

Educational and Health Status of Scheduled Tribes of Solabham Village in G Madugula Mandal of Visakhapatnam District, Andhra Pradesh

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ABSTRACT: In this study, an attempt has been made to examine the educational and health status of 100 ST households from Visakhapatnam District. More than 80 per cent of the head of the households are illiterates; and more than 65 per cent of the students are dropped from their education because of their financial problem. Total households are taking unprotected drinking water and 100 per cent of the households are using firewood as a fuel for their cooking. It is very bad to their health and environment. More than 80 per cent of the diseased persons are in the productive age-group of 15-60 years and more than 52 per cent of the diseased persons are affected from fever. About 91 per cent are opinioned that they are getting sufficient medicine from the government health centres. The Integrated Tribal Development Agency and the Girijan Cooperative Corporation are the two main institutions slated for the development of scheduled tribes. So it is imperative to make the functioning of the ITDA / GCC more people oriented by adopting participatory approach.

INTRODUCTION

The Scheduled Tribes (STs) are the segregated and isolated communities and are concentrated in the states of Orissa, Bihar, Madhya Pradesh, Andhra Pradesh, Maharashtra, Gujarat and Rajasthan where they constitute about 80 percent of the Scheduled tribe population of India. Even today, widely pervasive reality in respect of tribal communities in India is that most of them are geographically isolated, economically weak, socially ignorant, politically indifferent, culturally rich, behaviourally simple, trustworthy and leading their life in the lap of nature. They are facing problems, which force them to lead a life at bare subsistence level. They are in the situation featured with poverty, deprivation, disadvantages

which are difficult to be tackled effectively on their own and making the government in particular and society in general to intervene in a planned manner to solve the miseries of tribes and facilitate development process. A large number of tribal communities continue to be extremely backward and some of them are still in the primitive food gathering stage, where as some others have progressed a little in terms of economic and educational advancement.

The greatest challenge that the Government of India has been facing since independence is the proper provision of social justice to the STs, by ameliorating their socio-economic conditions. STs, Scheduled Castes (SCs) and denotified tribes constitute the weakest section of India's population, from the ecological, economic and educational angles. They constitute the matrix of India's poverty. Though the

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tribals are the sons of the same soil and the citizens of the same country, they are born and grown as the children of the nature. From the historical point of view, they have been subjected to the worst type of social exploitation. They are practically deprived of many civic facilities and isolated from modern and civilized way of living since so many centuries.

On the literacy front, the situation is very discouraging. The literacy rates of tribal population in Visakhapatnam, Andhra Pradesh and at all India level are very less when compared to that of general population. But the encouraging point is the growth rates of literacy for STs are far better when compared to that of general population in the above said areas during the period of 1981-2011 census. As a result, the gap between the literacy rates of general population and that of the scheduled tribe population is reducing very slowly.

With regard to female literacy, the results are very disappointing. The female literacy rates for Visakhapatnam, Andhra Pradesh and India are very low when compared to that of the total female literacy rates. But quite interesting aspect is the growth in literacy rates for scheduled tribe population are more when compared to that of general female population. The literacy rates of tribes in Visakhapatnam is 34.34 among this male reported 45.98 per cent and female reported only 22.27 these are very low when compare with state averages 37.04, 47.66, 26.11 per cents for total, male and female literacy rates.

The National Health Policy categorically emphasizes the urgent need for improving the tribal health especially through detection and treatment of endemic and other diseases specific to tribals. In pursuance of this policy commitment, the Ministry of Health and Family Welfare continued to give focused attention to improve the health conditions of STs by implementing various health care programmes besides relaxing norms with a major objective to attend to the health needs of STs. A separate Tribal Development Planning Cell has been functioning under the Ministry since 1981 to co-ordinate the policy, planning, monitoring and evaluation of the health care schemes for the welfare and development of STs.

In India there are 573 scheduled tribe communities and in Andhra Pradesh about 33 of them

dwell. In India, the President is empowered by the Constitution to declare a community as a scheduled tribe community.

The growth rates of STs in Andhra Pradesh are 5.47, 2.24, 6.50, 2.79, 1.81 and 1.78 for the years 1951, 1961, 1971, 1981, 1991, 2001 and 2011 census years respectively. Except 1971 and 1991, the decadal growth rate of tribal population was more than the growth rate of general population. From 1951 to 2011 the STs has increased by seven times but for the general population it is only 2 times.

The percentages of STs population to the total population in Andhra Pradesh are 3.68, 3.81, 5.92, 6.31, 6.59 and 7.00 for the years 1961, 1971, 1981, 1991, 2001 and 2011 Census years respectively. There is an increased trend in the percentage of scheduled tribe population to the total population of Andhra Pradesh.

MATERIALS AND METHODS

The primary data comprise of collecting information from the selected sample tribal households by way of canvassing a structured schedule among them. In addition, the secondary data are also taken from the Chief Planning Officer of Visakhapatnam District. The primary data has been collected during the months of June and July of 2011. A multi-stage random sampling technique is employed to select the sample households. In the first stage, one district viz., Visakhapatnam of Andhra Pradesh has been purposively selected for the study. Then, randomly one mandal was selected from the district, viz., G Madugula. In the third stage, one village from the mandal was selected i.e., Solabham 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 of socio-economic status.

