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Original Research Article

Demographic characteristics and health-seeking behaviour among scheduled tribes in west Tripura, Tripura: a cross-sectional study

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ABSTRACT

Background: Health-seeking behaviour (HSB) refers to the actions undertaken by individuals who perceive a health problem or illness and seek appropriate healthcare services or treatment. Understanding HSB and risk factors for non-communicable diseases (NCDs) among tribal populations is essential for planning effective public health interventions. This study assessed the demographic profile, socio-economic characteristics, lifestyle practices, healthcare-seeking behaviour, and prevalence of NCD risk factors among the Scheduled Tribe (ST) population of West Tripura district, Tripura.
Methods: A community-based cross-sectional study was conducted from April 2021 to March 2022 after Institutional Ethics Committee approval. Six ST-dominated villages in West Tripura district were selected. Data on socio-demographic characteristics, education, living conditions, dietary habits, lifestyle factors, addiction, and healthcare-seeking behaviour were collected through house-to-house surveys using a pretested structured questionnaire.
Results: A total of 5,829 individuals were surveyed, including 2,930 males and 2,899 females. The population included 1,461 children (771 males and 690 females). Poor living conditions, inadequate sanitation, unhealthy lifestyle practices, and low socio-economic status were identified as major determinants of disease burden. Although Tripura's literacy rate (87.22%) exceeded the national average (72.98%), 42.40% of participants reported gutkha or pan masala consumption, indicating a major behavioural risk factor for NCDs. Improved healthcare utilization and health status were observed, likely reflecting the positive impact of tribal welfare schemes.
Conclusions: Socio-economic conditions, lifestyle behaviours, and healthcare accessibility significantly influence health-seeking behaviour and NCD risk among the tribal population of West Tripura. Strengthening health education, tobacco-control strategies, and tribal welfare programmes may further improve health outcomes and reduce the burden of NCDs.

Keywords: Addiction, Cross-sectional study, Healthcare utilization, Health-seeking behaviour, Non-communicable diseases, Tribal health

INTRODUCTION

Understanding health-seeking behaviours (HSB) within a community especially among tribal populations is crucial for developing effective, needs-based healthcare programs.[1,2]

Health is also viewed as a state of dynamic equilibrium between an organism and its environment, involving

continuous and complex interactions with physical, environmental, and geographical factors such as mountains, plains, plateaus, and deserts as well as cultural influences, including customs, practices, and dietary taboos. Good health, therefore, signifies dynamic stability, normal functioning, and effective homeostatic regulation.[3]

Health seeking behaviour depends upon the severity of illness, the availability of health care facilities, the access to health care services and the economic condition of the individual/household and other such factors (Jayaprakash and Saravanan 2015).[4]

The country initially launched the "Rashtriya Swasthya Bima Yojana" (RSBY) to protect low-income households from the financial risks associated with hospitalization. In 2018, this scheme was revised and renamed "Ayushman Bharat".

The tribal groups are presumed to form the oldest ethnological sector of the national population. The term "Adivasis" (Adi-original; Vasi- inhabitants) has recently become current to designate these groups. The tribal population is at a higher risk of under-nutrition, because of the socio-cultural, socio-economic and environmental factors influencing food intake and health seeking behavior.[5]

Tripura, the second smallest state in northeastern India, is home to a substantial tribal population comprising 20 notified Scheduled Tribe (ST) communities. According to the Census of India 2011, the ST population of India is 104,281,034 out of a total population of 1,210,854,977. In Tripura, 1,166,813 individuals belong to Scheduled Tribes, accounting for 31.76% of the state's total population (3,673,917). Among the tribal communities, the Tripuri constitute the largest group (50.76%), followed by Reang (16.13%), Jamatia (7.14%), and Chakma (6.84%).[6] To improve the health status of tribal communities and promote health education, the Central Council for Research in Ayurvedic Sciences (CCRAS) initiated the Tribal Health Care Research Programme (THCRP). Under this programme, the present community-based survey was conducted by the Regional Ayurveda Research Centre, Agartala, Tripura. The present study was undertaken to evaluate the health-seeking behaviours, demographic profile, and socio-economic characteristics of the Scheduled Tribe population in West Tripura district, Tripura. It also aimed to assess lifestyle practices, healthcare utilization, and the community's perceptions and acceptance of Ayurveda as a preferred healthcare system.

