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Cultural Influences on Health Communication: Processes, Challenges, and Strategies among the Katkari Tribe in Western Maharashtra, India

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Abstract

Communication forms the foundation of human interaction, enabling the sharing of information and the transmission of symbolic meanings. Within public health, strong communication practices are vital for disease prevention, health promotion, emergency readiness, and the spread of governmental health programs and policies. This qualitative study examines the complexity of communication practices within the Katkari tribe, a minority community located in western Maharashtra, India. Drawing on anthropological perspectives, the research aims to understand the role of culture in shaping health communication within this group. The study objectives include identifying sources of health-related communication, analyzing communication patterns from a cultural standpoint, and recording barriers encountered in public health messaging. An inductive method of data analysis revealed key themes such as the role of Accredited Social Health Activists (ASHA), television, and social media in influencing health communication. Additional themes included the impact of media and technology on tribal health and lifestyle, challenges arising from gaps in understanding and behavioral response, linguistic barriers, social marginalization, deeply rooted misconceptions, cultural determinants of health behavior, and recommended strategies to address these issues. Enhancing health communication for tribal populations in India requires culturally appropriate methods, such as integrating traditional art forms and local artists, using multimedia channels like radio jingles and videos, providing incentives to healthcare workers, and applying visual materials in simplified language. Active participation of local communities is essential for the successful execution of health communication policies.

Keywords: Cultural influences, Health communication, Katkari Tribe, India

Introduction

Health communication refers to the systematic application of communication strategies to improve individual and community health outcomes [1]. It plays a crucial role in disease prevention, health promotion, and overall improvement in quality of life, making it a core element of public health initiatives [2]. Public health communication involves the evidence-based creation, targeted dissemination, and evaluation of health information that is relevant, reliable, accessible, and easy to understand. This process aims to effectively reach intended audiences and promote public health objectives [3]. It influences social norms, supports policy advocacy, informs and warns populations, and motivates behavioral change to achieve better health outcomes and stronger communities [3–5]. Thus, health communication serves as a strategic tool for advancing population health.

In this study, the terms 'Tribe' and 'Tribal' refer to a social group characterized by a distinct dialect, cultural uniformity, and shared social organization. Such groups may consist of multiple subgroups and often share common ancestry and religious practices [6]. Worldwide, tribal populations experience substantial health inequities, with nearly 15% living in extreme poverty and having restricted access to healthcare services [7]. These communities face disproportionately high rates of

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infectious diseases, including tuberculosis—up to 20 times higher than global averages—alongside persistent issues of malnutrition and inadequate sanitation [7]. In India, tribal communities constitute 8.6% of the population, and they face a multifaceted disease burden encompassing communicable and non-communicable diseases, malnutrition, mental health challenges, substance dependence, and obstacles related to healthcare utilization [8]. Consequently, health communication is a key mechanism for empowering tribal populations, addressing increasing disease prevalence, and reducing health disparities.

The Katkari community, classified as a 'Particularly Vulnerable Tribal Group (PVTG)' within the Scheduled Tribes, represents one of the most disadvantaged populations in India. They are spread across the regions of Gujarat and Maharashtra. Among Indian tribal groups, the Katkaris exhibit the lowest levels of socioeconomic status and educational achievement. While the literacy rate among Scheduled Tribes is around 56%, it is only 34% among Katkaris. Approximately 88% of the Katkari population relies on manual labor and lacks land ownership [9]. Findings from the 2013 Tribal Health Report highlight critical concerns among Katkaris, including undernutrition, anaemia, low institutional delivery rates, widespread tobacco and alcohol use, and a higher prevalence of tuberculosis compared to the national average. Additionally, they experience elevated mortality and morbidity rates, along with severely limited access to healthcare facilities [10]. Culturally appropriate communication is essential to foster trust, enhance access to healthcare, facilitate policy support, and manage public health emergencies, with greater community engagement contributing to improved health outcomes among tribal populations [11].

In light of this background, health communication stands out as a fundamental requirement and a primary intervention for all public health initiatives aimed at this community. However, there is a clear lack of research examining health communication processes within this population. To fill this gap, a qualitative study was undertaken among the Katkari tribe in western Maharashtra, India, with the following objectives:

1. To examine health communication practices among the Katkaris using an anthropological approach.
2. To identify challenges associated with health communication.
3. To record the needs and strategies for strengthening health communication among tribal communities.

