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Rural Tribal Health in Rajasthan: Assessing Determinants and Enhancing Well-being

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Abstract: The study includes the identification of different determinants which are related to the health status and well-being of the tribal population. This research work also measures the impact of demographic, social and economic factors on the health status and well-being of the tribal population. Accordingly, the survey method was being used for primary data collection. A well-structured questionnaire being designed having questions related to demographic, socio-economic aspects and also questions related to availability of health care services. Approximately 35% of respondents found the healthcare facilities acceptable, 30% rated them as good, 15% as excellent, while 15% considered them poor; additionally, 5% emphasized the urgent need for improved services in tribal areas. Nearly 30% of the respondents were dissatisfied with healthcare services in Rajasthan's tribal regions, while 17.5% were somewhat dissatisfied, 15% remained neutral, and nearly 30% were somewhat satisfied; additionally, about 7.5% were fully satisfied with the current tribal healthcare services.

1. Introduction

The overall development and progress of the nation depends on the health and wellbeing of the tribal population. Rajasthan is a state which consist of various tribal communities which have different historical contexts, cultural identities, social and economic conditions and so the health development related practices become critical aspect. The tribal population have various health related problems with limited resources and infrastructure. Lack of awareness, quality of health services and modern medical practices are also the challenges being faced by the tribal population. The study focuses on the multifaceted aspects that affect the health and wellbeing of the tribal population in Rajasthan. Through the evaluation of the various aspects and determinants associated with health status of the tribal population the research work tries to find valuable insights so the effective policies and strategies can be formulated for betterment of the tribal population.

Rural tribal communities in Rajasthan have long experienced disparities in health outcomes as a result of a combination of historical, geographical, social, and economic factors. Their limited access to basic amenities such as clean water, sanitation facilities, and healthcare infrastructure has led to a higher prevalence of communicable diseases, malnutrition, and maternal and child health issues. The interplay between these factors underscores the need for a comprehensive analysis that considers not only the immediate health concerns but also the broader determinants that shape the health landscape of these communities.

In order to understand the tribal health in Rajasthan different factors are being considered which includes income, education, occupation, sector (public/private), traditions, culture and beliefs. Challenges such as low literacy rates, limited healthcare access, lack of awareness about modern medicine, and gender fairness issues can affect how these communities take care of their health. This study aims to identify these factors to understand health differences and find ways to help.Improving tribal health means going beyond regular healthcare. One should respect their culture and how they live. Providing healthcare that blends with their traditions and modern medicine can build trust and cooperation. Also, improving healthcare, educating about health, offering job opportunities, and ensuring clean water can enhance their overall well-being.

2. Literature Review

Bhasin (2007) study delves into the health, settlements, and amenities of six tribal groups in Rajasthan, highlighting cultural influences. Factors affecting health encompass housing, services, and traditional medical practices deeply embedded in tribal life. Limited healthcare access results in a mix of therapies. Overcoming cultural barriers is essential for effective public health interventions. Tackling social attitudes, economic constraints, and healthcare access are pivotal in enhancing tribal well-being. The study underscores the need to bridge the gap between traditional and modern healthcare while considering the cultural context of these communities.

According to author Negi et al. (2019) health plays an important role in community well-being as it is critical for the human progress and development. India is being the second largest tribal population in the world with different socio-economic marginalities. The major challenges in the tribal region are to make aware people about the various health care practices being there in the region. Author tries to identify different socio-economic factors related to tribal health. Additionally, it underscores the necessity for a comprehensive national health policy tailored to address the distinct health needs of the indigenous population, acknowledging the urgent requirement for holistic intervention.

Kapoor & Dhall (2016) there are some common challenges which can be easily identified among the tribal population. Although identification of factors influences the health of tribal population is challenging as the tribal population in closely connected with nature and environment. According to this research work malnutrition is one of the most predominant reasons for diseases among the tribal population. It was also identified that the main reason behind the malnutrition is very low literacy rate and conventional socio-cultural practices.

According to author Debroy et al. (2023) the present tribal health system in the country faces different and unique challenges as compared to the non-tribal health system. Globally also the nations are facing different challenges related to health care in tribal regions. Main reasons behind distinct health issues are rituals, different languages, socio-cultural practices, customs etc. of the tribal population. Different organizations are giving the efforts towards providing better health care services but still there are many obstacles which are hindering the successful implementation of the health care services. The author further emphasized on the issues like availability of limited resources, infrastructure, languages, cultural barriers, geographical remoteness, scarcity of health care professionals, socio-economic differences, integration of traditional and modern health care practices etc. (Das et al., 2016). In order to overcome these barriers collective approach is required under which government, NGO's, medical specialist, and the tribal population should participate for better health services to the community. By overcoming these challenges, it is possible to increase the quality and accessibility of the health care services.