METHODS

Study design and setting

This study was an observational -cross-sectional study. The study was conducted in six villages, namely Vrigudasbari, Uttar Joynagar, Konaban, Jonmejoynagar, Champaknagar, and Shyamnagar-within the West Tripura district of Tripura (Figure 1). These villages were chosen for their substantial ST populations and their proximity to the Regional Ayurveda Research Centre (RARC) in Agartala, Tripura. The survey was carried out from April 2021 to March 2022.

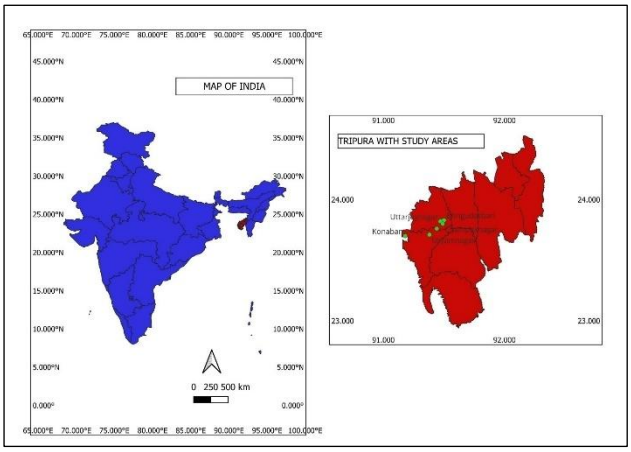

Figure 1: Map of India, Tripura, and west Tripura district showing the surveyed areas.

Study participants

Participants were exclusively drawn from the Scheduled Tribe-dominant population of six villages in West Tripura district, Tripura. The inclusion criteria for participants required that they be members of the scheduled tribe population residing in the specified villages or areas and be willing to participate in the health survey. Conversely, individuals who did not belong to the ST community were excluded from the study.

Study tool

Data were collected using a pretested, structured questionnaire administered through house-to-house surveys. The questionnaire was developed to obtain comprehensive information on socio-demographic characteristics, housing and environmental conditions, dietary habits, lifestyle practices, healthcare-seeking behaviour, and health status of the study population. The questionnaire was administered by trained investigators after obtaining informed consent from the participants.

Variables

The study collected information at the village, household, and individual levels. Village-level variables included general information about the study area. Household-level variables comprised caste, religion, type of housing, ventilation, household size, source and availability of drinking water, water purification practices, sanitation facilities (toilet and drainage), vector control measures, and type of cooking fuel used. Individual-level variables

included age, sex, marital status, education, occupation, physical activity, health-seeking behaviour, prevalence of non-communicable diseases, nutritional status, obesity, menstrual history of women, and preference for Ayurveda as a healthcare system. Information on school-going children included recurrent infections, history of pica, use of nutritional supplements, anthropometric characteristics, haemoglobin levels, and menstrual history, where applicable. Dietary variables included food habits, consumption of fruits and green leafy vegetables, and addictions such as tobacco, gutkha/pan masala, smoking, and alcohol consumption.

Quantitative variables included household size, frequency of healthcare visits, healthcare expenditure, age at first marriage, blood pressure, haemoglobin concentration, and blood glucose levels.

Data collection method

The survey data, collected as part of the outreach activity under the Tribal Health Care Research Programme of CCRAS at RARC, Agartala, in an ST-dominated area, involved prior communication with the BDO, Sarpanch, Gram Panchayat members, and other local authorities to explain the project's objectives, target beneficiaries, expected benefits, and implementation methods. Approval from the village authorities was obtained before commencing the activities.

