Putturaj *et al. International Journal for Equity in Health* (2025) 24:305
https://doi.org/10.1186/s12939-025-02637-6

International Journal for Equity
in Health

https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-025-02637-6

RESEARCH **Open Access**

Between rhetoric and reality: dignified health care for the Soliga Adivasi community in Chamarajanagar district, Karnataka, India

Meena Putturaj[1*], Prashanth NS[1], Tanya Seshadri[1], Madegowda C.[2] and Sara Van Belle[3]

Abstract

Background Despite national and regional efforts toward universal health coverage, Adivasi communities like the Soligas in Karnataka in India, continue to face barriers to dignified health care. This analysis explores how human dignity is upheld or neglected within formal, State-regulated health care services. It highlights the health care experiences of Soliga Adivasi communities in the Chamarajanagar district of Karnataka, Southern India, as they navigate institutional formal health services.

Methods We employed Interpretative Phenomenological Analysis (IPA) to investigate how dignity is compromised in health care within a context where respect, rights, and citizen agency are not actively promoted. Our study included 33 in-depth interviews with care-seeking individuals from Soliga community, their families, and NGO-affiliated health care providers. We also drew on insights from six community meetings, one participatory workshop, and a multi-stakeholder gram panchayat meeting involving elected officials, government representatives, health workers, and community leaders. These activities formed part of a long-term participatory action research initiative with Soliga Adivasi collectives in Chamarajanagar district. The qualitative data was analysed for attributes of dignified care, guided by existing literature and the Indian constitutional framework.

Results Systemic barriers, including delays, neglect, lack of autonomy and informed consent, disrespect, privacy breaches, culturally insensitive care, and exclusion from health governance spaces, undermined dignified health care for Soliga Adivasi communities. These challenges must be understood within the broader context of structural violence, shaped by displacement linked to forest conservation, inadequate social protection, and adverse social determinants such as poverty, limited education, poor housing, and ongoing human-wildlife conflict in forest regions where Soligas live.

Conclusion The Soliga Adivasi communities' health care experiences reveal everyday dignity violations in formal health care facilities, reflecting broader systemic inequities. This study emphasises the need for addressing the deeper social inequities and co-creating a health care context with policies, programmes and practices where the agency, self-respect and autonomy of Adivasi communities are valued and preserved through dignity-oriented health care service delivery frameworks and practice.

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*Correspondence:
Meena Putturaj
meena@iphindia.org

Full list of author information is available at the end of the article

Keywords Dignity, Health care, Soliga, Indigenous communities, Adivasis, India

Introduction

Embracing the idea of dignity in health care services has important implications. It lays the foundation for human rights in health care. It helps us to centre respectful care grounded in human rights as the goal of health care systems [1, 2]. Evidence demonstrates that dignified health care promotes patient satisfaction, clinical outcomes, and better quality of life [3–6]. The centrality of human dignity in health care motivates adhering to ethical principles in medical/health care. It is also the bedrock for building value-based health systems. When a person seeks care for illness, they become more susceptible to human dignity violations owing to their physical illness, but also due to the illness's social, economic, and psychological influences and consequences on the individual and their home environment [6]. Loss of human dignity in patient care and health systems causes physical and psychological distress in care-seeking individuals. At the worst, care-seeking individuals may lose the will to survive and thrive [7]. Furthermore, the loss of human dignity corrodes public trust in health care providers and health care systems [8].

Health care environments are particularly prone to human dignity violations. Depending on the nature of the illness and the familiarity of the service, care-seeking individuals and their families are dependent on health care providers to varying extents. Paternalistic attitudes of health care workers (which include both clinical and non-clinical staff), information asymmetry, lack of training in patient-provider dialogue and discrimination concerning age, gender, and social class adversely affect the dignity of care-seeking individuals. Furthermore, the physical environment of hospitals, especially if cleanliness is poorly maintained and/or the privacy of patients is not protected, undermines the dignity of care-seeking individuals [9, 10]. Institutional policies concerning staff workload, patient care documentation, staff burnout and the impersonal and overly bureaucratic workplace context could also affect the delivery of dignified car. [11–13]. Studies show that socioeconomically disadvantaged people experience longer wait times, have limited access to specialists, and achieve poorer health outcomes [14, 15]. These disparities are rooted in structural racism, underfunded public services, and class-based discrimination [16]. To preserve the dignity of patients, health systems should enable health care providers to convey empathy, humaneness, and kindness,°and thus contribute to trust in the care processes [17]. These attitudes should manifest in their professional behaviours, such as being respectful to the patients irrespective of their socio-economic differences, resulting in culturally competent care, and realising the rights of care-seeking individuals, such as the right to privacy, the right to confidentiality, right to information [18]. Jacobson (2007) [5] asserted that power asymmetry between care-seeking individuals and health care providers and administrators in hierarchical environments such as hospitals is the key driver of human dignity violations. However, in the above studies, dignity in health care is viewed as a notion that is primarily to be reflected in the communication between a care-seeking individual and a health care provider. Such studies fail to capture the larger structural complexities outside the hospital settings that shape dignity violations in health care settings.

Dignity should be perceived by the individual, and the worth of an individual as a person should also be manifested in the way we organise and deliver formal health care services to populations [19, 20]. Several studies have explored the perceptions of health care providers, such as nurses and care-seeking individuals, on the meaning and attributes of human dignity while receiving medical care in health care institutions such as hospitals [21–24]. A few studies elucidate the socio-political and cultural contexts of care-seeking individuals outside health care institutions (i.e. lives of care-seeking individuals outside health care institutions) and their implications for realising dignified health care [25, 26]. Research providing Adivasi care-seeking individuals' health care experiences from a dignity point of view in India is scarce. *Adivasi* is a term commonly used, especially in Southern India, to refer to Indigenous communities.

Historically, due to fractured structural and political systems entangled within the complexities of caste, class, gender, ethnicity, poverty, and beyond, Adivasis in India face challenges in leading a dignified life despite constitutional protections and affirmative action policies [27, 28]. In India, Adivasi citizenship is deeply entangled with land rights, where access to land and forests defines both cultural belonging and political agency [29]. The poor health status of Adivasi people, when compared to the non-Adivasi population, reflects deep-seated systemic failures in enforcing constitutional provisions to secure their land and cultural identity, and health care [30]. Though there are several measures taken nationally and regionally to ensure universal health coverage for all, including Adivasis, access to respectful, affordable and quality health care is an enduring concern for the Adivasi communities in India. The situation is no different for the Soliga Adivasi communities in Karnataka [31]. Catastrophic health expenditure, deficiencies in the health care infrastructure, shortage of health manpower in Adivasi areas, and difficulty in accessing geographical terrains accentuate health inequities in the Adivasi communities of India [31, 32].

This study presents the experiences of Soliga Adivasi individuals and their family members who sought medical care (modern medicine, which uses biomedical approaches for disease prevention and treatment) from public and private health care facilities in Southern Karnataka, India, and the experiences of staff of an NGO run hospital, other Soliga Adivasi community leaders and members through the lens of human dignity. We aim to analyse how human dignity is (not) manifested in formal health care services as experienced by the individuals belonging to the Soliga Adivasi communities in Karnataka, India. By formal health care services, we refer to the institutional, professionalised systems of medicine and medical care systems typically recognised and regulated by the State.

Theoretical background: human dignity and dignified health care

The concept of human dignity varies across different cultural contexts and is often shaped by historical, religious, philosophical, and social values. The ambiguous nature reflects the complexity of understanding a human phenomenon such as dignity [33]. Nevertheless, gleaning from the literature on human dignity, for the practical purpose of analysis, this paper identifies the following as the critical aspects of human dignity: Human dignity can be articulated as the grounds of respect, either self-respect or respect from others [34]. It is the recognisable capacity to assert rights. Having and exercising certain rights is key to realising human dignity. It is intertwined with the notion of human freedom (i.e. the agency to act, think or speak without restraint) [35, 36]. Substantial equality is a necessary condition to realise human dignity [37]. Expressing, realizing and recognising human dignity demands capabilities (freedoms and opportunities) for individuals and certain groups [38]. Human dignity is fragile;as Killmister (2020) says it can be “injured, lowered, embarrassed, humiliated, threatened, frustrated, even destroyed” in subtle and obvious ways [39].

The concept of human dignity in Indian philosophy is rooted in spiritual and ethical traditions, which view dignity as intrinsic to the human condition. In Vedanta, the *atman (self)* is considered identical to universal consciousness, which indirectly means that every being possesses inherent worth and dignity [40]. Buddhist philosophy locates dignity in the potential of all sentient beings to attain liberation through ethical conduct, mindfulness, and compassion (*karuṇā*) [41]. Similarly, Jainism emphasises *ahimsa* (non-violence) as a central principle that affirms the dignity of all life forms [42]. Sikhism upholds human dignity through service (*seva*), equality, and devotion, rejecting caste-based discrimination [43]. Dignity in Indian thought is relational and intertwined with dharma (duty) and loka-sangraha (welfare of all), suggesting that a dignified life involves fulfilling one’s responsibilities to others and society [44]. Yet, the persistence of caste and social inequality has often undermined these ideals. Contemporary scholars and movements draw on these philosophical foundations to reclaim dignity as a tool for justice and emancipation [45, 46].

Dignity is a foundational constitutional value in many legal systems, and its interpretation by courts has significantly influenced constitutional jurisprudence globally. See, for instance, the concept of dignity is central to constitutional law in India, South Africa, and Colombia. In India, the Supreme Court has read dignity into Article 21 in cases like Maneka Gandhi Vs Union of India, 1978 [47], Common Cause V.Union of India (2018) [48], and K.S Puttaswamy v. Union of India (2017) [49]. A few scholars view dignity as a transformative tool in Indian constitutionalism, but the practical reach depends on strategic litigation and conducive constitutional structures [50]. Chandra (2020) critiques its vague and inconsistent usage by Indian courts, highlighting the opportunistic and interpretative roles dignity plays in shaping health rights jurisprudence in India [51]. In South Africa, dignity is a founding constitutional value, as illustrated in the judgment S v. Makwanyane (1995) [52]. Liebenberg (2005) argues that dignity grounds socio-economic rights and demands structural redress [53]. Colombian courts link dignity to material well-being, particularly through enforceable rights [54]. Across these jurisdictions, dignity serves as a moral, structural, and enforceable principle. However, in India, dignity is less formally entrenched, often invoked by courts but not consistently applied or enforced. These differences reflect broader constitutional philosophies: India’s incremental and case-based approach versus the more radical, transformative visions of South Africa and Colombia.

Problematising health inequities, health-seeking behaviour and health care utilisation from the perspective of dignity

Conceptual understandings of health, health care, well-being and human dignity are intertwined with each other [35, 53]. For an individual to be healthy, access to quality health care is essential. Access to well-organised, safe health care is a critical resource for preserving the health of individuals and communities. In other words, we are concerned about health care because the constitutions of democratic nations (at least normatively) strive to preserve the core value of their citizens, i.e. dignity. The idea of dignity gives a sense of purpose to democratic nations. In other words, the efforts of a democratic nation are to preserve dignity for all its people [55, 56]. Scholars argue that promoting dignity can help persons to experience well-being and be restored to holistic health [1, 3].

The concept of human dignity is a foundational value in the Indian Constitution. It is explicitly referenced in the preamble, which assures dignity for every individual in the country. This reflects the influence of Dr. B.R. Ambedkar, the principal architect of the Indian Constitution, who viewed dignity as essential to social justice and the annihilation of caste. For Ambedkar, democracy was not just a form of government, but a way of life based on liberty, equality, and fraternity, which are necessary to uphold individual dignity [57, 58]. Contemporary scholars like Upendra Baxi (2012) emphasise that constitutional dignity must also be understood in the context of India's postcolonial and plural society, where social hierarchies and structural inequalities challenge the full realization of dignity for all [59].

