International Journal for Rapid Research in Engineering Technology & Applied Science (IJRRETAS)

(Peer-Reviewed, Open Access, Fully Refereed International Journal)

Volume 12 issue 10 October 2026 OPEN ACCESS E-ISSN: 2455-4723 Impact Factor 7.95

DOI: https://doi.org/10.65630/ijrretas.2026.v12i10.307

Tribal Communities In Bastar District: Challenges and the Role of Social Work

Amit verma

Rohit Kumar

Abstract

Healthcare accessibility is a multidimensional issue for tribal communities because physical distance, poverty, transport constraints, health-system capacity, language, cultural practices, health literacy and trust can interact to shape whether a person is able to obtain timely and acceptable care. This paper examines healthcare accessibility among tribal communities in Bastar district of Chhattisgarh from a social work perspective. The study uses a secondary-data analytical design based on official district information, Ministry of Tribal Affairs reports, national tribal-health initiatives, health-system documents and relevant academic literature. Bastar is a predominantly rural and tribal district; the district administration reports that tribal communities constitute about 70% of the population and identifies government hospitals as a major source of medical care. Official tribal-health evidence at the national level identifies recurring barriers including shortages of health personnel, infrastructure deficits, poor road and digital connectivity, economic costs, and socio-cultural and language barriers. The Ministry of Tribal Affairs has also reported a shortage of doctors at Primary Health Centres in tribal areas of Chhattisgarh, illustrating the wider health-system challenge. The paper argues that healthcare access should be understood not merely as the physical presence of a facility but as the ability to reach, afford, understand, trust and effectively use appropriate services. Social workers can bridge the gap between communities and health institutions through community organization, health education, case management, referral, psychosocial support, advocacy, culturally responsive communication and programme monitoring. The paper proposes a community-centred Tribal Health Accessibility Model combining outreach, transport and referral support, digital/telemedicine facilitation, local health volunteers, women and adolescent groups, traditional knowledge engagement, social protection linkage and accountability mechanisms.

Keywords Tribal health; healthcare accessibility; Bastar; Chhattisgarh; social work; Indigenous communities; health equity; primary healthcare; health-seeking behaviour; community participation.

International Journal for Rapid Research in Engineering Technology & Applied Science (IJRRETAS)
(Peer-Reviewed, Open Access, Fully Refereed International Journal)
Volume 12 issue 10 October 2026 OPEN ACCESS E-ISSN: 2455-4723 Impact Factor 7.95

1. Introduction

Health is a fundamental component of human well-being and social development. For tribal communities living in remote, forested and geographically difficult areas, however, access to healthcare may remain unequal even when formal health services are officially available. Accessibility includes much more than the existence of a hospital or health centre. It involves physical reachability, affordability, availability of staff and medicines, cultural acceptability, information, communication, continuity of care and the capacity of individuals and families to navigate the health system.

The Ministry of Tribal Affairs recognizes that tribal populations face distinctive health challenges associated with geographical isolation, socio-economic disparities and cultural differences. Its Tribal Health Cell emphasizes culturally appropriate and inclusive health policies, with attention to maternal and child health, nutrition, infectious diseases, non-communicable diseases, traditional knowledge and health-seeking behaviour.

Bastar provides an important setting for this analysis. The official district profile describes Bastar as a southern Chhattisgarh district headquartered at Jagdalpur, with an area of 6,596.90 square kilometres. It reports that approximately 70% of the population belongs to tribal communities, including Gond, Maria, Muriya, Bhatra, Halba and Dhruva communities. The district is also characterized by forests, hills and dispersed settlements.

The district administration states that government hospitals are the only source of medical care for the district and reports efforts to fill vacancies among paramedical staff, doctors and specialists and to improve equipment, laboratories and essential facilities. This official description itself demonstrates why healthcare access is a social-development concern rather than only a clinical issue.

