

From criminalised histories to rightful present – nomadic women demand equal rights to sexual and reproductive health: a study in Maharashtra, India

Deepa Pawar

Founder, Anubhuti Charitable Trust, Badlapur, India. *Correspondence:* deepa@anubhutitrust.org

Abstract: *This paper presents the findings of a research study in Thane District, Maharashtra, India, on access to sexual and reproductive health and rights (SRHR) for women and girls of Nomadic and Denotified Tribes (NT-DNT). NT-DNT communities face stigma and violence due to their historically criminalised status and nomadic lifestyle. Their precarious legal, social, and economic status has a negative impact on women's SRHR. Existing literature on this subject is sparse, and studies by researchers from within the community, which could bring about organic and community-led change, are almost non-existent. This study, carried out by a woman from a Nomadic Tribe, presents an insider's perspective on the experiences of and factors underlying the violation of the SRHR of girls and women of NT-DNT communities. The study used a human rights-based participatory methodology with qualitative methods including three focus group discussions with 21 women and 10 in-depth interviews with women and key informants from NT-DNT communities. The findings describe the gender, community, and health system barriers which hinder women's and girls' access to SRHR. Issues such as language barriers between the women and medical fraternity, criminalisation by the police, and extreme deprivation – more intense than faced by the general poor – are unique to women of these communities. The NT-DNT communities face extreme deprivation of basic resources such as identity documents, shelter, sanitation, education support, workplace safety, and transportation, which further deny women their sexual and reproductive rights. The paper aims to amplify these women's voices to advocate for better SRHR services for women and girls of NT-DNT communities.*
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Introduction

This paper is the work of a researcher from the Gadiya Lohar Ghisadi nomadic tribe. Nomadic and Denotified Tribes (NT-DNT) form 15% of India's population. Despite this, there is very little cultural or administrative understanding of these communities beyond the false and offensive view of them as “criminals”. Denotified tribes were unjustly labelled “criminal” by colonial British rulers, who passed the Criminal Tribes Act in 1871 in retribution for the uprising for independence by these communities. They are still treated as “habitual criminals” and stigmatised, and have been forcibly made landless and deprived of resources over decades of violent exploitation. Their exploitation manifests in ways such as the

police arbitrarily picking up the youth of NT-DNT communities and forcing them to appear periodically at the police station,¹ and regular mob lynching² based on false rumours of crimes.³

The NT-DNT communities are not counted in the Census. Unlike the Scheduled Castes (SCs) and Scheduled Tribes (STs), who are protected under the SC and ST Prevention of Atrocities Act 1989, the NT-DNT communities are not provided with any special legal protection, despite being a highly persecuted population. They often do not possess any identity documents due to their nomadic lifestyle. Issues of poor housing, risks associated with employment, poor educational status, and non-possession of official documents have been highlighted in several reports.^{4,5}

While several government-appointed commissions have looked into their problems, the recommendations of the commissions are seldom implemented. For example, the recommendations of the 2008 Renke Commission are yet to be implemented, more than a decade later.

NT-DNT communities are not caste-based, but occupation-based. Historically, they were matriarchal. However, later patriarchal injections from mainstream society, coupled with high social vulnerability, put the burden of upholding the communities' honour and culture on women's shoulders. This manifests in male dominance and high restrictions on women's mobility. The communities' occupations, however, continue to be predominantly women-led. These are labour-intensive, and often carried out in public places where women cannot "hide" their bodies from exploitative gazes and acts. For example, *Gadiya Lohar* women live and work on roadsides in make-shift tents, and their work involves beating iron with heavy four- to five-foot long hammers using their full body length. *Nathpanthi Davri Gosavi* women beg for alms in marketplaces, railway stations, and so on. *Wadari* women break stones. All the above makes women of NT-DNT communities vulnerable to sexual and reproductive health and rights (SRHR) issues in ways that are particular and different from those of other marginalised women.

These problems are exacerbated in emergencies such as the current COVID pandemic.^{6–8} Access to food, shelter, health care, safety in the workplace, education, mental health, and overall social security are rendered worse than usual. For example, cases of mob lynching² and abuse of women if they entered a village to use the toilet – instances shared with the author during relief work with these communities – increased during the COVID lockdown.

The literature on the sexual and reproductive health (SRH) of girls and women of NT-DNT communities is sparse and focuses on the prevalence of health problems and utilisation of services. In a study by Sarwade et al.⁹ about the reproductive health issues of the NT-DNT community in Nashik District of Maharashtra, more than half of the women reported one or more symptoms related to menstruation and reproductive tract infections, but more than two-thirds of them did not seek any treatment. Another study¹⁰ showed that 58.5% of Birhor women were non-literate, 84% used cloth during their menstrual periods and over 36% did

not use any contraceptives. These and other studies^{9–11} highlight the poor awareness of SRHR among NT-DNT women and girls, and their limited access to SRH services.

Existing literature corroborates the researcher's lived experiences and work observations. However, there is a gap in the literature about the reasons for the poor SRH status of women of NT-DNT communities, which this study attempts to address to some extent. This research hypothesises that poor access to available services due to discrimination, exacerbated by criminalisation, and issues arising out of their nomadic lifestyle are the underlying causes. Better access here goes beyond physical accessibility, to include affordability and services delivered with dignity, thereby acknowledging the social and cultural obstacles to accessing healthcare services.¹² This paper also attempts to amplify the voices of women from NT-DNT communities to advocate for policy and implementation improvements which could result in upholding their SRHR.

Methodology

This research is part of the author's rights-based work for social change within the NT-DNT communities. The author, who belongs to a nomadic tribe, has been working closely with the NT-DNT communities in Thane District, Maharashtra, India for organic and self-led change, through her organisation *Anubhuti*. During the COVID-19 2020 lockdown in India, *Anubhuti* reached over 8000 families across 15 districts. Cases of severe SRH issues, child and forced marriage, domestic violence, and social violence faced by women and girls were seen, compounded by problems of shelter, sanitation, and access to government health services.

The paper adopts a human rights lens for examining NT-DNT communities' SRHR. In addition, an intersectionality lens explores the multiple marginalisations of caste, class, ethnicity, gender, occupational status, and criminalised status that have direct impact on these women's access to SRHR.

The study examined the following research questions:

- (1) What are the SRHR needs of women and girls of NT-DNT communities?
- (2) Which of these SRHR needs are met through services that are accessible to them?