Thomas et. al. (2021) discussed that geographical distance and limitation in infrastructure have presented significant obstacles to delivery of better health care services in the tribal area of India. Majority of tribal population is residing in far remote areas which are not accessible easily like mountain terrains, forests, and areas with no or limited transportation facilities. The geographical area having different characteristics makes it very difficult to establish and maintain the health care practices and facilities and also confirm timely delivery of medical services and supplies. Kumar et.

al. (2020), the insufficient access to nearby healthcare facilities necessitates individuals to undertake extensive journeys for medical care, a predicament compounded during medical emergencies. Moreover, the remote locations hinder healthcare providers from offering on-site care, particularly for non-emergency procedures. Consequently, delivering timely and comprehensive healthcare services becomes arduous due to the scarcity of adequately equipped hospitals, clinics, and healthcare centres.

Jacob (2014) discussed about the tribal communities in India grapple with socioeconomic hardships like poverty and limited education access, obstructing healthcare utilization and fostering health inequalities. These challenges often lead to neglect of medical needs due to struggling to meet necessities, causing delays in seeking care. Lack of preventive healthcare awareness further amplifies health disparities within tribal groups. Overcoming these intricate issues demands a comprehensive strategy, tackling poverty, education, and promoting preventive health measures. Eswarappa (2022) suggested that embracing both traditional and modern approaches ensure comprehensive and culturally sensitive care, bridging the gap for holistic healthcare in tribal communities.

3. Objectives:

The objectives of the research work are as follows:

1.) To identify various determinants related to health and well-being of Tribal population.

2.) Measure the impact of demographic, socio-economic factors on the health and well-being of Tribal population.

3.1 Hypotheses:

$H1_0$: There is no significant relationship between demographic, socio-economic factors and the health status & well-being of Tribal population in Rajasthan.

$H1_a$: There is significant relationship between demographic, socio-economic factors and the health status & well-being of Tribal population in Rajasthan.

$H2_0$: There is no significant relationship between health care facilities and the satisfaction level of Tribal population in Rajasthan.

$H2_a$: There is significant relationship between health care facilities and the satisfaction level of Tribal population in Rajasthan.

4. Research Methodology

The research methodology employed in the study involves a systematic approach to gather, analyse, and interpret data related to the health and well-being of rural tribal communities in Rajasthan. The methodology encompasses various stages, including research design, data collection, data analysis, and interpretation.

Research Design: Quantitative Research.

Sampling Technique: Stratified Random Sampling Technique.

Sample Size: 400 respondents form different districts of Rajasthan.

The study was adopted quantitative research design being focused to identify the determinants impacting the health status and well-being of Rajasthan's tribal population. Through a structured survey which included demographic, socio-economic, and healthcare availability aspects, a comprehensive understanding of these factors emerged.

4.1 Tools and Techniques:

A well-structured questionnaire was being designed in order to collect primary data. The questionnaire consists of two sections. Section A included questions related to demographic aspects and section B includes questions related to socio-economic aspects, satisfaction level, availability of health care facilities etc. The instrument was being tested using Cronbach's alpha technique. The Cronbach's alpha value was found to be 0.8321 which interprets that there is high internal consistency between the items. In order to find the association between socio-economic factors and health status Chi-Square test was being used. Similarly, to find the relationship between health care facilities and satisfaction level Chi-Square test was applied.

5. Data Analysis

5.1 Demographic and Socio-Economic Aspects:

5.1.1 Income Wise Classification:

Table5.1: Income wise classification

Monthly Income Range	Number of Respondents	Percentage (%)
<1000	100	25%
1000-2000	140	35%
2000-3000	80	20%
>3000	80	20%

The income wise classification suggests that about 25% respondents were having monthly income less than 1000 rupees, about 35% respondents were having monthly income in the range 1000 to 2000 rupees,20% respondents confirm that they were having the income between 2000 to 3000 whereas about 20% were having income greater than 3000.

5.1.2 Age Wise Classification:

Table 5.2: Age wise classification

Age Group	Number of Respondents	Percentage (%)
20-30	160	40%
31-40	100	25%
41-50	80	20%
51-60	60	15%

Based on age wise classification the respondents were being categorized into four groups. It was found that about 40% respondents were from the age group 20-30 years, about 25% belongs to age group 31-40 years, about 20% were from the age group 41-50 years whereas about 15% were between the age group 51-60 years.

