DEMOGRAPHIC AND HEALTH SCENARIO OF TRIBAL PEOPLE IN RANGAMATI SADAR THANA

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ABSTRACT

In South East Asia, Bangladesh is a densely populated country with a well-off tribal presence. Around 58 tribes are living in different parts of the country. Bangladesh has 1.2 million tribal people, which is just above 1 percent of the total population. Whatever the inhabitants they diverge in their traditional social organization, marital customs, rites and rituals, food and other customs from the people of the rest of the country. This paper presents a short description of the demographic and health characteristics of the Tribal people of Rangamati Sadar Thana on the basis of data collected through a field survey. This paper also discovers that the tribal people are lagging behind the general population with respect to demographic, health, political and technological standings and still living with outdated lifestyle and principles.

INTRODUCTION

Even though human race instigates from a unique origin, the racial inequity keeps this reality far from its existence in modern world. Although as Bangladeshi, we like to establish ourselves as homogeneous national body, a significant part of the total community could not converge to a single dot. We should not consider tribal people as outsider who treaded here in the fallow land thousand years before and made it a cultivatable and living land. But it is their ill-fate that led them to be run downed even from obtaining a dignity of first-class citizenship and has lead them in poverty, malnutrition, starvation and so on.

The aborigines are intending to loose their unique feature, culture, ritual custom, language, and expectations from life very mercilessly in contrast to getting the blessing of modern science and technology that reduces the distance of the world in a great extent.

There are many major problems of the tribal peoples in our country that needs instant attention and quick solution. The problems correspond to various aspects of tribal people's viz. social, economical, educational, health, religion, land, law and order situation, self-centered tendency and so on. Many of these setbacks cannot be well-perceived due-to short of necessary and sufficient information.

The present study is an endeavor to collect factual information about the demographic and health characteristics of the tribal people in our country.

It is clear that such information is indispensable before we can discover the needs and requirements of the tribal peoples and suggest strategic and practical solution to their problems.

OBJECTIVES OF THE STUDY

The general objective of the study is to provide demographic and health scenario of the tribal people of Rangamati Sadar Thana.

The specific objectives are:

- To describe the demographic characteristics of the tribal population of the sample household in the study area.
- To draw a true picture of their health characteristics and health knowledge.
- To compare the result with that of the national label.

LIMITATIONS OF THE STUDY

As every research has some limitations, this research work is not an exception of this rule. Firstly, all data have been collected from the Rangamati Sadar Thana only. Beside this, only nine groups of tribal people were included in the study population even though many tribal people of different races are scattered in many places of Bangladesh and as such it does not represent the whole tribal people of this country and the results cannot be generalized.

Secondly, we did not collect data proportionately for different races. Time was limited to conduct the research work properly. Finally, this was a self-financed study, which confined the various scopes along with the scope of extending the study area and increasing the sample size.

METHODOLOGY

The study materials were collected through literature review and field survey. The research study considered both quantitative and qualitative data collection method. A number of persons from different races were chosen for in-depth interview in order to improve the quality and reliability of the information collected from the sample survey.

Study Area and population
Rangamati Sadar Thana of Rangamati District was considered as the study area; a hilly district of Bangladesh that has a significant number (2, 23,292) of tribal people and is the most populous Thana. All the tribal people of Rangamati Sadar Thana have been taken as study population.

Sample size and Sampling Procedure
We have selected proportionately 200 households sample from urban and rural areas of Rangamati Sadar Thana by using 'Two stage stratified cluster sampling', where the rural and urban areas are considered as strata's and the Mauzas are considered as clusters. A comprehensive interview schedule was used for collecting data to achieve the study objective.

A guideline of questions for in-depth interview was used to keep the respondents on track and a tape recorder was used to record the conversation.

DEMOGRAPHIC AND HEALTH CHARACTERISTICS OF THE TRIBAL PEOPLE SURVEYED

Introduction
This paper describes the composition of the tribal population surveyed with regard to some demographic and health characteristics. The demographic characteristics include age, sex, marital status, age at first marriage, family size, knowledge of family planning etc. whereas the health characteristics includes the kind of illness usually faced by them, normal sources of treatment, AIDS knowledge etc.

