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Health Inequalities and Access to Public Healthcare among Siddi Community in India.

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KEYWORDS

Siddi community, oral traditions, cultural identity, African heritage, collective memory.

ABSTRACT

The Siddi community in India is an African-origin marginalized group residing mainly in Karnataka, Gujarat, and Maharashtra, who continue to face socio-economic disadvantages despite their long historical presence in the country. Health inequalities remain a critical concern for the community, shaped by poverty, geographic isolation, low awareness of public health schemes, and limited access to quality healthcare services. Within the broader Indian healthcare system, marginalized and tribal population often experience unequal service delivery, and the Siddis represent a relatively understudied group in this context. This study examines health inequalities and access to public healthcare among the Siddi community in India, focusing on healthcare utilization patterns, availability of services, and barriers faced in accessing public health facilities. The paper highlights the community experiences of the Siddi community, the multiple structural and socio-economic challenges faced by them, including distance to healthcare centers, financial constraints, limited health literacy, and weak inclusion in government health care programs. Preventive healthcare practices are minimal, with many individuals relying on local remedies and delaying formal medical treatment. Women and children are particularly vulnerable due to inadequate maternal and child healthcare access. The study highlights that health inequalities among the Siddi community are driven by systemic exclusion and socio-economic deprivation, underscoring the need for targeted policy interventions and improved healthcare outreach to ensure equitable access to public health services.

1. INTRODUCTION

Health inequalities remain a persistent concern in India's public health system, especially among historically marginalized communities. The Siddi community, an Afro-descendant tribal group in India, represents one of the most distinct yet under-researched population in this context (Hofbauer, 2025; Cowling et al., 2014; Subramanian & Joe, 2023; World Health Organization, 2022; International Institute for Population Sciences & Ministry of Health and Family Welfare, 2022). According to the Census of India 2011, Scheduled Tribe populations constitute 8.6 percent of the total population, yet health disparities within tribal groups remain wide and uneven. The Siddi population is primarily concentrated in Gujarat, Karnataka, and Andhra Pradesh, with smaller clusters in Telangana. Historical accounts trace their ancestry to East African regions, with migration occurring through trade networks and colonial movements over several centuries, particularly between the 16th and 19th centuries as documented by scholars such as Pankhurst (2003) and Harris (2011). Public health reports by the Ministry of Health and Family Welfare, Government of India (2019) highlights that tribal people continue to experience high rates of malnutrition, infant mortality, and limited institutional healthcare access as compared to national averages. NFHS-5 data (2019 to 2021) further shows that Scheduled Tribes face higher levels of stunting in children under five and lower utilization of antenatal care services. Within this broader context, the Siddi community reflects compounded disadvantages due to geographic isolation, low literacy levels, and limited integration into mainstream health infrastructure.

Research by Mehta (2017) and Thapa (2020) indicates that Siddi settlements often have restricted access to primary



healthcare facilities, with long travel distances to government hospitals and dependence on informal or traditional healing systems. Studies also suggest that socio-economic deprivation, including low-income levels and irregular employment in forest and agricultural labor, directly influences health-seeking behavior and nutritional outcomes. Despite several tribal welfare schemes such as the Tribal Sub-Plan (1974), the National Health Mission (2013), and targeted initiatives under Ayushman Bharat (2018), evidence indicates uneven implementation of these schemes in remote tribal regions (Ministry of Health and Family Welfare, 2022; UNICEF India, 2021; Swachh Bharat Mission Gramin, 2020). The Siddi community, in particular, remains underrepresented in empirical health research, especially qualitative studies that capture lived experiences of healthcare access and inequality. This study therefore, focuses on understanding the nature of health inequalities among the Siddi community, their access to public healthcare services, socio-economic and structural determinants shaping health outcomes, and the effectiveness of existing policy frameworks in addressing their specific health needs.

Statement of problem

The Siddi community in India, an African-origin marginalized group primarily residing in India continues to experience persistent health inequalities despite its long historical presence in the country. Structural disadvantages such as poverty, geographic isolation, limited awareness of public health services, and inadequate access to healthcare infrastructure contribute to poor health outcomes within the community. Although India has implemented multiple public health programs aimed at improving equity and service delivery, marginalized tribal and socio-economically disadvantaged groups often remain excluded from effective healthcare access, and the Siddi community represents a largely under-researched population in this context. Existing scholarly work has focused mainly on their historical origins, cultural identity, and socio-economic conditions, health-related disparities and access barriers remain insufficiently examined. This lack of focused understanding limits the ability to identify specific health vulnerabilities and design targeted interventions. Therefore, there is a need to investigate health inequalities and access to public healthcare among the Siddi community in India.

