MAN, ENVIRONMENT AND SOCIETY
Vol. 1, No. 2, 2020, 187-201
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ISSN: 2582-7669
URL : www.arfjournals.com

PERCEPTION ON HEALTHCARE AND BELIEF SYSTEM: A SOCIO-CULTURAL STUDY ON *SIDDI* AND *HALAKKI VOKKALU* COMMUNITIES OF KARNATAKA

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Article History

Received : 20 October 2020
Revised : 27 October 2020
Accepted : 11 November 2020
Published : 31 December 2020

Key words

Illness, Treatment; Tribe; Practices.

ABSTRACT

The belief on sickness, health and cure comprises a medical system and medical systems forming a part of a cultural system. The health of an individual or community is largely influenced by social and cultural factors which are deeply embedded in social life. The present study employed a qualitative ethnographic method focused to understand the health beliefs, traditional health care institutions, problems and practices and their impact on the communities of *Siddis* and *Halakki Vokkalu* of Uttara Kannada District of Karnataka. Anthropological techniques were used supplemented by Focus Group Discussion (FGD) and in-depth interviews conducted with key informants to enrich the knowledge on the belief system and healthcare practices. Collected information was analyzed thematically using narrative strategies. People of both communities tend towards modern medicine than traditional medicine. For minor ailments, they prefer traditional home remedies or locally available medicines. They visit the hospitals if illness persists for a longer time, which affects their daily labour and earning capacity. Recommended to create awareness among women regarding breastfeeding practices and consumption of food supplements.

INTRODUCTION

The health-sickness process is tangible veracity for people of all cultures in the world. Frake (1961) explained sickness as a vehicle for pursuing other interests.

Every culture has its own notions about ailments and has different perceptions of life, death, sickness and treatments (Geertz 1973). Beliefs about sickness, health and cure comprise a medical system and medical systems forming a part of a cultural system. The health of an individual or community is largely influenced by social and cultural factors which are deeply embedded in social life. The influence of these factors varies from one community to another also within the community itself. 'Medicine, health and illness are all partly cultural categories and different cultures have their own logic and alternative means to deal with these' (Veena Bhasin 2007). The causes of health outcomes are complex and necessarily interrelated with important contributions stemming from genetics, lifestyle patterns and cultures, the environment, socio-economic well-being, social and economic policy, and of course the health-care system (Nolte and McKee 2004). All cultures have shared ideas of what makes people sick, what cures them of these ailments and how they can maintain good health through time. Generally, knowledge of the prevention and cure of sickness is passed on from generation to generation. It also depends on people's different notions about health, illness and practice. It is observed that people have varied responses to different medical systems. Therefore, it is necessary to understand the community in its socio-cultural context, particularly indigenous belief systems and notions to design effective integrated primary health care strategies to serve these communities.

OBJECTIVES

The objectives of the present study are

1. To understand the healthcare practices and belief system among *Siddi* tribe and *Halakki Vokkalu* communities of Uttara Kannada district of Karnataka
2. To highlight the practice of ethnomedicine in primary health care system of both communities

STUDY AREA

The District Uttara Kannada (North Canara) in Karnataka state of India is one of the picturesque districts with rich natural resources. The district is marked by varied geographical features with thick forest, perennial rivers and diverse flora and fauna and a coastal line of about 140 KM. It receives relatively heavy rainfall during the monsoon period. It is surrounded by Belgaum District and State of Goa in the North, by Dharwad District in the East, by Shimoga and Udupi Districts in the

South[1]. Arabian Sea forms the Western border. The area of the district is around 10.25 lakh hectares of forest land forms the bulk of the area to 8.28 lakh hectares. The cultivable land forms about 10 %, of the total area. The District consists of 11 Talukas viz. Karwar, Ankola, Kumta, Honnava, Bhatkal, Sirsi, Siddapur, Yellapur, Mundgod, Haliyal, Joida[2]. It has 35 Zilla Panchayat Constituencies, 123 Taluk Panchayats and 207 Gram Panchayats. According to the 2001 census, 9.66 lakhs of the population live in rural areas with a total population of 13.5 lakhs. Kannada and Konkani are the two major languages spoken.

Along with rich natural resources, the district significantly identifies with distinctive communities. The main communities include Siddi, Kunabi, *Halakki* Vokkaliga, Gonda and Gouli. The *Siddi*and *Halakki Vokkalu* communities have been studied by different anthropologists (Thurston 1909; Kadetotad 2003:1291-1296; Nayak 2012) and profiled, classified backward classes in Havanur commission report. It is also called the backward classes report which was submitted to the Government of Karnataka during the year 1973.