Age and Sex Composition of Tribal Household Population
The distribution of the household population covered in this survey is shown in Table 1 by five-year age groups, according to sex and urban-rural residence. The Survey household constitutes a population of 1055 people.

The population is approximately equally divided into females (52 percent) and males (48 percent). Because of relatively high levels of fertility in the past, there are more people in the younger age groups than in older age groups of each sex. Forty two percent of the population is below 15 and only about two percent is age of 60 or older. The proportions below age 15 are almost more than twice as high in rural areas (50 percent) than in urban areas (21 percent). Overall, the number of women slightly exceeds the number of men. This pattern is especially pronounced at age 10-29, which may be due in part to national migration of young men for work. However, some combination of over reporting ages of men and/ or under reporting of ages of women may account for the excess of men over women at age 40 and above. Figure-1 shows the distribution of the male and female household population by age group.

Table 1: Tribal household population by age, residence and sex

Age Group	Urban			Rural			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	9.2	7.0	8.1	16.8	15.4	16.1	14.6	13.0	13.7
5-9	5.9	5.0	5.5	17.2	16.4	16.8	13.8	13.1	13.5
10-14	6.4	7.0	6.8	17.7	18.0	17.8	14.4	14.8	14.6
15-19	12.8	16.3	14.6	9.4	10.8	10.0	10.2	12.4	11.4
20-24	13.6	16.3	14.9	7.1	8.0	7.5	8.9	10.4	9.7
25-29	9.4	10.1	10.0	8.3	9.4	9.0	8.7	9.8	9.3
30-34	7.3	8.1	7.8	5.7	7.1	6.4	6.1	7.5	6.8
35-39	6.6	5.0	5.8	6.0	5.1	5.6	6.3	5.1	5.7
40-44	7.9	7.0	7.4	3.6	3.0	3.4	4.9	4.1	4.5
45-49	8.5	6.2	7.4	4.5	3.8	4.1	5.9	4.5	5.1
50-54	4.6	3.8	4.2	2.1	1.3	1.6	2.8	2.0	2.3
55-59	2.9	2.9	2.9	1.3	1.0	1.2	1.8	1.6	1.7
60+	4.9	3.8	4.5	0.3	0.6	0.5	1.8	1.5	1.6
Total	100	100	100	100	100	100	100	100	100
Number	150	159	309	356	390	746	506	549	1055

Figure 1: Population Pyramid
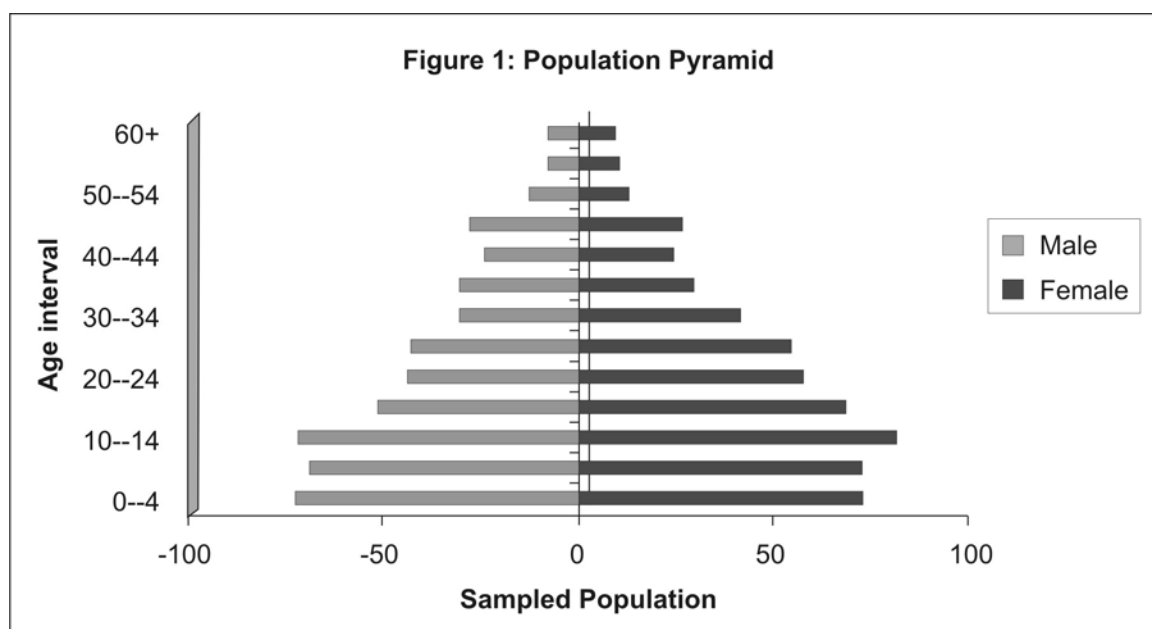
Household Composition

