INTERNATIONAL JOURNAL OF POLITICAL SCIENCE AND GOVERNANCE

Satya Rao Korada
Security Assistant, Central Tribal University of Andhra Pradesh, Vizianagaram, India

Dr. Appalaraju Korada
Associate Professor, Tashkent State University of Economics, Uzbekistan

A study of tribal awareness in governmental health and education welfare policies

Satya Rao Korada and Appalaraju Korada

Abstract
This paper looks at the level of awareness of tribal communities to Government Policies on Health and Education Welfare in Saluru and Makkuva Mandal of Parvathipuram Manyam District in Andhra Pradesh. The data were collected using structured questionnaires which included demographic characteristics, awareness scales and source of information using a descriptive research design and a sample size of 100 tribal respondents. The results obtained indicate that tribal respondents are moderately-highly aware about the health welfare scheme and about the education welfare scheme since the mean scores of 3.45 and 3.55 respectively are well above the moderate level (u = 3). Interpersonal networks and health workers (ASHA/ANM) were identified as the main sources of the information, and low literacy, low income, and geographical barriers remain the factors which influence the use of schemes regularly. The findings indicate the necessity of better outreach initiatives, better access to welfare services, and better community-oriented activities in the implementation and consumption of government welfare policies in tribal areas.

Keywords: Tribal awareness, health welfare policies, and education welfare schemes, government programmes

Introduction

Indigenous growth of the tribal communities in India has always been entwined with their access to the basic welfare services especially in health and education. In spite of the many policy initiatives on the part of the Government of India, there are still inequalities in awareness, access, and use in tribal regions. Literature including Chandra Guru *et al*. (2020) [4] indicate that tribal development is still imbalanced because of marginalization in the past, low institutional coverage, and social-cultural exclusion. The problem is especially acute in the prism of welfare policies aimed at promoting tribal peoples. In their research on spatial patterns of education and development in West Bengal Adhikari and Kamle (2021) [1] underline that the outcomes of developmental interventions, in particular the educational one do not differ because of the absence of policies but because of the poor dissemination, awareness differences, and problems with the implementation of the policies at the grassroots level. This goes to show that there is a necessity of conducting systematic research on tribal consciousness levels about available health and educational welfare schemes.

Learning between tribal and marginalized groups remains a multi-layered issue that has been caused by socio-economic factors, gender gaps, and cultural attitudes. According to Bhagavatheeswaran *et al*. (2021) [2], early marriage, demands within households, and lack of mobility are among the factors that negatively influence educational attendance among the adolescent girls of the Scheduled Caste and Scheduled Tribe groups in Northern Karnataka. In the same tone Calder and Huda (2021) [3] say that even though there were global and national policy improvements, adolescent girls, especially in marginalized groups, still face structural inequity, which prevents access to quality education. The visions supported by Yadav (2020) [12] confirm that education is a highly important factor in social development, but its efficiency is highly dependent on the knowledge and interest of the community in the available resources. All these studies are pointing in the same direction that there is a lack of awareness of the benefits of the educational welfare policies among tribal households, thus, diluting the effects of policies.

Tribal communities are still disproportionately disadvantaged in the sphere of health because

Corresponding Author:
Satya Rao Korada
Security Assistant, Central Tribal University of Andhra Pradesh, Vizianagaram, India

of the lack of awareness and access to health facilities. According to Basu (2000) [10] and Balgir (2004) [9], tribal issues on health are founded on genetic, cultural, and environmental aspects, which are aggravated by low integration with mainstream health systems. NFHS-3 evidence (Arnold *et al*., 2006) [6] and some later studies, including De (2017) [7] and Mahanta and Senger (2019) [8], indicate that tribal people have a low level of health awareness, unhealthy health-seeking behavior, and intensive information on government health schemes. Another example is provided by Daripa (2020) [5], who suggests that despite the government efforts to enhance the educational achievements and health results among the tribes, the policy implementation frequently may fail to reach the target population because of awareness barriers, lack of infrastructure, and cultural disconnection. In this regard, it will be important to investigate the levels of tribal awareness in regards to policies of the government on health and education welfare in order to comprehend the difference between the policy development and its ultimate implementation so as to inform more comprehensive and comprehensive development intervention initiatives.