Population: *Siddi* and *Halakki Vokkalu*

The *Siddi* community is also known by different synonyms such as *Habshi* and *Badsha*. As history speaks, *Siddis* are of African origin because they clearly show the Negroid racial strain in their physical feature. Descendants of Bantu people of East Africa, *Siddi* ancestors were largely brought to India as slaves by Arabs as early as the 7th Century, followed by the Portuguese and the British later on. When slavery was abolished in the 18th and 19th centuries, *Siddis* fled into the country's thick jungles, fearing recapture and torture. At present, the *Siddis* are living on the western coast of Gujarat, Maharashtra and Karnataka states (Vallangi 2016). In Karnataka, they mainly live in Dharwad, Belagavi and Uttar Kannada districts. They identified distinctly from the rest of the people living in the area by their physical features and various aspects of their culture. The population is around ten thousand and are generally found in villages nearby forest area of Haliyal, Yellapur and Ankola taluks. Dispersed *Siddis* adopted Hindu, Muslim and Christian religion. The Christian *Siddi* form a majority with Muslim closely following. They are extremely poor and backward and work mainly as agriculture labourers in the fields of other caste people as previously depended on hunting and gathering. The *Siddis* are classified under the list of Scheduled Tribe by the Union Government of India in 2003.

The *Halakki Vokkalu* community is known as the early settlers of the coastal regions of the Uttara Kannada district. Their way of life, adherence to their own traditional customs, social structure and functions reveal that they are descended from a primitive culture. *Halakki Vokkalu has* a belief that there are seven chief regions in Uttara Kannada district consists of 169 villages in which their community members have been living. This regional distribution of villages has been made by themselves. These are namely, Kadwad, Ankola, Kumbaragadde, Gokarna, Nursikote, Harite and Chandavar. Their settlements are between the western slope of Sahyadri and the Arabian Sea with river Kali in the north and river Sharavathi in the south (Gurav 1998). The *Halakki Vokkalu* community used to practice is animal husbandry (Campbell 1883), now they are mainly dependent on agriculture. Land and forest are the main economic resources. The majority of them are agricultural labours. Their secondary income includes making bamboo thatch shades for temples; women make bamboo mats, garlands and collect firewood from the nearby forest areas to sell in the towns. Some of the men are traditional doctors who are given medicine for some ailments. Endogamy at the community level and exogamy at clan level is the rules of marriage. Cross-cousin marriages are allowed. Monogamy is the norm; polygyny is rarely practiced. Extended families are common. Nuclear families also exist. They cremate their dead and death pollution lasts for 11 days. Though both *Siddis* and *Halakki Vokkalu*s living almost the same area and environment (Uttara Kannada district), there are many differences in terms of their beliefs and notions regarding health care and also lifestyle, food habits etc. *Siddis* are concentrated in Haliyal, Yellapur taluks of Uttara Kannada district but *Halakki Vokkalu* are concentrated in Yellapur, Karwar, Ankola and Kumta talukas. *Siddis* are residing close to the forest areas whereas the *Halakki*s living in the coastal belt near the hilly areas closer to the sea. *Siddis* can easily be differentiated from the rest of the people by their physical features. It is believed that the *Siddis* are of African origin settled in forest areas and *Halakki Vokkalu* are the original inhabitants of the hills of Uttar Kannada district.

METHODOLOGY

The present study mainly on the primary sources of information. Traditional anthropological techniques including interview, participant observations, case studies were used along with Focus Group Discussion (FGD) to understand their belief system and healthcare practices. Data were collected from *Siddi* (a Scheduled tribe)

and *Halakki* communities of Uttara Kannada district of Karnataka. The information on the *Siddis* (201 families) was based on the three religious segments viz. Hindu *Siddis* (40), Muslim *Siddis* (82), Christian *Siddis* (79). The *Halakki Vokkalu* data were based on 243 families. Data were analysed thematically using the narrative strategy.

Design and Setting: These communities are located in 78 villages in Uttara Kannada district in Karnataka. Of these, only 33 villages were selected purposively where the large population was concentrated. Information on *Siddi* community was enumerated from villages/hamlets of Halyal (12) and Yellapur takuk (4). For the *Halakki Vokkalu* community, the information was gathered in 12 villages in Ankola and 5 villages in Karwar taluks (Table 1).

