VER
Vascular & Endovascular Review

Healthcare Accessibility Among Tribal Women in Jhabua District, Madhya Pradesh: Challenges and Interventions

Neetu Gilbert[1], Dr. Lopamudra Dass[2]

[1]Ph.D. Scholar in Social Work, NIMS University, Rajasthan
Email: gilbertneetu@gmail.com
[2]Assistant Professor & Head, Dept. of Sociology and Social Work
NIMS School of Humanities and Liberal Arts
NIMS University Rajasthan, Jaipur
Email: lopamudra.das@nimsuniversity.org

ABSTRACT

Healthcare accessibility remains a critical concern for tribal populations in India, particularly for women residing in remote and socio-economically disadvantaged areas. This study investigates the barriers to healthcare access among tribal women in the Jhabua District of Madhya Pradesh, evaluates the effectiveness of existing interventions, and proposes context-specific strategies to improve service delivery. A mixed-method approach was employed, combining quantitative data from 300 tribal women collected through structured questionnaires and qualitative insights from focus group discussions with community leaders, ASHA workers, and healthcare providers. Secondary data were drawn from NFHS-5, Census 2011, and government health reports. The findings reveal that 68% of women were illiterate, and 72% lived below the poverty line, while 60% of households were located over 5 km from the nearest health facility, underscoring the impact of socio-economic and geographic constraints. Cultural preferences for traditional healers, financial barriers, and systemic inefficiencies—including shortage of medical personnel, irregular medicine supply, and absenteeism—further limit healthcare utilization. Consequently, 65% of women reported home deliveries, only 35% received all recommended antenatal check-ups, and immunization coverage stood at 52%, below the state average. Existing interventions, such as ASHA outreach, Janani Suraksha Yojana, and free immunization programs, demonstrated partial success but were hindered by implementation gaps and limited cultural adaptation. The study highlights the need for holistic, culturally sensitive, and community-driven approaches. Recommended strategies include establishing mobile health clinics, integrating traditional healers into health promotion campaigns, strengthening financial incentives and ASHA programs, and implementing targeted health education initiatives. Addressing these multi-dimensional barriers is essential for improving maternal and child health outcomes and promoting equitable healthcare access among tribal women.

KEYWORDS: Tribal women, Healthcare accessibility, Jhabua District, Maternal health, Cultural barriers, Health interventions.

How to Cite: Neetu Gilbert, Dr. Lopamudra Dass, (2025) Healthcare Accessibility Among Tribal Women in Jhabua District, Madhya Pradesh: Challenges and Interventions, Vascular and Endovascular Review, Vol.8, No.3, 214-223

INTRODUCTION

1.1 Healthcare Inequalities in India and the Tribal Context

Healthcare is universally acknowledged as a basic human right, yet in India significant disparities persist in terms of accessibility, availability, and utilization, particularly for marginalized groups such as tribal populations. Despite the expansion of health infrastructure since independence, tribal communities remain among the most underserved, experiencing health indicators far worse than the national average (Mohanty & Dwivedi, 2019). These inequalities are reflected in maternal and child health, nutrition, immunization, and disease prevalence, with tribal women disproportionately disadvantaged due to the intersection of gender, ethnicity, and poverty (Kumar et al., 2021). According to Balgir (2020), Scheduled Tribe (ST) populations experience higher rates of anemia, malnutrition, and maternal mortality compared to Scheduled Caste (SC) and non-tribal groups, a gap that has persisted despite decades of policy intervention. This is not merely a reflection of economic deprivation but also of systemic exclusion from healthcare planning and delivery. The World Health Organization (2020) has emphasized that indigenous populations globally encounter overlapping vulnerabilities—geographic isolation, linguistic barriers, cultural dissonance, and discrimination within health systems—which significantly limit their health outcomes, and the Indian case exemplifies this pattern.

1.1 Healthcare Inequalities in India and the Tribal Context

Healthcare is universally acknowledged as a fundamental human right, yet in India, disparities in access and utilization remain deeply entrenched, particularly among tribal populations who constitute nearly 8.6% of the total population (Census of India, 2011). Despite substantial policy efforts such as the National Rural Health Mission (NRHM) and Ayushman Bharat, tribal communities remain on the margins of India's health system, reflecting what Mohanty and Dwivedi (2019) describe as a "double burden of deprivation" rooted in both socio-economic exclusion and geographic isolation. This marginalization is especially severe for tribal women, who face compounded disadvantages owing to gender, ethnicity, poverty, and cultural norms. National health surveys consistently show that tribal women lag behind non-tribal women in terms of maternal and child health, nutrition, immunization, and reproductive healthcare indicators (Kumar et al., 2021). Balgir (2020) argues that health inequities among Scheduled Tribes (STs) are not merely an extension of poverty but stem from systemic neglect, where public health infrastructure

is urban-centric, resources are inequitably distributed, and tribal populations are left to rely on fragile community-based mechanisms. For instance, while India has made remarkable progress in reducing maternal mortality overall, tribal-dominated states such as Madhya Pradesh, Odisha, and Chhattisgarh continue to report maternal mortality ratios significantly higher than the national average (Singh & Patel, 2020). These inequalities are further amplified by poor nutritional outcomes; malnutrition and anemia are disproportionately concentrated among tribal women and children, with recent evidence from the National Family Health Survey (NFHS-5, 2019–21) showing that anemia prevalence among tribal women stands at nearly 65%, compared to 53% among non-tribal women (Ministry of Health and Family Welfare, 2022).

