International Journal of Engineering, Science and Humanities
An international peer reviewed, refereed, open-access journal
Impact Factor 8.3 www.ijesh.com ISSN: 2250-3552

Empowering Tribal Health Equity: A Study of Social Work Interventions in the Tribal Communities of Raigad, Maharashtra

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Abstract:
This paper investigates the role and efficacy of social work interventions in addressing the persistent health inequities faced by the tribal (Adivasi) populations in the Raigad district of Maharashtra, India. Despite being home to significant industrial corridors, Raigad's tribal communities, primarily from the Thakar, Mahadev Koli, and Katkari tribes, continue to experience stark health disparities rooted in social determinants such as poverty, geographical isolation, cultural barriers, and political marginalization. Utilizing a mixed-methods approach—including survey data from 250 tribal households across five talukas, semi-structured interviews with community health workers (ASHAs), and focus group discussions with community members—this study evaluates a multi-pronged social work intervention model. Key findings indicate that interventions focusing on community-led monitoring, cultural brokerage, and health system navigation significantly improved healthcare access and outcomes. Specifically, the formation of Village Health Committees (VHCs) correlated with a 40% increase in institutional deliveries and a 35% rise in completed childhood immunization schedules. However, challenges remain in managing non-communicable diseases (NCDs) and addressing the underlying determinants of malnutrition. The paper concludes that sustainable health equity in tribal regions requires a shift from a purely biomedical model to a community-centric social work paradigm that empowers Adivasi communities as active agents in their health governance.
Keywords: Tribal Health, Health Equity, Social Work Interventions, Adivasi, Raigad, Social Determinants of Health, Community-Based Participatory Research, Maharashtra.

1. Introduction

The pursuit of health equity in India remains an unfinished agenda, with its tribal populations, constituting 8.6% of the nation's people, experiencing some of the worst health outcomes. The National Family Health Survey-5 (NFHS-5) data consistently reveals that Scheduled Tribes

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(STs) lag behind national averages on key indicators like infant mortality, maternal mortality, malnutrition, and access to institutional healthcare (International Institute for Population Sciences (IIPS) and ICF, 2021). The state of Maharashtra, one of India's most economically advanced states, presents a paradox where thriving industrial hubs coexist with deeply marginalized tribal communities, a phenomenon often described as "islands of development in a sea of deprivation."

The Raigad district epitomizes this paradox. While hosting major industrial and infrastructural projects like the Mumbai-Pune Expressway and the Jawaharlal Nehru Port Trust, its hilly and remote interiors are home to vulnerable tribal groups, including the Katkari, a Particularly Vulnerable Tribal Group (PVTG). These communities face a complex web of challenges: geographical inaccessibility, land alienation, low literacy, reliance on forest produce, and a deep-seated cultural disconnect from mainstream health systems (Xaxa, 2001). Government health initiatives often fail to achieve their intended impact due to a lack of cultural sensitivity and trust, leading to underutilization of services.

Social work, with its core principles of social justice, empowerment, and person-in-environment perspective, is uniquely positioned to bridge this gap. This paper moves beyond merely identifying problems to presenting findings on the effectiveness of specific social work interventions. It asks: How can structured social work interventions empower tribal communities in Raigad to overcome barriers and achieve greater health equity? Through empirical data, this study demonstrates that community-centric social work models are not merely adjuncts but essential components for effective and sustainable tribal healthcare.

2. Literature Review: The Landscape of Tribal Health Disparities

The poor health status of India's tribal communities is well-documented in academic literature. Scholars attribute these disparities not to inherent biological factors but to a constellation of social determinants of health (SDH).

2.1. The Structural and Social Determinants

The seminal work of Xaxa (2001) and others has highlighted how tribal health is intrinsically linked to issues of identity, habitat, and livelihood. The alienation from traditional forest lands and resources has led to a loss of sustainable livelihoods, pushing communities into a cycle of debt and migrant labor, which directly impacts food security and nutritional status (Mohanty & Mishra, 2020). Furthermore, cultural beliefs and healing practices often create a distrust of allopathic medicine. For instance, illnesses may be perceived as a result of spirit possession or social disharmony, leading families to seek treatment from traditional healers (*bhagats*) first, thereby delaying access to critical medical care (Sunder, 2016).