- (3) What are the barriers and enablers that affect the access of these services?
- (4) What are the behaviours of government SRHR service providers towards these communities?
- (5) What are the recommendations of women of NT-DNT communities regarding SRHR services?

A human rights-based participatory methodology was used. As per the 2018 UN Document “A Human Rights Based Approach to Data”¹³ this is based on key principles such as participation, data disaggregation, self-identification, transparency, privacy, and accountability. Community members were involved in choosing the research topics, recruiting participants, creating tools, conducting analysis, and in dissemination. Some of the participating women are expected, with support from community leaders, to represent their SRHR issues to relevant stakeholders and policy-makers.

Methods

A qualitative research design was used for this study, which was carried out between the 25th of February and the 30th of March 2021. Five in-depth interviews (IDIs) were done with key

informants (community leaders, a lawyer, and medical workers who are themselves NT-DNT), to provide answers for all five research questions. These were followed by three focus group discussions (FGDs) with 21 women of NT-DNT communities who were between 18 and 35 years old to examine the first three research questions. Ten IDIs with women aged 18–35 years explored the more sensitive issues in questions 3), 4) and 5).

Sampling

Sampling was purposive. Care was taken to select representatives from diverse groups within the selected research demographic: marital status, working in different occupations (that expose them to different kinds of vulnerabilities); education status; disabled; trans women. Representation of different intersectionalities of women and girls of NT-DNT communities was thus attempted. Table 1 describes the seven NT-DNT communities represented.

Process

Focus group discussions and IDIs were done using FGD and interview guidelines respectively. FGDs were recorded through field notes which were expanded later. Interviews were similarly treated.

Table 1. NT-DNT communities represented in this research

Community Name	Description
Gadiya Lohar	Ironsmiths, living and working in makeshift tents on roadsides, or travelling in bullock carts with their traditional hand-made machinery
Nathpanthi Davri Gosavi	Asking for alms by showing pictures and symbols of gods and goddesses, commonly seen outside railway stations and bus stops with their tempos and carts decorated in religious symbols.
Muralis	Are part of the occupation-based “Vaghya Murali” community. The men are called Vaghya and women are called Muralis. They dance, sing, and perform at religious functions, weddings. This community is formed by individuals from various NT-DNT and other marginalised communities like SCs who enter this occupation when they are “given” to god – usually due to high poverty and superstitions.
Dhangar	Traditionally shepherds – grazing sheep and other animals and selling their produce.
Vanjari	Traditionally nomadic traders – transporting and selling grains and other produce on bullock carts.
Banjara	Traditionally earn their livelihood through public dance and song performances.
Mariyawale	Ask alms in exchange for a traditional performance involving a dance by the men to the beat of drums played by the women, while beating themselves with belts.

The researcher validated the information provided by asking follow-up questions.

Community leaders' support was gained by orienting them about the research and its objectives. They arranged logistics like the venue and seating arrangements. To mitigate the potential risk of women not being able to give voluntary consent, all male leaders were asked to leave after ensuring logistics support.

Analysis

The analysis was informed by issues prioritised by the participating women. These were SRHR symptoms experienced by women and girls; behaviour of service providers towards them; harm caused by lack of access to services; and the difference in accessibility that they perceived compared to other marginalised women. The data were analysed not only against indicators of SRHR but also of relevant human rights to life, dignity, shelter, decent work, sanitation, privacy, and mental health. The data collected were reviewed and categorised by the author as per the five research questions, then further screened according to the priority issues identified above. Data were then analysed against variables of community, age, occupation, disability, and so on. This analysis gave insight into how intersectionalities affected the severity of the participants' experiences. These were noted down after the first FGD and seven IDIs and checked for more insights in the remaining two FGDs and eight interviews. The author is from one of the communities being studied, which provided an insider's sensitivity to understanding the data and equipped the author to explain the questions and encourage the respondents to open up. The analysis was carried out with the objective of creating knowledge that can be used by policy-makers and implementers for improving SRHR access for women and girls of NT-DNT communities.

Ethical considerations

The principles of participation with empowerment, transparency, accountability, confidentiality, non-discrimination, beneficence, and non-maleficence were followed at every step of the research. The researcher was responsible for recruitment of participants with the help of local community leaders and key community women. Informed consent of participants, in writing (for those who were literate) or by thumb impression, was taken after explaining all pertinent points of

the research – its objectives, where it will be published, who is leading it, and how and with whom it will be used for advocacy – in their own languages. Care was taken that the participants' consent was voluntary by making sure that community leaders were not present during this process. All the respondents were informed that they could choose not to respond to one or more questions during the FGDs and the interviews. The participants were asked for their feedback to check if they had understood.

The researcher was aware of the risk of triggering unpleasant memories and trauma in response to some questions. This was mitigated by offering free counselling post data collection, if needed.

The Internal Ethics Committee of *Anusandhan* Trust, Mumbai, approved the research on the 23rd of February 2021, approval ID number IEC21/2021.

Results

Profile of the respondents

Twenty-one women participated in FGDs, of whom 10 were also included in IDIs. There were also five IDIs with key informants (three women and two men). The profiles of these 26 participants are given below.

Seven communities were represented in this study. Seven respondents were from the *Jagran/Gondhal/Murali* (performer community) and seven from the *Nathpanthi Davri Gosavi* (community involved in begging). Besides these, there were three members of the *Gadiya Lohar* (Ironsmith) community, three from the *Dhangar* (shepherd) community, and two each from the *Banjara* (performer), *Mariyawale* (perform in exchange for alms), and *Vanjari* (nomadic trader) communities.

Seven respondents were 25 years old and below, while the rest were between 26 and 35 years old. It may be noted that women of NT-DNT communities cannot give their exact age because of lack of documentation due to births at home, and not having attended school.

Most FGD participants had never been to school (six) or only studied up to class five (five). Seven respondents had studied till class 8, and only two and three respondents had studied till class 10 and 12, respectively. Three who completed graduation were the key informants – they were selected because they are rare college-educated representatives of NT-DNT communities. Eighteen respondents were married, six were currently

single (including separated, divorced, or widowed women) and two were never married.

Most of the participants (18) belonged to families that earned between Rs. 6000 to Rs. 15,000 per month (approximately between 70 USD to 200 USD). Only two families earned more than Rs. 25,000 per month, and these were key informants. To compare, the per capita income in Thane District was Rs. 157,373 per month in 2012–2013 (no more recent data available)¹⁴ and the national per capita income in 2020 was Rs. 32,800 per month.¹⁵

Gender-based barriers to SRHR

Awareness of bodies, sexuality, and sexual relations

All the women in the FGDs and interviews said they knew very little about their bodies and acquired this knowledge only after marriage and pregnancy.

