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RESEARCH ARTICLE

PRELIMINARY FINDINGS ON SOCIO-ECONOMIC STATUS, HEALTH AND EDUCATIONAL AMONG RURAL HOUSEHOLDS IN TOSEKGRE, WEST GARO HILLS, MEGHALAYA

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Abstract

Socio-economic status, health, and education are key determinants of rural development and overall quality of life. Understanding these indicators is essential for identifying the strengths and challenges faced by rural communities, particularly in tribal regions of Meghalaya, Northeast India. This study presents the preliminary findings on the socio-economic status, health, and educational conditions of rural households in Tosekgre village, West Garo Hills, Meghalaya. A quantitative descriptive research design was employed, and data were collected from 72 households using cross sectional survey and a self-structured interview schedule through household surveys. Descriptive statistics, including frequencies and percentages, were used to analyze the data, while selected associations between variables were examined using chi-square analysis. The findings revealed that the majority of respondents were cultivators, owned agricultural land and their own houses, and had access to banking services and government health facilities. Although most households reported access to nearby health centres and government health schemes, participation in health camps and levels of health awareness remained moderate. Educational attainment was predominantly at the primary and secondary levels, with school dropout reported in a proportion of households, largely due to financial constraints. Inferential analysis indicated a statistically significant association between health camp attendance and health awareness, suggesting that community-based health interventions contribute positively to improving health knowledge.

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The study highlights that while Tosekgre village demonstrates encouraging progress in basic infrastructure, healthcare access, and educational participation, sustained efforts are required to strengthen livelihood opportunities, health promotion initiatives, and educational support to achieve inclusive rural development.

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Introduction:-

Rural development remains central priority in India, as nearly two-thirds of the country's population continues to reside in rural areas where disparities in socio-economic conditions, healthcare accessibility, educational opportunities, and basic infrastructure persist (Office of the Registrar General & Census Commission, 2011). Understanding the living conditions of rural households is therefore essential for planning interventions that promote equitable development and enable improvement the rural communities' quality of life. Socio-economic status is widely recognised as one of the strongest determinants of health and educational outcomes. Household income, occupation, ownership of productive assets, and housing conditions, significantly influence access to healthcare, educational attainment, nutritional status and overall wellbeing (Marmot, 2005). Families with better socio-economic resources generally experience improved access to healthcare services, educational opportunities, and healthier living environments, whereas economically disadvantaged households often encounter multiple barriers that reinforce cycles of poverty and poor health.

Health and education are closely interconnected dimensions of rural development. Access to healthcare facilities, awareness of government health programmes, sanitation and healthy housing environments have a substantial contribution to community well-being. Education enhances employment prospects, health literacy and informed decision making, thereby improving household resilience and socio-economic mobility. Inadequate educational opportunities and limited healthcare access continue to pose significant developmental challenges in many rural regions of India (Cowling, Dandona, & Dandona, 2014). Rural communities, particularly in the Garo Hills region, experience variations in access to educational institutions, healthcare facilities, banking services, drinking water, communication, and other basic amenities. The District Census handbook for West Garo Hills demonstrates that infrastructure and public services differ considerably from one village to another, emphasizing the importance of local-level assessments rather than relying solely on district or state averages (Directorate of Census Operations Meghalaya, 2014).

Village-level household surveys provide valuable baseline information that complements secondary data by documenting the status of communities. Although government reports provide aggregate statistics for the district, they do not adequately capture the realities and developmental needs of individual villages. Against this backdrop, the present study brings forth the preliminary findings on the socio-economic, health and educational conditions of rural households in Tosekgre village.

Methodology:-**Research Design:-**

The study employed a descriptive research design using a cross-sectional approach to obtain preliminary information on the socio-economic status, health, and the educational conditions of rural households in Tosekgre village, West Garo Hills, Meghalaya. The study sought to provide a baseline understanding of the existing conditions of the community using primary data collected at the household level.