This paper is addressed to study the 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 in the study area.

The literacy levels of the head of the households have been presented in Table 1. It is very frightening thing that 81 per cent of the head of the households are illiterates. 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 1
Educational status of head of the households in Solabham village

	Education level	N	%
single column	Primary	05	05.00
Delete this	Secondary	11	11.00
column	Higher	03	03.00
delete cells	Illiterate	81	81.00
	Total	100	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 primary 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 70.73 per cent.

TABLE 2
Educational levels of the sample population of Solabham village

Education level	Male	%	Female	%	Total	%
Primary	38	45.24	46	54.76	84	19.05
Secondary	50	54.95	41	45.05	91	20.63
Higher	29	70.73	12	29.27	41	09.30
Illiterates	101	44.89	124	55.11	225	51.02
Total	218	49.43	223	50.57	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 45.83 per 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 3

Literacy levels in sample population of Solabham village

Literacy level	Male	%	Female	%	Total	%
Literates	117	54.17	99	45.83	216	48.98
Illiterates	101	44.89	124	55.11	225	51.02
Total	218	49.43	223	50.57	441	100.00

Distribution of the drop out children below the age-group of 14 years from their education in school in the sample area has been presented in Table 4. There 32 children who dropped from their education in the study are. Among them 18 girl children are dropped with 56.25 per cent and boys are 14 with 43.75 per cent.

TABLE 4

Distribution of the drop-out children (below 14 year age) in school in Solabham village

Drop-outs	N	%
Boys	14	43.75
Girls	18	56.25
Total	32	100.00

Table 5 explains the reasons for drop-outs from their education in the study area. 21 children with 65.63 per cent are dropped from their education because of their financial problem, while 11 children with 34.37 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 5

Distribution drop-out children according to their reason for not going to school

Reasons for drop-outs	N	%
Financial	21	65.63
Household work	11	34.37
Total	32	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 no one having the proper drinking water facility in the study area. Total households in the village are taking unsafe drinking water. This type of water availability in the village reflects the health status.

TABLE 6
Distribution of households according to water availability for drinking in the village

Drinking water availability	Households	%
Safe	—	—
Unsafe	100	100.00
Total	100	100.00

It is evident from Table 7 that there is no single household using fuel other than firewood in the study area. That means 100 per cent households are using firewood as a fuel for their cooking. This situation impacts on their health as well as on the environment.

TABLE 7
Distribution of households according to their source of fuel for cooking in the village

Type of fuel	Households	%
Firewood	100	100.00
Kerosene	—	—
Gas	—	—
Total	100	100.00

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. Of the total children having immunization card only 85.71 per cent are fully immunized, whereas 14.29 per cent are not fully immunized. This may cause some health problems to those who are not fully immunized.

TABLE 8
Immunization status of children (0-5 years) in Solabham village

Information about immunization	Yes	%	No	%	Total	%
Availability of immunization card	21	100.00	—	—	21	100.00
Fully immunized	18	85.71	03	14.29	21	100.00
Total available children (0-5 years)					21	

Table 9 explains about the reproductive age of women who are in the age-group of 15-49 years, especially about their ages at the time of marriage and at the time of their first conception in the study area. There are 106 reproductive women in the study

area among them 87 got married at the age of 15-18 years, that is 82 per cent, and only 18 per cent got married after 19 years. That means a very high percentage of women, 82 per cent, got married below the age of completed 18 years.

TABLE 9
Distribution of reproductive age (15-49 years) of women in the village Solabham

Age (in years)	Age at marriage	%
Less than 15	04	03.77
Between 15-18	83	78.30
19 years and above	19	17.93
Total	106	100.00

Sex-wise distribution of diseased persons in the sample area has been presented in Table 10. In the study sample 54 per cent males and 46 per cent females are found to be suffering from one or the other diseases. .

TABLE 10
Sex-wise distribution of diseased persons in the sample area

Sex	N	%
Male	71	54.19
Female	60	45.81
Total	131	100.00

It is evident from the Table 11, that 81 per cent of the diseased persons are in the productive age-group and the remaining 19 per cent are in the unproductive age-group. The disease prevalence rate in the age-group of above 60 years is very less. It is not because of their good health but it is because of the size of the sample in the total population.

TABLE 11
Age-group-wise distribution of diseased persons in the sample area

Age (in years)	Persons	%
Up to 14	22	16.79
15-60	106	80.91
60 and above	03	02.40
Total	131	100.00

Distribution of sample population according to the ailment and infection in the study area has been presented in Table 12. It is observed that 52.67 per

cent of the afflicted persons are suffering from fever while 36.64 per cent are from malaria and 10.69 per cent are from dengue.