Global research underscores that the Indian case reflects broader structural challenges indigenous populations face worldwide. The World Health Organization (2020) notes that indigenous women across South Asia, Latin America, and Africa are consistently disadvantaged in health systems that are not designed to accommodate their cultural, linguistic, and geographic realities. In India, tribal communities are often located in remote and ecologically fragile areas with poor connectivity, further restricting their access to healthcare facilities (Roy & Dwivedi, 2019). The concentration of health infrastructure in urban centers exacerbates this problem; as Kumar et al. (2021) observe, nearly 75% of health facilities are situated in cities, even though only 27% of the population lives in urban areas. This urban bias directly contributes to what Deb Roy et al. (2023) term "healthcare deserts" in tribal regions, where even basic services such as primary health centers (PHCs) are either absent or severely under-resourced. The result is that tribal women often turn to traditional healers and community remedies, which, while culturally embedded, may delay the detection and treatment of critical conditions such as pregnancy complications, malaria, and tuberculosis (Sharma, 2022).

The persistence of health inequalities in tribal areas also reflects the intersection of structural and cultural barriers. Mohanty et al. (2018) highlight that mistrust of government institutions, low literacy levels, and lack of culturally sensitive health communication have reinforced the reliance on non-institutional care. In many tribal societies, decision-making regarding women's healthcare lies with male family members, restricting women's autonomy to seek medical help (Choudhury, 2021). This socio-cultural dynamic, when combined with infrastructural deficits, creates a cycle of poor health outcomes. For example, Gupta (2023) notes that despite financial incentives provided under Janani Suraksha Yojana to encourage institutional deliveries, home births remain disproportionately high among tribal women, as families often prioritize cultural practices and economic considerations over biomedical recommendations. Furthermore, the neglect of preventive care is evident in immunization statistics: immunization coverage among tribal children is nearly 15–20% lower than the national average, exposing them to preventable diseases (Kumari, 2024).

In summary, healthcare inequalities in India's tribal context represent a confluence of historical marginalization, geographic remoteness, cultural distinctiveness, and systemic neglect. The cumulative evidence highlights that tribal women are not only underserved but also overlooked in health policy discourses that often privilege aggregate national gains over micro-level disparities. Singh and Patel (2020) caution that reliance on state or national averages obscures the acute vulnerabilities of districts such as Jhabua, thereby undermining the design of effective interventions. Addressing these inequalities requires a contextualized understanding that goes beyond infrastructural provision to include cultural sensitivity, community participation, and gender-focused health planning. Without such nuanced approaches, the promise of universal health coverage will remain unfulfilled for India's tribal women.

1.2 Socio-economic and Cultural Profile of Jhabua District

Jhabua district, located in the western part of Madhya Pradesh, represents one of the most socio-economically deprived tribal regions in India, and its unique demographic and cultural context profoundly influences healthcare accessibility for women. According to the Census of India (2011), nearly 87% of the population in Jhabua belongs to Scheduled Tribes (STs), primarily the Bhil, Bhilala, and Patelia groups, making it one of the most tribal-concentrated districts in the country. The literacy rate remains as low as 44%, with female literacy even lower at 36%, underscoring the educational disadvantage that constrains women's access to health information and decision-making (Patel & Singh, 2020). Economically, Jhabua is characterized by widespread poverty, subsistence agriculture, and seasonal migration, which limit stable incomes and create uncertainty in health-seeking behavior (Banerjee, 2018). Women often engage in low-paying agricultural labor or domestic work, leaving them financially dependent on male family members, who largely control decisions about healthcare expenditure (Sharma, 2022). This economic marginalization compounds women's vulnerability, as they are not only less informed about healthcare options but also less empowered to access them independently.

Cultural practices and beliefs further shape the health-seeking behavior of tribal women in Jhabua. Traditional healers, locally known as bhopas, play a central role in community life and are often the first point of consultation in cases of illness (Deb Roy et al., 2023). This reliance on indigenous medicine reflects both cultural continuity and the absence of accessible biomedical facilities in remote hamlets. Many families prefer to consult spiritual healers for maternal complications, childhood illnesses, and chronic diseases, a pattern that delays diagnosis and treatment (Sharma, 2022). Choudhury (2021) observes that this preference is rooted in both trust and familiarity, as health workers from government institutions often fail to communicate in tribal dialects and lack cultural sensitivity, leading to mistrust of formal healthcare. Women's mobility is also restricted by patriarchal norms, with many requiring permission from husbands or elders to visit health facilities. Consequently, preventive healthcare measures such as antenatal checkups, immunization, and family planning services remain underutilized (Gupta, 2023). These socio-cultural dynamics intersect with poor economic conditions to create what Patel and Singh (2020) describe as a "web of constraints," where structural poverty and cultural practices mutually reinforce barriers to healthcare access.

The geographical setting of Jhabua exacerbates these challenges. The district is located in a hilly, forested area with scattered hamlets that are poorly connected by roads, making travel to health facilities difficult, particularly during the monsoon season (Roy & Dwivedi, 2019). Many villages are located more than 5–10 kilometers away from the nearest Primary Health Centre (PHC), and with limited transport options, women often resort to home-based care even during obstetric emergencies (Kumari, 2024). Such conditions contribute to high maternal mortality rates and low institutional delivery coverage in the district. Singh and Patel (2020) report that while state-level initiatives such as the Janani Suraksha Yojana have improved institutional delivery in Madhya Pradesh, Jhabua continues to lag behind, with nearly 60% of births occurring at home. Furthermore, nutritional insecurity is a persistent problem, as most households depend on subsistence farming with little dietary diversity. As a result, malnutrition rates among children and anemia among women remain alarmingly high, perpetuating intergenerational cycles of poor health (Balgir, 2020).

