society for Promoting Christian Knowledge
KCC	:	Kuki Christian Church
KCH	:	Kangpokpi Christian Hospital
KNCC	:	Kuki National Christian Council
LMS	:	London Missionary Society

MACS	:	Manipur State AIDS Control Society
MBC	:	Manipur Baptist Convention
MoHFW	:	Ministry of Health and Family Welfare
MSDR	:	Manipur State Development Report
NECHA	:	North East Community Health Association
NEIGM	:	North East India General Mission
NER	:	North Eastern Region
NFHS	:	National Family Health Survey
NGO	:	Non-Governmental Organisation
NHP	:	National Health Profile
NRHM	:	National Rural Health Mission
OPD	:	Out Patient Department
PHC	:	Primary Health Centre
PHSC	:	Primary Health Sub-Centre
Rev.	:	Reverent
RIMS	:	Regional Institute of Medical Sciences
RMO	:	Residential Medical Office
SC	:	Schedule Caste
SPCK	:	Society for Promotion of Christian Knowledge
SPG	:	Society for Promotion of Gospel
ST	:	Schedule Tribe
STD	:	Sexually Transmitted Disease
TB	:	Tuberculosis
US	:	United States
YMCA	:	Young Men Christian Association

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INTRODUCTION

In the eighteenth century the Christian missions spread in Asian countries as an expression of western colonial expansion. During this period, there was interaction between missionaries and colonialists but with different forms at different levels. There was a 'total or partial collaboration of missions and colonial politics'[1] in order to nurture the controlled natives through impressive work of social services. The first few missionaries were sent as ordinary preachers before the concern for the health of their faithful workers' in the tropical regions. During this period medicine was construed as guarantors of un-interrupted preaching in the remote areas which were unknown to them. Historians have suggested the relationship of medicine and missionaries, that in the first half of the missionary movement the 'need' of medicine was felt because of the consciousness of their health in the mission field till it became a 'means' to evangelize the native through this. Therefore, allopathic medicine was brought to India by the British to cater to the civilian and military populations.[2] Medicine also served as a 'tool of the empire'[3] under the 'civilizing mission'[4] implied to uplift the backward colonial subjects to govern themselves.

Christian missionaries arrived in India under the influence of evangelical enthusiasm that had in the West through the religious revival movement, especially the Methodist. The revivalism may be termed as the working of inner spirit experience which generated among the people a sense of new enthusiasm and intense moral earnestness coupled with a deep concern for the 'unsaved'. As a result of this the missionary societies were formed with a view to mobilize their faith in distant countries. In most cases,

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[1] Dena, Lal (1988) *Christian Missions and Colonialism- A Study of Missionary Movement in Northeast India with Particular Reference to Manipur and Lushai Hills 1894-1947*, Shillong: Vendrame Institute, p. 1.

[2] Baru, Rama (1999) ''Missionaries in Medical Care'', *Economic and Political Weekly*, (February 27), p. 521.

[3] Harrison, Mark (1994) *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, New Delhi: Cambridge University Press, p. 2.

[4] Mann, Michael (2004) 'Torch Bearers Upon the Path of Progress': Britain Ideology of a 'Moral and Material Progress' in India in Tine and Mann Edited (2004) *'Colonialism as Civilizing Mission-Cultural Ideology in British India'*, London: Wimbledon Publishing Company, p. 4.

missionaries ventured into backward region where selfless services were rendered in terms of their expert knowledge and moral influence tended to have effect on the people.[5]

The act of missionaries' zeal on medical care was taken up as a moral obligation to help the sick and poor. There are number of instances where the Christian missionaries started medical work in those areas which they were constantly residing. Life is a gift of God and it involves the creative action of God. In order to fully realize the potential of humans, a healthy body and sound mind are necessary. In analyzing the realities of Indian and to be specific in Manipur state, the mission of the church in health care is one of the primary concerns to those who are involved in the service of healing and caring. The church mission on health and medical care is challenging and the efforts are worth mentioning in the absence of proper public health care facilities.

Health is a basic concern of all human beings. It is a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[6] In a healthy person there is harmony of physical, psychological, spiritual and social level. Healing becomes necessary if when there is imbalance of that factor mentioned above. It is the restoration of a person's life from the fall of illness to normalcy. To be able to carry out the holistic health approach, the 'medical' as a 'mission' was complimented to concretize the work of healing. Healing was viewed as a messianic ministry towards the embodiment of Jesus Christ who prevails over afflictions and gives hopes to a person.

Medical Mission of the church followed the same pattern of Jesus reaching out everyone without any allegiance to people, sex, age, race, religion, ethnicity, nationality, disability or socio-economic status.[7] Medical care is a special voyage to reach through the door of poor and marginalized people to give selfless practices of those in needs. Abiding to the call for attention in health and medical care the church groups established dispensaries and hospitals for a better caring in the hands of expert knowledge. Medical Mission is an approach to reach out the very section of people, individuals or

[5] Dena (1988), p. 13.
[6] World Health Organization adopted in the International Health Conference, New York, 19-22 June, 1946 and entered into forced on 7 April 1948.
[7] Stanislaus, L and Joshep, Jose SVD Ed. (2006) *Healing as Mission*, Indian Society for Promoting Delhi: Christian knowledge, p. viii.

communities who could not access the medical care. To be the credible witnesses in the world of sick and suffering the healing evangelism is a shared manifestation of God's love for human.

In India, health services are provided by the public and private sectors. The public sector provides health services through the Central and State Governments, Municipal Corporations, and other local bodies. The private health sector consists of the 'not-for-profit' and the 'for-profit' organizations. The 'for-profit' health sector is largely formed by the individual practitioners from various systems of medicine. The 'not-for-profit' health sector is heterogeneous with different objectives, sizes and the area they cater to. The not-profit is generally accepted as those of Non-Governmental Organizations (NGOs) and the Voluntary or Charitable organizations.

As it is in India, the health services are provided by public and private sectors in Manipur. Majority of the population are served by public sector and specialist cares are being provided mostly by the public sector. As the population grows, the need for specialized care has now started to grow in the private 'for-profit' sector in the state.

Coming to the Northeast India, the region is synonymous with what is called 'underdevelopment'[8], 'ethnic conflicts'[9], 'insurgency'[10], and 'economically backward area'[11]. Though this being the condition, there are indicators of health care status that are favourable in the region. The region has relatively high literacy and high enrolment rates in primary schools. Combined population of eight states is 38.5 million, which represents 3.8 per cent of the total population of India. Total area combining eight states accounts of 8.05 per cent of the total geographical area of the country.

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[8] Madhab, Jayanta (1999) ''North-East: Crisis of Identity, Security and Underdevelopment'', *Economic and Political Weekly, Vol.34, No. 6, (Feb. 6-12)*

[9] Fernandes, Walter (1999) 'Conflict in Northeast: A Historical Perspective', *Economic and Political Weekly, Vol. 34, No. 51, (Dec. 18-24)*.

[10] Shimray, U. A (2001) ''Ethnicity and Socio-Political Assertion-The Manipur Experience'', *Economic and Political Weekly, Vol.36, No. 39 (Sept. 29-Oct. 5)*, p. 3677.

[11] NCAER: *East India Human Development Report 2004*, New Delhi: Oxford University Press, p. 96.

North East Vision 2020 document has observed the widening gap of development between the region and the rest of the country. Even within the region, there are vast differences in the plains and hills. Despite being rich in natural resources, the region is affected by insurgency and weak governance, lags behind the rest of the country.

In the same manner, Manipur state is facing the setback of ethnic conflicts, insurgency and that further affects its already economically backwardness among the Indian states. There are differences in terms of health status and socio-economic indicators between hill districts and valley districts. Political instability in the state also creates disturbing atmosphere. Because of its close proximity to Myanmar, the narcotics trade, gun-running, fake currency and drug-trafficking are reported from this 'Golden Triangle' window.[12] The state has three Tibeto-Mongolian groups living together in a close affinity. Those are the Meiteis, Nagas and the Kukis.

Within this backdrop, the Christian missionaries established medical care in the state where public services and health care facilities got deteriorated. The arrival of missionary was not warmly welcomed by the people of the state. Rev. William Pettigrew of Arthington Aboriginese Mission, to be specific, was not allowed to open Mission Station at Mao and hence driven to Imphal valley. At Imphal he was told to move out from the valley since the people has accepted Vaishnavaite Hinduism as their faith. He then reached Ukhrul, the area dominated by Tangkhul Nagas and established the Mission Station. Shortly after he moved to this new found mission field dispensary work was carried out and after two decades or so, the 'Mission Hospital' at Kangpokpi was established with the help of Dr. Crozier in 1920. Now the state has five Christian hospitals in five of the districts ranging from specialist to general institutions.

This dissertation explores the role of Christian missionaries in medical care in Manipur. The broad objective is layout to study the characteristics and distribution of Christian hospitals in the state.

[12] Rajkhowa, J. P (2007) "Peace and Development", *Yojana*, Ministry of Information and Broadcasting, Government of India, Special Issue on North East, (December), p. 14.

In order to understand the role of Missionaries an understanding of the theological underpinnings is necessary and to locate missionary activity in medical care as an instrument of evangelization. In discussing the role of Christian missionaries in medical work, the ethical issues that are arising out of the care given by religious institutions are to be looked at.

The notion of the Christian missionary as an emissary sent to the world to preach gospel is to be understood within the Christian principle of professing faith. This is inherent in the practice to propagate the Godliness of Christ since the time of Apostle. The followers of Christianity have incorporated this idea in their efforts of evangelization. Historically, the rise of Christianity in European countries has led to Christian missionaries being sent to different countries that were their colonies, of which the Indian subcontinent was no exception.

There has been much debate regarding the association of Christian missionary activities with colonial expansionism. While the agenda of the Christian mission was to deliver the gospel to the people, colonialism used it further and consolidated their economic interests. Therefore, the colonial historians used the term 'enterprise' as medium to understand the scheme of colonialist perspective on expansion of empire.

However, the history of Christianity in India has mostly been written from the perspective of the 'history of the mission'. Such a perspective represents a missionary counter point to the view that has dominated so many general historians of modern India, i.e. the view that has equated the history of India with the history of the British government and administration.[13]

The studies on Christian missionaries are mostly based from the point of view of the formation of Church in the history. It is also seen that the missionaries proposed to look at the model of New Testament projected by apostles as the history of mission. This proposition is based on the theory that relates to the actions and events that occurred at the time of Jesus. As Christianity was propagated from the west to the east reaching the

[13] Khangchian, Dominic (2002) *Christian community and Change: Delhi 1850-1950*, Unpublished Dissertation, New Delhi: CHS, JNU, p. 7

Indian soil, the medium through which it permeated was commonly the European insight. Modern historians of India suggested the history of Christian as the 'cultural history', and the Christian Missionaries' own writings suggest a 'community'. Distinction between these two positions is clear, that for the European it is accepted Christianity as culture, whereas, in India it is adopted as community.

Before we go into a discussion of the colonial design on missionary, it is highly appropriate to know the saying of theology on Christian mission is. In pursuance to define the conceptual understanding of Christian Missionary for medical work, the first concern is to draw briefly what constitutes a 'mission' in Christian theology.

Mission is a word that defines the act of sending a 'person to conduct negotiations or propagate a religious faith'[14]. In Christian faith, the mission has been widely defined as that which is designed "to form a viable indigenous church-planting movement". The mission is motivated from theologically imperative theme of the Bible to make God known, as outlined in the Great Commission.

Therefore, the Christian Missionary Movement seeks to implement churches after the pattern of the first century Apostles. However, Christian missions can more broadly mean any activity in which Christians are involved for world evangelization. Christian Missions may take the forms of promoting development, education, health care, orphanages and economic and not necessarily the preaching of gospel. The manner in which the missionary administering care and healing for the sick have carried profound attributes to Christ's likeness towards mankind.

There are two forms of Christian mission in medical work and they are the Medical mission and Medical Evangelism. Mission often emphasizes evangelism, which seeks to reach the spiritual needs of individual primarily through teaching. The approach

[14] Concise Oxford English Dictionary, Indian Edition, Eight Edition, Oxford University Press, 1992. p. 569.

of medical mission is a descriptive term, while medical evangelism is broader, seeking to reach both the spiritual and physical needs of those who are served.[15]

Medical Mission is more of a prophetic ministry where the Christ-Centered life is promoted. This ministry significantly involved the call for repentance from dominant corrupting lives and pronounced the blessing if God's word was obeyed. This is a call for the marginalized sections of society and to bring about health, healing and transformation in society.

Evangelism involved highlighting the benefits of Christianity through various developmental services, education, medical amenities for the sick and providing charity to the serving natives. Numbers of critiques have suggested that the Christian missionaries were able to recruit or convert as many people in times of famine and epidemic. The Christian services mentioned above had sought to impress upon the 'native' to let it convert through these means.

The activities of the Christian missionaries hold promise for historiography as an important element of the cultural encounter between Indians and Europeans in the colonial period. The theme raises a number of significant issues, for example, the link between evangelical Christianity and the cultural construction of the colonial order, the extent to which the colonial state endorsed the activities of the Christian missionaries, and the reaction for the Indian to the evangelical project.[16]

Literature on history of Christianity in Manipur are mostly available in many of the established institutions while the characteristics, distribution, nature of services, difficulties and aims of the organizations which are crucial out-puts from Christian institutions in health outcome of the state are not available. The present study will give an insight to studies that observed the 'link between overall socio-economic development

[15] Eichman, Phillip (2001) *Medical Missions among the Churches of Christ*, Second Edition, Ohio: International Bible Society

[16] Gupta, Kaushik. Das (1997) *Missionary Activity and Colonial Response: Delhi 1952-1914*, Unpublished Dissertation, New Delhi: CHS, JNU, p. 1

and location of the institutions. It seeks to examine how these institutions are distributed.[17]

The role of Christian missionaries in medical care in Manipur will be studied and their contributions to health services provisioning in the state.

The Study Methodology

The dissertation will look into the role of Christian missionaries in medical care based on the study of Christian hospitals in Manipur. We propose to look at the evolution, structure, institutional form, programmes, and comprehensive view (Preventive, curative and rehabilitative) of the organization. It will also attempt to explore the community outreach programmes and services.

Objectives of the study:

The overall objective of this dissertation is to study the characteristics and distribution of Missionary Hospitals in Manipur

Specific Objectives:

1) To explore the history and status of Christian Missionaries in Manipur
2) To study the characteristics and distribution of Missionary Hospitals across districts in Manipur

In order to address the specific objectives, we are guided by the following questions:

- What are the motivations of the Christian missionaries to establish hospitals? Why does it occupy a central position in the mission?
- What are the views of Christian hospitals with regard to public health in Manipur?
- What services are being provided in the missionary hospitals?

[17] Baru (1999), p. 522.

Methods of Data Collection:

Data was collected from both primary and secondary sources. At the onset of the study, the relevant data requirement was listed out so as to identify which sources and data are related to the present study. Review of relevant literature in the form of published, unpublished reports and documents from the government and private sources was undertaken. Reports and books with special respect to Christian missionaries and the medical mission formed the background of the study.

Primary Data Collection:

- Listing and mapping of missionary hospital were done from various Christian head based organisation in Delhi. Visited institutes were: Christian Medical Association of India (CMAI), Emmanuel Hospital Association (EHA), Voluntary Health Association of India, Delhi Bible Institute (DBI), and Church of North India (CNI) for obtaining information of the Christian hospitals in India, especially in North East of India.
- Informal Interviews and mailed few questions to ascertain the information on numbers and address of the Christian hospitals. The Interview Schedule was prepared based on the need of the study.

Data Collecting Process:

The Primary data were collected in three phases. In the first phase of the study, the listing of missionary hospital was collected from visiting the umbrella organizations in Delhi. Effort was made to tap all the relevant data for the study. Contact and meeting the staffs of the umbrella organizations were done in order to extract sources of missionary hospitals and their association.

The second phase of data collection were organised through sending e-mail and phoning the various Christian institutions of Manipur.

The third phase of data collection was carried out on the basis of the list that we compiled and the information received from Christian based organisations in Manipur. In this phase the researcher visited the Christian hospitals on an average for two to three days each. Interview schedule (Appendix) was used for the administrative or the Directors of the institutions. Informal interviews and discussions were initiated from the technical staffs and the others office bearers. This was initiated in order to know what changes had occurred and most basic the history of the institutions. The field visit was done between the months of March to April 2009.

Research Design:

Exploratory research design was followed as the kind of data which was needed for the study was not available in literature. Although the literature on health and medical care services is available for other states of India, it is limited for Manipur.

Field of Study:

The study has covered whole of Manipur. Even as the whole of Manipur was captured and integrated in the study, the larger context to which non-present of missionary hospital in four districts of the state compelled to look into the five districts which are harbouring the Christian hospitals.

Scope of the Study:

The scope of this study will look into the Christian hospitals established in Manipur without referring to their denominations. The study does not include Christian health services provided under the various societies and organizations, including those providing out-patient services and are not registered as 'hospital' in the Directorate of Health Services, Government of Manipur. Reference shall be made in order to know a thorough history of the health service providers, though not registered.

Analysis and Discussion of Data:

Analyses were done using both the qualitative and quantitative data. To analyze the quantitative data, simple arithmetic calculations were done so as to use to understand

some aspect which is indentified in the objectives. Qualitative data was organized in descriptive form to address the research objectives of the study.

Limitation of the Study

There are two limitations that need to be acknowledged and addressed regarding the present study. The first limitation concerns the data related to Christian Mission Hospitals in the state that data for these institutions were found error due to under-reporting and lack of proper academic writing. The study has reservations on the aspect of in-patient and out-patient analysis because of the lack of data reporting.

The second limitation has to do with the extent to which data collection process was constraint resulted from frequent bandhs and strikes throughout the field visit. Much of the limited time was spent on adjusting the convenient time to meet with administrators of different institutions.

Chapterisation

In an attempt to bring about an overview of the topic under studied, the classification of chapters is realised. In the first chapter, the history of Christianity and missionaries in India and Manipur is brought together. And the missionaries' work on medical care is being discussed. The second chapter introduces Manipur in its socio-economic, culture, religions, etc., and to see the overview of health and health services of the state. It seeks to understand the various social elements of the state so as to see the realities of the situation. The third chapter brings into the study of Christian Hospital observed on field and the present status. This is an effort to explore the characteristics and distribution in the districts of Manipur. Lastly, the fourth chapter brings it to discussion and findings of the study.

CHAPTER 1

MISSIONARIES IN MEDICAL CARE IN MANIPUR

- *History of Christian missionaries in India*
- *Waves of Medical Missionaries*

1.1 History of Christian Missionaries in India

Christianity came to India from different parts of the world, at different historical moments and out of different impulses. One needs to find the differences of the Christian mission which are based on the modes and strategies of conversion linking with the varying political regimes and historical junctures. The history of Christianity in India may be date back to the first century, and there is a Christian community in the South-West Coast of the India that traces its origin back to the Apostle Thomas. This community has preserved its Christian faith throughout the centuries in spite of the fact that they have been surrounded by the non-christian and rather cut off from the mainstream of the Christian world.[1] There is an acceptance among the Christian community that the presence of missionaries is to be understood since the first century.

The Niyogi Committee [2] suggested the advent of Christianity in India through four definite periods; the Syrian period, the Roman Catholic period under the Portuguese domination, the protestant period under the British domination and, the modern period. Some argue that the presence of Christianity in India could be classified into two periods; one--Pre-British period and the British period. There has not been a singularly accepted period of Christianity in India. Thus, it can be said that the coming of Christianity in

[1] Thonippara (2004): St. Thomas-The first Indigenous Church in Hedlund (Ed) (2004): *Christianity is Indian-The emergence of an Indigenous Community*, New Delhi: Indian Society for Promotion of Christian Knowledge, p. 59.
[2] Niyogi (1956): *Christian Missionary Activities Enquiry Committee*, Madhya Pradesh, Nagpur.

India is not a sudden process but a gradual and ongoing. It is to be understood that no single unto-ward arrival is marked as starting point.

The history of Christianity in India is a matter of quest for proselytization, commercial interest and the conquest, so as, in other word, to able to control the trading enterprise. It would be missing out if the understanding of missionary zeal is taken from single or few missionaries point of view, and seemingly that needs exploration of the colonial writing. However, as the intricacies may be, attempts will be made to briefly study the areas where Christian missionaries first arrived at, and note the activities that were started. This chapter will attempt to bring out the brief history of Christian Missionaries arrival in India. While tracing where and when Christian missionaries arrived in India, the objective here is to discuss the historical settings where they started their mission. The important question is-who were they and how they arrived in India.

Even before Christ, there had been commercial links between Europe and India. These were both by land and sea with caravans which took the land route through Persia, and by ships down the Red Sea or the Persian Gulf. Commerce between India and Babylon by the Persian Gulf flourished from 700 to 480 B. C.

One of the first Christian missionaries was St. Paul. He contextualized the Gospel for the Greek and Roman cultures, permitting it to reach beyond its Hebrew and Jewish context. In the early Christian era, most missions were carried out by monks. Monasteries followed disciplines and supported missions, libraries and practical research, all of which were perceived as works to reduce human misery and suffering, thus enhancing the reputation of God.

The earliest known Christian community of India is the Syrian Christians in Kerala. The Syrian Christians attribute their origin to the evangelical efforts of Saint Thomas, who is believed to have arrived on the Malabar Coast in A.D. 52. The Syrian Christians regard themselves as the descendants of the high caste Nambudri Brahman converts of Saint Thomas.[3] However, the literary evidence on Saint Thomas coming to India is absent but there is a great deal of evidence to demonstrate the strength of

[3] Robinson, Rowena (2003) *Christians in India,* New Delhi: Sage Publication, p.39.

commercial links between India and the western world during that period suggests that the saint might have arrived in India. Thomas of Cana, a merchant is also said to have come to the Malabar Coast in A. D. 345 along with a number of Christians from Jerusalem, Baghdad and Nineveh and to have received the right to trade in one of the ancient kingdoms of Kerala. Syrians have been linked with maritime trade and commerce for centuries. They also have a history of warrior service and clientele under the region's chiefs. It is through their warrior and mercantile skills and tradition of rendering service as pepper brokers and revenue officers in the Malabar, for which they received honour and social privileges from the regional rulers that Syrians established themselves as a high status group within the indigenous hierarchy.[4]

European Christianity also made its advent into India during this period. The first Latin Christian missionary who is known to have visited India was John de Monte Corvino, afterwards Archbishop of Cambale in Cathay. He was sent out by Pope Nicholas IV as a Missionary to China, he on his way to China halted in India about the year 1291. He remained in the country for thirteen months, and baptized in different places about one hundred people. By the close of the thirteen century these European missionaries were able to create a chain of Christian colonies on the Western Coast of India between Thana (Mumbai) and Quilon (Travancore). Stimulated by the fear of Muslims, particularly Mongols and Rome got reconciled to many things which it did not like. In the early years of the Fourteenth century a complete Persian hierarchy was created.[5]

The missionary work of western Christendom began with the arrival of the Portuguese in 1498. This period is considered the beginning of the aggressive missionary Era of the Catholic Church in India. In 1498 Vasco Da Gama anchored off the coast of Calicut, but on that occasion he had no interaction with the Christian church. When he visited a second time in 1502, he was surprised to find a Christian community on the western coast of India. Large numbers of monks were sent to India with the Portuguese

[4] Ibid., p. 40, 41.
[5] Niyogi 1956.

fleets, and Goa soon became the centre of vigorous missionary enterprise. The Portuguese strategy of establishing the Protectorate of the King of Portugal over the Christians of the Malabar coast had become successful. Although in the sphere of trade and commerce the Portuguese on the west coast made very substantial progress but did not achieve success in their missionary endeavours. This created dissatisfaction to the King of Portugal and applied to Ignatius Loyola to send the entire Jesuit Order to India. Loyola could not grant the request, but in 1541 Francis Xavier was sent to the East, and the day of his arrival may well be called the birthday of Roman Catholic Missions in India. He was said to have baptized about 60,000 people, nearly all from the fisherman castes, living on the South-West and South-East coasts of India. This mass movement work of the Jesuit was in fact an appeal to material interest. He wrote to the King of Portugal that the hope of increasing the number of Christians was by the use of the secular power of the state. Special privileges were granted to Christians in order that the 'natives' may be inclined to submit themselves to the yoke of Christianity.

The Portuguese strategies on 'trade, conquest and Christianization went hand-in-hand'.[6] In 1514 Pope Leo X granted to the Kings of Portugal the right of patronage over churches and of nomination to all the Benefices which they would establish. In 1534 all trading stations from Bombay to Nagapatnam where the Portuguese flag was floating soon became catholic centres with resident chaplains. Now the successive waves of invasions of India by Catholic Missionaries for the west were started; besides the Jesuit (1542), the Dominicans (in 1548), the Augustinians (in 1572) also arrived in India with the active support of the Portuguese Kings. By the middle of 1577 a Christian centre was formed in Bengal by bands of Portuguese adventurers and an Augustinians Father and their slaves. Thus the Portuguese continued their work of winning Indians for Christ their Lord with the mighty sword in one hand and the crucifix in the other.[7] Thus the 'first notable success of christian missions outside the Portuguese frontiers has to be

[6] Robinson (2003), p. 42.
[7] Dharmaraj, S. Jacob (1993) *Colonialism and Christian Mission: Post Colonial Reflections,* New Delhi: Cambridge Press, p.18

understood in its political rather than its spiritual aspect'.[8] The expansion of catholics could be attributed when in 1872; the Augustinians distributed their missionaries in Basein, Bengal and other parts. The Jesuits had been making determined efforts to reform the Syrian church in accordance with Roman ideas and to bring it into subjection to the Pope. In 1594 a Jesuit Mission started from Goa to the court of Akbar the Mughal and they got his permission to establish Christian centres in Agra, Delhi and Lahore. A new beginning was started with the coming of Jesuit missionary Robert De Nobili in Madura, the capital of Hindu Kingdom from Italy. He saw the Xavier and other catholic Fathers policy failure to convert. He then made clear that unless the higher classes were won for Christ the Church was not going to drive her roots into the soil of India.

