Research Article

Socio-Demographic and Health Profile of Scheduled Tribes of Six Integrated Tribal Development Agency Spots in Kurnool District

Dr S Shaista Tabassum[1], Dr Jawadul Haq[2], Dr M Ramesh[3], Dr M Shamshad*[4]

[2,3]Research officer, [1,4]Research Associate, Clinical Research Unit, Kurnool, Andhra Pradesh, India. Under CCRUM (Central Council for Research in Unani Medicine), Ministry of AYUSH, Govt. of India.

Corresponding Author*: Dr M Shamshad, Research Associate, Clinical Research Unit, Kurnool, Andhra Pradesh, India. Under CCRUM (Central Council for Research in Unani Medicine), Ministry of AYUSH, Govt of India.

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Abstract

Introduction: A tribe is a self-contained, homogeneous group that exists independently of any hierarchical system. According to the 2011 census, 10.42 crore Indians are identified as 'Scheduled Tribes', comprising 8.6% of the country's total population and 11.3% of the rural population. Tribal habitations are scattered across vast areas with limited access to basic health necessities, rendering them vulnerable to various health hazards. This article focuses on demographic profiles such as age, gender, caste, religion, marital status, educational status, occupation, dietary habits, and addiction, enabling an assessment of the socio-economic and health status of tribal groups in the specified area. Objectives: The main objectives of the study were to conduct a socio-demographic survey, promote knowledge on disease prevention, and provide healthcare and free medication facilities through Unani medicine via mobile medical camps. Methodology: The study was conducted in six Integrated Tribal Development Agency (ITDA) spots inhabited by the Sugali or Lambada tribe of Kurnool District, Andhra Pradesh, characterized by low socio-economic status. Data was collected through door-to-door surveys and a pre-designed questionnaire provided by CCRUM. Results: A total of 3755 individuals were screened, of which 450 were selected for data collection. Among the 450 individuals, the majority were males (253 i.e., 56.22%) belonging to the Hindu religion, with 98.44% being Scheduled Tribes. Educational status was average, with 63.33% being illiterate. More than half of the individuals (51.55%) were married, and the majority (52.66%) were agricultural laborers, with almost all being non-vegetarians. Additionally, 26% of individuals were addicted to smoking. Conclusion: Common challenges faced by the Sugali tribes of Kurnool district include lack of resources, industrialization, and socio-economic factors such as illiteracy. These factors contribute to poverty, malnutrition, and various physical and psychological disorders among tribal communities.

Keywords: Tribals, Unani Medicine, Sugali, Mobile Medical Camps, Scheduled Tribes, Poverty, CCRUM.

1. Introduction

Scheduled Tribes represent distinctive indigenous population groups constitutionally recognized under Article 342, Order 1950. This list encompasses 744 tribes across 22 states. In Andhra Pradesh, 33 categories of Scheduled Tribes reside across 8 districts[1,2,3], constituting 6.6% of the state's population. The Scheduled areas, their primary

habitats, occupy 11% of the state's total landmass. However, the literacy rate among Andhra Pradesh's tribal communities stands at a mere 37.04%[2,4].

Our study focused on six ITDA spots within Kurnool district, namely Gummitham Thanda, Gudembai thanda, Goriman KondaThanda, Bugganipalle Thanda, Panyan Chenchu colony, and Gooty Erragudi. Predominantly inhabited by the Sugali Tribe, also known as Lambada or Banjara, these areas showcase diverse socio-economic challenges among tribal populations since India's independence[5]. In the Kurnool district, where tribal education initiatives date back to the British colonial era, there are notable instances of families from these communities' securing positions in government services. However, the overall educational backwardness among the tribal populations of Andhra Pradesh can be largely attributed to challenging economic circumstances.

The Banjara language, known as 'Gormati', reflects the cultural richness of this community. Historically, Banjaras would establish settlements, known as 'Thandas', where they would congregate with their trade goods and livestock. The leader of these settlements, referred to as the 'Naik', played a pivotal role in community affairs. The Banjara people earned their name from their tradition of roaming trade[5,6].

The Sugali tribe, a nomadic group found across India, primarily inhabits plains and boasts a distinct culture with shared characteristics[7]. Their livelihood pursuits predominantly involve agriculture, supplemented by daily wage labor, small-scale businesses, and engagement in construction or repair work both within and beyond their villages[8].

