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SOCIOECONOMIC, DEMOGRAPHIC, HOUSING, WASH, AND HEALTH-SERVICE PROFILE OF SCHEDULED CASTE SUB-PLAN (SCSP) BENEFICIARY FAMILIES IN HYDERABAD, INDIA - 2024-25

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Abstract

Background: The Scheduled Caste Sub-Plan (SCSP) supports targeted welfare and health interventions for socially and economically disadvantaged communities. NRIUMSD, Hyderabad, undertook a household survey to establish a baseline profile of beneficiary communities reached through its SCSP outreach activities.

Objectives: To describe the demographic and socio-economic profile of the surveyed population; assess housing and household amenities; evaluate water, sanitation and hygiene (WASH) conditions; examine health-seeking behaviour and health-care access; and assess maternal, postnatal and child health service utilisation.

Methods: A descriptive cross-sectional household survey was conducted during 2024–25 across five outreach localities in Hyderabad. A total of 595 individuals from 167 families were enumerated using a pre-structured household schedule. Descriptive statistics, including frequencies, percentages, means and standard deviations, were calculated; household-level indicators used the family denominator (n=167), while individual and applicable maternal/child indicators used their relevant denominators.

Results: The mean age was 35.9 years (SD 18.0), and 72.6% of respondents were female. Scheduled Caste participants constituted 75.1%, followed by Scheduled Tribe (14.6%) and OBC (10.3%). Overall literacy was 83.8%, with unskilled labour (29.7%), housework (26.7%) and studying (26.3%) as the leading occupational categories. Electricity was available in 93.0% of families, 82.5% lived in pucca houses, and 93.6% used piped water. However, 97.5% reported interrupted water supply and only 44.4% had closed drainage; 90.0% had flush toilets. A government health institution was reported in 89.6% of localities. Maternal and child health indicators were generally favourable: 96.8% of deliveries occurred in hospitals, 98.8% were conducted by doctors, and childhood immunisation coverage was high, while only 30.7% of pregnant women were registered at a family welfare centre during pregnancy.

Conclusion: The survey demonstrates substantial reach of SCSP outreach among disadvantaged communities and generally favourable housing, sanitation, health-care access and maternal-child health indicators. Priority areas for intervention include continuity of water supply, drainage, female literacy and livelihood opportunities, early antenatal registration, growth monitoring and supplementary nutrition. These findings provide a practical baseline for strengthening targeted community health education, preventive care, Unani outreach and welfare planning.

Keywords: Scheduled Caste Sub-Plan; socioeconomic survey; household demography; water, sanitation and hygiene; health-seeking behaviour; maternal and child health; Unani medicine; Hyderabad.

1. Introduction

1.1 Background

The National Research Institute of Unani Medicine for Skin Disorders (NRIUMSD), Hyderabad, functioning under the Central Council for Research in Unani Medicine (CCRUM), Ministry of AYUSH, Government of India, undertakes community outreach and research activities among socio-economically underprivileged populations, including under the Scheduled Caste Sub-Plan (SCSP). The SCSP is a Government of India strategy that channels earmarked funds toward the welfare and development of Scheduled Caste communities, including health, sanitation, nutrition and maternal and child care initiatives.

As part of its SCSP mandate, NRIUMSD conducted a household-level socio-economic and demographic survey across five outreach localities in and around Hyderabad. A structured household schedule (Survey form) was used to record information on family composition, education, occupation, religion and caste, housing and living conditions, water, sanitation and

hygiene (WASH) practices, health-seeking behaviour, and maternal and child health service utilisation, including antenatal, natal, postnatal and immunisation coverage.

This report analyses the resulting dataset to construct a socio-economic and demographic profile of the surveyed population, with the intent of supporting evidence-based planning of health education, outreach camps and welfare interventions targeted at Scheduled Caste and other marginalised families served by the Institute.

1.2 Objectives of the Study

- To describe the demographic profile (age, sex, marital status, religion and caste composition) of the surveyed population.
- To assess the socio-economic status of families in terms of education, occupation, diet and addictive habits.
- To document housing conditions and household amenities, including lighting, cooking fuel and construction type.
- To evaluate access to safe drinking water and sanitation facilities (WASH indicators).
- To examine health-seeking behaviour, access to government health institutions, and out-of-pocket versus government-borne health expenditure.
- To assess the coverage of maternal and child health services, including antenatal care, institutional delivery and childhood immunisation.

2. Methodology

2.1 Study Area and Design

This is a descriptive, cross-sectional household survey conducted by NRIUMSD, Hyderabad, under its SCSP outreach programme during 2024-25. Data were collected from five distinct survey localities, such as Raju Nagar, Talla Basti, Vivekananda Nagar, Babu Jagjeevan Rao Nagar, Adarsh Nagar situated within the Institute's outreach catchment area in Hyderabad.

2.2 Sample and Data Collection

A total of 595 individuals from 167 families were enumerated using a pre-structured, pre-coded household schedule (Survey form) covering demographic, socio-economic, housing, WASH, health-access and maternal-and-child-health domains. In most families a single respondent (predominantly an adult woman) was interviewed.

2.3 Variables and Measurement

Each variable in the Survey form was pre-coded with numeric response categories (for example, Religion: Hindu = 1, Muslim = 2, Sikh = 3, Christian = 4, others = 5). For this report, all coded responses were mapped back to their descriptive labels prior to analysis. Variables analysed include age, sex, marital status, religion, caste category, educational status, occupation, diet, Unani temperament (*Mizaj: Damvi, Balghami, Safravi, Saudawi*), addictive habits, source of lighting and cooking fuel, house construction type, source and adequacy of drinking water, toilet facility and hygiene practices, availability and utilisation of government health institutions, bearer of health expenditure, and antenatal, natal, postnatal and immunization service coverage.

2.4 Data Analysis

Data were compiled and analysed using Python (pandas). Descriptive statistics (frequencies, percentages, means and standard deviations) were computed for all variables. Household-level amenity and WASH indicators (housing, water, sanitation, cooking fuel and health-facility access) were de-duplicated to the Families (n = 167) to avoid double-counting where more than one member of the same household was surveyed, while demographic and individual-level socio-economic indicators are reported at the level of the 595 surveyed individuals. Maternal and child health indicators are reported among the sub-set of respondents to whom each item applied (for example, antenatal-care items apply to women with a recent pregnancy), with the applicable denominator (n) stated alongside each indicator.

2.5 Data Limitations

- The survey used non-random, purposive selection of outreach localities and respondents (predominantly adult women), so findings should be treated as descriptive of the surveyed population and its five localities rather than as a statistically representative sample of the general population.
- All information is self-reported by the household respondent and was not independently verified against records or clinical examination.

3. Results

3.1 Demographic Profile

The survey enumerated 595 individuals from 167 families across the five study localities. Table 1 presents the distribution of respondents by locality.

