A STUDY ON SOCIAL WORK INTERVENTION FOR ACCESS TO HEALTHACRE SERVICES AMONG TRIBAL COMMUNITIES IN RAIGAD DISTRICT MAHARASHTRA

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ABSTRACT

Access to healthcare remains a significant challenge for tribal communities in India, particularly in remote regions such as Raigad District, Maharashtra. This study explores the role of social work interventions in enhancing healthcare access among these marginalized populations. The research examines the barriers faced by tribal communities, including geographical isolation, socio-cultural beliefs, lack of awareness, and limited availability of healthcare facilities. Through community mobilization, health education programs, awareness campaigns, and facilitation of government health schemes, social workers play a pivotal role in bridging these gaps. The study employs qualitative and quantitative methods to assess the effectiveness of these interventions in improving health-seeking behavior, utilization of healthcare services, and overall health outcomes. Findings indicate that culturally sensitive, community-driven social work strategies significantly improve access to healthcare and contribute to reducing health disparities among tribal populations. The study emphasizes the importance of collaboration between social workers, healthcare providers, and local authorities to ensure sustainable improvements in healthcare access.

Introduction

In the context of this study, "tribe" and "tribal" refer to a social group that typically has a distinct dialect, cultural homogeneity, and a cohesive social structure. In addition to ruling deities, it may have many subgroups and share a common progenitor. Approximately 15% of tribal communities worldwide live in great poverty and have inadequate access to healthcare, resulting in severe health inequities. In addition to problems with starvation and sanitation, they have high incidence of infectious diseases, such as tuberculosis, that are up to 20 times higher than the global norm. The complex burden of illnesses, including infectious and non-communicable diseases, malnutrition, mental health, and drug addiction, as well as issues with healthcare-seeking behaviors,

must be addressed in India, where 8.6% of the population is tribal. Thus, health communication becomes crucial for empowering tribal groups, addressing the increasing incidence of illnesses, and reducing the inequities in health outcomes. Among India's most disadvantaged groups are the "Katkaris," who are classified as "Particularly Vulnerable Tribal Groups (PVTGs)" among the Scheduled Tribes. They are scattered throughout the Indian states of Gujarat and Maharashtra. The Katkaris have the lowest socioeconomic standing and level of education among all Indian tribes. The Katkaris have a literacy rate of about 34%, compared to roughly 56% for Scheduled Tribes as a whole. Eighty-eight percent of Katkaris are landless and work by hand. The main conclusions of the 2013 Tribal Health Report state that, in comparison to the country's overall population, the Katkaris suffer from issues like under nutrition, anemia, low rates of institutional delivery, high rates of alcohol and tobacco addiction, and a higher incidence of tuberculosis.

In light of this background and the previously described conversations, health communication becomes an essential requirement and the main intervention for all public health initiatives aimed at this particular population. Research on the dynamics of health communication in this demographic is conspicuously lacking. A qualitative study was created with the following goals, concentrating on the Katkari tribe in western Maharashtra, India, in order to fill the research gap:

1. To use an anthropological approach to comprehend health communication among the Katkaris, a tribal tribe in western Maharashtra.
2. To comprehend the difficulties associated with health communication.
3. To record the requirements and methods for enhancing tribal health communication.

The past has presented a number of difficulties for Indian tribal tribes trying to obtain high-quality medical care limited health outcomes and limited use of healthcare services are the results of geographic, social, and cultural isolation (Purty et al., 2005). With its numerous ethnic populations, the Raigad district of Maharashtra is a prime example of these issues, necessitating coordinated measures to solve the current healthcare inequalities [1]. For many generations, the Indian tribes have struggled to obtain basic medical care.

Dispersed throughout the vast country, these marginalized people have been forced to the edge of society, and the mainstream organizations meant to assist them often ignore their needs. The causes for this dire situation are multifaceted and result from a confluence of social, cultural, and geographic factors that have prevented these individuals from receiving the critical medical treatment they require.