TABLE 12

Distribution of sample population according the illness and infection in the village

Type of illness	Persons	%
Fever	69	52.67
Malaria	48	36.64
Dengue	14	10.69
Total	131	100.00

Distribution of afflicted persons whether they have consulted the doctor has been presented in Table 13. It is evident that 69.47 per cent of the persons suffering from illness have consulted the doctor, while 30.53 per cent have not yet consulted the doctor for their treatment in the study area.

TABLE 13

Distribution of afflicted persons whether consulted the doctor or not for their treatment

Opinion of persons with illness	Persons	%
Yes	91	69.47
No	40	30.53
Total	131	100.00

The expenses levels of the diseased persons in the study area have been presented in Table 14. It is evident that nearly 50 per cent of the diseased persons are spending Rs. 1,001 to Rs. 3,000 for their treatment since they have been afflicted, 14 per cent are spending more than Rs. 3,000, and 35.88 per cent are spending below Rs. 1,000 for the treatment.

TABLE 14

Distribution of afflicted persons according to their expenditure for their treatment

Level of expenditure for treatment	Persons	%
Below Rs. 1,000	47	35.88
Between Rs. 1,001-2,000	32	24.43
Between Rs. 2,001-3,000	34	25.95
Rs. 3,001 and above	18	13.74
Total	131	100.00

Table 15 explains the opinion of the sample households regarding the government medical

services. It is observed that 74 per cent of the households expressed their opinion that they have the medical officer's visit in the study area. 87 per cent are of the opinion that they are getting adequate services from the government health centers. Regarding the medicine availability 91 per cent have opined that they are getting sufficient medicine from the government health centers. That means the performance of government health centers in the study area is fairly good.

TABLE 15

Opinion of the sample households regarding the government medical services

Name of the services	Yes	%	No	%	Total	%
Visit of the medical officer	74	74.00	26	26.00	100	100.00
Sufficient Services provided	87	87.00	13	13.00	100	100.00
Sufficient Medicine provided	91	91.00	09	09.00	100	100.00
Unnecessary tests	21	21.00	79	79.00	100	100.00

The awareness about AIDS in the sample population has been presented in Table 16. It is evident from the table that 68 per cent are aware about the disease and 52 per cent know about the causes and symptoms of the AIDS. It may conclude that the government has to take more awareness programmes about the AIDS because nearly 50 per cent of the households do not know about the causes and symptoms of AIDS.

TABLE 16

Awareness about the AIDS in the sample population of the village

Knowledge about AIDS	Yes	%	No	%	Total	%
Have heard about AIDS	68	68.00	32	32.00	100	100.00
Causes of AIDS	52	52.00	48	48.00	100	100.00
Symptoms of AIDS	52	52.00	48	48.00	100	100.00

Distance from the households from the medical centers will have an effect on the health status of the

households. It is observed that from Table 17 that about 19 per cent of the households don't have any medical center less than 16 km away, and for 81 per cent households the medical center is 10 km away from their houses. Thus it may be assumed that the place and distance of the medical centre may negatively affect the health status of the households in the study village.

TABLE 17

Distance of the medical center from the sample households

Distance (km)	Households	%
10	81	81.00
16	19	19.00
Total	100	100.00

CONCLUSIONS

In the present study only the educational and health characteristics like literacy levels, health conditions and availability of health and educational facilities have been discussed and the situation prevailing in the village Solabham of G. Madugula Mandal of Andhra Pradesh.

Literacy levels in the study area are very unfavourable for the development of the village. The availability of infrastructure facilities is very poor in the study village. There is no safe drinking water facilities in the village Solabham. All the households are using firewood as a fuel for their cooking. The school and the health facilities are located at a far off place, thus causing hardship to the villagers, particularly patients and the school children.

Policy Implications

After studying the educational and health status of scheduled tribes in Solabham village the author likes to propose some suggestions for the development of the village and its tribal people in particular, and other villages of Andhra Pradesh in general.

1. This study brought out that STs are the most backward in the human development indicators. So human development projects for STs are recommended particularly health, education, drinking water and hygienic living conditions.
2. As education promotes the human development, especially women education, so

education of the girl child should be taken up seriously. Proper educational facilities for the village children need to be provided for the development of STs, this can be done only if the school is close to the village.

3. Tribal people are at risk with regard to their health as the disease prevalence rates are high in this region. So suitable situational measures have to be adopted to treat the scheduled tribe people, like providing mobile health units, training few couples in each village who can provide first aid treatment for minor injuries suffered from accidents particularly to the children of the village. Train people and health workers who can motivate villagers to use modern medicine and urge them to make approach for doctor, for this rural hospital centres has to be within fairly reachable distance from the villages.
4. The expenditure on food is more in the study area, and very negligible on other things like education and health. Though the respondents are spending more on food their intake levels are not up to the stipulated levels. So, it is suggested that government has to provide more income generating programmes so as to enable the villagers to have more purchasing power for nutritive foods.
5. Good governance is the key factor in delivering goods and services to the needy rural people. The delivery system must have to be made perfect so that the essential items reach the villagers in time of need. The beneficiary must receive hundred per cent of the benefits targeted for them.

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