Research Objectives:-

1. To assess the socio-economic status of rural households in Tosekgre village with respect to housing, occupation, income, and basic household characteristics.
2. To examine the health status of rural households, including access to healthcare services and awareness on health schemes.
3. To assess the educational status of rural households with respect to school dropouts, vocational training and educational facilities.

Study Area:-

The study was conducted in Tosekgre village, located in West Garo Hills, Meghalaya. The village was selected to obtain preliminary information on the socio-economic, health, and educational conditions of rural households.

Study Population:-

The study population comprised of households residing in Tosekgre village, with the head of the household or an adult family member serving as the respondent.

Sample Size:-

The study included 72 rural households from Tosekgre village.

Sampling Technique:-

A systematic random sampling technique was employed to select households for the study. Data was collected over a period of one week through household visits. Following the selection of a random starting point within the village, households were selected at regular intervals (every third household) until the required sample of 72 households was achieved.

Data Collection and Analysis:-

The data was collected primarily by conducting a face-to-face interview and adopted a structured questionnaire after obtaining informed consent from the respondents. Participation in the study was voluntary, and respondents were assured that the information collected would remain confidential and would be used solely for academic and research purposes. The data that was collected was analyzed by the usage of descriptive statistics, including frequencies and percentages, while chi-square analysis was employed to examine selected associations between the variables. The findings of the study are presented in tabular form to provide a preliminary profile of the study area.

Limitations:-

The present study has certain limitations. First, it was conducted in a single rural village in West Garo Hills, Meghalaya, and the findings should therefore be interpreted within the context of the study area. Second, the cross-sectional nature of the study provides a picture of the socio-economic, health, educational conditions at one point in time and does not permit assessment of changes over time. Third, the findings are based on self-reported information obtained from household respondents, which depends on the accuracy and honesty of the information provided by the respondents. Despite these limitations, the study provides valuable baseline evidence on the living conditions of rural households and offer important insights for planning community-based interventions and guiding future research in similar rural settings.

Results and Discussion:-**Table No: 1 Gender**

Gender	Frequency	Percentage
Male	41	57%
Female	31	43%
Total	72	100%

The findings show that 41 respondents (57%) were male, while 31 respondents (43%) were female, showing a slightly higher representation of male respondents in the study. However, the distribution includes both genders, providing a reasonably balanced representation of rural households in Tosekgre village and enabling the study to capture perspectives from both male and female participants.

Table No:2 Family Type

Family Type	Frequency	Percentage
Nuclear	55	76.4%
Joint	16	22.2%
Extended	1	1.4%
Total	72	100%

The findings show that nuclear families are the most common family type, with 55 households (76.4%), followed by joint families (16 households, 22.2%) and extended families (1 household, 1.4%). This suggests that the nuclear family has become the predominant household structure in Tosekgre village, reflecting a shift toward smaller family units, which may influence household decision-making, resource allocation, and access to health and educational opportunities.

Table No: 3 Type of Houses

Type of Houses	Frequency	Percentage
Pucca	17	24%
Semi-Pucca	21	29%
Katcha	34	47%
Total	72	100%

The findings show that Katcha houses are the most common type of dwelling, with 34 households (47%) followed by Semi-Pucca houses (21 households, 29%) and Pucca houses (17 households, (24%). This indicates that nearly half of the respondents continue to live in temporary or semi-permanent housing, reflecting relatively modest living conditions and suggesting the need for improved housing infrastructure and rural housing support initiatives.

Table No: 4 Occupations

Occupations	Frequency	Percentage
Labourer	5	7%
Cultivator	56	77%
Government Employee	3	4%
Business	4	6%
Private Job	2	3%
Others	2	3%
Total	72	100%

The findings show that cultivation is the primary occupation for most households, with 56 families (77%) engaged in farming. This is followed by labour work (7%), business (6%), government employment (4%), private jobs (3%), and other occupations (3%). These findings indicate that the village economy is predominantly agrarian, with the majority of households depending on agriculture as their main source of livelihood. The limited representation in salaried and non-farm occupations suggests relatively low occupational diversification and continued dependence on the agricultural sector.