2. METHODOLOGY

This study adopts a descriptive and analytical research design based on a qualitative approach to examine health inequalities and access to public healthcare among the Siddi community in India. It relies entirely on secondary sources of data, including government reports, policy documents, census-based summaries, academic journals, NGO reports, and published literature related to tribal and marginalized health in India. Relevant information is gathered from credible databases such as Ministry of Health and Family Welfare reports, National Family Health Survey findings, and peer reviewed studies focusing on healthcare access, health status, and socio-economic conditions of disadvantaged communities. The data is analyzed using qualitative content analysis to identify key themes such as healthcare accessibility, structural barriers, service utilization patterns, and health disparities. A thematic interpretation method is applied to understand how these factors shape health outcomes among the Siddi community as compared to other marginalized groups. The study does not involve any field survey or primary data collection and is based on systematic synthesis of existing evidence to develop a comprehensive understanding of health inequalities and public healthcare access among the Siddi community in India.

Objectives

1. To examine the nature and extent of health inequalities among the Siddi community in India.
2. To analyze the accessibility and utilization of public healthcare services by the Siddi community.
3. To identify the socio economic and structural factors affecting health outcomes among the Siddi community in India.
4. To assess the existing policies and interventions addressing healthcare access for marginalized tribal communities with special reference to the Siddi community in India.

Result

Health inequalities among the Siddi community in India

Health is a fundamental condition for human survival and development. It affects physical growth, mental well-being, productivity, and the ability of individuals to participate in education, work, and social life (World Health Organization, 2022). When people remain healthy, they can access opportunities and improve their living standards. Poor health reduces life chances and increases dependence, poverty, and social exclusion. Health also reflects broader social conditions such as income, nutrition, education, housing, and access to healthcare services (Subramanian & Joe, 2023). For marginalized communities like the Siddi population in India, health becomes a strong indicator of inequality as it reveals long standing gap in Siddi's access to health facilities and service delivery. The Siddi community, an Afro-descendant Scheduled Tribe mainly located in Gujarat, Karnataka, Maharashtra, and Goa, continues to experience limited access to healthcare and basic services due to geographic isolation and socio-economic disadvantage. Their health outcomes are shaped not only by disease patterns but also by structural deprivation, making health both a human right issue and a development priority (Hofbauer, 2025).

The figure given below indicates that health inequalities among the Siddi community in India are severe,



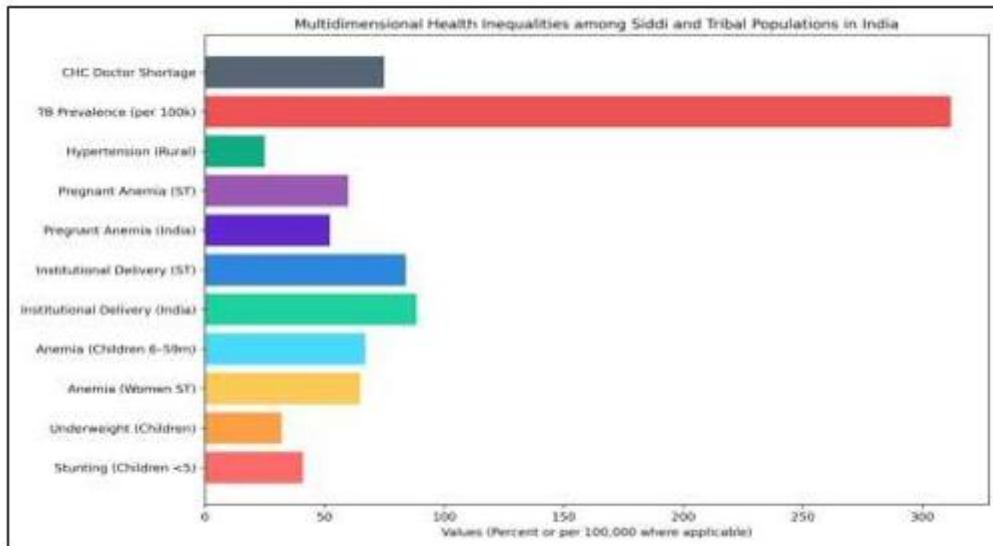
multidimensional, and structurally produced through long term marginalization, geographic isolation, and socio-economic deprivation. The Siddis are an Afro-descendant Scheduled Tribe mainly concentrated in Gujarat, Karnataka, Maharashtra, and Goa. Their population is estimated between 40,000 and 150,000, with no separate enumeration in Census of India 2011, reflecting administrative invisibility and undercounting of small tribal groups (Census of India, 2011). A major dimension is malnutrition and anemia. NFHS-5 (2019–2021) reports that 41.0 percent of children under five in India are stunted and 32.1 percent are underweight, with significantly higher levels among Scheduled Tribes (International Institute for Population Sciences & Ministry of Health and Family Welfare, 2022). Around 40–42 percent of ST children, remain stunted and about 65 percent of ST women suffer from anemia (NFHS-5, MoHFW, 2021). In Siddi settlements, these conditions are often worse due to food insecurity, seasonal hunger cycles, and low dietary diversity. Field studies in Gujarat and Karnataka report chronic under nutrition, delayed physical growth, and micronutrient deficiencies linked to low protein intake and unstable livelihoods (Singh & Dalal, 2020).