Table 2 shows that a small minority of household in study area are headed by females (2.5 percent), with more than 97 percent headed by males. Female-headed households are almost equally uncommon in rural and urban areas. The average household size in study area is 5.3 people, with nonexistent variation between rural and urban areas. Two person households are very rare in both rural and urban areas.

Table 2: Household composition by sex of household head and household size, according to urban-rural residence

Characteristics	Residence		Total
	Urban	Rural	
Household Headship			
Male	96.3	97.9	97.5
Female	3.3	2.1	2.5
Number of usual member			
2	1.7	0.8	1.0
3	8.3	2.1	4.0
4	30.0	15.7	20.0
5	26.7	42.1	37.5
6	15.0	26.4	23.0
7	13.3	10.0	11.0
8+	5.0	2.9	3.5
Total	100.0	100.0	100.0
Mean Size	5.2	5.3	5.3
Minimum	2	2	2
Maximum	9	11	11

Marital Status

Marriage is a Social System, which is found in every society. Marriage is the legalized sexual union between two opposite sex. It is one of the most important demographic factors.

Table 3 shows the marital status of the tribal population surveyed by sex, according to urban-rural residence. It is observed that overall 44 percent of the people are currently married. This proportion is slightly higher in urban areas (49 percent) as compared to (42 percent) rural areas with no existent variation between man and woman.

Overall 54 percent population are never married in the study area but this proportion is higher in rural areas (56 percent) compared with (49 percent) in urban areas and here also sex differential is not exist significantly. Formally Married populations are rare in the tribal society surveyed in both rural and urban areas.

Age at first Marriage

Table 4 gives information on age at first marriage. The Table shows the percentage of all married population (male & female) by different age at first marriage according to urban-rural residence. The median age at first marriage for overall population is age 16 whereas the median age is age18 and age 14 for men and women respectively.

About 20 percent of the total populations first age at marriage is age 13 or less and this proportions for women are almost eight times as high as men, this proportion is also two times higher for the population in rural areas, compared with urban areas. Most of the married people's (42 percent) 1st age at marriage is age 14-16 and as expected the percentages of women are higher than men in both rural and urban areas concerning this issue.

Table 3: Household population by marital status, sex and residence

Marital Status	Urban			Rural			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Currently Married	48.0	50.3	49.2	42.1	42.3	42.3	43.8	44.6	44.3
Formally Married	1.3	3.1	2.2	2.0	1.3	1.6	1.8	1.8	1.8
Never Married	50.6	46.5	48.5	55.9	54.4	56.1	54.3	53.5	53.9
Total	100.0	100.0	100.0	100.0	100.0	100	100.0	100.0	100.0

Table 4: All married population by different age at first marriage, sex and residence

Age Group	Urban			Rural			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
13 or less	1.3	21.1	11.9	5.7	40.0	23.5	4.3	33.7	19.7
14-16	21.6	50.6	37.1	35.0	53.0	44.3	30.7	52.1	42.0
17-19	48.6	17.6	32.0	50.9	9.4	26.3	50.2	12.2	30.2
20+	28.4	10.6	18.9	8.3	1.2	4.6	14.7	4.3	9.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	74	85	159	157	170	327	231	255	486
Median	17	14	15	18	14	16	18	14	16

About 30 percent of the overall population's marriage is age 17-19 with very significantly higher proportion of men than women in both rural & urban areas. Overall, only 9 percent of the population married by the age 20 or above and men are mainly concerned with this age group.

Differentials in age between spouses
Table 5 shows the differentials in age between spouses. For all married couples, the husband is older than the wife –generally 5 to 14 years older. Most of the couples (78 percent) age differences is 5-9, especially in rural areas. Also a significant percentage (13 percent) of couple's age differences is 10-14. The mean age difference between husband and wife is 7 years.