Locality (Spot)	Number of Persons	Percentage (%)
Raju Nagar	33	5.4
Talla Basti	63	10.6
Vivekananda Nagar	221	37.2
Babu Jagjeevan Rao Nagar	207	34.8
Adarsh Nagar	71	12.0
Total	595	100.0

Table 1. Distribution of Respondents by Survey Locality

The mean age of respondents was 35.9 years (SD 18.0; range 1-84 years; median 36.5 years). Age distribution shows the largest concentration in the 36-60 year (middle-age) group (44.3%), followed by 19-35 years (29.3%). Children and adolescents (0-18 years) together accounted for 19.0% of the sample, while elderly persons (60 years and above) accounted for 7.4%. Table 2 presents the detailed age-group distribution.

Age Group (years)	Number of Persons	Percentage (%)
0-5	22	3.5
6-14	62	10.4
15-18	30	5.1
19-35	174	29.3
36-60	263	44.3
60 and above	44	7.4
Total	595	100.0

Table 2. Age-Group Distribution of Surveyed Population

The overall dependency ratio (population aged below 15 and 60 and above, per 100 persons aged 15-59) was 32.9, indicating that for every 100 persons of working age, approximately 33 dependents (children and elderly) were present in the surveyed population.

Of the 595 respondents with recorded sex, 429 (72.6%) were female and 166 (27.4%) were male. This pronounced female preponderance reflects the survey's design, in which an adult woman was typically the principal respondent for maternal and child health items, alongside a full listing of household children. Figure 1 presents the age-sex distribution, which shows a male preponderance among children and adolescents (0-19 years) and a marked female preponderance from age 20 onward, consistent with women being preferentially enumerated as adult respondents. Figure 1a summarises the overall sex ratio of the sample.

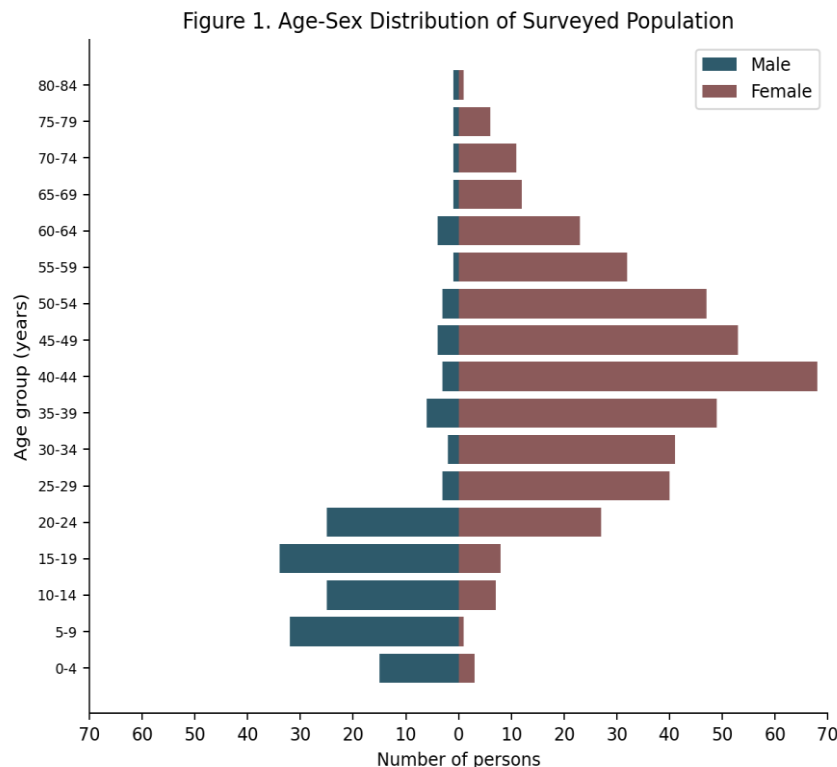
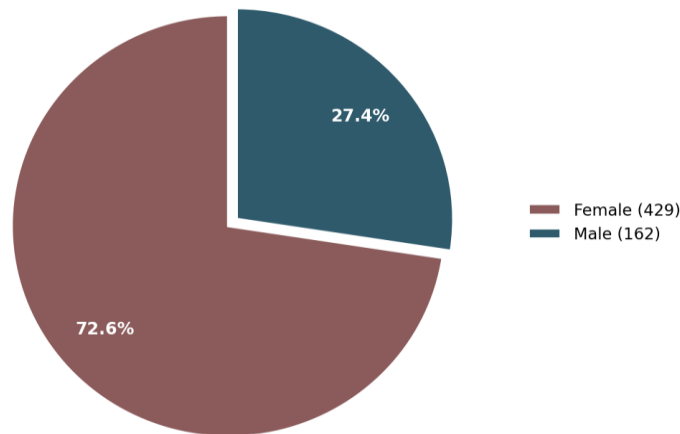


Figure 1. Age-Sex Distribution of the Surveyed Population

Figure 1a. Sex Distribution of Respondents (n=591)

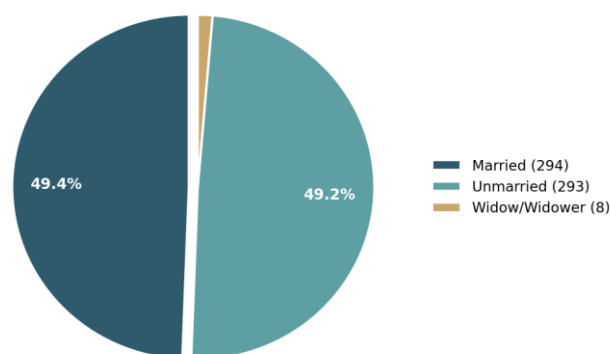
*Figure 1a. Sex Distribution of Respondents*

Regarding marital status, the sample was almost evenly split between married (49.4%) and unmarried (49.2%) individuals, with a small proportion widowed (1.3%); this even split reflects the inclusion of children and adolescents in the sample. Among adults aged 18 years and above only, 56.4% were married, 42.0% unmarried and 1.6% widowed. Table 3a and Figure 1b present the full breakdown.

Marital Status	Number of Persons	Percentage (%)
Married	294	49.4
Unmarried	293	49.2
Widow / Widower	8	1.3
Total	595	100.0

Table 3a. Marital Status of Respondents (All Ages)

Figure. Marital Status of Respondents (n=595)

*Figure 1b. Marital Status of Respondents*

With respect to religious composition, Hindus constituted the majority of the surveyed population (77.3%), followed by Muslims (20.0%) and Christians (2.7%). Table 3b and Figure 4 illustrate this distribution.

