A Study on Social and General Health Status of Tribal Community in Mankuylam Panjayath, Idukki District, State of Kerala, India.

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Abstract*— The word 'tribe' is generally used for a socially cohesive unit, associated with a territory, often possesses a distinct dialect and cultural norms. They are the aboriginal inhabitants of our country who have been living based on a natural environment and have cultural patterns congenital to their physical and social environment. It is a human social system existing before the emergence of nation-states and in some cases, continues to exist independent of the state structure. Adivasis is the collective name used by many indigenous people in India. The term 'Adivasi' is derived from the Hindi word 'adi' which means of earliest times or from the beginning and 'vasi' meaning inhabitant or resident. Officially Adivasis are termed as 'scheduled tribes' but this is the legal and constitutional term. The tribes have been confined to low status and are often physically and socially isolated instead of being absorbed. They are the poorest, most marginalized, oppressed, and depressed people in the country. Kerala, a southwest small state in India, has achieved outstanding achievements in all human development indices in the country popularly known as the 'Kerala Model'. In many respects, Kerala's health status is almost on par with that of developed economies. The state has succeeded in increasing life expectancy as well as reducing infant and maternal mortalities. However, the celebrated Kerala model of development has not made much change for the socio-economic life of the marginalized sections of Kerala. The indigenous population or the Adivasis has been struggling to cope with the means of daily survival in the state. The present study attempted to analyze the social and general health status of tribal communities of Mankulam panchayath of Idukki district in Kerala. The study surveyed 150 tribal households in the panchayath and it clearly showed how tribal communities lag in various development indices like income, housing conditions, education level, land ownership, and general health conditions compared with non-tribal groups in the area. Women are more vulnerable among tribals just like everywhere. Excluded communities such as tribals typically face a lack of access to healthcare services that others do not. School dropout cases are much higher among tribals than non-tribals. Lack of proper housing, sanitation facilities, and lack of awareness often leads to non-access to various health and social beneficiary programs for the community. Lack of adequate income is the main reason for household poverty which leads to low nutritional intake results in low body mass index and nutritional anemia especially in pregnant women. Poor social conditions are found to be the root cause of high alcohol consumption among tribal communities which is associated with a wide range of social and health problems including domestic violence, child neglect, loss of income, high morbidity, and early mortality. Above all most of the tribal hamlets are located within the forest area or in isolated pockets where road access is a real challenge, transportation issues are one of the prime reasons for the poor access to quality health care. The lack of sufficient manpower and infrastructure facilities in the health care facility aggravates the problem.

***Index Terms*- Adivasi, Aboriginals, Scheduled Tribes, Nutritional anemia, Body mass index, school dropouts**

I. INTRODUCTION

Tribal people accounting for 8 percent of India's population are spread all over Indian states and union territories. They are predominantly found in the central-eastern and northeastern parts of the country. Despite their rich cultural heritage and unique social structures, tribal communities in India face numerous challenges in integrating with mainstream Indian society. Adivasis or scheduled tribes have always been a geographically and socially isolated section of Indian society, besides being a cultural-economic marginal. The cultural contact of tribals with non-tribals has further pushed them downwards. The intrusion of non-tribals into the tribal tracts and the changed approach of the government towards forests have resulted in numerous tribal problems[1/]. (PREET SAGAR[1]). Problems of poverty, illiteracy. Unemployment etc.

are some of the basic barriers to getting tribal people status equal to other non-tribal people in India.[2] (MUNIA NIMISHA[2]). Large inequalities in health exist between indigenous and non-indigenous people worldwide[3]. (CUNNINGHAM[3]). The vast majority of the tribals in India live in uneven or forested zones where ignorance, intense physical situations, poverty, deficient admittance to consumable water, and absence of individual cleanliness and disinfection make them more helpless against sickness[4]. (SAHA AND SAHA[4]) They are frequently marginalized from the rest of the population, their human rights are often abused, and there are serious concerns about their health and welfare[5] (SUBRAMANYAM SV[5]). They are more at risk of severe malnourishment due to a lack of proper development, poor awareness about maintaining and enhancing the nutritional value of food, and lack of hygiene and sanitation[6]. (BAWADKAR[6]). The mortality burden across the life course in India falls disproportionately on economically disadvantaged and lower caste groups[7.] (SUBRAMANYAM SV[7]).