A 36-year-old *Nathpanthi Davri Gosavi* woman, a *Murali* who performs in religious functions and also works as a domestic worker, narrated:

“When I was pregnant with my first baby at age 17, women around would feed me bananas, tea with pepper, tea with sai (cream) – we thought that since bananas are slippery, sai is slippery – they will help the baby slip out easily! We did not know that the food comes out from another opening and the baby from a different opening!”

A 34-year-old *Gadiya Lohar* (ironsmith) woman said in a FGD,

“I knew nothing about where babies come out from even after my first delivery. The first time I understood is when someone from my family had their uterus taken out. I kept asking the nurses where is the thaili, [bag]? They laughed at me and explained that it is not a literal bag, but an organ where the baby lives.”

Women also expressed that they want things to be different for the next generation; they would like their daughters to have more information. They said that their girls get some information about menstrual periods at school but, on probing, it appeared that the daughters also know very little.

A newly married young woman, who has studied beyond class 12, said:

“I think I could not grasp the information because I was too shy to hear and understand it. There is a lot

of guilt when we hear talk about sexuality, that is how deeply ingrained it is that we must stay away from ‘such things’.”

She went on,

“I still consider myself lucky for having married at 21. Such a late marriage is unheard of in my village or community. My older sister was married at 17, her partner was older by 12 years at least. When she got pregnant very soon, she blamed him, and would not allow him to touch her fearing another pregnancy. This became a huge issue and affected their relationship badly.”

Other women also talked about how early marriage, huge age gap, lack of information about sexual relations and pregnancy, and lack of communication between partners (which they indicated they felt was the man’s responsibility because in most cases he was older) had led to souring marriages.

While this indicates that boys and men of the community have some knowledge of sexual relations, they too haven’t received this through channels such as education or health systems. They come to know through discussions among themselves, which are not always sensitive to the needs of women.

A key informant explained how even such informal information sources are not available for girls:

“Firstly, female relatives can’t give any information about sexual and reproductive health to us - because they themselves know very little. Girls don’t go to school. They are not even allowed to have friends after they reach puberty. With whom can they healthily discuss about sex and other things then?”

The NT-DNT communities have traditionally been matriarchal and more accepting of women’s discussion and expression of sexuality. Some of the communities, such as *Muralis* and *Gondhalis* (religious performers), are also accepting of trans identities. However, a lot of these gender-egalitarian attitudes are getting eroded due to outside influences. Women and trans groups continue to be visible in economic and religious processes as this is directly connected to the communities’ livelihood earning, lifestyles, and traditions. However, due to generations of persecution, which has included widespread sexual violence, the communities have become very closed, putting the burden of

protecting “community honour” on women and girls. Sexual violence is a constant threat for women whose occupations are on the roadside and public places. There is no support available for sexual violence survivors, either from within the community due to lack of resources, or from the public systems.

The shame attached to learning about sexuality outside marriage comes from this association of “honour” with sexual inexperience. There is also pressure on individuals from the family and community leaders to adapt to outside influences in an attempt to become more socially “acceptable”. These outside influences are from the mainstream, more dominant, and upper caste practices, which are traditionally more restrictive of women’s mobility and expressions.

“We can speak of pregnancy, delivery, menstruation, abortion etc. but where to speak of sexual desire? We need community support for this. I feel so guilty when I think of my sexual desires”, said a 33-year-old Dhangar woman, also a Murali, who has been living as a single woman after her partner died.

Community control on mobility without responsibility for safety

Women gave examples of how on the one hand the community is highly restrictive of women’s and girls’ decision-making and mobility, and on the other, stakeholders are not answerable for the safety of women and girls of NT-DNT communities.

One key informant narrated the story of her family of all girls. After their father passed away when they were very young, the girls and their mother worked at many odd jobs, lived in a hand-made house, and were vulnerable to all kinds of exploitation. Not only did they survive but they became amongst the first and most educated young women in their community. In response, their community taunted the girls for going to college. The oldest sister had to bear the brunt, with even women saying things like, “If you are going to college where there are so many boys, are you still virgins?” When the older sister – a social worker – started working, people from the community would gossip about the “kind of work” she was doing when she came home late. While the taunts affected their mental health, what was worse was that some of the community’s male members – who had not given any kind of support when the girls were at their most

vulnerable after their father had passed away – still tried to control and keep a watch on the sisters’ mobility, their growth, their development. The key informant asked, “Who is responsible for the safety of such a family when the community is hostile, police are hostile, and administration is hostile?”

For the most part, women to marry without family approval is a grave matter. There are strict and punitive norms against inter-caste marriages. A respondent, who married a man who is not of the NT-DNT community, spoke about how even community support – the only social support system for NT-DNT women – is violently withdrawn if they marry outside: “Inter-caste marriages are strictly banned, we are banished from the community. No one wants to marry our daughters, we are then completely devoid of any social support.”

Coping with menstruation, early marriage, and multiple pregnancies

Extreme poverty made routine reproductive health needs such as menstrual hygiene a major challenge. A key informant, the first woman lawyer in her community, shared about growing up in a very poor family of five sisters. Their menstrual protection was a bag of cloth strips their mother had torn up from an old saree. If several of them got periods simultaneously, the strips could not be washed and dried fast enough. Their mother would then shout at them and shame them because she could not afford to tear up another saree. Added to this was the stress of drying these strips hidden from the sight of men, as per the cultural norms of a patriarchal society. While this experience may be shared by girls in other poor families, it becomes even more difficult for NT-DNT girls because of their home structure. This respondent’s house was a makeshift house with two or more walls of cardboard.

Many women condemned child marriage as one of the worst ills. Ninety per cent of the women in FGDs and interviews were married before age 18:

“Most are married off at 16-17, or even at 12-13, to 28–29-year-old men who know everything about sexuality. The men have sexual relations with their much younger partners without giving them time to understand, and the young women are terrified.”

They termed this experience as abuse. A majority of them said that they did not want the

same for their daughters. They wanted education and later marriage for the next generation when girls have information and the freedom to make decisions about who they would marry.

Many women had gone through multiple pregnancies due to their lack of knowledge about safe sex, low control over their own reproductive decisions, and high family and community expectation for sons. Many women expressed irritation about this. One woman said, *“Because the community and family wants sons, many of us have to give birth to multiple daughters till a son is born. No one asks us what we want, and our daughters remain unloved by the family.”*

A key informant added that even after women are made to have multiple children, ruining their bodies and mental health, their troubles do not stop.

