Health and Educational Status of Scheduled Tribes in Anantapuramu District of Andhra Pradesh

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ABSTRACT

Despite number of initiatives for improving living conditions of the tribals, mostly they are dependent on agriculture either as cultivators or agriculture labourers. They are malnourished, poor, largely illiterate and rank miserably low in all sorts of health indicators despite of their wealth of traditional knowledge of keeping healthy. Their literacy levels are not adequate to compete with the general population and at the same time they declineto do any work in their native places. In this paper, an attempt is made tobring out general economic conditions, Education and health issues. Ecologically, the tribal households are far from homogenous; they display a diversity of high order. The areas of tribal concentration have been generally described as the forest and hilly areas of the country. Their ignorance and the long-sightedness of the money lenders play with the tribal lives. With less income they take less nutrient food and it leads to health problems among scheduled tribal. This paper addresses the health and educational status Ecoloscheduled tribes in the study area. Under this section we had dealt with literacy levels, dropouts, reasons for dropouts, distance of educational institutions and health characteristics like drinking water facilities, type of fuel used for cooking, gender and age wise classification of diseased persons, health assistance from government authorities, distance to the first aid facility, awareness about HIV/AIDS and Blood Donation so on. Before speaking about the development of Scheduled Tribes, it is important to study their background characteristics and profile. This Paper is addressed to study the educational and health status of the Scheduled Tribes in the study area.

Keywords

Health and Educational status of Scheduled tribes, Anantapuramu district

INTRODUCTION

Tribal economy is intimately connected with the forests. For centuries the tribal have lived in the fringes of forests and depended entirely on forests for their livelihood. Even today, forest products continue to him the main source of income and sustenance for many tribal communities. These communities live in abject poverty having very little access to capital assets, health and educational facilities and hardly any protection against vagaries of nature. Ecologically, the tribal households are far from homogenous; they display a diversity of high order. The areas of tribal concentration have been generally described as the forest and hilly areas of the country. Their ignorance and the long- sightedness of the money lenders play with the tribal lives. With less income they take less nutrient food and it leads to health problems among scheduled tribal. This paper addresses the health and educational status Ecoloscheduled tribes in the study area .Under this section we had dealt with literacy levels, dropouts, reasons for dropouts, distance of educational institutions and health characteristics like drinking water facilities, type of fuel used for cooking, gender and age wise classification of diseased persons, health assistance from government authorities, distance to the first -Aid facility, awareness about AIDS and so on.

The term 'tribe' originated around the time of Greek and the early formation of the Roman Empire. The Latin term, tribus has since been transformed to identify a group of persons forming a community and claiming descent from a common ancestor (Fried, 1975). The concept of a tribe differs from one scholar to another. Today the range of groups referred to as tribe is truly enormous. Tribes are the people with special attachments to land, kinship ties, unique culture, religious beliefs, material possessions that differentiate and separate them from the mainstream. The origin of India's indigenous people officially called Scheduled Tribe (ST) have been traced to races such as the Proto-Australoids who at one time practically covered the whole of India and the Mongolians who are located mostly in Assam and adjoining states in the north-east region. The Negrito strains are also available as indicated by frizzy hair, among the Andamanese and the Kadars of the south-west India (Memoria, 1957). The President of India by his special power declared some indigenous groups of our country as 'Scheduled Tribe' in 1950 under Article 342 of the constitution of India. Census records 705 Tribes as STs and among them 75 tribes are recorded as Primitive Tribal Groups (PTGs) (Census of India 2011), mainly based on the criteria of their low level of education, stagnant population growth and primitive economy. Today they are known as Particularly Vulnerable Tribal Group (PVTG) (Ministry of Tribal Affairs, Govt. of India). The tribal societies have remained isolated from the main stream of

Indian society. After 66 years of independence, STs are still at the lowest ebb of societal growth.

In every five year plan period the impetus on tribal development has been gaining momentum. Different tribal groups in India are at different levels of development. The level of development depends upon a large number of variables, the most important of them being the level of contact with the outside world and the extent of change that has occurred in pertinent cultural elements. The level of socioeconomic development of tribals in the western and central regions is very different from that in eastern and southern India. In general, living a poor quality of life, endogamy and other cultural practices make tribals vulnerable to various diseases particularly of communicable diseases and genetic disorders. Recently, it has been reported that they are also affected by non-communicable diseases like hypertension, cardiovascular disease, etc., which were not reported earlier.