In order to fulfill his plan, he addressed the people that he was a Brahmin from Rome. Having determined to make himself an Indian, he adopted the dress and the sacred thread of a Brahmin, and painted the sandalwood sign on his forehead. He kept aloof from men belonging to the lower castes and only allowed Brahmins or men of high caste to have access to him. He learnt Tamil, Telugu and Sanskrit and took up the Brahmin style of living. Through this act he was able to attract people in a big way. By the year 1607 to 1611, he baptized 87 Brahmins. It is said that he had converted about a lakh persons but they disappeared after his death in 1656.

The French Jesuits, who had their headquarters in Pondicherry from 1700, passed it on to the Paris Foreign Mission Society in 1776. At Calcutta a Catholic chapel was erected in 1700. The Italian Capuchins penetrated into Tibet in 1713. Thus, a network of Roman Catholic Mission was spread all over India from Tibet to Cape Comorin and from Punjab to Assam. Within two hundred years after the Portuguese landed in India it is claimed the Catholic Church had 9, 58,000 adherents in India.[9]

For almost a century the monopoly of the Portuguese in the east was unchallenged, and then came the ships of English, French, Dutch and Danish. During the

[8] Neill. Stephen (1966) *Foundations of the Christian Mission: Colonialism and Christian Missions*, London: Luttterworth Press, p. 73.
[9] Niyogi 1956.

seventeenth century none of these nations entertained any notion of conquest. They were there to trade. They lived quietly in small enclaves, which they had rented or purchased from the local rulers and within which they attempted as far as possible to reproduce the habits and manners of their own country. In course of time, some of them found themselves responsible for the welfare of a considerable body of Indians, as increasing numbers of merchants congregated to enjoy the more stable conditions of trade offered by their European colleagues, and others flocked together to escape from troubled territories to enjoy the protection of a European flag.[10] Comparatively the Dutch were better than the British. With their keen sense of the advantage of having a large Christian population devoted to their European masters, they combined the preaching of the gospel with the lure of political advantage in such a way as to win the hearts, or at least the calculating minds of some among their subjects. In Cochin and other centres where they had dispossessed the Portuguese, they took over the Roman Catholic converts and reconverted them.[11]

The missionary work of the protestant church began in India in 1706. Soon after the Dutch, the Danes entered India and established a number of factories on the eastern and western coasts of India. In 1706, German Lutherans, sent by King Frederick IV of Denmark, reached Tranquebar as Missionaries to the Danish Possession in India. Their work at first was mainly confined to the Danish and English settlements. Later they did a lot of preaching, teaching and Bible translation. Ziegenbalg, Grundler, Schwartaz and other under the patronage of the King of Denmark were the pioneers of the Protestant Mission in India. The Danish Missionary Society in association with German Missions opened the era of Protestant Missionary enterprise in India. The Bible was translated into Tamil by them. They laid the foundations of the Church in the districts of Tinnevelly, Trichinopoly, Tanjore and Madras.[12] [13] [14] The Protestant missionary work gained momentum only after the arrival and the expansion of the Anglican power.

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[10] Neill (1966), p. 74.
[11] Neill (1966), p. 76.
[12] Niyogi 1956.
[13] Dharmaraj (1993), p. 18.
[14] Neill (1966), p. 76.

The Danes had scarcely commenced assuming political power when they were superseded by the British. The first English Mission established in India was that of the Baptists in Bengal. By the Charter of 1690, the East India Company was charged to see all chaplains in the East India Service shall learn the language of the country in order that they may be better able to instruct the Gentoos, heathen servants of the Company and of its agents into Protestant religion. The 'founder of the English East India Company belonged to that race of sober, pious London burgesses, who took pleasure in the sermons of John Donne and though of a somewhat puritanical cast of thinking. They held the view that commerce cannot be a glorious enterprise, if it limits its objectives to those things after which the Gentiles seek'.[15] It was not likely that such instruction would be carried out unless chaplains were appointed to the larger ships. So the first Anglican clergymen in the East were ships chaplains. The question of appointing Company's chaplains to reside in India arose only when the English, like the Portuguese, discovered that enterprises of the East cannot be maintained without the presence of permanent or semi-permanent residents to care for them in the intervals between the coming and going of fleets.

There was a new responsibility that the 'Company accepted a measure of spiritual responsibility for all those in its service, whether Christian or non-christian. It was not a charter for unrestricted evangelization among the non-christian peoples of India, but at least it was recognized that ministrations to European alone would not suffice and that the Company must accept a larger responsibility'.[16]

Robinson observed that the Eighteenth century to the Nineteenth century is the period of the British. Also Neill suggests these periods as the non-Roman Catholic or Anglican era while other known these periods as the Protestant period. The British period, which means the East India Company controlled over the trade and the missionary zeal towards the non-christian people. The East India Company which was started as a trade company began to expand and later became the largest colonial power

[15] Neill, Stephen (1984) *A History of Christianity in India: The beginnings to A. D. 1707*, London: Cambridge University Press. p. 364.
[16] Neill (1984), p. 368.

in history. The Company openly encouraged missionary work until the middle of the eighteenth century, but towards the end of the century seeing the administrative responsibilities over the Indian territories, the Company decided not to interfere with the traditional cultures of the people by supporting missionary work.[17]

Robinson also suggests that though it employed chaplains of its own servants, merchants and soldiers, they were at first hostile to missionary activity. This was possible from the fact that, 'as a commercial enterprise, the Company could only hope to succeed by accommodation to indigenous social and cultural traditions, including religion. They feared that evangelical effort might give rise to violent reactions, creating political instability and threatening vital commercial interests'.[18]

In the early nineteenth century, there was a pressure from the missionaries and the returning civil servants of the British government that the propagation of Christianity would produce obedient citizens and strengthen the foundation of the empire. This policy was short lived. 'After the Company's charters were renewed in 1813 and finally in 1833, the Board of Directors changed the policy of the Company and under the pressure from Evangelical in England the missionaries began to arrive freely in India'.[19]

The Company did not follow the complete neutrality in religious affairs. Accommodation to indigenous religions meant that large sums of money were donated for the maintenance of temples and priests and Company officials attended the more important sacred celebration with the view to manifesting their respect for native traditions. It was this participation that provoked the missionaries to complain to the government. This after all had shifted the policy to permit the missionary effort.

William Carey, the first self-sponsored Baptist Missionary from England arrived in the Hooghly in November 1793. He had a hard life in his initial staying, for he did not have the permit from Company. After a couple of months of living on charity, an indigo

[17] Dharmaraj (1993), p. 18.
[18] Robinson (2003), p. 56.
[19] Dharmaraj (1993), p. 19.

manufacturer in North Bengal, George Udny, offered job as manager in his newly established indigo factories in Malda district. Carey accepted the job as Divine Providence and moved to Madnabati in Malda in June 1794. The plantation position helped Carey established closer touch with the worker from whom he learned the Bengali and Sanskrit languages. The workers who were under him were so poor that they were forced to depend upon the plantation owners. This gave Carey the positional advantage to use the workers as his congregation. When Udny's factories were destroyed due to the flood, Carey bought one of the factories and made plans to establish a community on the model of the Moravian Brethren. It was then that four families from England arrived in the Hooghly on an American ship. Since they had no permission form the Company to reside in India, they moved to Serampore, a Danish colony fifteen miles upstream from Calcutta. When Cary heard about it, he sold the factory and went down to join them at Serampore. This was the beginning of the Serampore Mission. Carey's motive in India was to learn the local languages and convert the Indian people. The British evangelical missionaries' concern during the Carey's era was to save souls from perdition.

Neill observed that the end of the eighteenth and the beginning of the nineteenth centuries was the great period for the formation of religious societies. The London Missionary Society was formed on an undenominational basis on 1795, the Church Missionary Society (Anglican) in 1799. American entered the field in 1810 with the American Board of Commissioners for Foreign Missions. The movement spread to Switzerland (1815), Denmark (1821), France (1822) and Germany (1824).[20]

The Church of England prevailed upon the East India Company to appoint chaplains and ardent evangelistic like Henry Martyn were brought to India. The Society for Promotion of Christian Knowledge (SPCK) made financial grants to the German Missionaries in South India. In 1814, the Church Missionary Society sent two clergymen to South India and in 1816 two others to Bengal as regular Missionaries. In 1820 the Bishop College in Calcutta was established for instructing native and other Christian

[20] Neill (1966), p. 92.

youth in the doctrine of the Church. With the arrival of Alexander Duff, the Scottish Missionary, in 1830, a fresh epoch began in the history of the Protestant Missions.

The converted Christians of India were mostly drawn from the lower castes and were looked down upon. This has made Alexander Duff a surprised, it seemed impossible to evangelize in India. Therefore, Duff conceived the plan to converting the Brahmans by means of English education saturated with Christian teaching and with the help of English providing them with Government jobs. This plan was followed by many missionaries, and high schools and colleges were founded during the next fifty years in all parts of India with lavish aid from Government.

Dharmaraj in his '*Colonialism and Christian Mission: Post Colonial Reflections*' brought out the two major factors that exerted a decisive influence upon missionaries work in India during the second quarter of the nineteenth century were approval of the permanent presence of missionaries in India through the Charter Act of 1833, and the legalization of English education in 1835. He observed that the Evangelicals in England and missionaries in India were the prime movers behind these changes. He assumed that Missionaries and mission societies were convinced that Western education would bring religious transformation and Cultural Revolution in Indian society, and thus prepare the way for evangelization of India.[21]

The legalization of English education, the abolition of restrictions on missionary presence, and the arrival of administrative leaders who were sympathetic to the evangelicals facilitated the proliferation of mission societies and Christian institutions across the nation. Scottish missionaries, such as John Wilson in Bombay (1832), John Anderson in Madras (1837), and Stephen Hislop in Nagpur (1844) established schools after the model of Duff to promote Christian knowledge among young native students. They were joined by the Church Missionary society, the Baptist Missionary Society, the London Missionary Society, The Basel Mission, and others, in parts of the nation. More American mission societies also entered India after 1833. The American Baptist sent their

[21] Dharmaraj (2003), p. 58.

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missionaries in 1835.They were followed by the Lutherans and other societies in the 1840s.

In order to protect the Christian converts and their inheritance in British India, the Act XXI of 1850 was passed. This was done because the then prevailing customary law stood as an impediment to conversion of Hindus to other religion.

Christianity and North East India: In the case of missionaries in the tribal areas of west, central, east and north-east India, there is evidence of extended patronage by officials. Conversion in the north-east had begun to advance while the British were in the process of shedding the role of traders to assume that of rulers. Annexation brought the British into contact with the tribal people of the hilly regions, whom they considered unpredictable, primitive and difficult to deal with. The missionaries' hoped that through evangelization and education would be able to civilize and domesticate the tribal. Among the missionaries who worked in the north-east, the Presbyterians and Baptists were prominent, though Methodists, Catholic and Anglicans were also present.[22]

The earliest known Christian contacts with north-east India were from the Catholic Missionaries in the seventeenth and eighteenth centuries. There was a small community at Bondashill in the Cachar district of Assam, the descendants of a small band of Portuguese soldiers who were given the land in return for the service to the Raja of Cachar. It is understood that the first recorded contact of the Catholic Missionaries with Assam was in 1626 when the Tibet-bound Jesuit Missionaries, Stephen Cacella and John Cabral visited parts of Goalpara and Kamrup districts on the way to Tibet. The beginning of missionary work in the region in the nineteenth century was made by the Baptists of Serampore. The earliest interest in the region was shown when an Assamese Pundit Atmaram Sarma of Kaliabar in the Nowgong district was employed for the purpose of translating the Bible into Assamese in 1811.[23]

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[22] Robinson (2003), p. 57.

[23] Jeyaseelan, L (1996) *Impact of the Missionary Movement in Manipur*, New Delhi: Scholars Publishing House, P. 19-24.

Phillip's *The Growth of Baptist Churches in Nagaland* writes that the American Baptist to Nagaland was started by Rev. and Mrs. Cyrus Barker and Miss Rhoda Bronson sister of Rev. Miles Bronson in 1840. Rev. Barker moved his family to the hills and commenced his work among the Nagas at Namsang in the Tirap Frontier Division of the North Eastern Frontier Agency. Due to severe illness they abandoned and moved back to Jaipur, therefore the work among Nagas ceased. No one was converted at that time, but time to time Nagas were converted.[24] Manipur was not left out in the map of missionaries endeavor when William Pettigrew landed in 1894, the first Baptist missionary. He brought the gospel to Manipur, and credited the pioneer of modern education in Manipur.[25]

History of missionary changed when the Sepoy Mutiny broke out in 1857. After this blunder by the East India Company toward the people aspiration of India, the direct rule was upon the British crown. This was however, a changed in the government administrative and the direct rule over the people. Dharmaraj argued that 'the Mutiny of 1857 was neither the outcome of fear or of hatred toward Christianity, but of genuine misunderstanding by the British India government which had failed to take into account the religious and cultural sentiments of the people in India and ruthless attitude of the British administrators in humiliating native leaders'.[26]

After the Mutiny, the interiorization of missions was promoted. It is said that the missionaries who were working in other parts of the country gathered data to prove that the uprising had never occurred in places where the mission stations had been established. Hence, such knowledge of missionaries and other societies resolved to intensify their evangelistic work, and asked the movement to aid the mission societies in their endeavour. Missionaries in India and the evangelicals in England demanded the government to commit itself to the propagation of Christianity by citing the cause of

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[24] Phillip, Puthuvali Thomas (1983) *The Growth of Baptist Churches in Nagaland*, Guahati: Christian Literature Centre, p. 50.
[25] Lolly. R.R (1985) *The Baptist Church in Manipur: A historical Survey of the Mission strategies and development of the Baptist Church in Manipur North Eastern India, 1894-1983*, Imphal: Manipur Baptist Convention, p. 18-21.
[26] Dharmaraj (1993), p. 84.

Mutiny. Sir Charleswood said that *'every additional christian is an additional bond of union with this country and an additional source of strength to the Empire'* [27]

The number of missionaries' societies considerably increased during the middle to late nineteenth century. The mission societies began to feel the need to join force and pool their forms of church government and of worship. At this juncture the native Christian began to demand Christian unity. As a result of this, regional mission conferences were held in Calcutta (1855), Benares (1857), and Ootacamund (1858). Having experienced some success with regional conferences, the first major General Missionary Conference for the whole of India was arranged in 1872 in Allahabad where 132 missionaries participated. The Conference held in 1879 at Bangalore emphasized the necessity of unity and oneness among Christian mission agencies in India.[28] No less, the nineteenth century mission was maintaining the legacy and Europeanization of India.

David in his *American Missionaries in India: A Difference* suggested that the most of the missionary work in India can be divided into two aspects; evangelical efforts and humanitarian services. The objects of the humanitarian work were education, medical or social services, was intended to serve as a preparation for evangelization. These humanitarian services served as contact points so that the people could come under the sphere of their influence.[29]

Some of the historian termed indigenization process which started after the Mutiny as the anti-colonial. Fields wrote, 'Christian missionaries were anti-colonial and hence indigenization process of native was done in the church leadership. This may however a leverage for larger proselytization, but was more in adaptation of time'.[30]

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[27] Cited in Dharmaraj (1993), p. 93.
[28] Dharmaraj (1993), p. 95.
[29] David. M.D (1995) "American Missionaries in India: A difference", in *Journal of American Studies*, Vol. 25. No. 1, Winter 1995, p. 40.
[30] Fields, Karen. E (1982) ''Christian Missionaries as Anti-colonial Militants'', *Theory and Society*, Vol. 11. No.1. (Jan., 1982). P. 95.

Many of the thinkers reasoned that the effort of missionary education was an arm of colonial conquest. Whether it is Bible or secular education, the missionary education system was such that they inculcate colonial values. At this point, Mackenzie arrived his conclusion by stating that 'without the sanction of colonial power, the missionaries were helpless'.[31]

Christian missionaries were pretty much involved in social and economic change of the society. There are instances that "they set up medical clinics, becoming involved in economic development programmes and teaching the virtues of hard work begetting materials rewards, all contribute to an increasingly interested audience, usually among the most politically and economically deprived segments of the population".[32] The development activities were extensively widened through the social involvement. Such development activities was strengthened through the Christian ethic "*he who does not work shall not eat*" made the Christian missionaries to even involved in agricultural efforts.[33] This philosophical notion of ethic impinged the missionaries to teach the locals to involve in agricultural productivity. Manshardt[34] opined that missionaries were very much involved in the reduction of poverty. Their approach to the poverty is through the apparatus of thriftiness and the waste of money upon ceremonies and feasts can be dealt by means of education.

The Christian missionaries adopted many social and humanitarian works to influence the poor population of the native Indian for proselytization. Stanley[35] observed that to bring to the "heathen" the gospel of the cross of Christ was to open before them

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[31] Mackenzie, Clayton G (1993) "Demythologizing the Missionaries: A Reassessment of the Functions and Relationships of Christian Missionary Education under Colonialism", *Comparative Education*, Vol. 29, No. 1, (1993), p. 50.

[32] Whiteford, B. Michael (2002) "Staying Healthy: Evangelism and Health Perception Differences by Gender in a Guatemalan Marketplace", In *Annals of the American Academy of Political and Social Science*, Vol. 583, Global Perspectives on Complementary and Alternative Medicine, (Sept,.2002), p.180.

[33] Miller, S. Elmer (1970): "The Christian Missionary, Agent of Secularization", In *Anthropological Quarterly*, Vol. 43, No. 1, (Jan., 1970), p. 17.

[34] Manshardt, Clifford (1930): "Missionary Approach to the Poverty and Ignorance of India", *The Journal of Religion*, Vol. 10, No. 3, (Jul., 1930), pp. 369.

[35] Stanely, Brian (1983): 'Commerce and Christianity': Providence Theory, the Missionary Movement, and the Imperialism of Free Trade, 1842-1860", *The Historical Journal*, Vol. 26, No. 1, (Mar., 1983), pp. 71.

not only the prospect of eternal life but also the road to unlimited social and economic development.

The modern missionary now focus on inserting a culturally adapted seed of Christian doctrines into a self-selected, self-motivated group of native believers, without removing the natives from their culture in any way. Modern mission techniques are sufficiently refined one that most native churches are natively pastored, managed, taught, self-supporting and evangelizing. The approach is to let native cultural groups decide to adopt Christian doctrines and benefits, when such major decisions are normally made by groups. In this way, opinion of the leaders in the groups can persuade much or most of the groups to convert. When combined with training in church planting and other modern missionary doctrine, the result is an adaptation of Christian values in their culture.

The modern period missionaries look for a co-operative effort to be able to self-sustain by founding many different ministries, often including several coordinating ministries, often with separate funding source. Establishing seminary, theological college, opening Non Governmental Organizations, organizing Bible camps, gospel music club, etc are newly introduced fields incorporated in mission approached.

From the above discussion, the Christian missions could be not be classified as one or the other, as it is greatly varied. Kumar[36] rightly stated that the types of missionary groups range from Catholic to non-Catholic and British to Non-British. This is possible as the history and legacy of Christian missionaries always had been negotiated with complexities. The list of some of the missions and denominations which operated in India were: These includes the London Missionary Society, American Presbyterian Mission, American Baptist Mission, Lutheran Mission, US, Free Church of Scotland, English Baptist Missionary Society, South Australian Women Mission, United Church of Canada Mission, the Wesleyan Methodists, the Irish Presbyterians, Women's Missionary

[36] Kumar. R. John. Suresh (2001) *Christian Medical Care in Tamil Nadu, 1947-2000: A Preliminary Exploration,* Unpublished Dissertation, New Delhi: CSMCH, JNU, p. 10.

Societies, Danish Missionaries, Society for the Propagation of Gospel, the American Arcot Mission, Church Missioanry Society, and Holy Cross Mission.[37]

1.2 Waves of Medical Missionaries

The wave of medical missionaries arriving in India was seen in the mid-eighteenth century. These missionaries were providing health services to the native Indian in their respective mission fields. It is a fact that the missionaries were treating the sick natives with which little knowledge they knew. The new era of Christian missionary is opened when the trained medical missionaries arrived in India by mid-eighteenth century. Even before the arrival of medical missionaries, the missionaries were, in many circumstances provide health services through healing and caring. In this section, it is our focus to explore what services were provided, and effort will be made to note those establishments by the medical missionary.

To begin with, the relationship between health and healing in the Christian understanding is essential to learn. The ministering of healing upon the sick is a pattern after that of Jesus Christ. The 'Mission' emphasizes evangelism which seeks to reach the spiritual needs of individuals primarily through teaching. This is a part of Great Commission—'to go and make disciples of all nations'. Here, the approaches of medical mission seek to reach both the spiritual and physical needs of those who are served. Appropriation of using medicine in mission is a concern which is intended to cure the sickness of an individual. The medical work is nothing less but *"a 'double cure' that mended both broken bodies and sin-sick souls"* wrote Fitzgerald.[38]

Christian missionaries had in various capacities back the survival of the Christian institutions by ways of providing the 'structural component for mission work, which are

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[37] Baru (1999), p. 522.

[38] Fitzgerald, Rosemary (2001) Clinical Christianity: The Emergence of medical work as a Missionary Strategy in Colonial India, 1800-1914, in Pati, Biswamoy and Harrison Mark (Edt): *Health, Medicine and Empire: Perspective on Colonial India*, New Delhi: Orient Longman Limited, p. 121.

organizational resources, doctrinal boundaries, internal power structures, sanctioned recruitment strategies and long term goals'[39]. Johnson et al[40] arrived at the juncture that the history of the relationship between religion and health is nearly as long as the history of humankind. Indeed, faith healing, divine healing, or healing in answer to prayer has been an element of many religious traditions. Christian belief and practice faith healing in every period of church history since the ministry of Jesus. The practice of praying for the sick was growing acceptance among Christian denominations. Thus, it has let to emergence of religious groups with therapeutically oriented theologies in bringing about recovery from illness.

In other sense, it may explain that the purpose of medical work is precisely to care for the sick in order to bring alive their soul to God. Adding to this, Arnold wrote, that 'missionaries were accordingly recruited specifically for their medical training, and hospital and dispensaries became central elements in missionary strategy. They identified themselves with western medicine's empirical and rational approach to counter the authority of their rivals. Therefore, medical work brought missionaries some conversion'.[41]

According to Eichman the purpose of medical mission is to open the door for evangelizing. He stated that 'we must try to lead them to Christ, but if they do not see Him in our lives and in our treatment of them, it will be hard for them to grasp the meaning of our message. When they see that we care, their hearts will open for the Gospel. Opportunities abound for evangelism through rendering ministry to the suffering bodies of lost souls'.[42]

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[39] Cavalcanti, H. B (2005): "Human Agency in Mission Work: Missionary Styles and Their Political Consequences", Source: *Sociology of Religion*, Vol. 66, No. 4, (Winter, 2005), pp. 381.
[40] Johnson. Daniel M., Williams. J Sherwood and Bromley. David G (1986) "Health and Healing: Findings from a Southern City", *Sociological Analysis*, Vol. 47. No. 1. (Spring. 1986). P. 66.
[41] Arnold, David (Ed) (1989) *Imperial Medicine and Indigenous Societie'*, New Delhi: Oxford University Press, p.17
[42] Eichman, Phillip (2001) *Medical Missions among the Churches of Christ*, Second Edition, International Bible Society.

Armenian and Acra also substantiate that 'healing in all its form was the objective of missionary work'.[43] Adding to that, the rising of the general health standard of serving people everywhere might have influenced general usefulness of the Christian act. In this, Worboys observes that the "aims of medical missionary work at this time and later were to continue the work of Christ the healer, to protect the health of missionaries themselves, to provide an opening into alien cultures to facilitate conversions, and to represent the superiority of western civilization".[44] This notion has been debated over time that the issue of saving bodies and saving souls was important and therefore very often a chapel was built even before a hospital. Seeing the plight of the people they served, the medical works observe as closer contact with native people. This has led to the process of bringing people to Christianity has much more to do with humanitarian gestures, and as it is, they tried to bring health aspect as one of the tool in the course.

The rationale for missionary's involvement in medical work was not merely a humanitarian motivation but also a desire to help needy people, says Dena[45]. Medical work was also one of the most effective means of destroying the traditional world view and belief system which was essentially supernaturalistic. The 'Christian missionaries were in the view of naturalistic rather than supernaturalistic concerning disease. Their understanding of illness involved making the proper diagnosis (which in turn depended upon proper training) and obtaining the required remedies'.[46]

Relationship between government officials and the Christian missionaries may well be understood from the account of Dena- that the British government officials had a friendly attitude towards Christian missions and there is no doubt that such friendly

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[43] Armenian, Haroutune K and Acra, Aftim (1988): "From the Missionaries to the Endemic War: Public Health Action and Research at the American University of Beirut", Source: *Journal of Public Health Policy*, Vol. 9, No. 2, (Summer, 1988), p. 261.

[44] Worboys, Michael (2000): "The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940", Source: *Osiris, 2nd Series*, Vol. 15, Nature and Empire: Science and the Colonial Enterprise (2000), p. 207-218

[45] Dena, Lal (1988) *Christian Missions and Colonialism: A study of Missionary Movement on North East India with particular reference to Manipur and Lushai Hills, 1894-1947*, Shillong: Vendrame Institute, p. 105.

[46] Miller, Elmer S (1970): "The Christian Missionary, Agent of Secularization", Source: *Anthropological Quarterly*, Vol. 43, No. 1, (Jan., 1970), p. 20.

relations between officials and missionaries were considered important because each partner got tangible benefits out of it. As long as the missionary movement did not pose a threat to the colonial occupation, the official served to reinforce the missionary efforts particularly through the system of grant-in-aid to educational schools and other humanitarian or philanthropic works. This benevolent paternalism often served as an effective means for legitimatization of their rule. On the other hand, so long as the government support helped the Christian missions in achieving their main aim-the propagation of the Christian faith, the missionaries also extended an unstinted help to the government. Such being the attitude of the two partners, stress and strains as arose between them tended to be compromised and solved for the sake of maintaining the system.[47]

Thus, the mutual relationship that existed between the officials and the missionaries was based on the temporary process of conditional reciprocity. It did not germinate from their ideological confluence, but grew out of necessity and expediency. The moment the missionary movement threatened political stability, the government did not show and least hesitancy to curb such mission movements. Also, the moment the missionaries realized that the government was interfering in their religious instruction, they were ready to delink their relationship with the government.[48]

Medical evangelism strives to open doors not only in the colonial world but also to many of the countries. Medical missions' programmes sponsored by the Christian societies allowed Christians to enter places once thought to be impossible. **The beginnings of medical evangelism** can be traced to the ministry of Jesus and the Apostles as recorded in the Gospels and Acts. There are, however, few details in the remainder of the New Testament regarding the care of the sick. One reference in James (5:14) reads: '*Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord*'. This verse suggests the Church, or at least some within the Church, continued to render service to those who were ill.