“Multiple pregnancies are seen as the fault and problem of women – not the men – so the community does not take any responsibility. I have seen women get up and start working the very next day after delivery, tying the child on their backs. Imagine what her body and mind must be going through.”

She went on:

“Many NT women, married and with children from a very young age, are affected mentally – which goes undiagnosed. I have seen female relatives struggle with mental health issues directly connected to early marriage, young motherhood, and heavy household work. So heavy that they get no rest for even a day after delivering a child, no break to feed their newborn babies – their lives are lived under extreme burden. It is no wonder we start looking old in our 30s.”

Health system barriers

Understanding the barriers to health care is not only a question of physical access and affordability, but also how approachable it is for the community.¹² During FGDs and IDIs with women and key informants, numerous incidents of inhumane and unconstitutional behaviour by service providers were narrated. While this sort of behaviour is routinely meted out to all poor and powerless people,¹⁶ women of NT-DNT communities face additional discrimination.

Degrading, neglectful, and abusive behaviour

NT-DNT women’s language, clothes, and level of deprivation are visibly different, even from other

marginalised community women, and they seem to be punished for this. It is very difficult for them to express their SRHR issues in mainstream languages – which are the only languages spoken by the medical fraternity.

According to a key informant, *“Doctors get irritated if they cannot understand the women or vice versa, and instead of explaining how to take the medicines, they just don’t communicate, don’t ask any questions during follow-up. They speak in a language completely alien to the NT women.”*

A 35-year-old Gadiya Lohar woman said,

“People anyway view us differently. We can feel that people are seeing us as lesser than them. When we face this in hospitals for these matters [sexual and reproductive], it is very insulting. Who are the people who go to government hospitals anyway? [implying that it is the poor who go]. And even there, we are treated differently. We would like that all are treated equally.”

A key informant, an NT-DNT woman lawyer who had achieved this distinction after overcoming numerous struggles, added,

“A woman is seen to be a person wearing “proper” [clothes] (matching saree and blouse), but there are women who don’t wear such matching clothes, whose clothes are lined with dirt because they are working women. They come directly from their jobs which are on the roads, with their animals, baskets of goods, or tools. After all this, when they reach a hospital or clinic, instead of showing some sympathy, health service providers look at them with contempt.”

Another key informant, a young woman from an NT-DNT community, who is a clerk at a government hospital in Mumbai, also thought that health service providers viewed women of NT-DNT communities as “lowly, dirty, living on roads”.

“NT-DNT community views doctors as gods because they are so much more qualified than our poor uneducated sisters, but this god discriminates against them ... Our people drink alcohol because they work extremely hard. Sometimes they visit the hospital in this state and then they are insulted and turned away very rudely.”

She said that this was the case because there are almost no doctors from the NT-DNT communities who will be able to represent these communities or understand their reality. Most doctors belong

to the upper castes¹⁷ and it seems that some of them bring their biases against marginalised castes into their professional practice.

Women from the NT-DNT communities often experienced abusive behaviour in health facilities, especially during delivery.

“My sister took me to the government hospital for my delivery. No one was paying any attention, my sister kept fighting with them but there was no response. I was there the whole night. The next morning, I felt like I needed to defecate. I asked the nurse if I could go to the toilet, she said yes, I went inside and sat down, and the baby came out! I picked her up, came out, took the baby to the nurse. She started shouting at me. She told me to lie down because the garbhashay (uterus) might come out, but she made me lie down right outside the toilet on the floor, cut the nalli (umbilical cord) and sent me home. It is easy to do all this with us, they don’t behave like this with others. Even after they did all this with me I left without saying a word.” (A 36-year-old Nathpanthi woman, also a Murali, studied up to class seven and married at age 22)

Procedures performed without explanation or consent

Some of the women narrated instances of medical or surgical procedures being performed on them without explaining to them what was being done, and sometimes, without seeking their consent. A 35-year-old Murali woman, who had studied up to class three and had married at age 14, talked about her experience with medical abortion in a private doctor’s clinic.

“After my first pregnancy, I got pregnant again in six months. We did not want the baby. I was sent for an abortion to a doctor. The doctor did not explain anything, I just kept waiting feeling very scared. Finally, they made me lie down and they just inserted a pill in my vagina, and after that left me just like that. The baby was aborted. I never got pregnant again.”

Another woman, who belongs to the Nathpanthi community, narrated her experiences of giving birth to eight children and losing four of them within a few months after delivery. The doctors did not explain to her the reasons for the babies’ deaths. She believes that her most recent caesarean to deliver twin babies was done badly, and that her body hurt all over even to the present day as a result.

A 30-year-old Gondhali woman, married at 15, educated up to class four, shared her experiences of a botched procedure done without her consent, in a well-known government hospital, for which the service providers took no responsibility:

“I now have only one (fallopian) tube because of an appendix (appendicitis) operation that was done without my consent when I was pregnant. It seems they cut one tube mistakenly. We nomadic people don’t usually visit hospitals, and when I did, such a thing happened.”

The consequence of such experiences is fear and mistrust of SRH service providers from the public sector. It is clear that women of NT-DNT communities are not unaware of their health problems. But their economic situation is such that they cannot attend to it immediately. When they finally do, they get horrifying treatment at government hospitals. They then go to private doctors where, if they are able to come up with enough money, there is some guarantee of treatment. For that they have to take loans. Following this, they spend their lifetime paying back the loans, placing the women under a further burden of guilt: first, for investing more time and resources than they can afford for their health – having internalised that women’s health is the lowest priority – and then for putting their families into debt for such a reason.

Responding to a common perception that women from NT-DNT communities do not seek timely health care due to their ignorance, a key informant said,

“If they (NT-DNT communities) are truly given good services, why will they not use and respond positively?... Why will they not listen if someone reaches them with information respectfully? The issue is that the administrative and political system don’t reach us with respect, as human beings.”

Community, social, and administrative barriers to SRHR

There is a need for a holistic understanding and approach to health care that looks at the social and cultural conditions of the community in focus.¹⁸ As explained in earlier sections, the NT-DNT communities occupy a particularly marginalised position, at the intersections of social, cultural, political, economic and administrative neglect, discrimination, and human rights violations.