Despite several Government of India policies on health and education welfare that have been created with the purpose of enhancing livelihood of the tribal communities, the awareness and the real application of these policies is critically low. Some of the studies further show that tribal people are still affected by barriers created by geographical isolation, low literacy level, socio-cultural factors and poor flow of information which does not allow them to comprehend or utilize the welfare benefits of the government holistically. Consequently, such problems as poor health results, low school attendance, gender gaps, and reliance on traditional practices exist even in the midst of well-formulated policies. These shows a great disconnect between formulation and implementation of such policies and therefore there is the need to determine the level of awareness of tribal households about such welfare schemes and what factors are influencing or hindering their usage.

Significance of the Study
The tribal consciousness in the health and education welfare policies of the government are important to understand as it directly determines the effectiveness and effect of these developmental policies. Even good policies will not help to attain the desired results when beneficiaries are not aware of their existence, eligibility or benefits. Through analysis of the degree of awareness, this paper assists in establishing key loopholes in communication, service provision and involvement of the community that curtail the success of the welfare programs in the tribal areas. The results will be useful to the policy makers, the local governance unit and the development agencies to facilitate the effectiveness of the outreach processes, the formulation of culturally sensitive interventions and the augmentation of the general accessibility of welfare programs and their use. Finally, the study will also help enhance inclusive growth, better health and education results, minimize inequalities, and enable the tribal communities to engage more productively in the national development processes.

Review of Literature
Adhikari and Kamle (2021) [1] investigated the education and development patterns of West Bengal, and there was a great difference between regions due to unequal access to schooling, socio-economic differences, and infrastructural inequalities. They focus on the fact that in tribal and backward areas, the results of education are still significantly lower than in developed areas since the delivery of services and administrative outreach is low. Equally, in a qualitative research study on Scheduled Caste and Scheduled Tribe adolescent girls in Northern Karnataka, Bhagavatetsewaran *et al*. (2021) [2] established key obstacles to education in the form of early marriage, household chores, fear of harassment, and socio-cultural limitations. Calder and Huda (2021) [3] also corroborated these arguments by demonstrating that girls in the marginalized context, during adolescence, are exposed to structural inequalities, inadequate learning conditions, and there is a high risk of dropping out. In line with such views, Yadav (2020) [12] emphasized the notion that educational development should be incorporated as part of wider social reforms as suggested by national commissions, and it should be inclusive and accessible and community-driven.

The studies of tribal health also give some essential information about the socio-economic and awareness issues. Chandra Guru *et al*. (2020) [4] presented the global overview of the development of tribal India and identified that geographical isolation, poverty, and low institutional presence of the tribes still impact education and health outcomes of this population. Basicu and Balgir (2004) [9] observed the health aspects of tribals and genetic susceptibilities and revealed that the tribal population has a low health indicator and depends largely on traditional culture. NFHS-3 (Arnold *et al*., 2006) [6] also indicated the lack of awareness and use of healthcare services among tribal communities. De (2017) [7] noted that the awareness of health among the rural tribes is still subpar since the tribes are illiterate and have limited access to the formal healthcare systems. Mahanta and Senger (2019) [8] also noted that dysfunctional drinking behavior and poor health seeking behavior deteriorate health. The same assertion was restated by Daripa (2020) [5] and Sachidananda (2020) [11] who indicated that even with government initiatives in education and welfare of the tribes, effective use of the schemes is hindered by deep-rooted socio-economic barriers and low awareness. Altogether literature points to the fact that both health and education gaps in tribal populations are tightly connected to the lack of awareness, socio-cultural restraints, and policy implementation gaps.

Research Gap
Despite the fact that the study offers a lot of information on the demographic and awareness of the tribal respondents on the health and education welfare policies, there is evident research gap on how such socio-economic factors actually affect the utilization and the success of such welfare schemes. Although, awareness levels are determined to be moderately high, the underlying barriers, including low education, geographical isolation, and low digital access, which can prevent scheme adoption, are not completely investigated in the course of analysis. Besides, the research does not measure inter-mandal differences between Saluru and Makkuva or excellent knowledge versus real behavioural results. These loopholes indicate that there is the need to undertake more analytical research that will relate demographic factors, awareness and patterns of real time use among the tribal societies.

Research Objectives
- To test the hypothesis that the level of awareness of the

tribal respondents about the health welfare policies is significantly greater than the moderate level.

- To test the hypothesis that the overall level of awareness of tribal respondents on the education welfare policy is significantly above the moderate level.

Hypothesis

- **Null Hypothesis:** The average level of tribal awareness about government health welfare policies equals to the moderate level (u = 3).
- **Null Hypothesis:** The average level of awareness of tribal respondents to government education welfare policies is the same as that of the moderate level (u = 3.00).