A dedicated project team conducted weekly population surveys in the designated area, following a pre-planned tour schedule. The surveys were carried out through door-to-door visits to every household, where each member was interviewed using a close-ended questionnaire to collect demographic information. The objective was to gather comprehensive data on living conditions, socio-demographic profiles, and health-seeking behaviours in the selected villages.

Bias

To minimize selection bias, participants' identities were verified using government-issued identification cards provided by the Government of India. Survey staff received comprehensive training to ensure accurate and unbiased data collection. However, as convenience sampling was employed, the potential for sampling bias remains.

Sample size

Considering the prevalence of (p) of NCD in selected population is 50%. A margin of error (e) is taken as 2% in the estimation of prevalence. The sample size is calculated by statistical formula.

n=2401

The sampling will be performed through the cluster sampling procedure so a design effect of 2 is considered in the sample size and required sample size is 2401*2=4402. Adding a non-response rate of 20% in the data collection require sample size, the calculation was 4802+961=5763 (approximately 5800).

Statistical analysis

A descriptive statistical method was used. Measures of frequency and position of data were also used. As it was an observational study, qualitative data have been presented in numbers and percentages.

Ethical consideration

Ethical approval was obtained from the Institutional Ethical Committee. To protect participant's rights and confidentiality, the name and address of the surveyed participants are not disclosed in the article.

RESULTS

The survey collected health seeking behaviours and socio-demographic data from a total of 5,829 individual belonging to the scheduled tribe (ST) community participants across six villages namely Vrigudasbari, Uttar Joynagar, Konaban, Jonmejoynagar, Champaknagar, and Shyamnagar. The sample comprised population 2,930 males and 2,899 females, including 771 male children and 690 female children (Figure 2).

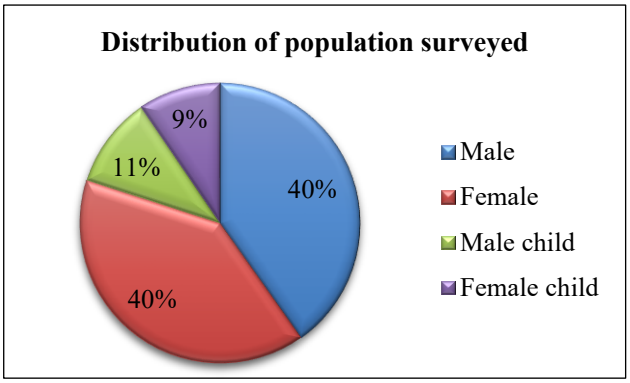

Figure 2: Distribution of population surveyed.

Household information

The data on the housing facility of 1191 houses was collected through a door-to-door survey. The majority of houses 49.88%, were of the kutcha type and 36.52%, semi-pukka with adequate ventilation. 92.19%. Houses had open/ surface drainage facilities. A majority of the population, 47.61%, used no purified water from tubewell boreholes or wells for drinking purposes. LPG facility is available in the of houses 42.15%, but wood coal/cow dung cake is used mainly for cooking purposes 57.85%. Toilet facilities were available in the majority of houses,

93.62%. About 97.15% of the houses used normal nets for prevention methods against vector-borne disease (Table 1).

Table 1. Status of basic house facilities in the village (n=1191).

Information	Variable	Number (%)
Type of house	Pucca	162 (13.60)
	Semi Pucca	435 (36.52)
	Kutcha	594 (49.88)
Ventilation	Adequate	1152 (96.72)
	Non-Adequate	39 (3.28)
Drinking water source	House tap	69 (5079)
	Public tap/community plant	545 (45.76)
	Tube well or borehole or well	567 (47.61)
	River/dam/lake/canals/ streams/spring etc	5 (0.42)
	Tanker supply	5 (0.42)
Drinking water purification	Boil	27 (2.27)
	Add bleach/ chlorine	74 (6.21)
	Cloth straining	245 (20.57)
	Electronic water purifier	7 (0.59)
	Let it stand and settle	37 (3.11)
	None	801 (67.25)
Toilet facilities	Inside house	27 (2.27)
	Outside house	1115 (93.62)
	Open field	41 (3.44)
	Public toilets	8 (0.67)
Vector born disease prevention	Normal net	1157 (97.15)
	Coils	2 (0.17)
	Mosquito repellent cream	2 (0.168)
	Electric devices	2 (0.168)
	None	28 (2.35)
Drainage facility	Open/surface drainage	1098 (92.19)
	Closed/covered drainage system	78 (96.55)
	Indiscriminate disposal in the open	15 (1.25)
Fuel for cooking	LPG	502 (42.15)
	Wood coal/cow dung cake	689 (57.85)