The social work perspective is particularly relevant because healthcare barriers frequently arise at the intersection of person, family, community and institution. A patient may reach a facility but fail to receive care because of missing documents, cost, language barriers, fear, lack of information, referral difficulties or inability to return for follow-up. Social workers can intervene at each of these points while also advocating for systemic improvement.

2. Background and Context of Tribal Healthcare in Bastar

Bastar's geographic and demographic characteristics influence the organization of healthcare. Large rural areas, dispersed settlements and forested terrain can increase travel time and transport costs. For households dependent on daily wages, agriculture or forest-based livelihoods, visiting a distant health facility may also mean losing income or arranging care responsibilities at home.

The national tribal-health evidence reinforces this pattern. The Ministry of Tribal Affairs' Annual Report 2022–23, drawing on Rural Health Statistics 2021–22, reported 25,383 Sub-Centres, 3,833 Primary Health Centres and 960 Community Health Centres in tribal areas nationally as of 31 March 2022, with shortfalls against prescribed requirements. The report specifically notes that the shortfall of doctors at PHCs was highest in tribal areas of Chhattisgarh, at 128.

The National Tribal Health Conclave also identified manpower shortage, infrastructure deficiencies, weak road/internet/mobile connectivity, economic barriers, socio-cultural and language barriers, and inadequate disaggregated data as major challenges to tribal healthcare. These factors are highly relevant to Bastar because they interact rather than operate independently.

Healthcare accessibility must therefore be examined through an equity lens. A nominally available service can remain effectively inaccessible if a person cannot travel to it, cannot afford the indirect costs, cannot communicate with providers, does not trust the service, or cannot complete the referral process.

3. Statement of the Problem

The problem addressed in this paper is the persistent gap between the formal availability of healthcare services and their effective utilization by tribal communities in Bastar. The issue includes both supply-side and demand-side dimensions. Supply-side constraints include infrastructure, human resources, equipment, medicines, diagnostics and referral capacity. Demand-side constraints include awareness, affordability, transport, cultural beliefs, language, gender relations and health-seeking behaviour.

A further challenge is continuity of care. Remote households may access a health facility for an acute illness but face difficulty returning for investigations, specialist consultation, treatment completion or follow-up. This can reduce the effectiveness of otherwise available services.

4. Major Challenges in Healthcare Accessibility

4.1 Geographical and Transport Barriers

Distance is a central determinant of healthcare access in remote settlements. Roads, seasonal conditions, availability of public transport and emergency mobility can influence whether families seek care early or postpone treatment. The National Tribal Health Conclave explicitly identifies topography and limited road, internet and mobile connectivity as barriers to formal healthcare access.

In Bastar, this challenge should be addressed through stronger outreach, mobile medical services, reliable referral transport, emergency communication and decentralized primary-care points. The objective should be to reduce the distance between the household and the first point of care.

4.2 Human-Resource Constraints

Healthcare accessibility depends on staff availability as much as buildings. Shortages of doctors, nurses, ANMs, laboratory personnel and specialists can increase waiting time, reduce service range and force patients to travel to higher-level facilities. The Ministry of Tribal Affairs has documented the shortfall of doctors at PHCs in tribal areas of Chhattisgarh.

Bastar's district administration has undertaken recruitment and strengthening efforts under the National Health Mission, including posts such as ANMs, nursing officers, community health officers, counsellors, laboratory technicians, physiotherapists and social workers in recent recruitment notices.

4.3 Infrastructure, Equipment and Medicines

A facility may be physically present but function below its intended capacity if equipment, laboratory services, medicines, electricity, water or maintenance are inadequate. Health-system strengthening must therefore focus on functionality, not merely facility counts.

4.4 Economic Barriers

Poor households may postpone care because of transport expenditure, diagnostic costs, medicine purchases, food and accommodation costs during referrals, and loss of daily earnings. The National Tribal Health Conclave identifies economic barriers and wage loss as factors that can lead to postponement of treatment.