5.1.3 Gender Wise Classification:

Table 5.3: Gender wise classification

Gender	Number of Respondents	Percentage (%)
Male	240	60%
Female	160	40%

About 60% respondents were male and 40% respondents were female. It was found that majority of respondents were male.

5.1.4 Caste Wise Classification:

Table 5.4: Caste wise classification

Caste Category	Number of Respondents	Percentage (%)
General	180	45%
Scheduled Caste (SC)	80	20%
Scheduled Tribe (ST)	100	25%
Other Backward Classes (OBC)	40	10%

Based on the caste wise classification the respondents were being categorised into four groups such as general, schedule cast, schedule tribe and other backward classes. Majority of respondents were from general category which accounts for about 45% whereas 20% respondents were from SC category, 25% respondents were from scheduled tribe category and remaining respondents were from other backward classes category which accounts for only 10%.

5.1.5 Highest Education Level:

Table 5.5: Education status

Education Level	Number of Respondents	Percentage (%)
Illiterate	120	30%
Up to 10th Std.	80	20%
Up to 12th Std.	140	35%
Graduation	60	15%

Education wise classification suggest that about 30% respondents were illiterate 20% respondents were educated up to 10^{th} standard and 35% respondents were educated up to 12^{th} standard. It was found that majority of the respondents were educated up to 12^{th} standard which accounts for about 140 respondents in number.

5.1.6 Occupation or Primary Source of Income:

Table 5.6: Occupation wise classification

Occupation / Source of Income	Number of Respondents	Percentage (%)
No Occupation	60	15%
Govt. Schemes	100	25%
Day Labour	160	40%
Other Craft Works	80	20%

The primary source of income of about 40% respondent in majority is day labour similarly 25% respondents are being engaged in government schemes work whereas about 20% respondents are earning their income through craft work and about 15% respondents are having no occupation presently.

5.1.7 Frequency of Illness and Disease Infections:

Illness and Disease Infections	Number of Respondents	Percentage (%)

Table 5.7: Occurrence of illness and disease

Always	268	67%
Sometimes	40	10%
Never	92	23%

Majority of respondents about 67% were getting regularly infected by the diseases whereas 10% were being have illness and diseases infection sometimes and 23% said they were never being affected by the infectious diseases.

5.1.8 Distance to Nearest Health Centre:

Table 5.8: Distance to nearest health centre

Distance to Nearest Health Centre	Number of Respondents	Percentage (%)
Less than 5 km	120	30%
5-10 km	150	37.5%
10-20 km	80	20%
More than 20 km	50	12.5%

Majority of respondents about 37.5% confirmed that distance to the nearest health center is about 5-10 kms whereas about 30% confirmed that it is less than 5 kms, 20% were with the opinion that the health centre is about 10-20 kms and 12.5% confirmed that it is more than 20 kms.

5.1.9 Availability of Healthcare Facilities:

Table 5.9: Availability of healthcare facilities

Availability of Healthcare Facilities	Number of Respondents	Percentage (%)
Excellent	60	15%
Good	120	30%
Fair	140	35%
Poor	60	15%
Very Poor	20	5%

About 35% respondents confirmed that the available health care facilities are fair enough whereas 30% confirmed that the health services are good and 15% confirmed that the health care services are excellent while 15% were with the opinion that the services or facilities are poor, 5% were with the view point that the services are very poor and are required to be improved in the tribal areas.

5.1.10 Preferred Healthcare Service Provider:

Table 5.10: Preferred healthcare service provider

Preferred Healthcare Service Provider	Number of Respondents	Percentage (%)
Primary Health Centre	130	32.5%
Government Hospital	120	30%
Private Hospital	100	25%
Others	50	12.5%

The majority of respondents about 32.5% confirmed that their preferred health care service provider are primary health centres whereas 30% confirm that their preferred healthcare service provider are government hospitals, 25% preferred private hospitals while 12.5% depend on others.

5.1.11 Community Health Worker (CHW) Home Visits:

Table 5.11: Community Health Worker (CHW) home visits

CHW Home Visits	Number of Respondents	Percentage (%)
Yes	150	37.5%
No	250	62.5%

37.5% confirmed that community health workers visit their homes while 62.5% were against the above view point.

5.1.12 Familiarity with Accredited Social Health Activist (ASHA) Worker:

Table 5.12: Familiarity with ASHA worker

Familiarity with ASHA Worker	Number of Respondents	Percentage (%)
Yes	80	20%
No	320	80%

A substantial majority (80%) of respondents are unfamiliar with Accredited Social Health Activist (ASHA) Workers, while only 20% report familiarity. This highlights a significant awareness gap about the pivotal role ASHA Workers play in community healthcare. Addressing this gap through focused awareness campaigns can optimize their contributions for better health outcomes.