Objectives

The primary objectives of the present study are to conduct a comprehensive house-to-house survey to gather demographic details and to facilitate care facilities through Mobile Medical Camps in the 6 ITDA spots under TSP in Kurnool district of Andhra Pradesh, namely Gummitham thanda, Gudembai Thanda, Goriman Konda Thanda, Bugganipalle Thanda, Panyam Chenchu Colony, and Gooty Erragudi. Additionally, the study aims to raise awareness about preventing various communicable diseases and to provide Unani treatment to individuals suffering from different health issues.

Methodology

The data of 450 individuals were collected through household surveys and Mobile Medical Camps in the 6 ITDA spots under TSP in Kurnool district of Andhra Pradesh. These activities were conducted from June 2022 to April 2023 by the Clinical Research Unit in Kurnool, Andhra Pradesh. Houses were randomly selected across all 6 ITDA spots for the survey. A total of 3755 patients were screened, from which 450 individuals were selected, and their data was collected using a pre-designed questionnaire provided by CCRUM. This questionnaire included information regarding socio-economic, demographic, and health profile particulars such as age, sex, caste, religion, marital status, educational status, occupation, dietary habits, addiction, income status, sanitation, and access to health facilities. Mobile medical camps were conducted thrice a week as part of the study.

Table 1: Age and Gender-wise Distribution of the Population

Age (inyrs)	Gender		Total	Percentage
	Male	Female		
20-30	43	41	84	**18.66%**
31-40	57	85	142	**31.55%**
41-50	38	59	97	**21.55%**
51-60	44	55	99	**22%**
61-70	15	13	28	**6.22%**
71&above	0	0	0	**00%**
Total	**197**	**253**	**450**	**100%**

The above table reveals that out of the total population surveyed, i.e., 450, there were 197 males and 253 females. Among the total 450 population, 84 individuals, i.e., 18.66%, were in the age group of 20-30 years, with 43 males and 41 females. Additionally, 142 individuals, i.e., 31.55%, were in the age group of 31-40 years, comprising 57 males and 85 females. Furthermore, 97 individuals, i.e., 21.55%, fell in the age group of 41-50 years, with 38 males and 59 females. Moreover, 99 individuals, i.e., 22%, were in the age group of 51-60 years, including 44 males and 55 females. Lastly, 28 individuals, i.e., 6.22%, were in the age group of 61-70 years, with 15 males and 13 females.

Table No. 2 illustrates that out of 450 individuals surveyed, the majority, totaling 443, were from the Scheduled Tribe (ST) category, constituting 98.44% of the population, with 193 males and 250 females. Additionally, 7 individuals, representing 1.55% of the population, belonged to the Other Backward Caste (OBC) category, comprising 4 males and 3 females. Notably, none of the individuals surveyed belonged to the Scheduled Caste (SC) or other categories.

The table above demonstrates the distribution of individuals according to religion. Out of the total 450 individuals surveyed, 448, accounting for 99.55%, belonged to the Hindu community, while 2 individuals, representing 0.44%, identified as belonging to the Muslim community.

Table 2: Caste-wise Distribution of the population

S. No.	Name of the Caste	Male	Female	Percentage
1	Scheduled Caste (SC)	0	0	**00%**
2	Scheduled Tribe (ST)	193	250	**98.44%**
3	Other Backward Castes (OBC)	4	3	**1.55%**
4	Others	0	0	**00%**
Total		**197**	**253**	**100%**

Table 3: Distribution of Population According to Religion

S. No.	Religion	No of Patients	Percentage
1	Hinduism	448	**99.55%**
2	Islam	2	**0.44%**
3	Sikhism	0	**00%**
4	Christianity	0	**00%**
5	Others	0	**00%**
Total		**450**	**100%**

Table 4: Distribution of population According to the Marital Status

Age Group	Unmarried		Married		Widow		Divorced		Total
	Male	Female	Male	Female	Male	Female	Male	Female	
20-30	4	0	0	0	0	0	1	1	**6**
31-40	0	0	57	93	2	10	5	0	**167**
41-50	0	0	47	67	0	9	0	0	**123**
51-60	0	0	32	47	0	0	2	0	**81**
61-70	0	0	17	20	7	1	1	0	**46**
71& above	0	0	22	05	0	0	0	0	**27**
Total	**4**	**0**	**175**	**232**	**9**	**20**	**9**	**1**	**450**

Table No. 4 shows that out of the total 450 individuals surveyed, the majority, comprising 407 individuals (90.44%), were married. Among them, 175 were males and 232 were females. Additionally, only 4 individuals (0.88%) were unmarried, and all of them were males in the age group of 20-30 years.