Table 1: List of Hamlet/Villages covered for the present study

Siddi		*Halakki Vokkalu*	
Taluk	*Hamlet/Villages*	*Taluk*	*Hamlet/Villages*
Haliyal	1. Thathvanagi	Ankola	1. Bellambar
	2. Nagshettikoppa		2. Belase
	3. Golehalli		3. Harwada
	4. Hosur		4. Badigere
	5. Adikehosur		5. Honnebail
	6. Bhagvathi		6. Hillur
	7. Tattigeri		7. Iranmali
	8. Samrani		8. Manjagun
	9. Kyosarrahalli		9. Ambarkodla
	10. Gadigere		10. Belkere-Sea bird colony
	11. Wada		11. Bogaribail
	12. Gardoli		12. Shirkulla
Yellapur	1. Gullapur	Karwar	1. Thodur
	2. Arbail		2. Amdalli
	3. Hittalgadde		3. Mudaga
	4. Madnur		4. Jadigadde
			5. Chendia Post or Chendia

Sampling Procedure and data collection: The present study mainly based on primary sources of data. Primary sources include interview schedules, focus group

discussions and participant observation. It relied on secondary sources of data, including published and unpublished works (mentioned elsewhere in the report). Initially, the respondents were identified through key informants by trained investigators. The purpose and procedure of the study were explained and requested them to participate voluntarily. To build rapport at the beginning, the participant observation method was adopted by informal discussion, participated in their daily activities, festivals, rituals etc. Later, brief information about their background was collected to construct good acquaintances. After a short discussion with their consent, the information related to the concept of health, beliefs, practices, remedial measures, treatment patterns, indigenous views on health and diseases, perceptions, notions, food habits and personal hygiene were discussed. On average, each interview lasted for 40 minutes. Participants were also requested to quit at any moment if they wish to and recorded their voices also. Discussions were also held with nurses, doctors, medicine men, Auxiliary Nursing Midwifery (ANM) and Accredited Social Health Activists (ASHA).

Series of FGDs were also conducted at different places with different groups considering the aspects of age and gender, including elected representatives, traditional healers, headman, teachers, ANM's, nurses and ASHA workers. A few detailed case studies were also conducted to enrich the knowledge of understanding. Seven semi-structured FGDs were executed across different tribal pockets in Halyal (Gardolli, Tatvanagi, Sambrani,), Yellapur (Gullapur) and Ankola (Amdalli, Mavinakoppa, Ambarakodla) taluks. Both pragmatic and methodological reasons motivated the decision to opt for FGDs. It helped us to understand the preliminary collective knowledge about their health care practices, belief, perceptions and preferences.

The initial idea was to organise FGDs among homogenous groups; because it provided a secure space to speak freely. We believed FGDs with purposely formed homogenous groups can make substantial assumptions and shared understandings. However, we conducted FGDs to the heterogeneous group also to understand the behaviour built; and collective identity manifests in practice. Some homogeneous focus groups were also organized exclusively for tribal women. Men were excluded to create a safe and open atmosphere for women to speak. Secondly, the inclusion of both younger and older participants from the same household was avoided so as to create an open-ended atmosphere. (The young members may hesitate to express their views freely, out of fear, as a mark of respect for elders). The discussions were conducted by a facilitator and moderator in the native language of the participants

(Marathi, Konkani or Kannada). The present study is based on responses, discussions, opinions and notes made during fieldwork to constitute the object for further analysis.

RESULTS AND DISCUSSION

Beliefs and perceptions: The majority of the respondents expressed their views about health in terms of the functional aspects, i.e. if they are able to do their daily labour work, household work or daily activities without any problems they feel healthy. Respondents also expressed their views on health in terms of precautionary measures to get away from ill-health. Based on the ability of a person to do his/her daily work without any physical problems (irrespective of their internal body conditions) they decide he is healthy. People don't care much about their general health.

'tras adre davakanege hogodu illandre illa'

When the health condition deteriorates to the maximum extent than they think of visiting the hospital.

People classify diseases as cold and heat. Cough, sneezing and other respiratory infections as illnesses of cold (*thandi/gaali kayle*); and boils, ulcers, piles, genitourinary disorders are believed to be problems caused by heat (*taapad kayle/siku*). These diseases are suspected to be caused by excessive internal cold or heat in the body respectively. Their expressions of cold or heat do not correspond to body temperature, but rather to internal organs state. Belief about the blood, which is pure or impure symbolizes the sickness or health status of the body.