Religion	Number of Persons	Percentage (%)
Hindu	460	77.3
Muslim	119	20.0
Christian	16	2.7
Total	595	100.0

Table 3b. Religious Composition of Respondents

Figure 4. Religious Composition of the Surveyed Population (n=595)

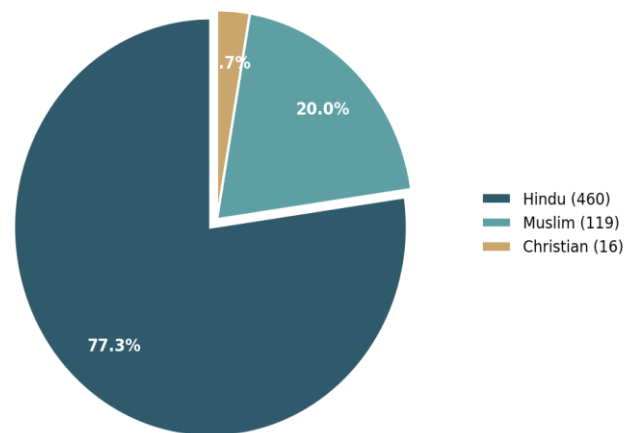


Figure 4. Religious Composition of the Surveyed Population

Consistent with the Scheduled Caste Sub-Plan mandate of the survey, the large majority of respondents belonged to the Scheduled Caste (SC) category (75.1%), followed by Scheduled Tribe (ST, 14.6%) and Other Backward Class (OBC, 10.3%). Table 3c and Figure 5 present the caste-wise distribution, and the composition varied appreciably across localities, with Babu Jagjeevan Rao Nagar recording the highest proportion of ST families (20.8%) and Adarsh Nagar including a notable Christian minority (16.9% of that locality).

Social Category	Number of Persons	Percentage (%)
Scheduled Caste (SC)	447	75.1
Scheduled Tribe (ST)	87	14.6
Other Backward Class (OBC)	61	10.3
Total	595	100.0

Table 3c. Social Category (Caste) Composition of Respondents

Figure 5. Social Category (Caste) Composition (n=595)

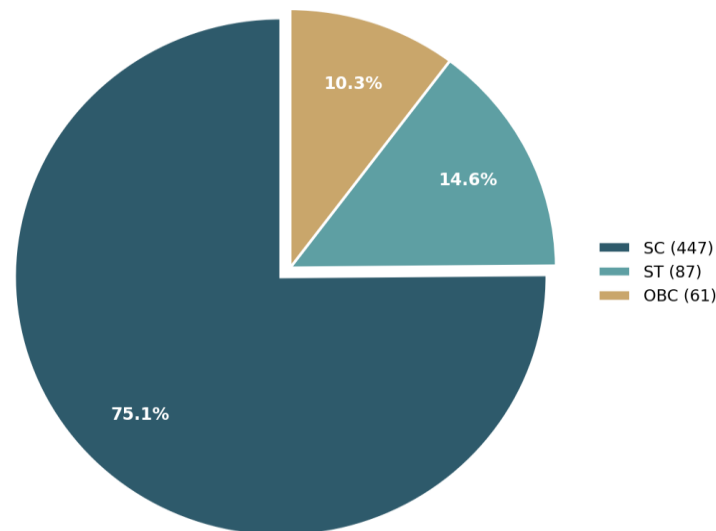


Figure 5. Social Category (Caste) Composition of the Surveyed Population

3.2 Socio-Economic Profile

Educational Status

The overall literacy rate (proportion of persons aged 7 years and above who were not illiterate) was 83.8%, with literacy considerably higher among males (93.2%) than females (80.9%). Among all respondents, the largest single category had completed high-school-level education (26.9%), followed by primary schooling (24.9%). About 17.8% of respondents were illiterate, while 17.2% were graduates or held higher qualifications. Table 3 and Figure 2 present the education profile, including its distribution by sex.

Educational Status	Female	Male	Total	% of Total
Illiterate	82	23	105	17.7
Semi-literate	15	17	32	5.4
Primary school	115	32	147	24.7
High school	108	52	160	26.9
Intermediate	34	12	46	7.7
Graduate or above	74	26	100	16.8
Total	429	166	595	100.0

Table 3. Educational Status by Sex

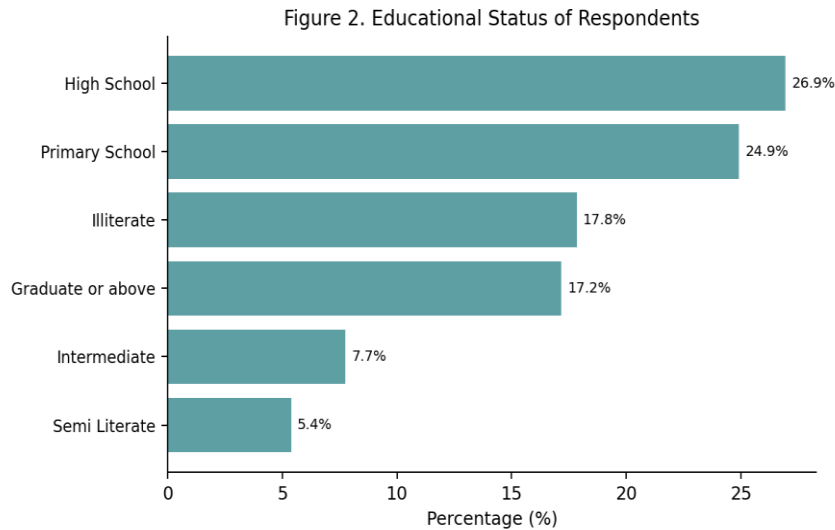


Figure 2. Educational Status of Respondents

Occupation

Unskilled labour was the single largest reported occupation (29.7%), followed by housework (26.7%) and studying (26.3%, largely comprising school- and college-going children and youth). Business/self-employment accounted for 8.8% of respondents, while skilled labour, retirement, unemployment and agricultural labour together made up the remainder. Notably, unskilled labour was reported by 34.6% of female respondents compared with 17.1% of male respondents, while business ownership was more common among females (9.6%) than males (5.5%) in this sample, reflecting the occupational patterns of the predominantly female respondent group. Table 3d and Figure 3 present the full occupational distribution.

Occupation	Number of Persons	Percentage (%)
Unskilled labourer	166	29.7
Housewife	149	26.7
Student	147	26.3
Business	49	8.8
Skilled labourer	23	4.1
Retired	10	1.8
Unemployed	6	1.1
Others	6	1.1
Agricultural labourer	2	0.4
Total	558*	100.0

Table 3d. Occupational Distribution of Respondents (*37 records had no occupation recorded)