The fundamental cause of this issue is the profound cultural divide that separates indigenous people's traditions and beliefs from the contemporary, westernized approach to healthcare. Many of these groups have serious reservations about Western medicine and would much prefer employ their age-old, oral healing methods that date back hundreds of years. The lack of confidence that this cultural mismatch has often created in modern healthcare facilities discourages tribal members from accessing the assistance they need.

The geographic isolation of tribal tribes has further exacerbated their healthcare issues. Accessing medical services can be challenging since many of these cultures reside in harsh, hilly, or densely forested areas [2]. Many have discovered that the physical obstacle brought on by the poor transit system and the long travel distances is insurmountable, leaving them alone and vulnerable to a range of health issues.

The Raigad area in Maharashtra, with its distinctive tapestry of ethnic variation, is a microcosm of the challenges faced by tribal tribes throughout India. This area is home to several different tribes, each with its own distinct cultural identity, beliefs, and traditions. Despite the differences in their experiences, they are all united by the struggle to get high-quality medical treatment. Due to these significant obstacles, a coordinated effort to address the healthcare inequalities that have plagued these communities for far too long is imperative. It is a plea for action that demands a multifaceted approach that acknowledges and respects these communities' cultural peculiarities while bridging the barriers that have long prevented them from accessing the healthcare resources they so desperately need.

Because social work is based on the ideas of social justice and empowerment, it may play a significant role in helping tribal people overcome healthcare constraints [3]. Social workers can enhance access to necessary therapies by bridging the gap between underprivileged communities and medical

professionals through community-based initiatives (Bhat, 1998).

Social work's core principles of social justice and empowerment provide a glimmer of light in this dire situation. At its core, the sector is committed to uplifting marginalized communities and advocating for their welfare and rights. This viewpoint clearly highlights the potential of social work to address the healthcare problems that indigenous communities encounter. The main reason social work is effective is because of its community-based approach. Unlike traditional top-down approaches to service delivery, social workers are trained to thoroughly immerse themselves in the communities they serve, gaining a comprehensive grasp of the specific cultural, social, and economic forces at work. With this intimate knowledge, they may develop tailored therapies that address the actual realities of tribal communities, gaining the trust and support of the same groups they wish to improve.

Because of their extensive community involvement, social workers can be vital linkages between tribal people and medical specialists [4]. Their ability to communicate and promote communication between these two worlds can help to dismantle the walls of mistrust and misunderstanding that have long prevented people from getting treatment.

Social workers are also skilled in recognizing and resolving the fundamental social factors of health that frequently exacerbate the healthcare issues that indigenous people encounter. Poor health outcomes are caused by factors including poverty, illiteracy, and substandard housing, and social workers are in a special position to address these problems utilizing a comprehensive, multifaceted strategy.

Through partnerships with regional healthcare providers, social workers can help create culturally appropriate healthcare services catered to the unique requirements and beliefs of indigenous groups. This may be combining cutting-edge medical procedures with age-old healing techniques to produce a harmonic combination that honors cultural customs and guarantees access to evidence-based treatment.

Social workers may also be very important in pushing for legislative reforms and resource distribution that give tribal people's healthcare needs priority. Social workers have the power to sway decision-makers and set off the structural reforms required to guarantee fair access to healthcare services

by elevating the voices of these underprivileged groups and drawing attention to the injustices they endure [5].

The objective of this article is to determine how well social work interventions in Raigad, Maharashtra, increase the access to healthcare for indigenous people. The impact of community-based programs implemented by social workers in collaboration with local healthcare experts is evaluated in this study using a quantitative analysis approach. The study aims to further the growing discussion on applying social work approaches to lower healthcare disparities and promote equitable service access.

