Health and Well-Being in Indigenous Communities in India: Integrating Traditional Wisdom with Modern Healthcare

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Abstract

Indigenous communities in India, constitutionally recognised as Scheduled Tribes (STs), experience diverse health needs shaped by geography, socio economic conditions, cultural contexts and unequal access to public services. Traditional health knowledge—including medicinal plants, community healing, local food practices and intergenerational knowledge passes to hold cultural and social significance in many communities. In this paper, I had used a qualitative narrative review approach to bring together existing scholarship and policy documents on healthcare access, traditional knowledge, social determinants of health and government initiatives.

The reviewed literature identifies barriers such as geographical remoteness, inadequate infrastructure and staffing, indirect treatment costs, language differences and limited cultural responsiveness. It also indicates that meaningful engagement with traditional knowledge requires a clear distinction between cultural significance and demonstrated clinical effectiveness. The paper argues that integration should not mean uncritical adoption of remedies or the replacement of modern clinical care. Rather, it should involve accessible and adequately resourced public healthcare, voluntary community participation, patient-safety safeguards and protection of knowledge holders' rights. Health policy must also address nutrition, livelihoods, environmental conditions, migration and continuity of care. Further this paper proposes a context-sensitive framework for collaboration and identifies areas requiring further empirical evaluation.

Keywords: Indigenous communities, traditional health knowledge, healthcare access, cultural responsiveness, patient safety, social determinants of health.

Introduction

India is home to diverse communities described as Indigenous peoples, Adivasis, or Scheduled Tribes. These terms have distinct historical, social and legal meanings and should not be treated as interchangeable in every context. Across many communities, knowledge relating to medicinal plants & food, healing practices and the local environment is transmitted through oral traditions and intergenerational relationships. Such knowledge may contribute to cultural continuity and community understandings of health and well-being.

At the same time, many Scheduled Tribe communities face persistent barriers to formal healthcare. These may include long distances to facilities, limited transport, shortages of health professionals and essential services, indirect costs, language differences and experiences of culturally unresponsive care. A report, "Tribal Health in India: Bridging the Gap and a Roadmap for the Future" (2018), frames tribal health as a matter requiring attention to infrastructure, human resources, financing, community participation and service delivery.

Indigenous health inequalities reflect interconnected socio economic, nutritional, geographic and institutional factors. Subramanian et al. (2006) found that socioeconomic disadvantage explained part of it, but not all, of the mortality gap between Indigenous and non-Indigenous populations. Jain et al. (2015) talks about diverse disease burdens and substantial undernutrition in a community health programme in central India, while Kumar et al. (2020) reviewed broader tribal public-health challenges. Moving from diagnosis to possible responses, Mohindra and Labonté (2010) highlighted affordable, multi-pronged interventions and community participation, while Nandi and Schneider (2014) examined how the Mitanin community health worker programme in Chhattisgarh addressed social determinants of health. Together, these studies support comprehensive, community-responsive healthcare alongside respectful engagement with traditional health knowledge.

This paper argues that improving Indigenous health requires two commitments at once: strengthening equitable access to modern healthcare and engaging respectfully but critically with traditional health knowledge. Neither cultural recognition alone nor infrastructure expansion alone is sufficient. Any proposed integration must protect patient safety, respect community autonomy, distinguish cultural significance from clinical efficacy and address the wider conditions that shape health. To understand it clearly the conceptual framework of paper is given below :

Stage 1: Challenges affecting health	Long distances to health services; shortages of staff, medicines and facilities; language and cultural barriers; poverty, food insecurity and housing difficulties.
Stage 2: Community knowledge and strengths	a. Traditional healing and local knowledge b. medicinal plants and local food practices c. support from family, elders and community d.knowledge of the local environment.
Stage 3: A respectful healthcare approach	a.Reliable and accessible modern health services b. communication in local languages c. safety and effectiveness checks for remedies d.protection of community knowledge and rights.
Stage 4: Expected contribution to health and well-being	a.Timely and appropriate care b. greater trust and participation c.safer treatment choices d. better attention to nutrition, living conditions and continuity of care.
Cross-cutting conditions	a.Community participation b. government support c. evidence and patient safety d.respect for cultural rights.