4.5 Language and Cultural Barriers

Health communication is less effective when patients cannot fully understand the provider or when providers lack familiarity with local cultural practices. The Ministry of Tribal Affairs specifically recognizes cultural differences, health-seeking behaviour and traditional knowledge as important considerations in tribal health policy.

4.6 Trust and Health-Seeking Behaviour

Trust is built through respectful communication, continuity, confidentiality and recognition of community knowledge. If patients perceive health institutions as unfamiliar or judgmental, they may delay formal care or use only traditional/home remedies. The appropriate response is not to stigmatize traditional practices but to encourage timely referral for conditions requiring medical diagnosis and treatment.

4.7 Maternal and Child Health

Maternal and child health requires special attention because distance, transport, nutrition, antenatal care, institutional delivery, immunization and postnatal follow-up are interconnected. Outreach workers and social workers can help identify high-risk households, support service navigation and

encourage continuity of care.

4.8 Sickle Cell Disease and Genetic Health

Sickle cell disease is an important tribal-health priority in India. The Ministry of Tribal Affairs' Swasthya portal includes a Sickle Cell Disease Support Corner for registration and information. For Bastar, social-work interventions can include awareness, screening referral, treatment adherence support, family counselling, stigma reduction and linkage to social protection.

4.9 Digital Divide and Telemedicine

Telemedicine can potentially reduce the burden of travel for specialist advice, but it cannot substitute for physical examination, diagnostics or emergency treatment in every case. Digital interventions must therefore be integrated with local health workers, reliable connectivity, privacy safeguards and referral pathways. The Ministry of Tribal Affairs documents telemedicine work in tribal settings as an emerging area of intervention.

5. Government and Institutional Responses

5.1 National Tribal Health Initiatives

The Ministry of Tribal Affairs has created dedicated tribal-health mechanisms because tribal health outcomes and access differ from those of the wider population. The Tribal Health Cell seeks to support evidence-based and culturally appropriate health policy and implementation.

5.2 Swasthya: National Tribal Health Portal

Swasthya is designed as a consolidated information platform for tribal health and nutrition, bringing together data and learning from multiple stakeholders. It also supports thematic work such as sickle-cell disease and telemedicine.

5.3 Dharti Aaba Janjatiya Gram Utkarsh Abhiyan

The Dharti Aaba Janjatiya Gram Utkarsh Abhiyan adopts a whole-of-government approach in tribal-majority villages and includes healthcare, education, skills and infrastructure. Its official objectives emphasize improving access to healthcare and other services through convergence.

5.4 National Health Mission and District-Level Services

The District Bastar administration's health department reports continuing efforts to strengthen health institutions, equipment, laboratories and human resources. Recent National Health Mission recruitment notices show the breadth of roles required for a functioning district health system, including social-work positions.

International Journal for Rapid Research in Engineering Technology & Applied Science (IJRRETAS)
(Peer-Reviewed, Open Access, Fully Refereed International Journal)
Volume 12 issue 10 October 2026 OPEN ACCESS E-ISSN: 2455-4723 Impact Factor 7.95

Table 1. *Healthcare Accessibility Barriers and Social-Work Responses*

Barrier | Effect on Community | Social-Work Response

Barriers	Impact on Healthcare Access	Suggested Intervention
Distance/transport	Delayed treatment and missed follow-up	Referral and transport facilitation
Staff shortage	Limited service availability	Advocacy, community feedback, and referral support
Cost/wage loss	Treatment postponement	Scheme/social-protection linkage
Language	Poor understanding	Local-language communication
Low health literacy	Late care-seeking	Health education and counselling
Cultural mismatch	Low trust	Culturally responsive practice
Digital exclusion	Difficulty accessing e-health	Digital facilitation
Referral complexity	Interrupted care	Case management
Gender barriers	Restricted service use	Women/adolescent groups and counselling
Stigma	Delayed care	Confidential counselling and community education

6. Role of Social Work in Tribal Healthcare

6.1 Social Casework

Social casework can help individuals and families identify barriers and create practical care plans. The social worker can assess household circumstances, explain available services, support documentation, arrange referrals, follow up on treatment and connect the family with welfare benefits.