Table 5: Differential in age between spouses

Age (Husband's age minus wife's age)	Residence		Total
	Urban	Rural	
0-4	14.0	3.8	6.9
5-9	56.1	87.7	78.1
10-14	22.8	8.5	12.8
15+	7.0	0.0	2.1

Age at first birth
The age at which childbearing begins has important demographic consequences for society as a whole as well as for the health and welfare of mother and child. In many countries, postponement of first births- reflecting an increase in the age at marriage- has contributed greatly to overall fertility decline.

Early initiation into childbearing is greatly a major determinant of large family size and rapid population growth, particularly in countries where family planning is not widely practiced. Moreover, bearing children at a young age involves substantial risks to the health of both the mother and child. Early child bearing also tends to restrict educational and economic opportunities for women.

Table 6 represents the percent distribution of women by age at first birth according to current age. For women age 15 and over, median age at first birth is presented in the last column of table. Childbearing begins early in tribal study area, with a large majority of women becoming mothers before they reach age of 20. The median age at first birth is between 15 and 17. The data show that the median age at first birth has increased slightly from 15 for older women to 17 for women in their early twenties.

This slight change to later age at first birth is reflected in the smaller proportion of young women whose first birth occurred before age 15, about 21 percent of women in their forties report having had their first birth before age 15, compared with only 7 percent of women age 15-19.

Health and Health Facilities
In this survey, health related characteristics of the respondents were assessed through a series of questions. Respondents were first asked whether they or any one else of their family were become ill during last three months. Then about the kinds of illness, sources of treatment, Why not went to Govt. hospital etc. were asked serially. Information about the health related characteristics of the households thus assessed is presented in Table 7 according to the respondent's urban-rural residence.

Table 6: Household wives by age at first birth

Current Age	Women with no Births	Age at first birth							
		<15	15-17	18-20	21-23	24+	Total	Number	Median age at first birth
15-19	50.0	7.3	42.7	0.0	0.0	0.0	100.0	38	17.0
20-24	8.0	15.2	15.2	22.8	2.0	0.0	100.0	33	17.0
25-29	0.0	27.3	27.3	22.1	0.0	0.0	100.0	33	16.0
30-34	0.0	13.3	13.3	23.3	5.9	0.0	100.0	30	16.0
35-39	0.0	28.9	28.9	16.3	5.8	0.0	100.0	25	16.0
40-44	0.0	20.9	20.9	10.6	3.6	0.0	100.0	12	15.0
45-49	**0.0**	**23.2**	**23.2**	**1.6**	**0.0**	**0.0**	**100.0**	**9**	**15.0**

Table 7: Health Characteristics according to urban-rural residence

Characteristics	Residence		Total	Number
	Urban	Rural		
Illness Status (Ailment during last three months)				
Yes	73.3	58.6	63.0	126
No	26.7	41.4	37.0	74
Total	100.0	100.0	100.0	200
Kinds of illness faced				
Jaundice	13.3	12.2	12.6	16
Common Cold	6.7	9.8	8.7	11
Malaria	20.0	15.9	17.3	22
Fever	28.9	32.9	31.5	40
Skin Disease	4.4	8.5	7.1	9
Diarrhoea	11.1	6.1	7.9	10
Others	15.5	14.6	15.0	19
Total	100.0	100.0	100.0	126
Treatment Received(after illness)				
Yes	71.8	55.2	62.7	79
No	28.2	44.8	37.3	47
Total	100.0	100.0	100.0	126
Treatment Sources				
Govt. Hospital/Union Health Care Center	37.0	31.9	33.9	37
Private Doctor	37.0	7.2	19.1	22
Pharmacy	19.6	27.5	24.3	28
Quacks/Kabiraj	4.3	26.1	17.4	20
Others	2.2	7.2	5.2	6
Total	100.0	100.0	100.0	113
Causes of not going to Govt. Hospital				
Lack of proper treatment and medicine	78.6	68.9	71.9	64
Absence of Doctor	17.9	0.0	5.6	5
Far from Village	0.0	24.6	16.9	15
Others	3.6	6.6	5.6	5
Total	100.0	100.0	100.0	89

Overall, 63 percent of the respondents or any one else of their family became ill during last three months and the occurrence of disease is comparatively higher in urban households (73 percent) than rural households (59 percent).