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[47] Dena (1988), .p.117.
[48] Ibid., p.117.

The New Testament teaches compassion and concern for others as a basic principle of Christian living. Compassion and care for the sick and needy by the early Christians no doubt continued through the early centuries. As time passed and Catholicism gained control of the religious world, much of the care for the sick was carried out by monastic orders. Some of these orders became known for the care of particular types of illness. The order of St. Lazarus, for example, was known for the treatment of lepers and the members of this order established many hospitals (known as 'lazarettos') throughout Europe for the treatment of leprosy.[49]

The theological motive behind the medical mission is also need reconsideration, because the intention of healing the sick is humanitarian, but it used as a contact for proselytization. Fitzgerald rightly pointed out that 'missionary medicine was not a simple humanitarian gesture promising to relieve sickness, suffering and disease; in missionary hands, medical interventions were designed not only to care and cure but also to christianise. Missionary medicine was some time known as the most impressive and persuasive means of presenting the gospel message to the peoples of other cultures and other faith. Medical agents were assigned an important place in the missionary army; their work was believed to constitute one of the most powerful forces for spreading knowledge of Christianity'.[50]

Over the spreading of western medicine, it is necessary to look into the perception of the missionaries regarding indigenous healing practices as their view takes course of favouring for western medicine. The missionaries were limited in the understanding of medical systems and method of indigenous healing. Though the missionaries were showing their sense of interest in the local languages, translating Bible into local languages, yet they were not inclined to accept the good old practices of indigenous healing that inherently prevalent in India since ancient time.

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[49] Eichman (2001)
[50] Fitzgerald (2001), p. 89.

Now, the perception of Christian missionaries regarding the indigenous healing was shown that, they thought, the moment when people believe in the missionary medicine it will wipe out the superstitious believe and would eventually accept Christianity.

Now let us look into the coming of medical missionary in India. The protestant missionary advance on the world began in the 1790s and early 1800s, missionary societies registered little interest in establishing medical work as a distinct arm of overseas service. Although medical men, such as Dr. John Vanderkemp and Dr. John Thomas, are listed among the earliest missionary agents sent to the foreign field, they were usually appointed to do 'ordinary mission work' with scarcely any reference to their medical skill. In concordance with theology of missions, most mainstream missionary societies of the first half of the nineteenth century believed the ideal candidate for missionary office was the ordained man whose clerical identity would ensure that mission work was thoroughly sound and uncompromising in terms of its spiritual strength. Candidates with medical expertise held no special for mission boards. Training in a secular vocation, such as medicine, seemed hardly relevant to the missionary calling. Until mid-century, men with serious missionary intentions were normally expected to seek ordination before they were commissioned to go forth as 'messenger of Christ'. Prior to the 1860s, nearly all British missionaries sent to India were ordained.[51]

The medical mission entered the Indian sub-continent during the late eighteenth century mainly in those regions which were directly under British rule. The initial missionary work carried out by the Baptist and American medical missions.[52] Also, the British medical presence in India dates from 1600, when small number of ship's surgeon arrived onboard the East India Company's first fleet. The number of British surgeons in India steadily as the Company extended its trading operations, but there was no regular medical establishment until 1763, when the Bengal Medical Service was formed. The Bengal service set fixed grades or ranks, and definite rules for promotion; it comprised 4

[51] Ibid., p. 91, 92, 93.
[52] Baru (1999), p. 521.

head surgeons, 8 surgeons, and 28 surgeon's mates. Medical services were soon formed on similar lines in the other two presidencies of Bombay and Madras. In 1775 the medical services were expanded, and medical boards set up in each presidency to administer European hospitals.[53]

Long before medical missions became a prominent feature of the mission, most missionaries had taken some interest in medical matters, only to safeguard their own survival overseas. Missionaries were advised to take ordinary precautions to conserve their health and strength in the mission field. Some prudent missionaries managed to acquire some rudimentary understanding of medicine prior to departure for the field or during furlough, but these were haphazard and fragmentary forms of preparation that might entail more than occasional attendance at medical school lectures or observation of patient treatment in a friendly doctor's consulting rooms. In many far flung isolated and lonely posting, beyond the reach of centres of European settlement, missionaries stricken by disease were compelled to do the best they could by doctoring themselves. This also happened that the medical missions set up dispensaries on the verandah of the mission bungalow or in some corner of the compound where people might gather regularly for treatment.[54]

The first American medical missionary was Dr. John Scudder, who went to Ceylon in 1819 and later moved to India. His work included not only medical care but also the establishment of schools and college. Seven of his sons later worked in India, also several of them as physicians. Dr. Ida Scudder established the Christian Medical College in Vellore, and became herself somewhat of a legend among early medical missionaries. Dr. John Scudder came to the north Arcot district, and established the Arcot Mission in 1853 with his father Rev. William Waterbury Scudder and his brother Rev. Joseph Scudder. All three were members of the Reformed Protestant Dutch Church and Missionaries of the American Board of Commissioners for foreign Missions. In 1886, the

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[53] Harrison, Mark (1994) *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, New Delhi: Cambridge University Press, p. 7

[54] Fitzgerald (2001), p. 104.

Ranipet Hospital and Dispensary were opened under Dr. Silas Scudder, a coordination between Dr. Scudder and the Madras government.[55]

Towards the end of the ninetieth century and the beginning of the twentieth century, some Protestant denominations provided training in basic medical care for missionaries before entering the field. The courage and the struggle of Dr. Paul Brand could be cited, as this example proved something that which Christian missionaries tried to access the medical apprentice through training, and became medical missionary.

Through all the review, the initial development of medical mission as a form of missionary endeavour was not welcome. They were in position that such added dimension by attending to the health needs of the local population will be a burdensome. It is not clear who started the medical mission, but has accepted the nineteenth century as the 'era of medical mission'.

Again, the medical mission spread far and wide of the country. Inspiration from the medical missionary to Kashmir Dr. William Elmslie in 1865 reaches the Lieutenant Robert Thorpe, a soldier in the British Army in India, who visited Kashmir and witnessed the suffering and sorrow of the people there in the nineteenth century. He appeal the British soldiers to raised enough funds for the Church Missionary Society to send medical missionary to the Kashmir valley. In 1864, the Rev. Robert Clark, the senior Church Missionary Society in the Punjab went over the mountain passes into the Kashmir valley. He was accompanied by his wife opened a dispensary for women-now the site of the Government College for Women, Nowakadal in Srinagar.[56]

With time, the need for medical intervention grew stronger. Viewing the plight of missionaries' health and their families the need for training in medicine was internalized though many objected. Now trained medical nurses and doctors were sent to the interior regions to do medical evangelism. They established medical clinics, dispensaries,

[55] Eichman, Phillip. 2001. and Kumar. R. John. (2001), p. 37.
[56] Mir, NA and Mir, V. Connel (2008) "Inspirational people and care for the deprived: medical missionaries in Kashmir", *Journal of Royal College of Physicians Edinburgh*, 2008, Vol.38. p. 85.

hospitals, etc. Missionaries took health and healing as a tool for delivering the gospel more meaningfully. Missionaries personalize their faith for local converts, and in so doing they reproduce religious conditions akin to those of their own experience.

During the mid-nineteenth century, the female missionaries' medicine provided a means of entering the previously impossible place began to explore. Women were secluded from the Indian population and the promise that medicine would allow missionaries to reach into the zenana was a powerful impetus for the development of women's medical mission work. The women were believed to be strong hold and sanctuary of Indian culture.

Harrison wrote, prior to 1870 there had been few initiatives in the health aspect of women, and that women were seldom admitted to hospital or sought western medical attention. The provision of medial relief was seen as one of the few ways by which western ideas could penetrate the veil of the zenana. There was a growing need of attending purdah women for medical check up as men folk could not do so. Missionary work provided one of the few openings to newly qualified women in Britain and the United States. Female practitioner from America began to set up missions in India in the 1870s, while the first British medical women to practice in India was Miss Fanny Butler, dispatched by the Church of England Zenana Missionary Society in 1880. Prior to 1880, some medical work was undertaken by female missionaries without medical quantifications, such as the work of the Society for Female Medical Education in the East. The establishments of these organizations suggest that the health of women in the British Empire had become an issue of some importance in Britain as well as in India.[57]

The early medical works were, in many of the sources throw lights on the presence of missionaries' women, known as Zenana. This can be seen from the account

[57] Harrison (1994), p. 95.

of South Australian Women Missionaries in India, who were started the medical work to bring the India's daughter to Christ[58].

The work for women in India was also carried out by the women missionaries of Society for the Promotion of Gospel. The women work was pioneered by Priscilla Winters, the wife of the Head of the SPG after Mutiny, Rev. Robert Winters, as soon as her arrival in 1862. She declared at the Punjab Missionary Conference that the inabilities of the male missionaries to preach their message to the women of India was a great calamity that might explain the comparatively small and low progress that Christianity has made in India. She started the stitching and sewing programmes for women.[59]

The new organization was formed, Female Medical Aid to the Women in India, commonly known as Dufferin Fund, name after its first president the Countess of Dufferin. Queen Victoria became the fund's patron, affording it a good deal of publicity. It aimed to provide the salaries of British medical women willing to work in India, and scholarships for Indian women wishing to train in western medicine. The medical education of British and Indian women was only one part of the attempt to spread the sanitary gospel.[60]

Women medical missionaries were largely limited to provide maternity and child health services which they perceived as a major need of Indian women. The motivation for doing medical work ranged from providing medical relief to gaining political mileage.[61]

The twentieth century can be called the American century because of the generosity and vision of American churches in supporting the missionary work expansion after the 1940 was phenomenal, wrote David. He also suggested the differences of

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[58] Allen, Margret (2000) "White Already to Harvest: South Australian Women Missionaries in India", In *Feminist Review*, No. 65, Reconstructing Femininities: Colonial Intersections of Gender, Race, Religion and Class, (Summer 2000), pp92.
[59] Khangchian, Dominic (2002) *Christian community and Change: Delhi 1850-1950*, Unpublished Dissertation, New Delhi: CHS, JNU, p. 79.
[60] Ibid,. p. 92, 96.
[61] Baru (1999), p.521.

attitude between the British and the American missionaries. He says, the British missionaries were privileged as they were directly involved in helping the government in making certain policy decisions especially in matters of education. The British officials depended upon missionaries on understating the local situation because the missionaries knew the local language and culture. However, the American missionaries did not have this privilege relationship. The American missionary attitude towards the Indians was far more friendly and democratic, while the British missionary attitude tended to be contemptuous as they looked upon the Indians as 'conquered' and 'inferior' people. The American missionary attitude was paternalistic toward the Indians while the British attitude was marked by ecclesiastical imperialism.[62]

It is clear that the process of indigenization and the transfer of power to Indians were initiated by the American missionaries much earlier than the continental missionaries. The American Young Men Christian Association (YMCA) missionaries were responsible for establishing the first physical educational college in Asia at Madras. It was Dr. Buck, an American YMCA missionary, who was given the responsibility by the Indian government to train and led the Indian Olympic Games, held in Pairs in 1924. The American missionaries took keen interest in developing agricultural, industrial and vocational training courses for Indian. They set up the Allahabad agricultural Institute, the first agricultural college in India. [63]

Thus, the different Christian denominational missionaries on medical activities were carried out in many parts of the Indian states. The important organization that set up by the Protestant medical mission was "Medical Missionary Association' formed in 1905, to bring together medical missionaries from all parts of the country for common counsel. In 1926, it renamed as Christian Medical Association of India (CMAI), a memberships is open to all christian medical practitioners, whether in church or mission service or not, who held a recognized qualification and are in sympathy with its aim.[64] Their main

[62] David, (1995), P. 39-45.
[63] Ibid. p. 40.
[64] Kumar (2001), p. 44.

objective is to do prevention and relief of human suffering irrespective of caste, creed, community, religion and economic status.[65]

The history of Catholic institution regarding the medical activities was started much later. It was, however, in the year 1943 founded the 'Catholic Health Association of India (CHAI)' by Dr. Mary Glowrey in association with 16 religious sisters involved in medical work in different parts of the India. The association is growing in its medical activities in response to their call for improvement in standard of health education and in promotion of catholic values.[66] There are 11 regional units working in the entire country.

[65]Christian Medical Association of India, (Online: Web) Accessed on 12 February 2009, URL: http://www.cmai.org/about/objectives.htm.

[66] Catholic Health Association of India, (Online: Web) Accessed on 12 February 2009, URL: http://www.chai-india.org/history.htm.

CHAPTER 2

AN OVERVIEW OF HEALTH AND HEALTH SERVICES IN MANIPUR

- *Introduction: Manipur*
- *Health Status and some indicators*
- *Overview of Health Care Services in Manipur*
- *Ethnic conflict, insurgency and its affect on health*

2.1 Introduction: Manipur

Manipur is one of the hilly states of the seven sisters of the North Eastern Region of India. It extends between 23° 85' and 25° 86' latitudes north and between 93° 03' and 94° 78' longitudes east. It covers an area of 22,327 square kilometers and is bounded on the north by Nagaland, on the west by Cachar of Assam, on the east by Myanmar and on the south by Mizoram and chin state of Myanmar. Of the total geographical area of the state, 90% is hill area and only 10% is valley[1]. The state has 352 kms. long international border with Burma (Myanmar) to the south east.

Manipur is inhabited by a diverse number of tribes and sub-tribes. The land is divided into two distinct parts, the valley and the hills. The valley is surrounded by steep hilly forest. The valley is dominated by the Meitei, Pangal, Loi, Yaithibi and Nepali communities and the 'hills men, though divided into numerous clans and sections, may be grouped generally into the two great divisions of Naga and Kuki'[2] tribes. The Meitei community follow the Vashnava cult of Hinduism while among the tribes, majority follow Christianity while others practice their traditional religion.

[1] Zeliang, Elungkiebe (2005b) *A History of the Manipur Baptist Convention*, Imphal: Manipur Baptist Convention, First Edition, March 2005, p.1.

[2] "Manipur" *Proceedings of the Royal Geographical Society and Monthly Record of Geography*, New Monthly Series, Vol. 13, No. 5 (May, 1891), p. 292.

Table 2.1 General Background

Area	22,327 sq. km
Capital	Imphal
Population 2001 Census	23,88,634
Literacy Rate (2008)	70.53%
Number of Towns	33
Number of Villages	2391
Number of Districts	9
Density of Population	103 per sq. km
Principal language	Manipuri
Climate	Sub-tropical temperate
Sex Ratio	974
Urban population (%)	26.6

The history of Manipur therefore has two distinct features, one- the history of the valley and the other, the history of hills. The history of Valley is very much evident in various literatures but the history of hills is mostly oral traditions. Having some common features like the terrain, racial characteristics, village systems based on familial ties and methods of cultivation, the state is not homogenous unit, but a home to several diverse ethnic groups and sub-groups. Each of these groups of people has its distinct history, culture and identity. Being a state of diverse communities the state has also witnessed ethnic violence between the Kukis and Nagas, and Meiteis.

Political history of the Meiteis in the Manipur valley existed as a princely state under its Kings or chiefs from ancient time. Most of the tribals in the hills lived in their own independent villages from time immemorial. Politically in 1762, the Meiteis entered into political alliance with the British India. Following the Anglo-Manipuri war in 1891, Manipur became a subordinate state under the British India. Gradually, the Britishers included the hills tribes in the map of Manipur for an administrative convenience. In 1949, Manipur merged with the Indian Union that took place officially at Shillong by the Maharajah and was given the status of "Part C State". In November 1956, Manipur became a Union Territory under the Union territorial Council Act, 1956. The Territorial Council consisting of 30 elected members and 2 nominated members was constituted on 1957. On the 21st January 1972, Manipur State was officially inaugurated by Prime

Minister Srimati Indira Gandhi at Imphal within the Indian Union with the Governor as the Head of the state and the Members of legislative Assembly were increased to 60[3]. The Manipur State Assembly has a total member seat of 60 and 2 seats for Lok Sabha. In the State Assembly of 60 members, one seat is reserved for Scheduled Caste and 19 for Scheduled Tribes. Also in Lok Sabha one seat is reserved for Scheduled Tribe.

Demographic Profile

The population of Manipur is 2.16 million, out of which 1.09 millions are males and 1.07 millions are females. Rural and urban breakup of the population shows that 73.4 percent of the populations are composed of rural areas and 26.6 percent in urban areas. The population density at present is 103 per sq. km. Population of Manipur constitute about 0.22 percent of the total population of India.

Table 2.2 Population of SCs/STs and their proportions to the total population

Country/State/District	Scheduled Tribes	Scheduled Castes
India	84, 326,240 (8.20%)	**166, 635,700 (16.20%)**
Manipur*	741,141 (34.20%)	**60,037 (2.80%)**
Senapati*	122791 (78.45%)	**238 (0.15%)**
Tamenglong	106349 (95.38%)	**3 (0.00%)**
Churachandpur	212482 (93.23%)	**205 (0.08%)**
Bishnupur	6143 (2.94%)	**1727 (0.82%)**
Thoubal	4274 (1.17%)	**33969 (9.32%)**
Imphal West	21118 (4.75%)	**13276 (2.98%)**
Imphal East	24712 (6.25%)	**10409 (2.63%)**
Ukhrul	134493 (95.53%)	**0 (0.00%)**
Chandel	**108779 (91.93%)**	**210 (0.17%)**

Source: *Census of India 2001*
*Excludes Mao-Maram., Paomata and Purul sub-divisions of Senapati District of Manipur.

The People and Language

[3]Lolly R. R (1985) *The Baptist Church in Manipur, (A Historical survey of the mission strategies and development of the Baptist Church in Manipur Northeast India, 1894-1983)*, Imphal: Manipur Baptist Convention, p.1.

- *Economic Survey Manipur 2007-2008*, 2008 Govt. of Manipur, Directorate of Economic & Statistics: Imphal pp.ii

The Manipur valley is home to more than two-third of its population. The Meiteis who lived in valley constitute the majority population in the state and are a fairly homogenous people. They are divided into seven clans: Ningthouja, Angom, Khuman, Moirang, Luwang, Chemlai and Khaba-Nganba. The Muslims, locally known as 'Meitei Pangans' are small in number but their contribution to the economy of the state is significant. The Meiteis and other non-tribal groups constitute 66 percent of the total population of the state. These groups speak Manipuri, a language of the Kuki-Chin group under the Assam-Burma branch of the Tibeto-Burman family.

There are 29 tribal groups recognized by the Government of India as Schedule Tribes (STs), seven Schedule Castes (SCs). The tribal groups are divided into Naga and Kuki. The recognized Naga groups are the Anal, Chiru, Chothe, Kabui (Rongmei), Kacha Naga (Zeme), Koireng, kairao, Lamkang, Mao, Maram, Maring, Monsang, Mayon, Sema and Tangkhul, who together form 18.7 percent of the state's population. Those Naga tribes who are yet to recognize are the Thangal, Liangmai, and Tharao. The recognized Kuki affiliated tribes include Thadou, Zou, Vaiphei, Simte, Paite, Aimol, Gangte, Kom, Hmar and Ralte[4].

The Tibeto-Burman languages are spreading across the northeastern states. The Manipur state is the territory of minor language groups in a contiguous geographical space and exhibit a complex pattern of ethnic diversity, where each ethnic or dialect groups tend to concentrate in pockets of geographical area. Manipur may be considered to illustrate the linguistic plurality in India. The principle state language is Manipuri even as the state has the ethnic population of different spoken dialects and language. The hills population derived from Nagas and Kuki-Chin (Mizo) tribes, where the plain inhabitants are Meitei or Manipuri (non-tribal). The hill inhabitants use Roman script after they accepted Christianity and the plain inhabitants use Bengali script as they later converted to Vaishnavaite Hinduism. There is non-tribal community of Pangal or Muslim who roughly account for 7 percent of the total population speaking Manipuri. According to

[4] Rao. O.M (2005) *Among the churches of the hills and valleys of northeast India*, Delhi: ISPCK, p.127.

Shimray, 'language is not only a tool for communication but also has ethnic socio-cultural and political implications. Various ethnic groups typically have their own dialects. These are often seen by those who use them as languages in their own right'[5].

Connectivity

Road is the principle means of transportation in Manipur. National highways dominate the road network of the state, a reflection of the fact that the purpose is external trade and security requirements rather than connectivity within state to benefit the common people. The state is connected with the rest of India by roadways, that the National Highway 39 links Imphal with the railway head of Dimapur in Nagaland at a distance of 215 kms to the north, and National Highway 53 run through the hills forest to link with Silchar in Assam towards the Southwest. The state also connected by air with Guwahati, Dimapur, Kolkata and Delhi. During rainy season many villages and districts are cut off mainland due to landslide and floods.

Districts of Manipur

For the administrative convenience, the State is divided into 9 districts. Out of the 9 districts, 4 are in the valley and 5 are in the hills. The districts in the valley are—1) Imphal East district, 2) Imphal West district (Capital city), 3) Bishnupur district, 4) Thoubal district. The hill districts are—1) Chandel district, 2) Churachandpur district, 3) Senapati district, 4) Tamenglong district, and 5) Ukhrul district. The districts are further divided into sub-divisions, and are together 38 in total. The valley areas also consider two parts, one is the Imphal valley in the heart of the state and the other is Jiribam valley in the west beyond the hills bordering Cachar district of Assam.The four valley districts together comprised about 61 percent of the total population of the state.

Every district of Manipur has distinct characteristics different from others. There are imbalances in development across districts. The variation and differences are juxtaposed with concentration of resources and facilities from one district to others beside

[5] Shimray, U.A. (2000) "Linguistic Matrix in Manipur", *Economic and Political Weekly, Vol. 35, No. 34 (Aug. 19-25, 2000)*, p. 3007.

the policy to bridge the gap which can be seen in terms of infrastructure and development. There is sharp deprivation of infrastructural development in the hill districts whereas the concentrations of facilitating institutions are abundant in the valley. This may however be knowledgeable to understand the high density of population in the valley and as the result most of the development works are carried out. The hill districts which are mainly the terrain and less populated has difficulties in bearing the overall development though not impossible.

Table 2.3 Area and population of Manipur by districts

Region/District		Area			Population	
		Sq. km	% to total	In '000s	% in total	Density (per sq. km)
A.	Hill	20,089	90.0	883	38.5	44
	Senapati	3,271	14.7	285	12.4	87
	Tamenglong	4,391	19.7	111	4.9	25
	Churachandpur	4,570	20.5	228	9.9	50
	Chandel	3,313	14.8	118	5.1	36
	Ukhrul	4,544	20.3	141	6.2	31
B.	Valley	2,238	10.0	1,41161.5	630	
	Imphal East	709	3.2	395	17.2	557
	Imphal West	519	2.3	444	19.4	855
	Bishnupur	496	2.2	208	9.1	419
	Thoubal	514	2.3	364	15.5	708
	Manipur	22,327	100.0	2,294100.0	103	

Source: Economic Survey Manipur 2007-2008

The five hill districts together constituted 38 percent of the total population. Of all the districts, Imphal West district had the highest population density and are followed by Thoubal. Tamenglong district recorded the lowest with 25 persons per sq. km. which is followed by Ukhrul district with 31 person sq.km.

Rivers

The main rivers of Manipur are the Iril in the Thoubal east, Imphal River in the Central Imphal, Irang, the Barak and Maku in the western hills. The largest river in Manipur is the Barak flowing from northern Manipur through western hills then to the Brahmaputra. The waters of several rivers in Manipur valley fall in the Loktak Lake or

the Imphal River which passes through the southern hills o Manipur and flows into Chindwin hills of Myanmar and becomes a tributary of the Chindwin River. The Loktak Lake is the largest lake in the entire Manipur. To the south of this lake we find a brow-antlered deer locally know as 'Sangai', an endangered animal.

Agriculture and Its Production

The state is predominantly an agricultural economy. Agriculture is the backbone of the state economy because the main occupation of the people of Manipur still depending on this. Agriculture sector has contributed a major share to the total state domestic product and provides employment to about 52 per cent of the total workers in Manipur.[6] According to Manipur State Development Report (MSDR), 57 per cent of the state's working population is comprised of cultivators and agricultural labourers. Due to the hilly terrain, there in only 6.73 per cent of the total population area of the state is classified as agricultural land. The four valley districts, which cover only 10.02 per cent of the total geographical area, include 73.18 per cent of the state's total agricultural land. The five hill districts, which account for 90 per cent of the total geographical area, contribute only 26.82 per cent of the state's agricultural land.[7]

The prospect of agriculture in the state is largely depended on the rain water as there is no development in the irrigation system. The productivity of crops are dependent not only the quantum of rains but also its equitable distribution over the days and months of the season. As it is limited in the arable land, the majority of the farming community have small and marginal land holdings and hence mostly subsistence farming. At presently the average size of operational land holdings for Manipur is 1.15 hectares. Small and marginal holdings constituted 59.66 per cent of the total arable land.[8]

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[6] Economic Survey Manipur 2007-2008, Directorate of Economics and Statistics, Government of Manipur, p. 73.

[7] Manipur State Development Report 2006, Delhi: Institute for Human Development, p. 107.

[8] Economic Survey Manipur (ESM) 2007-2008, Directorate of Economics and Statistics, Government of Manipur, p. 74.