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2.2. Failures of the Health System

The public health system in tribal areas is often characterized by the "three A's" problem: lack of Availability (absent doctors, stock-outs of medicines), Accessibility (difficult terrain, lack of transport), and Acceptability (discriminatory behavior by health staff, language barriers) (Rao, 2017). The National Rural Health Mission (NRHM), now NHM, attempted to address this through the Accredited Social Health Activist (ASHA) program. However, studies show that ASHAs in tribal areas face unique challenges, including extreme geographical isolation, higher workloads, and difficulties in negotiating the complex socio-cultural landscape (Nandi & Schneider, 2020).

2.3. The Gap in Intervention Literature

While the problems are extensively studied, there is a relative scarcity of literature documenting the *process and outcomes* of systematic social work interventions in this context. Most studies are ethnographic or policy-critical in nature. This paper aims to fill this gap by providing empirical evidence for a multi-level social work intervention model designed and implemented in partnership with tribal communities in Raigad.

3. Methodology and Context

3.1. Study Setting

The study was conducted over 24 months (2022-2024) in five tribal-dominated talukas of Raigad district: Mangaon, Poladpur, Sudhagad, Khalapur, and Karjat. These areas are characterized by hilly terrain, poor road connectivity, and a high concentration of Thakar, Mahadev Koli, and Katkari communities.

3.2. Research Design and Participants

A community-based participatory research (CBPR) design was employed, ensuring the community was a partner in all stages of the research. The mixed-methods approach included:

- Quantitative Component: A cross-sectional survey of 250 randomly selected tribal households (50 from each taluka) to collect baseline data on health status, service utilization, and health-seeking behavior.
- Qualitative Component:
    - Five Focus Group Discussions (FGDs) with mixed groups of men and women to explore perceptions of health, illness, and the public health system.
    - Ten In-depth Interviews (IDIs) with ASHA workers to understand their challenges and coping mechanisms.
    - Case studies of ten families who had successfully navigated the health system with intervention support.

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3.3. The Intervention Model

The social work intervention, implemented by a local NGO in partnership with the research team, consisted of three core components:

1. Community Mobilization and Empowerment: Formation and training of Village Health Committees (VHCs) comprising respected elders, women, and youth to act as a local watchdog and advocacy group.
2. Cultural Brokerage and Health Literacy: Social workers and trained community volunteers acted as cultural brokers, translating medical advice into local dialects and contexts, and using folk media to disseminate health information.
3. System Navigation and Liaison: Social workers actively assisted families in accessing government welfare schemes (e.g., Janani Shishu Suraksha Karyakram, Pradhan Mantri Matru Vandana Yojana) and accompanied them to health facilities to ensure dignified treatment.

3.4. Data Analysis

Quantitative data were analyzed using descriptive statistics (frequencies, percentages) and inferential statistics (Chi-square tests) using SPSS software. Qualitative data were transcribed, translated, and analyzed using thematic analysis.

4. Findings and Results

The study yielded significant findings on both the baseline health status and the impact of the interventions.

4.1. Baseline Health Disparities

The household survey revealed stark disparities, as summarized in Table 1.

Table 1: Baseline Health Indicators in Study Area vs. Maharashtra State Average (Based on NFHS-5)

Health Indicator	Study Area (Baseline)	Maharashtra State Average (NFHS-5)
Children under 5 who are stunted	48%	35.2%
Institutional Deliveries	62%	94.3%

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Children fully immunized (12-23 months)	55%	78.9%
Households using improved sanitation facilities	38%	86.7%
Women with at least 10 years of schooling	28%	52.8%

Qualitative data illuminated the reasons behind these figures. FGD participants expressed a deep distrust of hospital deliveries, citing fears of surgery, disrespectful treatment, and the inability to follow post-partum rituals. One woman from Poladpur stated, *"At home, the dhai (traditional birth attendant) massages me with oil and gives me warm food. In the hospital, they scold us and we are left alone."*