II. LITERATURE REVIEW.

India, with 8.5% of the tribal population, is finding it difficult to bridge the gap that exists between tribal and non-tribal populations concerning healthcare. The tribal population suffers a triple burden of diseases; in fact, it is quadruple, namely communicable diseases, non-communicable diseases, malnutrition, mental health, and additions complicated by poor health-seeking behavior. (Kumar MM etal, 2020)[8]. Access to health care is poor among tribals. for instance. Only 56% of ST children were taken to a health facility for treatment of fever in 2005 compared to 67% of non-ST children. Mothers of tribal children are also less likely to obtain antenatal or prenatal care from doctors or have an institutional delivery. Also, generally, absenteeism from doctors working in rural areas aggravates the problem. (PANDA. RK 2016)[9]

A study done among the tribal population by Deepa Chandran[10] (2012) observed the pathetic situation of Adivasis/ Tribal people in Kerala, a paradox within the highly acclaimed Kerala development model. According to Divya Chandran, marginalization of the tribal population is found in its worst form in Kerala, which often goes unnoticed due to various reasons Though Kerala presented a scene of a paradox within paradox in terms of acute marginalization of its tribal communities amid high human development achievements, signs of positive changes can be traced in various realms, even though the researcher state that under pressure from different politically mobilized tribal groups, there is an appreciable change that the policy markers gave the tribal backwardness in the state considerable weight during the last decade. Besides, Kerala is the only state where the tribal-total differential in housing and basic amenities deprivation has narrowed down during the previous decade.

It has long been suspected that tribal people have poor health and substantial unmet needs; health care for tribal people remained subsumed in rural healthcare settings. It was assumed that tribal people have the same health problems and similar needs; hence, the uniform national pattern of rural health care would also be applicable. The different terrain and environment in which they live, social systems, cultures, and health care needs were not addressed. Not surprisingly, health and health care in tribal areas remained unsolved problems. (Anderson I et al[11], 2016).

An in-depth study conducted by Mathew Sunil George, Riches Davey, Itismitha Mohanty, and Penney Upton[12] in 2020 Points out certain vital information about the critical health statistics of Kerala tribes. The study states that improving access to health care for indigenous communities would require UHC intervention to be culturally safe and locally relevant and promote active community involvement at all stages of the intervention. The researchers pointed out that continuing structural power imbalances that affect access to resources and prevent the full participation of indigenous communities also need to be addressed.

Even in low-income countries, non-indigenous people experience better health outcomes compared to indigenous people. (Anderson I et al[13] 2016) (Zhaoy et al. [14], 2013) (Government of Australia[15], 2015), (Mc Calman J et al. [16] 2016). (Anderson N[17], 2005), (Ministry of Health and Family Welfare, Govt: of India[18], 2019).

Advances in health care have significantly improved the prevention and treatment of disease globally. However, the benefits of these developments have not been distributed equally across society. In particular, the indigenous population often has less access to health services than their non-indigenous contemporaries. (Anderson I et al[19] 2016) (Zhaoy[20] et al, 2013), (Valeggia CR et al[21], 2015) (Sim F and Mackie P[22], 2019).

8.6% of the tribal population constitutes 30% of all cases of malaria and as much as 50% of the morality associated with malaria. The estimated prevalence of TB (per 100000) was 703 cases against 256 in the non-tribal population. Also, only 11% of pulmonary TB get treated based on smear-positive reporting. The proportion of new leprosy cases was found to be 18.5%) India was declared to have reached the WHO largest of elimination as a public health problem with less than 1/10000 cases by the end of 2023) The percentage of children underweight is found to be 42%, and about 77% of under-five children are anemic. It has been reported that malnutrition and child deaths are in spurts, reported mostly during rainy seasons. Almost 50% of adolescent ST girls have a Body Mass Index (BMI) less than 18.5. About 65% of tribal women (15-45 years of age) suffer from anemia (non-tribal 47%). More than 72% of tribal men 15-54 years of age use tobacco, and more than 50% consume alcohol, against 56% and 30% of non-tribal men, respectively. The children having full immunization coverage only 56%, which affects IMR at 44.4%, and the under-five mortality at 57.2%. (Narain J[23], 2019)
Martines-Rodriques, Marceline Aranda, Saseendran Prasanth, and Niteesh Kumar[24](2020), in their study about the contradictions of tribal development in Kerala, document some critical issues. The literacy rate among the Indian tribes is 59 percent, and among females, it is only 49.4 percent (2011 census), while the non-tribal population's national literacy rate is 74%. In Kerala, the non-tribal population’s literacy rate is 97%, while the tribal population is only 67%. The study notes that health is a fundamental issue faced by the tribes in Kerala. High infant and maternal mortality rates, nutritional deficiency, sickle cell anemia, Tuberculosis, Cancer, etc highly prevalent among the tribes of Kerala. According to the 2011 census, only 16.7% of tribal households have access to clean drinking water. The unavailability of septic latrines in the tribal colonies pollutes the drinking water and accentually raises many diseases. The development experience of the state of Kerala in southwest India is based generally on democratic principles of equality and popular participation. But when it comes to the case of Adivasi the mainstream society of Kerala largely treats them as secondary citizens and ignores their right to be socially and economically empowered. (Anu George[25], 2023)