Table No: 5 Average Monthly Income

Average Monthly Family Income	Frequency	Percentage
Below Rs 3000	4	6%
Rs3000–Rs6000	30	41%
Rs6000–Rs10000	16	22%
Above Rs10000	22	31%
Total	72	100%

The findings show that 41% of households have a monthly family income of Rs 3,000–Rs 6,000, this is followed by 31% earning above Rs 10,000, 22% households earning Rs 6,000–Rs 10,000, and 6% earning below ₹3,000. These findings indicate that the majority of households belong to the low- to middle-income group. While nearly one-third of households earn above ₹10,000 per month, a substantial proportion continues to have modest incomes, reflecting the economic constraints typical of rural communities and the need for sustained livelihood and income-enhancement initiatives.

Table No: 6 Bank Account

Bank Account	Frequency	Percentage
Yes	61	85%
No	11	15%
Total	72	100%

The findings indicate that 61 households (85%) have a bank account, while 11 households (15%) do not have bank account. This suggests a high level of financial inclusion among the respondents, indicating that most households have access to formal banking services. However, the absence of bank accounts among a small proportion of households highlights the need for continued efforts to achieve universal access to financial services in the village.

Table No: 7 Owning Agricultural Land

Own Agricultural Land	Frequency	Percentage
Yes	72	100%
No	0	0%
Total	72	100%

The findings reveal that all 72 households (100%) own agricultural land. This indicates that land ownership is universal among the respondents, underscoring the central role of agriculture in the village economy. The widespread ownership of agricultural land suggests that farming serves as the primary source of livelihood and remains a key asset contributing to the socio-economic well-being of rural households in the study area.

Table No: 8 Seek Treatment

Go for treatment	Frequency	Percentage
PHC	25	35%
Government Hospital	41	56%
Private Clinic	2	3%
Traditional Healer	4	6%
Self-medication	0	0%
Total	72	100%

The findings show that 56% of respondents seek treatment at government hospitals, followed by 35% who visit Primary Health Centres (PHCs). A small proportion prefer traditional healers (6%) or private clinics (3%), while none reported practicing self-medication. These findings indicate that public healthcare facilities are the primary source of treatment for most households, reflecting their accessibility and reliance on government health services. The limited use of private healthcare and traditional healers further suggests a preference for formal healthcare services among the respondents.

Table No: 9 Attended Any Health Camp

Attended any health camp before	Frequency	Percentage
Yes	31	43%
No	41	57%
Total	72	100%

The findings indicate that 41 respondents (57%) had not attended any health camp, while 31 respondents (43%) had participated in one. This suggests that participation in health camps remains relatively low despite the availability of healthcare services. The findings highlight the need to strengthen community awareness, improve outreach efforts, and encourage greater participation in health camps to enhance preventive healthcare and health education among rural households.

Table No: 10 Proper Ventilation

Proper ventilation	Frequency	Percentage
Yes	43	60%
No	29	40%
Total	72	100%

The findings indicate that 43 households (60%) have proper ventilation in their homes, while 29 households (40%) do not have and poor ventilation may affect health and overall living conditions. This suggests that although the majority of households have adequate ventilation, a substantial proportion continue to live in poorly ventilated homes. Poor ventilation can negatively affect indoor air quality, increase the risk of respiratory illnesses, and adversely impact the overall health and living conditions of household members.

Table No: 11 School Dropout

School Dropout	Frequency	Percentage
Yes	16	22%
No	56	78%
Total	72	100%

The findings indicate that 56 respondents (78%) had not dropped out of school, while 16 respondents (22%) reported being school dropouts. This suggests that the majority of respondents were able to continue their education. However, the presence of a notable proportion of school dropouts indicates that educational discontinuation remains a concern and underscores the need for targeted measures to address the factors contributing to school dropout in the community.