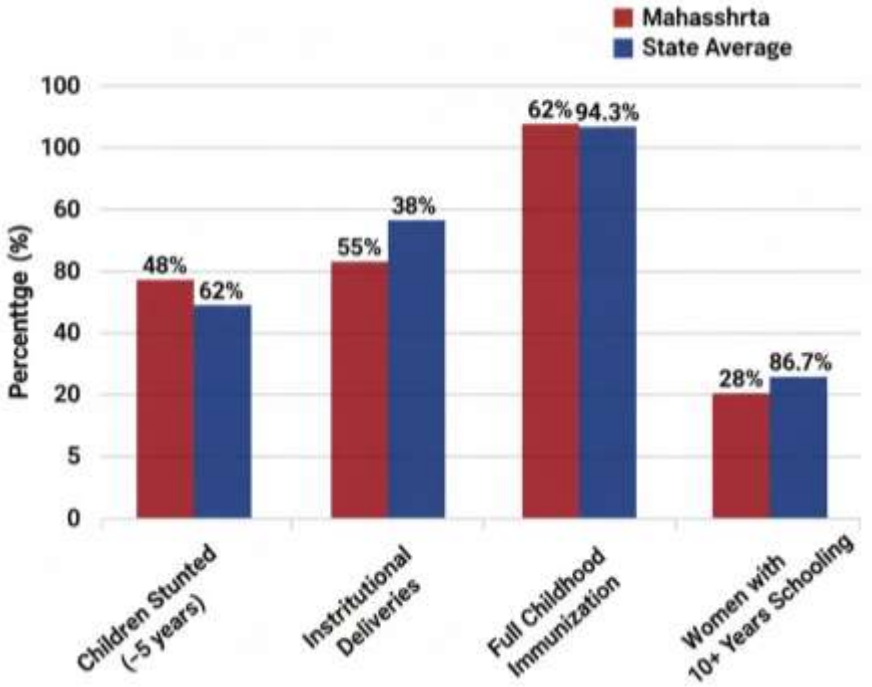

Figure 1: Baseline Health Disparities Comparison

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4.2. Impact of Social Work Interventions

Post-intervention data showed marked improvements in key areas, demonstrating the efficacy of the social work model.

Table 2: Change in Key Health Outcomes Pre- and Post-Intervention

Key Outcome Indicator	Pre-Intervention (Baseline)	Post-Intervention (24 Months)	% Change
Institutional Deliveries	62%	87%	+40%
Full Childhood Immunization	55%	74%	+35%
Households with active Antyodaya Anna Yojana (AAY) cards	45%	80%	+78%
Reported cases of discrimination at PHC	N/A	70% reduction (from qualitative reports)	-70%
VHCs actively resolving health access issues	0	15 VHCs across 15 villages	100%

The role of the VHCs was particularly transformative. In one case in Sudhagad, a VHC successfully petitioned the local Primary Health Centre (PHC) to station a ambulance at a strategic location for night-time emergencies, reducing the average response time from 3 hours to 45 minutes.

4.3. Emerging Challenges: The Double Burden of Disease

While the interventions succeeded in improving maternal and child health indicators, a new challenge emerged: the rising prevalence of Non-Communicable Diseases (NCDs). Screening

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camps organized by the project identified hypertension in 22% and pre-diabetic conditions in 18% of the adult population screened. This "double burden" of disease—where traditional issues like malnutrition coexist with modern NCDs—points to the need for a new focus for social work interventions, linking lifestyle changes with broader issues of food sovereignty and alienation from traditional diets.