Materials and Methods

In this study, "Health Communication" is understood as the manner in which health-related information is transmitted, how community members interpret and react to these messages, and the difficulties associated with their delivery, comprehension, and reception. The overarching aim is to encourage positive changes in health-related behaviours.

Population setting

The research was conducted in ten out of 35 villages identified by the university through its outreach programme as part of ongoing health promotion activities. This programme focuses on improving community well-being through sustainable empowerment, utilization of local resources, and environmentally responsible practices in villages located near the university campus. Data from the outreach programme indicate that these ten villages comprise tribal hamlets with an estimated tribal population of 1005 individuals. It is important to note that Indian rural villages typically consist of multiple hamlets [12]. In the study area, rural and tribal populations coexist, with certain hamlets populated exclusively by Katkari tribal communities.

The Katkari tribe, recognized by the Ministry of Home Affairs, India, as one of the country's 75 Particularly Vulnerable Tribal Groups, primarily resides in Maharashtra (Pune, Raigad, and Thane districts) and parts of Gujarat. Also known as Kathodis, the community derives its name from the traditional preparation of Katha (Catechu) obtained from the sap of the Khair tree. The Katkaris engage in various livelihood activities such as agricultural labour, selling firewood, and fishing, but face persistent challenges, including low literacy levels, poor health status, and limited income-generating opportunities, underscoring the need for external support. Traditionally associated with rice cultivation, the community continues to farm on small or leased landholdings. Following the harvest season, many members migrate to brick kilns or construction sites as daily wage workers, returning to their villages around the Holi festival in March. Limited financial literacy, dependence on daily wages, lack of savings practices,

and low educational attainment restrict their access to stable employment in local industries [9].

Study design

A qualitative research design was employed, using in-depth interviews (IDIs) as the primary data collection method. The interview guide consisted of open-ended questions addressing sources of health communication, mechanisms of information dissemination, experienced barriers in health communication, and culturally aligned needs and strategies for improving communication practices. The cultural dimension was explored through anthropologically informed interviews with key informants **(Table 1)** and tribal residents from the selected area. In total, 22 in-depth interviews were conducted by two medical social workers (MSWs) associated with the outreach programme, both of whom regularly engage with the community on health-related issues. Purposive sampling was used to select participants.

The ten villages are served by two Primary Health Centres, each managed by a Medical Officer (MO). Interviews included six ASHA workers (out of ten available), accessible Gram Panchayat representatives, and members of the tribal community. Data collection took place during March–April 2024. Interviews were stopped after reaching theoretical saturation, defined as the point at which no new insights emerge and the phenomenon under study is sufficiently understood [13]. The demographic and professional characteristics of respondents are presented in **Table 1** in the Results section.

Prior to data collection, the interview guide underwent pilot testing on a small sample to evaluate clarity, relevance, cultural appropriateness, flow, and duration. The MSWs received guidance and mentoring in qualitative data collection techniques. All interviews were audio-recorded, transcribed verbatim, and translated into English. The qualitative data were then imported into MAXQDA software (version 11) for analysis. Data analysis followed the thematic analysis framework proposed by Braun and Clarke [14]. This method involves systematic identification of recurring patterns, themes, and concepts, providing an in-depth understanding of participants' perspectives and experiences. The process included familiarization with the data, coding, theme development, and synthesis into coherent narratives. Thematic analysis allows both methodological rigor and analytical flexibility, enabling a nuanced interpretation of qualitative findings.

Table 1. Characteristics of the respondents

Serial No.	Participant ID	Role/Position	Gender	Age (years)	Educational Qualification	Primary Occupation	Years of Experience in Tribal Areas
1	RIHM1	Medical Officer	Male	43	BAMS	Medical Officer	6
2	NANM1	Medical Officer	Male	48	BAMS	Medical Officer	8
3	AND1	ASHA Worker	Female	53	Class 9	ASHA Worker	13
4	NAN1	ASHA Worker	Female	43	Class 10	ASHA Worker	9
5	NAN2	ASHA Worker	Female	43	Class 10	ASHA Worker	15
6	NAN3	ASHA Worker	Female	35	Class 10	ASHA Worker	15
7	RIH4	ASHA Worker	Female	30	Class 10	ASHA Worker	10
8	NAN6	ASHA Worker	Female	25	Class 10	ASHA Worker	3
9	AND2	Sarpanch (Village Head)	Male	32	Class 12	Business	2.5
10	AND3	Gram Panchayat Member	Male	24	Class 7	Daily Wage Labor	NA
11	RIH1	Gram Panchayat Member	Female	35	Not literate	Daily Wage Labor	NA
12	ANDS1	Gram Panchayat Member	Female	42	Not literate	Farming	NA
13	BHD1	Gram Panchayat Member	Female	55	Not literate	Farming, Fishing	NA
14	RIH2	Gram Panchayat Member	Male	30	Class 10	Daily Wage Labor	NA
15	RIH3	Gram Panchayat Member	Female	45	Class 9	Farming	NA
16	ANDS2	Gram Panchayat Member	Male	45	Class 12	Business	NA