In the valleys 'settled or permanent' cultivation is practiced while in the hills, the 'jhum or shifting' cultivation is widely practiced. In most of the years, the hills produced only one third of the state's total production. Rice is the staple food of Manipur and is grown in both the hills and the valleys. Cultivation is almost entirely mono-crop with rice accounting about 98 per cent of food grains production and about 70 per cent of the total cropped area is cultivated with paddy. Choice of crops to be grown by each cultivator is determined according to their own consumption needs. The four district of valley showed a high yielding in food crops under the permanent cultivation while jhum cultivation in Tamenglong and Chandel districts reported very low yields. [9]

Cultivation of horticulture crops are widely practiced as non-commerical enterprise by farmers in the homestead and orchard. Therefore, the production is less and need development. However, in recent years the cultivation of horticulture crops such as pineapple, potato, papaya and other vegetables are shown positive in commercial scale in many parts of the state.

Climate and Forest

In Manipur we find a sub-tropical monsoon climate. It has cold and dry winter and rainy hot summer. However, the climatic condition of the State varies according to the geographical structure. For instance, the hills areas have colder climate in comparison to the valley and Barak basin. The temperature ranges from sub-zero to 36° C. The forest area of the state is covered with dense evergreen forest and bamboo jungles[10]. The total area of the forest is 17,418 sq. kms. which is about 78 per cent of total geographical area of the state. About one lakh people depend on the forests for their survival. Only 2.4 per cent of the entire state domestic product is derived from forest and the expenditure allotted to it was not even one per cent of the total Ninth Plan, which is required steadfast focus and setting priorities in the new height of the state forestry. The state also faces the

[9] ESM 2007-2008, p. 79.

[10] Govt. of Manipur, Department of Environment and Forest: *Environment Report of Manipur 2005-06.*

threat of deforestation mainly due to the lack of definition of rights (vague ownership over forests of the hilly tracts in the insurgency-affected areas and lack of survey and settlement operations), no proper legislative framework for management, soil erosion results from the increasing practice of shifting cultivation and the illegal logging and trade in forest[11].

Economic backwardness, poor communications and scarcity of trained manpower resources are the characteristics of the state. The economic development varies even among the districts of the state. Economy of the people of Manipur state is basically agrarian. About 52 per cent of the total working population is engaged in agriculture activities for their livelihood. People in the hills practices slash and burn cultivation whereas those in the valley practice wet rice plantation. According to National Health Profile 2008 the Net Capita State domestic products at current prices 2006-2007 is Rs. 18393 as against the all India average of Rs. 29643.

The weakest aspect of Manipur's development performance is the availability and quality of infrastructure. The disperse distribution of the population in low density settlements is one contributory factor, along with the terrain and neglect of the remote areas.

Education

The Manipur educational background can be trace to the time when the early development of literature culture existed with the written manuscripts in Meitei *Mayek*. Since Manipur is divided into hill and valley, the consideration be made that the hill tribal or traditional education was taught and learned in the *Morung* or dormitories on an oral tradition, while the valley education was exclusive and highly developed literary and scholarly tradition for the nobility and elite. It can be noted that the education of an individual is a process of acquiring and experiencing knowledge from the birth till the death bed. The crucial factors like the attitudes, personality and thought process of a

[11] MSDR 2006, p. 60, 64. & Economic Survey Manipur 2007-08, p. 91.

person is characterized through the socialization process in the family and outside the community. However, with the coming of modern schools in bringing up children in the molded system, one has to go through the process of learning in the school. And hence, the education once was in the hands of family now overwhelmed by schools. In fact the contribution of education in the society is tremendously impact upon the social development.

The advent of British rule brought changes in the system of learning by bringing formal education to all sections of society though infrastructural disparities and literacy across section of people. The first formal education was brought by the American Baptist missionary William Pettigrew in 1894 ushering the English as the medium using Roman script. Pettigrew started a school at Imphal which later shifted to Ukhrul as resistance from the valley (MSDR 2006).

The State has done well in education largely due to socio-historical factors. Literacy rate are significant, especially among the Schedule Tribes of the State. However, the high literacy rates don't necessarily mean that education rates are high. This is because of high dropouts in the various stages of schooling. The school education system largely depends on the temporary teachers who form 36 percent of the teaching community against the national average of 20 percent.

Table 2.4 Number of recognized educational institutions by types

Year	Number of Institutions							All Institutions
	University	Colleges			Schools			
		General Education	Professional Education	Total	General Education	Professional & other	Total	
1950-51	-	1	-	1	537	-	537	538
1960-61	-	2	1	3	2029	314	2343	2346
1970-71	-	12	14	26	2979*	389*	3369	3394
1980-81	-	24	41	65	3576	511	4087	4152
1990-91	1	29	33	62	4307	2492	6799	6862
1995-96	2	50	38	88	3622	77*	3699	3789

2000-01	2	59	12	71	3970	78*	4048	4121
2004-05	2	62	69	131	4089	NA	4089	4222**
*Due to cancellation of non-formal education **Excluding professional and other education schools and colleges Source: *Economic Survey of Manipur, 2007-08*								

With the above table, the number of institutions in general and professional courses of education has shown increased from 1950-01 to 2004-05. Two universities are; Manipur University Canchipur Imphal, established on 1980, and converted to Central University in 2005, and secondly the Central Agriculture University Iroisemba Imphal are offering higher research facilities in different courses of humanities, sciences, vocational and specialized subjects. The Gross Primary Enrolment Ratio for the year 2005-06 for boys is 160.94, and girls are 154.79 with the total of 157.92 of the state.

Table 2.5 Public Expenditure on Education in Manipur

State/Country	Per Capita Expenditure	Expenditure on Education as % of total budget expenditure
India	969	12.76
Manipur	1448.56	19.48
Source: George, N. D. (2007) 'EDUCATION: Challenges', Yojana, Ministry of Information & Broadcasting, GoI, Special Edition on Northeast, (Dec.), p. 22		

The government expenditure on education in Manipur seems to be much better than the rest of India.

Table 2.6 Teacher-Pupil Ratio (2001–02)

Type of School	Hills	Valley
Pre Primary/Primary/J.B./UJB Schools	1:23	1:21
Middle/Jr. High/Sr. Basic Schools	1:15	1:22
High/ Higher Secondary School	1:19	1:21
Schools for Professional and other Education.	1:12	1:18
Source: Statistical Abstract Manipur 2005, Directorate of Economics and Statistics, Government of Manipur.		

Religion

Manipur is no less than other states of India in homing different religious communities. The religion is divided within the population of Manipur based on the settlement and groups. The valley population which is largely the Meitei community practice Hindu religion. The hill tribes Naga and Kuki practice Christianity and some tribal still practices their traditional custom. Muslim religion is practice by Meitei Pangan community. There are scattered population practices Buddhism, Jains and others[12].

In the history of Manipur the religion built a connecting between the people of the land and people outside the kingdom. This can be understood as to when the jealous religious missionary came into contact. The relationship created with the outside religion had affected in shrinking the rift between them. Be it good or bad the contact between different religious groups multiplies the rapport. In perceiving the relationship, the princely state witnesses the coming of Hinduism. Hinduism in Manipur is recent origin and owes it legacy to Maharajah Gharib Niwaz who converted to Hinduism by the Vaishnava missionary Shantidas Atnikary in the first quarter of the Eighteenth Century. After he became Hindu, the King declared Vaishnavism as state religion and advised his subjects to accept it. However, the old religious practices were not totally vanished despite the royal edict of severe punishment. Having accepted Hindu religion, the people are still practicing and beliefs the various forms of ancestor worship, witchcrafts, taboos and animistic deities. Maiba and Maibi (medicine men and women) are still popular among the Meitei community even as they accepted Hinduism.

The valley or Meitei community followed their own religion before conversion to Hindu Vaishnavas. They worshiped different gods such as: 'Lamlai'-god of the country side who controls rain, 'Umanglai'-god of the forest, 'Imunglai'-the household Deity,

[12] Jeyaseelan. L (1996) *Impact of the missionary movement in Manipur*, New Delhi: Scholar Publishing House, p. 14.

ancestors of each tribe and the spirits of the mountain passes, spirits of the lakes, rivers etc[13].

Before the advent of Christianity in Manipur the hill inhabitants or tribal people followed the traditional religion commonly known as animism. There is neither fixed place of worship nor did they worship idols in the animistic faith. Offerings and sacrifices are made every place where they expect the spirits to have their abode. The principal belief of animism is the existence of a Supreme-Being or God who they believe as the creator and sustainer of the universe. According to the Census 2001, the Christianity population sharing in the state is enumerated as 34 per cent of the total population, where in the five districts of the State are dominated by the Tribal people followed Christianity in majority. Although the tribal people accepted Christian as their religion there are few population still practice the traditional religion. The Hindu consisted 57 per cent of the total population and a considerable Muslim population of 7 per cent.

Table 2.7 Distribution of population by religion in Manipur

State/District	Total Population	Hindu	Muslim	Christian	Sikh	Buddhist	Jain	Others
Senapati	1,56,513	19.45	0.41	78.41	0.10	0.82	0.01	**0.64**
Tamenglong	1,11,499	2.86	1.28	94.88	0.06	0.01	0.01	**0.88**
Churachandpur	2,27,905	4.62	1.13	93.54	0.05	0.02	0.01	**0.58**
Bishnupur	2,08,368	71.46	6.81	2.95	0.06	0.00	0.00	**18.60**
Thoubal	3,64,140	60.72	23.85	1.41	0.03	0.01	0.01	**13.96**
Imphal West	4,44,382	74.48	4.30	4.07	0.15	0.07	0.03	**16.59**
Imphal East	3,94,876	60.87	15.94	5.93	0.05	0.02	0.01	**17.16**
Ukhrul	1,40,778	4.04	0.63	95.16	0.07	0.06	0.01	**0.01**
Chandel	1,18,327	4.82	1.96	92.23	0.11	0.05	0.02	**0.78**
Manipur*	**21,66,788**	**57.67**	**7.27**	**34.11**	**0.07**	**0.04**	**0.07**	**0.77**

Source: *Data C1 Manipur, Census of India 2001.*
*Excluding Mao-Maram., Paomata and Purul sub-divisions of Senapati District of Manipur

[13] Lolly R. R (1985) *The Baptist Church in Manipur-A Historical survey of the mission strategies and development of the Baptist Church in Manipur Northeast India, 1894-198)*, Imphal: Manipur Baptist Convention, p. 6; and Ahluwalia, B.K, Ahluwalia, Shashi (1984) *Social Change in Manipur*, Delhi: Cultural Publishing House, p. 137.

2.2 Health Status and Some Indicators

Health status of the people is largely affect by various compositions of provisioning, delivery, education, availability of food, safety, regulations of public health etc. The experiences of good health originate from the condition of the well being. For an individual to live a healthy life is attributing by numbers of factor of well being. The important constituents of well being are to be captured from various elements of development in the society through the reasonable sharing of resources. An individual being healthy and able to live long is somewhat an indirect benefit not to an individual only but also to the society as a whole[14]. The individual suffering from ill health has to divert the resources for treatment that instead may have impact on the well being. The ill health of a person is pervasive if when the economic conditions are far attainment.

Some aspect of government initiative is necessary to handle the individual health with the development of adequate health care facilities as being the mandate of the people. Health as a wholeness of an individual in every respect of his life and the community is influenced by material well being, which described as access to the income and assets required to lead a decent standard of living. This is, however, crippling by the factor such as absence of progress in agriculture, technology, education and the economy, and these has pressure on the population to assert redistribution of resources. In Manipur State, the material well being is low but has an impressive record on selective public health indicators. In tune with the infrastructure and manpower in health care services, the much read establishment of Government hospital in State and due regards to the private hospital, those efforts are indeed an elegant posture of health attainment in substantial evidence. The unique demographic features and agricultural based economy favourably harvest the good public health without being considered to the material well being of the state.

[14] Govt. of India, Planning Commission: *National Human Development Report 2001*, March 2002.

The state having been adopted traditional medical system prior to the coming of allopathic medicine became the national champions in some health indicators. As we see the traditional medical system is more holistic as it invariably stresses the position of man in relation to his surrounding social, economic, political, ecological environment than the allopathic medicine which is constrained to the human body. It is true that the same pattern of disbursement of finance in the making of traditional medical system as people friendly has been misleading towards allopathic research and development. Manipur, in many ways has allowed the allopathic health care to sprout in numbers, whereas the long standing traditional medical system decline in its effect.

There are large inter-district variations in education, health and family welfare further complicated by variations between the rural and urban population within the state. The standard of health and well-being varies very much with the environment which of course varies enormously among populations or even their sub-groups. It is agreeable than to assume the state as not homogenous groups of people in referring to the various subsequent indices present in the following.

Infant Mortality Rate (IMR)

The infant mortality rate is sensitive to the changes that have a bearing on the quality of life, especially to the health and longevity of population. In Manipur, the infant mortality rate is seen declining in these decades. The infant mortality rate is currently estimated at 12, out of that 9 are males and 15 are females as against the national level of 55 male and 56 female. The national infant mortality rate in rural area is 61 and 37 in urban, but for the rural areas of Manipur the IMR is 13 while the urban enjoys at 9. The report suggested the state of lowest IMR in the country[15].

Birth and Death Rate

Birth and Death rates in Manipur have been declining and compare very favorably with the all India figures although there is an increase in the urban death rate. The birth

[15] Govt. of India, CBHI: *National Health Profile of India 2008*, New Delhi, p.24.

and death rate of Manipur fares well in all India level. Even within the North Eastern states of India, the State of Manipur represents the lowest rate.

Table 2.8 Birth and Death rate of North Eastern States

Country/State	Birth Rate			Death Rate		
	Rural	Urban	Combined	Rural	Urban	Combined
India	24.7	18.6	23.1	8.0	6.0	7.4
Arunachal Pradesh	23.4	17.3	22.2	5.6	3.3	5.1
Assam	25.7	15.5	24.3	9.1	5.7	8.6
Manipur	14.4	15.2	14.6	4.2	4.9	4.4
Meghalaya	26.1	17.0	24.4	7.9	6.0	7.5
Mizoram	22.5	13.7	18.2	6.0	4.3	5.2
Nagaland	17.7	16.1	17.4	5.4	3.8	5.0
Tripura	17.9	13.5	17.1	6.6	6.4	6.5

Source: SRS, RGI, October 2008.

Sex Ratio

The sex ratio is the number of females per 1000 males. Sex ration in Manipur has fluctuated between 958 and 974 for the period of 1981 to 2001. The overall sex ratio of the national level is 933. Present sex ratio of the state fares very well comparison to other states of India. There is a significant variation in sex ratio in the state. In Manipur, the sex ratio varied between the rural and urban areas, the rural sex ratio is 966 while the urban area is 1009 per 1000 females. Sex ratio in population age groups of 0-4 years in Manipur is 961 while the all India ratio is 927.

Table 2.9 Distribution of Population and Sex Ratio as per 2001 Census

Country/State/District		Sex Ratio	
		in thousand	(females per 1000 males)
	All India	10,28,737	933
	Manipur	2,293	974
A.	Hill	882	963
	Senapati	285	935
	Tamenglong	111	922
	Churachandpur	228	944
	Chandel	118	981
	Ukhrul	141	916
B.	Valley	1,411	1009
	Imphal East	395	991
	Imphal West	444	1004
	Bishnupur	208	993
	Thoubal	364	998

Source: Economic Survey of Manipur 2007-08 & SAM 2005

Literacy Rate

For the human development education is one of the prime determinants. There are conventional indices which viewed educational achievement. They are-effective literacy rate, primary school enrolment rate, drop-out rates at the primary level, mean years of schooling at the primary level, pupil-teacher ratio and distance of schools from place of residence. The literacy rate is defined as the number of literates as a proportion of the population aged seven years and above. These indices look at the performance in the primary level in respect to minimum needs and does not corresponds to higher level of education. However, it is a tool to analyze the basic development in education is fulfilled.

Table 2.10 Literacy Rate of North Eastern States & all India*

State/India	Total	Male	Female
Arunachal Pradesh	54.3	63.8	43.5
Assam	63.3	71.3	54.3
Manipur	70.5	80.3	60.5
Meghalaya	62.6	65.4	59.6
Mizoram	88.8	90.7	86.7
Nagaland	66.6	71.2	61.5
Sikkim	68.8	76.0	60.4
Tripura	73.2	81.0	64.9
All India	64.4	75.3	53.7

**Percentage of literate to population aged 7 years and above*
Source: NHP 2008, pp29

Most of the North Eastern States are better than the national average with respect to literacy. Mizoram effective literacy rate is as high as 88.8 per cent and second in the national average. This is because of the Christian missionaries' effort in the state[16]. Tripura with 73.2 per cent is second in the North Eastern States. However, the averages of Arunachal Pradesh, Meghalaya and Assam lagged behind the national average and need much attention. Universal primary education for children in the age group of 6-11 years has been a major objective and has been achieving impressively in the North eastern states.

The literacy rate of Manipur is 70.5 per cent, excluding the Mao-Maram, Paomata, Purul sub-division of Senapati district of Manipur. In all the districts, the rural population has access to primary schools. In the state of Manipur, 90 per cent of the rural population lives in villages having primary schools[17]. The gender disparity in literacy rate is seen with female literacy rates being below those for males in all the districts. Chandel and

[16] NCAER: *East India Human Development Report 2004*, OUP New Delhi, pp101.

[17] Govt. of India, MoHFW, *RCH- DLSH 2 Manipur 2002-04*, New Delhi, pp.28.

Tamenglong districts represented the largest gap between male and female literacy rate of the state. However, Imphal, Ukhrul,and Churachandpur districts has the high female literacy rates.

Table 2.11 District-wise Literacy Rate of Manipur based on 2001 Census

State/District	Literacy Rate		
	Person	Male	Female
Manipur	70.5	80.3	60.5
1. Senapati	59.8	67.9	51.2
2. Tamenglong	59.2	68.7	49.0
3. Churachandpur	70.6	77.7	63.1
4. Chandel	56.2	64.3	48.0
5. Ukhrul	73.1	80.1	65.4
6. Imphal East	75.4	85.5	65.3
7. Imphal West	80.2	89.2	71.3
8. Bishnupur	67.6	79.6	55.7
9. Thoubal	66.4	80.4	52.5

Source: *Economic Survey Manipur 2007-08, pp14*

Inter-district variation suggests some districts relatively backward in literacy. In Manipur, it is Chandel, Tamenglong and Senapati which are lagging behind the other districts in the state. The hill districts, Ukhrul and Churachandpur fares very well among other districts in respect to literacy.

In NFHS-3 only 73 percent of women and 92 percent of men age 15-49 are liberate in Manipur. Twenty-two percent of women, compared with only 6 percent of men age 15-49 in Manipur have never been to school. Thirty-two percent of men have completed 12 or more years of education, but only 21 percent of women have attained that level of education. However, the proportion of adults age 15-49 who have completed 12 or more years of education is higher in Manipur than in any other Northeastern state; and the proportion of men who have completed at least 12 years of education is higher in

Manipur than in any other state in India, except Delhi (NFHS-3, Govt. of India, MoHFW 2008: 4)[18].

Table 2.12 Rank of districts wise indicators (based on weight average Z value)

Particulars	Senapati	Tamenglong	Churachandpur	Chandel	Imphal (U)	Bishnupur	Thoubal	Ukhrul
Agriculture Development	4	7	8	6	3	1	2	5
Industrial Development	8	7	6	5	1	2	3	4
Urbanization	5	5	5	4	1	3	2	5
Tertiary Development	8	7	4	3	1	5	6	2
Infrastructure Development	6	7	8	4	1	3	2	5
Bank Finance	8	4	6	7	5	2	1	3
Educational Development	6	7	3	8	1	2	4	5
Source: MSDR 2006								

According to the MSDR, the least agricultural development districts in the state are Tamenglong and Churachandpur while the most advance districts are Bishnupur, Thoubal and Imphal. Likewise, in the educational development the districts which are highly underdeveloped are Senapati, Tamenglong and Chandel, and the most advance are the Imphal and Bishnupur districts. Based on the seven indicators above the districts which falls under the hill are segmented as most overall least developed, whereas the valley districts are seemingly higher at all levels. These indices have inferred purposive weightage in order to draw simpler conclusion for ranking purpose. In the manner of the indices the rural based districts show inclination for improvement. This not only drawing the hill versus valley divides but also a reference as to what can be understood from policy towards the implementation

[18] Govt. of India, MoHFW: National Family Health Survey (NFHS-3) Manipur, India 2005-06, New Delhi. pp4.

2.3 Overview of Health Care Services in Manipur

In Manipur, the health services include that of Government services, private services and interventions from various Non-Governmental Organizations. Health services in public sector faces the gap of infrastructure, development and provisions of facilities although effort were kept pushing in. Adding to above the state has witnessed armed conflict which resulted unable to provide due services to the people[19].

Manipur is relatively less wealthy and poorly developed in the overall development compare to the rest of India, but beyond doubt, the state experiences high health outcome. The relative small area of land and apparent progressive provisioning of medical services although infrastructural deficiencies in development have slightly impact on the health outcome, but have drawn a remarkable position in the level of national health development.

Table 2.13 Health Service Infrastructure in Manipur

Particulars	Total	Hill	Valley		Total Bed		Hill	Valley	
1. State Hospital	1	-	1		200		-	200	
2. District Hospital	7	5	2		355		255	100	
3. T.B. Hospital	1	-	1		100		-	100	
4. Leprosy hospital	3	-	3		70		-	70	
5. Maternity & Children Hospital	1	-	1		40		-	40	
6. CHC	16	6	10		314		150	160	
7. PHC	72	36	36		370		238	132	
8. PHSC	420	222	198		-		-	-	
9. Medical Dispensary	20	13	7		-		-	-	
10. Homeo Dispensary	8	5	3		-		-	-	
11. Nature Cure Clinic	1	-	1		-		-	-	
12. Drug Addiction Centre		7+2	4+2	3		-		-	-
13. District TB Centre	6	5	1		-		-	-	
14. Mini District TB Centre		2	-	2		-		-	-
15. STD Clinic	6	5	1		-		-	-	
16. Leprosy Control Unit	4	3	1		-		-	-	
Total	575	304	271		1449		643	802	

Source: *State of Environment Report, Manipur 2006-07*

[19] Rural Women Upliftment Society, *Beyond Practical Gender Needs: Women in Manipur*, ISST, New Delhi, June 2005.

The State Health Department of Manipur has three tier administrative set up. The highest level of the organization is the administrative level. A cabinet minister heads it and the major decisions concerning such as policies, programmes and proposals are taken at this level. The minister is supported by a commissioner/secretary, joint secretary, deputy secretary and under secretary of Manipur secretariat.

At directorate level, the department is headed by the Director as the Technical and health Administrator of the state. The Director is assisted by Additional Directors, Joint Directors and Deputy Directors to give direction and undertake planning, supervision, evaluation and monitoring of various health programmes taken up in the state of Manipur.

The District level health administration is organized through the Chief Medical Officer as the head who is assisted by District level Programme officers. The District Health Organization is responsible for implementation of various health programmes under primary health care through a network of various health care centres and hospitals in the district.

The Department of Health, Government of Manipur is managing the services through the four main divisions and each division is headed by one Additional Director. They are- Public Health, Planning and Finance, Manpower Development and Medical Care. The Government of Manipur has been establishing the infrastructure as per the National pattern of health infrastructure. One Primary Health Centre for 30,000 population in the plain area and one Primary Health Centre for 20,000 population in hilly tribal area. One sub-centre for 5,000 population in the plain area and on sub-centre for 3000 population in hilly area. One Community Health Centre for every four PHCs.

Health department of Manipur is rendering health care services to the people of Manipur with special effort based on the system of Primary health Care approach.

Although department has been able to establish the required number of health institutions, wide infrastructure gaps still exist in the area of building equipments and manpower in the state. Now the emphasis is to optimally function of the already established institutions by providing the necessary infrastructures.

Table 2.14 District wise distribution of CHC, PHC, PHSC and Dispensaries

District/State	Government Hospital	Private Hospital	CHC	PHC	PHSC	Dispensaries	Beds Available
1. Senapati	1	1	2	12	66	2	143
2. Tamenglong	1	-	1	6	29	2	120
3.Churachandpur	1	2	1	9	61	7	207
4. Chandel	2	-	1	3	26	-	124
5. Ukhrul	1	1	1	6	40	2	144
Hill Total	**6**	**4**	**6**	**36**	**222**	**13**	**738**
6. Imphal East*	-	-	-	-	-	-	-
7. Imphal West	6	7	4	19	105	7	1413
8. Bishnupur	1	1	2	5	36	-	112
9. Thoubal	1	1	4	12	57	-	142
Valley Total	**8**	**9**	**10**	**36**	**198**	**7**	**1667**
Manipur	**14**	**13**	**16**	**72**	**420**	**20**	**2405**

Source: *Statistical Abstract Manipur 2005, p. 108*
**Pooled figures of Imphal East and Imphal West are shown against Imphal West*

Table 2.15 Average Population served by Government Hospital in Manipur

Sl. No	Items	Total				Population Served Per			
		Numbers	Beds	Doctors	Nurses, Midwives, & Dais	Hospital	Bed	Doctor	Nurse
1.	Government Hospitals (including CHC & PHC)	102	2,405	910	1,019	21,243	901	2,381	2,126

Health infrastructure is the important component to know the health services delivery and the system of provision in Manipur. Health infrastructure in Manipur

capture two broad indicator that categorized the level at which the state government is working toward at achieving good health outcome. They are the educational infrastructure and service infrastructure. These two component works tangentially to improvise the existing infrastructure into place. The state provides services such as public health, control of communicable diseases, health education, family welfare and maternal and child health care through the 28 Government hospitals (including CHCs), 420 sub-centres, 72 Primary Health Centres, 16 Community Health Centres and 20 dispensaries. There is 3 licensed blood bank facility of the State government available in the state.