Siddis tend to prefer non-vegetarian foods. As restrictions imposed by the forest department (Forest Rights Act -2006) on hunting of certain animals, they changed their food patterns into a vegetarian-based. The majority of the *Siddis* cannot afford to buy non-vegetarian food like chicken; mutton etc. from the market. So the consumption of non-vegetarian food is limited to more than a week or two. The rest of the day they consume varieties of pulses, vegetables and leafy vegetables, which are available from nearby petty shops, kitchen gardens or forest areas. As fish is cheaper than vegetables in a coastal region, *Halakki*s prefer fish as part of their staple food. If they do not get fish, they prefer to prepare the vegetable curry.

In India, breastfeeding in rural areas appears to be shaped by the belief of a community, which are further influenced by social, cultural and economic factors (Madhu *et.al.* 2009). According to medical research, breastfeeding within an hour of birth protects children from infections and reduces the risk of death during the first

month of life (Lakshmi 2011). Contrary to the statement, *Siddis* were not breastfeeding their neonatal baby for the first three days. On inquiry, an elder *Siddi* woman replied that milk of the mother is not suitable for the first three days as it is believed to be old milk that is accumulated over a period of nine months in the mother's breast. Hutter (1994) also found a similar kind of belief among the women of Dharwad Taluk towards the feeding practice of colostrum to the neonatal baby. Dash and Choudhary (2005) studied Santalas and non-Santalas, reported that most Santal mothers (53.12%) did not give Colostrum to their infants. Aravind (2002) studied the Baiga tribe and explained that these mothers squeezed the semi-liquid milk and discarded it until it became flowing milk.

As recommended by WHO (2001), breastfeeding women should drink a lot of water - 6 to 8 glasses a day of the amount needed to meet their thirst. But *Siddi* women who breastfeed, consume less water. It is believed that if they drink sufficient water, the breastmilk becomes diluted and the infant may suffer from cold-related ailments. Nutritional supplements, including folic acid, vitamin tablets, iron supplements, etc. are supplied for free of cost through public health care agencies. But pregnant women were not willing to consume the tablets as it fears them that baby in the womb will become too big for safe delivery. Confusion regarding the use of nutritional supplements should be clarified by the healthcare agencies through awareness programs.

Perception on Home Remedies and traditional medicine: Health-seeking preferences were studied by discussing the major source of health care with the participants. For minor illnesses like cough, fever, throat ache, headache or stomach problems, people prefers the home remedies or through the easily available generic tablets at nearby petty shops. If the illness persists even for a couple of days, they usually consult a private/public allopathic practitioner. Most of the people and even traditional healers also express that:

'*mane aushdi taguldilri, igina ootak hondalri, kusu huttak munche davakaani aushdi kotmela mane aushdi natangilla?*'

Even though every village consists of a medicine man majority of the community members strongly believe that traditional medicines or herbal medicines are not effective. Most of the community members are unanimous in their opinion that traditional medicine does not retain efficacy regarding the effect or curative properties of the traditional medicine. People attribute this ineffectiveness of traditional/herbal

medicine to the frequent use of allopathic medicines (vaccinations, tablets, syrups, injections). They also opine that the moment a person gets the injection (the needle is inserted into the body for the intravenous supply of medicines) since the birth it makes the body non-receptive to the herbal or traditional medicines. Though the people continue to prepare the home remedies for certain minor ailments with the help of available herbs known to them for generations, the tradition is losing its ground rapidly.

Every village has 'oushdi kodoru' (medicine-man) specialized in curing certain types of illnesses. This traditional knowledge is passed from father to son. They always treat it as a family affair, the techniques or different types of medicinal herbs or any other ingredients used are never shared with the outsiders other them their family members. Sometimes they show the herbs, but they never disclose the names of the herbs. They believe that it's a family secret. Usually, the medicine man discloses the techniques involved in the treatment or preparation of different medicine to the eldest son during his last days of the time of his death. Some of the traditional medicines are not only popular in their villages, but well known across the country. They believe that if they disclose the name of the herbs or any other ingredients, it will result in a decline in the curing effect of the medicine, or the medicines won't have the desired effect. Thus, this knowledge is supposed to be restricted to the successive generations of the medicine man within his family.

Government hospitals become the alternative when the cost of treatment is expected to be high, as in the case of serious health problems, which require expensive operations or long-term treatment. Also, when health emergencies occur and the possibilities to make arrangements over required cash are limited, they tend to choose government hospital facilities. The poor people express a dependency on the public sector, both for outpatient and for inpatient care. They have expressed a positive opinion about the availability of 108 ambulance service (the services can be availed by dialing the number 108). The awareness of health facilities and the public health schemes on health care on the rise among poor people.