6.2 Social Group Work

Groups can improve health literacy and peer support. Women's groups, adolescent groups, youth groups, caregiver groups and chronic-disease support groups can provide spaces for discussion and collective problem-solving.

6.3 Community Organization

Community organization can involve panchayats, village leaders, health workers, traditional practitioners, self-help groups, schools and civil-society organizations in identifying local health barriers and developing solutions. Community health mapping can identify hamlets, transport points, vulnerable households, referral routes and service gaps.

6.4 Health Education

Health education should be practical and locally understandable. Topics may include maternal care, immunization, nutrition, sanitation, menstrual health, communicable disease prevention, non-communicable diseases, sickle-cell disease, mental health, substance-use risks and when to seek urgent care.

6.5 Referral and Case Management

The social worker can act as a continuity bridge between household, sub-centre, PHC, CHC, district hospital and specialist services. A referral should not be considered complete when the patient is merely given a referral slip; successful referral includes reaching the next facility, obtaining care and completing follow-up.

6.6 Psychosocial Support

Illness can produce fear, stigma, family stress, financial pressure and treatment fatigue. Social workers can provide supportive counselling and facilitate family participation while protecting confidentiality and patient autonomy.

6.7 Advocacy

Social workers can document recurring access barriers and communicate community priorities to health authorities. Advocacy may address transport, staffing, medicine availability, respectful treatment, disability access, women's safety and culturally appropriate communication.

6.8 Interdisciplinary Collaboration

Effective tribal healthcare requires cooperation among doctors, nurses, community health officers, ANMs, counsellors, social workers, panchayat representatives and community organizations. The district's recent recruitment records illustrate that social workers are already recognized within several health programmes.

7. Proposed Bastar Tribal Healthcare Accessibility Model

This paper proposes a seven-stage model: Community Mapping → Risk Identification → Health Education → Access Facilitation → Referral → Psychosocial/Family Support → Follow-up and Accountability.

Stage | Key Activity | Expected Outcome

1. Community Mapping Map hamlets, services, transport and vulnerable groups Local access profile
2. Risk Identification Identify maternal, child, chronic, disability and sickle-cell risks Priority household list

3. Health Education Local-language awareness and prevention sessions Improved health literacy
4. Access Facilitation Documentation, transport, digital and scheme support Reduced access barriers
5. Referral Link PHC/CHC/district/specialist services Completed referral
6. Psychosocial Support Counselling, family support, stigma reduction Improved treatment engagement

7. Follow-up & Accountability Track care completion and community feedback Continuity and system improvement

8. Community Participation Strategy

Community participation should be built into programme design rather than added after implementation. Village-level health meetings can identify seasonal access problems, transport gaps, medicine shortages and communication barriers. Youth can support digital facilitation and health-information dissemination, while women's groups can contribute to maternal, child and adolescent health initiatives.

Traditional healers and community elders may also be engaged through dialogue. The purpose should be mutual referral and early identification of danger signs rather than replacing evidence-based treatment. Such engagement can improve trust and reduce the perception that formal healthcare is culturally disconnected.

9. Gender and Vulnerable Groups

Healthcare accessibility is not uniform across the tribal population. Women, children, older persons, persons with disabilities, people with chronic diseases and households in remote hamlets may experience additional barriers. A gender-responsive social-work approach should examine mobility, privacy, reproductive-health information, domestic responsibilities, safety and decision-making power.

Adolescent girls require confidential and age-appropriate information on menstrual health, nutrition, mental well-being and reproductive health. Persons with disabilities require accessible transport, buildings, communication and assistive support. Older persons and chronic-disease patients need continuity rather than episodic care.