Extreme poverty and deprivation

Women explained that their communities were not always at fault for their poor health. It is their deprived situation which is responsible. One woman said,

“Our occupations give very little income, so there is extreme poverty. Less money at home, less nutrition, especially for women and girls. The impact can be seen during complicated pregnancies and bad deliveries. It is not the family’s fault that women suffer health issues.”

A key informant pointed out a common fact for women of NT-DNT communities, that most visit institutions for deliveries unaccompanied by anyone. The woman gets herself admitted, delivers, takes care of herself and the baby till she is discharged, and leaves with the baby alone. The family cannot come because they cannot afford even one day’s wage loss. The key informant has observed that this is not the case with other poor communities such as Scheduled Castes, because the deprivation among NT-DNTs is more severe.

Housing and sanitation

Housing is an important determinant of SRHR since it is intricately connected to safety, shelter, rest, and privacy.¹⁹ A key informant described the housing situation of the NT-DNT communities as follows:

“Our people live under bridges, on the side of roads in cities. Our houses are simply tents, they are so kaccha (unstructured). There are no walls, no doors. The women don’t have any kind of privacy.”

Sanitation plays an intrinsic role in women’s SRHR: privacy, dignity, and safety, as well as basic bodily processes of relieving oneself and menstruation, are connected to toilets. Having toilets inside homes is a rarity among the poor in India anyway. According to a key informant, *“Every time the women need privacy to change pads, wash themselves, they have to pay to use the public toilet”*. A woman spoke about the shaming that NT-DNT women face for using public toilets: *“If there are used pads thrown in the toilet, we are blamed. Toilets are bound to get dirty. But the toilet attendant looks at our clothes and immediately judges that we have done it”*. NT-DNT women are singled out among other poor women using the toilet. A number of other women stated how unsafe it is simply to relieve

themselves, echoing many reports and studies highlighting how unsafe it is for women and children in public toilets.²⁰

Another key informant, a lawyer, drew attention to the fact that infrastructure is built with the needs of settled communities in mind:

“It is only 150 years since we have come to the mainland from forests or from completely nomadic lives. We can’t own or even rent houses in slum communities, where there are at least some basic facilities. Everything from houses, toilets, hospitals, roads, road lights, etc. are built with the assumption that they will be used by settled communities. They (settled communities) are much more privileged compared to us even if they too are poor.”

Even among the families of NT-DNT communities who are beginning to settle down, they can only afford rented accommodation in the worst rows of the poorest *bastis* (low-income settlements) where toilets are not accessible.

From the women’s responses, it seems that there is no political and administrative will to build structures for NT-DNT communities. This holds true both for groups of families who periodically migrate to the same piece of land every year, and for groups who are settling down.

Occupations

NT occupations are varied, with many so informal that they are invisible in laws and policies on workplace rights, such as the Maternity Benefit Act 1961 or Prevention of Sexual Harassment at Workplace Act 2013. For example, selling wares or offering repair of tools door-to-door, making and selling hand-made iron tools and weapons, performing on roads, begging in the name of religious symbols, and religious performances are the common occupations of NT-DNT communities. These occupations are performed in public spaces, physically demanding, do not allow for rest, and are vulnerable to exploitation.

A Murali woman, 34, who performs at private weddings and religious functions, said: *“I constantly feel anger, irritation, stress, I have heart problems which have never been treated. My job is exhausting. We dance through the night, into the early hours of morning, after which I walk back home”*. She endures all of this with a disability – she has a steel rod in one leg, due to an accident in her youth. During the 2020 lockdown, she took loans for health issues which she is still repaying.

Transportation

NT-DNT women usually walk everywhere. Most do not own even a bicycle and cannot afford even public transportation. Another woman living in one of the topmost houses of a hilly *basti* (because the rent is lowest on top) said, “*Transportation is needed for pregnant women because climbing up and down in such conditions is painful. I had to climb up and down with a newborn baby right after my delivery, with stitches on my vagina*”.

A key informant added that women in her own family, and other NT-DNT women, walked hours to and from the Primary Health Centre right up to their ninth month of pregnancy. Even doctors would be aghast that women who had come in from far to get their swollen body checked, would be walking back home, alone.

Findings show that facilities like Aanganwadis,* toilets, roads, streetlights, transportation are not always available near NT-DNT communities, which are on the outskirts of other *bastis*, and the sites are only periodically occupied since these communities are nomadic. Services like the Integrated Child Development Scheme, which provide nutrition and awareness to pregnant and lactating women and children under six years of age, do not reach these NT-DNT communities.

Lack of identity documents

“We (NT-DNT communities) have no lands, we don’t live in one place for long. So we cannot prove our existence and get any documents made. Most of us don’t have ration cards, and even if we do, they are never yellow (Below Poverty Line). It is a huge challenge to add our children’s names to these cards. The result is that we never qualify for food benefits.” (Key informant)

Even if people of NT-DNT communities manage to get their ration cards made, the cards are not useful most of the time because they apply only to ration shops in a fixed location. Their homes and their nomadic lifestyle, with all their belongings packed into one sack when moving around, and water often entering into their tents, are such that keeping documents safely is very difficult for these people.

*An Aanganwadi centre is part of the Integrated Child Development Scheme of the Indian Government, providing basic nutrition, education, and healthcare services to children under six years and their mothers.

Absence of a support system for sexual violence survivors

NT-DNT communities are somewhat progressive about trans identities – due to some cultural and religious acceptance in their occupations, for example in *Muralis* and *Gondhalis* who are religious performers. However, if there is any sexual violence there is no support from within the community or from outside.

Police violence and administrative hostility

Police violence and administrative hostility pervade the lives of persons from the NT-DNT communities. A key informant gave the example of *Dombari* women (known more popularly as *Madari*) who perform on roads with monkeys:

“I have seen the way men look at them and the women cannot do anything as the road is their workplace. They cannot ask help from the administration, because officials are hostile - routinely harassing the women to move, throwing and destroying their things. The police are even more feared. They beat NT women like animals! These stakeholders who themselves are violent towards us, will we approach them for our security?”

Recommendations from women of NT-DNT communities

The women who participated in the study were asked about the recommendations they would like to make to health service providers, the administration, and government as well as their own communities to address the violation of their SRHR. Their response are summarised below.

Accessible information

A young woman who lamented that the right information had not reached her at the right age said,

“Government should reach girls with appropriate information about SRHR. Through schools yes, but many NT girls don’t reach schools or don’t attend after reaching puberty which is when they really need this information. So, face-to-face interactions in the community are required.”