In Manipur, the better availability and more equitable distribution of health services in comparison to the rest of India in health care services. However, the physical provisioning and access to health services are less accounted due to the hilly regions. The state has 7 district hospitals and 1 state hospital .i.e. Jawaharlal Nehru Hospital as referral centre. The Regional Institute of Medical Sciences (RIMS) is an autonomous institution running under the North Eastern Council, Shillong, at Lamphel Imphal with the 6 beneficiary states. There are 9 drug de-addiction centres, TB centres at 6 districts, 4 leprosy control unit and 6 STD clinics in the state[20]

Even as the state health outcome is high, however, there is a weakness in waste management. The Government hospitals, health centres and private nursing homes and clinics dispose of the waste in their own ways according to their convenience. There are no incinerators in the state except one at Regional Institute of Medical Sciences. There is no proper system of disposal of waste in the Municipal Areas, areas under the Small Towns and other public places. Lack proper system of bio-chemical waste has resulted in unhygienic atmosphere.

It is said that the use of health care services is influenced by the standard of living of the household. This is why, as the increase of standard of living, use of private sector services also increases in both the in-door and out-door. In Manipur, 79 per cent of

[20] Govt. of Manipur, Department of Environment and Forest: *Environment Report of Manipur 2005-06*

households with a high standard of living use the private medical sector compared with 63 per cent of households with low standard of living. Within the low standard households, only 1/3rd uses public sector services for their health care[21].

Population Coverage of Health Centres

Table 2.16 Primary Health Structure and their Population Norms

Health Centre	Population Norms	
	Plain Area/General	Hills/Tribal/Difficult Area
Sub- Centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000
Source: RHS, MoFHW, GoI, 2007		

Table 2.17 Average Population Covered by CHC, PHC and PHSC in Manipur (Census 2001)

Sl.No	Country/State	CHC	PHC	PHSC
1.	All India	2,54,292	45,982	7,080
2.	Manipur	1,49,289	33,175	5,687
3.	Hills	1,63,845	27,308	4,428
4.	Valleys	1,40,556	39,043	7,098
Source: National Health Profile 2008				

[21] "Manipur", *The Official Journal of the Indian Society of Health Administrators, Vol. XVI. No. 1, July 2004, p.67.*

The availability of medical and paramedical personnel in the state is appluadable as it compared with the North Eastern States. When we look at the norm of Manipur within the hills and valley, the considerable amount of cross cutting differences are vividly seen in the character of average population covered by the Community Health Centre. This seems that the Public Hospital at their disposition in the state is better as when compared with the national level average. Let us look at the North East India average of population covered by each health centres.

Table 2.18 Average number of population covered in North East India

Sl.No.	State/Country	PHSC	PHC	CHC
1.	Arunachal Pradesh	2,897	12,917	35,418
2.	Assam	5,217	43,697	2,66,555
3.	Manipur	5,687	33,175	1,49,289
4.	Meghalaya	5,826	22,513	89,185
5.	Mizoram	2,428	15,589	98,730
6.	Nagaland	5,013	23,691	94,764
7.	Sikkim	3,679	22,535	1,35,213
8.	Tripura	5,525	42,656	3,19,920

Source: National Health Profile 2008

The above Table shows the averages population covered by each of these health centres in North East India is presented with mixture of both the medium and better preformed states. According to NHP 2008, the averages covered population in Arunachal Pradesh and Mizoram states show better posited when analysed comparatively of all the states. Manipur still needs to overcome the national norms.

The infrastructure of health services in the state is appreciated when compared to rural and urban areas. There are differences in the some indicators, of course, but generally has improved in both the hills and valley areas. Singh[22] argued that the development in hill and valley is not far away from each other when look at infrastructure and some social parameters. He analysed the hill and valley through comparing of

[22] Singh, Kumar, E. Bijoy (2005) "Development Discourse in Manipur: Hills versus Valley", *Eastern Quarterly, Vol.3, Issue III, October-December.*

economic development (measures by per capita income), health status, literacy rate and employment. Therefore, the conclusion was that even though hill people blame the Meitei (a valley people) for non-development in the hill is baseless as the determinant he used proved no differences. The most important think to remind is the physical provisioning of any development does not hold any difference. And the doctors from Imphal posted in hill districts, which come from Imphal on the starting of a week and leave behind the system in weekend seems questionable to physical provision of health services in Manipur.

HIV/AIDS in Manipur

HIV/AIDS is a major public health problem in Manipur; the state is third highest rate of sero-prevalence in the country after the Maharashtra and Tamil Nadu. The state is 'high prevalence' with 5 per cent of the high-risk groups and more than 1 per cent of the women in antenatal clinics testing HIV-positive. First case of HIV infection in the state was detected in the year 1990. At presently, the state is home to around 8 per cent of the country's total AIDS population.[23]

An estimate of Manipur State AIDS Control Society (MACS) of HIV-Positive cases in the state is around 40,000. The relationship with the drug use is common in Manipur. That is why the mode of transmission of HIV in the state is the sharing of injection equipment during injecting drug use (IDU). Manipur lies physically next to what is referred to as 'Golden Triangle', through which the most sources of illicit heroin and mafia go entwined. As it is the transit point, the international drug trafficking business and better quality of heroin is available cheaply in the state. The most prominently used injecting drug is heroin. It is affecting the youth population of the state.[24]

[23] Jacob (2008), p. 34.

[24] MSDR 2006, p. 204.

2.4 Ethnic Conflicts, Insurgency and Its Affect on Health

In the process of discussion, the initial section will be to understand the meaning of ethnic conflict, followed by the narratives of various conflicts and lastly to see the effects on health of an individual, community and the health system of the state.

North East India has been perceived as a remote and isolated region, ethnically so diverse and far distant from the dominant Aryan Indian influenced. North East is also described as 'neglected child' of India due to the kind of violence, insecurity, extortion, trafficking, corruption and repressions resulted from various ethnic conflicts and separatist movements. It is observed that the militarization in the region by the Indian Armed Forces which enjoy a subsequent special rights and extraordinary power to act at any inference of provocation can lead to death.[25] Complexities run high because of multi-cultural, religious, languages and dialects. Insurgency has become the mainstay of political and all other aspects of life. Northeast india is close to near total collapse from the points of view of governance, law and order, development and the government policies have not gone beyond ad hoc measures aimed at maintaining the status quo.[26] In Manipur, the insurgency movements have followed the ethical lines.

Manipur is one of the states in the North east part of India which has a caught in the ethnic quagmire with dominant groups indulging in an articulated campaign of ethnic assertion and consolidation process of expanding their respective spheres of influence. Sphere of influence shared the notion of specific group has the monopoly to exercise its influence over others effectively. The conflict conflagration strove as when uneven formation of middle class has eventually subscribed to the development of competitive

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[25] Egreteau, Renaud (2006) "Instability in the Gate: India's Troubled Northeast and its External Connections", *French Research Institute in India, Centre for Social Sciences, Occasional Paper No.16 (January).*

[26] Jacob, Happymon (2008) "Impact of HIV/AIDS on Governance in Manipur and Nagaland", *ASCI Research Report No. 6, April*, p. 3.

solidarity among them coupled with the weak state and central government control.[27] The rise of middle class in the progressive society has intricately woven to the fore of identity formation which posit a threat to others rising community.

Table 2.19 Distribution of Ethnic Groups

Districts	Ethnic Groups
Imphal (U), Bishnupur, Thoubal	Meiteis, Pangans, and few settlement of Kom
Ukhrul	Tangkhul Naga and few Kukis settlement
Senapati	Mao Naga, Poumei Naga, Maram Naga, Thangal Naga and few Kukis settlemnent.
Tamenglong	Zeliangrong Nagas (Zeme, Liangmei and Rongmei), Chiru Naga, and few Kukis settlement.
Chandel	Maring Naga, Monsang Naga, Lamkang Naga, Chothe Naga, Monyon Naga, Tharao Naga, and few Kukis settlement.
Churachandpur	Paite, Simte, Ralte, Mizos, Hmar, Suhte, Purum, Gangte, Vaiphei and Kukis.
Source: Shimray (2001) p. 3675	

Gilley suggested the 'ethnic conflicts' as the expression of 'modern hate' and largely the twentieth century phenomenon. The claimed that most ethnic conflicts are rooted in ancient tribal or religious rivalries is a standard argument for long time which is the product of enlightenment.[28] Conflict as an expression of two opposite groups fighting for dominance in their sphere of influence and sub-nationalism propagated from ethnical fraternity proposes to create a subservience people out of minority groups. An ideology such as 'right to self-determination' was proscribed in the ethnic mobilization to legitimate their calls for gaining recognition and consent of the larger people. An insertion of ethnic conflict in Manipur draws in this similar line.

[27] Kangujam, Sanatomba (2003) "Ethnic Discourses in the North East-In Search of an Alternative Paradigm", (Online: Web) Accessed on 12 June 2009, http://www.manipuronline.com/features/November2005/ethnicdiscources01_1.htm.

[28] Gilley, Bruce (2004) "Against the Concept of Ethnic Conflict", *Third World Quarterly, Vol.25, No.6.* p. 1155-1166.

The configuration of ethnic composition and demographical division in the state has clearly shown the different pattern of ethnic assertion on identity and cultural spheres. Oinam[29] argued that the ethnic conflicts in Manipur is substantiated by the fact of land and power, in which he goes on to say that dominance and subservience is perceived as it is elaborated in the respective dominant tribal areas. The contention was erupted from the claimed of Nagas that Kuki are migrants and have to pay taxes. Kuki adamantly objected to it, thus infuriated the Nagas and rose to brutal killings of each other. Kangujam inferred the ethnic conflict as the politics of middle class elite who were the products of Indian bureaucrats. Both the inter-ethnic group conflict and intra-ethnic group conflicts were observed in Manipur. The inter-ethnic group conflict was seen in the Nagas-Kuki conflict while the Kuki-Paite conflict was an intra-ethnic group conflict.[30] Nevertheless, the Nagas-Meitei conflict was much more complex and drawn nearer to communual tension.

The ethnic conflict is deeply rooted in the history of Manipur since the nineteenth century. The seed of discontentment between the Nagas and the Kuki tribes were shown in the First World War. Both the Nagas and the Kuki were recruited in the Manipur Labour Corpse, where as many as 1200 were organised, in which Tangkhul Nagas were the majority while Kuki refused to enroll themselves in the Labour Corpse and subsequently rose in open rebellion in 1917. They attacked government posts but soon began to raid the Tangkhul and Rongmei (Kabui) Nagas Villages. Therefore, the conflict started over the region which infuriated the stability and hence adopted the military expedition squarely to fulfill the group's aspiration and resorted to attack the neighbours' community.

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[29] Oinam, Bhagat (2003) "Pattern of Ethnic Conflict in the North East: A Study of Manipur" *Economic and Political Weekly, Vol.28, No.21 (May 24-30)*, p.2036.

[30] Kangujam (2003), p.8

The initial conflicts between the Nagas and Kukis broke out in the Chandel district, where the contention of who will control the areas of Moreh Town[31] created upheaval tension in both the groups. In mid-1992, the clashed between Nagas-Kukis began in the Chandel district. The reason behind was that Kukis living in an around the Moreh refused to pay tax to Naga insurgents on the ground that they did not subscribed to the Naga nationalism. Naga insurgents have been collecting this 'house tax' from every household in Nagas areas since its inception.[32] Though the initial clashed was started at Chandel the new has reached every tribal dominated areas. This has led to the expansion of ethnic tension all over the state and even to the neighbouring states.

Patel argued that the violent clashes between the Kuki and Nagas in Manipur are a direct consequence of the wandering nature of the Kuki tribesmen and the artificial boundaries imposed on them by various rulers. He further stated that in the past, the Meitei Kings had encouraged the Kukis as well as the Nepalese to settle in certain tracts so as to form human settlement buffer against raids from Nagas. They were placed between the Barak River and Valley so as to keep check on Zeliangrong Nagas in the western part, and likewise in the east, they were used as a barrier against Burmese.[33]

A Kuki-Paite conflict was broke out at Churachandpur district in 1997. The basis of intra-conflict was because of the killing of 10 villagers at Saikul village by Kuki militants. However, the depth of misunderstanding arose from the non-acceptance of the nomenclature 'Kuki' by non- Thadou speaking groups like the Zous, Simtes, Paites, and Vaipheis.[34]

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[31] A small town bordering Myanmar, which is used as the centre of trade for formal and informal goods. This is a transit point of unconstitutional activities such as the smuggling of heroin, guns and others network. This town is used as the centre for survival of many underground groups as the taxes on goods and other resources are huge.

[32] Shimray, U. A (2001) "Ethnicity and Socio-Political Assertion-The Manipur Experience", *Economic and Political Weekly, Vol. 36, No. 39 (Sept. 29-Oct. 5)*, p. 3677.

[33] Patel, J. Vibha (1994) "Naga and Kuki: Who is to Blame?" *Economic and Political Weekly, Vol. 29, No. 22, (May)*, p. 1331.

[34] Shimray (2001), p. 3677.

The human lives lost in the ethnic conflict starting from 1990 to the end of this decades expected to be as many as 750, excluding the Nagaland and Assam. About 1, 14, 300 people have been internally displaced in this period.[35]

In the conflict regions, the health services and health care provision of both the public and private services are disturbed is to be found in any study. The important equation here is that how a small state which has different ethnic groups living in a close knit region harbouring more than 10 insurgents groups, and even more divided into factions fighting each other could produce good health outcomes. Adding salt to the injured, the Armed Forces Special Powers Act (AFSPA) of 1958 is concurrently adopted in the state. Thus, the movement from one place to another makes more difficult not to think about going market even for a livelihood. And that not a single day passes without an incident related to insurgency in Manipur.[36]

Manipur has become the killing field when the ethnic groups fighting each other on the one hand and on the one side the government enter to abort the conflict through the gathering of arm forces from within and without the state. The so called 'disturb area' has cordoned off the people from their land and arm forces brief out their most search among innocent population under the pretext of identifying underground people. It is an insult to the already deprived people of affected by ethnic cauldron in the state.

India Human Rights Report 2006 clearly stated that under the cover of the AFSPA of 1958, the central security forces carried out arbitrary arrest, torture and extrajudicial killings with impunity in the name of fighting insurgency. The insurgency groups were also equally responsible in carrying out of killing, kidnapping, torture and extortion against the humanitarian law. Conflict between the security forces and armed opposition groups have led to the internal displacement in the Manipur. On every conflict women and children silently bore the brunt of violence, including rape and molestation.[37]

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[35] Oinam (2003), p. 2035.

[36] Jacob (2008), p. 18.

[37] India Human Rights Report 2006, Asia Centre for Human Rights, January 2007, New Delhi, p. 121.

In July 9 of 1987, the Assam Rifles (AR) Camp at Oinam village of Senapati District was attacked by underground group killing nine jawans and injuring three seriously. Raiders walked off with a large quantity of arms and ammunitions. By 11 of July, the AR launched 'Operation Blue Bird' to recover the arms and ammunitions. To carry out this operation, AR sealed off completely the areas and imposed curfew for four months. Hundreds of villagers of all sex were detained for interrogations by the para-military forces. Women were compelled to give birth to their babies in the open play ground in full view of the jawans. Houses were dismantled and agriculture crops were destroyed while carrying out house to house search. The civil administration cease to operate while AR running a parallel administration in the area.[38]

The rise of Nagas nationalist movement became a threat to India army. Indian armies were on suspicion that every Naga boy or a girl was a nationalist. This created problems interrupting the peace and harmonious fellowship at home and at work places. After the conflict started the youth avoid being ill-treated and get killed by minimizing the visit, meeting relatives and dropped education.[39]

It is seen that the normal life affected in the trouble areas. Thus, the conflict between Indian army or underground groups, inter-ethnic or intra-ethnic conflicts, the kind of life one has to live is never to think of good health as they are always running for safety and secure. If ethnic conflict and adding more military in these areas will serve the purpose then what is the present situation now?

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[38] Post Torture State of Mental Health, *Report of a Medical Study on the Delayed Effects of Torture on Nagas in Manipur. July 1990.* Calcutta: Drug Action Forum, P. 2-4.

[39] Imsong, Mangyang (2000) *Trapped! Indo-Naga Conflict and the Psychological Effect on Naga Youth,* Dimapur, p. 66.

Vision 2020: North Eastern Region

The Vision 2020 for North Eastern Region is-

> ... to achieve overall improvement in the health status of NER, both as an end in itself, and as a fundamental requirement for raising productivity and growth within the region. This will require raising access in the region (AIDS, cancer, alcoholism), and raising awareness about nutrition, environment, sanitation and disease prevention and control measures. The low use of existing facilities will be tackled by improving the quality and range of services offered both by the public and private facilities, by involving other agencies and putting in place innovative techniques that have worked in other parts of the country. North Eastern Region Vision 2020, NEC, MoDONER, GoI, Vol. II, p. 206.

The Vision plan has accepted the weakness in certain aspect of health care services in NER. It is stated that despite physical expansion of health care facilities, access to quality health services remain low in remote areas as well as in urban areas, especially for women and children. The problem of distant travel by people for consulting doctors, lack of proper diagnostic centre, lack of trained medical staff at every level and lack of supplementary infrastructures such as roads and environmental sanitation has whitewash the whole region.

In providing health care for the entire region has failed to give impact because of the low use of facilities of public services, dependence on traditional providers and lack of tertiary care. Increasing access to primary health care mainly to the poor rural areas will be addressed by National Rural Health Mission (NRHM).

Vision 2020 put forward a public health policy for the NER with three prong objectives:

i) To direct financial resources towards ensuring good health services in areas where private investment in unlikely to go

ii) To create an environment conducive to attracting and retaining private health providers with some incentives to enter certain areas, such as smaller towns, and

iii) And to protect consumers by enforcing regulation of private healthcare.

Action Plan

There are many action plan outline in the Vision 2020. Those under are prominent among them.

i) Goal to attain health for all by 2020

ii) Communitization of primary health care system

iii) A special programme for healthcare including trained 'bare-foot doctors' for rural areas

iv) Immunization programmes to be implemented in the remote areas of the region by using helicopters to ferry men and material as a special mission.

v) Set up of Regional Medical University and para-medical institutes

vi) Increase health sector budget upto 6 per cent of GSDP

vii) Integrated programmes for water, sanitation and health to be taken up.

The Vision 2020 for North Eastern region laid down in the action plan on the priority list did not see 'health for all by 2020' but security concerns top the list. Making new railways and commercial linkages are the top priority, whereas the making of new rail head in North Eastern Region is just to aggrandize the military presence. Hence, fear of international aggression and occupation on Northeast region has resulted in increasing military presence than the need of these states. Therefore, so long as the need is not meted in the development process, the infrastructures and increasing of health care would not do much in this region.

CHAPTER 3

CHARACTERISTICS OF MEDICAL MISSIONARIES IN MANIPUR

- *Looking the history of Missionaries' Medical Care in Manipur*
- *Resistance against Christian missionaries*
- *Church Groups Promoting Hospitals*
- *The Missionaries motivation*
- *Characteristics and distribution of Christian Hospitals*

The Nineteenth Century marks the beginning of the history of the involvement of Christian missionaries' in Manipur. In the history of Christianity missionaries in India, it is in Manipur where it has expanded rapidly. In chapter two, we had discussed the arrival of Christianity in North East India. And in chapter three, we highlight the composition of Christians in Manipur. In this chapter, we shall attempt to investigate the initial work of missionaries in medical care and then we will discuss the services being provided. Some of the specific characteristics of medical missionaries will be brought into the discussion. We will discuss the growth, expansion and the complex interwoven nature of its multi-cultural groups in Manipur.

A pertinent question shall be to see what keep them going with changing times and rising competition from other medical institutions in the state. Though the objective of this section is to read the characteristic of medical missionaries, there are numbers of restrain resulted from lack of available literature.

3.1 Looking the History of Missionaries' Medical Care in Manipur

The arrival of the missionaries in Manipur has led to establishment of dispensaries and hospitals as a means for facilitating evangelization. There is a conventional view within the Christian mission that charitable work in health care must become a part of

this process. Some of the literature suggests that 'medical mission' was an approach of humanitarian service, yet was not a strong aspect of the mission. As in central India, the work of medical care in serving population of Manipur was the same. Therefore, the principle of 'charitable relief and care for the sick is quite generally and wisely accepted as one of the more effective means of gaining the attention, sympathy, and good will of the people'.[1] The kind of attention drawn in favour of missionaries' zeal towards the medical care was not contested as due the prevailing health condition among the people of Manipur, especially the tribes in the hills was failing.

While it is assumed that the work of the 'medical mission' was mainly for proselytization, it also had an element of introducing hygienic practices to the 'native' population who were considered dirty and superstitious. Most of the tribes in Manipur, believed that 'sickness was caused by spirits' and thus the priest was called for necessary rites.[2] When the Christian missionary arrived, the tablets and tonic served at their behest best in relieving pains and sickness in matter of just one swallowing. There are numbers of instances where people gathered around the missionary just for the sake of tablets. The care for the sickness in the mainstream of Christian in Manipur, especially the Baptist Churches is seen today that most of the Christian leaders and members visit hospital to pray for the sick and healing of the ill patient.

Let us look at the initial moment of missionaries' arrival and their work on health care. To start with, the American Baptist Mission Burma made the first attempt to establish their mission station in Manipur in 1836. But this failed because of the opposition both from the ruling princes of the state and the British political agent. In 1840, a former missionary of London Missionary Society in India Rev. Jacob Tomlin suggested three places where the Welsh Calvinistic Methodist Foreign Mission Society, Liverpool could send their missionaries, among these, Manipur was one. The political situation in the state was the main factor which prevented the missionary from entering it. Above this,

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[1] Mason, M. C (1886) "Methods of Mission Work" in *The Assam Mission of The American Baptist Missionary Union- Papers and Discussions of the Jubilee Conference,* Nowgong, December 1886, p. 98-99.

[2] Jeyaseelan. L (1996) *Impact of the Missionary Movement in Manipur*, New Delhi: Scholar Publishing House, p. 177.

there was an opposition from the local native government because they already had accepted 'Vaishnavite Hinduism' as a principle religion by a royal edict in 1705. [3]

Arthington Aboriginese Mission was a mission society of an English millionaire named Robert Arthington of Leeds, London. Robert is to have commissioned thirteen missionaries in 1890 and one among them was the first missionary Mr. William Pettigrew to Manipur. Pettigrew came to India under this private society. He was a member of the Church of England but was 'convinced of the inadequacy of infant baptism and later baptized from R. Wright Hay, a Baptist Missionary Society missionary living in Dacca'.[4]

Before the advent of Pettigrew, Manipur was not a potential mission field. Pettigrew attempted many times to enter Manipur but the Political Agent (Mr. Maxwell) of the State refused permission. Even as these, Pettigrew decided to learn Manipuri language. He then moved to Silchar in February 1892 to enter Manipur as soon as the Government would permit him.[5]

Meantime, Major Maxwell went on furlough and Mr. Porteous came as the Acting Political Agent of the State. Having failed to obtain permission to enter Manipur, Mr. Pettigrew took hold of the situation and made friendly relation with the Acting Political Agent. He was able to impress Mr. Porteous to grant him permission for entry into the State. Mr. Porteous granted permission to start a school and recommending him to work among the hill tribes not in the valleys' population in 1894. Pettigrew started a school there at Imphal with just four boys. He then started preaching among the Manipuri people. When Major Maxwell return from furlough the situation was altogether different. Maxwell with due regards to the political situation of the state sought Pettigrew to leave

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[3] Dena, L (1988) *Christian Missions and Colonialism: A Study of Missionary Movement in North East India with Particular Reference to Manipur and Lushai Hills 1894-1947*, Shillong: Vendrame Institute, p. 31.

[4] Lolly, R. (1985) *The Baptist Church in Manipur: A Historical Survey of the Mission Strategies and Development of the Baptist Churches in Manipur, North East India, 1894-198'*, Manipur, p. 19.

[5] Zeliang, Elungkiebe (2005) *A History of the Manipur Baptist Convention,* Imphal: The Manipur Baptist Convention, March 2005, p. 19-21.

Imphal and stop the missionary work[6]. Pettigrew was given a chance to work among the hill areas which were under the direct administration of the agent. After a search in various areas, Pettigrew decided to establish his residence at Ukhrul, in the Tangkhul Naga area northeast of Imphal.[7]

Manipur was not under any denominational mission field until when Pettigrew was invited to attend the Missionary Conference at Sibsagar in December, 1895. He was recommended and ordained by the Missionary Union into the membership of Sibsagar Church. At that period, there were two missions working in the adjoining areas of Manipur that Welsh Presbyterian Mission at Aizwal and the American Baptist Mission at Kohima.

In 1901, the first convert were the twelve students of the school from both the Kuki and Naga, were baptized. The first few years of Pettigrew seemed to be heavily engaged in the construction of a mission bungalow, teaching, studying the local dialect, doing translation work and sometimes giving out medicines apart from assisting the state officials in the administration of the hill areas. Pettigrew in his dispensary work in Ukhrul reported that he had given medical treatment to 2,017 person in 1907, 1,201 in 1908, and 2,200 during 1909. He had collected an amount of Rs. 120, Rs. 74, and Rs. 75.10 in those years. In 1908, cholera epidemic was rampant in the valley of Manipur but the hills were untouched by it. The subsequent year 1909 also witnessed high malaria fever rampantly attacking the young and old with no escape.[8]

During the First World War, Pettigrew in his capacities had raised 2000 labourers from both the Kuki and Naga tribes to be sent to France. Under his leadership, he organized the labourers who were comprised of ex-student of the school. They made up

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[6]Adding to the opposition from the orthodox Hindu Manipuri, the Arthington Aborigines Mission Society had also the instructions that the mission worker would learn the language, give the gospel then move to another field, no permanent settlement.

[7] Downs, F.S. (1992) *History of Christianity in India: North East India in the Nineteenth and Twentieth Centuries,* Bangalore: The Church History Association of India, p. 84-85.