17	ANDS2	Gram Panchayat Secretary	Male	50	Class 12	Farming	NA
18	NAN4	Community Member	Female	53	Not literate	Farming	NA
19	NAN5	Community Member	Male	45	Class 9	Farming	NA
20	BHD2	Community Member	Female	28	Class 8	Farming, Self-Help Group Activities	NA
21	BHD3	Community Member	Female	40	Not literate	Daily Wage Labor	NA
22	AND3	Community Member	Female	55	Not literate	Farming	NA

Medical officer of primary health centre: The Medical Officer of a Primary Health Centre or Urban Primary Health Centre (PHC/UPHC) is primarily responsible for clinical duties such as case identification, treatment, referral, and follow-up, along with selected managerial and public health responsibilities. ANMs and ASHAs report to the Medical Officer.

ASHA: An Accredited Social Health Activist (ASHA) is a community-based health worker appointed by the Ministry of Health and Family Welfare (MoHFW) under India's National Rural Health Mission (NRHM).

Gram Panchayat: Under the Panchayati Raj Act, the Gram Panchayat is defined as the basic unit of local self-governance in India and serves as the principal institution for village administration. It functions as the executive body for a village or group of villages [15].

Sarpanch: The Sarpanch is the elected head of the Gram Panchayat and performs duties within the statutory village-level governance structure known as the Gram Panchayat.

Secretary of gram panchayat: The Panchayat Secretary is a non-elected official appointed by the state government to supervise and manage administrative activities.

Members of gram panchayat: A Gram Panchayat is divided into wards, each represented by an elected Ward Member, also known as a Panch or Panchayat Member. The number of members generally ranges from 7 to 31, with a minimum of seven. One-third of the seats are reserved for women, and additional reservations apply for Scheduled Castes and Scheduled Tribes.

Ethical considerations

Ethical approval for the study was obtained from the University's Independent Ethics Committee, as documented in a letter issued in February 2024. All procedures adhered to the principles outlined in the Declaration of Helsinki. Written informed consent was obtained from participants who were literate, while thumb impressions were taken from those unable to read or write. All respondents were provided with clear information about the study prior to participation. Personal identifiers were removed from the dataset, and electronic records were secured using password protection.

Results and Discussion

Characteristics of the respondents

The respondents comprised two Medical Officers (MOs) from Primary Health Centres (PHCs), six ASHA workers, seven Gram Panchayat representatives, including one Sarpanch, and five tribal participants from different villages. Both MOs possessed Bachelor of Ayurvedic Medicine and Surgery (BAMS) qualifications. The ASHAs had completed education up to the higher secondary level. Among the five tribal respondents, three were unable to read or write, while two had attained education up to the secondary level. With the exception of the MOs and ASHAs, the remaining participants were involved in agriculture, daily wage work, and small livelihood activities such as fishing and self-help group initiatives.

The themes are described in the sections below

Theme 1. ASHA as the central conduit of health communication, with television and Android smartphones serving supportive roles

According to the MOs, health-related communication largely originates from the Ministry of Health and Family Welfare (MoHFW) and is transmitted sequentially to Primary Health Centres (PHCs), sub-centres, and subsequently to ASHAs, who deliver health education at the community level. During emergency situations, PHCs directly communicate with Gram Panchayat heads for information dissemination. During the COVID-19 pandemic, mobile health units were also utilized to circulate health messages across villages. ASHAs play a crucial role in educating the tribal population on issues such as maternal care, sanitation, hygiene, immunization,

adolescent health, menstrual hygiene, infectious diseases, anaemia, and nutrition. Health messages are communicated in the local Marathi language, which is generally understood by the tribal population despite dialectical variations.