Table No: 12 Reason for School Dropout

Reason for Dropout	Frequency	Percentage
Financial Problem	7	9.7%
Domestic Problem	2	2.8%
Lack of Interest	6	8.3%
Personal Problem	4	5.6%
Not Applicable	53	73.6%
Total	72	100%

The findings show that 73.6% of respondents reported not applicable, indicating they had not dropped out of school. Among those who did, financial constraints (9.7%) were the most common reason, followed by lack of interest (8.3%), personal reasons (5.6%), and domestic responsibilities (2.8%). These findings suggest that economic hardship is the primary factor contributing to school dropout among the affected respondents, highlighting the importance of financial assistance and educational support programmes to improve school retention in rural communities.

Table No: 13 Educational Facilities

Educational Facilities	Frequency	Percentage
Yes	39	54%
No	33	46%
Total	72	100%

The findings show that 39 respondents (54%) reported the availability of educational facilities, while 33 respondents (46%) did not. This indicates that although a slight majority of respondents have access to educational facilities, nearly half perceive such facilities as unavailable. The findings suggest disparities in access to educational infrastructure and highlight the need to improve the availability and accessibility of educational services in the study area.

Table No: 14 Chi-Square Test of Association between selected Socio-Economic and Health-Related Variables.

Variables Compared	χ^2	df	p-value	Cramer's V
Family Income $\times$ School Dropout	2.151	3	.542	.173
Family Savings $\times$ School Dropout	0.122	1	.727	.041
Health Camp Attendance $\times$ Health Awareness	31.977	1	< .001	.666
Occupation $\times$ Family Income	18.779	15	.224	.295

The Chi-square analysis examined the associations between selected socio-economic and health-related variables among the respondents. Of the four relationships tested, only the association between health camp attendance and health awareness was statistically significant ($\chi^2 = 31.977$, $df = 1$, $p < .001$), with a strong effect size (Cramer's $V = .666$). This indicates that respondents who attended health camps were significantly more likely to have better health awareness, highlighting the effectiveness of community-based health interventions in promoting health knowledge. In contrast, family income and school dropout ($\chi^2 = 2.151$, $df = 3$, $p = .542$), family savings and school dropout ($\chi^2 = 0.122$, $df = 1$, $p = .727$), and occupation and family income ($\chi^2 = 18.779$, $df = 15$, $p = .224$) showed no statistically significant associations ($p > .05$). Although the association between occupation and family income demonstrated a small-to-moderate effect size (Cramer's $V = .295$), it did not reach statistical significance.

Discussion:-

The present study examined the socio-economic status, health, and educational conditions of 72 households in Tosekgre village, Meghalaya, providing a comprehensive understanding of the community's living conditions and well-being. The findings reveal that while the village has experienced gradual progress in financial inclusion, access to public healthcare, and educational participation, several socio-economic challenges including dependence on agriculture, low household income, inadequate housing conditions, and limited participation in preventive healthcare programmes, continue to influence the quality of life of rural households. These findings support the multidimensional nature of rural development, where improvements in one sector do not necessarily translate into overall socio-economic advancement.

The predominance of nuclear families reflects the changing family structure observed across rural India, where socio-economic changes, migration, and modernization have contributed to the decline of traditional joint families (Jayanthi & Rau, 2019; Cholakkal, 2019). Agriculture remained the primary occupation of the respondents, reaffirming its central role in sustaining rural livelihoods despite increasing occupational diversification reported elsewhere (Marphatia et al., 2019; Mishra, 2024). However, the finding that most households belonged to the low- and middle-income categories despite universal ownership of agricultural land indicates that land ownership alone does not guarantee economic security. Similar observations have been reported by Kochar (2011), who emphasized that income is influenced by agricultural productivity, market access, institutional credit, and livelihood diversification rather than land ownership alone.