[8] Zeliang, Elungkiebe (2005a) *History of Christianity in Manipur-Source Materials,* Guwahati: Christian Literature Centre, p. 24-25.

the majority of the Labour Corps. Though some died in the war but the survivors returned with a high spirit as they have seen the foreign land, which nevertheless has affected their view of Christian. This has culminated to the broadening of Christianity among the tribal population where the returned Labour Corps was predominantly residing.[9]

In 1917, with several appeals from the missionaries to work in the western hills, the Darbar and the Maharaja of Manipur accepted the permission to establish the Mission headquarter at Kangpokpi. Soon after the establishment, Dr. G. G. Crozier, MD from Tura was transferred to Manipur but the work of medical was not able to carry out work in their expectation because of the political turmoil in the state. Dr. Crozier was an able builder and good manger while taking up the task to erect most buildings for hospitals, dispensary, the bungalows, and the Mission school in the Kangpokpi Mission Compound. In 1919, the Mission School and in 1920 a Leper Asylum, a dispensary and an orphanage were established.[10]

The Leper Asylum was the first of its kind in Manipur and the dispensary was upgraded to a hospital with the name Mission Hospital Manipur. It was in the year 1958, the present name of the hospital was given-'Kangpokpi Christian Hospital (KCH)'. In an important milestone of development, the Kangpokpi Christian Hospital School of Nursing was established in 1982 under the Assam Nurses' Midwives Council. [11] Thereafter, the doctors and nurses were recruited from the state to mend the medical services.

Taking stock of different church denominations and their arrival in the state suggests two propositions, that, One- American Baptist Mission had started the church at Ukhrul, among the Tangkhul Naga, in the eastern hill, and in the Southern hill, the Presbyterian established its church. Secondly, the coming of other denominations, like Catholic, Seventh Day Adventist, and Independent church were under the behest of the

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[9] Jajo, Champhang (1990) *The Indigenization and Contextualization of Christian Life in a Tribal Context: In Manipur State of North-East India,* Manipur, January 1990, p. 30.

[10] Zeliang, (2005b), p. 133-134.

[11] Ibid., p. 137.

native peoples' invitation. We will be discussing these points that how these church groups started at the next section extensively.

We ought to see the ways in which medical care been carried out by the Christian missionaries. In the richness of the information pertaining to the kind of medical attention given by the Christian missionaries were in lone dispensary related activities and the distribution of tablets. The body of knowledge evolves from the various writing reveals only to the sequential and spatial treatment of sickness in the Nineteenth Century Manipur.[12] The treatment meted out in the dispensary was mostly in an un-institutional engagement of medical anecdote and completely vertical to the areas of Mission field. It may, however, be said that there was not even a good medical centre other than the Government dispensary though Pettigrew claimed to be treated many patients.

The growth of missionaries' medical care in Manipur is seen in a marked singularly working at Ukhrul prior to the transfer of headquarter, and later to the adjoining areas of Kangpokpi. Missionary medical cares in Manipur start with Ukhrul and come to rest there at Kangpopki in a seemingly central hypothesis. Later decades has suggested that most institutional service of medical care sprung up as duely initiated by Christian churches leadership. Areas which were toured by Rev. Pettigrew for the sake of endeavoring future mission field were left untouched by missionary in respect to care for the sick. In terms of medical care, the natural growth is popularly seen with the worthy effort from the local churches than the direct involvement of missionaries.

Medical Missionaries were pretty much obliged to the Mission station or headquarter because the other areas which were little far away from the Mission station did not receive any medical help, rather they had to travel long distances to avail services. In such a situation, having a far flung hospital is better than not having it at all. Even then, the Christian churches engaged in their own denominational medical mission. For instance, the Christian Hospital Imphal was established by the Kuki Christian Church Medical Mission.

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[12] Zeliang, (2005) *History of Christianity in Manipur-Source Materials*, Guwahati: Christian Literature Centre, February, p. 13.

After independence, the missionary had handed over important positions of leadership 'native' leaders. This was a major shift towards the dream of becoming 'ethno-denominational' tune, because most of the churches were created in the linguistic and region wise. Perhaps, it may be the courage of native leaders to see themselves building a healthy people out of church approach to health care. The kind of missionaries' medical care once was expected did not materialize, as the health care become only for those who fortunately enter into profession. Beyond doubt the Christian missionaries had done a meaningful work of medical care in Manipur.

3.2 Initial Resistance against Christian Missionaries in Manipur

The rapid growth of new local churches in Manipur also equally found difficult to supervise them. The Manipur mission field was directed to preach the Gospel among the Tangkhul Nagas, Kukis, Zeliangrong Nagas and Mao Nagas inhabiting in the hill areas because of the objection to stop the missionary activities in valleys from the Maharaja. Initial numerically strength was impressive in the first half of twentieth century with the church membership had grown from 14 in 1910 to 25,000 in 1950. However there were problems which made the condition more hostile and difficult to tasking of Christian movement. Firstly the Government restrictions that allow only two missionaries families and some part of hills were not permitted to enter. And secondly the resistance was observed among the people of hill villages mainly the village headman.[13]

First trail of resistance against the Christian missionary was when Rev. William Pettigrew journey towards the Imphal. Pettigrew initially was supposed to open mission station there at Mao (presently at Senapati district) but due to the local headman and the village elders voicing against missionary work he then moved down to Imphal. The same fate was witnessed when the then Maharaja of Manipur opined not to work among the valley's population although his educational work and raising of Labour Corpse in World War I was welcomed. Pettigrew moved his mission station from Imphal to Ukhrul and

[13] Downs, F.S (1971) *The Mighty Works of God- A Brief History of the Council of Baptist Churches in North East India: The Mission Period 1836-1950*, Guwahati: Christian Literature Centre, p. 156.

the student of his school actively involved in the propagation of Christianity in surrounding areas.

The problem within the missionaries cropped up between Pettigrew and Dr. Crozier, when later initially thought of working together couldn't get along partly because of theological differences. This has led to the divide and gains influence in respective areas which were later divided into two spheres. Pettigrew was given the North East and Sadar (the area North of Imphal to the border of Nagaland) regions and Dr. Crozier in the North West of the state. This was made to eliminate the tension but it was developed into tribal overtones as Pettigrew was working among the Nagas and Crozier among Kukis. Both of them has mastered in learning the local dialects respective to their working assignments. Eventually during the period of Second World War the tribalism among the church was emerged as one of the factor affecting the peaceful life.[14]

The expansion of church in the Manipur was obstructed in many of the villages. There was a separation between the non-Christian and Christian group in the village, the Christian stop observing the traditional festivals and other gennas while the local headmen and the village elders forced the Christian to observe. With equally the same as the missionary also listed church rules that were to be faithfully observed and failing will be disciplined by the church. There were misunderstanding between the non-Christian and Christian, that most non-Christian were on the believed that whatever ill and misfortune came at those period thought to be non observance of ritual and gennas by the Christians, an equal blame also meted out by the Christian stating that the sinful nature of the non-Christian has caused these thing. As non-Christian were majority in the villages, the Christian people have to move out from the village.[15]

The standoff between these two opposite groups resulted in legal fight for property and freedom of belief under the legal system in which the Christians hardly ever won. The rift reached the clan as mostly feeling of oneness prevailed among brother of same clan. A case of Christian religious leader being given banishment from the village

[14] Ibid., p. 159.

[15] Jajo (1990), p. 34.

was happened in Ukhrul district when the local pastor trying to proved that animistic belief were false chopped off trees from sacrificial spot. The pastor was ordered to pay penalty of the expenses to be incurred in organizing the rituals.[16]

Two deterrent movements occurred in Manipur resulting in unrest and fragmentation of church life along tribal or ethnical lines. They were the Kuki Rebellion of 1917-1919 and the Kampai Movement of the Zeliangrong Nagas[17]. Whatever their stated objectives, the movement was tended towards the Kuki-Naga conflicts.[18] The Zeliangrong Movement headed by Haipou Jadonang (the Naga Raj) and later by Rani Gaidinliu in late 1920s opposed the British government administration in the Zeliangrong areas was seen anti-Christian element. Many of the academicians misunderstood the movement as anti-Kuki uprising without being properly understand the objective of Zeliangrong movement.

Kuki Rebellion or some called it Kuki Punitive Measures has rooted from the Labour Corpse raised by Manipur Rajah for the First World War. The Kuki were on the view that they were not subjects of any nation, therefore refused to participate in war. So they revolt and took up arms against government. During this measure the neighbouring villages were held captives, collect taxes from non-Kukis and rendered homeless. This resulted in suspicion and enmity between the Kukis and Nagas. So much so the integrity and unity of Christian brothers also got fragmented. [19]

Even as the tensions prevails the Kuki evangelist contacted Zeliangrong areas occasionally with much difficulties. Later the Zeliangrong community accepted Christianity through the Namrijinpou, commonly known as Maipak. He was born at Khukiu village in the hills but he and his father moved to Imphal suburb of Keishamthong (a Rongmei colony). His father secures his employment in the Raja Band where he was elevated to Major. He was married to Pantigongliu but first period of

[16] Ibid,. p. 35.

[17] Zeliangrong is a composite name belonging to three brother tribes, viz. Zeme, Liangmei and Rongmei.

[18] Downs (1971), p. 157.

[19] Jajo (1990), p. 35.

marriage was tragedy because child born to them died in their infancies. At this time he met Pettigrew and baptized in 1914 at Imphal. By this act, the Manipur Raja didn't allow him longer to work for him and following this he resigned from the government service to work for his people.[20]

During this time he met Jinlakpou of Kaikao village of Tamenglong. Jinlakpou did not received Christianity immediately but later he was appointed government post at divisional headquarter. There the interest in Christianity was revived through contact with Kuki Christians. He was baptized in 1920, followed by more than ten house hold received Christian including his family. In short period of time more house hold converted to Christian. This has angered the village elders and ordered to leave the village. The matter reached the Sub-Deputy Officer at Tamenglong but was sided with villagers. Christian families were given a week to prepare for leaving with a fine of Rs. 400/-. Knowing this Pettigrew intervened with the state authorities securing to settle on a new site which is quarter a mile away from old village. The new Christian village was named Sempang with Namrijinpou was sent to initiate them. In 1951, the Christians of Sempang attempted to come back at Kaikao with fatal setback. While constructing a church building in the old village, they were attacked which resulted of three Christians died and eleven injured. Aftermath of Kaikao village has prompted the elders of different villages to deny entry of Christian missionaries in Zeliangrong areas. Through this setback the progress among Zeliangrong was not encouraging.[21]

The Mao Nagas received Christianity lately as compared to other Nagas and Kukis tribe. Mao region is strategic importance to the Government as the communication of road link was maintained with Kohima passing this land. In 1894, Pettigrew attempts to establish mission station was opposed with which the government also trying not to disturb the areas because of the road links. Voluntary Tangkhul Christians began to visit this areas and the student who were sent to Mission school at Kohima came baptized. When they returned they formed a small Christian community at Mao Gate. Elder of the

[20] Downs (1971), p. 174.

[21] Downs (1971), p. 176-180.

village gave petition to the Political Agent against them but was allowed to remain there. More persecution were began to grow when they evangelise villages. Christian were beaten, tortured and driven from villages. By this, some of the Christian took temporary refuge in nearby Tangkhul Christian villages. Till 1949 such beatings and publicly stripping of Christian was abated. The most interesting thing was that even the persecution was carried out aggressively; Christians were even stronger and better build up church in those areas.[22]

3.3 Church Groups Promoting Hospitals

Manipur is a multi-religious society where many religious have flourished for thousands of years. Hindu and the tribal traditional customary religions form the dominant community for time immemorial. Later Muslims, Christians, Buddhist, Sikhs and Jains came and live for a long time. Coming to the Christianity in Manipur, it was first introduced to the state in 1894 by the Arthington Aborigines Mission. Now the state has witnessed several institutions run by Christian's churches or groups in promotion of education, health, development projects, etc.

With regards to the establishment of the church organization promoting medical and health care services, mentioned may be made that of Council of Baptist Churches in North East India (CBCNEI), Manipur Baptist Convention (MBC), the Catholic Church, the Evangelical Free Church of India (EFCI) and Kuki Christian Church (KCC). The brief note of these associations of how it came into being and the present condition is thus highlighted in the following:

A. Council of Baptist Churches in North East India (CBCNEI)

'The history of the CBCNEI churches begins in a time of great political disturbance' says F. S. Downs.[23] North East India was witnessing disintegration from

[22] Jajo (1990), p. 43.

[23] Ibid., p. 1.

within the states and the external aggressions. The Brahmaputra valley was affected by increasing raids from the hillsmen and the Burmese invasion. British administration working in the region has a great impetus on the driving out of Burmese forces. With the presence of Britishers in the region, the knowledge of Christian missionaries for mission field was culminated.

The history of CBCNEI can be dated back in 1836 when the first American Baptist Missionaries landed the Brahmaputra at Sadiya, who journeyed up from the Bengal. Four American Missionaries who struggle through the tiring days to North East may be worth mentioning, namely: Nathan, Eliza Brown, Oliver and Harriet Cutter. Also some pioneers whose contribution to mission in Assam were the Browns, the Cutters, Miles and Ruth Bronson, among the Garos were Marcus, Mason, Elnathan Philipps, Fedelia and Ella, among the Nagas were Edward, Mary Clark, Charles and Anna King, and William and Alice Pettigrew among the people of Manipur. The first person to respond to their teaching of gospel for the entire North Eastern region was by name called Nidhi Levi, was converted to Christianity at Jaipur on June 1841. After four years later, i.e on 1845 the first indigenous Baptist Church of the region was established in Guwahati. There were three branches at Sibsagar, Nagaon and Guwahati, and each of these branches was made into a separate church. In order to have a common fellowship the Baptist Association of Assam was created though not survives later.

The beginning of twentieth century is seen as the expansion of mission and sprouting of Christian communities in the region. Though many associations were developed this was on the structures of linguistic and geographical parameter. Assam Baptist Christian Convention was formed in 1914, truly in order to serve the purpose of bringing all the churches together in one organization, i.e. the American Baptist Mission. In 1950, the associations which were related to the American Baptist Assam Mission formed as organization called the Council of Baptist Churches in Assam, later it was changed to the Council of Baptist Churches in Assam and Manipur. The present name CBCNEI was created from the two organizations- the Assam Baptist Christian Missionary Conference and the Assam Baptist Christian Convention in 1959.[24] This was

[24] Downs (1971), p. 184.

a process of indigenization from the American mission society of shedding responsibility and the major shift from mission to the church in common.

Today, the CBCNEI is one of the largest church organizations in India. The Council has a membership from church association mostly the Baptist churches in North East India. It has six members' church conventions. Those are: Assam Baptist Convention, Arunachal Pradesh Baptist Convention, Garo Baptist Convention, Karbianglong Baptist Convention, Manipur Baptist Convention and Nagaland Baptist Church Council. Under the 'health care ministry' the Council is closely monitoring the "Kangpokpi Christian Hospital, Kangpokpi Manipur.

B. Manipur Baptist Convention (MBC)

It was the long standing effort of Mr. Pettigrew that the first Baptist church in Manipur was established at Phungyo, Ukhrul in the year 1902. The second church was established at Keisamthong in Imphal in 1916.[25] Soon after that the third church was established at Tujangvaichong, the first Kuki Baptist Church. The ever increasing of local churches and the widening of missionary movement brought about a new outlook for proper organization which can take up local churches into uniformity among churches. Manipur Christian Association was formed at Ukhrul in November 1916 and the first meeting was held at Ukhrul in 1917. [26]

The Association was re-organized with respect to the tremendous expansion of Christianity to various tribes in Manipur. In 1928 the name association was changed it to the present 'Manipur Baptist Convention' having three associations or circles namely: North East Association, Sadar Hills Association and North West Association. These three associations were operating on regional basis where in some regions groups of tribal dominate others through their population. Later, the Convention felt the formation of

[25] Jajo (1990), p. 38.

[26] Dena (1988), p. 38.

association along with tribal groups, with this increasing diversity the different tribal association was formed and recognized as a separate organization. [27]

MBC is the regional body of the Council of Baptist Churches in North East India. At present there are twenty-eight constituent associations and several full fledged departments under the MBC. Each of the departments is headed by Secretary. Activities of MBC other than that of departmental includes training programmes for leadership, translation of Bible to regional dialects, holding conferences and celebration, promotion of gospel through audio and video media, and annual meetings of the organization. Under its capacity the Kangpokpi Christian Hospital, Kangpokpi Manipur is carried out in day to day administration.

C. The Catholic Church

The policy of British rule in India was then to permit only one Christian missionary to function the denomination. Because of which the Catholic missionary could not reach Manipur as the American Baptist Missionary was already actively functioning in church planting. It was when after the coronation of Raja Churachand Singh that Christian missionaries were allowed in Manipur. Following that Fr. Ansgar Koenigsbauer entered Manipur in the year 1912, the first Catholic missionary to enter the state.[28]

After thirty six years later, two Salesian missionaries, Fr. O. Marengo and Fr. A. Colussi who were working in Guwahati visited Imphal. They met the Maharaja and were allowed to preach the gospel among the hill tribes of Manipur. Having permitted to operate their mission in the hills, the two proceed to Ukhrul where the Tangkhul Nagas lives. The Catholic faith among the Tangkhul Nagas, of course the first hill tribes to accept the faith was brought by Mr. Dominic Shomi former student of St. Anthony's School, Shillong and Mr. George Hongrei former student of Don Bosco School, Guwahati.

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[27] Zeliang (2005b), p. 51-52.

[28] Jeyaseelan (1996), p. 68.

In the history of Manipur, the first ever community to convert to Catholicism was Tangkhul, while in 1952, 33 families with 350 members gladly accepted Catholic faith with the assistance of Mr. Dominic Shomi. With the new converts Catholic the need for Church was realized, till when Fr. Marocchino assisted in establishing the Catholic Church in Hundung, Ukhrul. The Church of Manipur grew in size and reaches every districts of the state. It eventually led to the inauguration of first boarding school in 1958 at Chingmeirong, Imphal. In the meantime the Sisters had also come and started the Little Flower School.[29] Since then the promotion of evangelization work in Manipur was multiplied with the influx of more priests and sisters.

Different parishes sprung up as the new converts keep coming. The diocese of Kohima-Imphal was erected in 1973 for the Nagaland and Manipur state with Rev. Abraham Alangimattathil as its first Bishop. Again the diocese of Kohima-Imphal was divided and the new diocese of Imphal was erected in 1980 by Pope John Paul II. Bishop Joshep Mittathany who was then the Bishop of Tezpur (Assam) was installed as the first Bishop of the Diocese of Imphal.[30] Later in 1995 His Holiness, John Paul II raised the diocese of Imphal to the status of an Archdiocese with Rev. Joshep Mittathany as the Archbishop.

Now the Catholic Church in Manipur has 36 parishes across the state, with 74 diocesan clergy, 37 other religious priests and 207 religious women. Numbers of institutional establishment are operating under the Archdiocese of Imphal. There is one graduate college, 1 technical institution, 3 senior secondary schools, 32 high schools, 49 primary schools, 1 hospital (Catholic Medical Centre, Koirengei Imphal) and 25 dispensaries.

D. The Evangelical Free Church of India (EFCI)

The Evangelical Free Church of India was previously known as the Indo-Burma Pioneer Mission (IBPM). Again the Indo-Burma Pioneer Mission was curved out from the North East India General Mission (NEIGM), formed in 1919 by Rev. Watkin Roberts

[29] Ibid., p. 71-74

[30] Downs (1992), p. 125.

a Welsh Missionary. Rev. Watkin Roberts was the private helper of Dr. P. Fraser at the Welsh Mission medical clinic at Aizawl in 1908. He was at his heart felt the need of establishing an independent mission field anywhere in the south Manipur hills. The call for this mission was so happened that a heathen tribal chief ask his explanation about the God whom Christians were talking at the village. Roberts took it as the calling for lost soul and seek the permission to cross the border, and eventually the permission was granted by the Political Agent of Manipur. With the request of chief and offer of his land for a mission station, Roberts immediately recruited native workers among the new converts for the new pioneer mission at Senvawm (or Senvon).[31]

It was understood among the missionaries that the whole of Manipur was exclusive field of American Baptist Mission, the coming of other mission societies or individual missionaries were taken as intruding the field. In the meantime, in 1911, the Secretary of American Baptist Mission had passed a letter to Rev. William Pettigrew stating that they wanted all particulars of the Kukis of Manipur with the view to extend their work among them. The letter also enquires whether Dr. Fraser and Roberts or Welsh Mission intended to work in Manipur. In this, Roberts replied by stating detail account of work done in the southern hills by an undenominational pioneer mission of which he was the founder. With this news brought misunderstanding between Roberts and Pettigrew.

At this point, Pettigrew immediately got an official order from the Political Agent of Manipur prohibiting the entry of Roberts in the state. Thus, the new mission station was manned entirely by the native workers even as in the absence of Roberts. To avoid the scour of American Baptist, the Welsh Mission kept them aloof from the conflict, and Pettigrew did not pursue the matter because of financial constraint. Finally, Roberts changed the new pioneer mission into the 'North East India General Mission' in order to do away the conflict.[32]

The smooth functioning of this mission comes to an end when suspicion and misunderstanding crop up against the mission funds utilization. One group supported

[31] Dena (1988), p. 49.

[32] Ibid., p. 51-53.

Roberts while others sided with Mr. Coleman. Mr. Coleman with an intention to solve the problem case a file against Rev. W. Roberts and his followers in which the later did not turn up. The court upheld the cause in favour of Mr. Coleman, and given him the NEIGM. However, Rev. W. Roberts in his turn founded a new Mission called 'Indo-Burma Pioneer Mission' just because of early converts Christian to spread the gospel to Burma (now Myanmar).[33]

On the plea of Mr. Coleman, the Government of Manipur termed the Indo-Burma Pioneer Mission outlawed making difficult for the followers of Rev. W. Roberts to retain the name IBPM within the state. Thus the culmination results from prohibiting avail separate name as 'Independent Church of India', majority of the population were from Hmars tribe. They opened a mission centre at Sielmat, Churachandpur in 1930.[34]

In 1958, the Mission was under the new native leadership of Rev. Rochunga Pudaite, which in his capacities changed the name of the mission to 'Partnership Mission'. Later in 1972, with the ever growing of local churches, the organization of these churches in its annual meeting adopted the name 'Evangelical Free Church of India' to become a separate identity from the Mission. Now the Partnership Mission is running the Sielmat Christian Hospital, Churachandpur. The EFCI headquarter is shifted from Sielmat to Shillong, Meghalaya in 1979 having residential for the president and departmental secretaries. It is currently operated in 14 districts of North East India and the church planting activities are underway in the Delhi area, Chandigarh, Patiala and Uttar Pradesh.[35] [36]

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[33] Jeyaseelan, op. cit., p. 91.

[34] Jajo, op. cit., p. 46.

[35] Jeyaseelan, op. cit., p. 111-113.

[36] Historical Background (Online: Web) Accessed on 2 June 2009, URL: http://www.efci.org.in/about%20us.htm.

C. Kuki Christian Church (KCC)

The Kuki Christian Church is a non-denominational and indigenous church organization belonging to the Kuki tribal people of Assam, Manipur and Nagaland states of North East India. It's headquarter is in Imphal the capital city of Manipur. The coming of Christianity among the Kuki community is almost hundred years now, and the majority of the population follow Christianity, which account of nearly 95 per cent of the total Kuki population.

First of the two Christian missions that had brought Christianity among the Kuki community were the Baptist and the Presbyterian. The Baptist mission considerably maximize their work along the Kukis of Manipur, Tripura and Burma region, while the Presbyterian mission extensively set their foot in the North Cachar hills and Lushai hills. From 1910 to 1947, there was little known of their differences in respect to medium of dialects being used in church services, and were very much in one organization under the North East India General Mission. After the growing number of churches in different parts of Kuki areas in Manipur, the new churches cropped up as there were confusions and misunderstandings with regards to church doctrines, funds utilization and the most specific difference was started from the linguistic line or tribe-wise to be called. With this regards numerous church group got divided into different denominations.

In 1986, the erstwhile North East India General Mission was renamed as 'Evangelical Congregational Church of India' (ECCI). Under the constituent of ECCI, there are numbers of Presbyteries associations which operate in different part of North East India. Seeing this as a dis-integrity among the Kuki tribes, the leaders from different church denomination came together at Keithelmanbi military village in 1959 to see the reason of disintegration of Kuki Christians and to control further divide among them. It was decided to form a Christian literature organization to look for commonly spoken language. In the same year the delegates from all denominations met again at Molnom village to discuss the heart of the matter. In the conference the federal organization of Kuki Christian called 'Kuki National Christian Council (KNCC)' was formed comprising all the Kuki Christian denomination organizations.

In the month of August 1959, the name KNCC was changed it to 'Kuki Christian Council (KCC)'. This changed of name has brought attention to the American and Welsh missionaries as they were in condition that if unification does happen then they would have to leave the field, thus functioning of council was stopped for while. However the leaders of unification movement revived the work in the late 1970s. In the year 1977, a conference was held at Nomjang, North Cachar hills, Assam and a resolution was passed to transform the 'Council' to 'Church' which is currently being used.

The Kuki Christian Church has established the 'Christian Hospital, Imphal' under the medical mission department of the organization. It was established by which the prevailing situations where outbreak of HIV/AIDS, poverty, lack of access to medical facilities, unable to bear the cost of treatment, no modern technology for diagnosis and on top of that the operation of insurgent groups compelled to open a people needed hospital. The hospital is being sponsored by the 'Fellowship of Associates of Medical Evangelism (FAME)' of United States.

3.4 The Missionaries' Motivation

This section will discuss the motivation of missionaries towards the establishment of medical care broadly in the context of the studied missionaries' hospitals. In many occasion religion is interpret as the mission to heal and to minister to the body and the spirit. This has been the motivating impulse for the medical work is as remained a driving force. One need to ask what motivate them and what was the immediate caused that has led to the present situation.

The philosophy of 'serving to human being is serving God' may be considered optimistic in the current study because the values and principle of Christian ethic has embedded enough to show them in the manner of care and healing of the sick people. The present study in a positively suggested that majority of the missionary hospitals emerged so as to tackle the social problems (like poverty, ignorance, unemployment, high mortality and morbidity of disease, spiraling of health care service charges, lack of health facilities, etc.) that has affected the health of the people in Manipur.