Figure 1. Conceptual framework for improving Indigenous health and well-being

Methodology

This paper is a narrative review based on scholarly studies, government reports, policy documents and institutional publications. It uses secondary sources and does not involve experiments, interviews, field visits, or ethnographic research. The sources are analysed thematically, focusing on healthcare access, traditional health practices and safety, social determinants of health, migration and government policies. The review identifies key challenges and opportunities for equitable and culturally sensitive healthcare. It does not measure intervention effects or establish causal relationships. The findings are limited to the sources reviewed and the proposed framework and indicators are recommendations for future evaluation.

Healthcare Access and Systemic Inequalities

a. Geographical, infrastructural and financial barriers

Geographical remoteness or long travel distance can delay care and difficult to obtain, particularly where services are concentrated in distant centres (Deb Roy et al., 2023). The existence of a health facility does not guarantee that qualified staff, medicines and equipment are consistently available.

The financial burden of treatment also extends beyond consultation fees. Transport, accommodation, food and lost wages can make healthcare unaffordable even when services are subsidised. These burdens interact with irregular livelihoods and limited access to information about public programmes. Health interventions therefore, need to address practical accessibility and affordability, not merely nominal service coverage.

b. Language, trust and culturally responsive services

Healthcare encounters depend on communication. Patients need to understand diagnoses, treatment options, risks and follow-up instructions, while providers need to understand patient's experiences and concerns. Language differences and dismissive attitudes towards local beliefs can undermine trust, informed consent and continuity of treatment. Soman et al. (2024) emphasise that infrastructure and policy provision may not translate into effective utilisation when cultural, linguistic and awareness barriers persist.

In hard-to-reach areas of Odisha similarly indicates that local socio economic conditions, geographical remoteness and reliance on traditional healers can shape healthcare-seeking behaviour (Nallala et al., 2023). Such findings support locally adapted service delivery rather than a uniform model imposed across highly diverse communities. Mohindra and Labonté (2010) also noted limitations in the evidence available on the effectiveness of population-health interventions for Scheduled Tribe communities and highlighted the importance of affordable & feasible approaches developed in collaboration with communities. Therefore, Intervention design and evaluation should be sensitive to differences between regions and between communities.

Traditional Health Knowledge, Well-Being and Clinical Safety

a. Diversity and significance of traditional knowledge

Traditional health knowledge may include medicinal plants, household remedies, community healing practices, food knowledge and culturally meaningful ways of responding to illness. Its forms and meanings differ across communities, environments, families and knowledge holders. It should not be described as one uniform system or assumed to be shared equally by all members of a community.

Traditional practices may carry cultural, social, psychological and supportive significance. Local food knowledge and relationships with the environment is connected with livelihood practices and intergenerational learning. Beyond plant-based remedies, traditional Indian approaches to well-being also include practices such as Yoga, breathing exercises and meditation. Seshadri and Seshadri (2025) discuss these practices in relation to holistic health and their potential complementary role in contemporary healthcare. Their discussion provides a broader perspective on traditional approaches to physical and psychological well-being. However, these practices should not be treated as representative of all Indigenous healing systems, which vary across communities and require context-specific study. Their relevance to Indigenous healthcare should therefore be considered alongside community preferences, accessibility and appropriate scientific evidence.