Demography status of the ST population

It was observed that of the total surveyed population 77.81% were married. The percentage of divorced/ separated is 6.36%. The majority of ST were literate 88.78%, the education status 24.50% had received education up to the 10th grade. The majority of respondents were addicted gutaka/panmashala, 42.4% of the survey population. The majority of surveyed persons are home makers, the 36.16%, and more than 98.87% of surveyed persons follow nonvegetarian diets (Table 2).

Table 2: Demography status of ST population (n=4318).

Variable	Number	Percent
Marital status		
Married	3360	77.81
Unmarried	675	15.63
Widow	8	0.18
Divorce/separate	275	6.36
Educational status		
No formal schooling	483	11.18
Less than primary	411	9.51
Primary school (up to 5th)	497	11.50
Middle school (up to 8th)	975	22.57
High school (up to 10th)	1058	24.50
Inter-mediate(12th/Diploma)	643	14.89
Graduate and above	251	5.81
Occupation status		
Govt. employee	192	4.44
Non-govt. employee	372	8.61
Self-employed	1358	31.44
Non-paid	15	0.34
Student	349	8.08
Homemaker	1562	36.17
Unemployed (able to work)	163	3.77
Unemployed (unable to work)	307	7.10
Diet		
Vegetarian	49	1.13
Non-vegetarian	4269	98.87
Addiction		
Tobacco	357	8.27
Gutakha/Pan masala	1831	42.40
Alcohol	541	12.52
Smoking	251	5.81

Menstrual history of women of the age group between 18 to 41 years above

The women of the age group between 18 and 41, 57.88% had regular cycles without any associated complaints, 7.33% complained of irregular menstrual cycles whereas 33.77% had natural menopause. About 44.02% have painless menstrual cycles and 3.64% complain of pain during menstrual flow (Table 3).

Children survey up to 18 years

The survey reveals that most children, 82.73% are currently attending school. Among these children, the most common illnesses reported were respiratory tract infections 51.02%, a small percentage of children took multivitamin-mineral/general health tonics 7.41% and appetizers 5.63% (Table 4).

Prevalence of non-communicable disease

Among the total surveyed 4329 adult population, 36.15% male and 37.19% female were not having any kind of no communicable disease. 11.17% of the population suffered from Raktagatavata (Hypertension), followed by 8.34% Sandhigatavata (osteoarthritis) and 5.40% suffered from Madhumeha (diabetes) The percentage of cancer, stroke and COPD/asthma was 0.06%, 0.02% and 1.64% respectively. 0.25% of population have more than one non-communicable diseases (Table 5).

Table 3: Data on the menstrual history of women between age of 18 and 41years above (n=2156).

Menstrual history	18-30 years	31-40 years	41-years and above	Total, N (%)
Menstruation regularity				
Regular	609	465	174	57.88
Irregular	34	41	83	7.33
Surgical menopause (hysterectomy)	0	4	18	1.02
Natural menopause	0	1	727	33.77
Menstrual pain				
Painless	360	373	216	44.02
Yes, starts even before menstruation and relieved once bleeding starts	104	53	6	7.56
Yes, begins with menstrual flow	179	80	35	13.64
Menopause attained	0	5	745	34.78
Duration				
(1-2 days)	83	176	170	19.90
(3-7 days)	535	319	80	43.32
(>7 days)	25	11	7	1.99
Menopause attained	0	5	745	34.79
Nature of menstrual bleeding				
Scanty(spotting)	41	152	165	16.60
Moderate/normal (3-4 pads/24 hours)	568	333	86	45.78
Excessive (>4 pads/24 hours)	34	21	6	2.83
Menopause attained	0	5	745	34.79
Interval				
Normal (cycle 21 to 35 days)	580	430	129	52.83
Cycle <21 days	44	50	48	6.59
Cycle >35 days	6	14	64	3.90
Acyclic or inter-menstrual bleeding	13	12	16	1.90
Menopause attained	0	5	745	34.78

Table 4: Data of children surveyed up to 18 years from all villages.

