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THE PRECARIOUS HEALTH STATUS OF NOMADIC TRIBAL WOMEN IN INDIA: ISSUES AND CHALLENGES

Sociology

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ABSTRACT

Introduction: Nomadic tribes are most vulnerable groups in India as they have no specific place of habitation and are moving from place to place based on their occupations. Generally, they settle at the temporary settlements at the outskirts of villages, towns or cities. As such, they are compelled to live in unhygienic environment, eat malnourished food, drink polluted water, practice open defecation, etc, which lead to frequent ill health. Nomadic women are suffering from all these problems in addition to gender inequality, domestic violence, etc. Consequent to these problems, there is higher rate of maternal and infant mortality among nomadic tribes. Even these women are suffering from Anaemia, diarrhoea, Malaria and such other health problems frequently. **Objectives of the Study:** The study intervenes into the health problems faced by nomadic tribal women in India by analysing the statistical sources. **Significance of the Study:** Assurance of Healthcare is human right, but nomadic women are deprived from healthcare and in this context, the present study is treated as urgent and significant. **Methodology:** Various secondary sources including statistical reports are analysed for the present study. Based on the same information is collected and critically analysed to find out the problems of nomadic women to get equal healthcare facilities. **Findings:** Though providing equal healthcare facilities is human right, the nomadic women are deprived from basic healthcare and education as they are frequently wandering and don't have identity cards such as Aadhar Cards, Ration Cards, etc to get the healthcare facilities from the Government. **Suggestions:**(i) Set up Mobile Health Units so that, all the nomadic tribes living at different villages, towns, cities can get healthcare facilities. (ii) Train few nomadic women as community health workers, which helps to promote healthcare of nomadic women. (iii) Mandatory official formalities to produce Identity Cards (Aadhar, etc.) to get free healthcare facilities needed to be relaxed (iv) Promotion of education, providing self-employment training, etc to nomadic women so that, they can settle at single place to avail different Government welfare facilities. **Conclusion:** It is essential to formulate Healthcare Policy to include nomadic tribes with special concern towards women and children.

KEYWORDS

Nomadic Tribes, Nomadic Women, Healthcare.

INTRODUCTION

India is hometown to almost more than half of the world's tribal population. The population of nomadic tribes in India is 150 million, approximately 15% of total Indian population (Ministry of tribes). On an average, there are 533 tribes were spread throughout various regions of India (Sarwade, et al, 2019). Nomadic tribes have specific features because of the ever-changing habitat also each tribe is unique in its culture, tradition, values, and believes. Nomadic tribes, on an account of their “Nomadic” and distinct mode of existence are at a disadvantage.They move from place to place in search of livelihood and hence deprived of benefits of citizenship in the republic as they don't have “fixed address of residence”. In such a context, nomads face problem of registration as citizens, sequentially deprived of basic human needs. The deprivation and poverty continue in the community. Most of the nomads beg food, gather food, live in extreme unhygienic condition and drink any available water (Sarwade, et al, 2019).

Of all the tribes, the nomadic tribes are highly backward and they are away from civilized society.A nomadis a member of a community of people who live in different locations, moving from one place to another. Among the various ways nomads relate to their environment, one can distinguish the hunter-gatherer, the pastoral nomad owning livestock, or the "modern" peripatetic nomad (Pisal Anita Sambhaji, 2016). The nomadic tribes have no fix place of habitation and move from place to place and live in temporary settlements especially at the outskirts of the village, town or city. They are compelled to eat malnourished food and polluted drinking water and even go for open defecation, which results in poor health conditions. They live at the outskirts of the cities or towns and they are unable to visit health centres. Further, many of them don't have identity cards such as Aadhar, Ration Cards, etc to get facilities such as Ration, Healthcare facilities, etc from the Government.

In the vast and diverse socio-cultural landscape of India, nomadic tribal communities represent a living tapestry of ancient traditions, unique livelihoods, and profound resilience. From the pastoralist Gaddis of the Himalayas to the iron-working Gadia Lohars of Rajasthan and the hunter-gatherer Van Gujjars, these communities are in constant motion, a lifestyle that defines their identity but also renders them almost invisible to the static infrastructure of the state. At the heart of this invisibility are nomadic tribal women, who stand at the intersection of multiple vulnerabilities—gender, indigeneity, poverty, and mobility-placing their health in a state of profound and persistent jeopardy.

Healthcare is most significant responsibility of the Government and even provision of equal health facilities is basic human right. The health of a nation is often measured by its most vulnerable citizens. By this metric, the health status of nomadic tribal women presents a sobering challenge to India's public health apparatus. Their life, dictated by seasonal migrations and economic imperatives, systematically excludes them from conventional healthcare systems designed for sedentary populations. They exist outside the reach of Anganwadi centres, primary health clinics, and immunization drives, which are predicated on a fixed address. This exclusion creates a cascade of adverse health outcomes that span the entirety of their lifecycle.