As the findings show, there is a language barrier between the system and these communities. Only when there are more and more representatives from the community in the administration and speaking their language, awareness initiatives

that proactively reach these communities, and programmes that are sensitive to their unique realities, will trust be built, and create the much needed awareness.

Education for girls

Many women in FGDs who could not study beyond class three or four, therefore want education for their daughters: “*Scholarships are needed for our girls. Some girls really want to study but because of family/community pressure or because they cannot afford it, they cannot continue their education. Scholarships will help them*”. They added that education is intrinsic to all development, including knowing about and accessing SRHR.

In a situation where a significant part of the community is not supportive of girls’ education, scholarships will be very helpful for girls to take care of the financial aspect and thus advocate for their continued education in families.

Collectivisation of women and sensitisation of men

A key informant recommended that:

“Women should be given information about their rights, they should be organised so they have power in collectives, information should be given face-to-face. Service providers should also work with men to explain that they can be good partners and take responsibility for their partners’ Sexual and Reproductive Rights.”

Specific schemes or policies for women and girls of NT-DNT communities

Women in FGDs also asked for specific schemes or policies for women and girls of NT-DNT communities. One of the strongest requests was for toilets. Women asked for clean, affordable, well-lit, safe, and accessible toilets which can be used at night. The local administration was to keep track of the spots where NT-DNT communities routinely camped and provide constructed or mobile toilets in these locations. There was also a request for more studies on the health issues affecting NT-DNT communities, so that medical professionals understood their problems. A robust redressal and justice system to address problems faced with the health services was another demand: “*Where will we complain, hospitals throw us out if we speak up and then where will we go?*”

Discussion and conclusions

For this paper, the author brings her lived experiences as a *Gadiya Lohar* (NT-DNT) young woman, coupled with her intersectional anti-caste feminist politics. Being part of the community meant that she did not need to “enter” as a researcher; she already was an “insider”. Working with these communities as a feminist and anti-discrimination activist, she has added the lenses of human rights and gender justice, as well as an understanding of the social, political, and administrative barriers that NT-DNT community women face when accessing SRHR. These lenses have emerged organically due to her personal and related experiences of discrimination, violence, and indignity. Her work experience as an activist, leading multiple programmes on SRHR and related matters with NT-DNT and other marginalised communities, gives her a wider view of the issues. This study helped her analyse her personal experiences through the eyes of a researcher. The participatory methodology was an extension of her activism and commitment to work collaboratively.

The findings of this study show there is very little knowledge about SRHR, especially before marriage, among women of NT-DNT communities. The low marriage age of 12–13 years is a cause for concern. Research participants shared that they know about sexuality only from experience of sexual relations, and very little about other aspects such as body literacy, safe sex, and their sexual and reproductive rights. They do not have access to this knowledge because of low levels of education, and also because service providers like Accredited Social Health Activists (ASHAs) and workers from the Integrated Child Development Service (ICDS) centres[†] are not available near NT-DNT settlements.

Since nomadic tribes themselves are not homogenous, in addition to certain overall SRH needs, there are also community- and occupation-specific variations which policy-makers and service providers need to be aware of. The stories shared by the respondents indicate great suffering among women of NT-DNT communities compared to other marginalised communities. Some reasons are the stigma of criminalisation, lack of identity documents, NT-specific labour-

[†]These are frontline workers at the community level who are responsible for providing SRHR-related information and services

intensive occupations, specific discrimination and ill-treatment by the administration and health service providers, as well as their extreme poverty, shifting homes, living on the outskirts even of deprived settlements, very low levels of education, languages not understood by the health system and lack of social support.

Verbal and physical abuse of women during labour in healthcare facilities has been widely documented.^{21–23} This study finds similar unconstitutional and inhumane behaviour including neglect, disrespectful or no communication, refusal to touch, and carrying out procedures without information or consent. It also finds a big gap in knowledge among the medical fraternity regarding the realities of women of NT-DNT communities, leading to miscommunication, biases, shaming, and misbehaviour. Other studies²⁴ highlight the way a lack of knowledge about the culture and traditions of the nomadic populations can lead to loss of trust between health facilities and communities.

Sexual and reproductive health services, facilities, and infrastructure are created keeping in mind the majority, that is, settled communities.²⁵ Since NT-DNT communities are largely not “settled” in the mainstream sense of the term, a different framework is needed to design services accessible to them. However, NT-DNT communities who can guide this different way of thinking, have very little representation even in Gram Panchayats (elected Village Councils), much less at state and national levels.

NT-DNT communities, unlike other oppressed communities such as SCs and STs, are not covered by affirmative action policies and do not have specific laws to protect them against atrocities. Census surveys do not classify them separately. This means that NT-DNT communities, estimated to be around 15% of India’s population, are merged into other social categories. NT-DNT communities are neither caste-based, nor are they truly tribes. These are occupation-based communities with particular characteristics different from all other marginalised groups, and in need of specific responses to their problems.

NT-DNT communities have been historically matriarchal, which shows in the way their women are publicly visible and lead economic activities. As a woman in one of the FGDs said, “*We, the Murali, dance in front of people. Gadiya lohar women hit the iron. Makadwale, Dombari, Gondhali, rope walkers, all of this work is such that we do not hide our*

body from the public eye, we are free with our movements”. But due to modernisation and the influence of external patriarchal norms, and extreme and routine social violence, the community has started placing restrictions on the sexual and reproductive rights of women and girls. The pressure to uphold community honour, and to bear sons even at the cost of multiple pregnancies, is a reflection of the influence of patriarchal norms. However, the women perceive that it is their community’s powerlessness that creates the biggest barrier to their SRHR. In the face of any discrimination or violence, their families and community are powerless to provide the social support needed to demand justice, and hence react by restricting the freedom of girls and women.

The history of criminalisation and persecution of the NT-DNT communities has not only rendered the community nomadic, living in *kaccha* houses, but made their lifestyle itself *kaccha* or structureless. *Kaccha* in Hindi means raw or unprepared. In the context of housing, the word signifies construction that is fragile, made of materials like mud instead of brick and concrete. It denotes a weaker, temporary, unplanned, and precarious status. Without written histories, losing the memories of their (true) pasts – that is, their histories before criminalisation and subsequent persecution, without any land or village to call their own, no permanent homes, their languages without scripts and unrecognised, their previously criminalised legal status “de-notified” after Indian Independence when the earlier colonial law was repealed, but still seen despite that as habitual offenders and even criminals for all practical purposes – every aspect of their lives is *kaccha*.