Variables	0-10 years, N (%)	11 to 18 years, N (%)	Total number	Percent
Education (school going)				
Yes	547	703	1250	82.73
No	253	8	261	17.27
History of pica				
Yes	5	2	7	0.46
No	794	710	1504	99.54
Recurrent infection (for RTI and GI more than 3 episodes in last 6 months) (for skin infection-any infective lesion in last 6 months)				
Respiratory tract infections	482	289	771	51.02
Gastrointestinal tract infections	320	117	437	28.92
Skin infections	227	204	397	26.27
None	91	212	303	20.05
Diet				
Vegetarian	127	8	135	8.93
Non-vegetarian	672	704	1376	91.07

Continued.

Variables	0-10 years, N (%)	11 to 18 years, N (%)	Total number	Percent
Use of health supplements				
Iron supplement	7	39	46	3.04
Calcium Supplement	2	16	18	1.19
Multivitamin-multi-mineral/general health tonics	34	78	112	7.41
Appetizers	27	58	85	5.63
None	729	521	1250	82.73

Table 5: Prevalence of non-communicable diseases.

Age group in years	Number of screened populations	Non-communicable disease													
		HTN		Diabetes		Cancer		Stroke		COPD/ Asthma		Osteoarthritis		None	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
Above 18-30	1233	1	3	0	4	1	1	0	0	13	17	4	3	570	616
31-40	1053	27	9	10	10	0	1	0	0	8	8	3	8	494	475
41 and above	2043	273	171	120	90	0	0	1	0	15	10	128	215	501	519
Total	4329	301	183	130	104	1	2	1	0	36	35	135	226	1565	1610
Total (%)		6.95	4.22	3	2.40	0.02	0.04	0.02	0	0.83	0.81	3.12	5.22	36.15	37.19

DISCUSSION

The under-utilization of a public healthcare facility is common in all developing countries whereas the use of private healthcare is growing in developing and under-developed countries.[7]

The WHO guidelines for drinking water quality advocate for an integrated approach to assessing and managing water quality spanning from its source to the consumer. These guidelines prioritize safeguarding microbial quality to prevent waterborne infectious disease, which is a critical objective.[8] In the current study, it was found that hand pump water was the main drinking water source for all the houses of the villages, whereas a few houses were dependent on the tap and well/pound for their daily water needs. Tube well or borehole or well (47.61%) while public tap/community plant (45.76%) of households. Surprisingly, the majority of the population (67.25%) did not employ any purification methods for drinking water. In countries such as India, approximately 80-90% of diseases are directly linked to the consumption of unsafe drinking water.[9]

Sanitation facilities were present in most households, with approximately 93.62% having toilets, though these were typically located outside the house. For vector-borne disease prevention, 97.15% of households used standard mosquito nets. 92.19% of households have open surface drainage systems. The guidelines emphasize the protection of microbial quality as a critical goal to prevent waterborne infectious diseases.[10]

The widespread use of conventional biomass fuels like wood, shrubs, animal dung, crop residue, and coal combustion is a major contributor to this problem, particularly in developing nations where these solid biomass fuels are prevalent for domestic cooking. Regarding cooking fuels, approximately 57.85% of households used wood, coal, or cow dung due to their easy availability, while a percentage used LPG is 42.15%, primarily due to cost considerations.

In Tripura, the Scheduled Tribe population accounts for 15.1% of the total population.[11] Quantitative data on nutrition and food intake in the state are scarce. However, a Government of India survey conducted in 1998 revealed that the consumption of cereals and millets, pulses and legumes, leafy vegetables, roots and tubers, and other vegetables among the population was inadequate. In terms of dietary habits, a vast majority 98.87% of the population consumed non-vegetarian food, reflecting the availability of non-vegetarian items.