The concept of health among them has remained elusive and ill-defined. The tribals are more biased towards body functioning and physical vigor on account of their isolation from the rest of society, their group consciousness and life style. Majority of the tribals believe that 'one who can do hard work and is free from the influences of sprits is not sick'. All these beliefs have kept the tribes away from optimal utilization of various health service launched by the government from time to time. The three rounds of National Family Health Survey (NFHS) also revealed the under utilization of health services among the tribe. For successful planning of tribals development, knowledge of their distribution pattern is essential in addition to their social, economic and demographic status. However, there is a paucity of information on tribal population dynamics within the context of regional milieu. In this document the data from population census has been used to study the distribution of tribal population in India. Such studies will help the academicians and the policy makers in formulating effective developmental programmes to improve the quality of life of tribes. In the present document an attempt has been made to map, illustrate the district wise distribution of the scheduled tribes in the states and union territories of India.

TRIBAL POPULATION IN INDIA

India is the second most populous and the seventh largest (area wise) country in the world. The total geographical area of India is 32, 87,263 sq km, of which 6, 92,027 sq km is covered by forests, which constitutes 21.1% of its total (Forest Survey of India, 2011). The overall population density of India is 382 per sq km (Census of India, 2011). Distribution of tribal population According to the 2011 Census there are 24, 94, 54,252 households, of which 2, 14, 67,179 households belong to ST population. Total population in the country is 1,21,05,69,573, out of these 10, 42, 81,034 are classified as ST with 5, 24, 09,823 males and 5, 18, 71,211 females. Age-sex distribution of tribal and nontribal population is presented in the population pyramids (Figure 1 & 2). The population pyramid reveals that the sex composition among ST is nearly equal, whereas in non-tribals, it is male preponderance especially in age-groups less than 25 years. However, age structure among tribals is in favour of younger population as compared to non-tribals. The decadal growth rate of the tribal population during 2001-2011 is 23.7% which is higher than India's total decadal growth (17.6%). The tribal population of India constitutes 8.6% of total population of the country and majority of them reside in the rural areas (90%). (Tribal Health Bulletin, Vol. 20 (Special Issue), January 2014).

Sex ratio among tribals in India is 990 females for 1000 males; it is higher than the national sex ratio of 943. Sex ratio among tribals are highest in Goa (1046) and lowest in Jammu and Kashmir (924). The child sex ratio among tribals in India is 957 females for 1000 males. It is highest in Chhattisgarh (993) and lowest in Lakshadweep (907).

Literacy rate among tribals (excluding children aged 0-6 years) are 59%; and it is 68.5% among males and 49.4% among females. Literacy rate in tribal is lower than the national average of about 74%. There is literacy gap of 19.1% between males and females and it is higher in rural area (19.9%) as compared to the urban areas (12.9%). Overall literacy rate among tribal is the highest in Lakshadweep (91.7%) and lowest is Andhra Pradesh (49.2%).

State wise dependency ratio and ageing index among tribals are overall dependency ratio in India is 73.7%, and is highest in the state of Jammu & Kashmir (93.1%) and lowest in Goa (48.1%). The young and old age dependency ratio is 61.7% and 12%, respectively. Similarly ageing index of India is 19.4%, and it varies from 11.3% in Meghalaya to 42.7% in Goa.

ANDHRA PRADESH

Andhra Pradesh is the fourth largest and fifth most populous state of India that lies between latitudes of 12° 40'N and 19° 50'N and longitudes of 76° 45'E and 84° 40'E. It is surrounded by Chhattisgarh in the North West and Maharashtra in the north direction, Tamil Nadu in the south, Karnataka in the west, Orissa in the north-east and coastal area of Bay of Bengal in the east. Total area of the state is 275,045 km of which 16.9% covered by different types of forest. Population density of Andhra Pradesh is

308 per km which is lower than national average of 382 km.

DISTRIBUTION OF TRIBAL POPULATION

According to census 2011, there are 2, 14, 67,179 tribal households in the state. Total tribal population in the state is 59, 18,073 with males being 29, 69,362 and females 29, 48,711. Age-sex distribution of total tribal and non-tribal population is presented in the population pyramids. The decadal growth rate of the tribal population during 2001-2011 is 17.8 % which is higher than state's decadal growth rate (11%). The tribal population of Andhra Pradesh forms 7% of state's total population and 5.7% of India's total tribal population.