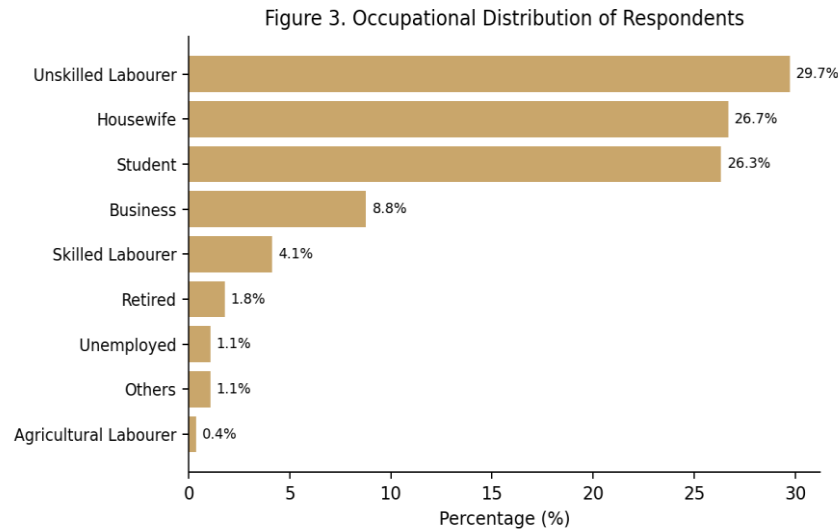


Figure 3. Occupational Distribution of Respondents

Diet and Unani Temperament (Mizaj)

Diet was overwhelmingly non-vegetarian (99.2%), with vegetarian and egg-inclusive vegetarian diets each reported by less than 1% of respondents. Consistent with the Unani medical framework used in the survey instrument, respondents' temperament (Mizaj) was also recorded: the Balghami (phlegmatic) constitution was most common (69.0%), followed by Saudawi (melancholic, 14.5%), Damvi (sanguine, 12.3%) and Safravi (choleric, 4.2%). Table 3e presents the dietary pattern and Table 3f / Figure 3a the Mizaj distribution.

Dietary Pattern	Number of Persons	Percentage (%)
Non-vegetarian	590	99.2
Vegetarian	3	0.5
Vegetarian + Egg	2	0.3
Total	595	100.0

Table 3e. Dietary Pattern of Respondents

Figure. Dietary Pattern of Respondents (n=595)

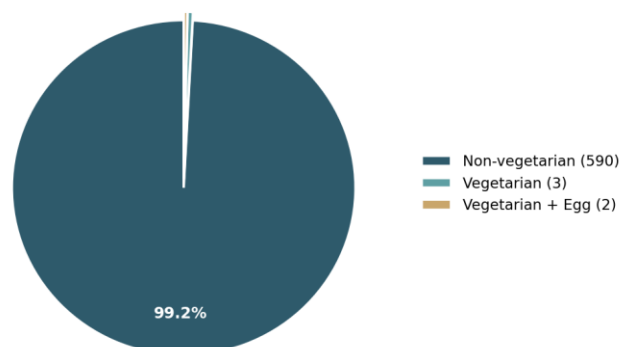


Figure 3a. Dietary Pattern of Respondents

Mizaj (Unani Temperament)	Number of Persons	Percentage (%)
Balghami (Phlegmatic)	410	69.0
Saudawi (Melancholic)	87	14.5
Damvi (Sanguine)	73	12.3
Safravi (Choleric)	25	4.2
Total	595	100.0

Table 3f. Unani Temperament (Mizaj) of Respondents

Figure. Unani Temperament (Mizaj) of Respondents (n=594)

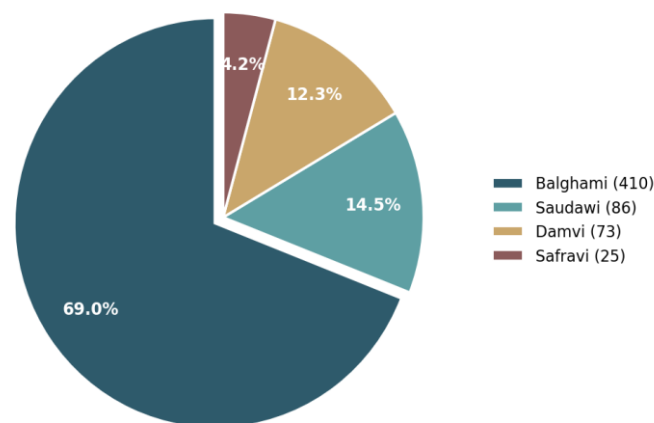


Figure 3b. Unani Temperament (Mizaj) of Respondents

Addictive Habits

Approximately 28.1% of respondents (167 of 595) reported some form of addictive habit. Among those reporting an addiction, smoking was most common (54.5%), followed by alcohol use (30.5%), other unspecified habits (10.2%), tobacco chewing (4.2%) and snuff use (0.6%). Given the demographic skew of the sample toward adult women, these proportions should be interpreted with caution and in conjunction with the data-quality caveats noted in Section 2.5. Table 3g and Figure 3c summarise the pattern.

Type of Addiction	Number of Persons	Percentage (%)
Smoking	91	54.5
Alcohol	51	30.5
Others	17	10.2
Tobacco	7	4.2

Type of Addiction	Number of Persons	Percentage (%)
Snuff	1	0.6
Total (with any addiction)	167	100.0

Table 3g. Type of Addictive Habit among Respondents Reporting an Addiction (n=167)

Figure. Type of Addictive Habit (n=167)

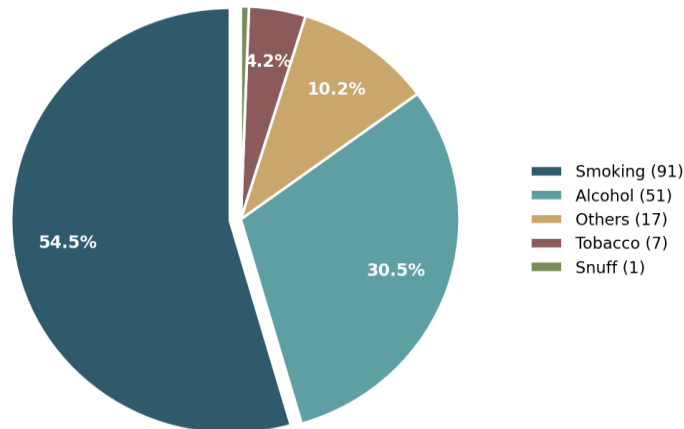


Figure 3c. Type of Addictive Habit (n=167)

3.3 Housing and Household Amenities

Housing conditions among the 167 surveyed families were relatively favourable. Electricity was the main source of lighting in 93.0% of families, with the remainder (7.0%) relying on kerosene. Almost all families (99.6%) reported adequate ventilation and sunlight in their rooms. A majority of houses (82.5%) were of pucca (permanent, brick/concrete) construction, while 17.5% remained kachcha (temporary/mud) structures. Table 5 summarises all housing and amenity indicators, and Figures 6, 6a and 7 present the key distributions.