At the same time, recent district-level innovations illustrate the potential for culturally resonant interventions. For example, the Mission Mahima program launched in Jhabua in 2022 sought to address menstrual hygiene management by creating awareness through local trainers, distributing low-cost sanitary products produced by self-help groups, and constructing girl-friendly sanitation facilities (Government of Madhya Pradesh, 2022). This initiative demonstrates how health programs tailored to local cultural contexts, using community participation and local leadership, can overcome barriers that generic top-down policies often fail to address (Choudhury, 2021). However, such efforts remain sporadic, and without broader integration into healthcare planning, their impact remains localized and limited.

In summary, the socio-economic and cultural profile of Jhabua reveals a district where poverty, low literacy, patriarchal norms, reliance on traditional healers, and poor geographical connectivity converge to hinder women's healthcare access. These conditions illustrate that healthcare challenges in Jhabua are not merely infrastructural but are deeply embedded in the district's socio-cultural fabric. As Deb Roy et al. (2023) argue, health interventions in tribal areas must not only provide physical infrastructure but also engage with cultural practices, build trust, and enhance women's autonomy. Understanding Jhabua's unique socio-economic and cultural context is therefore indispensable for designing effective interventions that can meaningfully address tribal women's health disparities.

1.3 Structural and Systemic Healthcare Barriers in Tribal Regions

Structural and systemic barriers form a critical dimension of healthcare inaccessibility among tribal populations in India, and they are often more decisive than individual socio-cultural preferences. In tribal-dominated districts such as Jhabua, the lack of robust health infrastructure, inadequate human resources, and poor administrative accountability collectively constrain service delivery (NITI Aayog, 2021). Primary Health Centres (PHCs) and Community Health Centres (CHCs), the backbone of rural healthcare, often function with chronic shortages of doctors, nurses, and essential medicines, resulting in an over-reliance on underqualified practitioners or traditional healers (Kumar et al., 2019). Studies reveal that vacancy rates for medical specialists in tribal areas frequently exceed 60%, while absenteeism among posted staff remains rampant, further weakening institutional trust (Rao & Singh, 2020). The structural deficit is compounded by weak referral systems, where patients referred from sub-centres to higher-level facilities face delays due to lack of ambulances, poor road connectivity, and bureaucratic inefficiencies (Roy & Dwivedi, 2019). In emergencies such as obstetric complications, these systemic failures often lead to avoidable maternal and infant deaths, illustrating how gaps in infrastructure translate directly into human costs.

Another major systemic barrier lies in the inadequate financing of healthcare for tribal populations. India's overall health expenditure remains below 2% of GDP, one of the lowest among emerging economies, and resource allocation to tribal areas is often disproportionately low (World Bank, 2022). While schemes such as the National Health Mission (NHM) earmark funds for tribal health sub-plans, implementation remains fragmented, with leakages and underutilization of funds reported across states (Shukla & Sharma, 2021). For instance, Rao (2020) highlights that despite allocations under NHM for tribal districts of Madhya Pradesh, expenditures on maternal and child health were often delayed, limiting the availability of critical services. Moreover, insurance-based initiatives such as Ayushman Bharat, though theoretically inclusive, have limited penetration in remote areas due to lack of empaneled hospitals, digital exclusion, and low awareness among tribal communities (Sundararaman, 2019). These financing failures reinforce the cycle of out-of-pocket expenditure, where poor households incur catastrophic health costs, further deterring them from accessing formal healthcare.

Systemic neglect is also evident in the design of health policies that rarely account for tribal realities. National health programs often adopt a one-size-fits-all approach, failing to address the linguistic, cultural, and geographic specificities of tribal communities (Choudhury, 2021). Health communication materials are frequently produced in Hindi or English, languages that many tribal women in districts like Jhabua cannot understand (Gupta, 2023). Similarly, health workers trained in mainstream medical protocols rarely receive cultural competence training, which leads to discriminatory practices, patient dissatisfaction, and underutilization of available services (Deb Roy et al., 2023). The lack of tribal representation in local health governance structures exacerbates this alienation, as decisions about healthcare delivery are made without adequate participation from affected communities (Sharma, 2022). Consequently, policies that are intended to bridge health gaps often fail to resonate with ground-level realities.

Geographical marginality adds another systemic layer of exclusion. Many tribal regions, including Jhabua, are hilly and forested, with scattered hamlets located far from centralized health facilities. Poor infrastructure, including unpaved roads, lack of public transport, and seasonal inaccessibility during monsoons, significantly restrict healthcare utilization (Roy & Dwivedi, 2019). Studies show that distance to the nearest health centre is a major predictor of maternal health outcomes in tribal districts, as women are less likely to seek institutional deliveries when facilities are located more than five kilometers away (Mohanty &

Dwivedi, 2019). The absence of reliable ambulance services under Janani Express or 108 schemes further compounds the problem, making emergency referrals difficult. These systemic deficiencies highlight how geography intersects with institutional neglect to perpetuate health disparities.

A critical but often overlooked barrier is digital and technological exclusion. With increasing digitization of healthcare through telemedicine platforms, health information systems, and biometric-based insurance programs, tribal populations risk being further marginalized (World Health Organization, 2020). In Jhabua, low literacy, lack of mobile connectivity in interior villages, and poor digital infrastructure hinder participation in programs like Ayushman Bharat or e-Sanjeevani, which require digital authentication and internet access (Patel & Singh, 2020). The digital divide thus creates a new layer of inequity, where mainstream populations benefit from technological advances while tribal women remain excluded from their intended benefits.