10. Discussion

The evidence reviewed in this paper indicates that healthcare accessibility in Bastar is a systems-and-society issue. Physical infrastructure is necessary but insufficient. The district administration's emphasis on strengthening staff, equipment and laboratories is important, but access also depends on whether remote families can reach facilities and navigate referrals.

The national tribal-health evidence suggests that manpower shortages remain a significant structural problem. The documented shortage of doctors at PHCs in tribal areas of Chhattisgarh demonstrates why simply creating facilities without ensuring human resources may not produce equitable access.

Economic barriers deserve equal attention. When a household depends on daily earnings, the opportunity cost of seeking treatment can be substantial. Social protection linkage, transport assistance and decentralized services can therefore function as health interventions as much as welfare interventions.

Cultural responsiveness is another central issue. Tribal health policy increasingly recognizes that health-seeking behaviour and traditional knowledge must be understood within cultural context. The social worker can translate between institutions and communities without assuming that one system of knowledge must simply replace another.

Digital health has potential but should not become a new source of exclusion. Telemedicine and online health information can reduce travel burdens, yet remote communities may have limited connectivity, devices or digital skills. The appropriate model is assisted digital access integrated with physical outreach and referral.

11. Policy Recommendations

1. Strengthen functional primary healthcare in remote tribal settlements with adequate staff, medicines, diagnostics and essential equipment.
2. Expand mobile medical and outreach services for difficult-to-reach hamlets and seasonal settlements.
3. Develop a district-level tribal health access map showing service points, transport routes, vulnerable settlements and referral pathways.
4. Strengthen emergency and referral transport systems, especially for maternal and critical-care cases.
5. Recruit and retain health personnel willing and trained to work in tribal and remote settings.
6. Introduce systematic local-language and culturally responsive communication training for health staff.
7. Integrate professional social workers into primary healthcare, mental health, chronic disease and tribal-health programmes.
8. Create community-based health navigation/case-management systems for patients requiring referral and follow-up.
9. Link eligible households with health insurance, pensions, nutrition and other social-protection programmes.

10. Strengthen sickle-cell awareness, screening referral, counselling and long-term support among tribal populations.
11. Use telemedicine as a complement to, not a substitute for, functional local primary care.
12. Establish community feedback and social-audit mechanisms for health services.
13. Collect disaggregated data by tribal community, gender, geography, age and vulnerability to identify hidden inequities.
14. Build partnerships among health departments, tribal institutions, panchayats, social-work departments, NGOs and community-based organizations.

12. Implications for Social Work Education and Practice

Social-work education in Bastar should prepare students for interdisciplinary community health practice. Fieldwork can include village health mapping, health-awareness campaigns, referral assistance, community needs assessments and evaluation of health programmes. Students should learn about tribal rights, cultural competence, public-health systems, counselling, documentation, social protection and research ethics.

Professional social workers can also contribute to programme evaluation. Indicators should include not only number of beneficiaries but actual access, waiting time, referral completion, treatment adherence, patient satisfaction, perceived dignity, financial burden and equity across remote locations.

13. International Social Work Perspective

The Bastar case is relevant to international social work because it demonstrates how geographic marginalization and cultural difference can create unequal access to essential services. Similar issues arise among Indigenous and remote communities in many countries. The transferable lesson is that healthcare equity requires community participation, respect for culture, accessible services and social protection alongside clinical care.

The proposed approach aligns with the broader goals of universal health coverage and the Sustainable Development Goals, particularly SDG 3 (Good Health and Well-being), SDG 10 (Reduced Inequalities) and SDG 16 (Peace, Justice and Strong Institutions). The social-work contribution lies in connecting individual needs with community resources and institutional accountability.

14. Limitations

This is a secondary-data analytical paper and does not report original interviews, household surveys or clinical measurements from Bastar. Current district-level health indicators may not be available in a sufficiently disaggregated form through public sources. The paper therefore avoids

presenting unsupported prevalence or utilization estimates.