Even their occupations are *kachha*, as a majority of them work in the informal sector, without bathroom breaks, holidays, benefits, maternity leave, protection against sexual harassment, or other labour rights. Lacking these, when these women face exploitation, ill-treatment, and abuse, they are completely vulnerable, with no one to protect or speak up for them. In such situations, women from NT-DNT communities are living under multiple power hierarchies – of family, the community, the mainstream settlements, the government and administrative system, and finally, the wider world.

As the findings of this study show, the lack of access to their SRHR of girls and women from the NT-DNT communities is a direct consequence of their *kachha* identity and of their historical

criminalisation. This author also asserts that the discrimination they face in accessing their SRHR is part of this culture of criminalisation that women and girls of NT-DNT communities face, which disallows them from claiming their right to bodily dignity. They are deprived of a sense of belonging, social support networks and social confidence, because being nomadic and constantly migrating, they are not able to build relationships with other communities, with people from the administration, or with their elected leaders.

There is a need for strong support from the larger system for the SRHR of girls and women of NT-DNT communities, reflected in the recommendations from the participants of this study. The concept of “cultural safety”, which is based on respectful engagement that recognises and strives to address power imbalances inherent in the healthcare system, and “cultural humility”, which is a process of self-reflection to understand personal and systemic conditioned biases, will help the healthcare system to be sensitive to the needs of these highly marginalised communities.²⁶ As recommended by the respondents, increased support for education, accessible

information, dignified treatment by healthcare service providers, redressal and justice systems that respond to their complaints, increased study by the medical fraternity of NT-DNT community realities, specific schemes and policies for women and girls of NT-DNT communities, and provision of facilities such as toilets, roads, transportation, and houses, are all part of the package of support needed from the government. Without these, girls and women from the NT-DNT communities will not be able to realise their SRHR.

As one woman said in her interview, “*The system should reduce our people’s helplessness, instead of taking advantage [of our vulnerability to exploit us further]*”.

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References

1. Dhaka R, Dhaka V. Denotified tribes and the role of police (special focus on experiential perspective with examples). A paper submitted for national seminar on victims and the criminal justice system. Panchkula: Organized by Institute of Correctional Administration, Chandigarh and Haryana Police Department; 2017; https://www.google.com/urls=t&source=web&rct=j&url=http://tiss.edu/uploads/files/DNTs_and_Police.pdf&ved=2ahUKEwujbSCqe3sAhWUdnOKHU8NCTAQFjAJegQIAhAB&usq=AOvVaw1Cc49Hw0sSPIGhE45z-GOU.
2. Shantha S. Maharashtra: three Pardhi men killed for asserting their land rights. *Wire*, May 16; 2020. <https://thewire.in/caste/maharashtra-beed-pardhi-men-killed-land-rights>.
3. “Three Men Lynched in Maharashtra, BJP Leaders Push Communal Angle”. *Wire*, April 20. <https://thewire.in/rights/three-men-lynched-in-maharashtra-two-from-nomadic-tribe-bjp-leaders-push-communal-angle>.
4. Agrawal P, Sinha M. A report on the status of Pardhis in Mumbai City. Mumbai: Tata Institute of Social Sciences; 2012. <https://tiss.edu/view/11/projects/tanda/>.
5. Praxis Institute for Participatory Practices. Mera Bap Chor Nahi hai (My father is not a thief). A report by the ground level panel of denotified and nomadic tribes on their status with respect to the sustainable development goals; 2017. <https://www.praxisindia.org/pdf/DNT-EventReport.pdf>.
6. Pawar D. Mental justice of the NT-DNTs in context of the pandemic. *Economic and Political Weekly*, February; 2021. <https://www.epw.in/engage/article/mental-justice-nt-dnts-context-pandemic>.
7. Chabria R. Lack of access to SRHR and health care during the pandemic how the pandemic has impacted the SRHR and what are the immediate steps that should be taken to mitigate it. *BW Defence*, July 13; 2021.
8. Singh S. Impact of COVID-19 on women’s access to family planning services. *DNA India*, March 8; 2021. <https://www.dnaindia.com/analysis/comment-impact-of-covid-19-on-women-s-access-to-family-planning-services-2879831>.
9. Sarwade R, Rahul JH, Chavan T. Issues of reproductive health after child marriage: a study among NT-DNT community in Nashik District of maharashtra. *Panacea J Med Sci*. 2019;9(3):117–122. doi:10.18231/j.pjms.2019.025.
10. Parvin N, Kundu RN, Chakrabarti D, et al. Reproductive health problems and awareness among the Birhor females of Purulia District, West Bengal, India. *Human Biol Rev*. 2020;9(3):238–250. <http://www.humanbiologyjournal>.