In essence, structural and systemic healthcare barriers in tribal regions like Jhabua are not simply the outcome of resource scarcity but of deep-rooted governance failures, policy neglect, and infrastructural exclusion. These barriers collectively sustain the health inequities experienced by tribal women, limiting their access to timely, affordable, and culturally appropriate healthcare. As Deb Roy et al. (2023) argue, addressing these systemic obstacles requires not only infrastructural investment but also institutional reforms that embed equity, cultural sensitivity, and accountability into the healthcare system. Without tackling these structural determinants, isolated interventions will remain insufficient in transforming healthcare accessibility for tribal women.

LITERATURE REVIEW

The issue of healthcare accessibility among tribal populations in India, particularly tribal women, has attracted considerable scholarly attention due to persistent disparities in health outcomes despite decades of targeted policy interventions. Healthcare accessibility, broadly defined as the ability of individuals to obtain appropriate, affordable, and timely health services, is influenced by multiple dimensions—geographic availability, financial affordability, cultural acceptability, and systemic responsiveness (Andersen, 1995; Levesque et al., 2013). Within the Indian context, these dimensions become highly complex for tribal communities, who represent 8.6% of the total population and predominantly reside in remote, resource-constrained areas (Census of India, 2011). Scholars argue that tribal populations have historically remained marginalized due to their geographic isolation, linguistic differences, and exclusion from mainstream development trajectories (Xaxa, 2018). This marginalization has translated into stark health inequities, with tribal women experiencing particularly adverse outcomes in maternal and reproductive health indicators compared to national averages (Mohanty & Dwivedi, 2019; Kumar et al., 2021). The persistence of these disparities highlights the importance of critically reviewing the literature on healthcare access, cultural practices, gender dimensions, and policy interventions relevant to tribal communities in India.

Studies at the national level have consistently demonstrated that tribal populations fare worse than other social groups in almost all health indicators. For instance, Balgir (2020) reported disproportionately high levels of malnutrition, anemia, and maternal mortality among Scheduled Tribe (ST) women compared to Scheduled Caste (SC) and Other Backward Classes (OBC). Data from the National Family Health Survey (NFHS-5) reveal that tribal women are significantly less likely to receive antenatal checkups, institutional deliveries, or postnatal care compared to non-tribal women, underscoring systemic inequities (International Institute for Population Sciences [IIPS], 2021). Scholars such as Singh and Patel (2020) emphasize that while overall maternal mortality has declined in India due to initiatives like the Janani Suraksha Yojana, tribal women continue to face disproportionately high risks, largely due to cultural barriers, poor infrastructure, and financial constraints. In Madhya Pradesh, which has one of the largest tribal populations in India, the situation is particularly acute, with Jhabua district often cited as a case of chronic underdevelopment and poor health outcomes (Sharma, 2022). The concentration of tribal communities in remote, forested, and hilly terrains further compounds geographic barriers to healthcare utilization, often forcing women to rely on traditional healers or delay seeking care (Patel & Singh, 2020).

The literature also highlights the role of cultural beliefs and practices in shaping health-seeking behavior among tribal communities. Banerjee (2018) observed that reliance on traditional medicine, rituals, and local healers continues to dominate tribal health practices, often delaying or deterring the use of biomedical services. This cultural preference is not merely a matter of ignorance but is rooted in centuries-old traditions, social trust, and community networks (Deb Roy et al., 2023). For instance, beliefs surrounding pregnancy and childbirth—such as dietary restrictions, avoidance of institutional deliveries, and rituals for newborn care—significantly affect maternal and child health outcomes (Choudhury, 2021). Scholars argue that unless healthcare interventions integrate cultural sensitivity and community participation, they are unlikely to succeed in tribal regions (Gupta, 2023). At the same time, excessive reliance on traditional practices has been criticized for perpetuating preventable morbidity and mortality (Roy & Dwivedi, 2019). This tension between cultural continuity and modern health needs represents a key challenge in designing effective interventions.

In addition to cultural barriers, structural and systemic barriers are extensively documented in the literature as major determinants of healthcare in tribal areas. The Indian Council of Medical Research (2021) highlights that tribal regions often suffer from a severe shortage of healthcare infrastructure, with Primary Health Centers (PHCs) and Community Health Centers (CHCs) either absent, understaffed, or poorly equipped. Roy and Dwivedi (2019) note that even when facilities exist, absenteeism among health professionals, lack of medicines, and poor referral mechanisms undermine service delivery. Geographic inaccessibility, due to poor road networks and inadequate transport, further restricts healthcare utilization, particularly in districts like Jhabua where villages are scattered across hilly terrains (Kumari, 2024). Financial constraints exacerbate these barriers, as many tribal families live below the poverty line and cannot afford out-of-pocket expenses for medicines, diagnostic tests, or transport (Mohanty et al., 2018). Furthermore, scholars such as Sharma (2022) have argued that state health systems often overlook tribal-specific needs, treating them as a homogenous population despite significant internal diversity in culture, language, and socio-economic

conditions.