Awareness towards Public Health Programmes

Janani Suraksha Yojana: The scheme was launched by the union government under the NHRM (National rural health mission). This scheme provides for financial assistance to eligible (BPL Card holders) pregnant women. Financial assistance is provided under '*thaayi bhagya*' scheme, for normal delivery, a pregnant woman is paid

Rs.700 in rural areas and Rs.600 for the women in urban areas. Rs.1500 is given to the pregnant women if the operation is cesarean. Post-delivery, a medical kit is issued to the lactating mother, under '*thayee madilu*' the scheme, which contains soap, a dress for the baby and a blanket. The majority of the women are not aware of the scheme. Earlier the payments were made in cash, but now it is through cheques.

Arogya kavacha/ Ambulance services 108: This scheme implemented under Public-Private Partnership (PPP). As the name indicates one can dial the number 108 for emergency services. This scheme is notable for two reasons- First, the usefulness of this scheme wherein the Ambulance reaches the required place within a stipulated time and every community member is aware of this scheme. This scheme is popular among the people living in village areas/interior parts/ hilly areas. The scheme is quite popular and it has made a big impact on people's lives. Many of the community members expressed; how the emergency services have been availed by the pregnant women during the time of emergency and also the many accident victims who would have lost their lives if the ambulance wouldn't have arrived in time.

Preference of private health services over government health services: The majority of the *Halakki*s prefer private health care services (private clinics, or private hospitals) over government health care services (government hospitals or PHCs). They prefer the private services due to several reasons. They opine that government doctors do not care much about the patients, not available on time (*nursi bayi bandaga atu),* time-consuming because of the long waiting times, lack of infrastructure facilities and equipment which are required for diagnosing or treating a particular or different type of illness. They prefer nearby private facilities where that they get better treatment and quick recovery. Even though public health care facilities are provided free of cost, people opt for private health services. People feel that treatment in government hospitals requires a longer duration to recover from any kind of illness that affects their daily labour or earning capacity

People perceive public health care to be of lower quality compared to private health care. The private sector charges more money and provides good and quick service. An old man belonging to *Halakki community* expressed that 'the private doctors make us come over and again, that way they increase their profit. They charge Rs.40 to Rs.100 depending on the disease and diagnosis, and then ask us to come in the morning again'. Respondents said 'for a single visit, we have to spend 100 rupees to

300 rupees depends on the sickness, injection and tablet which they are given. At least Rs.500 has to give for delivery cases. (*san mandina kollodu; dod mandi badukodu*). They feel that an ideal treatment should always have an injection.

The medical costs plus the availability of financial resources are discussed in the FGDs and a personal interview as the most important determinants of the health-seeking process. Different sources seem to be tapped to raise the required money for the treatment expenditure ranging from the use of substantially limited savings and sale of assets, household things and small jewelry to the borrowing of money from family, neighbors, a local microfinance institutes or local money lenders. Repaying the loan is another difficulty that was expressed by some participants and at the same time they appreciated the self-help group's activities. The consultancy in government hospitals is provided free of cost, but in most cases, the prescribed medicines have to be purchased from private druggists.

After analyzing the observations on the quality of care, it appears that both in the public and private sector; people experience negligence and indignities. They have a negative opinion about the public health facilities as in the case of Maya (name changed to protect the identity), a *Siddi* woman. She said "We the villagers being uneducated, don't know the formalities of the government hospital. The nurse or ward boy do not give proper information (*ningen tilitada?*) and no one can enter the doctor's cabin unless they give permission". Responding to this comment, nurses reacted that they find it difficult to describe the symptoms properly so that one arrives at a proper diagnosis. Sometimes patients fail to give proper information about the illness. Sometimes nurse has a feeling that patients do not understand the seriousness of the illness if one speaks politely. Some *Siddi* local leaders were also said about indirect social discrimination from officials and staffs by looking at their physical features (frizzy hair and black col our etc). Taking into account the indirect costs and indispensable bribery, many respondents from the *Halakki Vokkalu* community are of the opinion that the cost of public care is similar to that of private care. Free public health care facility discourages the people to utilize the service to the fullest as it neglects their interest. It would fetch orientation towards private health care providers though it needs more money. Table 2 shows the treatment preferred for illness by *Siddis* and *Halakki c*ommunities. It shows the knowledge on treatment patterns in government, private and traditional medicines.

