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INDEX PAGE

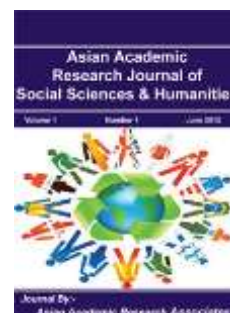
SNO	ARTICLE TITLE	PAGE NO
1	DETERMINANTS OF BOTTLE FEEDING PRACTICES IN SOLIGA TRIBE OF MYSORE DISTRICT, KARNATAKA, INDIA DR RENUKA M; DR K JAGADISH KUMAR; DR PRAVEEN KULKARNI; DR KHYRUNISSA BEGUM; DR M R GANGADHAR	1 – 11
2	HUMAN RIGHTS AND HUMAN VALUES IN INDIAN PHILOSOPHY DR. K. VENKATESAN	12 – 16
3	PROBLEMS AND PROSPECTS OF SSI'S - A STUDY IN DAVANAGERE CITY H. VENKATESHA; DR. S. N. YOGISH	17 – 39
4.	KHAP PANCHAYATS: CONTINUITY, CONFRONTATION AND CONTRADICTION NAVNEET KAUR	40 – 45
5.	HEALTH DETERMINANTS OF BAIGA: A PARTICULARLY VULNERABLE TRIBAL GROUP IN CENTRAL INDIA DR. FARHAD MOLLICK; SHAILENDRA KUMAR VERMA	46 – 55
6.	DYNAMICS OF CROPPING PATTERN IN GUJARAT STATE: A MARKOV CHAIN APPROACH DR.N.J.ARDESHNA; DR.R.L.SHIYNAI	56 – 66
7.	TEACHING AND LEARNING CHALLENGES & STRATEGIES TOPIC- STRATEGIES & CHALLENGES OF E-LEARNING SAMRIT MONA	67 – 74
8.	MODERATING EFFECT OF ENVIRONMENTAL MANAGEMENT ACCOUNTING (EMA) ON QUALITY AND COMPETITIVE ADVANTAGE SAYEDEH PARASTOO SAEIDI; DR. SAUDAH SOFIAN; PARVANEH SAEIDI; SAYYEDAH PARISA SAEIDI	75 – 85
9.	EMERGING ISSUES AND RECENT TRENDS IN INDIAN FDI DR. P. SIVA KUMAR	86 – 103
10.	DOMESTIC WATER DEMAND FORECASTING UNDER DIFFERENT SOCIO-ECONOMIC SCENARIOS FOR A CENTRAL HIMALAYAN WATERSHED, INDIA KIREET KUMAR; SNEH JOSHI; HIMANSHI SHARMA; TANUJA PANDEY	104 – 120
11.	WOMEN AND HUMAN RIGHTS DR. T.M. RAJENDRA PRASAD	121 – 127
12.	STATUS OF WEFARE PROGRAMMES IN INDIA DR. C VENKATESWARLU; B VIJAJA LAKSHMI; DR. MORUSU SIVA SANKAR	128 – 137
13.	IMPACT OF POVERTY DR. C VENKATESWARLU; B VIJAJA LAKSHMI; DR. MORUSU SIVA SANKAR	138 – 146
14.	VARIATION STUDIES IN TREE MORPHOLOGICAL PARAMETERS IN ANOGEISSUS LATIFOLIA WALL IN HIMACHAL PRADESH H.P SANKHYAN; R. BAWA; TANVI GUPTA; N.B SINGH	147 – 157
15.	VALUE CRISIS IN INDIAN EDUCATION DR.K.JAYARAMAIAH; DR.G.THULASIRAM	158 – 165
16.	CHANGING POPULATION STRUCTURE OF GUWAHATI CITY INDIA A GEOGRAPHICAL ANALYSIS ZONA BHUYAN	166 – 176
17.	ANTECEDENTS OF CUSTOMER SATISFACTION-A STUDY ON THE INDIAN DOMESTIC LOW COST AIR CARRIERS RICHARD REMEDIOS	177 – 195
18.	STUDY ON EDUCATION OF CHILD LABOURERS DR. S. S. PATIL; MS. VANI. E.J	196 – 201