Research Methodology

In the current study, a descriptive research design was used, as it was necessary to identify the level of awareness of the respondents (tribal) regarding Government Health and Education Welfare Policies. Descriptive research will best suit the situation where one wants to know the current situation, behaviour of a certain group, demographic value and change in awareness of various groups of a population. Here the design helped the researcher to describe the perceptions of tribal communities towards welfare schemes offered by the government in a systematic manner. The experiment was done in Saluru and Makkuva mandal of Parvathipuram Manyam District, which were inhabited mainly by tribes. These regions have hilly landscape, socio-economic susceptibility, geographical isolation, and rather low access to government. They are the best geographical locations to study the degree of awareness and access to health and education welfare policies amongst the tribal households because of their distinct socio-economic and demographic characteristics. The respondents to be used in the study were 100 tribal respondents. A mixed non-probability type of sampling was used because of the dispersed tribal settlements and lack of total sampling frame. Saluru and Makkuva mandals were selected in the first stage due to purposive sampling as they represent high concentration of tribal populations and suitability to the objectives of the research. In the second phase, convenience sampling was used to reach households that were easily accessible when visiting the field whereas snowballing was used to identify other respondents in secluded or inaccessible hamlets. This sample method combination is popular in tribal study wherein locomotion can be limited, villages are not centralized and formal household records are not possessible. Structured questionnaires that were issued by means of face-to-face interviews were used as primary data collection because of the low level of literacy and communication barriers in the tribal areas.

The survey was divided into three large parts which included demographic profile, scales of awareness and source of information. The demographic part captured information on gender, age, education, occupation, income, family type and proximity to health and educational facilities. The two different scales of awareness tested included Health Welfare Policies (HA1-HA10) and Education Welfare Policies (EA1-EA10) with the scale ranging between (1) Not Aware at All to (5) Fully Aware. The sources of information that were captured using multiple-choice items included ASHA/ANM workers, media, relatives and awareness camps. The data analysis consisted of both descriptive statistics (frequencies, percentages, means, and standard deviations) and inferential statistics, i. e. the One-Sample t-test (to check whether the level of awareness was significantly greater than the moderate level of u = 3), Independent Sample t-test (to test the female and male differences), and One-way ANOVA (to test the women and men differences according to the level of education, income groups and distance). The statistical analysis implemented SPSS and MS Excel to guarantee the accuracy, reliability, and meaningful interpretation of the obtained results.

Data and Results analysis
Demographic Profile

Table 1: Distribution of Respondents by Demographics

Variable	Category	Frequency (N=100)	Percentage (%)
Gender	Male	58	58%
	Female	40	40%
	Other	2	2%
Total		100	100%
Age (in years)	Below 25	12	12%
	25-34	28	28%
	35-44	30	30%
	45-54	20	20%
	55 and above	10	10%
Total		100	100%
Educational Qualification	Illiterate	18	18%
	Primary (1-5)	22	22%
	Upper Primary (6-8)	20	20%
	Secondary (9-10)	15	15%
	Higher Secondary (11-12)	10	10%
	Graduate	10	10%
	Postgraduate & above	5	5%
Total		100	100%
Occupation	Agriculture	35	35%
	Daily wage labour	30	30%
	Government employee	4	4%

	Private employee	8	8%
	Self-employed	10	10%
	Unemployed	10	10%
	Others	3	3%
Total		100	100%
Monthly Household Income (₹)	Below 10,000	42	42%
	10,001-20,000	30	30%
	20,001-30,000	15	15%
	30,001-40,000	8	8%
	Above 40,000	5	5%
Total		100	100%
Type of Family	Nuclear	64	64%
	Joint	36	36%
Total		100	100%
Distance to Nearest Health Centre	< 2 km	20	20%
	2-5 km	40	40%
	5-10 km	25	25%
	> 10 km	15	15%
Total		100	100%
Distance to Nearest School	< 1 km	28	28%
	1-3 km	46	46%
	3-5 km	20	20%
	> 5 km	6	6%
Total		**100**	**100%**

Sources: Primary Data

The demographic profile of the respondents is important as it gives useful information with regards to the socio-economic background of tribal households surveyed. The gender analysis depicts that most of the respondents are males (58%), then there are females (40%), and a very low percentage are other genders (2). This is in keeping with the general participation trend of tribal societies which tend to have the men portraying the household in polls. The age distribution is relatively equal between the age categories with the highest number of 35-44 years (30%), then the 25-34 years (28%). This indicates that survey questionnaire mostly collected the answers of people who are within their economically active and socially responsible age bracket.