5.1.13 Challenges in Accessing Medical Services:

Table 5.13: Challenges in accessing medical services

Challenges in Accessing Medical Services	Number of Respondents	Percentage (%)
No	180	45%
Yes	220	55%

Majority of respondents about 55% were with the view point that there are various obstacles while accessing the medical services whereas about 45% were against the above-mentioned opinion. The findings suggest that heath care services should be enhanced in the tribal areas so that access is easy for the individuals of the region.

5.1.14 Access to Clean Drinking Water:

Table 5.14: Access to clean drinking water

Access to Clean Drinking Water	Number of Respondents	Percentage (%)
Always	120	30%
Often	100	25%
Sometimes	90	22.5%
Rarely	60	15%
Never	30	7.5%

30% respondents confirmed that they always have access to clean drinking water which accounts for about 120 respondents, 25% said that they often have access to the clean drinking water whereas 7.5% confirmed that they do not the access to clean drinking water. Overall, the data showcases varying levels of access to clean drinking water, with a notable majority having reliable access, while a smaller but still significant portion faces challenges in securing this basic necessity. The findings highlight the importance of addressing water access disparities and ensuring that clean drinking water is accessible to all members of the population.

5.1.15 Access to Proper Sanitation Facilities:

Table 5.15: Access to proper sanitation facilities

Access to Proper Sanitation Facilities	Number of Respondents	Percentage (%)
No	280	70%
Yes	120	30%

Majority of respondents about 70% were with the opinion that they were not having the access to proper sanitation facilities whereas only 30% confirmed that they are having proper sanitation facilities. There is need to increase the sanitation facilities in order to have better hygiene environment.

5.1.16 Satisfaction Level:

Table 5.16: Satisfaction with present healthcare services

Satisfaction with Present Healthcare Services	Number of Respondents	Percentage (%)
Dissatisfied	120	30%
Somewhat dissatisfied	70	17.5%
Neutral	60	15%
Somewhat satisfied	120	30%
Satisfied	30	7.5%

About 30% respondents in all were dissatisfied with the present healthcare services in the different tribal regions of Rajasthan, 17.5% were somewhat dissatisfied, 15% were neutral about the health care services whereas nearly 30% respondents were being somewhat satisfied and about 7.5% were fully satisfied with the present health care services in the tribal region of Rajasthan. These findings emphasize the need for healthcare providers and policymakers to address areas of concern and work towards enhancing the quality and accessibility of healthcare services to meet the diverse needs and expectations of the tribal population.

5.2 Hypotheses Testing Results:

$H1_0$: There is no significant relationship between demographic, socio-economic factors, and the health status & well-being of Tribal population in Rajasthan.

To find the association between socio-economic factors and the health status above mentioned hypothesis was being framed and it was further divided various sub-hypotheses which association between various aspects related to socio-economic environment. These sub-hypotheses were being further analysed and tested using the statistical technique Chi-Square test. The corresponding results are as follows:

5.2.1 Income and Health Status & Well Being:

$H1.1_0$: There is no significant relationship between socio-economic factor: income and the health status & well-being of Tribal population in Rajasthan.

Table 5.17: Income and health status& well being

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	528.488[a]	6	.000
Likelihood Ratio	509.510	6	.000
Linear-by-Linear Association	292.410	1	.000
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.00.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The outcomes confirm that as the p-value is found be 0.00 which lesser than the standard alpha value of 0.05, so the null hypothesis is being rejected further it can be interpreted that there is significant relationship between socio-economic aspect income and the health status and well-being of the tribal population of Rajasthan.

5.2.2 Age and Health Status:

H1.2_0: There is no significant relationship between demographic factor: age and the health status & well-being of Tribal population in Rajasthan.

Table 5.18: Ageand health status& well being

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	505.775[a]	6	.000
Likelihood Ratio	518.347	6	.000
Linear-by-Linear Association	306.823	1	.000
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.00.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The findings confirm that as the p-value is found be 0.00 which lesser than the standard alpha value of 0.05, so the null hypothesis is being rejected further it can be interpreted that there is significant relationship between demographic aspect age and the health status and well-being of the tribal population of Rajasthan.

5.2.3 Gender and Health Status:

H1.3$_0$: There is no significant relationship between demographic factor: gender and the health status & well-being of Tribal population in Rajasthan.