Fever is the most commonly occurred disease among the ill tribal respondents or any one else of their family in study area, accounting for 32 percent with nonexistence variation in urban and rural areas.

Malaria is another main occurred disease accounting for 17 percent and this proportion is higher among the urban households.

Almost 13 percent of the tribal people are affected by Jaundice with a slightly higher proportion among the urban households. Common cold, Diarrhoea and skin disease are the other frequent diseases that affect the tribal people in study area with the same efficiency.

About 63 percent of the respondents received treatment for remission and the percentage of the respondents received treatment are higher (72 percent) in urban areas, compared with 55 percent in rural areas.

From the Table 7, it is also come to light that a large proportion of respondents (40 percent) normally get their treatment from Govt. hospital/Union Health Care Center and the respondents of urban areas are utilizing Govt. hospital/Union Health Care Center more than that of rural areas. 37 percent of the urban households depend on private doctor for treatment whereas this proportion is very small (7 percent) among the rural households. A good percentage (24 percent) of people also goes to the pharmacy to receive treatment mainly in rural areas. Pharmacies are situated in the Hats and Bazaars near the villages and the physicians, who have no institutional training, are the shopkeepers of those pharmacies.

Most of the villagers (26 percent) are also depending on their conventional quacks (or Kabiraj in local parlance). Clearly majority of the respondents, basically in rural areas are taking their treatment from the unregistered and unqualified physicians.

Table 7 also reveals the information about the causes of not going to Government hospital for receiving treatment. It is observed that 72 percent of the respondents do not go to Govt. hospital because they do not get proper treatment and medicine from Govt. hospital. A higher proportion of urban respondents gave this opinion than the rural respondents. Other common causes opines by the respondents for not going to Govt. hospital are: the health centers being far from their villages (17 percent), absence of doctor (6 percent) and others (6 percent).

Knowledge of Family Planning Methods
In this survey, knowledge of Family Planning Methods was assessed by asking the respondents whether they know or don't know the ways or methods by which a couple could delay or avoid pregnancy. Respondents who were able to name any method or way to avoid pregnancy were considered as having knowledge about Family Planning Methods otherwise not. Here, it is noticed that due to lack of proper cooperation from the women, the respondents was the household's head instead of their wives.

Knowledge of family planning methods thus assessed is shown in Table 8 according to urban-rural residence of the households.

Table 8: Knowledge of family planning methods by residence

Knowledge of Family Planning Methods	Residence		Total	Number
	Urban	Rural		
Yes	76.7	57.1	63.0	126
No	23.3	42.9	37.0	74
Total	100.0	100.0	100.0	200

Table 8 Shows that overall 63 percent of the respondents are known about the family planning methods and knowledge is much higher among the respondents in urban areas as compared with rural areas. Unfortunately, a remarkable proportion of respondents (37 percent) are still apart from the knowledge of family planning method. The percentages of rural respondents having no knowledge about the family planning methods are almost twice as high as in urban respondents

Sources of knowledge of family planning Methods
Table 9 shows the Information about the sources of knowledge about the family planning methods.

Among the 63 percent respondents who were familiar with family planning methods, almost 64 percent know about the family planning methods from Family Welfare Assistant (FWA) and the remaining 36 percent know from the source of mass media (Radio, Television, Poster, etc) and this proportion of respondents vary significantly for the urban-rural residence.

Table 9: Sources of knowledge of family planning methods by urban-rural residence

Sources of Knowledge	Residence		Total	Number
	Urban	Rural		
Family Welfare Assistant (FWA)	37.0	78.8	63.5	80
Radio/TV/ Poster, etc	63.0	21.3	36.5	46
Total	100.0	100.0	100.0	126

Rural respondents mainly come to know about the family planning methods from Family Welfare Assistant whereas urban respondent's main source of knowledge about family planning methods is mass media. Clearly, majority of the respondent's main source of knowledge about family planning methods are the Family Welfare Assistant.