Health Statistics of Tribal Women:

Report of the National Family Health Survey (NFHS)-4, 2015-2016 conducted by the Ministry ofHealth & Family Welfare shows that the Infant Mortality Rate (IMR) was more i.e. 44.4 per 1000 live births inSTs as compared to the average IMR i.e. 40.7 per 1000 live birth of the country. The situation appears the samein the Under 5 Mortality Rate (U5MR) i.e. it was more (57.2 per 1000 live births) in STs as compared to theaverage (49.7 per 1000 live births) of the country. Likewise, the percentage of females aged from 15 to 49 yearswith anemia was also higher (59.8%) in tribal as compared to the national average (53%). The tribal populationwas found for a higher HIV prevalence (0.46%) than the other belonging to other castes (Punetha and Pandey, 2023).

Health Problems of Nomadic Tribal Women:

The health issues faced by nomadic tribal women are not merely a list of ailments but a complex web of interconnected problems rooted in their lifestyle, environment, and social standing.

- **Reproductive and Maternal Health:** This remains the most critical area of concern. High rates of early marriage and frequent childbirth, coupled with a near-complete absence of prenatal and postnatal care, contribute to dangerously high maternal and infant mortality rates. Institutional deliveries are a rarity, with childbirth often taking place in unhygienic conditions within temporary shelters, assisted by traditional birth attendants whose knowledge may not be adequate to handle complications.
- **Nutritional Deficiencies:** A life of transit often means a diet that is inconsistent and lacks diversity. This leads to chronic malnutrition and severe micronutrient deficiencies. Anemia is near-ubiquitous among these women, with prevalence rates often

exceeding 70-80%. This not only impacts their own health and work capacity but also leads to low-birth-weight babies, perpetuating an intergenerational cycle of poor health.

- **Epidemic and Occupational Diseases:** Living in close quarters with livestock exposes many nomadic women to a higher risk of zoonotic diseases. Furthermore, inadequate access to safe drinking water and sanitation makes them highly susceptible to water-borne illnesses like cholera, typhoid, and diarrheal diseases. Skin infections and respiratory illnesses, exacerbated by exposure to harsh weather and rudimentary living conditions, are also rampant.

Barriers to Healthcare Access:

The poor health indicators among nomadic women are a direct result of formidable barriers that can be categorized into structural, socio-cultural, and economic dimensions. A closer look reveals the depth of their predicament.

Table 1: Key Barriers to Healthcare Access for Nomadic Tribal Women

Barrier Category	Specific Manifestations
Structural Barriers	Invisibility & Lack of Identity: Absence of a permanent address makes it impossible to obtain official identity cards (like Aadhaar), ration cards, or enrol in welfare schemes.
	Geographic Inaccessibility: Healthcare facilities are often located far from their migratory routes or temporary camps.
	System Rigidity: The healthcare system is static and facility-based, failing to cater to a mobile population. Immunization schedules and treatment regimens are difficult to follow.
Socio-Cultural Barriers	Language & Communication: Healthcare providers often do not speak tribal dialects, leading to mistrust and miscommunication.
	Gender Norms: Women's autonomy is limited; they may require permission from male family members to seek care, and are often discouraged from being examined by male doctors.
	Distrust of Modern Medicine: A deep-seated reliance on traditional healers (Bhopas, Ojhas) and a lack of positive experience with the formal healthcare system fosters suspicion.
Economic Barriers	Poverty & Opportunity Cost: Direct costs of treatment and transport are prohibitive. Indirect costs, such as the loss of a day's wages for the woman and her escort, are a major deterrent.
	Financial Exclusion: Lack of bank accounts and formal identification prevents access to government health insurance schemes like Ayushman Bharat.

Suggestions for Inclusive Healthcare:

Based on the above discussion, following suggestions are made for inclusive healthcare of nomadic women.

1. **Mobile Health Units:** The most effective intervention is to take healthcare to the people. Well-equipped mobile clinics, staffed with female healthcare workers and supplied with essential medicines, should be deployed along major migratory routes. These units can provide antenatal care, immunizations, nutritional supplements, and treatment for common ailments. GPS tracking of migratory patterns can aid in optimizing their routes.
2. **Community Health Liaisons:** Training individuals from within the nomadic communities, especially women, as community health workers (CHWs) can bridge the cultural and linguistic gap. These CHWs can act as a vital link between their community and the formal health system, promoting health-seeking behaviours and ensuring follow-up.
3. **Flexible and Unique Identification:** The government must create a special category of identification for nomadic populations. Biometric-based smart cards that store health records could overcome the "no address" barrier, allowing them to access services and schemes wherever they are.
4. **Integration with Traditional Systems:** Rather than dismissing traditional healers, programs should aim to train and integrate them into the primary healthcare framework. They can be educated to identify high-risk pregnancies or dangerous symptoms and act as first-line referrers.

CONCLUSION

Women are the backbone of a family's overall health, ensuring their access to high-quality treatment can also benefit the health of children and families. There is no doubt that the health of women affects the health of families and communities. The health status of nomadic tribal women is a silent emergency, hidden in plain sight along the dusty tracks and remote pastures of India. Their plight is a stark reminder that development and progress are meaningless if they do not reach the last mile, or in this case, the moving mile. Ensuring their health and well-being is not just a matter of public health ethics but a constitutional imperative of equality and justice. Until policy and practice are re-engineered to embrace mobility and respect cultural diversity, these resilient women will continue to be veiled by their movement, their health a casualty of a system that has yet to learn how to see them.

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