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HEALTHCARE PRACTICES AMONG THE SIDDI TRIBAL COMMUNITY OF KARNATAKA

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ABSTRACT

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 focused to understand the health beliefs, traditional health care institutions, problems and practices of Siddis community of Uttara Kannada District of Karnataka. Focus Group Discussion (FGD) and in-depth interviews were conducted to enrich the knowledge on belief system and healthcare practices. People tend towards modern medicine than traditional medicine. They visit the hospitals if illness persists for a longer time, which affects their daily labour and earning capacity.

Keywords: *Siddi; Health; Tribe; belief;*

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INTRODUCTION

Every culture has its own notions about ailments and has different perceptions of life, death, sickness and treatments (Geertz 1973). 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. The causes of health outcomes are complex and necessarily interrelated with important contributions stemming from genetics, cultures, environment, socio-economic well-being and health-care system (Nolte and McKee 2004). Generally, knowledge of prevention and cure of sickness is transferred from one generation to another. It also depends on notions about health, illness and practice. 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.

People and settings

The *Siddi* community of Uttara Kannada district in Karnataka state were studied to understand the community knowledge on health care practices. *Siddis* are of African origin because of clearly shown negroid racial strain in their physical feature (Thurston and Rangachari, 1909). *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. In Karnataka, they mainly live in Dharwad, Belagavi and Uttar Kannada districts. They identified distinct 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. *Siddis* are residing close to the forest areas and can easily be differentiated from the rest of the people by their physical features. The *Siddis* are classified under the list of Scheduled Tribe by Union Government of India in 2003.

METHODOLOGY

The present study mainly on primary source 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. Siddi (a Scheduled tribe) population were selected from 16 villages purposively where the large population was concentrated (Table 1). Information were enumerated from villages/hamlets of Halyal (12) and Yellapur takuks (4) 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).

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. 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, participant observation method was adopted by informal discussion, participated in their daily activities, festivals, rituals etc. Later, the brief information about their background was collected to construct good acquaintances. After a short discussion with their consent, the information related to concept of health, beliefs, practices, remedial measures, treatment pattern, indigenous views on health and diseases, perceptions, notions, food habits and personal hygiene were discussed.

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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 The present study is based on responses, discussions, opinions and notes made during fieldwork to constitute the object for further analysis.

Beliefs on healthcare

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 person 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. People classify diseases like cold and heat. Cough, sneezing and other respiratory infections as illnesses of cold and boils, ulcers, piles, genitourinary disorders are believed to be problems caused by heat.

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 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 garden or forest areas.

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 become diluted and infant may suffer from cold related ailments. Nutritional supplements, including folic acid, vitamins 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 a safe delivery. Confusion regarding the use of nutritional supplements should be clarified by the healthcare agencies through awareness programs.

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Home Remedies and traditional medicine

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. 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 the traditional medicine does not retain efficacy regarding the effect or curative properties of the traditional medicine. They also opine that the moment a person gets the injection since from 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 medicine-man specialized in curing certain type 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. 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 the 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 case of serious health problems, which requires 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 for government hospital facilities. The poor people express a dependency on the public sector, both for outpatient and for inpatient care. They have expressed positive opinion about the availability of 108 ambulance service. The awareness of health facilities and the public health schemes on health are on the rise among the poor people.

Public health programmes

Janani suraksha scheme was launched by the union government under the NHRM (National rural health mission). This scheme provides for financial assistance to the 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 caesarean. Post-delivery, a medical kit is issued to the lactating mother, under '*thayee madilu'* scheme, which contains of soap, dress for the baby and a blanket. The majority of the women are not aware of the scheme.

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Arogya Kavacha scheme implemented under Public Private Partnership (PPP) programme. One can dial the number 108 for emergency ambulance 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 and also in hilly areas.

Private health services over government health services

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 borrowing of money from family, neighbors, 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. Free public health care facility discourages the people to utilize the service at the fullest as it neglects their interest. It would fetch orientation towards private health care providers though it needs more money.

CONCLUSION

A vast majority of people do not prefer traditional medicines always and for all ailments. They visit the hospitals if illness persists for a longer, which directly effect on 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. Awareness programme needs to be created among women regarding breast feeding practices and consumption of food supplements.

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