Figure 1 Health inequalities among the Siddi community in India.

Source: (Rural Health Statistics, MoHFW, 2022, Central TB Division, 2022, NFHS-5, 2019- 2021).

Maternal health inequality is also significant. NFHS-5 (2021) reports institutional delivery in India at 88.6 percent, it is around 84 percent among Scheduled Tribes, with lower access in remote rural regions. Anemia among pregnant women is 52.2 percent nationally and exceeds 60 percent in ST populations. In Siddi dominated areas, studies report low antenatal care uptake and delayed emergency obstetric referrals due to distance from primary health centres and transport barriers (Ministry of Health and Family Welfare, Rural Health Statistics 2021–2022). Rural health data from Karnataka and Gujarat shows specialist shortages in rural CHCs reaching 70–80 percent, directly affecting maternal care access (Rural Health Statistics, MoHFW, 2022). Health service accessibility in tribal regions is further constrained by infrastructure gaps and workforce shortages in primary health care system (Das & Mohpal, 2016). Disease burden shows a triple pattern. Tuberculosis remains high in tribal population, with the National TB Prevalence Survey (2019–2021) estimating 312 per 100,000 prevalence nationally. Tribal and remote rural clusters experience higher undiagnosed and untreated cases due to weak screening systems (Central TB Division, 2022). Malaria remains endemic in forest fringe regions where many Siddi settlements are located in Gujarat and Karnataka. At the same time, non-communicable diseases have risen, with hypertension affecting around 25 percent of rural adults in India (ICMR India Hypertension Study, 2021). Tribal health outcomes in such contexts are further shaped by socio economic inequality and uneven service delivery (Cowling et al., 2014).



Graph 1 : Health inequalities among Siddi Tribe in India.

Child health disparities are also evident in the above graph. NFHS-5 reports that 67.1 percent of children aged 6–59 months in India are anemic, with higher prevalence in tribal groups due to poor diet and infection burden. Siddi children additionally face delayed developmental milestones in speech and motor skills, linked to chronic under nutrition and repeated infections (FairPlanet field report, 2020). Environmental and structural drivers intensify these inequalities. The Swachh Bharat Mission Gramin report (2020) highlights persistent sanitation gaps in rural tribal clusters. UNICEF India WASH report (2021) links unsafe drinking water and poor sanitation to repeated diarrhoea disease, which worsens nutrient absorption and increases stunting. Substance use also contributes, with studies in western India showing higher alcohol consumption among tribal men, often linked to poverty and social exclusion, leading to household economic stress and reduced child care capacity. Health inequality among the Siddi community reflects cumulative disadvantage across nutrition, maternal health, infectious disease, child development, and environmental conditions. Malnutrition affects more than 40 percent of children, anemia affects more than half of women, infectious diseases remain persistent, and non-communicable diseases are rising. These inequalities continue because geographic isolation, weak service availability, and structural exclusion reinforce each other across generations.