Housing / Amenity Indicator	Category	% of Families (n=167)
Source of lighting	Electricity	93.0
	Kerosene	7.0
Adequate ventilation & sunlight	Yes	99.6
House construction type	Pucca	82.5
	Kachcha	17.5
Separate kitchen room	Yes	81.8

Housing / Amenity Indicator	Category	% of Families (n=167)
Primary cooking fuel	LPG	70.8
	Firewood	24.5
	Electricity	3.2
	Biogas	1.4
Cooking hearth (chulha) sharing	Family sharing	84.6
	Nuclear (independent)	15.4

Table 5. Summary of Housing and Household Amenity Indicators

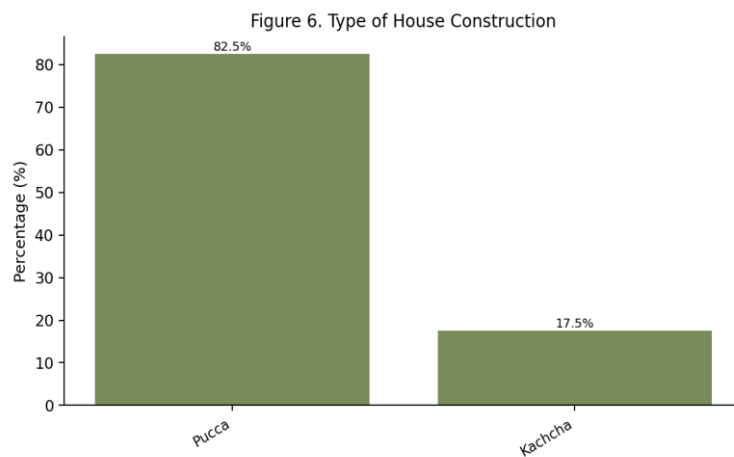


Figure 6. Type of House Construction

Figure 6. Type of House Construction (n=595 households)

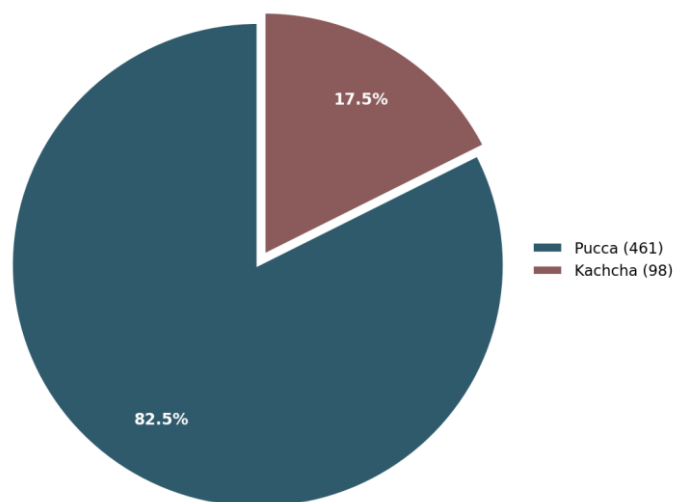


Figure 6a. Type of House Construction (Share)

Figure 6a. Main Source of Lighting (n=595 households)

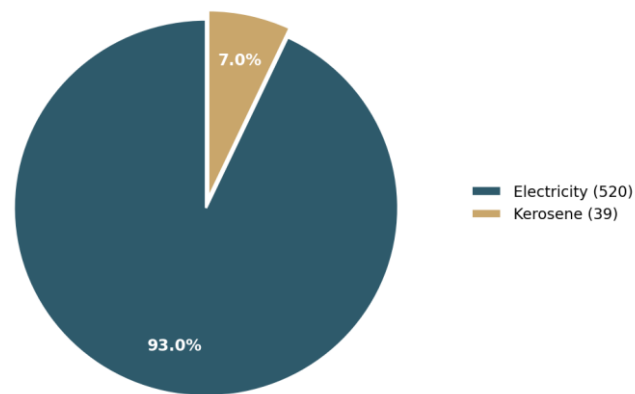


Figure 6b. Main Source of Household Lighting

A separate kitchen area was present in 81.8% of families. Liquefied Petroleum Gas (LPG) was the predominant cooking fuel (70.8%), though a substantial minority (24.5%) continued to use firewood, with small proportions relying on electricity (3.2%) and biogas (1.4%). Among families sharing a common cooking hearth (chulha), 84.6% shared it on a family basis, and 15.4% cooked as a nuclear (independent) unit.

Figure 7. Primary Cooking Fuel Used by Households

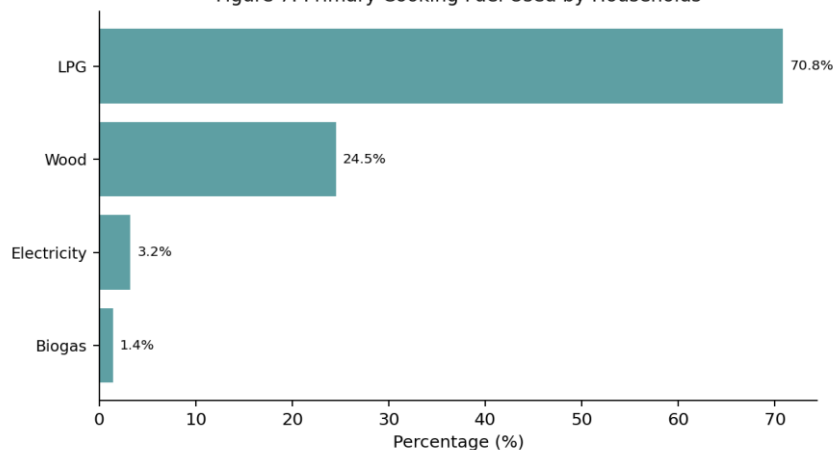


Figure 7. Primary Cooking Fuel Used by Families

3.4 Water, Sanitation and Hygiene (WASH)

Piped water supply was the main source of drinking water for 93.6% of families, with the remainder (6.4%) dependent on groundwater sources such as borewells or hand pumps. The water source was located inside the house for 90.3% of families. Notably, water supply was reported as interrupted in 97.5% of families, with only 2.5% enjoying a continuous supply, and 98.2% of families routinely stored water to cope with supply interruptions. Regarding waste-water disposal, 44.4% of families had access to closed drains, 39.9% had no drainage arrangement at all, and 15.7% relied on open drains, as shown in Table 4.

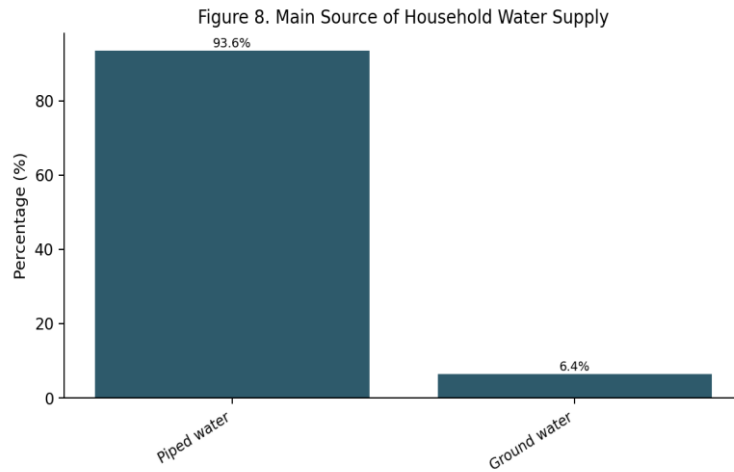


Figure 8. Main Source of Household Water Supply

Figure 8. Main Source of Household Water Supply (n=595 households)