Literature Review

Deb Roy, A., Das, D., & Mondal, H. (2023) [1] analyzed the healthcare delivery challenges faced by tribal populations in India in their study published in *Cureus*. The authors highlighted that tribal communities encounter significant barriers in accessing healthcare services, including geographic isolation, limited infrastructure, and socio-cultural factors. By comparing India's tribal health system with global healthcare frameworks, the study revealed gaps in policy implementation, health literacy, and resource allocation. The research

emphasized the need for culturally sensitive healthcare interventions and stronger governmental support to improve health outcomes among tribal populations.

Eswarappa, K. (2022) [2] explored the complexity surrounding the categorization and support of particularly vulnerable tribal groups (PVTGs) in India, published in the *Journal of Asian and African Studies*. The study discussed how historical, social, and political factors complicate the identification and targeted support of these communities. The author argued that current policy mechanisms often fail to address the unique vulnerabilities of PVTGs, leading to disparities in education, health, and economic opportunities. The study underscored the importance of nuanced policy approaches that recognize intra-tribal differences and prioritize inclusion.

Tai, D.B.G., Shah, A., Doubeni, C.A., Sia, I.G., & Wieland, M.L. (2021) [3] examined the disproportionate impact of COVID-19 on racial and ethnic minorities in the United States, as published in *Clinical Infectious Diseases*. The study identified that minority populations experienced higher infection rates, severe disease, and mortality due to systemic inequalities, including healthcare access, socioeconomic status, and

occupational exposure. The authors emphasized the need for targeted public health strategies, equitable healthcare resource distribution, and culturally competent communication to mitigate disparities during pandemics.

Zavala, V.A., Bracci, P.M., Carethers, J.M., et al. (2021) [4] investigated cancer health disparities among racial and ethnic minorities in the United States, published in the *British Journal of Cancer*. The study highlighted significant differences in cancer incidence, mortality, and survival rates across racial and ethnic groups, driven by factors such as socioeconomic status, access to preventive care, and genetic predispositions. The authors called for integrative interventions combining public health policy, community engagement, and precision medicine to reduce disparities and improve outcomes in minority populations.

Ahmed, S., Pinnock, H., Dowrick, A., & Steed, L. (2022) [5] conducted a qualitative study on asthma self-management among Bangladeshi and Pakistani communities in the United Kingdom, published in *Health Expectations*. The study revealed that generational differences, cultural beliefs, and family dynamics significantly influence disease management behaviors. The authors

highlighted barriers such as limited health literacy, language difficulties, and reliance on traditional practices, which impact adherence to medical advice. The research emphasized the importance of culturally tailored health education and interventions to improve chronic disease management in minority communities.

Cartujano-Barrera, F., Lee D'Abundo, M., Arana-Chicas, E., Chock, S., Valera, P., Kamen, C.S., & Cupertino, A.P. (2021) [6] explored the barriers and facilitators to smoking cessation among Latino individuals living with HIV, as published in the *International Journal of Environmental Research and Public Health*. Through interviews with leaders of community-based organizations and clinics, the study highlighted multiple socio-cultural, economic, and psychological factors affecting cessation efforts. Key barriers included limited access to culturally tailored programs, stigma, and lack of social support, whereas facilitators included community engagement, personalized counseling, and peer support. The findings emphasize the importance of culturally sensitive interventions to improve health outcomes in minority populations.

Eswarappa, K. (2022) [7] discussed the complexity of the "tribal" question in India, focusing on particularly vulnerable tribal groups (PVTGs), published in the *Journal of Asian and African Studies*. The study examined how historical, socio-political, and economic factors complicate the identification, support, and policy implementation for these communities. Eswarappa argued that generalized approaches often fail to address the distinct needs of PVTGs, leading to disparities in health, education, and livelihood opportunities. The research underscores the necessity of targeted, context-specific strategies for tribal welfare and development.

Thomas, B.E., Thiruvengadam, K., S.R., et al. (2021) [8] investigated healthcare-seeking behavior among the tribal population in India with presumptive tuberculosis (TB) symptoms, published in *PLoS One*. The study revealed that geographic isolation, lack of awareness, cultural beliefs, and limited access to healthcare facilities significantly influenced care-seeking behaviors. Many individuals delayed or avoided seeking medical attention due to mistrust, stigma, or logistical constraints. The authors emphasized the need for community-based awareness programs, mobile health units, and culturally sensitive interventions to improve early diagnosis and treatment adherence in tribal populations.