Table No. 5 exhibits the educational distribution of the surveyed individuals. Among the total 450 individuals, the majority, 285 (63.33%), were illiterate, with the highest concentration found in the age group of 20-30 years. Additionally, 113 individuals (25.11%) were semi-literate, with the majority also falling into the 20-30 years age group. Moreover, 13 individuals (2.88%) had completed primary school education. Furthermore, 28 individuals (6.22%) had completed high school

education. Interestingly, 10 individuals (2.22%) had attained education up to the intermediate level, and all 10 members were in the age group of 41-50 years. The percentage of the population who achieved graduation or higher education was minimal, with only 1 individual in the age group of 31-40 years.

According to the above table, it is observed that 6.88% of individuals were not working, 1.11% were landholders, 52.66% were agricultural laborers, 16.44% were unskilled laborers, 9.33% were skilled laborers, 1.11% were engaged in business, 0.88% were students, and 11.55% were housewives. The majority of the population belonged to the category of agricultural laborers, indicating a predominance of individuals with low socio-economic status.

Table 5: Distribution of Population According to the Educational Status

Age Group	Illiterate	Semi Literate	Primary School	High School	Intermediate	Graduation or above	Total
20-30	113	53	0	09	0	0	**175**
31-40	75	22	0	15	0	1	**113**
41-50	55	14	5	03	10	0	**87**
51-60	33	17	1	01	0	0	**52**
61-70	09	07	7	0	0	0	**23**
71& above	0	0	0	0	0	0	**0**
Total	**285**	**113**	**13**	**28**	**10**	**1**	**450**

Table 6: Distribution of Population According to the Occupation

S. No.	Occupation	NumberofPatients	Percentage
1	None	31	**6.88%**
2	Landholders	5	**1.11%**
3	Agricultural labourers	237	**52.66%**
4	Unskilled labourers	74	**16.44%**
5	Skilled labourers	42	**9.33%**
6	Business	5	**1.11%**
7	Students	4	**0.88%**
8	Housewife	52	**11.55%**
9	Unemployed	0	**00%**
10	Retired	0	**00%**
11	Others	0	**00%**
Total		**450**	**100%**

Table 7: Distribution of Population According to Dietary Habits

S. No.	Type of Diet	Number of Patients	Percentage
1	Vegetarian	0	00%
2	Non-Vegetarian/Mixed	450	100%
3	Vegetarian+Egg	0	00%
Total		450	100%

Table 8: Distribution of Population According to the Addiction Habits

S. No.	Addiction Type	No of Patients	Percentage
1	None	74	16.44%
2	Tobacco	30	6.66%
3	Snuff	24	5.33%
4	Smoking	117	26%
5	Bhang	90	20%
6	Alcohol	115	25.55%
7	Others	0	00%
Total		450	100%

Table 9: Sources Available for Screened Individuals at Six ITDA Spots

Facilities	No of Patients	Percentage
Drinking water Facility		
Piped water	446	99.11%
Ground water	4	8.89%
Total	450	100.%
Storage of Water		
Present	450	100.%
Absent	0	00%
Total 450		100%
Types of Houses		
Pucca house	286	63.55%
Kaccha house	164	36.44%
Total	450	100%
Source of Energy		
Electricity	450	100%
Kerosene	0	00%
Total	450	100%
Toilets Facility		
Pit toilet	314	69.77%
Open field	136	30.22%
Total	450	100%

It is evident from Table No 8 that almost all the individuals were non-vegetarians.

Table No. 8 presents data on addiction habits among the surveyed population. The findings indicate that the maximum number of individuals, totaling 117 (26%), were addicted to smoking, while 30 individuals (6.66%) were addicted to tobacco.

Additionally, 24 individuals (5.33%) were addicted to snuff, and 90 individuals (20%) were addicted to Bhang. Furthermore, 115 individuals (25.55%) were addicted to alcohol. Notably, 74 individuals (16.44%) did not report any history of addiction or drug abuse.

Table No. 9 indicates that the majority of people, comprising 99.11%, had access to drinking water from piped water sources, and all individuals had facilities for the storage of water. Regarding housing, 63.55% of the houses were categorized as Pucca (permanent) houses, while 36.44% had Kaccha (temporary) structures. In terms of sanitation, 69.77% of people had pit toilets, while 30.22% lacked toilet facilities. Additionally, almost all houses had access to electricity as a source of lighting.