Table 5.19: Gender and health status& well being

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	295.522[a]	2	.000
Likelihood Ratio	358.950	2	.000
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.00.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The Chi-Square value is found to be 295.522 and the corresponding p-value is found to be 0.00 which interprets that as the p-value (0.00) < 0.05 (standard alpha value), so it can be concluded that the null hypothesis is being rejected and it can be concluded that there is association between the demographic factor gender and health status based on the type of health care services being provided by the institutions in the tribal region.

5.2.4 Education and Health Status:

H1.4$_0$: There is no significant relationship between socio-economic factor: education and the health status & well-being of Tribal population in Rajasthan.

Table 5.20: Education and health status& well being

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	354.760[a]	6	.000
Likelihood Ratio	376.394	6	.000
Linear-by-Linear Association	220.873	1	.000
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.00.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The Chi-Square value is found to be 295.522 and the corresponding p-value is found to be 0.00 which interprets that as the p-value (0.00) < 0.05 (standard alpha value), so it can be concluded that the null hypothesis is being rejected and it can be concluded that there is association between the socio-economic factor education and health status.

5.2.5 Occupation and Health Status:

$H1.5_0$: There is no significant relationship between socio-economic factor: occupation and the health status & well-being of Tribal population in Rajasthan.

Table 5.21: Occupation and health status& well being

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	399.351[a]	6	.000
Likelihood Ratio	411.316	6	.000
Linear-by-Linear Association	216.322	1	.000
N of Valid Cases	400		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.00.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The Chi-Square value is found to be 295.522 and the corresponding p-value is found to be 0.00 which interprets that as the p-value (0.00) < 0.05 (standard alpha value), so it can be concluded that the null hypothesis is being rejected and it can be concluded that there is association between the socio-economic factor: occupation and the health status & well-being of Tribal population in Rajasthan.

Finally, it can be concluded from the above individual sub-hypothesis testing results that the null hypothesis $H1_0$ is being rejected and it can be interpreted that there is significant relationship between demographic, socio-economic factors, and the health status & well-being of Tribal population in Rajasthan.

5.2.6 Health Care Facilities and Satisfaction Level:

$H2_0$: There is no significant relationship between health care facilities and the satisfaction level of Tribal population in Rajasthan.

Table 5.22: Satisfaction level and availability of healthcare facilities

Satisfaction Level and Availability of Healthcare Facilities:Crosstabulation						
Count						
	Availability of Healthcare Facilities					Total
	Very	Poor	Fair	Good	Excel	

		Poor				lent	
Satisfaction Level	Dissatisfied	0	0	0	60	60	120
	Somewhat dissatisfied	0	0	10	60	0	70
	Neutral	0	0	60	0	0	60
	Somewhat satisfied	0	50	70	0	0	120
	Satisfied	20	10	0	0	0	30
Total		20	60	140	120	60	400

Table 5.23:Satisfaction and availability of healthcare facilities: Chi-Square results

Chi-Square Tests			
	Value	Degree of freedom	Asymptotic Significance (2-sided)
Pearson Chi-Square	791.383[a]	16	.000
Likelihood Ratio	733.073	16	.000
Linear-by-Linear Association	325.485	1	.000
N of Valid Cases	400		
a. 5 cells (20.0%) have expected count less than 5. The minimum expected count is 1.50.			

Test Applied: Chi-Square test.

Result: Null hypothesis being rejected.

The findings confirm that as the p-value is found be 0.00 which lesser than the standard alpha value of 0.05, so the null hypothesis is being rejected further it can be interpreted that there is significant relationship between health care facilities and the satisfaction level of Tribal population in Rajasthan.

6. Conclusion

Mainly the research work was focused on identification of factors or determinants affecting the health status and well-being of the tribal population in various districts of Rajasthan. In order to collect data a well-structured questionnaire was being designed and being tested using the Cronbach's Alpha method. The results of Cronbach's Alpha method have shown good internal consistency. The majority of respondents about 32.5% confirmed that their preferred health care service provider are primary health centres. About 35% respondents confirmed that the available health care facilities are fair enough whereas 30% confirmed that the health services are good and 15% confirmed that the health care services are excellent. Hypothesis testing results confirm that the null hypothesis $H2_0$ was being rejected as the p-value (0.000) is found to be lesser that the standard alpha value of 0.05, so it can be interpreted that there is significant relationship between the availability of healthcare facilities and the satisfaction level among the tribal population in Rajasthan. The outcomes underscore the importance of enhancing healthcare services in tribal areas to address dissatisfaction and improve overall well-being. The study provides valuable insights for policymakers and stakeholders to focus on targeted interventions to bridge the gaps in healthcare provision and enhance the satisfaction of the tribal population in Rajasthan.

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