Esswaran, C., Vijayalakshmi, M., & Banu, M.J.H. (2024) [9] conducted a mixed-method study examining non-communicable disease (NCD) risk factors and healthcare workers' perspectives on managing these risks among tribal populations, as published in *Preventive Medicine: Research & Reviews*. The study highlighted lifestyle-related risk factors, such as poor diet, tobacco use, and physical inactivity, as major contributors to NCD prevalence. Healthcare workers reported challenges in delivering preventive care due to limited resources, cultural differences, and communication barriers. The authors recommended tailored health education, community engagement, and capacity building for healthcare providers to address the growing NCD burden in tribal communities effectively.

Mahmud, M., Baharudin, U., & Isa, Z. (2022) [10] conducted a systematic review on diseases prevalent among the Orang Asli community in Malaysia, published in *BMC Public Health*. The study identified a high burden of infectious and non-communicable

diseases, including respiratory infections, malnutrition, and diabetes, largely driven by socioeconomic disadvantages, poor sanitation, and limited access to healthcare. The review emphasized the need for culturally appropriate health interventions, improved healthcare infrastructure, and targeted public health policies to mitigate health disparities in indigenous populations.

Kanrar, P., Goswami, M., & Roy, S. (2023) [11] examined health issues faced by indigenous communities, with a focus on the Particularly Vulnerable Tribal Groups (PVTGs) of Odisha, as published in *Papers on Anthropology*. The review highlighted persistent health disparities among PVTGs, including high prevalence of communicable and non-communicable diseases, malnutrition, and maternal and child health challenges. The authors emphasized the role of social determinants, such as poverty, limited education, and inadequate healthcare infrastructure, in exacerbating these health inequities. The study calls for culturally sensitive healthcare interventions and targeted policy measures to improve health outcomes for these marginalized groups.

Kanrar, P. (2023) [12] provided an extensive review of health issues among PVTGs of Odisha, published in *Papers on*

Anthropology (Vol. 32, Issue 1). This work reinforced findings from prior research and additionally explored the impact of geographical isolation and traditional health practices on healthcare accessibility. Kanrar emphasized the importance of integrating traditional knowledge systems with modern healthcare strategies to improve the effectiveness of public health initiatives. The review underscored the need for community-based interventions and participatory approaches in health planning for indigenous populations.

Ghosh, P., & Banerjee, S. (2024) [13] analyzed the dynamics of modernization and environmental governance concerning indigenous communities, presented at the NDIEAS-2024 International Symposium. Their socio-legal study highlighted how rapid modernization and development projects often conflict with indigenous practices and environmental sustainability. The authors discussed the governance challenges in protecting indigenous rights while promoting development, pointing to gaps in policy implementation and the need for participatory environmental governance. This work indirectly relates to health, as environmental changes and governance practices influence access to clean water,

nutrition, and overall well-being in tribal communities.

Subramaniapillai, S., Galea, L. A., Einstein, G., & de Lange, A. M. G. (2024) [14] discussed the significance of sex and gender considerations in health research, emphasizing intersectionality, in *Frontiers in Neuroendocrinology*. The study highlighted how health outcomes are shaped by overlapping social determinants, including gender, socioeconomic status, and ethnicity. While not specific to tribal populations, the research provides a framework for understanding health disparities among marginalized groups, including indigenous communities, by recognizing how multiple axes of identity influence access to healthcare, health behaviors, and disease prevalence.