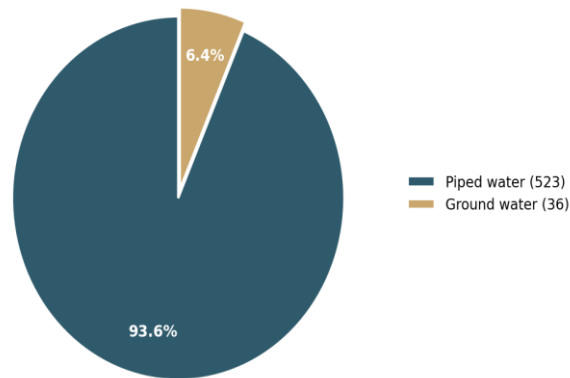


Figure 8a. Main Source of Household Water Supply (Share)

WASH Indicator	Category	% of Families (n=167)
Main water source	Piped water	93.6
	Ground water	6.4
Nature of water supply	Interrupted	97.5
	Continuous	2.5
Waste-water drainage	Closed drains	44.4
	No drains	39.9
	Open drains	15.7
Toilet facility	Flush toilet	90.0
	Pit toilet	6.3

WASH Indicator	Category	% of Families (n=167)
	No facility / open field	3.8
Hand-washing agent after toilet use	Soap	91.2

Table 4. Summary of Household WASH Indicators

Sanitation coverage was high: 90.0% of families had access to a flush toilet, 6.3% used a pit toilet, and 3.8% had no toilet facility and relied on open-field defecation. Where present, the toilet was located inside the house for 95.5% of families. Personal hygiene practices were generally favourable, with 91.2% of families using soap for hand-washing after toilet use, though bathing frequency was predominantly on alternate days (80.5%) rather than daily (5.7%), which may reflect water-availability constraints given the high prevalence of interrupted supply noted above.

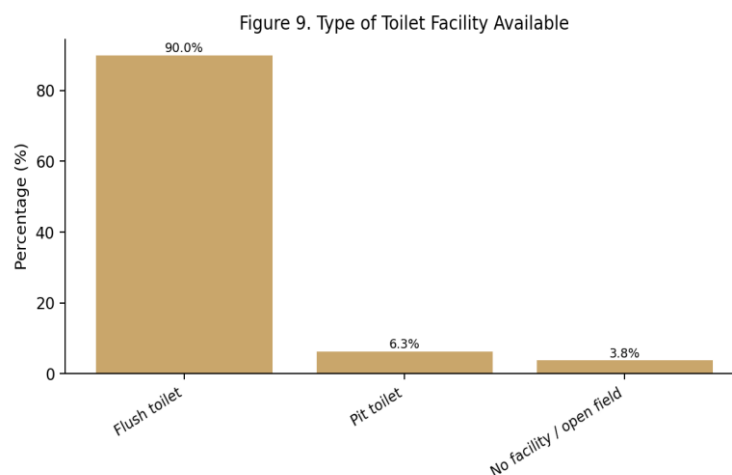


Figure 9. Type of Toilet Facility Available to Families

Figure 9. Type of Toilet Facility Available (n=595 households)

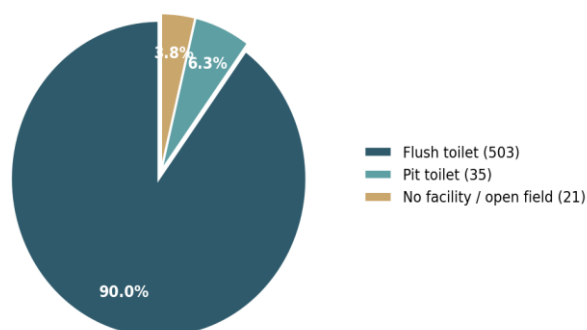


Figure 9a. Type of Toilet Facility Available (Share)

3.5 Health-Seeking Behaviour and Access to Medical Care

A government health institution (other than a Primary Health Centre or Maternal and Child Health centre) was reported to be present in the locality by 89.6% of families, and among those

with access, 97.8% reported actually availing of the facility. When seeking general medical care, families most commonly attended a dispensary (49.5%) or polyclinic (40.4%), with 9.5% attending a hospital or MCH & Family Welfare centre. Table 6 summarises all health-access indicators, and Figure 10 presents the facility-type distribution.

Health-Access Indicator	Category	% of Families
Govt. health institution present in locality (n=556)	Yes	89.6
	No	10.4
Avails facility when present (n=551)	Yes	97.8
	No	2.2
Type of facility used for general care (n=545)	Dispensary	49.5
	Polyclinic	40.4
	Hospital / MCH & FW Centre	9.5
	Others	0.6
Preferred bearer of health expenses (n=547)	Both (individual + govt.)	81.4
	Government	18.1
	Individual	0.5
Household reporting emergency in last 1 year (n=167)	Yes	62.1
	No	37.9

Table 6. Summary of Health-Seeking Behaviour and Access Indicators

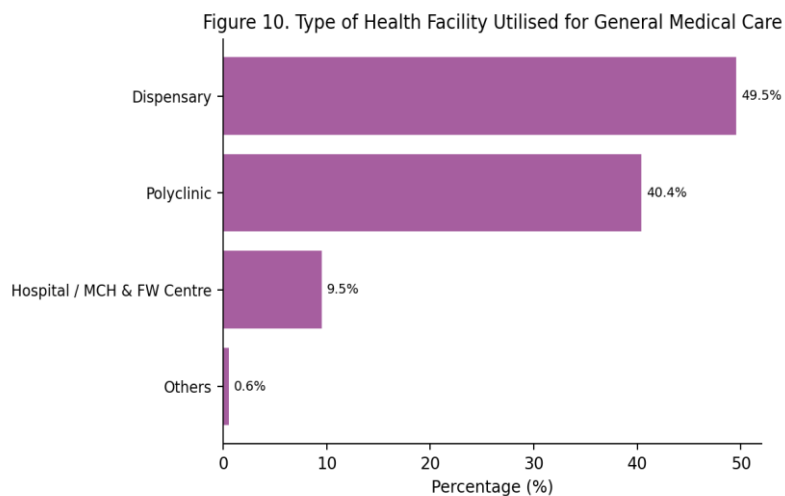


Figure 10. Type of Health Facility Utilised for General Medical Care

With regard to health expenditure, the majority of families (81.4%) felt that costs should be jointly borne by the individual and the government, 18.1% favoured the government bearing the full cost, and a very small proportion (0.5%) felt the individual alone should bear the expense, reflecting a strong preference for continued public subsidy of health care among the surveyed population.