Housing conditions further reflected moderate socio-economic development, with nearly half of the households residing in Katcha houses and about 40% reporting inadequate ventilation. These findings are consistent with those of Prasad, Kumari, and Poddar (2009), who reported that poor housing quality is associated with lower living standards and adverse health outcomes in rural communities. Comparable studies from Ethiopia and Bangladesh have similarly demonstrated that inadequate housing contributes to increased vulnerability to communicable diseases and poor health.

An encouraging finding of the study is the high level of financial inclusion, with 85% of households possessing bank accounts. This suggests the positive impact of government financial inclusion initiatives and improved access to formal banking services. Similar findings have been reported by Jayanthi and Rau (2019) and Kochar (2011), who concluded that access to banking services enhances household financial management, savings behaviour, and resilience, particularly when accompanied by financial literacy and income-generating opportunities.

With regard to healthcare, most respondents relied on government hospitals and Primary Health Centres for treatment, reflecting confidence in the public healthcare system. Nevertheless, participation in health camps

remained relatively low (43%), indicating that preventive healthcare services are still underutilized. Similar findings were reported by Garg, Chowdhury, and Sheikh (2024), who found that limited awareness, accessibility barriers, and socio-economic constraints reduce participation in community-based preventive health programmes. Despite this low participation, the inferential analysis revealed the most important finding of the study. The Chi-square test demonstrated a statistically significant association between health camp attendance and health awareness ($\chi^2 = 31.977$, $p < .001$), with a strong effect size (Cramer's $V = .666$). This indicates that respondents who attended health camps possessed significantly higher levels of health awareness than those who did not. The finding supports previous research by Bhaumik et al. (2020), who reported that community-based health education programmes substantially improve health awareness and healthcare-seeking behaviour among rural populations. Similarly, Perry et al. (2017) emphasized that community health interventions play a critical role in improving health literacy and promoting preventive health practices in resource-constrained settings.

Educationally, the village demonstrates encouraging levels of school retention, as more than three-fourths of the respondents reported no school dropout. However, among households experiencing dropout, financial constraints emerged as the primary reason, reaffirming that poverty continues to be a major barrier to educational attainment. Similar findings have been documented by Patel et al. (2018), Marphatia et al. (2019), and Mishra (2024), who identified household poverty, low parental education, and economic insecurity as major determinants of school discontinuation in rural India. Additionally, nearly half of the respondents perceived educational facilities as inadequate, suggesting that improvements in infrastructure and accessibility remain essential. Garg et al. (2024) similarly emphasized the need to strengthen rural educational infrastructure to improve learning outcomes and human development.

The Chi-square analysis further indicated that the associations between family income and school dropout, family savings and school dropout, and occupation and family income were not statistically significant ($p > .05$). Although occupation and family income showed a small-to-moderate effect size, the relationship was not significant. These findings suggest that educational continuation and household economic conditions in Tosekgre are influenced by multiple contextual factors beyond income alone. Similar conclusions were drawn by Huisman and Smits (2009), who found that household characteristics, parental attitudes, and community-level factors often exert a stronger influence on educational participation than economic indicators alone.

Conclusion:-

Overall, the study indicated that Tosekgre village is undergoing gradual socio-economic development, reflected in improved banking access, dependence on public healthcare services, and relatively high educational retention. However, persistent challenges which include low household income, reliance on subsistence agriculture, inadequate housing quality, limited utilization of preventive healthcare services, and financial barriers to education continue to constrain sustainable development. The significant association between health camp participation and health awareness further demonstrates the effectiveness of community-based health interventions in promoting public health. Consistent with previous national and international studies, the findings suggest that sustainable rural development requires an integrated and multidimensional approach that simultaneously strengthens livelihoods, housing, preventive healthcare, financial inclusion, and educational opportunities, thereby improving the overall well-being of rural communities such as Tosekgre. Addressing these challenges requires integrated rural development strategies supported by coordinated efforts among the health, education, and other sectors. Such collaborative interventions can contribute to sustainable socio-economic development and improve the overall well-being and quality of life of the community.

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