Traditional food systems in some Indigenous communities include locally cultivated crops, forest-derived foods, seasonal fruits, vegetables. These systems may contribute to dietary diversity, cultural identity and intergenerational knowledge. Kapoor et al. (2022), reviewing 52 Indian studies, documented the nutritional composition of Indigenous foods, including their nutrient content, antinutrients and mineral bioavailability. Their review highlights the potential nutritional value of traditional foods while showing the importance of considering nutrient availability and food-specific limitations. Nevertheless, food practices vary across communities and

ecological regions and traditional diets should not automatically be assumed to meet every nutritional requirement.

b. Patient Safety and Collaboration

Traditional use may provide a basis for further investigation, but it does not establish clinical effectiveness or safety. Remedies intended for treatment should be assessed for ingredient quality, preparation, dosage, toxicity, contamination, adverse effects, medicine interactions, and evidence of effectiveness. Patients should be able to discuss traditional remedies openly with healthcare professionals, who should explain risks and uncertainty without dismissing cultural beliefs. Practices that may cause harm or delay urgent treatment require safeguards. Recognition of traditional medicine does not mean every remedy is effective for every condition.

Where appropriate and supported by communities, traditional healers and formal healthcare providers may collaborate to improve awareness of warning signs and timely referrals. Such arrangements should define roles clearly, protect confidentiality and informed choice and ensure that traditional practitioners do not replace qualified clinicians. Their effectiveness should be evaluated through referral timeliness, patient experience, continuity of care, safety and health outcomes.

c. Ethical Protection of Traditional Knowledge

we should acknowledge knowledge holders and respect community-specific limits on sharing. Traditional knowledge should not be treated as freely available simply because it belongs to a community. Where it contributes to commercial products or intellectual-property claims, applicable protections, attribution and fair benefit-sharing should be considered. Environmental conservation is also important when knowledge is linked to medicinal plants and other local resources.

Social Determinants of Health and Community Well-Being

Indigenous health is shaped not only by medical services and healing practices but also by income, education, housing, food security, safe drinking water, sanitation, livelihoods, environmental conditions, gender relations and access to public services. All these factors are responsible for the illness and the ability to obtain treatment. A Committee on Tribal Health (2018) underscores the need to consider wider structural and institutional circumstances alongside healthcare delivery. Menstrual hygiene management is another gender-related dimension of well-being, involving affordability, informed choice, culturally appropriate health education and safe disposal facilities. Tamilmani and Peninnah (2026), examining menstrual hygiene management in rural Tamil Nadu, highlight the importance of considering women's preferences and local practices when designing sustainable and inclusive interventions.

a. Nutrition, land, forests and livelihoods

Food security includes the availability, affordability, diversity and nutritional quality of food. In some communities, local food systems are connected to agriculture, forests, seasonal resources and customary knowledge. Changes in access to land and natural resources, environmental degradation, displacement or livelihood insecurity may affect food supplies. These relationships differ across communities and should be examined without assuming universal dependence on forest resources.

Where medicinal-plant knowledge is linked to local ecosystems, environmental change may also affect access to resources and the conditions under which knowledge is practised and transmitted. Health planning should recognises these connections while respecting legal rights, community priorities and the diversity of livelihoods.

b. Migration and continuity of care

Seasonal migration may provide income but can disrupt healthcare when people move between rural and urban locations because repeated consultations, ongoing medication, follow-up appointments and caregiving

arrangements can become difficult to maintain. Women, children, older people and people requiring continuing treatment may be affected when household resources or responsibilities change. Choksi, Deogam, and Rathwa (2022) discuss the effects of reverse migration following India's COVID-19 lockdown through accounts from Indigenous communities in Gujarat and Jharkhand. Their work illustrates how experiences differed according to land ownership, access to resources and reliance on migrant labour.

The pandemic and lockdown disrupted employment, transport, food markets, household income and access to services. These disruptions interacted with existing inequalities rather than affecting every household in the same way. Community networks and local knowledge could provide support, but could not substitute for reliable public services and healthcare. These experiences highlights the importance of locally understandable public-health communication and emergency planning that considers language, community leadership, livelihood conditions and access to essential resources.

The broader implication is that healthcare integration cannot be reduced to adding traditional remedies to formal facilities. It must be connected with nutrition, sanitation, livelihood security, social protection and continuity of care for mobile populations.