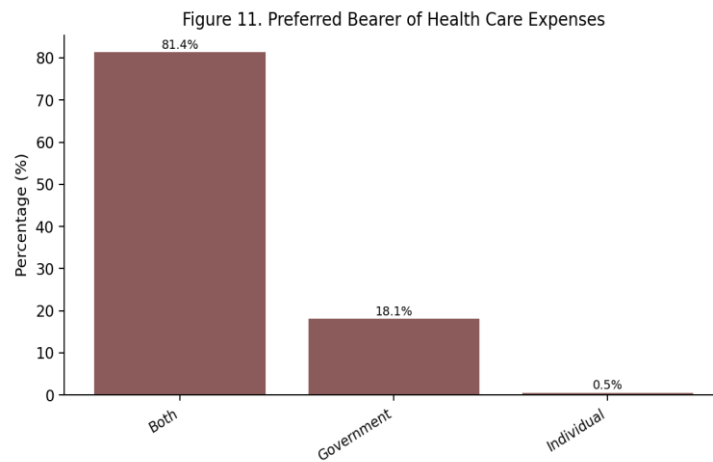


Figure 11. Preferred Bearer of Health Care Expenses

Figure 11. Preferred Bearer of Health Care Expenses (n=547 households)

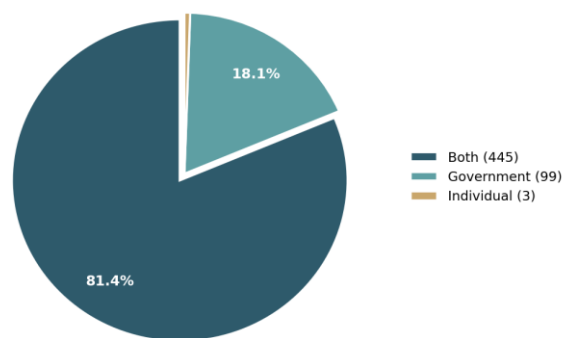


Figure 11a. Preferred Bearer of Health Care Expenses (Share)

A notable 62.1% of families reported that a family member or neighbour had experienced a health emergency in the preceding one year, underscoring the continued burden of acute illness and injury in the surveyed communities and the importance of accessible emergency care.

Figure. Household Reporting a Health Emergency in Last One Year (n=595)

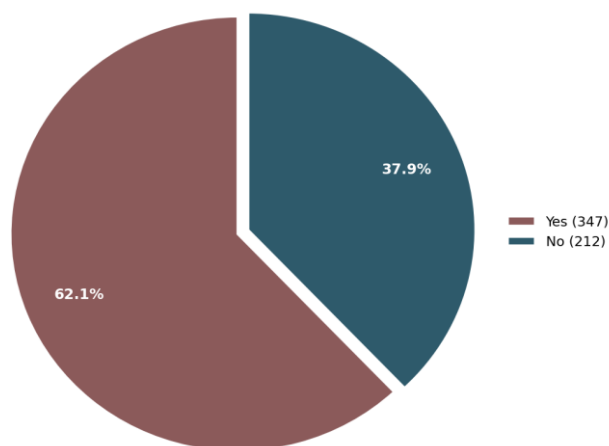


Figure 11b. Families Reporting a Health Emergency in the Last One Year

3.6 Maternal and Child Health Services

Awareness of the local health centre was high, with 85.9% of respondents aware of its existence and 89.9% reporting having visited it at some point. However, only 30.7% of women had formally registered at the family welfare centre during their pregnancy, indicating a substantial gap in early antenatal registration despite generally high awareness and facility utilisation.

Among women with a recent pregnancy ($n=403$), antenatal care (ANC) service uptake was reasonably high: 79.9% received Tetanus Toxoid (TT) injections, 87.1% received Iron and Folic Acid (IFA) tablets, 87.6% underwent blood examination, and 87.6% had their blood pressure recorded during pregnancy, as shown in Figure 13.

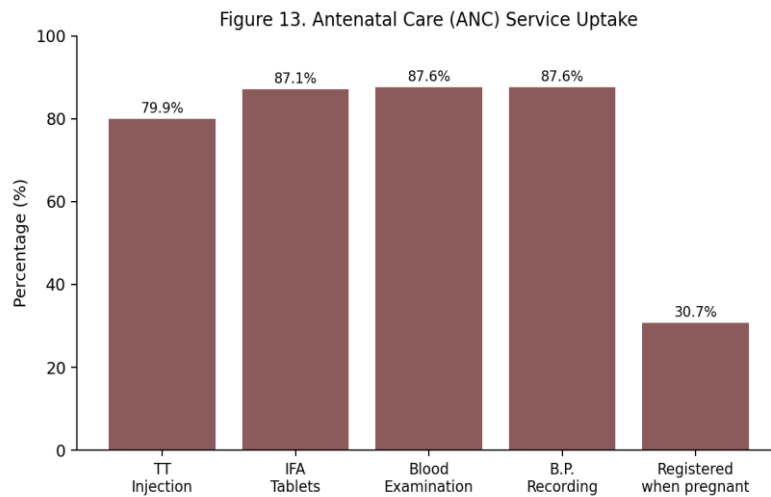


Figure 13. Antenatal Care (ANC) Service Uptake ($n = 403$)

Institutional delivery was near-universal: 96.8% of deliveries took place in a hospital, with only 3.2% occurring at home. Deliveries were overwhelmingly conducted by a qualified doctor (98.8%), with local or trained dais and ANMs accounting for the remainder, reflecting strong penetration of skilled birth attendance in the surveyed population.

Figure. Place of Delivery ($n=403$)

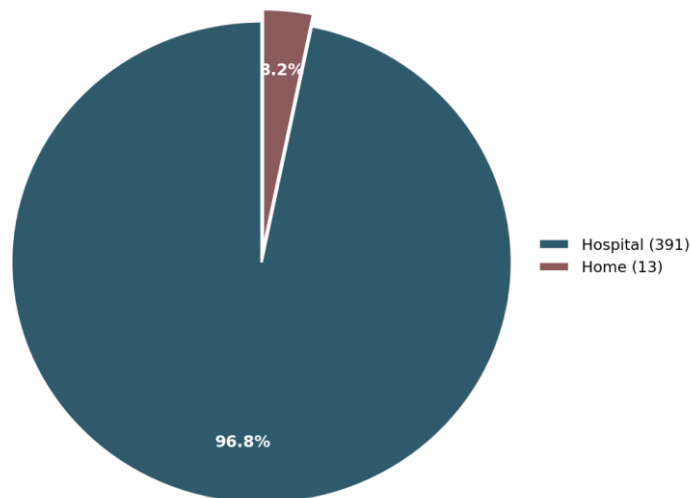


Figure 13a. Place of Delivery ($n=403$)

Postnatal care indicators were similarly favourable: 89.9% of women visited the health centre after delivery, 99.3% took their child regularly to the centre thereafter, and 99.3% were aware that certain diseases are preventable through immunisation. Overall, 98.3% of children were reported to have been immunised.