Viewing health through the lens of dignity recasts health care not merely as a technical service but as a moral and constitutional obligation rooted in respect for human worth. This perspective helps expose how health inequities, health-seeking behaviours, and health care utilisation, especially for marginalised communities are shaped by structural injustices that systematically undermine their dignity. Dignity in health care must not be reduced to respectful communication or patient-provider politeness; it must instead be understood through the lens of structural justice. For marginalised communities in India, Dalits, Adivasis, Muslims, LGBTQ + individuals, persons with disabilities, dignity is routinely compromised by entrenched casteism, patriarchy, economic precarity, and institutional neglect [60, 61]. Health inequities are not accidental but arise from systemic hierarchies that deem certain lives less valuable than others. Health-seeking behaviour is shaped by long histories of humiliation and exclusion in public health facilities [62], and under-utilisation often reflects a rational assertion of self-respect rather than ignorance. Even where health services are technically available, undignified conditions, such as overcrowding, discrimination, lack of privacy, and coercive practices, undermine constitutional guarantees. Ambedkarite ethics and Buddhist principles of social justice emphasise recognition of individual worth beyond caste or class, advocate for a dignity-based health system that must address both material access and relational justice, ensuring that no individual is made to feel inferior in their moment of vulnerability [63–65]. Dignity, therefore, is not a peripheral value; it is central to the moral and constitutional legitimacy of health care in India.

Attributes of dignified health care

Drawing on scholarly literature from bioethics, public health, constitutional law, and Indian socio-legal scholarship, we can identify several core attributes of dignified health care. These attributes are not merely procedural but reflect deep normative commitments to justice, equality, and recognition of the inherent worth of individuals. Dignified health care encompasses more than respectful communication; it demands structural, ethical, and interpersonal reforms grounded in justice and recognition. Core attributes include autonomy and informed consent, ensuring that care-seeking individuals are treated as moral agents capable of making decisions about their bodies [64, 66–69]. Non-discrimination and equity are essential, particularly in the Indian context, where caste, class, and gender hierarchies systematically distort access and treatment [60, 61]. Dignity also requires recognition and empathetic engagement [34, 70, 71]. Privacy and confidentiality, often violated in overcrowded and under-resourced Indian public hospitals, but these are crucial to affirming personhood [65]. Additionally, services must be accessible and culturally appropriate [72, 73]. Indian legal and constitutional frameworks under Article 21, as interpreted in various cases, and literature on health governance indicate that health care must protect dignity through participatory governance (i.e. people's engagement in decision-making spaces on matters concerning their health and well-being [51, 74, 75]. Finally, as scholars like Ambedkar (1957) [63] and Farmer (2003) [76] argue, true dignity in health care requires addressing structural violence and social determinants, ensuring not only respectful treatment but also just and equitable life conditions.

We concur with Etinson (2020) [77] who argues that to understand the uniqueness of human dignity, we ought to investigate it through a negative methodology that is to find the meaning of human dignity in the places, situations and circumstances where it is harmed, insulted, frustrated, humiliated and degraded. When structural oppression and human dignity violations are pervasive, the oppressed are made to believe in the normalisation of the oppressive practices nurtured in the disguise of institutions, rules, and procedures. "As long as the oppressed remain unaware of the causes of their condition, they fantastically *accept* their exploitation" [78]. Oppression operates most effectively when those experiencing human dignity violations remain silent.

In India, the treatment of individuals, whether in medicine, law, or public and private institutions such as banks or schools, is often marked by shame, humiliation, silencing, and disregard. These practices are not incidental; they are rooted in deeply ingrained assumptions that view citizens as "incompetent, passive, ignorant, stupid, arrogant, or naive [79]." Such perceptions are sustained by colonial continuities and entrenched upper-caste, class, and gendered hierarchies that continue to shape and perpetuate injustices across the Indian health care and legal systems [79–82]. Marginalised, subordinated, and disadvantaged communities are routinely met with condescension, disdain, and degradation. A pervasive culture of disrespect has become institutionalised, one that systematically denies these communities their self-respect, dignity, and agency. In a context where ideas of rights, dignity, or citizen agency are not actively promoted or publicly discussed, and where no structured efforts are made to inform ordinary citizens of their entitlements [79], it is unrealistic to expect marginalised groups to spontaneously use the language of dignity or rights to describe their experiences. When care-seeking individuals are expected to be passive recipients of care, as is often the case in medical systems in India shaped by bureaucratic and hierarchical norms [80–82], it is neither logical nor equitable to assume that Adivasi communities, such as the Soligas, would articulate their reflections in terms of dignity or respect. In this scenario, an interpretative approach is not only appropriate but necessary. It enables us to unpack the embedded meanings, normative assumptions, and social structures that shape the health care experiences of marginalised communities. It allows us to trace how institutional disrespect is reproduced and how alternative notions of justice, respect, and worth are asserted, often implicitly [83, 84].

The authors explicitly frame this work as interpretative: that is, an attempt to examine the health care experiences of the Soliga Adivasi communities through the lens of dignity. Dignity is not something objectively measured, but we see it as a culturally situated, linguistically mediated, and socially embedded phenomenon. Such an interpretative inquiry is essential because it exposes the violence of institutionalised disrespect embedded in systems like health care, and contributes to the project of reimagining more just, culturally attuned, and ethically accountable health care systems.

Aim of the study

This study aims to interpret how dignified health care is enacted in everyday health care encounters within underserved contexts, through the experiences and perspectives of the Soliga Adivasi community. Specifically, we analyzed the presence or absence of key attributes associated with dignified health care: attention to structural violence and social determinants of health, autonomy, informed consent, respectful communication, non-discrimination and equity in care, recognition and empathetic engagement, privacy, confidentiality, accessibility, cultural appropriateness of care, and opportunities for participatory health governance.

Methods

Research approach

We used an interpretative phenomenological analysis (IPA) research approach. IPA focuses on the experiences of individuals and the researcher's interpretation of those experiences in light of the broader context. It is instrumental when participants do not articulate abstract concepts directly, but the researcher can identify underlying experiential qualities tied to dignity [85]. Such an approach helps reveal how dignity is compromised or upheld in health care services, even when the term itself is not used by participants [86]. We used the qualitative data that was part of the ongoing five-year participatory action research (*Ikyathe-* ಐಕ್ಯತೆ, a project named in the Kannada (regional) language) conducted in partnership with the collectives of the Soliga Adivasi communities in Chamarajanagar district (Fig. 1). The participatory action research focused on exploring the social mechanisms for the Adivasi community to engage in health governance processes.

Study setting

The Soliga Adivasi communities are one among the 12 forest-based Adivasi communities who live in and around forested areas of Biligiri Rangaswamy (BR) hills and Male Mahadeshwara hills of Yelandur, Hanur and Kollegala subdistricts of Chamarajanagar district. They also live in Mysuru, Kodagu, Mandya and Ramanagar districts of Karnataka state and a few neighbouring districts of Tamil Nadu. As per the Census, their population is 33,871 in Karnataka and 5965 in Tamil Nadu state in India [87]. There is a diversity of perspectives regarding the religious identity of the Soliga Adivasi communities. A section of the Soligas identify themselves as Hindus, often influenced by long-standing interactions with neighbouring caste Hindu communities, institutions and State mechanisms. Others within the Soliga communities strongly assert their Adivasi religion with a distinct identity rooted in animistic and nature-based traditions, where forest spirits, ancestral worship, and sacred landscapes form the core of their belief systems. The residential places where Soliga communities live are referred to as *Podu/doddi or colony* in Karnataka. The Soliga people share an intimate, spiritual, and material relationship with the forests of the BR hills. Their lives are entwined with forests for their livelihood, identity, rituals, and belonging. Their main occupation was shifting cultivation until it was banned by the Wildlife Protection Act, 1972. They also collect non-timber forest products such as soap nuts, lichen, gooseberry, broomsticks, honey, herbs, roots, and tubers for their livelihood. Some of them engage as daily wage labourers in coffee and tea plantations in their area or as migrant labourers in neighbouring districts and states [88, 89]. When BR Hills was declared a wildlife sanctuary in 1974 and later a tiger reserve in 2011 under Project Tiger, it marked a significant shift in the governance of forests in the region. With this declaration, traditional Soliga livelihoods such as shifting cultivation, collecting forest products and hunting were completely banned by the state. Several scholars have criticised the action of the state for separating people from their land under the garb of conservation as a "fortress conservation approach" [90–92]. Facing resistance from the forest department,

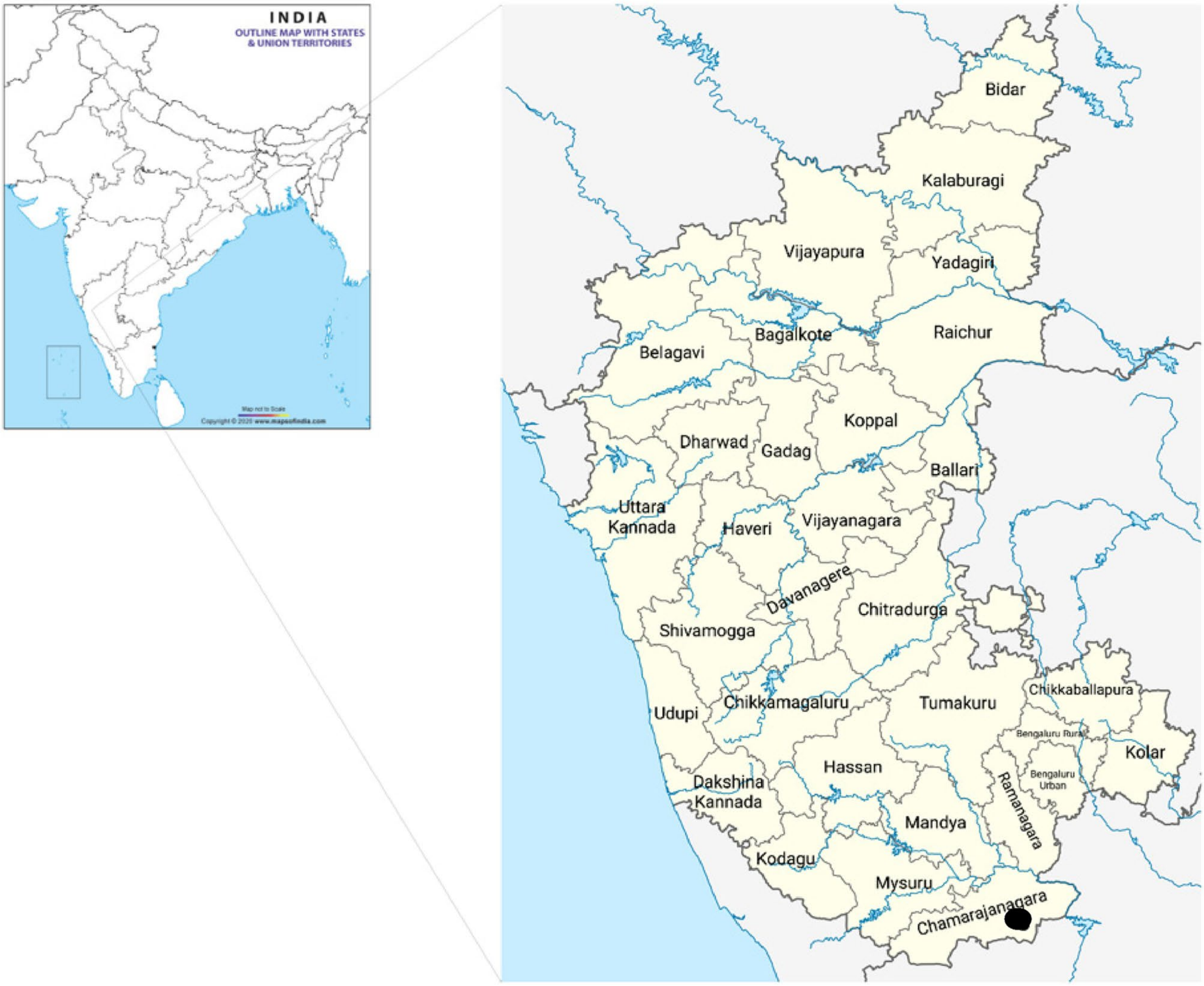

Fig. 1 Location of Chamarajanagar district in Karnataka state, India. Source: Wikimedia commons

the community-based organisation called Jilla Budakattu Girijana Abhivrudhi Sangha and subdistrict level Taluk Soliga Abhivrudhi Sanghas turned to the Forest Rights Act of 2006 to claim their land rights and the rights to collect minor forest produce for their livelihood. They won the legal battle, and around 45% of the Soliga households received land rights, were allowed to do settled agriculture, secured cultural rights to follow their customary religious practices within the forest regions and were permitted to extract forest produce sustainably [93]. However, the Sanghas' struggle to fully benefit from the community forest rights continues even today, since some Soliga households are yet to receive their land rights. Despite some efforts to improve the lives of the Adivasi communities in India through various development programmes, access to motorable roads, electricity, clean drinking water, health care, and education remains challenging for the many Soliga households who live inside or on the fringes of the forests.