Although ASHAs are regarded as the main source of health information, their work is often supported through collaboration with Multipurpose Workers (MPWs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), and Gram Panchayat members. Television is an important medium in the villages for accessing news and weather updates, with approximately 1–2 television sets available per village on average. Exposure to television has influenced certain lifestyle changes, including improvements in personal hygiene, dietary habits such as increased consumption of sprouts and green leafy vegetables, and awareness of health risks, for example, the harmful effects of tobacco chewing, though this impact is limited to a small segment of the population.

Most respondents noted that the Katkari community has limited access to digital devices and smartphones. Only a small number of younger individuals who can afford such technology use smartphones, making digital communication largely impractical. Although ASHAs have created WhatsApp groups to share important health-related information, these platforms are accessed by only a few members. Overall, while the reach of television and smartphones remains limited, the community shows interest in information related to vaccination, health screenings, and government welfare schemes, and actively participates in immunization drives and screening camps. Community members expressed a preference for in-person meetings to understand health information, particularly regarding government programs, rather than relying on digital platforms. For health-related guidance, ASHAs are trusted more than social media. ASHAs reported that only about 20% of community members consistently follow the guidance provided during health education sessions. (Theme-wise verbatim excerpts are provided in Annexure 1.)

Theme 2. Barriers in the health communication process

Participants emphasized that cultural factors strongly shape health-related behaviours within the tribal community, with these influences being deep-rooted and enduring. The community experiences a sense of "cultural disconnect" when attempting to adapt to mainstream societal practices. Their distinct cultural identity differentiates them from the broader population, resulting in hesitation toward accepting health messages and resistance to discontinuing traditional rituals and customs. This reflects a form of "cultural resilience," wherein adherence to indigenous practices is prioritized over adopting external norms, including those related to healthcare utilization or addressing substance dependence.

The findings also indicate a prevailing mistrust of government healthcare services among the tribal population, with some preferring home births over institutional deliveries. ASHAs reported ongoing difficulties in motivating families to choose hospital-based deliveries. Despite repeated health warnings and tragic outcomes—such as the death of a woman from oral cancer linked to tobacco chewing—the community remains resistant to changing addictive behaviours, particularly tobacco use and alcohol consumption. Similar negative attitudes were observed during the COVID-19 pandemic, when participation in screening, testing, and vaccination efforts was limited. Engagement in such initiatives often depended on expectations of financial incentives from the government.

The study further revealed that trust within the community is primarily placed in individuals who have consistently supported them, including brick kiln owners, agricultural landlords who employ them as daily wage labourers, and ASHAs. ASHAs noted that community members tend to maintain confidentiality when discussing health concerns with outsiders such as clinicians or paramedical staff, often keeping emotional and social distance, which reinforces isolation and hampers effective health communication. An additional challenge identified was the community's strong reliance on traditional knowledge passed down through generations.

Subtheme 1. Health communication challenge: closing the gap between comprehension and practice

Addressing health behaviours within the community requires more than simply delivering information. Although community members understand health concepts communicated in local and national languages such as Marathi and Hindi, converting this awareness into sustained behavioural change remains a major challenge. A common difficulty is the necessity for repeated reinforcement. Even when individuals are aware of health guidance, practices like washing hands before eating often require continual reminders. The key

challenge lies in encouraging consistent adoption of essential health behaviours. Motivation plays a central role in influencing actions. Furthermore, preventive health messages are frequently ignored until conditions progress into severe, chronic, or visibly symptomatic stages. Therefore, the central task of health communication is to develop approaches that go beyond information sharing and successfully foster long-term motivation for preventive health actions.

Subtheme 2. Language barriers, social isolation, and deeply rooted misconceptions as major obstacles to health communication

Effective communication with tribal populations is complex, with language emerging as a prominent barrier. Health messages delivered in Marathi are often difficult for tribal members to fully understand without detailed explanations in their native Katkari dialect. While the community is bilingual and capable of speaking and understanding Marathi, they are more comfortable communicating in their own language. Illiteracy further complicates health communication, as difficulties with reading and writing limit comprehension of written materials, including medication instructions and preventive guidelines. ASHAs and MOs noted that community members often struggle to remember dates and recognize specific symptoms, prompting health workers to use probing questions and associate information with local events for confirmation. Language limitations, combined with low self-confidence resulting from minimal external exposure, hinder effective communication and trust-building with ASHAs and healthcare providers.