Knowledge of AIDS

Acquired Immune Deficiency Syndrome (AIDS) is an illness caused by Human Immunodeficiency Virus (HIV), which weakens the immune system and leads to death. The virus is generally transmitted through sexual contact, through HIV-infected women to their unborn children, or through contaminated needles (injections) or blood. HIV and AIDS prevalence in Bangladesh have been on the rise. There have been various efforts to prevent HIV transmission, such as public health education through the media and the activities of both government and nongovern-mental organizations.

This survey included a section of questions on AIDS in order to assess knowledge about the transmission mechanisms and prevention of infection with the AIDS virus. The respondents were asked whether they had heard of AIDS and if so, how does it spread out and what can a person

do to avoid this etc. Knowledge of AIDS thus assessed is shown in Table 10 according to urban-rural residence of the respondents. Only 25 percent of respondents in tribal study area have heard about AIDS. Urban-rural residence has a very strong association with knowledge of AIDS.

Table10: Knowledge of HIV/AIDS by residence

Ever Heard of AIDS	Residence		Total	Number
	Urban	Rural		
Yes	51.7	12.9	24.5	49
No	48.3	87.1	75.5	151
Total	100.0	100.0	100.0	200

Knowledge of ways to spread out AIDS

Table 11 presents the percent distribution of the respondents who ever heard of AIDS by knowledge of ways to spread out HIV/AIDS according to urban-rural residence.

About 59 percent of the respondents reported that sex with AIDS infected person is one of the major ways to spread out AIDS.

Table 11: Knowledge of ways to spread out AIDS/HIV by residence

Way to spread out AIDS	Residence		Total
	Urban	Rural	
Sex with AIDS infected persons	63.0	58.2	59.3
Unscreened blood transfusing	47.0	38.9	41.9
Use of unstadilized syringes	58.9	13.2	35.8
Through pregnancy of AIDS infected mothers	20.3	8.1	13.7
Through breast feeding	7.0	3.9	6.1

Overall 36 percent of the respondents reported that AIDS can spread out by using unstadilized

syrines and the percentage of the respondents who opine this is about four times higher in urban areas, compared with rural areas. Other cited ways to spread out AIDS are 'through pregnancy of AIDS infected mothers' and 'through breast-feeding', cited by 14 percent and 6 percent of the respondents respectively. Comparatively urban respondents have better knowledge about the ways to spread out AIDS than the rural respondents.

The Comparative Situation between Tribal and General People

In this section, it has been tried to compare the study result with that of the national result regarding the demographic and health characteristics. This comparison has been shown in Table 14. This comparison also shows that, almost in every aspect of their lives the tribal peoples are lagging behind the common peoples of Bangladesh.

Table 14: The Comparison between Study Result and National Result

Sl No.	Indicator	Figure of the study population	National figure	Ratio= Study figure / National figure	Comparative situation of the study population
1	Average household size	5.3	5.2	1.02	Slightly higher
2	Sex ratio	92 males/ 100 females	98males/ 100 females	0.93	Slightly smaller
3	Population by age (percent)				
	<15	42.0	39.2	1.07	Slightly higher
	15-59	56.6	54.4	1.04	Slightly higher
	60+	1.4	6.4	0.21	More lower
4	Household Headship (percent)				
	Male	97.5	91.3	1.06	Slightly higher
	Female	2.5	8.7	0.28	More lower
5	Age at first marriage				
	Male	19.5	25.4	0.76	Lower
	Female	15.1	18.3	0.82	Lower
6	Mean age at first birth	16.1	17.8	0.90	Lower
7	Mean age difference between spouses	7.3	9.3	0.78	Lower
8	Person ever heard of HIV/AIDS (percent)	24.5	30.8	0.79	Lower

Average household size is higher in study area as compared with the national level. First age at marriage and mean age at first birth is lower among the study population than that of the national population.

Bivariate Analysis

Demographic and health characteristics also depend on some common factors. Here we have tried to find out the possible relationship between the different variables. Cross tabulation and possible statistical analysis have been done to examine and measure the relationship between each pair of variables. In this connection Chi-square test has been used to test the existence of the relationship between variables.