- com/article/reproductive-health-problems-and-awareness-among-the-birhor-females-of-purulia-district-west-bengal-india/.
11. Katarki P, Sinha M, Raghavan V. Living on the edge: Immunization coverage among children of nomadic and de-notified tribes in the slums of m-east ward, Mumbai. *ESocialSciences*, TISS Working Paper (id:8366); 2016. https://www.academia.edu/2766385/Living_on_the_edge_Immunization_coverage_among_children_of_Nomadic_and_De_notified_Tribes_in_the_slums_of_M_East_Ward_Mumbai.
 12. Davy C, Harfield S, McArthur A, et al. Access to primary health care services for indigenous peoples: a framework synthesis. *Int J Equity Health*. 2016;15:1. doi:10.1186/s12939-016-0450-5 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5045584/>.
 13. OHCHR. A human rights based approach to data - leaving no one behind in the 2030 Agenda for Sustainable Development. United Nations; 2018. <https://www.ohchr.org/Documents/Issues/HRIndicators/GuidanceNoteonApproachtoData.pdf>.
 14. Yeshwantrao N. Thane district's living standards up by 58% in last six years. *Times of India*, June 7; 2014. <https://timesofindia.indiatimes.com/city/thane/Thane-districts-living-standards-up-by-58-in-last-six-years/articleshow/36164187.cms>.
 15. PTI. India placed 72nd on global list with average monthly wage of Rs 32,800: report. *Economic Times*, August 28; 2020. https://economictimes.indiatimes.com/news/economy/indicators/india-placed-72nd-on-global-list-with-average-monthly-wage-of-rs-32800-report/articleshow/77806437.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst.
 16. Khubchandani J, Soni A, Fahey N, et al. Caste matters: Perceived discrimination among women in Rural India. *Arch Womens Ment Health*. 2017;21(2):163–170. doi:10.1007/s00737-017-0790-1, https://www.researchgate.net/publication/318418060_Caste_Matters_Perceived_Discrimination_among_Women_in_Rural_India
 17. Shirsat P. The chronicle of caste and the medical profession in India. *J Humanit Soc Sci*. 2017;22:9.
 18. Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health - final report of the commission on social determinants of health. World Health Organization, August 27; 2008. <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>.
 19. Dongarwar D, Salihu HM. Place of residence and inequities in adverse pregnancy and birth outcomes in India. *Int J Matern Child Health AIDS (IJMA)*. 2019;9(1):53–63. doi:10.21106/ijma.291.
 20. Kulkarni S, O'Reilly K, Bhat S. No relief: lived experiences of inadequate sanitation access of poor urban women in India. *Gend Dev*. 2017;25(2):167–183. doi:10.1080/13552074.2017.1331531.
 21. Bhattacharya S, Sundari Ravindran TK. Silent voices: institutional disrespect and abuse during delivery among women of Varanasi District, northern India. *BMC Pregnancy Childbirth*. 2018;18:1, doi:10.1186/s12884-018-1970-3, <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1970-3>.
 22. Patel P, Makadia K, Kedia G. Study to assess the extent of disrespect and abuse in facility based childbirth among women residing in urban slum area of Ahmedabad. *Int J Multidiscip Res Dev*. 2015;2(8):25–27.
 23. Khanday Z, Tanwar Y. Exploring religion based discrimination in health facilities in Mumbai. Mumbai: CEHAT; 2013. <http://www.cehat.org/cehat/uploads/files/R%2091%20Exploring%20religion%20based%20discrimination.pdf>.
 24. Ali M, Cordero JP, Khan F, et al. 'Leaving no one behind': a scoping review on the provision of sexual and reproductive health care to nomadic populations. *BMC Women's Health*. 2019;19:1. doi:10.1186/s12905-019-0849-4, <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-019-0849-4>.
 25. Van der Kwaak A, Maro G. Understanding nomadic realities: case studies on sexual and reproductive health and rights in Eastern Africa. Amsterdam: Royal Tropical Institute Press; 2012. https://www.academia.edu/29115150/Understanding_Nomadic_Realities_Case_studies_on_sexual_and_reproductive_health_and_rights_in_Eastern_Africa.
 26. First Nation's Health Authority. FNHA's policy statement on cultural safety and humility; 2015. <https://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf>.

Résumé

Cet article présente les conclusions d'une étude de recherche menée dans le district de Thane, Maharashtra, Inde, sur l'accès à la santé et aux droits sexuels et reproductifs des femmes et des filles issues de tribus nomades et de tribus

Resumen

Este artículo presenta los hallazgos de un estudio de investigación realizado en el Distrito Thane de Maharashtra, en India, sobre el acceso a servicios de salud y derechos sexuales y reproductivos (SDSR) para mujeres y niñas de Tribus Nómadas

dénotifiées. Ces communautés font face à la stigmatisation et la violence en raison de leur statut historique de tribus criminelles et leur mode de vie nomade. Leur situation juridique, économique et sociale précaire a des conséquences négatives sur la santé et les droits sexuels et reproductifs des femmes. Les publications disponibles sur ce sujet sont rares, et les études de chercheurs au sein de ces populations, qui pourraient amener des changements organiques sous l'égide de la communauté, sont presque inexistantes. La présente étude, réalisée par une femme appartenant à une tribu nomade, présente une perspective « de l'intérieur » sur les expériences et les facteurs sous-tendant la violation des droits sexuels et reproductifs des filles et des femmes issues des communautés nomades et dénotifiées. Cette étude a utilisé une méthodologie participative fondée sur les droits humains avec des méthodes qualitatives, notamment trois discussions par groupe d'intérêt avec 21 femmes et dix entretiens approfondis avec des femmes et des informateurs clés issus de ces communautés. Les conclusions décrivent les obstacles liés au genre, à la communauté et au système de santé qui entravent l'accès des femmes et des filles à la santé et aux droits sexuels et reproductifs. Des problèmes tels que les barrières linguistiques entre les femmes et le corps médical, la criminalisation par la police et l'extrême dénuement, plus intense que celui dans lequel vivent les pauvres de la population générale, sont spécifiques aux femmes de ces communautés. Les tribus nomades et dénotifiées font face à un manque extrême de ressources essentielles comme les papiers d'identité, les abris, les équipements d'assainissement, le soutien à l'éducation, la sécurité sur le lieu de travail et les transports, qui concourent à nier les droits sexuels et reproductifs des femmes. L'article souhaite amplifier la voix des femmes pour plaider plus efficacement en faveur de meilleurs services de santé sexuelle et reproductive pour les femmes et les filles des tribus nomades et dénotifiées.

y No reconocidas (NT-DNT, por sus siglas en inglés). Las comunidades NT-DNT enfrentan estigma y violencia debido a su condición históricamente penalizada y su estilo de vida nómada. Su precaria condición jurídica, social y económica tiene un impacto negativo en la SRHR de las mujeres. Existe escasa literatura sobre este tema y los estudios realizados por investigadores en la comunidad, que podrían producir cambios orgánicos liderados por la comunidad, son casi inexistentes. Este estudio, realizado por una mujer de una Tribu Nómada, presenta la perspectiva de una persona enterada de las experiencias y los factores subyacentes a la violación de SDR de niñas y mujeres de comunidades NT-DNT. El estudio utilizó una metodología participativa, basada en los derechos humanos, con métodos cualitativos: tres DGF con 21 mujeres y diez entrevistas a profundidad con mujeres e informantes clave de comunidades NT-DNT. Los hallazgos describen las barreras de género, de la comunidad y del sistema de salud que obstaculizan el acceso de las mujeres y niñas a servicios de SDR. Problemas como barreras lingüísticas entre las mujeres y la comunidad médica, penalización por la policía y privación extrema – más intensa que la enfrentada por las personas pobres en general – son exclusivos de las mujeres de estas comunidades. Las comunidades NT-DNT enfrentan privación extrema de recursos básicos, tales como documentos de identidad, refugio, saneamiento, apoyo educativo, seguridad en el lugar de trabajo y transporte, por lo cual se les niega a las mujeres sus derechos sexuales y reproductivos. El objetivo de este artículo es amplificar las voces de las mujeres para abogar por mejores servicios de SDR para las mujeres y niñas de comunidades NT-DNT.