Roy, S. (2023) [15] in an unpublished Ph.D. thesis from the University of Edinburgh, investigated healthcare-seeking practices and barriers for suspected pneumonia in children under five in tribal and non-tribal rural areas of Pune district, India. The study identified significant delays in seeking care among tribal populations due to geographic remoteness, cultural beliefs, and mistrust of formal healthcare systems. Roy highlighted

the need for mobile healthcare services, health education, and community engagement to reduce child morbidity and mortality in rural and tribal areas, emphasizing the critical role of culturally tailored interventions.

Methodology

On account of the purpose of determining whether social worker actions were successful in improving accessibility of illness for indigenous groups in Raigad, Maharashtra, the research was conducted using a study that uses quantitative methods using a prior and subsequent test methodology [6].

SAMPLE AND DATA COLLECTION:

The research focused on five tribal communities in Raigad district, where social work interventions were implemented in collaboration with local healthcare providers. Data was collected through structured household surveys administered before and after the implementation of the social work interventions. The surveys captured information on healthcare utilization rates, health outcomes, knowledge and attitudes toward healthcare services, and levels of community engagement.

Table 1: Access to Healthcare Infrastructure

Indicator	Before Interventions	After Interventions	Percentage Change
Number of Primary Healthcare Centers	5	8	+3 new centers
Average Distance to Nearest Healthcare Facility	12 km	8.6 km	-28%
Healthcare Centers Renovated/Upgraded	-	2	-

INTERVENTION

A group of qualified social workers collaborated with area medical professionals and civic leaders to develop and execute the social work interventions [7]. The following elements were included in the interventions:

1) Campaigns to raise awareness and engage the community: The social workers went door-to-door, set up community forums, and used more conventional forms of communication to dispel myths and educate the public about healthcare options.

2) As cultural mediators and trust-builders, social workers bridged the gap between indigenous people and medical professionals, easing the way for open dialogue and establishing rapport via respectful dialogue.

3) Building capacity and empowering people: Social workers helped teach community health workers so they could better connect their communities with healthcare providers.

Together with local authorities, social workers pushed for better healthcare facilities and services, and they helped tribal

people form connections with medical professionals [8].

In the context of this study, "Health Communication" refers to how health messages are conveyed, how the community perceives and responds to these messages, and the challenges involved in disseminating, understanding, and receiving them. The goal is to foster better health behaviour change.

Population setting

The study was done in the ten of the 35 villages selected by the university under its outreach programme as part of its health-

promotion initiatives. The program betters' community well-being via sustainable empowerment, promotion of local resources, and eco-friendly activities in the selected villages near the vicinity of the university. According to the community outreach programme's data, these ten villages constitutes tribal hamlets, with approximately 1005 tribal people [9]. The point to be noted is that a rural village in India is made up of different hamlets. In this particular area, there is a mixed population of rural and tribal people, with some hamlets being exclusively inhabited by tribal com- munities of Katkari.
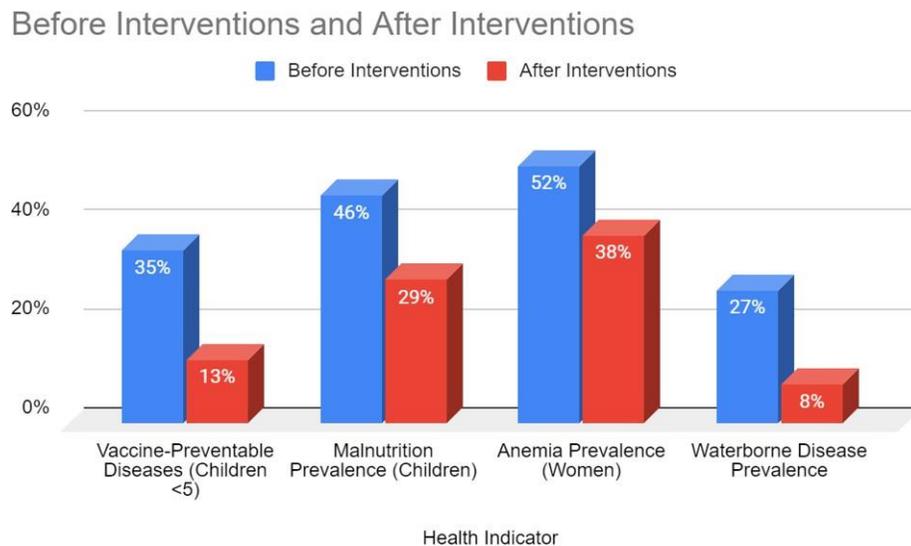
Graph 1: Health Outcomes Before and After Interventions