Lack of education is one of the significant factors for the slow advancement of tribal communities in all dimensions of life. The disparity in quality education always produces a wider gap within society because of the development of two parallel systems of education. The 2021 Kerala secondary school leaving certificate (SSLC) recorded an all-time high pass percentage compared to earlier years. Despite a liberal exam pass policy that reflected in the highest pass percentage, one district in the state underperformed; Wayanad, the district with the highest population of tribal communities in Kerala. More than 86% of students who failed the SSLC exam in 2021 belong to scheduled tribes (STs) (THE WIRE JOURNAL, AUG-2021)[26].

Despite the benefits accruing to the ‘Kerala Development Modal,’ the exclusion of tribal communities in the Western Ghats continues to be a policy concern. While the Kerala model was able to uplift the living conditions of a large segment of the Kerala population, it is also responsible for producing high levels of economic and social inequality in the state. A study done by Damodaran Rajasenan, Augusto de Venazi, and Rajeev Bhaskar[27] (2019) among the tribal settlements in Wayanad and Idukki districts in Kerala observed specific critical issues. The irregularity of the food supply and high costs associated with retrieving such foodstuff is the reason for chronic poverty, which further leads to malnutrition and health issues. Tribal hamlets are usually located in remote areas, creating transportation issues. The study says that the exclusion of the Indian tribal population is well beyond the mere experience of being poor, whereas poverty refers to a lack of disposable income. Exclusion entails a relative loss of social rights and a struggle to access essential services such as education, proper housing, and health care.

Primary health care has proven to be a highly effective and efficient way to address the leading causes and risks of poor health and well-being today and handle emerging challenges that threaten health and well-being tomorrow. More importantly, the mere establishment of PHCs and sub-centers cannot overcome the poor health of marginalized rural, tribal, or Adivasi populations in India. The scarcity of trained human resources to deliver quality health services is a major problem and an obstacle to extending health services to rural and tribal areas. Traditional healers, often the first point of care, can be sensitized and trained to deliver simple interventions and to assess when to refer to higher centers. Tribal boys and girls with minimum education can be prepared as community health workers and incentivized to work in their community. (Kumar MM, Pathak VK and Ruikar M[28],2020).

An effective Primary Health Care system is an essential and crucial part of any country to achieve not only a better, healthier life but also a stable social life. The concept and implementation of a quality PHC system is significant and vital, especially in middle and low-income countries, including India, where the majority of the population lives in rural areas. Health and economy have a direct correlation; as the economy of a country improves, the health of its citizens improves, and vice versa. Primary healthcare must be accessible must be accessible to the people to whom it is being given. A big hospital or a medical college located 30km away from the patient's home cannot be considered as Primary healthcare. Primary Healthcare must be acceptable as well as affordable to the people. Primary Healthcare is the basis of the Health Infrastructure of the country. A suitable infrastructure can help a country to achieve health-related Sustainable development goals.

III. SIGNIFICANCE OF THE STUDY.

Kerala is considered to have gained some remarkable achievements in the health care indicators which stands in the top position among the remaining Indian states. Even amid its extraordinary development famously known as the ‘Kerala Model’, the status of tribals in the state was pathetic. This study attempts to analyze the main issues and challenges of the health care system and the level of inequities in the tribal communities of Mankulam Panjayat of the Idukki district.