The district profile and Census-era statistics also need careful interpretation because administrative boundaries and population distributions can change. A future field study should use current block and village-level sampling and should disaggregate results by gender, age, tribal community, distance from facility and socioeconomic status.

15. Future Research Agenda

- Conduct a mixed-method household study of healthcare accessibility across selected Bastar blocks.
- Measure travel time, transport cost and total indirect cost of seeking care.
- Study patient experiences of PHCs, CHCs and district hospitals.
- Examine maternal and adolescent health service utilization among tribal households.
- Assess awareness and referral pathways for sickle-cell disease.
- Evaluate telemedicine feasibility in remote tribal settlements.
- Study the role of traditional healers in care-seeking and referral.
- Evaluate the effectiveness of social-work case management in improving referral completion.
- Develop a tribal health accessibility index combining geographic, economic, institutional and cultural dimensions.

16. Conclusion

Healthcare accessibility among tribal communities in Bastar cannot be reduced to the question of whether a health facility exists. Effective access requires that people can reach the service, afford the journey and indirect costs, communicate with providers, trust the institution, receive appropriate treatment and continue care after referral. The available official evidence points to a combination of human-resource, infrastructure, connectivity, economic and socio-cultural challenges in tribal healthcare, while the Bastar district administration reports ongoing efforts to strengthen its health system.

A social-work approach can strengthen this system by addressing the barriers that sit between households and health institutions. Social workers can provide casework, counselling, health education, group work, community organization, referral support, social-protection linkage and policy advocacy. These roles are especially valuable where healthcare problems are intertwined with poverty, geography, gender, cultural difference and limited institutional access.

The proposed Bastar Tribal Healthcare Accessibility Model places the community at the centre of service navigation and accountability. It calls for convergence among public health institutions,

tribal development agencies, panchayats, community organizations and professional social workers. The ultimate objective is not merely increased service utilization, but equitable, timely, dignified and culturally responsive healthcare.

References

1. District Bastar, Government of Chhattisgarh. (2026). About District. District Administration Bastar.
2. District Bastar, Government of Chhattisgarh. (2026). Health Department. District Administration Bastar.
3. District Bastar, Government of Chhattisgarh. (2026). National Health Mission recruitment and human-resource notices. District Administration Bastar.
4. Government of India, Ministry of Tribal Affairs. (2023). Annual Report 2022–23. Ministry of Tribal Affairs.
5. Government of India, Ministry of Tribal Affairs. (2024). Dharti Aaba Janjatiya Gram Utkarsh Abhiyan: Guidelines and programme information.
6. Government of India, Ministry of Tribal Affairs. (2026). Tribal Health Cell: Tribal Health Initiatives.
7. Government of India, Ministry of Tribal Affairs. (2026). Swasthya: National Tribal Health Portal.
8. Government of India, Ministry of Tribal Affairs. (2026). Telemedicine initiatives in tribal areas.
9. Government of India, Ministry of Statistics and Programme Implementation. (2025). Periodic Labour Force Survey publications. MoSPI.
10. International Labour Organization. (2024). India Employment Report 2024: Youth employment, education and skills. ILO & Institute for Human Development.
11. International Labour Organization. (2024). Elevating the potential of rural youth: Paths to decent jobs and sustainable futures. ILO.
12. National Commission for Scheduled Tribes. (2017). Report on health and medical services for Scheduled Tribes. Government of India.
13. World Health Organization. (2019). Primary health care on the road to universal health coverage: 2019 monitoring report. WHO.
14. World Health Organization. (2021). Operational framework for primary health care: Transforming vision into action. WHO.
15. United Nations. (2015). Transforming our world: The 2030 Agenda for Sustainable Development.
16. Ministry of Health and Family Welfare, Government of India. (2021). Tribal Health: Report of the Expert Committee on Tribal Health. Government of India.

17. International Journal of Social Work and Human Services Practice. (2024). Relevant literature on culturally responsive social work and Indigenous communities.