Interestingly, the community possesses extensive knowledge of traditional medicines and home remedies, which are often treated as confidential and not shared with outsiders. These remedies are sometimes not disclosed to clinicians, even when used alongside medical treatment. ASHAs emphasized the importance of frequent home visits to strengthen relationships and reinforce health messages. The Sarpanch (Gram Panchayat Head) highlighted the community's social isolation, noting that globalization has had little influence on their way of life. He expressed concern over the limited reach of government services and non-governmental organizations to tribal areas, which further intensifies their isolation.

The study also identified unconventional health beliefs, such as viewing alcohol as protective against infections or considering it more nutritious than milk. Additional misconceptions include dietary beliefs related to avoiding raw vegetables during stomach ailments, the classification of foods as "hot" or "cold," preferences for consuming specific animal meats during illness, and experimentation with various forest-sourced vegetables. These deeply ingrained beliefs significantly limit acceptance of formal health messages.

Subtheme 3. Confidentiality challenges in health communication: managing non-verbal modes

ASHAs reported that maintaining confidentiality poses a challenge when conveying sensitive health information, such as diagnoses of tuberculosis (TB), leprosy, or pregnancy status. To protect privacy, they often rely on non-verbal forms of communication within households or group settings, using gestures, signs, and body language. These non-verbal cues must be carefully employed to ensure accurate message delivery while safeguarding individual confidentiality. Both ASHAs and community members demonstrate considerable skill in this form of communication, effectively using gestures and coded signals. The community takes pride in its ability to preserve secrecy through these informal communication systems.

Theme 3. Strategies to reduce barriers: strengthening trust and encouraging action

Building trust within the community can be facilitated by leveraging relationships established during emergency situations, which often serve as entry points for developing rapport. Another promising approach involves the use of incentives to enhance engagement with health communication initiatives. However, caution is required when considering direct financial incentives due to the risk of misuse, particularly for addictive behaviours. Consequently, alternative forms of incentives should be explored to promote participation and positive health outcomes in these isolated communities. Importantly, the community tends to respond more readily when health messages are linked to concrete outcomes. For example, associating health behaviours with consequences—such as restricting access to medications at government facilities for individuals engaging in harmful practices like excessive alcohol consumption—can act as a strong motivator for behavioural change. This clear connection between actions and consequences reinforces the value of healthy

behaviours and encourages individuals to adopt positive changes for their overall well-being.

This qualitative investigation examined the mechanisms and obstacles associated with health communication within a tribal population in western Maharashtra, India. The findings highlight the importance of vertically structured healthcare systems in shaping communication pathways, with ASHAs functioning as the main channel for health messaging, while television and smartphones play secondary roles. The study identifies multiple challenges, including the influence of tribal culture, linguistic barriers, social marginalization from mainstream society, persistent misconceptions, difficulty in translating knowledge into practice, and concerns related to confidentiality during message delivery. In response, strategies centered on building trust and promoting actionable behaviours emerged.

ASHAs working in tribal areas may or may not belong to the same tribe, but they are typically recruited from the same or nearby villages, which facilitates rapport and community connection. This positioning supports their effectiveness as health educators, a role clearly outlined under the National Health Mission (NHM) guidelines and widely examined in existing literature [16].

Television has the potential to serve as an effective medium for health communication, provided that access among tribal populations is improved. The limited number of television sets in the study villages reflects restricted accessibility, consistent with findings among the Sabar tribes of Odisha [17]. In contrast, the Gond tribe in Chhattisgarh (central India) has shown positive responses to health awareness campaigns delivered through television and radio broadcasts [18]. However, evidence suggests that television usage patterns differ across tribal groups, with some communities primarily using it for entertainment rather than educational purposes. Studies among tribes in Madhya Pradesh indicate substantial scope to formalize television as a tool for social development and empowerment [19]. Designing culturally appropriate television programs to convey health information can support cultural exchange and reduce socio-economic inequalities. The findings also point to the need for future research exploring tribal-specific requirements for television-based health communication.