Healthy menstruation is often described, both in medical literature and popular culture, as a regular monthly bleeding cycle.[12] In the survey, among 2,156 females with a menstrual history, 57.88% reported regular menstruation, while 7.33% experienced irregular cycles. Additionally, 33.77% had undergone natural menopause, and 44.02% reported painless menstruation. Regarding menstrual patterns, 43.32% had a bleeding duration of 3-7 days, 45.78% reported moderate or normal flow (approximately 3-4 pads per 24 hours), and 52.83% had a normal cycle interval of 21-35 days. No cases of primary amenorrhea were reported.

Literacy of Tripura was found to be 87.22% which is greater than the average literacy rate of 72.98% of India. The current study finds that 88.81% of the surveyed

respondents are literate, while 11.18% are illiterate, indicating a significant improvement in literacy rates among tribal populations. This progress can be attributed to the National Policy on Education of 1986 (revised in 1992), which has been instrumental in enhancing the educational status of Scheduled Tribes (STs).[13] The policy has provided special interventions and incentives to improve educational access for tribal communities living in remote and isolated areas.

Unemployment remains one of the most pressing global challenges.[14] In the surveyed Scheduled Tribe (ST) population of 4,318 individuals, the employment distribution was as follows: 4.08% of males and 0.37% of females were employed in government jobs, while 7.48% of males and 1.13% of females were employed in non-government sectors. Self-employment accounted for 27.44% of males and 4.00% of females. Additionally, 0.30% of males and 0.05% of females were engaged in non-paid work, and 4.24% of males and 3.84% of females were students. Homemakers constituted 0.42% of males and 35.76% of females. Furthermore, 2.30% of males and 1.48% of females were unemployed but able to work, whereas 3.84% of males and 3.27% of females were unemployed and unable to work.

Addiction to chewing tobacco, betel leaf, or betel nut is common among villagers in India.[15,16] In the survey conducted among 2,980 participants, 42.40% reported being addicted to gutkha or pan masala, 12.52% to alcohol, and 5.81% to smoking.

Reducing substance use in tribal communities requires culturally sensitive, community-driven approaches that respect traditional values while addressing modern health challenges.[17,18] Effective measures include culturally tailored awareness and education initiatives, active participation of community elders and traditional healers, promotion of indigenous practices and healthy living, community-based rehabilitation programs, and integrated interventions involving both families and schools.

Regarding non communicable disease total screen population 4329 out of them, 11.17% were found to be suffering from hypertension, osteoarthritis 8.34%, and diabetes 5.40%.[19] This shows that the habitat in which the tribal people are living is not very favourable to communicable diseases, and also the lifestyle which the tribal people are living is preventing them from the occurrence of diseases like diabetes, hypertension, osteoarthritis, etc.

The health-seeking trends reveal that child health concerns were the primary reason for visits to the Ayurveda Health Center, accounting for respiratory tract infection (RTI) 51.02%, gastrointestinal tract infection (GIT) 28.92% and skin infection 26.27 % of visited.[20]

This study has few limitations. To validate the study findings and to reach the root cause of the observed issue, condition-specific objective-based long-term studies are required.

CONCLUSION

The demographic profile and health-seeking behaviour of the Scheduled Tribe (ST) population in Tripura indicate significant deprivation, marked by low economic status and poor living conditions. Basic needs such as sanitation, safe drinking water, transportation, healthcare services, and educational facilities remain inadequately met in these villages. The high prevalence of diseases, largely associated with poor hygiene, economic constraints, and limited health awareness, highlights the multifaceted challenges confronting these communities. Sustaining and expanding health programmes is essential to ensure that critical healthcare services reach the tribal population. Incorporating Ayurvedic principles and treatments into existing healthcare systems offers a timely and holistic approach, with the potential to improve health outcomes in rural areas and enhance the overall well-being of marginalized groups.