Table 2: Treatment preferred for illness by *Siddis* and *Halakki* Communities

Government Hospital	*Private Hospital*	*Traditional Medicine/Herbal*
Give technical reason	Give technical reason	Not clear
Free but need to bribe to staff	The Cost is high also bribe to staff	cashless treatment and kind
Quick-relief	Quick-relief	Slow
Neglect	Neglect	Care
Procedural	Procedural	No proper procedure
Refer to a private hospital	Admit even they cannot cure	Refer to allopathic medicine only if results failed
Give poor information about the disease	Do not give proper information about the disease	No medicine for all the diseases
Prescriptions to buy outside	Overprescription and special tests	Leveled prescription
Suitable for all age groups and curable	Suitable for all age group and curable	Not sure
Educated and Practicing	Educated and Practicing	Ancestral knowledge
Innovations	Innovations	Obsolete

Table 3 shows the information on common ailments and diseases, method of medicinal intake, ingredients used and preparation procedure was collected from the study area. Listed are the homemade and natural remedies used by *Siddis and Halakkis* in order to cure certain common ailments. This knowledge of disease and cure, transform orally from generation to generation.

Table 3: Illness and Home remedies adopted by *Siddi* and *Halakki* communities

Disease and its local term	*Intake/ application*	*Ingredients used (also with local name)*	*Method of preparation*
Fever	Drink	Pepper +Jaggery	Boil both the ingredient and extract the solution
Cough	Drink	Sugar candy (Sugar candy) + Ginger + Lemon juice Clove	Boil both the ingredient and extract the solution
Throat pain	Drink	Cumin seeds + Pepper + Ginger	Boil both the ingredient and extract the solution

contd. table 3

Disease and its local term	*Intake/ application*	*Ingredients used (also with local name)*	*Method of preparation*
Chicken pox	Apply on skin	Unripened Coconut + *Apathy Chelli*	Extract the juice
Stomach pain	Drink	*Kahi maddina gida* + Tulsi	Grind and extract the juice
Momps/*Mangana bavu/keppatraya*	Apply on cheeks	Leaf of *Kappattina tree* + Lemon Juice	Grinding
Burning micturition *(Uri mutra)*	Drink	*Shedi Mannu* + *Daate* + Water	Grind, boil and extract
Head ache	Apply on forehead	Tea powder	Boil and sieve
Blood purification	Drink	Leave of Neem tree	Grind and extract the juice
Wound	Apply on the place of wound	Leaves of Mimosa Pudica + coconut water *OR* Roots of *Kajjalu* + *Clove* + Cinnamon + *Gaali Chakke*	Boil and extract the juice, Grind and apply

CONCLUSION

A vast majority of people of both communities do not prefer traditional medicines always and for all ailments. They visit the hospitals if illness persists for a longer, which directly affect their daily labour and earning capacity. People prefer private health care services over public health services due to several reasons such as inaccessibility of doctors, the cost of the treatment, duration of the recovery etc. *Siddis* are not concerned much about their personal hygiene and general health. An awareness programme needs to be created among women regarding breastfeeding practices and consumption of food supplements. There is an urgent need for the recognition of herbal medicine treatment for paralysis and bone fracture at Bellambar and Todur village of Uttara Kannada district respectively, which are on the verge of extinction. The majority of people who do not cure ailments in allopathic medicine, visit those places as a last measure to get cured. These treatments are known to be cost-effective when compared to modern allopathic treatment and medicine. There is also a need for scientific study of these treatment methods as well as the biochemical study of these herbal medicines and their effects by a competent medical team, so that future generations may utilize services before the knowledge gets extinct.

The belief system and health care practices are unique in every ethnic group. It has its own notions about health, sickness, cure, etc. depending upon their cultural settings, geographical locations, food habits etc. Common programmes devised for all ethnic groups may not fit into the cultural settings of many communities. There is an urgent need for community/tribe-specific health schemes as well as awareness programmes which go a long way in creating a healthy nation.

Notes

1. *http://www.kvkuttarkannada.org/DISTRICT_PROFILE.html* accessed on December 09, 2020.
2. *http://uttarakannada.nic.in/aboutus.html* accessed on December 08, 2020.

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To cite this article:

Jai Prabhakar S.C. Perception on Healthcare and belief system: A Socio-Cultural Study on *Siddi and Halakki Vokkalu* Communities of Karnataka. *Man, Environment and Society*, Vol. 1, No. 2, 2020, pp. 187-201