Policy Frameworks and Government Initiatives

Government programmes provide frameworks for addressing healthcare access and the wider conditions affecting well-being. The Expert Committee on Tribal Health's 2018 report, Tribal Health in India: Bridging the Gap and a Roadmap for the Future, provides a central policy context for all these issues. It highlights the need to address the particular circumstances of tribal health, including service delivery, infrastructure, human resources, financing and community participation. It supports the argument that equitable care requires both effective public services and responsiveness to the social and cultural circumstances of the communities served.

a. National Health Mission and primary healthcare

The National Health Mission provides a broad framework for strengthening public healthcare, including primary care and maternal and child health services. In remote areas, its practical contribution depends on functioning facilities, trained staff, equipment, medicines, transport, outreach where appropriate and dependable referral arrangements. Engagement with community members and knowledge holders may help services understand local concerns, but must supplement rather than replace trained personnel and properly equipped facilities.

b. PM-JANMAN and PVTGs

The Pradhan Mantri Janjati Adivasi Nyaya Maha Abhiyan (PM-JANMAN), launched in November 2023, is intended to improve the socioeconomic conditions of 75 Particularly Vulnerable Tribal Groups across 18 states and one Union Territory. Its multi-sectoral objectives include basic services and infrastructure related to housing, drinking water, education, healthcare, nutrition, connectivity and livelihoods. Mobile medical units are among the interventions identified in programme information.

c. Dharti Aaba Janjatiya Gram Utkarsh Abhiyan

Launched in October 2024, the Dharti Aaba Janjatiya Gram Utkarsh Abhiyan aims to address development and infrastructure gaps in tribal-majority villages through coordinated interventions across government ministries. Its relevance to health lies in the connections between healthcare, nutrition, education, sanitation, water, transport and livelihoods. Coordination is important because infrastructure alone does not guarantee better health outcomes if facilities lack staff, medicines or culturally appropriate communication. Claims about impact should be based on evidence of implementation and outcomes.

d. Traditional medicine policy and international guidance

The World Health Organization's Global Traditional Medicine Strategy 2025–2034 provides an international policy framework emphasising evidence, safety, appropriate regulation, responsible integration, cross-sectoral collaboration and respect for cultural heritage and Indigenous Peoples' rights (World Health Organization, 2025).

Key questions for policy and research include whether remote communities can reach facilities reliably and whether these qualified staff & medicines are consistently available, whether information is linguistically and culturally accessible, whether departments coordinate services, whether programmes improve patient experience and health outcomes and whether traditional knowledge holders participate meaningfully in decisions about documentation and use. These questions require location-specific evidence rather than assumptions that the same conditions apply everywhere.

e. Policy and Implementation Matrix

The matrix below translates the policy discussion into practical actions and possible ways to monitor implementation. It links existing policy frameworks with recommendations developed in this review. The indicators are proposed monitoring measures, they are not presented as evidence that a programme has already achieved these results.

Table 1. Policy and implementation matrix for Indigenous health and well-being

Priority area	Policy / programme connection	Suggested implementation actions	Possible monitoring indicators
Accessible primary healthcare	National Health Mission (NHM); Expert Committee on Tribal Health (2018); Ayushman Bharat Health and Wellness Centres (HWCs)	Strengthen local primary care, outreach, staffing, essential medicines, diagnostics, transport and referral arrangements in underserved areas. Apply norms for health facilities in remote and tribal areas, deploy Mobile Medical Units where needed and support timely emergency transport. Plan services around local geography and seasonal access barriers.	Availability of staff and essential medicines; functional health facilities, availability of mobile and emergency services, travel or waiting barriers reported by patients.
PVTG and remote-village service gaps	PM-JANMAN; Dharti Aaba Janjatiya Gram	Coordinate health services with village-level infrastructure and	Local Villages reached; continuity of outreach; habitation-level