There is nothing less that push for creating hospital among the Christian church groups was carried out with the understanding of "Christians' care for sick and down trodden". Hospital purposefully was established to care for those who could not go for treatment at other states, which involved lot of money and time consuming. Many of the Christian hospitals were started due to the prevailing situation of unhealthy socio-economic conditions and the deteriorating of healthcare facilities.

In the same manner the prevalence of poverty, illiteracy, ignorance, insurgency, pandemic, high incidence of diseases in the area are some of the logicality behind obligation to open dispensary and hospital. Adding to this aforesaid points Mr. Haokip conditions, the establishment of hospital as *'majority of our people (the Kuki tribe) could not speak Manipuri language and there are lot of problems arose even when admitted to hospital because of this barrier'.*[37] This may however be said that those hospital are readily commensurate with the socio-religious affinity lines. It seems that socio-religious aspect of the tribal has made them a responsibility to cater their own people. Perhaps the motivated synthesis was the religious, socio-economic and health condition and above all to cater the tribal population if perceived tribal Christianity.

The convincing character of Christian establishment of hospital is clearly shown in terms of their faith and their professing. Firstly, as we are aware that those who believe in Christ shall be like him, which means in term of service to the people they should be shown mercy for the sick and care him, love for the down trodden, give comfort, shelter, food, (project as good Samaritan), and after that tell them about the love of God. This is also taken as the commandment one has to follow in order that the unbeliever may come to know Christ. By this way the motivation was enhanced for establishing hospital.

3.5 Characteristics and Distribution of Christian Hospitals

The history of medical care in Manipur is closely link with the coming of Christianity in the state and their growth. It is seen in the earlier section that many

[37] Interviewed on 23rd March 2009. Dr. Haokip is a Senior Medical Officer of the Christian Hospital Imphal.

Christian hospitals were set up by the mission agencies and church organizations. Christian hospitals are growing in numbers while playing significant role in providing health care to the people. Comparatively the Christian hospitals are small and medium in size but mostly in rural areas of the state. This section narrates the characteristics based on the primary data collected from the five selected hospitals.

The Christian health care mission in Manipur is almost a century of progress. The growth of Christian hospital is largely seen as post Independence factor. It means to subscribe the local church organization candidly been constructive to set up as many hospitals as in the hill districts. We may say the fruit of the Christian missionaries is reaping in terms of setting up new hospitals in rural areas. Therefore, the breakup of Christian hospitals is presented here under:

Table 3.1 Christian Hospitals in Manipur

Name of the Hospital		Catholic Medical Centre, Koirengei	Christian Hospital Imphal	Kangpokpi Christian Hospital, Kangpokpi	Leishiphung Christian Hospital, Ukhrul	Sielmat Christian Hospital, Churachandpur
Year of Estab.		1999	2003	1920	1999	1964
Church affiliation		Catholic Church	Kuki Christian Church	Baptist	Baptist	Evangelical Free Church of India
Location	District	Imphal West	Imphal East	Senapati	Ukhrul	Churachandpur
	Rural/ Urban	Urban	Urban	Rural	Rural	Rural
Bed strength		150	30	60	50	25
Services offered®		OPD, ENT, Gynae & Obstetrical cases, operation facilities, Inpatient medical & surgery, HIV/AIDS CCPT	OPD, Gynae & obstetric case, general medicine, Inpatient medicine & surgery, pediatric-ian	OPD, general medicine, inpatient, operation facility, Nursing School for Female Health Workers (ANM)	OPD, general medicine, gynae, inpatient, operation facility, DOTS centre.	OPD, general medicine, gynaecology, inpatient-medicine &surgery.
Specialties offered		Key Hole surgery & Arthroscop ic surgery	No	No	No	No

Outreach service & Programme	Medical Camps	Medical Camps	Community outreach programmes + Health Camps	Medical Camps	No

@Indicates that all the hospitals has X-ray machine, ultrasound machine, ECG, and laboratory.

Source: Questionnaire and Survey 2009.

Distribution of Hospitals across Districts

As per the Table 3.1, the Christian hospitals are distributed in five of the districts of Manipur. If we see the representation of hospital in the distributed table, then we are able to say those hospitals are skewed towards the more developed areas. There is not much variation as almost all the hospital buildings stood in the heart of the town or near the town. This, if we say that Christian hospitals are working for the rural population will henceforth misleading the population though they are sincerely working in the 'rural areas' of the state. Among the hill districts, the more developed and advance are the Ukhrul and Churachandpur. Beside that they received Christianity earlier than the districts of Chandel and Tamenglong. Therefore, the resulted breakup of Christian hospitals is adjusted to the region where the social development has occurred.

Rural-Urban Distribution

According to 2001 Census out of nine districts, four districts show rural only, namely the Ukhrul, Senapati, Churachandpur and Tamenglong. We see the distribution of religion in Manipur in the Table 2.6 of the Chapter two that the four districts have a Christian population of more than 90 per cent except the Senapati district in their respective areas. As we see the Imphal East and West districts are in the urban areas with the Christian population of 4 per cent and 5 per cent respectively.

Location and Area of Operation

The above discussion has brought some knowledge that most of the Christian hospitals are concentrated in the areas where the development is much more advanced. The area of operation each hospital is rendering may be understood as how much the service is popular among the patient population. Each hospital some how operates in their spheres of denominational attachment. It meant that church affiliation of the hospital is very much vibrant string of attracting.

The location of the Christian hospitals is centered on the most strategic point of activity in the town. Furthermore, they are central for the patients as the distance is a hindrance for visit. Most of the Christian hospitals are situated in the semi-urban and urban areas of the city or at the adjoining areas of headquarter of the district. The Kangpokpi Christian Hospital is situated at the Mission Compound, 4 km. from the town of Kangpokpi. And the Leishiphung Christian Hospital is at Somsai village, 11 km. from the Ukhrul headquarter town. The other three hospitals are in the city and town respectively.

The location of a hospital has a vital role in its operation to the adjoining areas as well. Based on the type of services in the hospital the line of operation was elaborated. Again the church denomination of the hospital has a tremendous influence on the areas to which the hospital will operates. Catholic Medical Centre operates as a referral centre for all the Christian hospitals of the state by being provider of specialist care and intervention of different diseases. CMC has its dispensaries in different parishes and schools. The level of operational areas is beyond the block. Therefore, with regards to services provided by the CMC and the tertiarical intervention to medical care has placed the hospital as centre for majority of the Christian hospitals of the state.

Leishiphung Christian hospital operates in wider areas as it is the only private hospital other than the Government Hospital and the district also bordering Myanmar which subscribe to more population. The adjoining areas to Ukhrul district of Myanmar villages have no medical facility. Thus, the areas of operation exceed to the region of Myanmar border villages. Most importantly the hospital in the Imphal City has a lot to do

with the view that they have better equipments and even the needed major operation can be done just because of the city. This is to say that many patients from far flung areas come for treatment not that it operate on those areas.

Characteristics of the Administration

Each of the hospital has their own ways of administration style. Depending on the availability of manpower and size of the hospital, the way in which style of administration is perfected through election of senior member or sometimes elected by the board members.

Table 3.2 Head of the Administration

Name	Institution	Hospital	Chapel
Catholic Medical Centre	Director	Director Superintendent post vacant	Father
Christian Hospital Imphal	Senior Medical Officer	Senior Medical Officer	Chaplain
Kangpokpi Christian Hospital	Medical Superintendent	Medical Superintendent	Chaplain
Leishiphung Christian Hospital	Director	Medical Superintendent	Chaplain
Sielmat Christian Hospital	Administrative Officer	Administrative Officer	Administrative Officer
Source: Questionnaire and Survey 2009			

Organizational Characteristics

A characteristic of the organization differs altogether in respect to their functions. The function may symbolize the organization services or rather becomes activity in day to day operation. The organization characteristics is comprised of many factors like the size, network, partnership, alliance, staff professional and the focused medical team ready to serve. If these factors are better prepared then the organization may able to attain the satisfaction of the people.

We may well be understood organization as the moving forward in carrying out their key operation of daily activity. The size of an organization does really affect the function and give rise to breaking of different departments. In Christian hospital especially in Manipur, one can see small size and are easily maintained with no hassle for getting job done. The structure of organization is largely depended on the size of the organization.

A. The Residential characteristics

The present study suggested that majority of the missionary hospitals are providing the services through residential set up.

Across all the hospitals, one character is common that all of them have their own the land. Two out of five hospitals have a residential place for medical staffs. In most of the hospital the residential medical officers do not stay in the campus. The buildings are *pucca* built and majority has first floor of the building. Among the five Christian hospitals, two hospitals don't have enough spaces as they are in the congested residential area.

Characteristics of the Services

The characteristic of the services that are provided in the missionary hospitals whether be in the initiation of health care or medical care related to preventive, promotive or curative aspect are thus reflected in their services. In this section of characteristic of service we can put across some question- do they provide training or others health programmes for the community? What aspect of intervention being taken care of the service seekers? It is to see the entity at which missionary hospitals are being rooted in the depth of service providers may however be looked from the service they provide. We may see the different kinds of service being provided in the mission hospitals as based on the present study.

A. *Nature of service*: The nature of service is broadly categorised into institutionalised and community outreach services. Thus, the broad points are discusses here under:

Institutionalised service: The institutional services are which that provides service through or within the institution of hospital. In most cases of the present study suggests that institutional services are provided for those who seek medical attention. The case whatsoever of missionary hospitals has its valid taking on the institutional service because of their formation of medical staffs and others related department associated with it.

The present study suggests that dispensaries services are providing under the Catholic Church. There is no other religious group promoting dispensaries in the state.

Community Outreach services: Community outreach service is which service reaches the community. Mission hospitals in a broad sense shared their expertise not only in the hospital but have shown concern through the outreach programmes and service to the people who could not come to hospital. Most of the hospital have their own way of outreaching the unreach people. Medical Camps were held mostly in villages depending on the call from village. We can assume it as a gesture towards the popularity of hospital rather than the needful work, when it comes to the demand of people. This may even suggest that those hospitals that have enough manpower could only perform this kind of task at their busy schedule. Among five Christian hospitals, only Sielmat hospital doesn't have outreach services though doing well in their institution.

B. Areas of services

Every hospital has a definite type of patient drawing from different parts of Manipur. Depending on the kind of services the hospital is providing subsequently draws the patient. It seems to capture a picture in Manipur that mostly the hospital which is highly developed in acquiring of equipments and others related technology of the speciality concurrently attracts people even from far off places. Taking Catholic Medical Centre as an example, where many high ends equipments are equipped to serve the ill stricken patient.

The kind of services providing in the Christian hospitals are normally the out-patient, gynaecology, pediatric care, maternity service (includes delivery, pre-post natal care), in-patient for medicine and surgical case, obstetric cases, and operation (minor and

major). The other service based on the diagnostic are X-Ray, Ultrasound, ECG, and laboratory testing. Amongst these services, the maternity service and operation facilities observed a higher patient drawing from these services. However, the nature of service is very much influence by the fact of specialist in the concern department and the staff professionality.

The field of services provided under these institutions is basically the curative. The most important aspect of Christian hospitals is the continuing growth of services in curative nature and interacts with the opportunities open through it.

C. Healing and Counseling services

Healing and Counseling service also serve as the addition to the hospital function. It is a process to bring the body and mind into the radiance of Godliness, so that whatever the illnesses may it be, shall find deliverance and healing. A chapel functions as the religious solace for those who seek God in the premise of hospital. In the chapel services, the Chaplain or the religious priest ('Father'-in Catholic) administers the religious prayers. The role of chaplain is important in this service. A chaplain does all the prayer, healing and counseling of a patient in the hospital. Moreover, this is a kind of inviting the Holy Spirit to heal the troubled body through the initiation from religious priest, so also to admit the presence of Jesus Christ.

Was that the evangelization built into the institution? Missionary hospitals in its evangelistic activities largely integrated the 'ward prayer' and pray for the patient who is awaited for the treatment. Such was the case that the researcher personally observed in some of the mission hospitals. This was carried out with giving religious teaching that God alone can heal and can be taken away the illness. A prayer service was integrated with hospital ward visits as a discourse intertwined in the policies of the hospitals in its ideal.

Financial Characteristics

To see the financial characteristics of the missionary hospital, mentioned be made in terms of their land owning and building constructions, paying salary for the employees, the method of purchasing equipments and their sources of fund in the following lines.

A. Land owning and building construction

To establish institution it needs land and the land acquiring process is altogether different in different place depend on the size and utility of it. The present study enquires the mechanism at which how they own the land through their own capital or any other sources. In most of the study reveals that majority acquired land through their own investment but it was not certain how much was the cost of the land at their buying price. When asked about how they got such a money to acquire land, they suggest the nexus of church supporting groups contributed the much money as mostly mission hospital are owned by groups of church organization.

Donation drive was carried out in the churches for the construction of hospital in religious meetings or through individual contacts. Well wishers were encouraged to fund the construction cost at many instances revealed the studied hospitals.

B. Salary and purchasing of equipments

The paying of salary for the employees suggests a character which defines the inate affinity that mission hospital does not pay a good salary. Within the system of medical fraternity the salary among medical professional working for public, private and mission differs a lot. Here in the present study which is predominantly the mission hospital set up found out that lesser amount of salary were paid against the high private hospital. Though this being the condition, the medical personnel working in the mission hospital justify that they sacrifice and are happy about it of what little sacrifice being done.

Of all the mission hospital, the Leishiphung Christian Hospital is contrary to the above mentioned proposition because they are paid handsomely from the sponsoring groups of United States. When asked about the pay, the medical superintendent of the

hospital brought about the issues of financial meltdown at United States and hence the salaries of the staff were delayed.

In pursuance to the purchasing of equipments for the hospitals effort and mechanism at which those are carried out may be seen something that brought light to the connection with the foreign aids of some mission hospitals. This acquiring of instruments has placed highly tactical as one equipment need a tremendous exercise of getting mechanical and staff ready. Sources from the interviews with administrators and other workers of the mission hospitals throw light towards the funding system and getting things arrived.

Leishiphung Hospital directly received equipment from United States where others mission hospital due take equipment from within the country. The equipments were delivered from the United States sponsored groups without spending huge money on it until arrived at Ukhrul. Many of the others hospital didn't have a close contact with the foreign national for that purpose. It is observed that only the Leishiphung has its contact.

C. Sources of Fund

Christian hospitals basically rely on their daily earning through the user fees and other medical fees for their survival. Though the institution was established by church organization but the source for financial mechanism was not addressed. For most of the Christian hospitals the state, central fund were not received but were attached with Maternity and Child Health programmes along with the National Rural Health Mission of the Manipur Government. They are able to collect few amounts due from the institutional delivery in case if delivered in their respective hospital.

State and Central Government did not necessarily help Christian hospitals through providing of financial assistance until it hard fought through the long and corrupted ways to get the assistance. Some hospitals engaged in 'Doctor without Frontiers or Medical Sans Frontiers' for technical support in times of medical camps. They do receive a small marginal amount of money through holdings various medical camps, or any such relevant activities in their respective field areas.

Every possibility were work out in order to get some help from foreign aids considering the denomination the hospital adopted and the kind of services they provide. This has become one of the drawing attention pieces of work being conducted. Some of the hospitals got 'White Cross Fund' but majority says they didn't. All the missionary hospitals have FCRA act adopted for financial transferring easy.

D. Budgeting and reports

The accountability shown in regards to the financial mechanism and reports of the institutions are varies depending on the organisation. This meant that for the type of affiliation with religious denomination groups in which they have to show how it was performed and materialised the way it has to be. It may be understandable enough to let us learn that those mission hospitals are accountable to the funding agencies or the groups which are sponsoring them but have not shown to public usage. All the selected hospitals for study were not materialised in making budgets annually as most of the hospital depends largely on user fees.

It is observed the nature of keeping records and writing about how the institution function when necessary target and improvement need great enthusiasm to put into paper were deprived by the loaded daily chores in the hospital. The scrap list of figures in most hospitals seen hanging on the wall but require more rigorous work on putting the right figures for critical evaluation of the services being provided.

E. User fees

Rising cost of the everyday commodities has affected the present scenario of the Christian hospitals. Also the competitiveness of the private hospitals in health and medical services have very much change the mission hospital to reconsidered the user fees in order to keep up at par with the private institutions. It would be an important earmarked to see whether the service is compromise with the user fees in the mission hospitals or not.

For the reason to accommodate the expenditure and the future prospect of the hospital the services which are commonly natural to the locality are dearly charged.

Sources of the study suggest that most of the mission hospitals could hardly have a balance even when such user fees were levied upon patients.

Health Staffing

Health manpower indicates the overview of distribution and disparities of trained medical practitioners in a given time and institution. The manpower of the missionary hospital are put across in the following to show how the doctors, nurses, para-medical and other health workers are concurrently working in this set up. Some of the data provided by the State and Central Government on Private Hospital, especially the Manipur could not be wholly taken as errors are found. The breakup of staffs' position in different Christian hospital is shown here below:

Table 3.3 Staff Position of different Christian Hospitals in Manipur

Sl. No	Name of Hospital	Doctor	Nurse	Chaplain	Pharmacy	Technician	Driver	House keeping & other
1.	Catholic Medical Centre	16	28	01	Maintained by Nurses and Sisters	01	02	60
2.	Christian Hospital Imphal	04	20	01	02	02	02	12
3.	Kangpokpi Christian Hospital	02	08	01	Maintained by Nurses	02	01	20
4.	Leishiphung Christian Hospital	03	08	01	Maintained by Nurses	02	03	12
5.	Sielmat Christian Hospital	02	09		01	01	01	07
6.	**Total**	**27**	**73**	**04**	**03**	**08**	**09**	**111**

Source: Questionnaire and Survey 2009

The position of staff among the missionary hospital varies accordingly to the size of the institution. Basically the mission hospital has a number of consultant and close contact with those doctors who are working at the government hospitals. Depending on

the case of the patient, the consultant comes into contact. For instance, for a major operation General Surgeon is contacted from state hospital.

Qualified doctors are less seen in the mission hospital as the selected study look into the specialisation and higher qualification of the employed doctors. Only two mission hospitals have higher qualified doctors while others manage by just medical graduate. It also largely seen in the present study that those hospital which are comparatively bigger in institutions keep larger number of staffs. Differentiation of service with regards to gender regardless to the professional qualification is also seen in Christian hospitals in Manipur. The data of the medical staffs and other para-medical staff of the hospitals show some inclination toward 'pro-gender' job. Citing an example, the nursing work is carried out mainly by the female while administrative and other related work is done by male, though not all.

Population Coverage

Table 3.4 Average Population serve by Missionary Hospital

Particulars	State/District Population	Population Per Doctor	Population Per Nurse	Population Per Hospital Bed
Catholic Medical Centre	4,44,382	27,773	15,871	2,963
Christian Hospital Imphal	3,94,876	98,719	19,743	19,744
Kangpokpi Christian Hospital	1,56,513	78,256	19,564	2,608
Leishphung Christian Hospital	1,40,778	46,926	17,597	2,816
Sielmat Christian Hospital	2,27,905	1,13,953	25,323	9,116
Manipur*	21,66,788	80,251	29,682	6,879

*Excluding Mao-Maram., Paomata and Purul sub-divisions of Senapati District of Manipur.
Source: Questionnaire and Survey 2009.

Aims of the Organization

Two themes evolve from the present study. Firstly, the mission hospitals at large want to improve in their infrastructural development. Secondly, out of five hospitals studied, two hospitals prepared to open nursing school for General Nurse Midwives courses in the future.

So far as the infrastructure of the mission hospital is concern the available equipment and building are needed for up-gradation. This infrastructure talks about two broad areas. One is the building completion and on the other hand is the equipment. Majority hospitals aspire to finish the construction and keep the necessary equipment placed properly so that patient is treated without any problems. They felt the need of having better technology in order to explore the untreated case as it was in the past.

Difficulties and Problems

The main important problem that mission hospitals face is good leadership. It will be a blessing when a good leader who has integrity and able enough to bring development in the institution. Most significant among all difficulties is the selection of medical doctor who have the comprehensive medical education and a good Christian character and behavior. The desire of the mission hospital is the one who is intellectually capable, spiritually sensitive to the needs of the patients and able to minister them spiritually as well as medically. Such were the criteria of a responsible doctor in Christian hospital which is hard to find as medical doctor don't perceive themselves going to mission hospital.

Mission hospitals as a charitable institution did not free from all sort of problems related to the running of institution, equipment, salary, threat from the underground groups, human resources and communal tension in the state. Due to the prevailing situation of state development the most deserve work can not be done in an ease. Situation was such that before every step to furnish work the authority of the concern hospital has to see whether it can be carried out in within their capacity or to get clearance from various underground groups.

Running a hospital is not a simple task especially in Manipur because of the presence of many underground outfits who for many times came after taxes of many kinds. The institution of hospital is seen as somewhat the estate one has built up. So the problem related with underground outfit is important to negotiate it first before everything put into practice. Due to the frequent movement of such groups affect the hoarding of hospital equipment. Without this knowledge, functioning of mission hospital is one of the impossible things.

Field Observations

To the above aforesaid discussion has brought light to the missionary hospitals whichever ways of services being provided to the people of Manipur. The kind of orientation in the services which are exclusively been provided in the missionary hospitals can be viewed largely with the curative aspect of health care.

The present studied mission hospitals are becoming the most emerging growth due to the poor infrastructure and lack of government investment in health, and the demand for better health facilities by the rising middle class groups in Manipur. An equal addition this is the changing pattern of disease. For example the affluent diseases are on the rise and the cost of per episode is costlier.

It is nevertheless the handsome return of investment in health care that has impinged in the religious groups and not only to serve the undeveloped people or the community but has an immense citation of commercial value in it. At this juncture of weakening care culture for the infirm and sick, the positive question can be asked how these mission hospitals as service providers take notice of their role in making good health outcome. In an attempt to deliver services which are marginally occupied the central sphere of their activity refers to most basic curative form of orientation.

The curative aspect of health is rather a minimal consumption of money and human resources as it is in the hospital set up. If taken others form like the preventive, promotive and rehabilitative care, it could not empower because of the need of these activities were many.

For the reason of making profit and business in the health care services, the missionary hospitals are very much in tune with both the ways in which profit is earned with proper and hardwork and use it for the service of others. In this very assessment, the profit which is earned should direct it to the development of activities of community and the subsidizing the poor patient whose economic conditions are poorly performed. Therefore, such understanding could establish equity among the service seekers with no partiality.

As it is noted above that the mission hospitals are inclined towards the services of curative aspect than to others. We generally assume to be generous at their services but how such condition was at time posed them to subsidize the cost of treatment belonging to poor family is a question still quandary.

Now let us look into the question who is serving whom? It is crucial to note that the range of services available to the people is in varying across sections of people. There are some factors that have affected the utilization of service available correspond to the prevailing dependent economic and geographical surroundings. Field data collected in the selected study suggest that majority of the in-patient and out-patient belongs to the lower and middle class families. Few cases of very poor patient were seen when compared with patient from both the inpatient and outpatient.

It is observed that income still a binding factor which before coming to mission hospital assessed of their own knowledge as to how much will they be able to pay. This being done in what they said to avoid the uneasy sense of loosing self-spirit in the mission hospital premises. When such self inspection of abrupt means and measure of financing the treatment is suggest go ahead then followed by admission to the hospital. Therefore, even in the mission hospitals, the kind of cost that is employed does not really apply to the poor patients.

CHAPTER 4

ROLE AND CHARACTERISTICS OF MISSION HOSPITAL IN MANIPUR

- *Health and Health Services in Manipur*
- *Proportion of Mission Hospitals in Health Services Delivery*
- *Characteristics of Christian Mission Hospitals and their Role in Health Services Delivery*

4.1 Health and Health Services in Manipur

The concept of 'Health for All' that was put forth by the Alma Ata conference on primary health care in 1978 has been influential in shaping health policy worldwide. This approach highlights the principles of universality, equity and comprehensiveness for achieving the objective of health for all. The financing and provisioning of health care is seen as a responsibility of the government with 'for-profit and non-profit' sectors playing a complimentary role. It is well known that there are several gaps in the provisioning of health services in terms of availability, accessibility and affordability. There are rural-urban, inter, intra state gaps in the availability of infrastructure, human resources, supplies in the public sector. The private 'for profit' sector does little in terms of redressing these gaps since they are mostly located in urban and better developed areas. The 'non-profit' forms a small segment of the private sector and is mostly located in the better developed regions within states.

The need for serving marginalized populations was realized by the Christian community. To run the medical care services, hospital became an integral component in Christian vision for care and sick. The medical mission invested in hospitals to provide health services for those who could not get services from public and private due to their socio-economical constraints.

In the present study, the researcher has been able to understand the nuances of the state provision to health care services in both the hill and valley areas. The state health care services are based on the Primary Health Care approach. Most of the hill districts population is served by the Christian mission hospitals though District Hospitals of the state operate in deteriorating condition.

Manipur is a hilly state with a population density of 103 per sq.km. The state is divided into nine districts, five hills and four valleys. Five hill districts formed the 38% of the total population. The land is inhabited by numbers of tribal and sub-tribal communities. Population profile may be divided into three communities, i.e. the Meitei (Manipuri speaking people), the Nagas and the Kuki-Chin tribes. The state is home for many cultural and multi-religious groups. The Meitei population crosses over 70% of the total population. Two dominant religions is seen in the Table 2.6, that the Hindu religion formed 57% while 34% are Christians, and others comprised of Muslim, Sikh, Jain, etc.

The rural population in the state is 73%, while the other 27% is composed of urban areas. The population of Manipur constitute about 0.22% of the total population of India. As majority is formed by the Manipuri people, the state adopted Manipuri as the state language. According to the Manipur State Development Report the development is concentrated in the four valley's districts. Almost all the five hill districts are untouched by the infrastructural development. The improvement seen in those hill districts are the education facilities. There is a long way to go along with the valley population.

Health status of the state is seen as good compared to other states in India. How a state which is less developed and economically not strong has good health outcomes is a mystery. Some health indicators of Manipur are showing improvement although the ethnic conflicts and insurgency problems is disturbing its good functioning. It is also seen that the allopathic hospitals and services are comparatively more than the traditional medicine system. The pattern of government spending on the development and infrastructure of allopathic medical system is encouraging while the traditional system of

medicine is dying out in the state. There are indications that most of the tertiary health care facilities are situated in urban-valley areas.