ANANTAPURAMU DISTRICT

Distribution of Scheduled Tribe Population

S. No.	Name of district Total population	Total population	Tribal population							
			Tribal population	Share of state tribal population	Sex ratio	Children aged 0-6 yrs (%)	Sex ratio (0-6 years	Total Literacy rate	Male literacy rate	Female literacy rate
1	Anantapuramu	4081148	154127	2.60	962	12.45	886	54.98	65.44	44.24

Source: Census of India 2011, Registrar General of India. * Percentage of India's tribal population.

THE DATA AND METHODOLOGY

The primary data comprise of collecting information from the selected sample tribal households in the tribal areas of Anantapuramu district of Andhra Pradesh by way of canvassing a structured schedule among them. In addition, the secondary data are also taken from the Chief Planning Officer of Anantapuramu District. Multi-stage random sampling technique is employed to select the sample households. In the first stage, one district viz., Anantapuramu of Andhra Pradesh has been purposively selected for the study. Then, randomly one Mandal was selected from the district, viz., Mudigubba. In the third stage, one village from the mandal was selected i.e., Adavi Bramhanapalli Thanda (A.B.Palli Thanda) village. In the fourth stage a sample of 100 tribal households in the sample village were randomly selected and interviewed with a pre-prepared schedule. The schedule contains all range of aspects like socio-economic, demographic and health status.

HEALTH AND EDUCATIONAL FEATURES OF THE SAMPLE POPULATION

Under this section we had dealt with literacy levels, dropouts, reasons for dropouts, distance of educational institutions and health characteristics like drinking water facilities, type of fuel used for cooking, gender and age wise classification of diseased persons, health assistance from government authorities, distance to the first Aid facility, awareness about AIDS and so on. The literacy levels of the head of the households have been presented in It is very frightening thing that 81 per cent of the head of the households are illiterates.

Table 1: Educational Status of Head of the Households in the Sample Area

S. No	Education level	Number of persons	Per cent
1	Primary	05	05.00
2	Secondary	11	11.00
3	Higher	03	03.00
4	Illiteracy	81	81.00
Total		100	100.00

The literacy per cent of the head of the households is 19 per cent. Among the literates 11 per cent are studied up to secondary level, 5 per cent studied only primary level of education and only 3 per cent are acquired higher level of education.

Table 2: Educational Levels of the Sample Population

S.No	Education level	Male	Percent	Female	Percent	Total	Percent
1	Primary	29	70.73	12	29.27	41	09.30
2	Secondary	50	54.95	41	45.05	91	20.63
3	Higher	38	45.24	46	54.76	84	19.05
4	Illiteracy	101	44.89	124	55.11	225	51.02
	Total	218	49.43	223	50.57	441	100.00

The educational levels in the study area have been presented in Table-2. It is clear that the literates in the study area are very low, 19 per cent of the population is educated up to rimary level, 20.63 per cent up to secondary level and only 9.30 per cent are obtained up to higher level. About 55 per cent females and 45 per cent males studied at primary school level, 54.95 males and 45.05 females in secondary level and in higher the female per cent is very low with 29.27 per cent and males with 70.73per cent.

Table 3: Literacy Levels in the Study Area

S.No	Literacy level	Male	Percent	Female	Percent	Total	Percent
1	Literates	117	54.17	99	45.83	216	48.98
2	Illiterates	101	44.89	124	55.11	225	51.02
3	Total	218	49.48	223	50.52	441	100.00

The literacy levels in the study area have been presented in Table-3. It is very alarming situation in the study that the literacy levels are 48.98 per cent, among this 54.17 per cent male and 45.83per cent are female. The total illiterates are 51.02 per cent among them 44.89 are male and 55.11 per cent are females.

Table 4: Distribution of the Drop out Children (Below 14 Years Age) From Their Education in the Sample Area

S.No	Drop Outs	No. of Children	Percent
1	Boys	13	40.63
2	Girls	19	59.37
Total		32	100.00

Distribution of the drop out children below the age group of 14 years from their education in the sample area has been presented in. There 32 children who dropped from their education in the study are. Among them 19 girl children are dropped with 59.37 per cent and boys are 13 with 40.63 per cent.

Table 5: Distribution Drop out Children according To Their Reason for Not Going to School in the Sample Area

S.No	Reasons for Dropouts	No. of Children	Percent
1	Financial	23	71.88
2	Household Work	09	28.12
	Total	32	100.00

Table-5 explains the reasons for drop outs from their education in the study area. 23 children with 71.88 per cent are dropped from their education because of their financial problem while 09 children with 28.12 per cent are participating in their household work. So, finally it may conclude that poor economical status leads to more drop outs from schools.