Access to public healthcare services among the Siddi community

Public healthcare accessibility for the Siddi community in India remains structurally limited, uneven, and underutilized, despite formal inclusion under Scheduled Tribe health and welfare frameworks (Kuttiatt et al., 2024; Cowling et al., 2014; World Health Organization, 2022; Das et al., 2016; Ministry of Health and Family Welfare, 2022; Haddad et al., 2011; Singh & Dalal, 2020). The Siddis are an Afro-descendant tribal group mainly concentrated in Uttara Kannada (Karnataka), Gir Somnath and Junagadh (Gujarat), and parts of Maharashtra and Goa. Their settlements are often small, dispersed, and located in forest fringe or hilly terrain, which directly affects healthcare reach and service delivery. A key barrier is geographical inaccessibility and distance from facilities. According to the Ministry of Health and Family Welfare Rural Health Statistics (2021–22), India has 157,935 Sub-Centres, 31,053 PHCs, and 5,481 CHCs, but tribal and remote areas continue to show major spatial gaps in functional access and staffing (MoHFW, 2022). In many Siddi villages in Gujarat and Karnataka, field studies report that residents travel 5–15 km to reach the nearest PHC, often without regular public transport (Ministry of Tribal Affairs, Government of India, 2021). The World Health Organization India Health System Review (2022) also notes that rural and tribal populations face significantly lower service density compared to urban populations, especially for maternal and emergency care.

A second major issue is human resource shortages and weak service availability. Rural Health Statistics (MoHFW, 2022) reports that CHCs in rural India face a shortage of 80 percent of specialist doctors, including obstetricians and pediatricians, who are essential for tribal maternal and child health. This shortage is more severe in forest and tribal belts where recruitment and retention of health staff is difficult. As a result, even when facilities exist near Siddi settlements, they often function with limited capacity. A third barrier is low utilization of available services despite physical presence. NFHS-5 (2019–21) shows that institutional delivery in India is 88.6 percent overall, but significantly lower among Scheduled Tribes at around 84 percent, with even lower rates in remote rural regions (IIPS & MoHFW, 2021). Antenatal care coverage (at least 4 visits) is 58.1 percent nationally, but again lower among tribal populations due to distance, awareness gaps, and cultural barriers. In Siddi communities, qualitative studies report delayed antenatal registration and low uptake of preventive services such as iron-folic acid supplementation.

Cultural reliance on traditional medicine is another major determinant of low access. A study on tribal health behaviour in India found that 28.6 percent of rural tribal population prefers traditional healing systems, up to 32.8 percent report

first contact with local healers before formal medical consultation (Sharma, 2021). In Siddi settlements in Gujarat (notably Jambur village), ethnographic research documents strong trust in indigenous healers and belief systems that attribute illness to spiritual or natural imbalance, which delays hospital visits (9VOM Publishing, 2025). Health awareness and literacy gaps further reduce access. NFHS-5 (2021) data indicates that Scheduled Tribe women have lower exposure to mass media and lower awareness of maternal health services as compared to national averages. Literacy rates among Siddi communities are also lower than state averages in both Gujarat and Karnataka, limiting awareness of schemes such as Janani Suraksha Yojana (JSY), free institutional delivery, and nutrition supplementation programs.

Socio-economic constraints remain critical. According to NFHS-5 (2021), around 27 percent of rural households report financial difficulty in accessing healthcare, mainly due to transport and wage loss. For Siddi households dependent on daily wage labour, even “free” public healthcare becomes costly due to indirect expenses such as travel, food, and missed income. Public health interventions exist but shows uneven effectiveness. Anganwadi Centres under ICDS, ASHA workers under NHM, and mobile health units have been deployed in tribal regions. Ministry of Tribal Affairs initiatives also target nutrition and maternal care in Particularly Vulnerable Tribal Groups (PVTGs). However, implementation studies show that outreach frequency is irregular in remote settlements, reducing continuity of care (Ministry of Tribal Affairs, 2021). Public healthcare accessibility for the Siddi community is physically present but functionally weak. The main barriers are 5–15 km travel distance, up to 80 percent specialist shortages in rural CHCs, lower antenatal and institutional care coverage in tribal groups, and high reliance on traditional healing systems. These factors combine to produce low utilization and delayed treatment, sustaining long-term health inequality.