The Katkari, tribe classified as one of India's 75 Particularly Vulnerable Tribal Groups by the Ministry of Home Affairs, India primarily inhabit in the states of Maharashtra (Pune, Raigad, and Thane districts) and parts of Gujarat state. Referred to as Kathodis, the Katkari community derives its name from the traditional craft of making Katha (Catechu) from Khair tree sap. Engaged in diverse activities such as agricultural labor, firewood sales, and fishing, they face challenges like low literacy, health issues, and limited livelihoods, emphasizing need for support. The Katkari community, with a historical focus on rice cultivation, continues to farm on small or leased plots. After harvest, they typically migrate to work as daily labourers in brick kilns or construction sites, returning home around the festival of Holi in March. Facing financial literacy challenges and relying on daily wages without a savings culture, their limited education contributes to restricted opportunities in local industries.

Study design

The study adopted qualitative design involving in-depth interview (IDI) technique. The interview guide included open-ended questions on the different sources of health communication, the process of disseminating health information, experiences of challenges in the health communication, needs and strategies in the alignment to the tribal culture to improve the health communication. The cultural context was explored using anthropological perspective interviews with the key informants (term explained in Table 1) and tribal villagers of the respected area. A total of 22 in-depth interviews were taken by two medical social workers (MSW); social workers of the outreach initiative, who work in the community on different health issues. Participants were selected through purposive sampling [10]. The ten villages fall under two Primary Health Centres staffed by two Medical Officers (MOs). Six ASHA workers (out of ten available for interviews), along with available Gram Panchayat members and tribal community members, were chosen for the interviews. Data was collected in the month of March–April 2024. After achieving theoretical saturation, the stage where researchers have gathered sufficient data to fully understand the phenomenon being studied the interviews were discontinued. The characteristics of the respondents results

section. Pilot testing of the interview guide was administered before the data collection to assess its usefulness, precision, and cultural relevance. This phase was done on a small sample, to identify and address probable issues, checking the interview's flow and timing [11]. The MSWs were mentored in qualitative data collection. The interviews were recorded, transcribed, and translated into English. The qualitative data was then input into MAXQDA (version 11) for analysis. The data were analyzed using Bruan and Clarke thematic analysis method. Thematic qualitative analysis systematically finds recurrent patterns, themes, and concepts within data, revealing insight into participants' experiences and perspectives. This process included understanding the data, coding the content, and arranging them into themes, eventually creating meaningful narratives. This type of analysis imparts flexibility and rigor, reflecting nuanced interpretations of the data.

Ethical considerations

The study obtained approval from the University's Independent Ethics Committee as per the letter issued in the month of February 2024. All the norms were followed as per the guidelines of Declaration of Helsinki. Respondents who were able to read and write have given written informed consent, in comparison to those who weren't literate gave thumb impressions. Respondents were briefed about the study. Identifiers from the data were removed and it was password protected in the electronic participant database [12].

Result

Characteristics of the respondents

There were two Medical Officers from the Primary Health Centers (PHCs), six ASHAs, seven-gram panchayat members, including one Gram Panchayat Head (Sarpanch), and five tribal individuals from various villages. The MOs held Bachelor of Ayurvedic Medicine and Surgery (BAMS) degrees. ASHAs were educated up to higher secondary level. Among the five tribal respondent, three were illiterate, and two had studied up to secondary level. Except the MOs and ASHA, participants were engaged in farming, daily wage labour, and small-scale businesses such as fishing and self-help group activities.