	Utkarsh Abhiyan; NHM	other essential services, organise locally suitable outreach and follow-up, Strengthen habitation-level health-worker coverage and prioritise underserved areas in health-service planning.	health-worker availability; access to maternal, child and preventive services; gaps identified and addressed
Language, trust and culturally responsive care	National Health Mission and local health-system planning	Use local-language communication and understandable health information; train providers in respectful communication, informed consent and non-discriminatory care. Involve community representatives voluntarily in service design and strengthen links between community-level health workers and formal health facilities.	Availability of local-language information or interpreters; patient-reported understanding and respect; community feedback; complaints and their resolution; successful referrals from community-level workers.
Traditional knowledge and patient safety	WHO Global Traditional Medicine Strategy 2025–2034; relevant national standards and safeguards	Enable respectful discussion of traditional remedies without assuming effectiveness. Where remedies are proposed for clinical use, assess identity, quality, dosage, toxicity, interactions and evidence, encourage patients to disclose remedy use without fear of dismissal and protect community knowledge holders	Safety review and referral protocols in place; adverse events documented and reviewed, patients report being able to disclose remedy use; evidence of appropriate consent and protection of traditional knowledge.

		through appropriate consent and safeguards.	
Financial protection and continuity of essential services	NHM; National Free Drugs Service Initiative; National Free Diagnostic Service Initiative	Reduce out-of-pocket expenditure by improving the availability of essential medicines and diagnostic services at tribal-area facilities. Monitor supply interruptions and strengthen follow-up for patients requiring continued care.	Frequency of medicine stock-outs; availability of essential diagnostic services; patient-reported out-of-pocket expenditure; continuity of treatment and follow-up.
Health-system capacity and workforce retention	NHM; High Priority District approach; NHM incentives for remote-area personnel	Monitor staffing shortages and strengthen recruitment and retention in remote facilities. Where applicable, use hard-area allowances, flexible specialist-engagement arrangements and other permitted incentives. Review whether additional support reaches underserved tribal communities.	Staff vacancy and retention rates; availability of specialists; continuity of services; resource allocation and expenditure in identified priority districts.

A Culturally Responsive Model of Integration

Traditional healing and modern healthcare should not be viewed as competing systems. A culturally responsive approach should combine equitable healthcare access, community participation, respect for traditional knowledge and evidence-informed patient safety. This requires culturally appropriate communication, ethical protection of knowledge holders and stronger public healthcare services. Attention should also be given to social determinants such as nutrition, sanitation, education and livelihood security. The proposed approach is conceptual and requires further evaluation to assess its effects on healthcare access, patient experience, safety and health outcomes.

Recommendations for Policy and Practice

Policy and practice should prioritise accessible primary healthcare, responsive communication and reliable systems in remote tribal areas. Traditional remedies require respectful safety and effectiveness assessments, while traditional knowledge needs proper consent, recognition and safeguards. Healthcare planning should also address social determinants, including nutrition, sanitation, education, livelihoods and the continuity of care for migrant

households. Finally, government programmes should be evaluated using implementation evidence, community feedback and relevant health outcomes rather than relying solely on announced objectives.

Conclusion

Health and well-being among Indigenous communities in India are shaped by healthcare access, socioeconomic conditions, cultural identity, traditional knowledge, environmental circumstances and public policy. Geographical isolation, financial constraints, inadequate services and communication barriers can restrict formal healthcare access, while nutrition, livelihoods land and resource access, migration and social protection influence health beyond the clinic.

Traditional health knowledge is an important cultural and social resource, although its forms and significance vary across communities. Respect for this knowledge must be accompanied by careful evaluation of therapeutic claims and safeguards for patient welfare. Traditional practices should neither be dismissed categorically nor assumed to be safe and effective simply because they are longstanding. Modern healthcare must remain accessible, adequately resourced and guided by appropriate standards of safety and evidence. Meaningful integration requires engagement, community participation, ethical governance and accountable health-system coordination. Progress also depends on addressing the social determinants of health and evaluating policy implementation.

Similarly, findings from specific regions should not be generalised to all Indigenous communities. Evaluations are also needed to determine whether government programmes improve healthcare access, service quality and health outcomes. Last but not the least a culturally responsive approach can support more equitable healthcare when community rights and knowledge are respected alongside the right to timely, safe and appropriate medical care.

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