Socio economic and structural determinants of health among the Siddi community

Health outcomes among the Siddi community in India, an Afro-Indian Scheduled Tribe mainly residing in Karnataka and Gujarat, are shaped by historical isolation, economic marginalization, low literacy, and reliance on traditional healing systems (Hofbauer, 2025; Cowling et al., 2014; Subramanian & Joe, 2023; Das & Mohpal, 2016; World Health Organization, 2022; Karmwar & Srivastava, 2025). These factors do not operate separately. They reinforce each other and create long term disadvantages in health access, health behaviour, and disease outcomes. Many Siddi settlements remain located in remote forest and hill regions such as Uttara Kannada in Karnataka and Gir and Talala regions in Gujarat, where distance from primary health centres, weak transport networks, and limited outreach services delay diagnosis and treatment. Studies on tribal health in these regions consistently show that travel time and transport cost act as primary reasons for delayed hospital visits (Reddy, 2021). Socio-economic conditions explain much of the health burden. Most Siddi households depend on seasonal agricultural labour, forest work, or informal daily wage employment, which produces unstable income and high vulnerability to poverty. This directly affects nutrition, as households often shift to low cost, low diversity diets dominated by cereals. Field based reports on tribal nutrition in Karnataka shows higher risk of anemia and under nutrition in communities with similar livelihood patterns (Singh & Dalal, 2020). Food insecurity becomes worse during lean agricultural seasons, which increases susceptibility to infectious diseases and weakens maternal health. Low literacy rates, especially among women, has led to reduced awareness of antenatal care, immunization schedules, hygiene practices, and early treatment seeking. This leads to delayed hospital visits, often only after conditions become severe.

Structural barriers aggravate these outcomes. Health infrastructure in Siddi dominated areas remains uneven, with staff shortages, irregular mobile health services, and under-resourced primary health centres. This creates a gap between policy coverage and actual service delivery. Geographical isolation increases dependency on traditional healers and home remedies, not only because of belief systems but also because biomedical care is physically less accessible. Cultural interpretations of illness also play a role. In some cases, illness is attributed to spiritual causes or taboos, which leads to combined use of herbal medicine, spiritual healing, and modern treatment. This medical pluralism often delays consistent treatment for chronic conditions such as tuberculosis, hypertension, and diabetes, which is increasingly reported in tribal populations (Subbarayappa, 1997). Social exclusion adds another layer. Distinct physical features of African descent sometimes expose Siddi individuals to discrimination and social distancing in public spaces. This affects confidence in engaging with health systems and reduces routine use of preventive services. Evidence from tribal health utilization studies in Karnataka, including areas like Yellapur Taluk, shows low awareness of non-communicable diseases and irregular follow up for chronic illness, mainly due to weak health education exposure and limited counseling at primary care level (Roy et al., 2015).

Maternal and child health outcomes are shaped by both knowledge gaps and cultural restrictions. In several tribal settings, including Siddi communities, pregnancy related dietary restrictions and reduced intake of iron and folic acid supplements are reported due to beliefs about fetal health. This increases risks of maternal anemia, low birth weight, and child malnutrition. NFHS based tribal data in Karnataka and Gujarat consistently shows higher anemia prevalence among women in marginalized tribal groups compared to state averages, reflecting structural inequality in nutrition and healthcare access (International Institute for Population Sciences & Ministry of Health and Family Welfare, 2022). Alcohol consumption in some households further affects health outcomes indirectly by reducing household financial



stability and increasing neglect of nutrition and healthcare spending (Kapoor et al., 2017). This does not operate uniformly across the community but remains a contributing factor in vulnerable households. Although the Government of India has classified the Siddis as a Scheduled Tribe and introduced welfare schemes related to health, nutrition, and livelihood, implementation gaps remain significant. The main challenge is not absence of policy but weak last mile delivery, low awareness, and poor infrastructure alignment with remote settlement patterns (Kuttiatt et al., 2024). As a result, health outcomes remain shaped by intersecting barriers that include poverty, geography, education, cultural practices, and institutional exclusion.

Effectiveness of policies for healthcare access in the Siddi community in India

Existing policies and interventions in India have improved healthcare access for marginalized tribal communities, but their effectiveness remains uneven, especially for isolated groups like the Siddi community in Karnataka and Gujarat (Subramanian & Joe, 2023). The gap is not policy availability, but implementation strength, accessibility, and cultural fit in remote tribal settings (World Health Organization, 2022). Existing policies, such as the Tribal Sub-Plan and mobile medical units, have had limited effectiveness in improving healthcare access for marginalized tribal groups like the Siddis in India (Kuttiatt et al., 2024). Barriers like geographic isolation, cultural disconnect, and understaffed local clinics persist, requiring targeted, culturally sensitive community-led approaches (Karmwar & Smita, 2025).