Box 1 Long term engagement with a Soliga Adivasi community collective, Jilla Budakattu Girijana Abhivrudhi Sangha in Chamarajanagar district

The authors TS, PNS, and MP are affiliated with the Institute of Public Health (IPH), Bengaluru. Since 2014, IPH Bengaluru has been collaborating on health research projects with the Jilla Budakattu Girijana Abhivrudhi Sangha, a Soliga Adivasi community-based organisation in Chamarajanagar district, Karnataka. This long-standing partnership has given rise to a participatory learning site focused on addressing health disparities among Adivasi community in India. Over the years, this engagement has grown beyond the bounds of conventional research, evolving into a collaborative journey that strives to centre on the voices, knowledge systems, and priorities of the community. Through a sustained presence, co-designed initiatives, and solidarity in collective struggles, IPH Bengaluru seeks to accompany the Soliga people as an ally in their pursuit of health and well-being and promote Adivasi epistemology in health system discourses. This collaboration has been critically reflected upon and documented in several academic publications, contributing to broader conversations on decolonizing research, participatory methodologies, and health equity [94–96]. Reflections on the authors' positionalities are detailed in Supplementary File 1.

Data collection

We conducted 33 in-depth interviews at the homes of individuals with chronic illness and their family members from the Soliga community who sought care in public and/or private health care facilities in semi-urban and urban areas of Chamarajanagar and Mysuru district, respectively. Six in-depth interviews included health care providers of a non-profit primary health care centre called Vivekananda Girijana Kalyana Kendra(VGKK) located in Biligiri Rangana (BR) Hills. MP participated in the mobile health unit visits (four days) of VGKK hospital staff, which supported referral health care services to the Soliga Adivasi communities in the remote villages of Chamarajanagar district. We also used the meeting reports of the workshops and meetings with Soliga community leaders and members conducted as part of the PAR project, *Ikyathe* and in the *Adivasi Arogya Samiti* (an Adivasi Health Committee, a platform co-created by Adivasi collectives and the Institute of Public Health Bengaluru) [97].

We used Image Theatre [98, 99] to hold discussions with the Soliga community leaders and members during the meetings and workshops. Image theatre (an applied theatre technique) is the use of still images sculpted and expressed by bodies, i.e. participants freeze their bodies to express a situation along with the feelings, emotions and thoughts about the issues they choose to demonstrate through a scene [99]. The non-verbal, physical mode of expression in Image Theatre allows participants to access and communicate tacit, emotional, and experiential knowledge that may not easily surface through traditional verbal methods [100]. The images were done very quickly without any preparation by the participants. The on-the-spot formation of images expresses the true memories that the bodies hold without any filtering. The participants of the Image Theatre resonated with the Image Theatre because it allowed them to tell their narratives without relying on written or spoken language. The method aligned with their cultural ways of storytelling and collective reflection. All qualitative data emerging from the 33 in-depth interviews, field notes, seven meetings and one workshop with Soliga community leaders and members were analysed for the presence or absence of the attributes of dignified health care as outlined in the introduction section. The findings of this analysis were shared and discussed during the meetings and workshops with the community leaders and members. The research team members regularly met and deliberated on the data collection and data analysis processes. Any contestations were resolved through dialogue and reaching a consensus among the research team, community leaders and members. The different data sources used in this study are compiled in Table 1, and the characteristics of the in-depth interview participants are shown in Table 2.

Ethical considerations

This study was approved by the Ethics Committee of the Institute of Public Health Bengaluru, study ID 5/2024/FR dated 12/08/2024. For the in-depth interviews, written consent was obtained from literate participants, while oral consent was secured from those unable to read or write and for the participants engaged in community meetings and workshops. Many scholars and ethics committees acknowledge that oral consent aligns with Adivasi communities' oral traditions and mitigates power imbalances associated with literacy [101, 102]. It also fosters trust and culturally appropriate engagement, thereby supporting genuinely informed participation [103]. For the Image Theatre component, participants provided oral consent for the use of their photographs and narratives in the research. This ongoing collaboration through letter of agreement and MoUs with the collectives of Soliga Adivasi communities at the district level in Chamarajanagar ensured that consent remained informed, voluntary, and continuous throughout the research process. There are no details of the individuals reported within the manuscript.

Data analysis

We began the analysis with open coding of the qualitative data, identifying recurring patterns, concerns, and experiences across interviews, field notes, and reports from community meetings and workshops. Using a constant comparison approach [104], we iteratively examined the data across all four sources, interviews, field notes, community meeting reports, and workshop deliberations, against the predefined attributes of dignified care. This allowed us to interpret whether, and how, each attribute was present or absent in the health care experiences of the Soliga community. We shared preliminary findings during district-level community meetings with Soliga leaders and members. Their feedback and critical reflections were incorporated into the final analysis, in keeping with the participatory ethos of the broader research project. This process not only validated our interpretations but also enriched them with additional community insight and perspective.

Results

To structure the qualitative data in the results section, the analysis was organised around key thematic categories derived from the core attributes of dignified health care identified in the literature. Each attribute, such as addressing structural violence and social determinants of health, autonomy, informed consent, privacy, confidentiality, non-discrimination, respectful communication, recognition, empathetic engagement, and participatory health governance, served as a theme. Participant narratives, field notes, and texts from the meeting and

Table 1 Data sources

S.No	Data source/type	Description
1.	In-depth interviews	In collaboration with a senior community health worker from the Soliga Adivasi community, we conducted 33 in-depth interviews in Biligiri Rangana (BR) Hills with individuals living with chronic illnesses and their families. These participants had accessed care from public and/or private health care facilities in the semi-urban and urban areas of Chamarajanagar, Mysuru, and Bengaluru districts. Ten of them had been discharged against medical advice. Additionally, six interviews were held with health care providers from Vivekananda Girijana Kalyana Kendra (VGKK), a non-profit primary health centre in BR Hills. We also integrated data from 11 in-depth interviews conducted under the THETA (Towards Health Equity and Transformative Action) project, aimed at promoting health equity among the Soliga Adivasi community in Chamarajanagar district. We identified participants for the in-depth interviews through our long-standing collaboration with VGKK hospital and our sustained involvement in facilitating referral health care services for the Soliga Adivasi communities in Chamarajanagar district. Participants were purposively selected based on their frequent interactions with health facilities, either as individuals seeking care or as caregivers, within the past five years. Selection also took into account the socio-economic diversity within the community, allowing us to understand how factors such as income level, employment, education, and household conditions influence access to and experiences of health care. All VGKK health workers, who have been instrumental in coordinating referral care and navigating both public and private health systems, contributed valuable insights to the participant identification process. During the interviews, participants were encouraged to narrate their health problems and describe the sequence of actions they undertook to seek medical care. We used probes to explore their interactions with health care providers, perceptions of provider attitudes, experiences with hospital staff, and emotional responses to the care received. We also discussed the challenges they faced, including logistical, financial, and cultural barriers, and their expectations regarding health care services. Attention was given to how their socio-economic circumstances shaped these experiences.
2.	Meetings with Soliga Adivasi community members and leaders	Seven community meeting reports were included in this study. Three meetings were conducted as part of the Participatory Action Research (PAR) project *Ikyathe*, where community members and leaders critically reflected on their health care experiences, one of which employed Image Theatre as a method. Each of these meetings had around 18–20 participants. Three additional meetings were held through the Adivasi Arogya Samity, an institutional platform established between the authors' organization and Adivasi collectives in Chamarajanagar district. The Samity comprises approximately 35 members and served as a space to present study findings and gather feedback from community leaders and members. The final meeting was a multistakeholder forum involving community health workers, school teachers, Adivasi and non-Adivasi leaders, elected representatives, health care providers, and government functionaries at the Panchayat level (a Panchayat being a local self-government body in India covering a cluster of villages). All meetings were documented by the project team.
3.	Workshop with Soliga Adivasi community leaders and members	A two-day planning workshop was conducted with 26 participants from the Soliga Adivasi community, including men, women, youth, and community leaders, as part of the Participatory Action Research (PAR) project. The workshop aimed to identify key issues for the first PAR cycle. In two of the sessions, participants used Image Theatre to reflect on their health care experiences and their interactions with government functionaries concerning health and well-being. A detailed workshop report was developed.
4.	Field notes developed following in-depth interviews and organisation of mobile health units by VGKK hospital to Soliga Adivasi villages in Chamarajanagar district.	The PI made notes documenting the difficulties in accessing the remotely located houses of participants, their housing conditions, road connectivity, the physical environment they live in, and their neighbourhoods; the PI's feelings beforehand; the challenges participants face living in such conditions, both during and after the interviews, and the experience of organising and participating in the mobile health services for Soliga communities. The PI visited six remote Adivasi villages in Chamarajanagar district over four days, accompanying the mobile health unit staff of the VGKK hospital.

Table 2 Characteristics of the participants engaged in the in-depth interviews ($n = 33$)

S.No	Profile of the participants (in-depth interviews)	Number out of 33
1.	Care-seeking individuals	19
2.	Family members of the care seeking individuals	8
3.	Health care providers of the VGKK hospital	6
4.	Men participants	18
5.	Women participants	15

workshop reports were then grouped within these thematic categories. This approach ensures analytical coherence, allowing the empirical data to reveal how violations of dignity are experienced by Soliga Adivasi communities, manifested, and sustained in practice.

Addressing structural violence, social determinants of health, and broader inequities

Except for a few ($n = 3$), a majority of the Soliga participants were living in conditions marked by irregular incomes, inadequate housing, and limited access to food (despite the availability of government public food distribution systems and nutrition programmes), health care, and education. Most participants lived in small homes, often temporary shacks constructed from mud and local materials and worked as landless labourers. Many Soliga participants who were interviewed, as well as those attending community meetings, reported that accessing formal health care often required borrowing money, selling personal belongings, or relying on informal support networks. Some leveraged government social health insurance schemes, such as Ayushman Bharat Arogya Karnataka (hereinafter referred to as ABArK), with the support of a local NGO hospital, VGKK. Indirect health care costs for travel and food remained burdensome for many participants. Several Soliga participants, engaged in this study, residing deep within forest areas, often faced limited access to roads, essential services, and stable livelihood opportunities. During the workshop, participants reflected that their traditional way of life was increasingly at odds with the modern conservation agenda implemented by forest officials. Consequently, many Soliga individuals were forced to seek daily-wage labor in nearby coffee and pepper plantations owned by wealthy estate owners, or migrate to other districts and states for seasonal work. Ironically, while environmentalists appeal to the powerful to protect fragile ecosystems, forest-dwelling communities like the Soligas are simultaneously being lured, or coerced, into abandoning their ancestral lands, where generations have lived in harmony with the forest and its wildlife.

Fig. 2 Photograph from the Image Theatre session held as part of the workshop with community leaders and members

For those who migrate, social protections are non-existent. One young Soliga man in his early 20 s, for instance, sustained serious chest injuries after falling from a tree while working on a plantation in Kodagu. According to his brother, the plantation owner refused responsibility, and the injured worker had to rely on the VGKK hospital and a few individuals to access care in both public and private facilities during a year-long recovery.

Those who remain in forest settlements faced growing man-animal conflict. One woman participant described how elephants and leopards frequently roam near her small one-room house with a tiled roof. Her family, including a toddler, must exercise extreme caution, particularly at night, even for basic needs like using the toilet. During community meetings, multi-stakeholder forum meetings and health care providers of VGKK hospital expressed concerns about school dropouts and the poor quality of public education in Soliga Adivasi villages.

During reflections shared after the Image Theatre session at the workshop (Fig. 2), a few participants noted that corrupt practices, such as informal payments to health care providers and staff in public health facilities, act as a barrier to accessing medical care for Soliga communities. These experiences are not isolated misfortunes but manifestations of structural violence, systemic harm embedded in policies, economies, and institutions that marginalize vulnerable communities. The pressures of displacement, lack of health care protections, denial of labor rights, and exposure to ecological risks are all rooted in broader power structures that favor conservation and economic development over Adivasi rights and well-being.

The physical and social environments in which the Soliga people live fundamentally shape their health care experiences. These conditions influence how they perceive, internalize, and articulate, if at all, their sense of dignity within formal health care settings. These lived realities also highlighted how social determinants of health, such as income, housing, education, environmental safety, and social exclusion, profoundly affect the lives of Soliga. Ensuring dignified health care, therefore, requires addressing these structural and social barriers that continue to perpetuate inequality and injustice.

Respectful communication

A few participants during the interview indicated that the communication of health care providers and staff towards care-seeking individuals in the hospitals is condescending. Such behaviours are explicitly offensive to the dignity of Soliga individuals. Soliga's cultural values emphasise respect, relationality, and mutual recognition.