Childhood immunisation and supplementary nutrition service coverage (n=574-584) was high across most antigens and services: BCG (93.0%), DPT/Polio/Booster (99.0%), Measles (99.0%), Vitamin A supplementation (96.9%) and provision of Oral Rehydration Salts (96.9%). Coverage was comparatively lower, though still substantial, for maintenance of growth charts (72.9%) and provision of supplementary nutrition (73.0%), suggesting these two programme components may benefit from strengthened follow-up. Table 7 and Figure 12 summarise immunisation and nutrition service coverage.

MCH / Immunisation Indicator	Denominator (n)	% Coverage
Aware of local health centre	595	85.9
Ever visited health centre	595	89.9
Registered at family welfare centre when pregnant	590	30.7
ANC: TT injection taken	403	79.9
ANC: IFA tablets taken	403	87.1
ANC: Blood examination done	403	87.6
ANC: B.P. recorded	403	87.6
Delivery conducted in hospital	403	96.8
Delivery conducted by doctor	403	98.8
Visited centre after delivery (PNC)	406	89.9
Child taken regularly to centre	402	99.3
Child immunised (overall)	403	98.3
BCG	584	93.0
DPT / Polio / Booster	584	99.0
Measles	584	99.0
Vitamin A drops	584	96.9
ORS provision	584	96.9

MCH / Immunisation Indicator	Denominator (n)	% Coverage
Growth chart maintained	575	72.9
Supplementary nutrition provided	574	73.0

Table 7. Summary of Maternal, Postnatal and Child Health / Immunisation Indicators

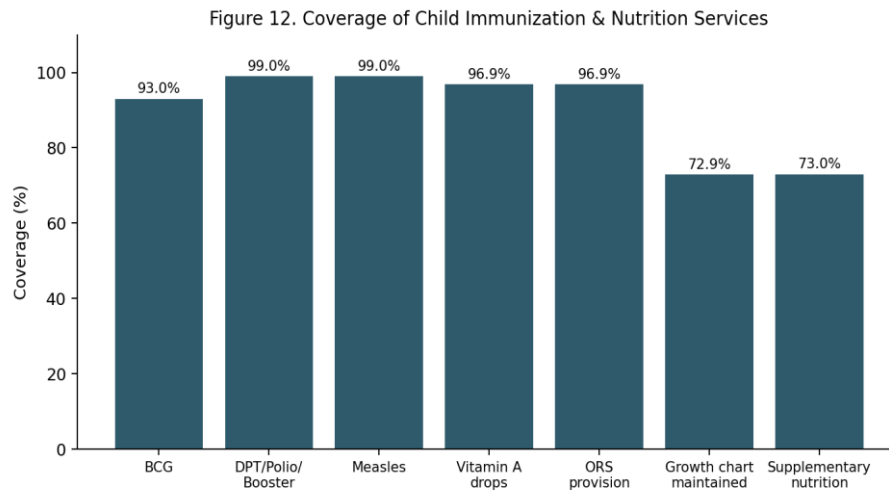


Figure 12. Coverage of Child Immunisation and Nutrition Services

4. Discussion

This household survey provides a comprehensive socio-economic and demographic profile of SCSP beneficiary communities served by NRIUMSD, Hyderabad. The population profile — predominantly Scheduled Caste, with a substantial Scheduled Tribe and OBC minority — confirms that the outreach effectively reached its intended target group. Overall literacy (83.8%) compares favourably with many disadvantaged-community benchmarks nationally, though the persistent gender gap in literacy (93.2% male versus 80.9% female) and the concentration of women in unskilled labour and housework point to continuing socio-economic disparities that warrant targeted educational and livelihood interventions for women and girls.

Housing and basic amenities were generally adequate, with high electrification, predominantly pucca construction, and near-universal access to piped water and improved sanitation. However, the very high prevalence of interrupted water supply (97.5%) and the substantial minority of families without proper drainage (39.9% with none, 15.7% with open drains) represent important infrastructural gaps that could contribute to vector-borne and water-related disease risk if left unaddressed.

Health-seeking behaviour and maternal and child health indicators were, on the whole, encouraging. Institutional delivery under skilled attendance was near-universal, and childhood immunisation coverage for key antigens exceeded 93%. This suggests that public health outreach — potentially including the Institute's own SCSP camps — has achieved good penetration for facility-based maternal and child care in this population. The comparatively low rate of early pregnancy registration (30.7%) stands out as an exception and may indicate that women are accessing antenatal and delivery services later in pregnancy or through informal

channels before formal registration, a pattern that merits further qualitative investigation and targeted early-registration campaigns.

The strong preference of families for shared (individual-and-government) or fully government-borne health expenditure (99.5% combined) reflects the continued economic vulnerability of this population and reinforces the importance of publicly subsidised health services, including AYUSH and Unani outreach camps, for this community.

5. Limitations of the Study

- The survey covered five purposively selected outreach localities and is not a random or population-representative sample; findings describe the surveyed population and should not be generalised to the wider district or state population without caution.
- The pronounced female preponderance in the sample (72.6%) reflects the survey's respondent-selection approach and limits the ability to draw firm conclusions about certain individual-level indicators (for example, addictive habits) by sex.
- All data are self-reported and were not independently verified against medical or civil records.
- A small number of fields displayed internally inconsistent entries (for example, marital status recorded for minors), suggestive of occasional data-entry or digitisation errors in the original Survey form; these were retained as recorded rather than corrected, and readers should interpret affected indicators with caution.
- Maternal and child health indicators apply only to the sub-set of respondents for whom the relevant life event (pregnancy, delivery, or having a young child) had occurred, and the applicable sample size is smaller than the full survey sample.

6. Conclusion and Recommendations

The SCSP household survey conducted by NRIUMSD, Hyderabad, confirms that its outreach programme is effectively reaching Scheduled Caste, Scheduled Tribe and OBC families, and documents generally favourable housing, sanitation, and maternal and child health outcomes alongside continuing gaps in water supply continuity, drainage infrastructure, female literacy and livelihood diversification, and early antenatal registration. Based on these findings, the following recommendations are made:

- Strengthen early antenatal registration through community-level awareness drives, given that only 30.7% of pregnant women registered at the family welfare centre despite high overall awareness of and visitation to health facilities.
- Prioritise improvements in water-supply continuity and household drainage infrastructure, particularly in localities with a high proportion of families lacking closed drains.
- Expand adult literacy and vocational skill-building programmes targeted at women, to narrow the observed gender gap in literacy and to diversify the occupational base beyond unskilled labour and housework.

- Reinforce growth-monitoring and supplementary nutrition follow-up for children, as these showed comparatively lower coverage (about 73%) than immunisation coverage (93-99%).
- Continue and expand SCSP-funded outreach health camps, including Unani preventive and promotive care, given the strong community preference for subsidised or government-supported health care.
- Consider periodic follow-up surveys with a more balanced sex distribution and a probability-based sampling design to strengthen the representativeness of future rounds and enable trend monitoring over time.

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