Infant Mortality Rate (IMR) in the state is one of the lowest in India. Even as the state enjoys the lowest rate, the differences are observed between rural and urban areas. For rural areas the rate is 13 while the urban is at 9. Birth and Death Rates (Table 2.6) in Manipur have seen declined and suggested the favourable comparison of national level. In the entire North East, the Manipur state fares well comparatively.

Sex ratio of the state is 974 which is better than the national level of 933. But the breakup of rural and urban areas shows variation, rural areas at 966 while urban areas is 1009. The literacy rate of the state shows better than the national averages. Present literacy rate of Manipur is 70% (with 80% male and 60% female literate) which is very much higher than the national averages of 64%. Inter-districts variation suggests a relative backward district within the state. Those are Chandel, Tamenglong and Senapati districts. Unfortunately these districts always come under the most backward and poorly performed in terms of socio-economic and political development.

Organization of Public Health Services in Manipur: Main service providers of the state are the Public Hospital, the private, non-governmental and the Voluntary organizations. The state provides health services through the three tiers approach to the population. Government of Manipur established the infrastructure as per the National pattern of health policy. State government is providing health services to the people with system of Primary Health Care approach. Even as the numbers of health centres are growing, the gaps of equipment and manpower still inadequate correspond to availability of each centres. Table 2.12 shows the district wise distribution of Community Health Centre (CHC), Primary Health Centre (PHC) and Primary Health Sub-Centre (PHSC) of Manipur. There are seven district hospitals, in which five Districts has its hospital with majority didn't work. Only the Churachandpur District Hospital is working in all the sanctioned departments.

The State Health Department is operated in three tier system. At the top, the Cabinet Minister head the organization, at Directorate level the Director assisted in technical and administrative works. And in the district level the Chief Medical Officer head it. There are seven district hospitals in total in Manipur. Five of the hospitals are situated in five districts of hill, and two are in urban-valley districts. The Government of Manipur is establishing the health centre base on the national norms. For the entire state there are only three blood bank facilities. Even as the state has been able to show improvement in the infrastructures of development in different health centres the management in the waste generates from these hospitals were not properly disposed. There is no other incinerator than Regional Institute of Medical Science (RIMS).

4.2 Proportion of Missionary Hospitals in Health Services Delivery

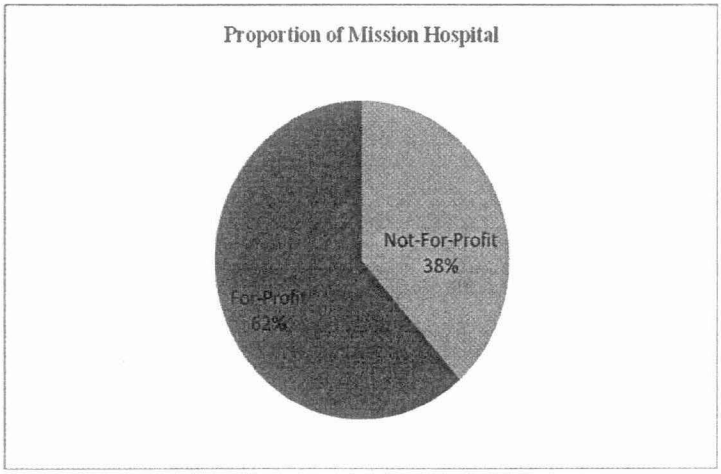
The national experience of private sector tends to focus on profit making and the concerned for public health is less perceived. In Manipur, due to lack of socio-economic and political development, the private sector largely observed its growth and development in the delivery of health services. Within the private sector, the 'for-profit' and 'not-for-profit' are divided. The 'not-for-profit' sector is comprised of Non-Governmental Organizations, voluntary or charitable institutions. This 'not-for-profit' sector is composed of faith-based and community-based organizations. Almost all the Faith-based organizations in Manipur provide general health service but few provide specialized services.

The dominant system of medicine in Missionary Hospitals is allopathic. The nature of services also varies across all the Mission Hospitals in Manipur. In the private sector of health services delivery in Manipur, the not-for-profit sector occupies 38 per cent of the total sector. In the entire health service providers, the faith-based (which is Mission Hospital) organizations comprised only 4 per cent, while the 'for-profit' sector occupies 7 per cent. The private sector shared only 10 per cent of the state total health services providers.

Table 4.1 Health Service Providers in Manipur

Health Service Providers		Number
Public Sector (including CHC & PHC)		102
Private Sector	For-Profit	8
	Not-For-Profit	5
	Total	115
Source: Statistical Abstract Manipur 2005-06, GoM.		

Figure 1 Proportion of 'Not-For-Profit' Hospital



4.3 Characteristics of Christian Mission Hospitals and their Role in Health Services Delivery

Some of the characteristics observed throughout the study of Christian mission hospital in Manipur is that majority of institutions have only two to four medical doctors to mend the services. Para-medical staffs are lacking across the studied hospitals. As far as the establishment is concerned, majority of the hospitals were established in the late

nineties with one established in 1920, and other in 1964 respectively. The mission hospitals in Manipur is a mixture of both the better performed and lower performed in pursuance to their size and area cater to. It is observed that majority of the hospitals landholding has more than 10 acres of land, with maximum upto 250 acres.

This study also provides the variations in bed strength across the mission hospitals. The trend is that bigger hospital has more bed strength and the services are better provided with specialized department.

All the hospital under studied is managed by Christian umbrella organisation or group of individuals. Four out of five hospitals are managed by church group organization while only one hospital is managed by group of individual.

Almost all the hospital has the facilities for minor surgeries but only one hospital has a facility to perform sophisticated operation.

There was no contact with missionary societies until the princely state under the influence of British rule. It was only when that the control of administration in the state affairs was under the British colonial government that the missionaries set their vision on Manipur. The first Christian missionary who started the medical care was the Baptist missionary Rev. William Pettigrew in Manipur. He started schools and preaching among the Tangkhul Naga of the eastern part of Imphal. With the resistance from the valley population he shifted the mission station at Ukhrul. There the education and medical services were got strengthened. The introduction of education in hill areas has amounted to the more converts.

In the previous chapter we have seen the work of medical through dispensary. The work for medical care services was encouraged when the little care being taken received handsome surprise by more acceptances to Christianity. It was accepted that the missionary medicine can better performed because the tribal people were in the believed that when someone is sick he or she is possessed by spirit, which need certain rites to be

performed. But the missionary medicine which is tablet of pain killer or any other pills can relieved them in few matter of minutes.

The hill district health condition was appalling that Pettigrew ask the Maharaja of Manipur to permit him to work in the western hill of Kangpokpi. The permission was granted and the Dr. Crozier from Tura of Assam was transferred to Kangpokpi Mission to look after the medical care and dispensary. In 1920 the Leper Asylum was established and orphanage home came up after that. The small dispensary was upgraded to Mission Hospital Manipur. Later in the year 1958, the Mission Hospital Manipur was christened it to the present name Kangpokpi Christian Hospital. By 1982, the KCH started the course of Auxiliary Nurse Midwifery for the rural population under the affiliation of Assam Nurses' Midwives Council. At present the KCH Nursing School is affiliated with the Manipur Nursing Council.[1]

After Manipur got statehood, the foreign missionary left the state with local leaders continuously struggle the lopsided health services of the state public medical care. Through the local churches leaders the much needed Christian hospital strive to open it energy in the hill districts. In 1964, another mission hospital came alive in the Churachandpur district. This time with no effort from the missionary abroad but through the initiation of church leaders the present Sielmat Christian Hospital stood grandiosely in the heart of Churachandpur headquarter. The medical care through the institutional services was strengthened when in 1999, the Catholic Medical Centre and Leishiphung Christian Hospital established.

Among the Christian denominations, the Catholic Church group is the only organisation supporting the dispensaries service. The role of Christian missionary in medical care in Manipur suggests that in the initial phase much of the work was done by the early missionaries, later there was a growth of Christian hospitals as a result of the hardwork of local church leaders across Christian denominations.

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[1] Zeliang, Elungkiebe (2005) *A History of the Manipur Baptist Convention*, Imphal: Manipur Baptist Convention, p. 137

The motivation of Mission Hospitals in Manipur considered these following: a) the philosophy of 'serving to human being is serving God' is constantly seen the impulse for creating a condition for medical care for the needy, b) the impeding situation of social and economic condition of the state has aroused the Christian leaders to work for health care of the people. Governmental infrastructure on health care seems not appealing in the region where missionaries actively involved. The failing condition of the state government regiment in checking the health situation of the people in rural or hill areas has provoked the missionaries to establish such projects.

Based on our Study we are able to provide insights into the characteristics of Mission Hospitals.

1. **Distribution:** The distribution of mission hospitals seen in both rural and urban areas of the state. Out of five hospitals, three are in the rural areas while two are situated in urban. It is certain in the present study that the presence of mission hospitals in the state is determined by the large Christian community. The determining factor that has its affect on the concentrated distribution of the Mission Hospitals are as; a) presence of large Christian population in the areas, b) Infrastructure and development in the area, and c) Road ways and communication of the area. These three factors commonly accommodated the preposition of concentrated Mission Hospital in those areas which are literally better off.

Even within the distribution, the location of the mission hospital is tangible with better places in districts headquarter. The location thus far have not revealed to the remote areas of the rural region. In this conjunction it is noted that mission hospital almost are situated in the midst of towns and more developed areas.

2. **Area of operation**: The area to which mission hospital operates is largely based on the kind of services they provide. It may be noted that the coverage of each mission hospital define in terms of their location and type of infrastructures they have. Taking the Catholic Medical Centre, Koirengei Imphal as an example, one will find the catching of patient due to their high technological equipment no matter what the other hospital refers to

them. Mostly the mission hospital operates in the areas which government health services are less functioning and are rudimentary in development.

3. **Administration and staffing**: The administration style and leadership is completely differing from each other. In respect to the present study the mission hospital need lot of manpower in administrative post as it suggest many vacant positions. Out of five hospitals studied, only two hospitals have medical superintendent to take control of the daily chores of medical department. Nursing superintendent whose position is to take care of the nurse in duty and wards are vacant in majority of the mission hospitals.

Regarding the medical staff of the Mission Hospitals in Manipur, the scenario is such that mostly the doctors are comprised of government service. They let the patient wait till the doctor of government hospital come. In the finding of the study suggest that Mission Hospitals give the number of medical doctor but deny giving detail of them. They maintained that work is done. If pursue for description of the doctors, they keep them as consultant at last. Through this we may able to know that medical staff is indeed less in the Mission Hospitals in Manipur.

We have seen in the Table 3.3 in the Chapter Four, in which the para-medical staff in the Mission Hospitals is left vacant in majority. The five studied Mission Hospitals of Manipur suggest that only two has qualified for pharmacy operation, and in the technician department the scenario is poorly adjusted. This means the Mission Hospitals maintained the quality through very few individual para-medical staffs. The credible of Mission Hospital is questionable in this regard.

It is observed that the more the administrative functions are performed better the institutions establishment equally better. To cite this point, we found out that the Catholic Medical Centre and the Leishiphung Christian Hospital have directors to look after the institution while having each head of the department.

4. **Characteristic of services**: The services are divided into institutional and community outreach services. In the study, the institutional services were much higher compared to

community outreach services. Medical camps were conducted only to the demand and call from the villages. This suggest two things, one is whether they have priority of institutional delivery over the community outreach activities. And secondly, the mission hospital doesn't have enough medical team to operate in the villages or other areas.

The mission hospital provides services of inpatient-outpatient, maternity and child health care, gynaecology, obstetric, medicine and surgical services for minor and major operation. Services which are based on the laboratory also provide in all the mission hospitals. Most of the services are curative in nature. The reason for curative orientation was primarily the economic as this service make out major proportion of their earning services. There is Specialist service only at the Catholic Medical Centre Imphal. The services are the arthroscopic surgery and Key Hole surgery.

Apart from the above services, there are hospitals whose service is integrated with the state government service. Leishiphung Christian hospital provides a treatment for the Tuberculosis, and is having technical support from the state government. Treatment is done there with free medicine and others related programmes.

Majority of the mission hospitals have registered for the services of Maternity and Child Health programmes from the National Rural Health Mission. They provide maternity benefits to the mothers and child as well.

The state of HIV/AIDS in the state is alarmingly high. So the state government has given the private service providers to open a testing and counseling of the infected patient. With this in agenda, the mission hospitals were selected to do the same. Catholic Medical Centre Imphal (CMC) was associated with the state AIDS Control Society for treatment through inpatient and ODP facilities. CMC is highly standardized in their ethical services with qualified medical team has been able to carry out this service.

Counseling service is also one of the prominently observed in the mission hospital that foster the patient to go for any extend of treatment. Such service is entrusted to enable the health seekers to go for difficult examination and diagnosis if case arises.

5. **Finance**: The financial condition of the various Mission Hospitals under studied were shown highly self-sustaining. The following are observed in the studied hospitals:

a) The processes of getting land and construction of buildings are borne out of the contribution and fund drive from religious meeting and individual contacts. The two hospitals which associated with the foreign aids for construction were the Kangpokpi Christian Hospital and Christian Hospital Imphal. These two hospitals built the hospital with the help from abroad.

b) Salary for the medical staffs and others administrative were almost same in the Mission Hospitals. The salary is lesser than their counterpart in private hospital. Most medical graduate don't think of working among the Mission set up.

c) Majority of the Mission Hospitals in Manipur got the equipment from the foreign help. Some of the hospital got the second hand equipment from World Vision and others. The purchasing of machine was depending on the amount which the hospital can or to ask from abroad. This also a very long process in which the mission hospital has to build up relationship with religious organisation who can contribute towards this kind. Few of the hospital could get equipment because of their joining with different health projects from national and international organisation.

d) The studied Mission Hospitals suggest no sources of fund received from state and Central Government concerning the health programmes other than the NRHM associated Maternal and Child Health services. They receive few amount of money if at all they have institutional delivery.

At presently the source to which the running of institution is derived only from the user fees of the patient. The international fund of 'White Cross' is receiving by Kangpokpi Christian Hospitals only. Funds regarding the machination of the hospital have found in Christian Hospital Imphal. Every Mission Hospital in the state registered themselves to access to the Foreign Contribution Regulation Act 1976 (FCRA), which

are not functional as foreign aids on health projects are absorbed by the Voluntary Organisations and Non-Governmental Organisations.

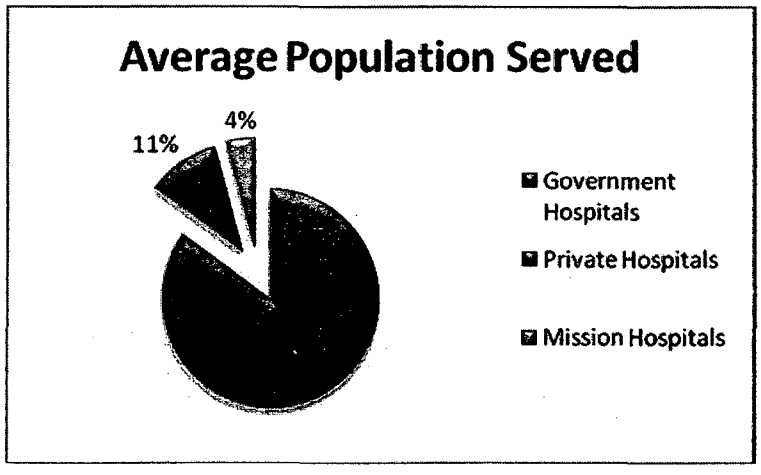
Small and marginal amount of capital is received from the Medical Team of foreign visiting groups if they happen to conduct medical camps.

e) Reporting and budgeting of studied hospitals is under performed. Majority of the hospitals couldn't bring forth the annual check and balances of the institution because they are largely depend on the user fees of the patients. Mentioned may be made that they are not keen to show how much and how the capital is accumulated through which we may able to know what exactly they are doing. Allocation of fund and capital investment couldn't be ascertained as reports and budgeting system find nowhere.

Most importantly the Mission Hospital in an average don't have any sort of report or any writing about their efficacy of history and their services other than the local newspaper presentation of any medical camps being conducted.

6. **Population Coverage of Mission Hospital:** We have seen in the earlier section that what benefits and services are providing for the people in both the rural and urban areas of the state. As duely the population coverage of each hospital suggest a wide range of variations (Table 3.4). Government Public Hospitals (including the District, CHC, PHC hospitals) still served the majority of the population. The Private Hospitals includes that of For-Profit and Non-Profit Hospitals. The Mission Hospitals in Manipur served only 4% of the total population.

Figure 2



7. **Aims of the organization**: The aims of the various organizations direct us to understand that they move along the creation of more health workers. Basic nuances evolved out from the studied hospitals suggest that the infrastructure and upgradation of equipment come first of the future aspiration. As of now whatever services have been provided through the basic technology and need more high technology for diagnosis and treatment. This is show the inclination towards the curative aspect of health services in the mission hospitals. Two of the mission hospitals want to open a nursing school for General Nurse Midwives course if the infrastructure is completed.

8. **Problem and Difficulties:** Most problematic areas which the Mission Hospital in common faces are the recruitment of medical doctor. The criteria which Mission Hospitals look for does not always corresponds with the kind of their training they possessed. And secondly, the various underground groups' movement is deterrent to the development of free atmosphere.

Summary of findings:

- Christian Missionary and Medical Care: In the central India, the arrival of Christian missionaries was observed in the first century followed by Roman Catholic in late thirteenth century. Under the long regime of evangelization in India by Portuguese of Roman Catholicity, the change was seen when in early eighteenth century the Protestant under the Dutch and German Lutherans came and established missionary work. After that period the British entered the sub-continent with the introduction of East India Company at Bengal. Medical missionary entered India where the direct rule of British was observed. The formation of missionary societies was also flourished in the beginning of nineteenth century.

  In Manipur, the entry of Christian missionary was only when William Pettigrew in 1894 landed at Imphal. He started school there at Imphal but was stop due to the objection from the valley population, and later shifted to Tangkhul Naga area of Ukhrul district. Pettigrew built a small dispensary at Ukhrul before he transferred the Mission Station to Kangpokpi. He and Dr. Crozier started dispensary there at Kangpokpi which in 1920 established 'Mission Hospital Kangpokpi'.
- Motivation: The motivation for Christian to open mission hospital was because of the prevailing health condition of the people in and around the Manipur. Due to the bad communication and poverty the facilities there at Imphal could not be utilize by rural folks. It was also the principle of 'helping human being is helping God'.
- Church groups: The different church denomination groups promote their own hospital.
- Distribution: Mission Hospital is distributed in five district of the state. Three are in the rural areas whereas two of the hospitals are in Imphal city. It is seen in the study that the mission hospitals concentrated in the more developed areas of the

districts. Within the rural areas, the mission hospitals are situated in the better places.

- Services: Majority of the services are institutional care. The community outreach programmes through medical camps were organised depending on the demand of the villages. There is no intention of mission hospital going for outreach programmes. Catholic Medical Centre is the only hospital providing specialist care and services in the entire Mission Hospitals of Manipur.
- Finance: The sources of finance in the Mission Hospital are the user fees. User fees are collected from the curative services. Few monetary benefits were gained through joining hands with the NRHM and other health projects. At presently the majority of the hospital doesn't receive any fund and monetary aids from any social organisation and governments.
- Staffing: Manpower in the Mission Hospital largely needs improvement. Trained Laboratory Technician and pharmacist are greatly in need.

In conclusion we see that Manipur consists of multi-religious and ethnic groups. The health status of the state is significantly better among the Northeast states of India, and the best favourable of some indicators in entire India. Manipur since the British period to the post-Independence is yet to have a sound development in order to provide socio-economic stability and empowering the self-sustaining economy. The main hurdles to the state development are the political instability and insurgency problems. Adding to that is the ethnic conflict which resulted in hindrances to economic planning and social stability. It seems that the problem is adjunct to the question of periphery and far distancing from the mainland areas.

The health infrastructure in the state is poorly maintained in majority of hilly areas. Efforts are being made to ensure the rural population to get the health facilities through three tier health system. The state is providing health services to the people through the approach of Primary Health Care system. Health services are mainly provided by the Government hospital.

In the absence of public health care facilities, private service providers are catered to a large population. Private providers are largely in the urban areas and provide curative services. Most curative services are provided in the private hospitals. Mission hospitals in Manipur are struggling for better infrastructure so as to compete with the growing private hospitals in the urban areas. Large numbers of medical doctors are needed in the Mission Hospitals. Lack of trained medical staff has threatened the services of Mission Hospitals in substantial way.

Three out of five mission hospitals are working in the rural areas of the state. Most of the Mission hospitals are situated in the rural areas in better developed districts. More developed districts have higher number of hospitals than the poorly perform ones. The curative aspect of services has undermined the community outreach programmes. There should be policies and rules to regulate user fees of the private hospitals because there is no such rule, as it is, there is a likelihood of unfettered overcharging for some diagnoses and treatments. Checking of these things will enhance the good services to better one.

The role of Christian missionaries in medical care in Manipur is very much important in bringing out good health outcomes especially in rural areas. Although few in number, the mission hospitals in Manipur deliver medical care to the deprived people who could not go to Imphal for treatment or to the private hospital.

The study suggests that in Manipur, Mission Hospital can play a vital role in health care provision. As it is in the curative services, the Mission hospitals need to focus on community outreach programmes because many people of the far villages could not come even to the district headquarter for treatment. Therefore, as evident from the outcomes in the community of interior areas of whatever little work the Mission Hospitals have been doing; it would be a blessed improvement if more emphasis is made on this aspect. There has to be a collaborative work from the State Government in providing necessary help for these Mission Hospitals to carry out this work.

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ANNEXURE

INTERVIEW SCHEDULE

[The Interview Schedule is for educational purpose only. It has both close-ended and open-ended questions. The schedule has 30 questions to serve the objective of the study. You're requested to provide all the details]

I. General Information:

1. Name of the hospital and address:
2. Date of establishment:
3. Type of ownership:
    a. Single owner
    b. Partnership
    c. Husband-Wife
    d. Private Limited
    e. Society/Trust
    f. Any others

4. **Owner (s)/Head information:**

Name	Age	Sex	Religion/ Church	Home District	Qualification	Others

5. a) Were you and your partners ever worked in the government medical service or Non-Governmental Organization?

Yes [ ] No [ ]

If yes, what position?

b) For how long and in what capacity?

c) Did you-

i. Resigned from the service? [ ]
ii. Took voluntary retirement? [ ]
iii. Any other ? [ ]

7. Are you a member of Indian Medical Association?

Yes [ ] No [ ]

8. a) Is your institution an own accommodation [ ] or rented [ ]?

b) If own accommodation, how much was the cost towards-

i. Land (Sq area)

ii. Construction

c) If rented, how much is the monthly rent per room?

d) If Lease accommodation, then for how many year?

9. Have you worked abroad?

Yes [ ] No [ ]

If yes, then where and how long?

II. Details of the Nursing home/Hospital:

10. What was the bed strength?

Bed Strength			
At on establishment		At present	
General	Private	General	Private
Total			

11. How many wards?

12. Staffing:

Categories	Numbers	Qualification	Part Time	Full Time	Salary
1. Doctors					
2. Nurses					
3. Chaplain					
4. Technicians					
5. Attenders					
6. Scavengers					
7. Any others					

III. Services and facilities offered:

13. Services offered:

Services	Specialist	Charges
1. Out-Patient	----------	----------
2. In-Patient		
a. General	----------	----------
b. Maternity	----------	----------
c. Surgical	----------	----------
d. Any others (Specify)		
3. Pathological/Biochemical/Laboratory		----------
4. X-Ray/ECG/Scanner/Ultrasound		----------
5. Operation theatre		----------
6. Family Planning:		
a. Spacing method		----------
b. Abortion		----------
c. Sterilization		----------
Counseling Yes [ ] No [ ]		
7. Immunization:		
a. OPT		----------
b. Polio		----------
c. Measles		----------
d. BCG		----------
8. Pharmacy:		----------

14. a) If you have laboratory, then
    a. full time pathologist
    b. consultant pathologist
    c. technicians
    b) If not then where do you refer cases for investigation?

15. How much do you charge towards room rent per day?
    a. General ----------
    b. Private ----------
    c. Special/Deluxe ----------
    d. Any other ----------
16. Do you have outreach programmes outside the hospital?
    Yes [ ] No [ ]
    If yes, then please specify

17. Do you have collaborative activities with other organization?
    Yes [ ] No [ ]
    If yes, Specify

18. Is your Institution recognized by the Manipur Government for Family Welfare activities?

Yes [ ] No [ ]

If yes, then, do you provide MCH?

Yes [ ] No [ ]

IV. Patients related:

19. What are the sources of referral to your nursing home/hospital?

a. Personal
b. Through consultant
c. Any others (specify)

20. Are the patients coming from?

a. Self-referral
b. Private practitioners
c. Public sector
d. Any others

21. Who forms the bulk of your clientele?

a. Upper income/Rich
b. Middle classes
c. Wage labourers
d. Any other (specify)

22. What benefits, services or products does your hospital provide with respect to its charitable functions?

23. What is the hospital's policy as to administering emergency services to person without apparent means to pay?

24. Does the hospital have any arrangement with police, fire and voluntary ambulance services as to the delivery or admission of emergency cases?

Yes [ ] No [ ]

If yes, specify:

25. Does or will your hospital engages in activities involving the influencing of legislation or the intervention in ways of campaign?

Yes [ ] No [ ]

If yes, specify:

V. Financial mechanism of the organization:

26. Sources of funds:

a) Central Government

b) State Government
c) Foreign aids
d) Public donation
e) Collection of contribution
f) Any other. (Please specify)

27. How did you finance your present Nursing home/hospital?
    a. Invest own capital
    b. Bank loan
    c. Any other (specify)

If applied for Bank loan, name the Bank.

28. Do you have any sources from which you have taken loans or received subsidies?
    Yes [ ] No [ ]

If yes, name them.

29. Have you report the treated cases to Government agency?

30. Organization Chart