In Soliga ways of life, every being, human or non-human, is seen as part of an interconnected web of life, deserving of acknowledgement and care. To be treated as invisible or object-like in a hospital setting violates these relational norms and reinforces a sense of exclusion from the very systems meant to offer healing. The following quote by a health care provider of the VGKK hospital illustrates disrespectful communication experienced by Soligas in health care facilities.

> *There have been many a time when we send patients to the district hospital, and they get admitted to men's or women's wards. The morning rounds will happen, and after that, nobody will touch them, see them, or talk to them, and they feel like they've just been thrown here. You know, like nobody, they feel like 'the NGO hospital VGKK couldn't take care of me. So they've thrown me into this hospital. Here also, nobody is looking at me. The doctor is not coming. Why should I be here?' Within two days, they get discharged against medical advice and leave"- Health care provider, NGO hospital VGKK.*

Another woman participant who was admitted to the district hospital for severe anaemia following an abortion at home expressed her frustration with unresponsive communication from doctors and nurses in the tertiary-level health care facility.

> *"I was five months pregnant. I had an abortion at home. I did not go to the hospital after that. After three days, a health worker from VGKK hospital visited my home; she advised me to go to a hospital immediately since I had severe swelling in my body. I got admitted to a government hospital in the Chamarajanagar district. The doctors told me that I may need a blood transfusion. Even after waiting for 13 days in the hospital, a blood transfusion was not done. There was no information. The doctor or the nurses won't speak much, even though we ask them. I felt frustrated. The staff at the hospital are not ready to listen to us. My husband is an alcoholic; my mom sold the cattle to organise medical care here in this hospital. People like us should never go to big hospitals like that. What kind of doctor is he if he is not able to understand my (health) problems?"- Woman, early 20s, BR Hills.*

The next quote highlights how individuals seeking care are left without proper communication or guidance in public health care facilities.

> *"My mother and I used to stand in the queue for 2–3 hours. If we came out of the line, again we had to stand for another 2–3 hours (to submit the required documents to avail the social health insurance benefits)…, but I don't know that ABArK (social health insurance) office"- Family member of a woman care-seeking individual admitted at a government hospital (a 35-year-old man), BR hills.*

The capacity to negotiate with the health care providers at the government hospitals, even for the medical doctors of VGKK to organise care for Soliga Adivasi individuals, proved to be a demanding task. A medical doctor working in VGKK expressed that

> *"If it is difficult for a medical doctor to have conversations with another medical doctor, things could be much worse for the care-seeking individuals".*
> *"These two patients, unfortunately, were out of our trust. The moment we sent them to Mysore. We don't have any interns, and we don't have a tribal health navigator in Mysore. The only conversation I can have is with the PG over there or the Senior Resident doctor consulting. Most of the time, they are not interested in picking up my calls, also because maybe they have so many patients to look after. I don't know their reasons for it, but for them to have a conversation say about one patient, they feel they don't need to have this conversation, so they don't want to talk about it, maybe, so I understand what the patient feels because if the doctor is speaking to me like this, so it might be a whole other level with the patient"- Medical doctor, in their late 20s, NGO hospital VGKK, BR hills.*

These instances collectively underscore how inadequate, impersonal, and often dismissive interactions are widespread in health facilities.

Autonomy/informed consent

Respecting autonomy means providing clear, comprehensive information so care-seeking individuals can make voluntary, informed choices. At government hospitals, information desks and large posters promoting social health insurance schemes, aiming to guide care-seeking individuals and their families, are a common sight. However, despite their willingness and attempts to engage with these schemes, none of the Soliga participants and their family members engaged in this study were able to independently complete the necessary paperwork without the NGO staff support during hospitalisation. There is a systemic lack of proactive information dissemination by the government in Adivasi villages regarding health insurance schemes, hospital procedures, and available health programs. As a result, people are often left to navigate the complexities of the health system on their own, usually only discovering critical information when they reach a hospital, often in moments of vulnerability or crisis. Drawing from the authors' PNS and TS own experiences in organising care for Soliga communities, as well as insights shared by VGKK hospital staff, hospital procedures were complex and inaccessible for many Soliga people without the active support of VGKK staff. One participant, who accompanied his mother to a district-level government hospital, expressed a resigned understanding that being poor meant having fewer choices(thus restrictions in their autonomy), and that seeking free health care often required enduring long delays, even in serious situations.

> *"... I don't know that I have to get signatures from 2–3 officers in the required document. So I was standing in the queue to get the bill for MRI scan, thinking that I had the signed document with me. After seeing the document, the staff at the counter asked me to go to another counter to get the bill. When I went to the other counter after standing in the long queue, the staff at the new counter told me to go to another office near the eye hospital to get the signature on the document. Then I went to that counter, thinking that it was the ABArK office and asked the staff there in the office. The staff took the photocopies of the Aadhar card, ration card, and other documents from me and put the seal and signature. My mother and I used to stand in the queue for 2–3 hours; if we came out of the line, again we had to stand for 2–3 hours. So... I paid the full charges for the MRI scan, thinking that at least then the staff would do the MRI scan early for my mother"-Family member of a woman care-seeking individual who was admitted to a government hospital, her late 20s, BR hills.*

When people are forced to depend on charity for basic needs, it can feel like a loss of autonomy and always keep them in a position of dependence at the cost of their inherent dignity and rights. Accessing health care for many of the Soliga participants (as indicated in interviews and community meetings), even in dire medical emergencies, constantly required leveraging social networks and support from charity and NGO intermediaries who know the health system well to be able to use it. A few participants of the workshop indicated that people who get respect during visits to health care facilities are typically those who are socially connected to health care providers. But their narrations indicated that to even get noticed by a health care provider, the care-seeking individuals and their family members have to constantly be open about their networks, NGO support and assert it to the health care providers and hospital staff while seeking health care. The experiences of Soliga participants highlight how bureaucratic and institutional barriers severely undermine patient autonomy and limit access to essential information needed to make informed decisions about medical care.

Non-discrimination, recognition and empathetic engagement

In the context of health care delivery, where health care providers did not have long-standing relationships with Soliga communities or were not sensitised to their sociocultural realities, health care experiences for the Soligas were marked by discrimination and a lack of recognition as individuals and empathetic engagement. See, for instance, the following situation. While waiting in the inpatient ward of a public health facility to interview a family member of a Soliga woman admitted for evaluation of a severe headache, MP observed a distressing situation. The patient and her family had travelled from a remote Adivasi village deep within the forest. Her son described how they had been waiting for nearly three days to get an MrI scan done. Each day, his mother was instructed not to Drink water from 6 am onwards in preparation for the scan. Yet, for two consecutive days, she was taken to the MrI room, made to wait until 3 p.m., and then sent back to the ward without the scan being completed. Each time, a vague reason was given, and the process was repeated the next day.

Noting the growing distress and the mother's worsening condition, particularly the combination of prolonged fasting and severe headache, MP suggested accompanying the son to speak with the in-charge nurse to seek clarity about the delay. However, the son hesitated, expressing fear that he would be scolded by the staff. He admitted he was afraid to approach care providers or question them in any way.

MP then approached the nurse on his behalf, explaining the family's living conditions and the difficulty they faced in accessing hospital care from such a distant and isolated location. She emphasised the urgency of the scan, given the mother's condition and prolonged fasting. In response, the nurse said, "What can I do? I have also worked in tribal areas for 15 years. I know about their life. There are so many patients, we cannot say when the scan will be done." A resident doctor, sitting beside the nurse and writing in a patient file, added without looking up: "This is a government hospital; things will be delayed a bit. This is what can be expected here."

After this exchange, the nurse turned to the son and, in a sharp tone, asked, "Why are you bringing people to question me? You could have come and asked yourself." The son, visibly embarrassed and hurt, lowered his gaze and remained silent.

This encounter reveals how discrimination, lack of recognition, and absence of empathetic engagement shape the health care experiences of the Soliga community. The son's fear of approaching staff reflects internalised marginalisation, while the staff's dismissive and rude responses highlight institutional indifference. Despite the family's hardship and the mother's worsening condition, their concerns were minimised, and their dignity was overlooked. Such interactions expose systemic power imbalances and a broader failure to treat Adivasi people as equals and deserving participants in care.

The following quotes reflect th**e** navigational challenges, fear, and vulnerability experienced by Soliga care-seeking individuals and caregivers when accessing care. The reliance on literate intermediaries and NGO staff underscores not only barriers related to literacy and bureaucracy but also a lack of empathetic engagement from health care providers.

> *"If we go alone from here, we have to spend money for the bus, in hospital they say a hundred things like go here and there, get the token, letter, get sign here etc, we don't know all those things because we have not read, and we can't do all those things they say, so it is better to take a person who is literate, since they can do all the work easily for us."- Grandfather of a 15-year-old girl with Type I Diabetes Mellitus.*
> *"My mother is there to support me. But she can't do all that (in hospital) because they say go here and there for scans, blood tests and other things, so I didn't go"- a woman with a chronic health condition, Late 30s, BR hills.*
> *If we go (to hospitals outside BR hills) without the staff support of the NGO hospital VGKK, we will have fear thinking what will happen, what they (health care providers) will do"- Grandmother of a 15-year-old girl with Type I Diabetes Mellitus.*

A few participants had perceived differences and distanced themselves from the care providers and hospital staff because of the attitude of health care providers and hospital staff, and existing patient care practices in the hospitals.

> *"If the doctor asks only, I will say otherwise; I won't say. Mostly doctors just ask what is the health problem I'm facing, and they just give tablets and medicine for that. They are not interested in knowing my life or sorrows"- a woman with a chronic health condition, late 30s, BR hills.*
> *"There is some social conditioning that happens as children and adults among these people, which tells them under no circumstances to trust the outsider. I mean, I'm not talking about you, but many of us who are working there as doctors and all the formal health care establishments are outsiders. They did not believe, very recently, even ANMs and Nurses. Only now they've begun to see that my kind of person is also a health care provider"- Medical doctor, who lived in the BR hills and worked with Soliga communities for more than a decade.*

Following an Image Theatre (Fig. 3), community members expressed that despite enduring long waiting times, sometimes stretching into weeks, they continued to seek consultations with senior doctors, diagnostic tests, and necessary treatments. However, their capacity to persist was tested by the lack of timely information and communication from the health care providers. Without updates or explanations, many felt disoriented and excluded, leading to a deep sense of uncertainty. The above experiences of Soliga's highlight a serious gap in empathetic engagement within the health care system. Participants were not simply waiting for services; they were waiting in a void, without recognition of their presence, time, distress, or dignity.

These experiences reflect how deeply rooted social hierarchies, fear, and unfamiliarity with formal systems contribute to feelings of exclusion and perceived discrimination among the Soliga communities. Despite needing care, individuals hesitate to speak, seek help, or access services without support, fearing judgment or mistreatment. The lack of culturally sensitive engagement from health care providers reinforces mistrust and perpetuates a sense of "othering."

Privacy and confidentiality

For several Soliga participants we interviewed, as indicated earlier, accessing health care often involves seeking support from NGO hospital workers or others who can assist them, either financially or by helping them navigate the health care system. This means that each time they attempt to access medical care, they are required to disclose their health or illness status to multiple people, potentially compromising their right to privacy and confidentiality.

In crowded public health facilities, Soliga individuals have little or no opportunity to discuss their medical issues in private. However, this does not imply that breaches of privacy or confidentiality are acceptable within Soliga communities. On the contrary, such violations can have devastating consequences for individuals and their social well-being.

For example, during an Adivasi Arogya Samvada meeting, a community member criticized a community health officer (CHO) behaviour for publicly revealing the sickle cell disease diagnosis of a 16-year-old Soliga boy in front of his schoolmates and teachers. As a result, the boy

Fig. 3 A photograph from the Image Theatre performed by Soliga community members during a community meeting

felt deep shame and began to fear the disease's potential complications, even though he was asymptomatic at the time. Having witnessed his father's suffering and multiple hospitalizations due to the same condition, the boy believed he would suffer a similar fate. He stopped attending school and feared he would never get married, as his diagnosis had become public knowledge. The community leader pointed out that the CHO should have been more cautious and taken a more empathetic approach rather than disclosing the boy's medical condition in a public setting.