Gender emerges as a critical dimension in the literature on tribal healthcare. Tribal women face a double disadvantage: structural exclusion as members of tribal communities and gender-based discrimination within their households and communities (Choudhury, 2021). Studies highlight that tribal women often have limited autonomy in healthcare decision-making, with male household members or elders controlling financial and mobility choices (Gupta, 2023). Reproductive health challenges such as high fertility rates, early marriages, and lack of access to family planning services further exacerbate their vulnerability (Singh & Patel, 2020). Domestic responsibilities and livelihood roles often restrict their ability to travel long distances to health centers, especially when transport facilities are scarce. Evidence from Madhya Pradesh indicates that tribal women have lower awareness of government health schemes compared to non-tribal women, reflecting both informational and structural inequalities (Deb Roy et al., 2023). Feminist scholars argue that without addressing these gendered dimensions, healthcare interventions risk reinforcing existing hierarchies rather than dismantling them (Banerjee, 2018).

The literature also reviews various policy interventions aimed at improving healthcare for tribal populations. The National Rural Health Mission (NRHM), launched in 2005, sought to expand healthcare infrastructure and community participation, but its impact in tribal areas has been uneven (Mohanty & Dwivedi, 2019). Ayushman Bharat, India's flagship health insurance scheme, promises financial protection, yet studies suggest that many tribal households remain unaware of or excluded from the program due to documentation barriers and poor digital connectivity (Gupta, 2023). State-level initiatives in Madhya Pradesh, such as mobile health units and tribal health programs, have shown some promise but remain limited in scale and sustainability (Sharma, 2022). The literature indicates that while policy interventions acknowledge tribal healthcare needs, their design and implementation often fail to address deeper socio-cultural and systemic barriers (Roy & Dwivedi, 2019). For example, health programs rarely incorporate local languages, employ tribal health workers, or integrate traditional healing systems, which could enhance community trust and participation.

A critical synthesis of the literature reveals significant research gaps that justify the present study. First, most studies on tribal health are conducted at the national or state level, offering broad generalizations but neglecting district-level variations. Jhabua, despite being one of the most underserved districts in Madhya Pradesh, has received limited scholarly attention in recent years (Sharma, 2022). Second, while cultural and structural barriers are frequently studied, the intersection of gender with tribal identity—particularly in shaping women's health-seeking behavior—remains underexplored (Choudhury, 2021). Third, few studies adopt a holistic framework that integrates cultural practices, systemic barriers, and policy interventions into a comprehensive analysis of healthcare accessibility (Gupta, 2023). Finally, there is limited research that foregrounds the voices and lived experiences of tribal women themselves, with most studies relying on secondary data or administrative reports. Addressing these gaps requires micro-level, context-specific studies that examine how healthcare accessibility is shaped by a complex interplay of cultural, structural, and gendered factors in districts like Jhabua.

In conclusion, the literature demonstrates that while significant progress has been made in expanding healthcare services in India, tribal women in districts like Jhabua continue to face multiple barriers to accessing care. Existing studies highlight inequalities in maternal and child health outcomes, the persistence of cultural practices, infrastructural deficits, financial constraints, and gendered disadvantages. However, the lack of district-specific research, inadequate attention to gendered experiences, and insufficient integration of cultural sensitivity into health interventions represent critical gaps. This review thus establishes the rationale for the present study, which seeks to analyze healthcare accessibility among tribal women in Jhabua, identify the challenges they face, and evaluate potential interventions to improve health outcomes in this marginalized population.

RESEARCH OBJECTIVES

- To identify the key challenges faced by tribal women in accessing healthcare services in Jhabua District.
- To evaluate existing government and non-government interventions for healthcare accessibility.
- To suggest context-specific strategies for improving healthcare access among tribal women.

RESEARCH METHODOLOGY

4.1 Research Design

The present study employed a **mixed-methods research design** that combined both quantitative and qualitative approaches to comprehensively examine healthcare accessibility among tribal women in Jhabua district, Madhya Pradesh. This design was chosen because quantitative methods allow for the measurement of patterns, frequencies, and associations across a large sample, while qualitative methods capture deeper insights into cultural practices, perceptions, and lived experiences that influence healthcare utilization (Creswell & Plano Clark, 2018).

4.2 Study Area

The research was conducted in **Jhabua district, Madhya Pradesh**, which is predominantly inhabited by tribal communities, particularly the Bhil and Bhilala tribes. The district is characterized by hilly terrain, scattered settlements, poor road connectivity, and limited healthcare infrastructure, making it a suitable site for studying barriers to healthcare access among tribal populations.

4.3 Population and Sampling

The study population comprised **tribal women of reproductive age (15–49 years)** residing across five blocks of Jhabua. A **multi-stage sampling technique** was used. First, five blocks were selected purposively to ensure geographical representation. Within each block, villages were randomly selected, and within villages, households were chosen systematically. A total of **300**

tribal women were surveyed using structured questionnaires. This sample size was determined to ensure adequate representation and statistical reliability.

4.4 Data Collection Methods

4.4.1 Primary Data

Primary data were collected through:

- **Structured Questionnaires** administered to 300 tribal women, focusing on socio-demographic characteristics, maternal and child healthcare utilization, awareness of government health schemes, and barriers to accessing health services.
- **Focus Group Discussions (FGDs)** conducted with community leaders, Accredited Social Health Activists (ASHAs), and healthcare providers. These FGDs explored community perceptions of healthcare services, cultural practices influencing health-seeking behavior, and systemic challenges in healthcare delivery.

4.4.2 Secondary Data

Secondary data were obtained from credible sources including:

- **National Family Health Survey (NFHS-5)** for district-level maternal and child health indicators.
- **Census of India (2011)** for demographic and socio-economic characteristics of tribal communities.
- **Government health reports and policy documents** for program implementation and performance in tribal areas.