Discussion

In recent times, studies on the tribal population in India have attracted scholarly attention from academic circles (New Ref)[10,11]. Scheduled Tribes represent distinctive indigenous population groups constitutionally recognized under Article 342, Order 1950. This list encompasses 744 tribes across 22 states[1,2,3]. Broadly the STs inhabit two distinct geographical area – the Central India and the North- Eastern Area. More than half of the Scheduled Tribe population is concentrated in Central India, i.e., Madhya Pradesh (14.69%), Chhattisgarh (7.5%), Jharkhand (8.29%), Andhra Pradesh (5.7%), Maharashtra (10.08%), Orissa (9.2%), Gujarat (8.55%) and Rajasthan (8.86%). The other distinct area is the North East (Assam, Nagaland, Mizoram, Manipur, Meghalaya, Tripura, Sikkim and Arunachal Pradesh)[12]. However, most of the studies focus on the historical, sociological and anthropological perspectives, paying little heed to the political dynamics of the tribal communities[13].

The findings of the present study underscore several key aspects of the socio-demographic and health profile of the surveyed population. Firstly, it is evident that the majority, 99.55%, adhere to the Hindu religion, while an overwhelming 98.44% belong to Scheduled Tribes (STs). This highlights the cultural and ethnic homogeneity within the community.

Moreover, a significant proportion of the population, constituting 63.33%, were found to be illiterate, indicating challenges in accessing formal education and potential barriers to socio-economic advancement. This aligns with the observation that the majority of individuals belong to low socio-economic status.

Interestingly, the gender distribution reveals a noteworthy trend, with 56.22% of the surveyed population being females, outnumbering males (43.77%). This suggests a potential gender imbalance within the community, warranting further exploration.

Regarding infrastructure and amenities, it is encouraging to note that the vast majority of individuals have access to basic necessities such as drinking water, with 99.11% accessing piped water and all individuals having facilities for water storage. However, the prevalence of Kaccha houses (36.44%) and the absence of toilet facilities for a significant portion of the population (30.22%) underscore challenges in sanitation and living conditions that need to be addressed.

Nevertheless, access to electricity is widespread, with almost all households having lighting facilities. This indicates progress in infrastructure development and access to modern amenities.

In conclusion, while certain areas such as access to basic amenities and infrastructure have seen improvement, challenges remain in education, gender equity, and sanitation. Addressing these challenges will be crucial for improving the overall well-being and socio-economic status of the community.

Conclusion

The findings of this study suggest that the majority of the surveyed Scheduled Tribes (STs) come from low economic backgrounds and exhibit an average level of literacy. Additionally, it was observed that individuals within this demographic tend to have mixed dietary habits. Furthermore, a significant portion of the ST population relies on agriculture

as their primary source of income. Moreover, there appears to be a prevalent trend of addiction among STs, with a notable proportion engaging in smoking, alcohol consumption, and the use of bhang. These conclusions shed light on the socio-economic and behavioral characteristics of the ST community, emphasizing areas that may require targeted interventions or support.

In addition to the conclusions already drawn, several other insights can be inferred.

A. Socioeconomic Vulnerability: The predominance of low economic status within the ST community suggests a vulnerability to economic hardships and limited access to resources and opportunities.

B. Education Challenges: While the literacy rate was reported as average, it indicates that there may still be significant gaps in educational attainment within the ST population, which could impact their ability to access higher-paying jobs or engage effectively in decision-making processes.

C. Health Risks: The prevalence of smoking, alcohol consumption, and bhang use among a sizable portion of the STs raises concerns about potential health risks and the need for targeted health interventions and awareness campaigns to address substance abuse issues.

D. Dependency on Agriculture: The reliance on agriculture for livelihood underscores the importance of agricultural support programs, infrastructural development, and sustainable farming practices tailored to the specific needs and challenges faced by ST communities.

E. Cultural Factors: The observation of mixed dietary habits and the use of substances like bhang may also reflect cultural practices within the ST community, highlighting the importance of cultural sensitivity in designing interventions and policies aimed at improving their well-being.

F Interconnected Challenges: The combination of economic, educational, health, and cultural factors indicates the complex and interconnected nature of the challenges faced by ST communities, emphasizing

the need for holistic approaches that address multiple dimensions of well-being simultaneously.

Overall, these conclusions provide a deeper understanding of the multifaceted realities and needs of the ST population, informing more targeted and effective interventions and policies to support their development and well-being.

Acknowledgement

Conflict of Interest: None

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