In another instance, during a discussion between local community leaders and health care providers at a Primary Health Centre, a health care worker openly stated that a community leader had tuberculosis (TB) and was not coming for treatment. Other Adivasi leaders present at the meeting immediately objected, stating that it was inappropriate to name the individual and disclose his health condition in front of others. The health care worker defended the action by arguing that public knowledge might motivate the individual to seek treatment. While this reasoning may appear logical, it nonetheless constitutes a clear violation of privacy and confidentiality.

Accessibility and culturally appropriate care

A few participants felt that they were simply denied care for no reason. A few others felt that the treatment was inadequate and inappropriate given the seriousness of the medical problem they had.

> *"We don't know what the reason is, but they were not admitting. When we asked anybody in the hospital, they used to say stay here, only the doctor has not come yet. Whenever we asked to admit, they used to say Wait"- Family member of an ANC mother in a government hospital, early 40s, BR hills.*
> *"The treatment wasn't satisfactory. They would administer painkiller injections but did nothing else in the government hospital in Chamarajanagar,"- Family member of a man (early 20s) who sustained a serious chest injury due to a fall from a tree while working in a coffee plantation.*

All participants from the Soliga community faced financial hardships in accessing care despite the social health insurance programmes of the government. Their experiences reflect not just economic hardship, but also a violation of their sense of dignity. As indicated by community leaders and members during a discussion following an Image Theatre session, informal payments for free services in public health facilities and exorbitant fees in private health care facilities were common issues. Their narratives underscore that financial barriers are not merely transactional, but they are deeply tied to how individuals are seen, treated, and respected within the health system. Financial hardship emerged as a central concern among Soliga participants in their efforts to access timely and appropriate medical care.

> *"I couldn't go due to money problems even though I was seriously ill"- a woman in her late 30s, BR hills.*
> *"Whether it is a government or a private hospital, we should have money in our hands before going; without money, we can't go. Where do we get money?*

> *Barely we have half acre of land, our survival is based on that"- Grandmother of a 17-year-old girl with Type I diabetes, BR hills.*
>
> *"At a big (private) hospital, they did 3 operations. We paid INR 70,000. X mam from the NGO, helped us. There was a name problem on the social health insurance card until we paid the money; they were taking care of all the facilities[i.e., the hospital provided good care and full attention when they were paying out of pocket]. But when the error in the health insurance card was rectified and my brother was eligible to avail the treatment under the social health insurance scheme, poor treatment was meted out to my brother [i.e., once the payment was to come from the government insurance scheme, the hospital's attitude and quality of care worsened]. So we got him discharged from the hospital"- Family member of a care-seeking individual who underwent major surgeries in a tertiary-level private health facility in Bengaluru, a man in his late 40s, BR hills.*

All Soliga Adivasi individuals and their family members who were part of this study had to make elaborate arrangements in terms of money, travel, and family support for seeking care in hospitals that are located far away from their villages. For instance, for a person who is living in Beduguli, a remote Soliga village in BR hills, it would take 2–3 h (which can vary depending on road conditions in the forests, weather, and vehicle availability) to reach the district hospital in Chamarajanagar. Due to limited public transportation, community members rely on private vehicles in times of illness and medical emergencies. Each such trip can cost around INR 4000–5000 (USD 45–60). Most of them utilise services from government hospitals if they need secondary or tertiary care. A few participants reported seeking care from private health care facilities despite financial hardships with the hope of finding a cure for their ailments. For major surgeries, a few participants had sought the help of NGO hospital VGKK to utilise the public social health insurance scheme (ABArK) and/or to navigate the private medical care system when services were unavailable in public health facilities or where long waiting periods made timely care unattainable.

Fig. 4 A photograph from the Image theatre session conducted as part of the workshop with community leaders and members

During the discussions following the Image Theatre session at the workshop (Fig. 4) with community leaders and members, a few participants shared that poor road infrastructure, limited mobile network coverage, and inadequate ambulance connectivity in remote Soliga Adivasi settlements often lead to delays in accessing health care. They linked these challenges to a lack of coordination among various departments, including the Forest Department, Transport Department, and Health Department. Even with support from the NGO hospital VGKK staff, IPH Bengaluru staff and Adivasi leaders from the community-based organisations, when they reached the hospitals (especially government hospitals), they had to wait for hours and days to get basic investigations and treatment done. See, for example, the following quote,

> *" My mother got admitted to this hospital (government) on Monday. Two staff members from an NGO hospital, VGKK, came with us and made all arrangements for my mother to get admitted here. In the hospital, we were told that an MRI scan had to be done. But they kept postponing the date. Even the NGO staff called the concerned people here at this hospital. Five days have passed, but the MRI scan is still not done…They won't do anything on holidays "- Family member of a woman care-seeking individual who was admitted to a government hospital, in their late 20s, BR hills.*

For a Soliga living in the forest or in the fringes of the forest, delays and long waits in accessing medical care in cities can severely undermine culturally appropriate care. The health care facilities situated outside the forest areas often operate in ways that are unfamiliar and uncomfortable, creating a cultural disconnect that can lead to feelings of alienation and anxiety. Long waiting times can also disrupt the individual's connection to traditional healing practices and community support, which are often central to their understanding of health and recovery. Moreover, being away from their environment for extended periods may interfere with important cultural responsibilities, adding further stress. See, for instance, in the words of a young Soliga mother who admitted her child, who was prematurely born at home, to a secondary health care public facility,

> *"They are asking me to go to another city, Mysuru, with my child, since there is no treatment for my*

> *child's sickness at this facility. I cannot stay too long outside my home (which is in a remote forest area). I feel anxious and shy to talk to the hospital staff. Here, at least, there is a tribal health navigator who helps us with the hospital procedures. In Mysuru, we will not have such people to help us. So I do not want to go."- Mother of an infant child admitted in a secondary health care public health facility.*

Participatory health governance

Participatory health governance ensures that marginalized communities have a voice in shaping health systems, leading to more responsive and respectful care. When communities are actively involved in decision-making, health care delivery is more likely to uphold dignity, cultural relevance, and accountability. Throughout the participatory action research process, including community workshops, meetings with local leaders, and ongoing engagement with Adivasi collectives in Chamarajanagar district, significant barriers to participation in health governance spaces were observed. These included limited or no access to decision-making forums such as Village Health, Sanitation and Nutrition Committees (VHSNCs). Health care providers and government officials from other sectors often viewed communities primarily as passive recipients of services, rather than as active stakeholders. For example, during a multistakeholder meeting in one gram panchayat (the basic unit of rural local self-government in India), frontline health workers and government representatives emphasized health education as a tool to secure community compliance with government schemes, rather than promoting meaningful dialogue or accountability. Several community members, both Adivasi and non-Adivasi, reported limited awareness or memory of participating in any structured meetings dedicated to reviewing the state of local health services. While gram sabhas (village assemblies) are held at the panchayat level, they are not typically focused on health-related issues and rarely facilitate inclusive discussions on health service quality or access.

During a community-level meeting, a participant from a local collective noted the importance of being informed about their rights to claim them, emphasizing that inclusion in decision-making bodies is essential for holding the system accountable. In a separate Image Theatre session (Figs. 5, 6 and 7), several participants shared frustrations with bureaucratic follow-up processes, particularly in areas such as forest rights implementation. These processes often required persistent engagement over long periods, sometimes years, with little progress unless pressure came from higher authorities. As a result, participants described strategies such as bypassing local officials to approach senior administrators directly or mobilizing in large groups to ensure their concerns were taken seriously. They expressed a strong sense that individual voices were frequently dismissed unless amplified through collective action.

Fig. 5 Photographs from the Image Theatre session with Soliga community leaders and members, which opened up critical discussions concerning health governance realities for Soliga communities

Fig. 6 Photographs from the Image Theatre session with Soliga community leaders and members, which opened up critical discussions concerning health governance realities for Soliga communities

The health care experiences of the Soliga community illustrate how the failure of participatory health governance creates a disconnect between health systems and the lived realities of marginalized groups. When community voices are excluded from decision-making, care becomes impersonal, exclusionary, and often disrespectful, reinforcing existing power imbalances, disregarding cultural contexts, and ultimately undermining the dignity and autonomy of those seeking care.

Discussion

In this section, we situate the key findings of the study within the broader Adivasi socio-political, legal context and compare our findings with existing literature on health inequities in Adivasi communities in India, identifying points of convergence and divergence. We then

Fig. 7 Photographs from the Image Theatre session with Soliga community leaders and members, which opened up critical discussions concerning health governance realities for Soliga communities

reflect on the implications of these findings for health policy and service delivery,

This study foregrounds the persistent violations of dignity experienced by Soliga Adivasi individuals within the health care system. These violations manifest in multiple forms, from significant delays in accessing medical care to a troubling dependence on non-governmental organizations and individual actors to navigate complex health systems. Participants' narratives reflect experiences of neglect, the absence of respectful communication, and a lack of empathetic, culturally appropriate care from health care providers. Breaches of privacy and confidentiality further erode trust, while complex hospital procedures and bureaucratic hurdles leave many feeling disempowered and unable to independently access care. The systematic exclusion of Adivasi communities from health governance and decision-making spaces compounds these barriers, reinforcing the structural inequalities that deny equitable and dignified care. These lived realities also make visible the profound influence of social determinants of health, including income, housing, education, and social exclusion, on the everyday lives of the Soliga. Pressures such as displacement, lack of social protections, denial of labor rights, and exposure to ecological risk are not incidental but embedded in broader political and economic structures that prioritize conservation and development over Adivasi rights and well-being. These structural barriers must be understood as a form of violence. These findings concur with studies and reports on other Adivasi communities in India [30, 32, 105–109]. However, we problematize the findings, such as delays in accessing formal health care, denial of care, lack of recognition and empathetic engagement, dehumanising experiences in the health facilities, and lack of opportunities to engage in formal health governance spaces for the Soliga Adivasi communities as matters of human dignity. India is not unique in facing these issues; similar patterns of health care disparities among the Indigenous communities are evident across various regions and health care systems worldwide [107–109]. Factors such as geographical remoteness, communication issues, poverty, and culturally unsafe care deter access to health care for Indigenous communities [110–115]. Further, studies demonstrate that dysfunctional interactions within hospital settings make the care-seeking individuals from Indigenous communities feel alienated [110, 115]. The barriers that deter culturally safe, respectful care for Indigenous communities are rooted within the broader systemic issues, such as marginalisation, social exclusion, wilful neglect by the State and poor resource allocation for functional health care systems for Indigenous communities [31, 32, 114–120].

Indian constitutional jurisprudence has gradually expanded the interpretation of dignity within the domain of health, recognizing that issues such as poor access, lack of privacy, and exclusion from decision-making are not merely service delivery failures but fundamental rights violations. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) [121], the Supreme Court held that the right to life under Article 21 includes timely and adequate access to health care services, affirming that denial of such access undermines human dignity. The Court further emphasized informed consent, autonomy, and privacy in *Suchita Srivastava v. Chandigarh Administration* (2009) [122], as core attributes of dignity and freedom. In *Devika Biswas v. Union of India* (2016) [123], the Court condemned forced sterilizations and emphasized the importance of consent, bodily integrity, and respect in public health programs. The right to confidentiality was highlighted in *Mr. X v. Hospital Z* (1998) [124], establishing that unauthorized disclosure of a patient's condition can amount to a dignity violation. More broadly, *Navtej Singh Johar v. Union of India* (2018) [125] located dignity within a framework of non-discrimination and equal treatment, affirming that constitutional morality must guide State action. While courts have yet to robustly address participatory governance in health, the spirit of *People's Union for Civil Liberties v. Union of India* (2003) [126] in the context of the right to food and social accountability mechanisms provides a foundation for recognizing meaningful community participation as part of dignified care. However, the everyday realities faced by Soliga Adivasi communities, marked by disempowerment, exclusion, and structural neglect, underscore the gap between constitutional ideals and actual practice. Recognizing these violations as failures of dignity demands a shift from narrow biomedical approaches to rights-based, culturally responsive, and community-anchored health governance.

The findings of this study represent a clear departure from how dignity has been articulated within India's constitutional framework and interpreted by the courts. The manifestations of dignity violations within health care services for Soliga Adivasi communities are not isolated incidents affecting a specific social group; rather, they must be understood within the broader context of structural injustices historically and systemically faced by Adivasi communities across India. Situating these experiences within this larger framework allows for a deeper understanding of the structural drivers behind such dignity violations in health care.