At the national level, India's tribal health framework operates through constitutional safeguards such as Article 275(1), along with major schemes including the National Health Mission (2005 onward), Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (launched 2018), and targeted tribal welfare programs under the Ministry of Tribal Affairs (Ministry of Health and Family Welfare, 2022). These initiatives focus on reducing out of pocket expenditure, expanding primary healthcare, and improving maternal and child health outcomes (Cowling et al., 2014). The National Health Mission also includes Mobile Medical Units designed to bring basic healthcare services to remote and inaccessible tribal hamlets (Haddad et al., 2011). Additionally, Particularly Vulnerable Tribal Group (PVTG) schemes provide targeted support for the most marginalized tribal populations through funds for health services, drinking water, and local infrastructure (Reddy, 2021). Accredited Social Health Activists (ASHA workers), introduced under NHM in 2005, serve as frontline female health workers linking communities with institutional delivery and immunization services (Kumar & Dubey, 2024). For example, NFHS 4 (2015–16) to NFHS 5 (2019–21) shows improvement in institutional deliveries in India from 78.9 percent to 88.6 percent, including gains in tribal population (International Institute for Population Sciences & MoHFW, 2022). Immunization coverage among children aged 12–23 months increased from 62 percent to 76.4 percent in the same period (Munda et al., 2026). These indicators show that service availability and uptake have improved at the national level.

Despite these improvements, effectiveness for the Siddi community remains limited due to structural and social constraints. Many Siddi settlements in Uttara Kannada (Karnataka) and Gir, Talala, and Junagadh regions (Gujarat) remain geographically isolated (Sana Khader, 2020). Lack of regular public transport, forces individuals to walk long distances to reach the nearest public health facilities (Singh & Dalal, 2020). Travel time often exceeds 30 to 90 minutes in difficult terrain, which delays emergency care and reduces preventive service use (Roy et al., 2015). Severe infrastructure deficits further reduce impact. Remote tribal areas frequently lack functional Primary Health Centres, consistent drug supply, diagnostic facilities, and trained medical staff (Hongal & Kshirsagar, 2023). Even when facilities exist, understaffing and absenteeism reduce reliability of services (Das & Mohpal, 2016). Mobile medical units exist under NHM, but their coverage is often irregular in hard-to-reach forest hamlets (Balsari et al., 2017). The Siddi community context highlights these challenges more sharply. Geographic isolation combined with weak transport networks limits routine access to antenatal care, immunization, and chronic disease screening (Adhya et al., 2025). In many cases, health seeking occurs only during advanced illness stages, which increases complication rates (Hofbauer, 2025). Cultural disconnect and lack of trust also affects utilization. Modern healthcare is sometimes perceived as insensitive to local beliefs and practices (Al Hussein & Shahba, 2023). Many Siddi households continue to use a mix of biomedical treatment, herbal medicine, and spiritual healing. This medical pluralism is not only cultural but also a response to accessibility gaps. It can delay consistent treatment for conditions such as tuberculosis, hypertension, and maternal complications.

Socio-economic determinants further restrict outcomes. High rates of poverty, landlessness, and low literacy reduce the ability to afford transport, medicines, nutritious food, and repeated consultations (Kapoor et al., 2017). These conditions limit the effectiveness of strictly clinical interventions, as health outcomes depend heavily on nutrition, awareness, and stable income (Cowling et al., 2014). Maternal and child health indicators remain a key concern. NFHS 5 (2019–21) reports that anemia among women aged 15–49 remains at 57 percent nationally, with higher levels in tribal population (International Institute for Population Sciences & MoHFW, 2022). In Siddi influenced regions, field studies from Karnataka between 2018 and 2022 show delayed antenatal registration, low uptake of iron and folic acid supplements, and continued dietary restrictions during pregnancy due to cultural beliefs (Raghuvanshi et al., 2025). These factors contribute to maternal anemia, low birth weight, and child undernutrition. Preventive care awareness remains low. Studies in tribal regions such as Yellapur Taluk in Karnataka (2017–2020) show limited awareness of non-communicable



diseases such as hypertension and diabetes, resulting in low screening and weak follow up (Roy et al., 2015). Policies introduced from 2005 to 2025 have expanded healthcare infrastructure, outreach programs, and financial protection in India's tribal regions. However, their effectiveness for the Siddi community remains moderate due to three persistent barriers. Geographic isolation limits physical access, weak infrastructure reduces service quality, and socio-cultural gaps reduce utilization. Sustainable improvement requires stronger last mile delivery systems, consistent mobile health outreach, improved staffing in rural facilities, and culturally responsive health education delivered through community-based approaches.