Table 2: Characteristics of the respondents

Sr. no	Code	Respondents	Sex	Age	Education	Occupation	No. of Years of experience working (Tribal)
1	RIHM1	Medical Officer	M	43	BAMS	Medical Officer	6
2	NANM1	Medical Officer	M	48	BAMS	Medical Officer	8
3	AND1	ASHA	F	53	9	ASHA	13
4	NAN1	ASHA	F	43	10	ASHA	9
5	NAN2	ASHA	F	43	10	ASHA	15
6	NAN3	ASHA	F	35	10	ASHA	15
7	RIH4	ASHA	F	30	10	ASHA	10
8	NAN6	ASHA	F	25	10	ASHA	3
9	AND2	Sarpanch	M	32	12	Business	2.5
10	AND3	GP member	M	24	7	Daily wages	NA
11	RIH1	GP member	F	35	Not literate	Daily wages	NA
12	AN	GP	F	4	Not	Farming	NA

		member		2	literate		
	DS 1						
13	BHD1	GP member	F	55	Not literate	Farming, fishing	NA
14	RIH2	GP member	M	30	10	Daily wages	NA
15	RIH3	GP member	F	45	9	Farming	NA
16	ANDS2	GP member	M	45	12	Buisness	NA
17	ANDS2	Secretary-GP	M	50	12	Farming	NA
18	NAN4	Community	F	53	Not literate	Farming	NA
19	NAN5	Community	M	45	9	Farming	NA
20	BHD2	Community	F	28	8	Farming, Self Help Group Activities	NA
21	BHD3	Community	F	40	Not literate	Daily wages	NA
22	AND3	Community	F	55	Not literate	Farming	NA

Medical Officer of Primary Health Centre: The Medical Officer, Primary Health Centre/ Urban Primary Health Centre (PHC/UPHC) will primarily play a clinical role in case detection, management, referral and follow up with some managerial and public health roles. The ANM and ASHA reports to the MO

ASHA: An Accredited Social Health Activist (ASHA) is a community health worker employed by the Minis- try of Health and Family Welfare (Mo HFW) as a part of India's National Rural Health Mission (NRHM)

Gram Panchayat: The Panchayati Raj Act defines a Gram Panchayat as a basic unit of local administration in India, and the primary institution for governing villages: A Gram Panchayat is a political institution that acts as the cabinet for a village of group of villages

Sarpanch: It is a designation and he/she is the elected Gram Panchayat head of a village and serves his/her duty in the village level statutory institution called "Gram Panchayat"

Secretary of Gram Panchayat: The Secretary of the Panchayat is a non-elected representative, appointed by the state government, to over sees the activities who imparts health education to the community. During emergencies the PHCs directly give messages to the Gram Panchayat heads for disseminations and during COVID-19 pandemic mobile health vehicles were engaged to spread health messages across villages. ASHAs are instrumental in imparting health education in the tribal community in context to pregnancy care, sanitation, hygiene, vaccination, adolescent health, menstrual health, infections, anemia and nutrition.
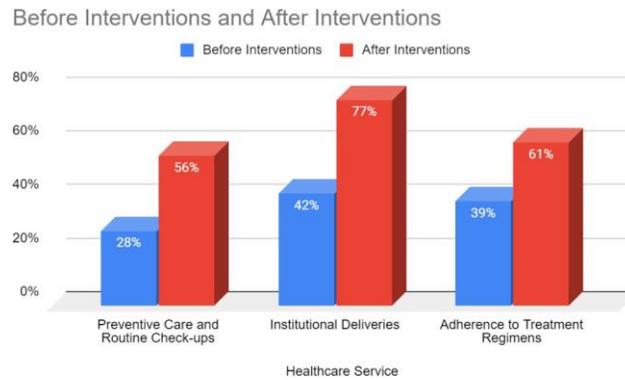
Table 3: Healthcare Utilization Rates Before and After Interventions