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**HEALTH DETERMINANTS OF BAIGA: A PARTICULARLY VULNERABLE
TRIBAL GROUP IN CENTRAL INDIA**

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ABSTRACT

Tribal groups constitute 32.45 percent of the total population of Chhattisgarh state. There are 43 tribal groups including 05 primitive tribal groups inhabiting in Chhattisgarh. Baiga was identified as one of the Particularly Vulnerable Tribal Group (PVTGs) of Chhattisgarh as well as Madhya Pradesh because of their isolated living, dependency on forest economy, low literacy and high mortality rate. A large number of Baiga mainly live on and around Achanakmar-Amarkantak Bio-Sphere Reserve. The major part of the Bio-Sphere Reserve lies in Chhattisgarh mainly over Bilaspur district and the remaining part of the area extends into Dindori and Shahdol district of Madhya Pradesh. Baiga tribe residing in Bilaspur district of Chhattisgarh state was selected for the study. They inhabited in Lormi, Kota and Gourela block of Bilaspur district. Three villages each from three blocks were selected for the study on the basis of concentration of Baiga families in the village. An attempt was made to collect the data from each and every family. Out of 390 Baiga families inhabiting in three villages, information on demographic features was collected from 385 families. 270 ever married women in the age group 15-44 were also interviewed. Health is one of the important indicators of social development. In recent years the slogan of “Health for all” by 2000 AD has been extended to 2020 AD. The national health policy also includes the provisions of health services to tribal areas. But health workers have failed to introduce modern health care services in tribal areas. This could be because of lack of knowledge about the culture and society of tribal people. The challenges regarding health for Baiga can be seen as health care for children, antenatal and postnatal care of the mother, disease associated with poor economy, unsafe drinking water, low literacy level and cultural belief associated with various diseases. An attempt has hereby made to examine the health status of Baiga in terms of some important health indicators. Factors affecting fertility like age at marriage, age at first birth, number of children have also discussed here. Information on health status among the Baiga will be helpful to understand the realities of health problems prevailing among them and also useful to implement health care services. The present paper therefore aims to understand the health status among the Baiga by looking demographic variables, health indicators and some health statistics.

Key Words: *Health, Mortality, Fertility, Health Care Services*

1. INTRODUCTION

In recent years the slogan of 'Health for All' by 2000 AD has been extended to 2020 AD. The world health organization defined health as a state of complete physical, mental and social well being and not merely the absence of disease and infirmity. The concept of health revolves around the socio-cultural factor. Socio-cultural factors affect the health of the community, because certain practices, values, religious beliefs and taboo create an environment that helps in spread of disease and also develop a method of diagnosis and treatment of disease. It is therefore important to assess the role of socio-cultural factors affecting the health of the community. The national health policy includes provision of health services to tribal areas. But a number of studies have pointed out that the tribal always go indigenous practices of treatment because of which health workers have failed to introduce modern health care programmes in tribal areas. This could be because of lack of knowledge about the culture and society of tribal people. The concept of health and disease is as varied as their culture and society. The health problem should be viewed within the context of the socio-economic and cultural factors affecting the health. It is therefore necessary to have the knowledge about the culture and society for the implementation of modern health care programmes. An effort has hereby made through present studies to understand the factors affecting the health of Baiga. Baiga was identified as one of the primitive tribes inhabiting Madhya Pradesh and Chhattisgarh because of their isolated living, dependency on forest economy, low literacy and high mortality rate. A large number of Baiga families live in and around Achanakmar- Amarkantak Biosphere Reserve. The major part of the area lies in Chhattisgarh mainly over Bilaspur district and the remaining part of the area extends into Dindori and Shahdol district of Madhya Pradesh. The total area of Amarkantak Biosphere Reserve is 3,835.51 sq.km. An area of 1,224.98 sq.km. lies in Madhya Pradesh and the remaining area of 2,610.53 sq.km. falls in Chhattisgarh state. Baigas are mainly concentrated in Bilaspur and Kawardha District of Chhattisgarh state. Anthropological studies are necessary to understand the realities of health problems prevailing among the tribal. Tiwari (1984) reported high mortality rate among the Baiga. The reason for this was inadequate health care, malnutrition and not having access to modern health care services thus dependence on indigenous medicine. They believed on witchcraft, ghost, spirit and breach of taboo regarded as real causes of death. Elwin (1939) observed that Baiga believed in natural and supernatural causes of disease. They believe in spirits, ghost and breach of taboo for causing of disease and epidemics. The method of treatment includes magico-religious health