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Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee (IEC clearance No F. No2-2/2003-CARI Ghy/Admn/517 dated 28.06.2021)

REFERENCES

1. Patle RA, Khakse GM. Health-seeking behaviour of elderly individuals: a community-based cross-sectional study. Natl Med J India. 2015;28(4):181-4.
2. Gerald EI, Ogwuche CH. Educational level, sex and church affiliation on health seeking behaviour among parishioners in Makurdi metropolis of Benue State. J Educ Policy Entrep Res. 2014;1(2):311-6.
3. Sonowal CJ, Praharaj P. Traditional vs transition: acceptance of health care systems among the Santhals of Orissa. Stud Ethno-Med. 2007;1(2):135-46.
4. Jayaprakash J, Saravanan R. Economic analysis of health seeking behaviour of tribal women in Villupuram district, Tamil Nadu. Asia Pac J Res. 2015;1(29):26-37.
5. Malhi R, Goel D, Gambhir RS, Brar P, Behal D, Bhardwaj A. Rashtriya Swasthya Bima Yojana (RSBY) and outpatient coverage. J Family Med Prim Care. 2020;9(2):459-64.
6. Tripura Population Census, 2011. Available at: https://www.censusindia.co.in/states/tripura. Accessed on 20 December 2023.
7. Chauhan RC, Kandan M, Purty AJ, Samuel A, Singh Z. Determinants of health care seeking behavior among rural population of a coastal area in South India. Int J Sci Rep. 2015;1:118-22.

8. Nair UJ, Floyd RA, Nair J, Bussachini V, Friesen M, Bartsch H. Formation of reactive oxygen species and of 8-hydroxydeoxyguanosine in DNA in vitro with betel quid ingredients. Chem Biol Interact. 1987;63:157-69.
9. Mog USAJ, Debbarma J. Socio-economic status of tribal communities in Tripura. Int J Mov Educ Soc Sci. 2018;7(1):361-70.
10. Sarkar R. A study on the health and nutritional status of tribal women in Godam Line village of Phansidewa block in Darjeeling district. IOSR J Humanit Soc Sci. 2016;21(11):15-8.
11. Tripura human development report: a summary. Available at: http://tripura.nic.in/hdr/tripura%20hdrsummary.pdf. Accessed on 12 July 2016.
12. Hasson KA. Not a "real" period? Social and material constructions of menstruation. Gender Soc. 2016;30(6):958-83.
13. Government of India, Department of Education, Ministry of Human Resource Development. National policy on education 1986: as modified in 1992. New Delhi: Government of India; 1992.
14. Debbarma J, Debbarma S, Darlong PCN. Active job seekers among Scheduled Tribes (ST) community in Tripura. Int J Multidiscip Res. 2024;6(2):1-10.
15. Bhat SJS, Blank MD, Balster RL, Nichter M, Nichter M. Areca nut dependence among chewers in a South Indian community who also use tobacco. Nicotine Tob Res. 2010;12(7):599-606.
16. Ghosh S, Yadav A, Pandey A. Tobacco prevalence among women in Tripura state, India: a cross-sectional study from West Tripura district. In: World Conference on Tobacco Control; 2025.
17. Kelley A, Witzel M, Fatupaito B. A review of tribal best practices in substance abuse prevention. J Ethn Subst Abuse. 2019;18(3):462-75.
18. Ghosh S, Yadav A, Pandey A. Tobacco prevalence among women in Tripura state, India: a cross-sectional study from West Tripura district. Paper presented at: World Conference on Tobacco Control; 2025.
19. Kumar A, Choudhary R, Yadav S. A study of non-communicable risk factors among the tribal population of Lefunga block, Tripura: a cross-sectional study. Int J Community Med Public Health. 2018;5(issue):4478-84.
20. Bhat S, Srikant N, Singh S, Dua P, Ota S, Khanduri S, et al. Health care seeking trends in Ayurveda clinical research facilities: a Central Council for Research in Ayurvedic Sciences standpoint. J Res Ayurvedic Sci. 2017;1(3):209-16.

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