IV. OBJECTIVES OF THE STUDY.

To analyze the health status of tribal communities in the panchayath.
To examine the various challenges the tribals face in achieving quality health care in the area.
To examine various social factors that affect tribals ' seeking behavior and geographical aspects (connectivity and transportation problems) affect accessing quality health care

V. MATERIALS AND METHODS.

STUDY DESIGN.

The study was carried out among tribal and non-tribal communities in Mankulam panchayath in the Idukki district in the state of Kerala. Idukki district has the second highest population in the tribal community after Wayanad district in Kerala. Mankulam is a panchayat with more than 2500 indigenous people residing in isolated pockets in forest-covered areas with a severe shortage of connectivity and transportation facilities.

TARGET AUDIENCE AND DATA COLLECTION

Mankulam is a panchayat located on the eastern sloping plateau of western ghats, in Devikulam taluk of Idukki district of Kerala, and covers an area of 1023 sq. km. The population of Mankulam consists of tribals and non-tribals: the two tribal communities being the mannan who are fewer in numbers than the majority category Muthuvan. There are about 13 tribal settlements in Mankulam panjayat. The Muthuvan primarily lives in Devikulam and Admail blocks in Devikulam taluk of Idukki district. Most of the tribal settlements are within the forest area. The tribals are dependent upon the forests for their livelihood throughout the year. At one time the settlements were completely remote and had no contact with outsiders, but that has changed now.

The study covers the population of tribal and non-tribal communities in the area. A field survey was conducted between December 2023 and April 2024in Mankulam panchayath. As per the figures of the forest department, there are about 13 settlement colonies of

tribals in the area. as families in the settlement. A random sampling technique has been adopted to collect data from the population. The sample size consists of 150 households (682 individuals) from the tribal and 146 households from the non-tribal community (640 individuals) in the panchayath. The sample has been collected from all 13 wards of the panchayat to get equal representation from all geographical areas. (grama panchayats have been divided into wards for administrative purposes). Attempts have been made to include an equal number of men and women in the sample.

In-depth interviews (IDs) with the community took place during house visits. Questionnaires including open-ended questions have been given to members of households to answer to assess the satisfaction level of health care to beneficiaries. Data on other facts including the level of immunization among children, rate of missing doses of immunization, etc have been checked directly by the mothers (cross-checked with the immunization cards) with the help of community health workers. Information on Special issues among women like domestic violence has been collected from housewives with the help of lady health promoters. The body weight of teenage girls (13-19 years of age) was measured directly during house visits. Weight is measured using standard methods. Underweight was defined as body mass index (BMI) < 18.5 kg/m^2. The pallor of conjunctiva and nail was used to asses anemia status among the community members. The prevalence of nutritional anemia among tribal women of reproductive age (18-45) was assessed by assessing hemoglobin levels using a hemoglobin strip apparatus and classified as nonanemic, mild, moderate, and severe anemia based on the World Health Organization classification.

Data have been collected on various health services and associated challenges among communities collected from the sources of health care providers. Observation on beneficiaries conducted in the health facility (Primary Health Centre, Mankulam) during working hours, to monitor their interaction with the health care provider. It is a clear fact that the indigenous community feels apprehensions and insecurity when interacting with mainstream society and this seclusive attitude often affects their healthy involvement with the outside world. So, the observational study helped to get some ideas about the quality and dynamics of interaction.

Data was collected on basic health figures and other facts of the non-tribal community from various sources including the health department, local self-government, and community health workers. this helped the study to have a basic comparison between the indigenous and non-indigenous communities in the panchayath.

Interviews have been conducted among the health care providers (Primary Health Centre, Mankulam) to assess the quality of services provided by them.

VI. RESULTS

Health assessments and data collection were completed for a total of 1222 tribal and non-tribal people (150 tribal households and 146 non-tribal households) in the area across all age categories and genders. Characteristics of the sample are presented in Table 1 by social group. Inequalities are evident between tribal and nontribal members for indicators of education and socioeconomic status. Over one-third of tribe members have no formal education compared to less than 10% of non-tribe members. The proportion of tribe members living in BPL households (98%) (Below the Poverty Line) is much higher than for non-tribe members. (71%)

The literacy rate among adults (>18) among tribal communities is only 68% while in non-tribals it is 91% which is found to be a significant difference. Only 15% of the members in the settlement have gone up to high school education.