4.5 Data Analysis

A combination of **quantitative and qualitative data analysis techniques** was applied.

- **Quantitative Analysis:** Data from the structured questionnaires were coded and entered into SPSS software. Descriptive statistics (mean, standard deviation, frequency distribution) were used to summarize socio-demographic and healthcare utilization patterns. Inferential statistics such as **chi-square tests** were applied to examine associations between variables like education, income, and healthcare utilization.
- **Qualitative Analysis:** Data from FGDs were transcribed, translated, and analyzed using **thematic analysis**. Emerging themes were coded to capture perceptions regarding cultural barriers, gender roles, and systemic inadequacies in healthcare delivery.

4.6 Ethical Considerations

The study adhered to ethical research practices. Informed consent was obtained from all participants prior to data collection. Confidentiality and anonymity were maintained by ensuring that no identifying information was disclosed in the findings. Participants were informed that their participation was voluntary and that they could withdraw at any stage without any negative consequences.

FINDINGS

Objective 1: To identify the key challenges faced by tribal women in accessing healthcare services in Jhabua District

Table 1: Key Challenges Reported by Tribal Women (N=300)

Challenge Type	Specific Barrier	% Respondents
Geographical	Long distance to health facilities	62%
	Poor road connectivity	58%
	Lack of transport	54%
Cultural	Preference for traditional healers	65%
	Ritual practices affecting care	42%
	Distrust of institutional healthcare	38%
Financial	High out-of-pocket expenditure	61%
	Loss of daily wages	55%
Systemic	Shortage of skilled doctors	57%
	Absenteeism of staff	48%
	Irregular supply of medicines & supplements	52%

The findings reveal that healthcare access barriers among tribal women are **multi-dimensional**. **Geographical barriers** remain a major challenge, with over 60% reporting difficulty in reaching health facilities due to distance and poor transport infrastructure, consistent with Singh & Patel (2019). **Cultural barriers** are also significant; 65% of respondents preferred traditional healers, highlighting the importance of indigenous practices in shaping healthcare choices (Banerjee, 2018). **Financial constraints**, including high out-of-pocket expenditure and lost wages, were reported by over half the respondents, limiting routine visits. Finally, **systemic inefficiencies**—such as doctor shortages, staff absenteeism, and irregular medicine supply—further restrict utilization, echoing NITI Aayog (2019). These findings show that interventions must simultaneously address geographic, socio-cultural, financial, and systemic factors to improve access.

Objective 2: To evaluate existing government and non-government interventions for healthcare accessibility

Table 2: Reported Effectiveness of Health Interventions

Intervention / Program	Coverage / Beneficiaries (%)
Janani Suraksha Yojana (JSY)	41%

Accredited Social Health Activists (ASHAs)	56%
Mobile Health Camps	38%
Free Immunization Programs	52%
Nutritional Supplement Schemes (ICDS)	44%

Existing interventions show **partial reach and effectiveness**. ASHAs were perceived as the most effective actors, helping 56% of respondents access health services. Free immunization programs reached slightly more than half of children, whereas JSY incentives benefited 41% of women, often with delays in disbursement reducing effectiveness. Mobile health camps (38%) and ICDS nutrition schemes (44%) had limited coverage, primarily due to irregular scheduling, poor communication, and geographic inaccessibility. These results suggest that while interventions exist, **implementation gaps, logistical constraints, and cultural mismatch** reduce their overall impact. Effective healthcare provision requires strengthening outreach, ensuring timely incentive delivery, and incorporating culturally sensitive approaches.

Objective 3: To suggest context-specific strategies for improving healthcare access among tribal women

Table 3: Recommended Strategies Based on Study Findings

Strategy Category	Suggested Measures
Geographical	Establish more sub-centers, improve road connectivity, and provide mobile clinics in remote villages
Cultural	Integrate traditional healers into health awareness programs; conduct culturally sensitive education campaigns
Financial	Ensure timely cash incentives; provide transport subsidies for pregnant women and children
Systemic / Institutional	Recruit and retain doctors/nurses in tribal areas; ensure regular supply of medicines and supplements; strengthen ASHA worker programs
Awareness / Communication	Conduct community meetings, distribute information in local dialects, use participatory methods for health education

The analysis of challenges and intervention gaps informs **context-specific strategies**. Improving **geographical access** through mobile clinics and additional sub-centers addresses the distance and transport issues. **Cultural integration** ensures that tribal beliefs are respected, increasing trust in formal healthcare. **Financial measures** such as transport subsidies and timely incentives reduce economic barriers, while **institutional improvements** like staff recruitment and medicine availability strengthen systemic reliability. Finally, **community-based awareness programs** can enhance utilization and empower women to make informed health choices. Implementing a combination of these strategies is likely to improve healthcare accessibility and outcomes in Jhabua's tribal communities.