Summary of Results from Bivariate Analysis

Household size in relation to the race of household:

There is no significant association (p-value=0.33) between household size and to the race of household. The table shows that about 65 percent of the Chakma, 56 percent of the Tanchonga and 50 percent of the Tripura households have 2-5 members in their family. Also about 50 percent Tripura, 45 percent Tanchonga and 35 percent of

the Chakma households are with more than 5 family members.

Household size in relation to the Fathers education:
It is observed from the above table is that father's education is significantly associated (p-value=0.03) with household size. About 83 percent of the fathers who had obtained HSC and higher level of education has 2-5 family members whereas this family size is for the 62 percent of the illiterate fathers. Also about 48 percent of the fathers who had obtained secondary level of education have the family members more than 5 and almost 38 percent of the illiterate fathers have this family size.

Household size in relation to the Mothers education:
Mother's education has been found to be significantly associated (p- value=0.01) with the household size. Table 15 reveals that, the family size decreases slightly as the education level of the mother increases. Almost 38 percent of the illiterate mothers are in the family with more than 5 members whereas this percentage decreases with the increases of mother's education level.

Household size in relation to the Fathers occupation:
There is a significant association (p- value=0.00) between the father's occupation and the household size. About 54 percent of the agriculture workers and 41 percent of the businessmen have their family size more than 5. Besides these 80 percent of the day laborers, almost 74 percent of the fishermen and service holders, 62 percent of the woodcutters, 59 percent of the businessmen and 46 percent of the agriculture workers have their family size 2-5.

SUMMARY AND CONCLUSION

This study has investigated 200 households in the study area and 10 persons were interviewed who were well known to the tribal people of the study area.

The average household size in study area is 5.3 people, with nonexistent variation between rural and urban areas. Two person households are very rare in both rural and urban areas. The households in study area are mainly headed by males (97 percent).

The population is approximately equally divides into females (52 percent) and males (48 percent). Because of relatively high levels of fertility in the past, there are more people in the younger age groups than in older age groups of each sex. Forty two percent of the population is below 15 years of age and only about two percent is age 60 or more.

The marital status of the tribal population surveyed shows that overall 44 percent of the people are currently married and overall 54 percent population are never married. Formally Married populations are rare in the tribal society surveyed in both rural and urban areas.

It is also observed that the median age at first marriage for overall population is age 16 whereas the median age of both men and women are 18 year and 14 year respectively. About 20 percent of the total populations first age at marriage is age 13 or less and this proportion for women is almost 8 times as high as men.

For all married couples, the husband is older than the wife –generally 5 to 14 years older. Most of the couples' (78 percent) age differences are 5-9, especially in rural areas.

Childbearing begins early in tribal study area, with a large majority of women becoming mothers before they reach age of 20. The median age at first birth is between 15 and 17.

Overall, 63 percent of the respondents or any one else of their family became ill during last three months and the occurrence of disease is comparatively higher in urban households (73 percent) than rural households (59 percent).

It is also noticeable that fever is the most commonly (32 percent) occurred disease among the ill tribal respondents or any one else of their family in study area. About 63 percent of the respondents received treatment for remission. It is also come to light that, a large proportion of respondents (40 percent) normally get their treatment from Govt. hospital/Union Health Care Center and the respondents of rural areas are utilizing Govt. hospital/Union Health Care Center more than that of rural areas.

Most of the villagers (26 percent) also are depending on their conventional quacks/Kabiraj. Clearly majority of the respondents, basically in

rural areas are taking their treatment from the unregistered and unqualified physicians.

It has been observed that 72 percent of the respondents do not go to Govt. hospital because they do not get proper treatment and medicine from Govt. hospital. Unfortunately, a remarkable proportion of respondents (37 percent) are still apart from the knowledge of family planning method. The percentage (43) of rural respondents having no knowledge about the family planning method which is almost twice as high as in urban respondents. It is also found that among the respondents who are familiar with family planning methods, almost 64 percent know about the family planning methods from Family Welfare Assistant (FWA). Only 24 percent of respondents in tribal study area have heard of AIDS/HIV.

From the bivariate analysis it has been observed that family size is significantly associated with mother's education, father's education as well as father's occupation.

In our country the demographic and health status of the tribal people are significantly lower than the general people. All the governmental and non-governmental organizations working for the tribal people could take the significant steps to improve the above-mentioned status of the concerned people.

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