Among those who are employed 92% of tribals and 68% of non-tribals members reported working as daily wage labourers. It is noted that, unlike other tribal communities in other districts in the state, 98% of tribal families in the panchayath have a house with concrete or asbestos roofing which was constructed under government schemes. Normally even if housing is provided free by the government to all tribals in the state, very few communities are willing to reside under concreted roofing as most of them like to live in huts made of grass. 94% of households have an attached

toilet facility with the houses in tribals whereas in non-tribals it is 100%.

The dropout rate of scheduled tribe (ST) in Kerala remains higher than that of students in another category. The survey was conducted among 185 children (aged between 6-18 years both boys and girls) from tribals and 178 children from non-tribal families in the panchayath the number of school dropouts among tribal children was 9 (0.5%) which was much higher than non-tribals: only one. (0.07%) in the panchayath.

Table -1 Socioeconomic status – Tribals vs non-tribals.

TABLE-1

SOCIO-ECONOMIC STATUS TRIBALS VS NON TRIBALS		
	TRIBALS	NON TRIBALS
BPL Status	668(98%)	455(71%)
Literacy Rate >18 years	348(68%)	323(91%)
Casual Labor	442(98%)	418(68%)
House with attached toilet facility	148(98%)	146(100%)
School dropouts	9(0.5%)	1(0.07%)

Source. Author's field study analysis

VII. SYSTEMATIC EXPLOITATION OF TRIBALS

The tribal people have been systematically robbed of their land and belongings in the district. Whenever they organize themselves to protest against injustice and ask for land, their agitation has been borne by force by mainstream society. Of 55, 815 tribal people in Idukki district, 3078 families do not have habitable houses. As many as 317 families do not own land. During this survey, it was reported that around 39 households (9%) live in damaged houses, which are not repaired due to financial issues and they are almost inhabitable during the rainy season. When it comes to non-tribals the households without proper housing are only 2% in the panjayath. The rate of non-possession of land among tribals is 3% and non-tribals is only 0.5%.

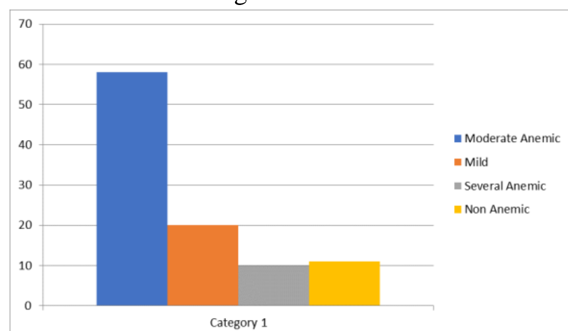
VIII. HEALTH SURVEY

The study conducted among 148 expecting and nursing mothers (tribal 78 and non-tribal 70) showed some crucial results. 100% of tribal women have registered their pregnancy with the local health agency. However, women among tribals, out of 78 surveyed 63 (82%) have less information about various government programs like the Maternity Benefit Programme (MBP) OR Janani Suraksha Yojana (JSY) than non-tribal women (96%). Among tribal women, 82.9% had 1st trimester registration of pregnancy whereas 98.5% of non-tribal women had the same. Only 78% of tribal women make regular follow-up visits during the first and second trimesters of pregnancy while among non-tribals it is 98%.

IX. PERVALENCE OF NUTRITIONAL ANEMIA AMONG TRIBAL WOMEN

Nutritional anemia was assessed among the tribal women of the study area in the reproductive age using a hemoglobin analyzing strip meter. The study was done among 110 women between the ages of 18 to 45 years. It was reported that only 12 % of tribal women in this category were found to be non-anemic. 58 % were found to be moderate anaemic, 20 % had mild anaemia and 10% of tribal women were suffering from severe nutritional anaemia. Malnutrition often leads to being underweight as well which is primarily affecting women in society. During the survey, we observed a considerable number of teenage girls (13-19 age group with lower body weight than the desired BMI ratio. Out of 77 girls screened, 68 % had low body weight, whereas in non-tribals the rate was only 14%which was found to be a huge gap.

Figure 1 shows the prevalence of nutritional anemia among women 18-45.



Non-anaemic- 11 (12%)
Moderate anemic-63 (58%)
Mild anaemic- 22 (20%)
Severe anemic-11 (10%)
Source. Author's field study analysis.