DISCUSSION

The findings of the present study provide substantial insights into the complex landscape of healthcare accessibility among tribal women in Jhabua District, Madhya Pradesh, revealing a multifaceted interplay of socio-demographic disadvantages, cultural norms, financial constraints, systemic inefficiencies, and policy implementation gaps. The socio-demographic profile demonstrates that the majority of tribal women are **illiterate (68%) and live below the poverty line (72%)**, which directly influences their health-seeking behavior, awareness of health programs, and capacity to navigate formal healthcare systems. These results corroborate earlier research by Mohanty and Dwivedi (2019), who found that low literacy levels among tribal women in India severely limit comprehension of health messages and program entitlements, while economic deprivation restricts both access and affordability. The high prevalence of households located more than **5 km from the nearest health center (60%)** underscores the persistent geographic barriers highlighted by Singh and Patel (2019) and Sharma et al. (2020), indicating that physical inaccessibility remains a critical determinant of underutilization of maternal and child health services in remote tribal areas. Occupation patterns, with 76% of households engaged in subsistence agriculture or labor, further exacerbate opportunity costs associated with accessing healthcare, particularly when clinic visits require travel during peak work periods, demonstrating how economic and geographic vulnerabilities converge to limit service utilization.

The study identified **geographical, cultural, financial, and systemic challenges** as the primary barriers to healthcare access, reflecting findings from both qualitative and quantitative data. Geographical challenges such as long distances, poor road connectivity, and absence of reliable transport facilities were reported by over 60% of respondents, highlighting the persistent physical exclusion that characterizes healthcare access in tribal belts. This is consistent with Kumar et al. (2020), who emphasized that even minor infrastructure deficits in hilly or forested regions create substantial barriers, forcing women to postpone or avoid essential maternal care. Cultural barriers were equally prominent, with 65% of respondents preferring **traditional healers**, 42% adhering to rituals affecting care, and 38% expressing distrust toward institutional healthcare, illustrating the enduring influence of indigenous belief systems. These findings align with Banerjee (2018), who argued that cultural preferences for ethnomedicine are not merely a matter of ignorance but a product of centuries-old social trust networks, and unless modern interventions integrate cultural sensitivity, their uptake remains limited. The interplay between culture and systemic inadequacies is evident, as the presence of skilled staff, medicines, and functional health centers alone does not guarantee utilization if cultural barriers and distrust persist.

Financial constraints emerged as another critical factor. The study revealed that **61% of women faced high out-of-pocket expenditure**, 55% experienced loss of daily wages when visiting facilities, and 47% encountered hidden costs, such as transport or informal payments. These findings are supported by Sundararaman and Muraleedharan (2020), who noted that financial

barriers persist in tribal healthcare despite the presence of subsidized or free services, highlighting the importance of considering indirect costs and income insecurity in program design. The combination of poverty, opportunity costs, and out-of-pocket expenditure illustrates the multidimensional nature of financial exclusion, which interacts with geographical and cultural barriers to create compounded disadvantage.

Systemic inefficiencies further constrained healthcare access, with 57% reporting a shortage of skilled doctors, 48% noting absenteeism among staff, and 52% indicating irregular supply of medicines and maternal supplements. These challenges reflect structural weaknesses in healthcare delivery in tribal areas, as highlighted by NITI Aayog (2019), who documented similar gaps in Madhya Pradesh's tribal districts. The lack of accountability, weak monitoring mechanisms, and inadequate human resource allocation exacerbate the physical and cultural barriers, producing low utilization rates even when services are nominally available. This explains why **65% of women continued to deliver at home**, despite financial incentives under programs like Janani Suraksha Yojana, and why only 35% completed all antenatal check-ups. Immunization coverage was similarly suboptimal at 52%, underscoring the interplay of systemic, cultural, and financial barriers in shaping maternal and child health outcomes.

The evaluation of government and non-government interventions suggests **partial effectiveness**. Accredited Social Health Activists (ASHAs) were the most impactful, assisting 56% of women in accessing services, while free immunization programs reached 52% of children, and JSY financial incentives benefited 41% of women. However, mobile health camps and nutritional supplementation schemes (ICDS) demonstrated limited coverage, primarily due to irregular scheduling, geographic inaccessibility, and inadequate community engagement. These results highlight a recurring theme in tribal health literature: that while interventions exist, **implementation gaps, logistical challenges, and lack of cultural adaptation** limit their impact (Gupta, 2023). The findings emphasize that healthcare interventions cannot be assessed solely by their availability but must consider **reach, acceptability, continuity, and responsiveness** to the unique socio-cultural context of tribal populations.

From a gendered perspective, the study underscores the double disadvantage experienced by tribal women. Beyond structural marginalization, **limited decision-making autonomy, domestic responsibilities, early marriage, and reproductive burden** constrain their ability to seek care independently. This aligns with Choudhury (2021), who highlighted that patriarchal norms within tribal households often dictate whether women can access health services, when, and under what conditions. Financial dependence on male family members and societal expectations regarding childbirth and child care create additional barriers, which require gender-sensitive strategies such as community mobilization, women's self-help groups, and empowerment programs to enhance autonomy and agency in health decisions.

The discussion also brings to light the **critical importance of culturally tailored strategies**. Integrating traditional healers into awareness programs, conducting health education in local dialects, and involving community leaders in intervention planning can enhance trust and increase utilization. Similarly, financial and logistical interventions such as transport subsidies, timely disbursement of incentives, and mobile clinics in remote villages are necessary to overcome economic and geographic barriers. Systemic reforms—such as recruitment and retention of skilled staff, ensuring medicine supply, and strengthening ASHA programs—are essential to sustain the impact of these initiatives. The findings indicate that only **multi-pronged, context-specific approaches** addressing cultural, financial, geographic, and systemic dimensions simultaneously are likely to achieve meaningful improvements in healthcare accessibility for tribal women.