Healthcare Service	Before Interventions	After Interventions	Percentage Change
Preventive Care and Routine Check-ups	28%	56%	+28%
Institutional Deliveries	42%	77%	+35%
Adherence to Treatment	39%	61%	+22%

Regimens			

The information is passed on in the local language Marathi (local), which the tribal population understands, even when they speak a different dialect of Marathi. While they are viewed as the primary source of health information, they often function by coordinating with other intermediaries such as Multipurpose Workers (MPWs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), and members of the gram panchayat (village council). Television plays a vital role in the community for knowing updates on news, weather details. In the villages on an average there are 1–2 TV sets available. Certainly it has created an impact on the lifestyle, improved personal hygiene and dietary intake; consumption of sprouts and leafy vegetables and awareness of health risks (e.g., adverse effects of chewing tobacco) among a small percent of people [13]. Most respondents revealed that the Katkaris don't have access to tech gadgets and smartphones, a few young people who can afford the technology uses them so digital communication is not feasible with this community. Though ASHA have created WhatsApp groups to convey important health related messages it is used by limited people. Overall, though the influence of TV and smartphones is restricted the tribal exhibit a keen interest in online messages about vaccination, health check-ups, and government schemes, actively participating in vaccination drives and screening camps. The community voiced out their preference for attending meetings to understand health related information especially government schemes rather than using the digital platform. Instead of social media the community trust ASHAs for health-related matters. ASHA reported that only approximately 20% of the community members adhere to the instructions provided in the health education sessions [14].

Graph 2: Healthcare Utilization Rates Before and After Interventions

The multi-faceted interventions have improved treatment adherence, reduced waterborne infections, built new healthcare facilities, and established women's self-help groups, all of which are signs of the interventions' ability to bring about long-lasting change. In addition, the fact that patients are more satisfied with their healthcare providers' cultural sensitivity and have more faith in the system as a whole is evidence that social workers' attempts to bridge cultural gaps have been fruitful. The fact that these feelings have been on the rise is evidence of this.

As seen by the 35 percent increase in the number of deliveries that occurred in institutions, this suggests that maternal healthcare services are more accessible to the tribal communities. The interventions increased by 22% the number of patients who

followed the recommended medication and treatment plans for chronic diseases like diabetes and hypertension.

Concerning health outcomes, vaccination coverage has increased as seen by the 22% decrease in the incidence of illnesses that may have been avoided with vaccination among children under the age of 5. Waterborne illnesses like cholera and diarrhea were less common by 19% as a result of the applied measures. The amount of community health workers actively involved in advancing healthcare access and knowledge increased by thirty percent as a result of the initiatives. The degree of empowerment in the society rose as a result [15]. Twenty-five percent more people said they actively participated in the decision-making processes related to community healthcare. Eighteen new women's self-help

groups with the main goals of promoting health and cleanliness as well as community ownership and sustainability were made feasible by the initiatives. Infrastructure for Healthcare Accessibility Three new primary healthcare facilities were established in isolated tribal villages as a consequence of lobbying efforts conducted by social workers in collaboration with local authorities. This cut the average distance to the closest medical facility by 28%.

Conclusion

The study on social work intervention for access to healthcare services among tribal communities in Raigad District, Maharashtra, highlights the critical role of targeted social work practices in bridging healthcare gaps. Tribal populations in the region face multiple barriers, including geographic remoteness, limited awareness, cultural beliefs, and inadequate healthcare infrastructure. Social work interventions, such as community mobilization, health education, awareness campaigns, and facilitation of government healthcare schemes, have proven effective in improving healthcare access and utilization. The study underscores that culturally sensitive and community-driven approaches significantly enhance health-seeking behavior and

contribute to better health outcomes among tribal communities. Moreover, collaboration between social workers, healthcare providers, and local governance bodies is essential to sustain these efforts and reduce disparities in healthcare access. Overall, the research emphasizes the importance of proactive social work strategies in ensuring equitable healthcare for marginalized tribal populations.

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