As constitutionally recognized Scheduled Tribes, Adivasis have long faced systemic exclusion from development planning, political representation, and equitable access to public services, including health care [127, 128]. Their geographic isolation is often compounded by cultural and linguistic differences, reinforcing a perception of Adivasis as "other" within State institutions, including the health care facilities [129]. The legacy of colonial forest policies and post-independence development projects has led to large-scale displacement, land alienation, and disrupted traditional livelihoods, weakening community autonomy and increasing dependence on State and NGO interventions [130]. Within the health sector, caste and class-based hierarchies and biomedical dominance often silence Indigenous knowledge systems and render Adivasi experiences invisible or illegible [131]. However, in our study, while participants shared experiences of feeling unwelcome or hesitant within hospital settings, it was not always apparent whether participants were overtly discriminated against by health care providers because of their Adivasi identity. Several participants noted that poor people from other communities often faced similar treatment in hospitals. This suggests that class-based discrimination may be deeply entangled with, at times indistinguishable from, the marginalisation experienced by Adivasis, making it difficult to isolate discrimination based on Adivasi identity. We need further studies in this area to understand how the complex dynamics between caste, class, and Adivasi identity play out in health care contexts. The lack of Adivasi peoples' representation in health governance spaces reflects broader patterns of exclusion, where decisions about tribal welfare are made without meaningful participation, further entrenching power asymmetries.

The feelings of fear and otherness among Indigenous communities instilled by formal health care services are a manifestation of internalised oppression, shaped by generations of structural violence that marginalised Indigenous voices and eroded trust in institutional modern health care [29]. Subramani (2025) argues that the everyday indignities faced by underserved communities during their health care encounters in India are a result of systemic oppression that is often reinforced by class, caste, and gender hierarchies in India [80].

Neoliberal economic reforms in the name of development and forest conservation force the displacement of forest-dependent Adivasi communities in India. Development-induced displacement of Adivasi communities strips away their socio-cultural identity, loss of land, opportunities for their livelihood, and access to health, education, human rights, and thus affects their dignity and well-being [105, 116, 117]. The colonial legacy of labelling Adivasis as "primitive" and "uncivilised" has resulted in epistemic injustice, infantilization and therefore their misrepresentation as threats to the law and order of the State. Such discourses expose the Adivasi communities to various forms of exploitation and oppression and deny basic resources needed for a dignified living [118–120]. Adivasi worldviews on health, rooted in Indigenous knowledge and cultural practices, are frequently overlooked due to assumptions tied to formal education [29, 112, 132, 133].

We see these similar discourses reflected in the way the formal health care services are designed and delivered to Adivasi communities in India. For example, poor health infrastructure, shortage of health workforce in Adivasi areas and poor representation of Adivasi communities in the health workforce, discriminatory behaviour of health care providers and health facility staff [112, 134–136] signal that the needs, concerns or identities of Adivasis are systematically neglected in the formal health care services. Such discourses often problematize geographical isolation, lack of awareness, inadequate education, poor sanitation, and traditional healing practices, situating the barriers to accessing dignified health care at the individual level for Adivasi communities [137–140]. Adivasi communities feeling dismissed, undervalued or invisible in health care settings or the system at large have serious implications on their dignity. A feeling of shame and indignity induced by formal health care services may deter Adivasi communities from seeking care in times of need, thereby accentuating health inequities [62]. When communities are made to feel dismissed or invisible in health care or broader societal systems, it's more than just a lack of service; it's a message that their lives, health, and humanity are not valued. The formal health care system in India treats care-seeking individuals in general as passive recipients of care and sustains a culture of disrespect through its actions and inactions [98].

Dignified health care for Soliga Adivasi community will be a reality only when the multiple forms of life's precarities they are facing are structurally addressed. Policy makers and implementers who are involved in governing health care systems should critically reflect on existing approaches and practices and their impact on accessing dignified health care by the Adivasi communities. There is a critical need to strengthen the economic and educational foundations of the Soliga Adivasi communities to enable greater self-reliance, including in accessing health care, without relying solely on external aid. Measures such as the introduction of cultural mediators in health facilities who could empower Adivasi communities to navigate hospital structures and procedures, the empathetic approach of health care providers and enabling financial mechanisms to access health care by Adivasi communities are essential to realising dignity in health care. Successful interventions to uphold dignified health care require integrated care models and active partnerships with Adivasi communities in health governance [31, 113, 115]. Addressing how health care providers may contribute to dehumanising practices is essential. This calls for rights-based professional training, regular sensitisation, and stronger accountability within health systems to deter actions that undermine the dignity of care-seeking individuals, alongside broader efforts to disrupt historical legacies of exploitation and marginalisation that socially diminish communities in vulnerable situations, positioning them as inferior or of lesser worth within society. Approaches such as using storied case examples or applied theatre in health professional training offer promising pathways for change by enabling dialogue, fostering critical reflection, and supporting social transformation. There is a need for reimagining health care services, approaches and practices in the health care service delivery that affirm human dignity for Soliga and other Adivasi communities.

Strengths and limitations

One important strength of this study is that it problematizes issues such as poor access to health care and low utilization of services by Adivasi communities as matters of dignity. These issues are often minimized or overlooked in the biomedically oriented health care systems, framed merely as concerns related to quality of care, rather than being recognized as structural injustices. Another strength of this study is its broad conceptualization of dignified health care, extending from respectful and responsive communication between care-seeking individuals and health care providers, to the meaningful participation of these individuals in health governance spaces, and encompassing the many layers in between. This was made possible through diverse data sources embedded within long-term, collaborative participatory action research partnerships and sustained engagements with collectives of Soliga Adivasi communities in Chamarajanagar. We acknowledge that human experiences are relational and, hence, it becomes crucial to explore the perspectives of other actors, such as non-NGO health care providers and policy implementers, to deepen our understanding of dignified health care in the Indian context. While the term dignity may not always appear explicitly in classical Indian philosophy, many Indian thinkers and traditions have explored ideas deeply connected to human dignity, such as self-worth, ethical duty, justice, and the inherent value of human life through various vocabularies in Indian languages. In the Kannada language, which is also spoken by the Soliga community alongside their language, terms such as *swabhimaana(*ಸ್ವಾಭಿಮಾನ*)*, *Nyaya(*ನ್ಯಾಯ), *dharma* (ಧರ್ಮ), *maana* (ಮಾನ), *mariyadey*, (ಮರ್ಯಾದೆ) *gowravha (* ಗೌರವ), *ghanathe* (ಘನತೆ), *Maanaviyathe* (ಮಾನವೀಯತೆ) and *karuney* (ಕರುಣೆ) represent various dimensions of the concept of dignity. The conceptualization of dignity in the literature is dominated by Western perspectives, posing limitations to research on dignity in non-Western settings. In this study, we broaden these conceptualizations by extending the notions of dignity in culturally grounded ways. There are notable similarities across cultural contexts in understanding dignity, even though different terminologies and expressions are employed. Different communities experience exclusion and disrespect in diverse ways based on their social, cultural, economic and historical contexts. A one-size-fits-all understanding of dignity risks overlooking these nuances. Therefore, there is a critical need to disentangle the indignities experienced by other communities within formal health care services in India and other systems of medicine.

Conclusion

The Soliga Adivasi communities' health care experiences elucidate the everyday dignity violations in the health care context of India and are significant to normative discourse on dignified health care. While various communities may encounter indignities within formal health care systems, the consequences of such experiences are far more profound and damaging for populations in marginalised and vulnerable situations, such as the Adivasi communities. This study underscores the urgent need for governments, policymakers, and health system actors to transform health care delivery for Soliga Adivasi communities. Stakeholders must intervene at the structural level, through concrete policies, accountable implementation of those policies, and dignity-oriented health care service delivery practices that actively preserve and promote the agency, self-respect, and autonomy of Adivasi communities. Such interventions are essential for enabling equitable and dignified lives for the Soliga people within and beyond health care systems.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12939-025-02637-6.

Supplementary Material 1

Acknowledgements
We extend our heartfelt thanks to Jilla Budakattu Girijana Abhivrudhi Sangha, Taluk Soliga Abhivrudhi Sanghas, Chamarajanagar district, Vivekananda Girijana Kalyana Kendra, and other Soliga community members and leaders for their collaboration and support in this study. We thank Ms.Madevi who supported us in data collection. We also would like to thank Dr. Ravi Ramaswamy and Radha Ramaswamy who facilitated the image theatre sessions during the workshop with Soliga community members and leaders.

Authors' contributions
MP conceptualised, collected, analysed data, drafted the manuscript and revised the manuscript based on the inputs from co-authors. MP is the lead investigator of the larger participatory action research project (Ikyathe) in which this study is nested. PNS supported in conceptualisation, data collection, analysis and critical review of the manuscript drafts. TS supported in planning and facilitated data collection, data analysis and critical review of the manuscript versions. CMG contributed to data analysis and critical review of manuscript versions. SVB contributed to the planning of data collection, data analysis and critical review of manuscript versions. PNS, TS, SVB, and CMG (part of Jilla Budakattu Girijana Abhivrudhi Sangha) are collaborators and mentors in a larger participatory action research project (Ikyathe) led by MP.

Funding
The time and the contributions of MP to develop this article and partial funding to publish the article were supported by DBT/Wellcome Trust India Alliance Early Career Fellowship IA/CPHE/22/1/506530. The time and the contributions of PNS, TS, and CM for this paper were supported by the DBT/Wellcome Trust India Alliance Grant IA/CRC/20/1/600007 awarded to PNS, IPH Bengaluru.

Data availability
The qualitative data that support the findings of this study are not publicly available. Restrictions on the availability of these data are due to the provisions of informed consent, as approved by the institutional ethics committee, which stipulate that the primary data will not be shared with any third parties outside the research team. The anonymized data can be used for analysis and development of research manuscripts, publications, and scientific presentations by the project team. The data are, however, available from the authors upon reasonable request and with the permission of the Institutional Ethics Committee of the Institute of Public Health, Bengaluru.

Declarations

Ethics approval and consent for participate
This study was approved by the Ethics Committee of the Institute of Public Health Bengaluru study ID 5/2024/FR dated 12/08/2024.

Consent for publication
For the in-depth interviews. Written consent was obtained from literate participants, while oral consent was secured from those unable to read or write and from the participants engaged in community meetings and workshops. For the Image Theatre component, participants provided oral consent for the use of their photographs and narratives in the research. As this nested study was part of a broader participatory action research (PAR) project, participants maintained consistent engagement with the research team and were involved in all stages of the project. This ongoing collaboration through letter of agreement and MoUs with the collectives of Soliga Adivasi communuties at the district level in Chamarajanagar ensured that consent remained informed, voluntary, and continuous throughout the research process. There are no details of the individuals reported within the manuscript.

Competing interests
The authors declare no competing interests.

Author details
[1]Centre of Adivasi Health, Institute of Public Health , 3009, II-A Main, 17th Cross, Krishna Rajendra Rd, Banashankari Stage II, Bengaluru, Karnataka 560070, India
[2]Jilla Budakattu Girijana Abhivrudhi Sangha, Hospodu, BR Hills, Chamarajanagar, Karnataka, India
[3]Institute of Tropical Medicine, 155 Nationalestraat, 2000 Antwerp, Belgium