Table 6: Distribution of Households according to their Available Facility for Drinking Water in the Sample Area

S.No	Water Facility	Number of Households	Percent
1	Protected	12	12.00
2	Unprotected	88	88.00
	Total	100	100.00

Distribution of households according to their available facility for drinking water in the sample area has been presented in Table-6. It is observed that 12 Households with 12 percent having the proper drinking water facility in the study area. 88 with 88 Percent households are taking un protected water for their drinking. This type of water facility will reflect the health status.

It is very clear from Table-7 that there is 71 percent household using firewood, 08 percent using Kerosene and 21 percent households are using Gas for their cooking in the study area. This situation is very severe to their health as well as the environment.

Table 7: Distribution of Households According To Their Source of Fuel for Cooking In the Sample Area

S.No	Type of Soil	Number of Households	Percent
1	Firewood	71	71.00
2	Kerosene	08	08.00
3	Gas	21	21.00
	Total	100	100.00

Table 8: Child (0-5 Years) Immunization Status in the Sample Area

S.No	Information about Immunization	Yes	Percent	No	Percent	Total	Percent
1	Availability of Immunization Card	21	100.00	00	00.00	21	100.00
2	Either fully Immunized	18	85.71	03	14.29	21	100.00
3	Total available children (0-5 Years)	21					

Immunization of the child in the age group of 0 to 5 years has been presented in Table-8. It is observed that there are 21 children in the above given age group. 100 per cent of the children having immunization card among them 85.71 per cent are fully immunized, where as 14.29 are not fully immunized. This may causes them to face some health problems like physically handicapped, mentally disordered and other diseases.

Table 9: Distribution of Reproductive Age (15-49 Years) Women in the Sample Area

S.No	Age	Age at Marriage	Percent	Age at Conception	Percent
1	<15	05	04.67	02	01.87
2	15-18	83	77.57	24	22.43
3	19 and above	19	17.76	81	75.70
Total		107	100.00	107	100.00

The table shows about the reproductive age women who are in the age group of 15-49 years, especially about their ages at the time of marriage and at the time their first conception in the study area. There are 107 reproductive women in the study area among them 88 are got married at the age of 15-18 years with 82.24 per cent and only 17.76 per cent are married after 19 years. That means still 82 per cent of the women in the study area are married below the age of 18 years.

Table 10: Gender Wise Distribution of Diseased Persons in the Sample Area

S.No	Gender	No.of Persons	Percent
1	Male	73	55.73
2	Female	58	44.27
Total		131	100.00

The table explains the Gender wise distribution of diseased persons in the sample area has been presented. Out of 462 total populations in the study area the percentage of diseased persons are 29 with 131 members, among them 56 per cent are male and 44 per cent are female diseased persons.

Table 11: Distribution of Sample Population According Affected Diseases

S.No	Type of Disease	No. of Persons	Percent
1	Fever	67	51.14
2	Malaria	48	36.64
3	Dengue & others	16	12.22
Total		131	100.00

Distribution of sample population according affected diseases in the study area has been presented. It is observed that 51.14 per cent of the diseased persons are effected from Fever while 36.64 per cent from Malaria and 12.22 per cent from Dengue.

The table expenses levels of the diseased persons in the study area have been presented. It is evident that nearly 49.62 per cent of the diseased persons are spending Rs. 1,001 to Rs. 3,000 for their treatment, 13.74 per cent are spending more than Rs. 3,000 and 36.64 per cent are spending below Rs. 1,000.

Table 12: Distribution of Diseased Persons According To Their Expenditure for Their Diseases

S.No	Level of Expenditure	No. of Persons	Percent
1	Below 1000	48	36.64
2	1001 to 2000	31	23.67
3	2001 to 3000	34	25.95
4	3001 and above	18	13.74
Total		131	100.00

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Table 13: Awareness about the AIDS in the Sample Population

S.No	Knowledge about AIDS	Yes	Percent	No	Percent	Total	Percent
1	Heard about AIDS	70	70.00	30	30.00	100	100.00
2	Causes	52	52.00	48	48.00	100	100.00
3	Symptoms	50	50.00	50	50.00	100	100.00

The table shows the awareness about AIDS in the sample population has been presented. It can see from the table 70 per cent are heard about the disease and 52 per cent are known the causes and symptoms of the AIDS. It may conclude that the government has to take more awareness programmes about the disease because nearly 50 per cent of the households do not know the causes and symptoms of the AIDS.