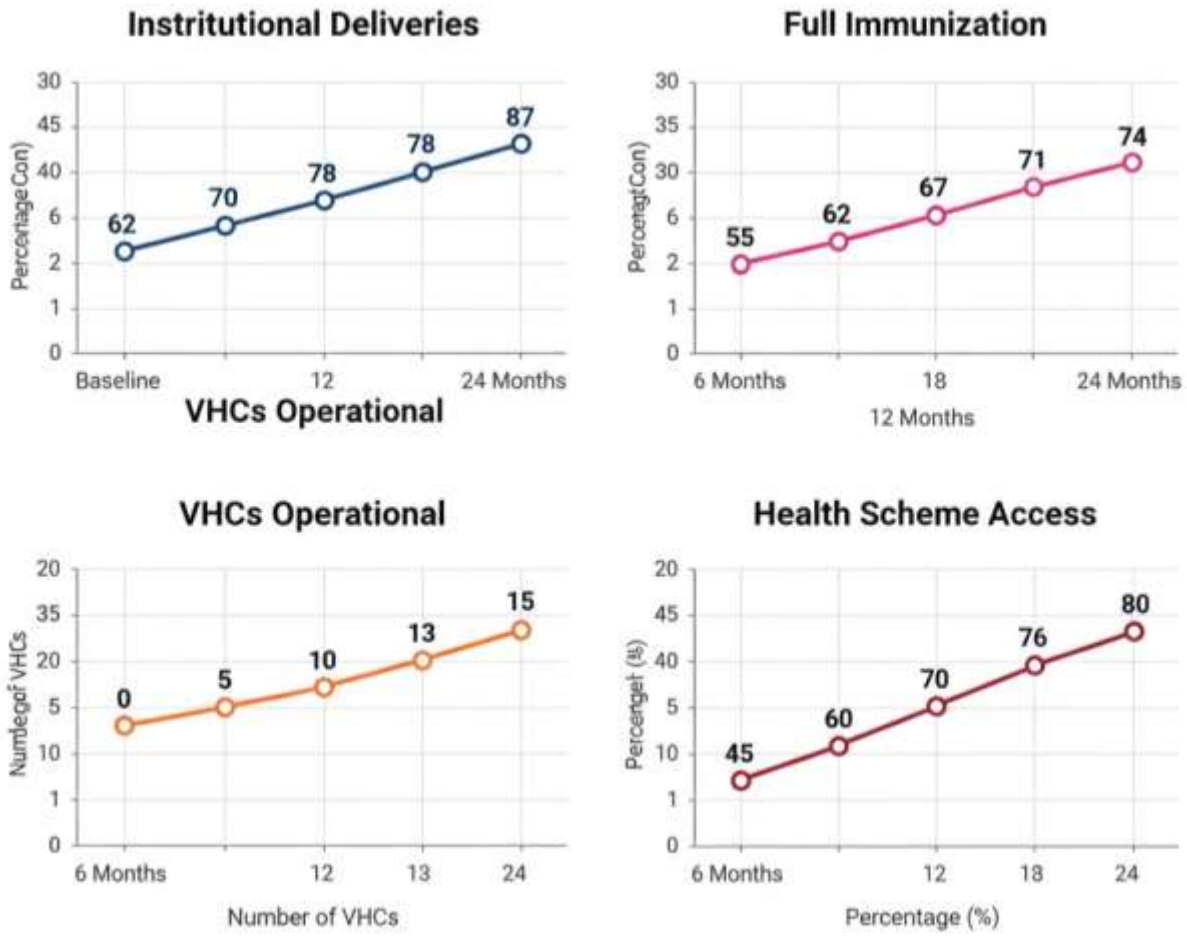

Figure 2: Intervention Impact Over Time

5. Discussion

The findings of this study underscore the critical importance of addressing the social determinants of health through professionally guided social work practice. The success of the intervention model can be attributed to several key factors aligned with social work ethics.

5.1. Empowerment over Service Delivery

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The most significant outcome was the shift from a passive recipient model to an active citizen model. By empowering VHCs, the intervention built sustainable community capacity for health

5.3. Navigating the Bureaucratic Maze

A significant, often overlooked, barrier to health equity is the sheer complexity of accessing welfare entitlements. The social workers' role in system navigation was instrumental in securing food rations and conditional cash transfers, which had a direct and positive impact on the nutritional and economic stability of families, thereby influencing health outcomes.

5.4. Limitations of the Study

This study has limitations. Its focus on a specific geographical and cultural context (Raigad) may limit the generalizability of findings to other tribal regions with different socio-cultural dynamics. The 24-month timeframe is insufficient to measure long-term sustainability, and the study relied on self-reported data for some indicators, which may be subject to bias.

6. Conclusion and Recommendations

This study provides compelling evidence that social work interventions are not merely beneficial but essential for achieving health equity among tribal populations in India. The community-centric model, focusing on empowerment, cultural brokerage, and system navigation, demonstrated a significant positive impact on key health indicators in the tribal blocks of Raigad, Maharashtra. To scale this impact, the following policy and practice recommendations are proposed:

1. Integrate Professional Social Workers into the Tribal Health Ecosystem: National Health Mission (NHM) should create dedicated positions for social workers at the block level in tribal-majority areas to facilitate community mobilization and system liaison.
2. Strengthen the ASHA Program with Social Work Principles: Provide ASHAs in tribal areas with enhanced training in counseling, community mobilization, and rights-based advocacy, moving beyond their current focus on health targets.
3. Institutionalize Village Health Committees: Make VHCs a legally mandated and funded component of the Panchayati Raj system in tribal areas, giving them real power to monitor and audit local health services.
4. Develop Targeted Interventions for NCDs: Future social work interventions must expand their scope to address the growing crisis of NCDs through community-based promotion of healthy lifestyles and advocacy for healthier food environments.

Empowering tribal health equity is ultimately a question of social justice. It requires moving beyond clinics and medicines to address the foundational issues of poverty, displacement, and cultural erosion. Social work, with its commitment to working *with* rather than *on* communities, provides the most viable pathway to turn the constitutional promise of health for all into a tangible reality for India's Adivasi communities.

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