Received: 30 April 2025 / Accepted: 7 September 2025

References

1. Galea S. Elevating dignity as a goal for health system achievement in the COVID-19 era and in the future. JAMA Health Forum. 2021;2(8):e212803.
2. Kerasidou A, Bærøe K, Berger Z, Caruso Brown AE. The need for empathetic health care systems. J Med Ethics. 2020;47(12):e27.
3. Beach MC, Sugarman J, Johnson RL, Arbelaez JJ, Duggan PS, Cooper LA. Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventive care? Ann Fam Med. 2005;3(4):331–8.
4. Zirak M, Ghafourifard M, Aliafsari Mamaghani E. Patients' dignity and its relationship with contextual variables: a cross-sectional study. J Caring Sci. 2017;6(1):49–51.
5. Jacobson N. Dignity and health: a review. Soc Sci Med 1982. 2007;64(2):292–302.
6. Amininasab SS, Azimi Lolaty H, Moosazadeh M, Shafipour V. The relationship between human dignity and medication adherence in patients with heart failure. J Med Ethics Hist Med. 2017;10:5.
7. Hall S, Goddard C, Speck PW, Martin P, Higginson IJ. It makes you feel that somebody is out there caring: a qualitative study of intervention and control participants' perceptions of the benefits of taking part in an evaluation of dignity therapy for people with advanced cancer. J Pain Symptom Manage. 2013;45(4):712–25.
8. Holmberg M, Valmari G, Lundgren SM. Patients' experiences of homecare nursing: balancing the duality between obtaining care and to maintain dignity and self-determination. Scand J Caring Sci. 2012;26(4):705–12.
9. Baillie L. The impact of staff behaviour on patient dignity in acute hospitals. Nurs Times. 2007;103(34):30–1.
10. Henderson A, Van Eps MA, Pearson K, James C, Henderson P, Osborne Y. Maintenance of patients' dignity during hospitalization: comparison of staff-patient observations and patient feedback through interviews. Int J Nurs Pract. 2009;15(4):227–30.
11. Baillie L, Ford P, Gallagher A, Wainwright P. Nurses' views on dignity in care. Nurs Older People. 2009;21(8):22–9.
12. Matiti MR, Trorey GM. Patients' expectations of the maintenance of their dignity. J Clin Nurs. 2008;17(20):2709–17. https://doi.org/10.1111/j.1365-2702.2008.02365.x.
13. Pereira MJ, Oliveira AC, Silva RM, Santos LM. Challenges for hospital management in supporting nurses to deliver humanized care. ResearchGate; 2025 Feb 11 cited 22 Aug 2025 . Available from: https://www.researchgate.net/publication/352071196_Challenges_for_hospital_management_in_supporting_nurses_to_deliver_humanized_care
14. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. Lancet. 2017;389(10077):1453–63.
15. Foster HME, Polz P, Gill JMR, Celis-Morales C, Mair FS, O'Donnell CA. The influence of socioeconomic status on the association between unhealthy lifestyle factors and adverse health outcomes: a systematic review. Wellcome Open Res. 2023;8:55.
16. Blas E, Sivasankara Kurup A, Organization WH. Equity, social determinants and public health programmes. World Health Organization; 2010 cited 23 Apr 2025. Available from: https://iris.who.int/handle/10665/44289
17. Kinnear D, Williams V, Victor C. The meaning of dignified care: an exploration of health and social care professionals' perspectives working with older people. BMC Res Notes. 2014;7(1):854.
18. Jemal K, Hailu D, Mekonnen M, Tesfa B, Bekele K, Kinati T. The importance of compassion and respectful care for the health workforce: a mixed-methods study. J Public Health. 2023;31(2):167–78.
19. World Health Organization. Regional Office for the Western Pacific. People-centred health care: a policy framework [Internet]. Manila: WHO Regional Office for the Western Pacific. 2007 [cited 2025 Apr 25]. Available from: https://www.who.int/publications/i/item/9789290613176
20. Sæteren B, Nåden D. Dignity: an essential foundation for promoting health and wellbeing. In: Haugan G, Eriksson M, editors. Health promotion in health care – Vital theories and research. Springer; 2021. Chapter 7.
21. Martin-Ferreres ML, Wennberg-Capellades L, Rodríguez E, Llaurado-Serra M, de Juan Pardo MA. Challenges for hospital management in supporting nurses to deliver humanized care. Nurs Inq. 2025;32(1):e12422. https://doi.org/10.1111/nin.12422.

22. Lin YP, Tsai YF, Chen HF. Dignity in care in the hospital setting from patients' perspectives in Taiwan: a descriptive qualitative study. J Clin Nurs. 2011;20(5–6):794–801.
23. Oosterveld-Vlug MG, Pasman HRW, van Gennip IE, Muller MT, Willems DL, Onwuteaka-Philipsen BD. Dignity and the factors that influence it according to nursing home residents: a qualitative interview study. J Adv Nurs. 2014;70(1):97–106.
24. Hofmann B. Respect for patients' dignity in primary health care: a critical appraisal. Scand J Prim Health Care. 2002;20(2):88–91.
25. Subramani S. Othering and ethics of belonging in migrants' embodied health care experiences. Sociol Health Illn. 2024;46(8):1942–61.
26. Theodosopoulos L, Fradelos EC, Panagiotou A, Dreliozi A, Tzavella F. Delivering culturally competent care to migrants by health care personnel: a crucial aspect of delivering culturally sensitive care. Soc Sci. 2024;13(10):530.
27. Rao VS, Abingdon, editors. *Adivasi rights and exclusion in India* [Internet]. 1st ed. Abingdon, Oxon: Routledge; 2019 [cited 2025 Apr 23]. Available from: https://www.routledge.com/Adivasi-Rights-and-Exclusion-in-India/Rao/p/book/9780367733421
28. Vaidya A. Shadows of colonialism: structural violence, development and Adivasi rights in post-Colonial Madhya Pradesh. South Asia: Journal of South Asian Studies. 2018;41(2):315–30.
29. Negi D, Azeez EP. Diminishing traditional methods and inaccessible modern health care: the dilemma of tribal health in India [Internet]. ResearchGate; 2024 Dec 9 Cited 17 Nov 2025. Available from: care_the_dilemma_of_tribal_health_in_India. https://www.researchgate.net/publication/351763021_Diminishing_traditional_methods_and_inaccessible_modern_health
30. Thresia CU, Srinivas PN, Mohindra KS, Jagadeesan CK. The health of Indigenous populations in South Asia: a critical review in a critical time. Int J Health Serv Plan Adm Eval. 2022;52(1):61–72.
31. Seshadri T, Madegowda C, Babu R, Nuggehalli G. S P. Implementation Research with the Soliga Indigenous Community in Southern India for Local Action on Improving Maternal Health Services [Internet]. Rochester, NY: Social Science Research Network; 2019 Cited 23 Apr 2025. Available from: https://papers.ssrn.com/abstract=3483650
32. Xaxa V. Report on the high-level committee on socio-economic, health and educational status of tribal communities of India. 2014 May Cited 23 Apr 2025; Available from: http://archive.nyu.edu/handle/2451/36746
33. Lorentsen VB, Nåden D, Sæteren B. The paradoxical body: a glimpse of a deeper truth through relatives' stories. Nurs Ethics. 2019;26(6):1611–22.
34. Baumann P, Persons. Human beings, and respect. Pol J Philos. 2007;1(2):5–17.
35. Hojman DA, Miranda Á, Agency. Human dignity, and subjective Well-being. World Dev. 2018;101(C):1–15.
36. Parisoli L. The anthropology of freedom and the nature of the human person. Personalist Forum. 1999;15(2):347–65.
37. Schachter O. Human dignity as a normative concept. Am J Int Law. 1983;77(4):848–54.
38. Nussbaum MC. *Frontiers of justice: disability, nationality, species membership* [Internet]. Cambridge (MA): Belknap Press of Harvard University Press; 2006. Cited 10 Sep 2024. Available from: https://www.researchgate.net/publication/238318583_Frontiers_of_Justice_Disability_Nationality_Species_Membership
39. Killmister S. Contours of dignity. Oxford, New York: Oxford University Press; 2020. p. 192.
40. Thangeo L. An Introduction to 'Self and Ātman'. In: Wilburn H, Holmes J, editors. *Philosophical Thought* [Internet]. Tulsa (OK): Tulsa Community College; 2022 Aug 12. pp. 105–115. Available from: https://open.library.okstate.edu/introphilosophy/chapter/an-introduction-to-self-and-atman/ (Accessed 2025 Jul 7).
41. Rahula W. *What the Buddha taught* [Internet]. New York: Grove Press; 1959 Cited 23 Apr 2025. Available from: https://www.theravada.gr/wp-content/uploads/2021/05/Dr_Walpola_Rahula_What_the_Buddha_Taught.pdf
42. Jaini PS. The Jaina path of purification [Internet]. Berkeley: University of California Press; 1979 Cited 23 Apr 2025. 402 p. Available from: http://archive.org/details/jainapathofpurif0000jain
43. Singh R. The Sikh way of life . New Delhi: India Publishers; 1968.
44. Mukundananda S. *Bhagavad Gita: The Song of God* [Internet]. [cited 2025 Apr 23]. Available from: https://www.holy-bhagavad-gita.org/chapter/3/verse/20-21
45. Ambedkar BR. *What Congress and Gandhi have done to the Untouchables* [Internet]. Bombay: Thacker & Co.; 1945 Cited 19 Aug 2025. Available from: https://indianculture.gov.in/ebooks/what-congress-and-gandhi-have-done-untouchables-1
46. Guru G. Humiliation: claims and context. New York: Oxford University Press;: Oxford; 2011. p. 252.
47. Maneka Gandhi v. Union of India, AIR. (1978) SCC 597.
48. Common Cause v. Union of India. (2018) 5 SCC 1.
49. Justice KS. Puttaswamy v. Union of India, (2017) 10 SCC 1.
50. Choudary S, Khosla M, Mehta BP. The Indian constitution. UK: Oxford University Press; 2016.
51. Chandra S. Dignity in the adjudication of health care rights in India. In: Neill OC, Foster C, Herring J, Tingle J, editors. Routledge handbook of global health rights. London: Routledge; 2021. p. 168–79.
52. Makwanyane Sv. and Another, 1995 (3) SA 391 (CC).
53. Barclay L. In sickness and dignity: a philosophical account of the meaning of dignity in health care. Int J Nurs Stud. 2016;61:136-41.
54. Landou D. The reality if social rights enforcement. Harv Int Law J. 2012;53(1):189-247.
55. Elshtain JB. Democracy and human dignity. Soundings: Interdisciplinary J. 2004;87(1/2):15–26.
56. Austin G. The Indian constitution: cornerstone of a Nation. Oxford; New York: Oxford University Press; 1999.
57. Ambedkar BR. Dr. Ambedkar's last speech in the Constituent Assembly on adoption of the Constitution [Internet]. New Delhi: Constitution and Social Justice Archive; 1949 Nov 25 [cited 2025 Apr 23]. Available from: https://csja.gov.in/images/p1195/s_1_constitution_vision_of_Justice/Dr_Ambedkars%20speech.pdf
58. Tabhane T. Dignity, fraternity, knowledge: Lessons on Ambedkar's social democracy from Deeksha Bhoomi. *The Caravan* [Internet]. 2021 Oct 20 Cited 7 Jul 2025. Available from: https://caravanmagazine.in/religion/dignity-fraternity-knowledge-lessons-on-ambedkars-social-democracy-from-deeksha-bhoomi/
59. Baxi U. The future of human rights. New Delhi, New York: Oxford University Press; 2006.
60. Baru R, Acharya A, Acharya S, Kumar SKA, Nagaraj K. Inequities in access to health services in India: caste, class and region. Econ Polit Wkly. 2010;45(38):49–58.
61. Baral A,Shrestha S Thapa S, Shreesh K, Shrestha M, Thapa D, editors. South Asia state of minorities report. Majoritarianism and its impact on minorities. The South Asia Collective ; Kathmandu: 2024. Cited 27 Aug 2025. https://soscbaha.org/wp-content/uploads/2024/11/south-asia-state-of-minorities-report-2023.pdf
62. Jeffery P, Jeffery R. Only when the boat has started sinking: a maternal death in rural North India. Soc Sci Med. 2010;71(10):1711–8.
63. Ambedkar BR. The Buddha and His Dhamma. Digitallibraryindia; JaiGyan: 1957. (Accessed on Jul, 7)https://archive.org/details/in.gov.ignca.15980
64. Qadeer I. Universal health care in India: panacea for whom? Indian J Public Health. 2013;57(4):225–30.
65. Sen A, Iyer A. Who gains, who loses and how: leveraging gender and class interactions to secure health entitlements. Soc Sci Med. 2012;74(11):1802–11.
66. Delmar C. The interplay between autonomy and dignity: summarizing patients' voices. Med Health Care Philos. 2013;16(6):975–81.
67. Kirchhoffer D. Dignity. Autonomy, and allocation of scarce medical resources during COVID-19. J Bioeth Inquiry. 2020;17:691–6.
68. Zamanzadeh V, Babaei N, Valizadeh L, Avazeh M. Human dignity of patients in nursing: a concept analysis. Indian J Med Ethics [Internet]. 2022 Sep 2 Cited 7 Jul 2025;VIII(2):108.
69. Fuseini AG, Ley L, Rawson H, Redley B, Kerr D. A systematic review of patient-reported dignity and dignified care during acute hospital admission. J Adv Nurs. 2022;78(11):3540–58.
70. Malenfant S, Jaggi P, Hayden KA, et al. Compassion in health care: an updated scoping review of the literature. BMC Palliat Care. 2022;21:80.
71. Kneafsey R, Brown S, Sein K, Chamley C, Parsons J. A qualitative study of key stakeholders' perspectives on compassion in health care and the development of a framework for compassionate interpersonal relations. J Clin Nurs. 2016;25(1–2):70–9.
72. Dangmei J, Singh A. Embracing cultural competence to reduce disparities and inequities in the public health care services of India. Asian J Res Bus Econ Manag. 2017;7(8):288–97.
73. Larsen R, Mangrio E, Persson K. Interpersonal communication in transcultural nursing care in India: a descriptive qualitative study. J Transcult Nurs. 2021;32(4):310–7.
74. World Health Organisation. Voice, agency, empowerment- handbook on social participation for universal health coverage. Geneva: World Health Organisation; 2021.