A path forward for improving efficacy

Figure 2 presents framework of recommendations for improving healthcare access among the Siddi community, arranged from foundational to advanced interventions. The diagram begins with culturally sensitive care and trust building as the base layer, followed by strengthening primary healthcare infrastructure and expanding frontline health workers such as ASHA workers. It then highlights community led health governance and integration of traditional and modern healthcare systems to improve acceptance and continuity of care. The middle layers focus on maternal and child health interventions, improved transportation and emergency referral systems, and targeted health education supported by digital outreach to enhance awareness and early treatment seeking. The structure shows that each layer supports the next, where access, trust, service quality, and awareness work together to shape health outcomes. The pathway below the figure emphasizes that improving healthcare for the Siddi community requires moving beyond uniform delivery models toward location specific, culturally grounded, and community driven systems. It also shows that effectiveness depends on trust, continuity of care, accessibility, and local relevance, rather than policy availability alone.



Figure 2 Strategies to improve healthcare access among the Siddi community in India.

3. CONCLUSIONS

Health is a basic condition for dignity, survival, and development. In the case of Siddi community in India, health outcomes reflect deep and long-standing structural inequalities. The evidence shows that health inequalities among the Siddis are severe and persistent. They face higher vulnerability to communicable diseases, maternal and child health risks, malnutrition, and untreated chronic conditions. These gaps are not random. They are shaped by historical exclusion and continued social marginalization. Access to public healthcare remains limited in practice. Even where services exist, utilization is low due to distance, lack of transport, low awareness, language barriers, and distrust shaped by repeated exclusion. Many Siddi settlements remain geographically isolated, which further reduces timely access to primary and emergency care. Preventive healthcare use is also weak, leading to late diagnosis and avoidable complications. Socio-economic and structural factors strongly determine health outcomes. Poverty, low education levels, insecure livelihood, poor housing, and limited political representation restrict health opportunities. Discrimination and social invisibility deepen these barriers. These factors interact and create a cycle where poor living conditions directly translate into poor

health status across generations. Policy responses exist through schemes like Ayushman Bharat, National Health Mission, and tribal welfare programs. However, implementation gaps remain significant. Outreach is uneven, culturally appropriate care is limited, and monitoring is weak in remote tribal pockets. The Siddi community often remains outside consistent policy attention despite being a recognized Scheduled Tribe. The situation shows that health inequality among the Siddis is not only a medical issue. It is a structural and governance issue. Real improvement requires targeted outreach, culturally sensitive healthcare delivery, stronger last mile service delivery, and focused inclusion of the Siddi community in health planning and monitoring systems.

Limitations of the Study

This study is based entirely on secondary data drawn from government reports, academic publications, policy documents, census summaries, NGO reports, and other existing literature on tribal and marginalized health in India. As a result, it does not include primary fieldwork or direct engagement with the Siddi community. The absence of field-based data limits the depth of understanding of lived experiences, local healthcare practices, and present day service utilization patterns. Regional differences across Gujarat, Karnataka, Maharashtra, and Goa could not be examined in detail due to limitations in available disaggregated data. The analysis focuses mainly on broad themes such as health inequality, access barriers, and structural deprivation, finer aspects like intra community variation, gender specific health issues, and local coping strategies receive limited coverage.

Directions for Future Research

Future studies should adopt field based and ethnographic approaches to generate primary evidence from Siddi settlements across different Indian states. Comparative regional research can help identify variations in healthcare access, cultural practices, and socio-economic conditions. Mixed method designs combining surveys, interviews, and participatory observation can provide richer insights into lived health experiences. Further research should also explore gendered health outcomes, youth health behavior, migration patterns, and the impact of urbanization and digital exposure on health awareness. Longitudinal studies can help track changes in health access and policy impact over time.

Ethical Consideration

This research is entirely based on secondary sources and does not involve any human participants, interviews, surveys, clinical trials, or collection of personal data. Therefore, formal ethical clearance was not required. All interpretations and analyses are derived from publicly available materials and existing scholarly work. The author maintains full responsibility for the originality of the analysis and arguments presented in the study. AI assistance was used only for language refinement and structural clarity. intellectual ownership remains with the author. Standard academic integrity practices, including proper citation and referencing, have been followed throughout.

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