The level of education qualifications indicates that a large percentage of the respondents are of low educational attainment since 18% of the respondents are illiterate and the 22% are of education level primary. The percentage of grads is only 10 and postgrads is only 5 meaning that there is not much higher education access in the tribal regions. This poor education level directly affects the level of awareness of welfare programs, access to governmental services, and decision-making skills. The occupational structure also indicates the rural and agrarian character of the tribal economy with the 35 percent involved in agriculture and 30 percent in the daily wage labour. Their employment in the government (4%), or in private sectors (8%) is minimal, and 10% are self-employed and unemployed. These trends represent financial weakness and lack of diversification of employment.

The socio-economic factors that influence tribes in the tribal society include income levels with 42 percent of the households having less than [?]10,000 per month and the other 30 percent falling in the range of [?]10,001 to [?]20,000. The percentage that makes over [?]40,000 is only 5 per cent which shows that there is stability in the income of the low income earners and low financial capacity. The family structure data reveals that nuclear families (64) are prevailing over joint families (36), and this could affect the household decision making and scheme utilization behavior. In terms of access to the needed services, 40 percent of the respondents are within 2-5 km distance to the closest health centre and 25 percent are within 5-10km distance to closest health centre which is also a very important geographical barrier to access to healthcare services. School accessibility, on the other hand, is relative as 46% of the residents live within 1-3km and 28% within 1km of a school. But even the 6 percent who live beyond 5 km distance will have difficulties of accessing education. In general, the demographic features represent the normal tribal socio-economic status and constitute an important background in understanding the awareness of the health and education welfare policies.

Table 2: Descriptive Statistics

Statistic	Value
Sample size (N)	100
Mean (HA_Mean)	3.45
Standard Deviation (SD)	0.80
Test value (μ_0)	3.00

Descriptive statistics indicate that the general mean level of awareness of the respondents on policies of health welfare is 3.45, which is greater than the moderate level value of 3.00. It means that tribal respondents on average have a fairly good level of awareness regarding governmental health schemes. The standard deviation of 0.80 indicates the middle level of change in the degree of awareness of the selected sample of 100 respondents.

Table 3: Awareness of Health Welfare Policies

Test Value (μ_o)	N	Mean (HA_Mean)	SD	t-value	df	p-value (Sig.)	Decision on H_{01}
3.00	100	3.45	0.80	5.63	99	0.000	Rejected

As the p-value (0.000) is not equal to or greater than 0.05, the null hypothesis (H01) is dismissed. This affirms that the average awareness score (3.45) is much better than the test average score of 3. Thus, the awareness of the respondents with regard to the health welfare policies is significantly better-than-moderate.

Null Hypothesis: The average level of tribal awareness about government health welfare policies equals to the moderate level (u = 3).

Table 4: Descriptive Statistics

Statistic	Value
Sample size (N)	100
Mean (EA_Mean)	3.55
Standard Deviation (SD)	0.78
Test value (μ_o)	3.00

The average outcome of education welfare policy awareness is 3.55 as opposed to the reference level of 3.00 meaning that the respondents have moderate-high level of awareness on education welfare initiatives. The standard deviation is 0.78 which suggests that the variability of respondents concerning educational policy awareness is acceptable with the 100 respondents.

Table 5: Awareness of Education Welfare Policies

Test Value (μ_o)	N	Mean (EA_Mean)	SD	t-value	df	p-value (Sig.)	Decision on H_o2
3.00	100	3.55	0.78	7.05	99	0.000	Rejected

The null hypothesis H01 is rejected because p < 0.05. The average score in the awareness related to education welfare policies (M = 3.55) is well above the moderate level and this implies that tribal respondents were well aware.

Null Hypothesis: The average level of awareness of tribal respondents to government education welfare policies is the same as that of the moderate level (u = 3.00).

Table 6: Sources of Information about Government Health Schemes

Source of Information	Frequency (N)	Percentage (%)
Health worker (ASHA/ANM)	38	38%
Friends / Relatives	20	20%
Village leaders / PRI members	12	12%
School teachers	8	8%
TV / Radio / Newspaper	10	10%
Social media / WhatsApp	6	6%
Government meeting / Awareness camp	12	12%
Others (specify)	4	4%
Total	100	100%

Sources: Primary Data

The statistics indicate that most of the respondents (38 percent) got information on government health schemes through ASHA/ANM health workers who are very instrumental in creating health related awareness among tribal communities. The information flow of friends and relatives was 20 percent, which shows that they are strongly dependent on the informal networks. Awareness was also significantly contributed by government meetings and awareness camps (12%), and village leaders/PRI members (12%). It was found that, in traditional media sources like TV/radio/newspapers gave information to 10% of the people surveyed, and only 6% heard about schemes through social media, as digital access in tribal regions remains low. Only a small percentage (4 percent) stated other sources. In general, the results imply that the frontline health workers and interpersonal networks represent the most powerful sources of information distribution in tribal areas.