Immunization among tribal children.
For assessing the utilization of immunization services, 98 tribal mothers and 96 non-tribal mothers having a child of the age of 12 to 24 months of age are considered for the study. Children who received BCG, measles, and three doses of each of DTP and polio (excluding polio 0 are considered to be fully vaccinated. All the vaccines must be administered by the time the child is one year of age. The proportion of partially immunized children (the child had not only been immunized. But received only one or two doses of vaccine for his/ her age as per UIP schedule), among tribal and non-tribal was 4% and 1% respectively. The proportion of tribal children receiving complete immunization without delay was 82% and among non-tribal children, 94% respectively.

X. MENSTRUL HYGIENE AMONG TRIBAL GIRLS

98 adolescent girls between the ages between the ages of 13-17 from tribal and non-tribal girls who attained menarche were surveyed to assess and compare the menstrual hygiene pattern. It was reported that 82 % of tribal and 94% of non-tribal girls are using sanitary pads regularly. Around 68% of tribal girls reported changing pads three times a day during menstruation, while in non-tribals it was 92%. 16% of tribal girls reported that sometimes they use thick clothes instead of pads as purchasing sanitary pads may not be affordable to them or getting to the nearest shop is time-consuming.

XI. ADDICTION AND RELATED SOCIAL ISSUES

The survey was done among 150 households of tribal hamlets in the panchayath. The members selected were above 18 years old. It was reported that 80% of men consume alcohol once a week, 60% of them at least three days a week and nearly 44% of men above 18 years consume alcohol every day. Surveys among women for alcohol consumption were difficult as many of them were reluctant to answer due to social reasons. We collected information from third parties and it was reported that around 21% of women consume alcohol at least once a week and 45% of women drink alcohol in the festival seasons. Betel leaves with tobacco chewing were found among 98% of women and men > 50 years of age in the hamlet. We collected information on illicit drug usage among teenage boys and young men aged 15-25 among tribals and it was reported that around 42% of this age group consumes parts of the cannabis plant, which is often cultivated illegally in deep forests.

The 100% of surveyed members of the settlement responded that transportation issue is the major problem they face in accessing timely health care. Most of the hamlets are located within the deep forest and they need to travel by walking kilometres of distance to reach the nearest health facility. Moreover, the Primary Health Centre, Mankulam has only one doctor who too available from 8 am- 2 pm only. in case of any emergency health needs after this time, the tribes have to travel nearest secondary health facility that is Taluk hospital Admail which is 37 km away from Mankulam.

XII. DISCUSSION

Social, financial, and health inequalities are evident in the manual panchayath, with tribal communities bearing a higher burden of inequalities compared to non-tribal groups. Financial stability is the most important factor for the advancement of a society. However, in the panchayath, nearly 98% of tribal households fall below the poverty line (BPL). This is primarily because of the lack of opportunities in

modern society to engage in a good income-generating occupation. Lack of higher education, seclusion from mainstream society, and exploitation from mainstream society culminate the problem. The majority of the children have gone up to high school level only. The school dropouts among tribals are comparatively higher than in non-tribal communities. It was reported that girls in tribal communities outnumbered boys in school dropout cases: six out of nine During interviewing the members of households. Early marriage of girls could be the reason for more girl students dropouts: the study observed. it is reported that teenagers are forced to work to add to their household income. The tribal promoters reported that tribal children normally skip classes and once they stay away, they never return to school. The school officials, when contacted for the research, reported that tribal students generally find it difficult to mingle with other students as they face identity issues and feel insecure among non-tribal students. It also doesn't help when the parents are illiterate and unaware of the importance of education.

Social and financial backwardness often primarily affects the effective healthcare utilization of a society and it is very evident in the tribal communities as the huge gap exists between tribals and non-tribals in their healthcare utilization pattern. The study was done among pregnant and nursing mothers among tribal and non-tribal women in the panchayath to identify the remaining differences that exist in the utilization of services between tribal and non-tribal women and it was reported a huge gap in using services starting from pregnancy registration, follow up checkups and availing maternal benefit programs. The study found that the main reason for the skipping follow-up check-ups is mainly due to a lack of awareness and transportation issues in reaching the nearest health facility (Primary Health Centre, Mankulam). The nearest health facility to access a gynecological service from the Mankulam panchayath is located in Admail town which is 37 km away. The study found that remarkable progress has been achieved in reducing mother and infant mortality rates among tribals in Mankulam settlements. No such has been reported for the last 3 years in the hamlets. This is mainly because of the intervention of local health workers and routine and regular visits to the settlements to create awareness among tribal women regarding the importance of institutional delivery. The survey showed that 100% of lactating tribal mothers in the hamlet received gynecological care during their last trimester in the secondary hospital and underwent institutional delivery.