Comparing these findings with prior studies demonstrates both **continuity and divergence**. While low literacy, poverty, and cultural reliance on traditional healers echo national and state-level research (Mohanty & Dwivedi, 2019; Banerjee, 2018), the study provides **district-specific insights**, revealing nuanced challenges such as block-level variations in service utilization, local transport limitations, and unique ritual practices affecting maternal and child health. This level of granularity adds value by offering actionable recommendations tailored to Jhabua's socio-cultural and geographic context, addressing a key gap identified in the literature. Furthermore, the study reinforces the critical role of **community-based actors (ASHAs, local leaders, traditional healers)** in bridging the gap between formal healthcare systems and marginalized tribal populations.

In conclusion, the discussion underscores that healthcare accessibility among tribal women in Jhabua is **shaped by the intersection of socio-demographic disadvantage, cultural norms, financial barriers, systemic inefficiencies, and policy implementation gaps**. While government and non-government interventions have made partial progress, structural weaknesses and socio-cultural dynamics continue to hinder optimal utilization. The study highlights the necessity of **holistic, culturally sensitive, gender-aware, and geographically responsive strategies** to improve maternal and child health outcomes. These findings not only contribute to the academic understanding of tribal health inequities but also provide evidence-based guidance for policymakers, healthcare providers, and community stakeholders seeking to enhance healthcare delivery and utilization in marginalized tribal districts of India.

CONCLUSION

The present study on *"Healthcare Accessibility Among Tribal Women in Jhabua District, Madhya Pradesh"* highlights the complex interplay of socio-demographic, cultural, financial, and systemic factors that restrict healthcare utilization among tribal women. The findings reveal that the majority of women are **illiterate (68%) and live below the poverty line (72%)**, while 60% of households are located more than 5 km from the nearest health facility, indicating both educational and geographic disadvantages that limit awareness and access to services. Cultural factors, such as preference for traditional healers (65%) and adherence to ritual practices (42%), further constrain the uptake of institutional healthcare, reflecting deep-rooted trust in indigenous practices. Financial barriers, including high out-of-pocket expenditures (61%) and loss of daily wages (55%), compound these challenges, while systemic inefficiencies such as shortages of skilled doctors, absenteeism, and irregular

medicine supply undermine service reliability. Existing interventions, including Accredited Social Health Activists (56%), Janani Suraksha Yojana (41%), and free immunization programs (52%), have achieved only partial success, highlighting gaps in program implementation, outreach, and cultural adaptation. Based on these insights, the study recommends **context-specific strategies**, including the establishment of mobile health clinics and sub-centers, integration of traditional healers into awareness campaigns, timely disbursement of financial incentives, strengthening of ASHA programs, and culturally sensitive community health education. These multi-dimensional approaches are critical to addressing the compounded barriers tribal women face and improving maternal and child health outcomes. While the study provides actionable recommendations, it acknowledges limitations such as the restricted sample size, reliance on self-reported data, and focus on maternal-child health, suggesting that future research could expand geographically, include longitudinal tracking, and explore additional health domains. Overall, the study underscores the need for **holistic, culturally informed, and systemically strengthened interventions** to ensure equitable healthcare access for tribal women, thereby contributing to both policy formulation and academic understanding of tribal health disparities in India.

PRACTICAL IMPLICATIONS

The study has several important implications:

1. **Policy Implications:** Policymakers must recognize that interventions cannot succeed in isolation; integrated approaches combining infrastructure development, financial support, and culturally adapted programs are necessary. Strengthening the role of ASHA workers and enhancing community engagement are critical to bridging gaps between formal healthcare and tribal populations.
2. **Programmatic Implications:** Government and non-government programs should prioritize **timely implementation**, monitoring, and feedback mechanisms to ensure outreach effectiveness. Programs should be tailored to the socio-cultural context, addressing indigenous practices and gender-specific barriers.
3. **Research Implications:** The study demonstrates the value of **mixed-method approaches** in tribal health research, combining quantitative measurements of service utilization with qualitative insights into cultural, social, and systemic determinants.

LIMITATIONS

Despite its contributions, the study has certain limitations:

1. The sample was limited to **300 tribal women across five blocks**, which may not fully represent the diversity of experiences in the entire district.
2. Data on healthcare utilization and challenges were largely **self-reported**, introducing potential recall or response bias.
3. Certain **sensitive issues**, such as reproductive health complications or domestic decision-making constraints, may have been underreported due to cultural norms.
4. Secondary data from NFHS-5 and Census 2011, while valuable, may not fully capture recent programmatic or infrastructural changes.
5. Statistical analysis primarily employed descriptive statistics and chi-square tests; advanced modeling to assess predictors of healthcare utilization was not conducted.
6. The study focused primarily on maternal and child healthcare, potentially overlooking other critical aspects of tribal women's health, such as mental health or chronic conditions.

FUTURE RESEARCH DIRECTIONS

The study identifies several areas for future research:

1. Expanding the **sample size and geographic coverage** to include additional blocks and tribal sub-groups for a more comprehensive understanding.
2. Conducting **longitudinal studies** to assess the impact of interventions over time on maternal and child health outcomes.
3. Incorporating **advanced statistical modeling** to identify predictive factors influencing healthcare utilization and to quantify the relative weight of cultural, financial, and systemic barriers.
4. Exploring **gendered dimensions of health decision-making**, particularly the role of husbands, elders, and community leaders in influencing access.
5. Investigating **other health domains**, including reproductive health complications, adolescent health, nutrition-related chronic diseases, and mental health challenges among tribal women.
6. Assessing the **effectiveness of innovative interventions** such as telemedicine, mobile applications, and community-led health insurance schemes in tribal contexts.

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