Findings of the Study
- The researchers established that tribal respondents had an average-to-high awareness of health and education welfare policies. The general mean score in health policies awareness was 3.45 and in education policies awareness it was 3.55 which was significantly higher than the neutral level (u = 3). This means that tribal societies have fairly fair understanding of key government initiatives.
- Most of the respondents (38 percent) and ASHA/ANM health workers were found to be the sources of health-related information, which demonstrates their pivotal role in spreading the policy. Internet sources (20%), friends/relatives (12%), and village leaders (12%), also had a major role to play. The social media as a source of information was only used by 6 percent of people, which means that there was very little access to the digital world in tribal regions.
- It was found that a high percentage of the respondents were illiterate (18% illiterate; 22% primary) and 42% lived in very low-income households with less than [?]10,000 per month income. These socio-economic limitations indicate that the level of awareness may be enhanced further in case specific communication approaches are reinforced among the low-literacy populations.
- Although 46 percent of the respondents resided in a distance of 1-3 km of a school, only 20 percent of the respondents lived within a distance of 2 km of a health centre. High percentages (40% and 25%) were forced to travel 2-10 km to access healthcare, which means that there are geographical barriers to health services, and this might influence their use of welfare schemes.
- The One-Sample t-tests of health (t = 5.63, p < 0.001) and education (t = 7.05, p < 0.001) awareness were statistically significant, which proves that the level of tribal respondents awareness is far beyond the moderate level. This indicates that the government awareness campaigns are working, but there is still more that can be done in the remote locations.

Conclusion
This paper has come up with the conclusion that the level of awareness of both health and education welfare policies among tribal respondents in Saluru and Makkuva mandals is

moderate to high in nature but there are differences according to the socio-economic and geographical attributes. Frontline employees and social networks are still the main sources of information spread, and access to digital and a low level of literacy still limit the level of awareness and use. Enhanced outreach activities, access to health services, and the better communication level at the community level are the key to achieving the welfare schemes reaching and benefiting tribal communities.

References

1. Adhikari A, Kamle M. Spatial pattern of education and development in West Bengal. Ann Natl Assoc Geogr India. 2010;30(2):55-67.
2. Bhagavatheeswaran L, et al. The barriers and enablers to education among scheduled caste and scheduled tribe adolescent girls in northern Karnataka, South India: a qualitative study. Int J Educ Dev. 2021;85:102473.
3. Calder R, Huda K. Adolescent girls and education: challenges, evidence, and gaps. Pathways Perspect Soc Policy Int Dev. 2021;7(13):1-7.
4. Chandra Guru BP, Mahesh B, Shivaram HS, Dileep Kumar M, Rajagopala K. Tribal development in India: an overview. Int Contemp Res J Manag Soc Sci. 2020;1(2):75-79.
5. Daripa SK. Tribal education in India: government initiative and challenges. Int J Res Soc Sci. 2020;7(10):760-773.
6. Arnold F, Parasuraman S, Arokiasamy P, Kothari M. National Family Health Survey (NFHS-3), 2005-06. Mumbai: IIPS; 2006.
7. De K. Health awareness among tribes of rural India. J Mol Genet Med. 2017;11(1):1747-1762.
8. Mahanta PK, Senger KS. A qualitative study on reasons of harmful drinking and health-seeking behaviour among tribal individuals with alcohol dependence syndrome. J Emerg Technol Innov Res. 2019;6(5):2036-2041.
9. Balgir RS. Hereditary persistence of foetal haemoglobin in a tribal family of Orissa, India. Natl Med J India. 2004;17(3):138-140.
10. Basu S. Dimensions of tribal health in India. Health Popul Perspect Issues. 2000;23(2):61-70.
11. Sachidananda. Tribal education: implications for development. New Delhi: Concept Publishing Company; 2020. p. 253-255.
12. Yadav MS. The education commission's perspectives on society, education and development. In: Prakash V, Biswal K, editors. Perspectives on education and development - revisiting education commission and after. New Delhi: Shipra Publications; 2020.