Nutritional anemia is a major health challenge among low-income populations, especially in pregnant women. Nutritional anemia is highly prevalent among tribals compared with non-tribal communities. They found around 90% of tribal women of reproductive age suffer from mild to moderate nutritional anemia often reflects the community’s low family income resulting in low nutritional intake.

The survey attempted to take responses from tribal mothers for the reason of the delayed or non-vaccination of children. The awareness among mothers plays some role in this matter. Mothers with high school and above education were more aware of the importance of vaccination among children than less educated mothers. Children of Mothers with high school or above education are fully vaccinated without any delay, observing that mothers’ education status played an important role in the timely immunization of their children. Some mothers in the tribal hamlet complained about the transportation issues to reach the health facility. very few replied that the after-effects of vaccination in children including fever make them scared about a child’s vaccination.

The study also observed that sanitary menstrual hygiene practices among women are less prevalent in tribal communities in the panchayath compared to non-tribals. Awareness programs and tribal health policies need to be accelerated for the promotion of menstrual hygiene. The government agencies can promote sanitary hygiene practices among tribal women by dispensing sanitary napkins free of charge as purchasing menstrual pads may be an affordability issue for them.

Domestic violence is a major reason for poor psychological well-being among tribal women. The prevalence of heavy alcohol consumption among tribal men severely affects their family life, the well-being of tribal children, and above all the psychological well-being of the housewife. The survey was done among married women above thirty years

old with at least one child in the settlement. It was reported that 72% of women suffer from mild to moderate domestic violence either physical or verbal from their husbands. Women responded that drinking alcohol was found to be the main reason for domestic abuse. Moreover, we observed that poor education, lack of awareness, and secluded life from the external society all make them more vulnerable and force them to be silent and suffer atrocities.

Most of the tribal people in the rural parts of the district are out of the reach of recent health advancements in the district. It was reported that tribal families shun modern healthcare facilities for culture and tradition. community members are often reluctant to take advanced treatment as it is believed to be against their cultural beliefs. It has to be noted that lack of awareness of good health among tribal communities is the prime reason for this problem.

100% of members from the tribal community were complaining about the transportation and connectivity issues, lack of adequate manpower in the health facility lack of free medicines from the government-running hospitals, and above all lack of adequate interest from the provider's side; needs to be addressed in an emergency manner.

CONCLUSION

In this study, the researcher attempted to analyze the general social and health status of tribal communities of Mankulam panchayath and tried to get an idea about the gap between tribals and non-tribals in the area. It is evident that apart from the financial, connectivity, or lack of awareness leading to poor health access to tribal communities, the study suggests some other factors that include social exclusion from mainstream society, which must be addressed. There is a need for future research to systematically test the role of discrimination in the health of Scheduled Tribes and other marginalized groups in India.

In this study, the researcher points out some of the basic issues the tribals are facing. A low level of education leads to a lack of general awareness often resulting in exclusion from the outside world. Proper policies must be implemented to avoid early school dropouts among tribal children. Existing Nutritional programmes he reassesses by the agencies to seal the loopholes within the system.

Inadequate public provision of health care and increased reliance on private players are particularly affecting the most vulnerable sections of society. Exclusion from infrastructure, quality health care and education, etc has led tribal communities to a situation where they find it difficult to cope with the outside world's present situations.

Even in Kerala. Known for the socially advanced or egalitarian state, the health condition of the tribal community continues to lag behind other social groups. Policies and programs should be designed to benefit the tribes. Legal action should be implemented to protect them from exploitation by the external society. Policymakers should bear in mind that tribals are aboriginals and they have their own distinct culture and heritage. So, it must be a slow and sustainable reform to develop their condition by protecting their tradition as well. Improving the health of tribes will likely require multipronged efforts that try to address the very roots of inequality, discrimination, and social injustice that constrain their opportunities to live healthy lives.

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