Table 14: Distance to the Medical Center (PHCs & CHCs) to the Sample Households

S.No	Distance in Km	No. of Persons	Percent
1	1-5 Km	81	72.00
2	5-10 Km	19	19.00
Total		100	100.00

Distance to the medical centers will have an effect on the health status of the households. About 19 per cent of the households they don't have any medical center blow the 5-10 Kms and 81 per cent nearer to medical centers (PHCs & CHCs) with distance of 1-5 Kms. It may negatively affect the health of the households in the study area.

SUMMARY

In this Paper we have mainly discussed about the socio-economic, educational and health characteristics like population, sex ratio, marital status, literacy levels, health conditions and availability of health and educational facilities and economic characteristics like availability of housing facility, land, different source of income, cost of cultivation and expenditure pattern.

Most of the households are male headed families with 89 per cent, which means the male domination is more in the study area. In all households' productive age group people are leading their families. Agriculture sector is their primary occupation. It is identified that more than 50 per cent of the households are having large size family. The sex ratio in the study area is pretty good; it is 1017 for total population, 1186 for below 15 years age group and 964 for the productive age group.

It is observed that there is no Pucca houses in the study area and 94 per cent of the households are having the Semi-Pucca houses. Still there is no electricity facility for 14 per cent of the households. The availability of household assets is very poor only 71 per cent having a clock / watch, 49 per cent having the radio, 51 per cent television sets. More number of the households in the study area is having the white and AAY ration cards with 72 per cent and 19 per cent respectively, still 9 per cent of the households don't have any ration card. Absence of pink ration cards shows that all the households of this village are living below the poverty line. The people's participation in public organization is very poor except in SHGs, ITDA and GCC with 95 per cent, 87 per cent and 92 per cent respectively and in remaining organizations like Educational committee, Panchayat, WUA, VSS and Health committee is almost negligible. The performance of government welfare programmes is not good in the study area except MGNREGS programme. All the sample households are expecting facilities like pucca housing, road and transportation, employment, schools and hospitals. Nearby 90 per cent of the households are expecting banking and marketing facilities from the government. About 50 per cent of the households are not getting even Rs. 50,000 as their income per annum. That indicates still there is no proper income source in the study area.

The occupation structure in the study area is very interesting 56 per cent of this sample population is

engaged in agricultural sector as labours; which means the dependence on primary sector is very predominant and almost all households are depending only on the agriculture sector. The student community is occupied next to the agriculture labour with 41 per cent. There are no government employees in the study area. The major source of income is from agriculture sector followed by minor forest products, mulch cattle and other labour works. Due to poor land holding size nearly 62 per cent of the people are getting only Rs. 10,001 to Rs. 30,000 from the agriculture. There is no land for 21 per cent of the sample population. The income from the minor forest products is also very low. Availability of live stock is one of the major income source, 33 per cent of households are not having any live stock. About 55 per cent of the households are getting incomes Rs. 10,001 to Rs. 30,000 and 12 per cent are getting 30,001 to Rs. 40.000 from mulch cattle.

The ownership right on the land is very less in the study area. Still 21 per cent of households are not having any land. Nearly 74 per cent of sample households are having the land 1-2 acres. The major crops which are cultivated by the sample population are paddy, Groundnut and others, with 60 per cent and 19 per cent respectively. Expenditure pattern in the study area shows that their backwardness. Still most of the households are spending more on food and very less only expending on education and other things like entertainment and health care. The indebtedness is more in the study area because their poor living conditions. Most of the people are depending on the money lenders for their credit sources, less on SHGs and banks.

Literacy levels in the study area are very unfavorable to the development. It is 81 per cent for heads of the households and 81 per cent of total population are illiterates. Still 55 per cent of the female population is illiterates. Droup outs are also high with 32 number of children among which 13 boys and 19 girls. The availability of infrastructure facilities is very poor in the study area. There is no proper drinking water facilities in the study area still they are drinking unprotected water. All the households are using firewood as a fuel for their cooking. The school and the health facilities are located at a far of place, more than 10 Kms. from their village.

The mean age at the marriage of women is model. Still 77.57 per cent of the women are getting marred below the 18 years age and only 17.76 per cent are getting married at 19 years and above. There are 21 children who are below the 5 years age group, among them 18 children are fully immunized. The disease prevalence is more in male with 54 per cent and female with 46 per cent. Productive age group people are affected more from diseases (with 80 per cent). Fever and malaria are the main diseases which are affecting the sample population. 86 per cent of the diseased persons are consulting the doctors and they are spending about below Rs.3, 000 on treatment. It is good for people's health point of view almost all people they are aware about AIDS, causes and symptoms of disease.

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