75. Islary J. Ensuring public health care service and health rights in communities through participatory health governance. Indian J Health Wellbeing. 2022;12(4):466–9.
76. Farmer P. Pathologies of power: health, human rights, and the new war on the poor. Berkeley: University of California Press; 2003. - repeated 15.
77. Etinson A, editor. Human rights: moral or political? Oxford. New York: Oxford University Press; 2018. p. 520.
78. Freire P. Pedagogy of the oppressed. London: Penguin; 2017.
79. Subramani S. Passive patient culture in India: disrespect in law and medicine [Internet]. London: Routledge; 2025 Mar 21 Cited 25 Apr 2025. Available from: https://www.routledge.com/Passive-Patient-Culture-in-India-Disrespect-in-Law-and-Medicine/Subramani/p/book/9780367655365
80. Putturaj M, Van Belle S, Krumeich A, Prashanth NS, Engel N. It's like asking for a necktie when you don't have underwear: discourses onpatient rights in Southern karnataka, India. Int J Equity Health. 2023;22:47.https://www.routledge.com/Passive-Patient-Culture-in-India-Disrespect-in-Law-and-Medicine/Subramani/p/book/9780367655365
81. Narayan N. Enculturalising casteism in health care in India. CASTE Glob J Soc Excl. 2022;3(2):1–18.
82. Thapa R, van Teijlingen E, Regmi PR, Heaslip V. Caste exclusion and health discrimination in South asia: a systematic review. Asia Pac J Public Health. 2021;33(5):421–32.
83. Wiesner C. Doing qualitative and interpretative research: reflecting principles and principled challenges. Polit Res Exchange. 2022. https://doi.org/10.1080/2474736X.2022.2127372.
84. Medico D, Santiago-Delefosse M. From reflexivity to resonances: accounting for interpretation phenomena in qualitative research. Qual Res Psychol. 2014;11(4):350–64.
85. Eatough V, Smith JA. Interpretative phenomenological analysis. In: Willig C, Stainton-Rogers W, editors. Handbook of qualitative psychology 2nd edition. London, UK: Sage; 2017. pp. 193–211.
86. Kincheloe JL, McLaren P, Steinberg SR, Monzó L. Critical pedagogy and qualitative research: advancing the bricolage. In: Denzin NK, Lincoln YS, editors. The SAGE handbook of qualitative research. 5th ed. Thousand Oaks: SAGE; 2017. pp. 235–60.
87. Office of the Registrar General. & Census Commissioner, India. Census tables [Internet]. Government of India; [cited 2025 Apr 25]. Available from: https://censusindia.gov.in/census.website/data/census-tables
88. Kothari A, Camill P, Brown J. Conservation as if people also mattered: policy and practice of community-based conservation. Conserv Soc. 2013;11(1):1–15.
89. Agnihotri S, Madegowda C, Si A. Tiger Becomes Termite Hill: Soliga/Solega Perceptions of Wildlife Interactions and Ecological Change. Front Conserv Sci [Internet]. 2021;2. Cited 25 Apr 2025. Available from: https://www.frontiersin.org/journals/conservation-science/articles/10.3389/fcosc.2021.691900/full
90. Rai DN, Devy SM, Ganesh T, Ganesan R, Setty RS, Hiremath JA et al. Beyond fortress conservation: the long-term integration of natural and social science research for an inclusive conservation practice in India. Biol Conserv. 2021;254:108888.
91. Madhusudan MD, Sinha A. Saving wildlife in a changing India. Econ Polit Wkly. 2025;LX:2: 33–9.
92. Sangha KK, Madegowda C, Balasubramanian M. Reshaping conservation incorporating Indigenous perspectives. Glob Ecol Conserv. 2024;54:e03197.
93. Shrivastava KS, Down To E. 2011 Cited 23 Apr 2025. Finally, community forest rights. Available from: https://www.downtoearth.org.in/environment/finally-community-forest-rights-34233
94. Pratt B, Seshadri T, Srinivas PN. What should community organisations consider when deciding to partner with researchers? A critical reflection on the Zilla Budakattu Girijana Abhivrudhhi Sangha experience in Karnataka, India. Health Res Policy Syst. 2020;18(1):101.
95. Pratt B, Srinivas PN, Seshadri T. How is inclusiveness in health systems research priority-setting affected when community organizations lead the process? Health Policy Plan. 2022;37(7):811–21.
96. Srinivas PN, Kochupurackal SKU, Juneja A, Seshadri T, Mahadeva C, Venkategowda M et al. Reimagining Innovation in Health Equity: Making a Case for a Community-embedded Participatory Learning Site for Adivasi Health Research. J Community Syst Health. 2025;2(1). Cited 2024 19 Jun. Available from: https://journals.ub.umu.se/index.php/jcsh/article/view/1102
97. Boal A. Games for actors and non-actors. 2nd ed. London: Routledge; 2002.
98. Boal A. Theatre of the oppressed. New York: Theatre Communications Group; 1985.
99. Prentki T, Preston S, editors. The applied theatre reader. London: Routledge; 2009.
100. Smith TL. Decolonizing Methodologies: Research and Indigenous Peoples. 2nd ed. London & NewYork: Zed Books; 1999.
101. Fitzpatrick EFM, Martiniuk ALC, D'Antoine H, Oscar J, Carter M, Elliot JE. Seeking consent for research with Indigenous communities: a systematic review. BMC Med Ethics 2016; 17: 65.
102. Peltier C, Dickson S, Grandpierre V, Oltean I, McGregor L, Hageltorn E, Young NL. Culturally appropriate consent processes for community-driven Indigenous child health research: a scoping review. BMC Med Ethics. 2024;25(1):3.
103. Negi DP, Azeez A. Impacts of development-induced displacement on the tribal communities of India: an integrative review. Asia-Pac Soc Sci Rev. 2022;2(2):50–62.
104. Hewitt-Taylor J. Use of constant comparative analysis in qualitative research. Nurs Stand. 2001;15(42):39–42. https://doi.org/10.7748/ns2001.07.15.42.39.c3052.
105. Mohindra K, Labonté R. A systematic review of population health interventions and scheduled tribes in India. BMC Public Health. 2010;10:438.
106. Varilek BM, Mollman S. Health care professionals' perspectives of barriers to cancer care delivery for American Indian, rural, and frontier populations. PEC Innovation. 2024;4:100247.
107. Sehgal A, Henderson R, Murry A, Crowshoe L (Lindsay), Barnabe C, editors. Advancing health equity for Indigenous peoples in Canada: development of a patient complexity assessment framework. BMC Prim Care. 2024;25(1):144.
108. Harfield S, Purcell T, Schioldann E, Ward J, Pearson O, Azzopardi P. Enablers and barriers to primary health care access for Indigenous adolescents: a systematic review and meta-aggregation of studies across Australia, Canada, New Zealand, and USA. BMC Health Serv Res. 2024;24(1):553.
109. Lewis ME, Blackmore I, Kamaka ML, Wildcat S, Anderson-Buettner A, Modde E, et al. Understand the way we walk our life: Indigenous patients' experiences and recommendations for health care in the united States. Int J Environ Res Public Health. 2025;22(3):445.
110. Marrone S. Understanding barriers to health care: a review of disparities in health care services among Indigenous populations. Int J Circumpolar Health. 2007;66(3):188–98.
111. Mbuzi V, Fulbrook P, Jessup M. Indigenous peoples' experiences and perceptions of hospitalisation for acute care: a metasynthesis of qualitative studies. Int J Nurs Stud. 2017;71:39–49.
112. Soman B, Lathika AR, Unnikrishnan B, Shetty RS. Tracing the disparity between health care policy-based infrastructure and health belief-lead practices: a narrative review on Indigenous populations of India. J Racial Ethn Health Disparities. 2024;11(6):3572–83.
113. Wylie L, McConkey S, Corrado AM. Colonial legacies and collaborative action: improving Indigenous peoples' health care in Canada. Int Indig Policy J. 2019;10(5).
114. Islam R, Sheikh MA. Cultural and socio-economic factors in health, health services and prevention for Indigenous people. Antrocom Online Journal of Anthropology. 2010;6(2).
115. Lewis ME, Myhra LL. Integrated care with Indigenous populations: considering the role of health care systems in health disparities. J Health Care Poor Underserved. 2018;29(3):1083–107.
116. Arun Sapre A, Gori S. Development-Induced displacement in India and the tribal rights: A quest for social justice. J Asian Afr Stud. 2025;60(1):265–75.
117. Kumar S, Mishra AJ. Development-induced displacement in India: an indigenous perspective. J Manag Public Policy. 2018;10(1):25–36.
118. Gupta SD. Imagining the 'tribe' in colonial and Post-Independence India. Politeja. 2019;29(259):107–21.
119. Bala SM, Thiruselvakumar D. Overcoming problems in the practice of public health among tribals of India. Indian J Community Med. 2009;34(4):283–7.
120. Sushmita C. The poor health infrastructure in India's scheduled areas failed its Adivasis. *Scroll.in*. 2020. Cited 7 Jul 2025. Available from: https://scroll.in/article/981694/coronavirus-the-poor-health-infrastructure-in-indias-scheduled-areas-failed-its-adivasis
121. Paschim Banga Khet Mazdoor Samity v. State of West Bengal. (1996) 4 SCC 37.
122. Suchita Srivastava v. Chandigarh Administration. (2009) 9 SCC 1.
123. Devika Biswas v. Union of India. (2016) 10 SCC 726.
124. Mr. X v. Hospital Z, (1998) 8 SCC 296.
125. Navtej Singh Johar v. Union of India. (2018) 10 SCC 1.
126. People's Union for Civil Liberties v. Union of India. (2003) 4 SCC 399.
127. Xaxa V. Protective discrimination: why scheduled tribes lag behind scheduled castes. Econ Polit Wkly. 2001;36(29):2765–72.

128. Baviskar A. In the belly of the river: tribal conflicts over development in the Narmada Valley. Delhi; New York: Oxford University Press; 1995. Cited 23 Apr 2025. Available from: http://archive.org/details/inbellyofrivertr00bavi
129. Tandon I. Othering' adivasi identities: perpetuating tribal stereotypes among the Bhil of India. Ethnologies. 2021;43(2):41–61.
130. Fernandes W. India's forced displacement policy and practice: is compensation up to its functions? In: Mathur HM, editor. India social development report 2008: development and displacement. India: Oxford University Press; 2005. pp. 109–23.
131. Nayar KR. Social exclusion, caste & health: A review based on the social determinants framework. Indian J Med Res. 2007;126(4):355–63.
132. Rao V, Walton M, editors. Culture and public action. Stanford (CA): Stanford University Press; 2004. p. 464.
133. Xaxa V. Politics of language, religion and identity: tribes in India. Econ Polit Wkly. 2005;13:1363–70.
134. Nakkeeran N, Sacks E, Srinivas NP, Juenja A, Gaitonde R, Garimella S, et al. Beyond behaviour as individual choice: a call to expand understandings around social science in health research. Wellcome Open Res. 2021;6:212.
135. George S. Health for not all: mapping the discriminated and detached terrains of health services in rural India. J Health Syst. 2015;1(1):20–6.
136. Barik D, Thorat A. Issues of unequal access to public health in India. Front Public Health. 2015;3:1–3.
137. Raju TS, Asha A. Literacy and health awareness among tribal women in North coastal districts of Andhra Pradesh. Turk Online J Qual Inq. 2024;15(1):111–25.
138. Srikanth M, Bellapukonda P, Sirigineedi M. Protecting tribal peoples nearby patient care centres using a hybrid technique based on a distribution network. Int J Health Sci. 2022;6(S5):4836–45.
139. Shrivastava SR, Shrivastava PS, Ramasamy J. Implementation of public health practices in tribal populations of India: challenges and remedies. Healthc Low-Resour Settings. 2013;31(1):e3-3.
140. Srinivas PN, Seshadri T, Velho N, Babu RG, Madegowda C, Basappa CY, et al. Towards health equity and transformative action on tribal health (THETA) study to describe, explain and act on tribal health inequities in India: a health systems research study protocol. Wellcome Open Res. 2019;4:202.

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