The study further reveals limited use of smartphones for health education among the tribal population. Women generally did not possess smartphones, whereas most men and younger individuals had access to them, mainly for entertainment and social networking platforms such as WhatsApp, Instagram, and Facebook. Comparable findings were reported in Jharkhand, where restricted smartphone access among tribal populations limited the reach of mHealth interventions aimed at improving maternal health awareness. Despite lower literacy levels compared to villages receiving conventional health education, the intervention successfully improved antenatal care awareness among pregnant women [20]. Another study from Jharkhand found that approximately one-third of tribal participants owned smartphones, primarily for communication and entertainment [21]. In contrast, tribal communities in central India demonstrated higher smartphone availability (around 80%), though usage remained largely entertainment-focused [22]. These observations suggest a need for governmental efforts to enhance technological access and digital literacy within tribal communities to strengthen public health outcomes.

The findings underscore the profound role of culture in shaping how health messages are received by tribal communities. Although community members listen attentively to health information, they remain deeply committed to preserving their cultural beliefs and practices. This strong cultural attachment often results in resistance to modifying addictive behaviours, accepting vaccinations, or seeking medical care, leading to poor health-seeking practices despite ongoing health education efforts by ASHAs. These patterns align with anthropological concepts such as “Ethnocentrism” and “Cultural Resilience,” which explain the prioritization of indigenous cultural values and reluctance to adopt external health messages due to limited openness to change [23]. The community’s ability to sustain and reinforce its cultural identity and knowledge systems is clearly evident. This study contributes novel insights into how cultural dynamics influence the acceptance of health communication.

As discussed, illiteracy and the use of local dialects contribute significantly to misinterpretation or misunderstanding of health messages. Previous literature highlights the dominance of “dominant languages” over “minor languages” in healthcare environments, where health materials are produced in Marathi—the official local language of Maharashtra—rather than in tribal dialects [24]. This observation is supported by studies reporting that educational resources developed by government agencies and NGOs often fail to reach tribal populations effectively due to high illiteracy levels and

limited familiarity with tribal languages among service providers [25]. Both globally and within India, the absence of health information in native languages presents a major barrier, restricting tribal communities' ability to make informed health decisions [26]. In Bengal, elderly tribal individuals speaking Santhali frequently face communication difficulties with healthcare providers, adversely affecting care delivery [27]. Addressing linguistic barriers in healthcare requires strong political commitment to ensuring equitable and non-discriminatory health services for marginalized groups, including illiterate tribal populations [28]. The role of literacy as a determinant of effective health communication is well established, with evidence demonstrating that education improves health literacy, supports informed decision-making, enhances access to healthcare, and promotes healthier behaviours [29].

Social isolation from mainstream society further compounds barriers to health communication and healthcare access, intensifying health inequities and negatively affecting overall well-being. Despite the relatively short physical distance between tribal hamlets and nearby rural villages in the study area, promoting cultural integration, inclusivity, and mutual acceptance could yield positive outcomes. Research in this specific context remains limited, although existing studies consistently identify isolation as a key factor influencing health-seeking behaviour among tribal populations [30].

A novel finding of this study is the use of gestures and coded non-verbal communication by ASHAs and tribal members to maintain confidentiality while sharing sensitive health information. There is limited existing literature to support or refute this observation. Incorporating culturally sensitive strategies and actively involving the community in developing health communication content—particularly during cultural festivals and events—may enhance effectiveness. Innovative approaches adopted in Rajasthan and Tamil Nadu provide useful examples. In Rajasthan, live performances by local folk artists were used to convey health messages, blending entertainment with cultural expression to engage tribal audiences. In Tamil Nadu, a combination of traditional and modern media—such as posters, hoardings, radio jingles, and videos featuring popular film personalities—was employed to communicate health information, helping to bridge gaps in health communication [31].

The persistence of myths and misconceptions related to diet, alcohol consumption, and other health practices further supports the concept of "Ethnocentrism." At the same time, the community articulated its needs and proposed strategies for improving health communication within its cultural framework. Large-scale, multisite studies across India could help identify common and context-specific barriers to tribal health communication, thereby informing more effective policy development.

Conclusion

The study is limited by its qualitative design, which restricts generalizability and replication. Nevertheless, the findings highlight the importance of culturally appropriate approaches that emphasize community participation, traditional art forms, multimedia communication, incentives for frontline health workers, and linguistic inclusivity. Integrating these strategies can strengthen health communication efforts and contribute to improved health outcomes among India's tribal populations.

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