care system to propitiate supernatural power. They also believe on folk medicine based upon traditional beliefs, religious head and traditional medical practitioner and herbal medicine for treatment of certain diseases. Mitra (2000) observed that poor health among the Abujmaria and Kamar primitive tribe was the result of socio-economic and living condition, illiteracy, ignorance, poor sanitation and lack of awareness about health education. She suggested that anthropological perspectives of tribal health can be useful in introducing modern medical system in any community. Mukherjee (2000) discussed the magico- religious health care system and role of forest in the treatment of various diseases. He also analyzed the constraints for the acceptance of modern health care services. Among the tribals, the belief in the interference of supernatural agency is particularly strong in the context of health and disease. The big challenge to health for Baiga can be seen as health care for children, antenatal and post natal care of the mother, disease associated with poor economy, unsafe drinking water, low literacy level and cultural beliefs associated with the disease.

2. AREA AND PEOPLE

Baiga residing in Bilaspur district of Chhattisgarh state was selected to understand the realities of health problems among them. Baiga Vikhas Pradhikaran classified the Baiga village of Bilaspur district into five clusters named as Sarasdol, Chaparoa, Lormi, Chuktipani and Kurdar. They live in isolation mostly in forest and hilly areas. They practice the primitive technology for agriculture and their economy mainly depends on forest. They have low literacy rate and high mortality level. They inhabit in Lormi, Kota and Gourela block of Bilaspur district. They are mainly concentrated in Kota block of the district. It is surrounded by Achanakmar forest area. The population of Baiga in Bilaspur district is 24,218 out of which 54.61 percent live in Kota block followed by Gourela (23.54 percent) and Lormi (21.95 percent). A total of 5201 families reside in 62 villages of three blocks, out of which 54.37 percent of Baiga families live in Kota block.

Three villages each from Lormi, Kota and Gourela block were selected for the study. These villages namely Umaria, Jalda and Shalegori were chosen from Kota, Lormi and Gourela block constituting 390 Baiga families. The population of Baiga in three villages was 1779 out of which 60.31 percent Baiga population lived in Shalegori of Gourela block followed by Umaria (26.65 percent) of Kota block and Jalda (13.04 percent) of Lormi block. Out of 390 Baiga families residing in three villages, 385 families (98.72 percent) were covered to determine their health status. Villages were selected on the basis of concentration

of Baiga population in the village. Information on fertility was collected from 270 ever married women.

3. FAMILY BACKGROUND

A total number of 420 families inhabited in these villages at the time of investigation. The villages have high concentration of tribal (97.14 percent), more particularly Baiga (92.86 percent). The majority of families belong to *MARAVI*, *DHURVA* and *MARKAM* clan in those villages. Umaria and Jalda were dominated by *MARKAM*, whereas Salheghori by *DHURVA* clan. *NAGBASIA*, *PORTE*, *PUNDRU*, *SONWANI* and *TEKAM* clans were also found. 69.1 percent constitute nuclear family. The medium size families (4 to 6 members) have highest numbers (53.77 percent) followed by small size families (2 to 3 members). The mean family size is 4.63 persons per family.

4. DEMOGRAPHIC CHARACTERISTICS

Age and sex are basic demographic characteristics which have an important role in the study of health. Significant inferences can be drawn from the age and sex composition of any population. The studied families numbering 385 Baiga families have 1779 individuals. More than one third of the population (40.81 percent) is below 15 years of age, i.e., child population and 6.29 percent is above age 59 (the older age groups) with the remaining 52.9 percent in the 15 to 59 age group. Almost an equal number of men and women are in the Umaria and Salheghori villages, but the number of females is more than males only in the Jalda village. Female are more in the age group below 15, but less in the age group 15 to 44 and 45 to 59. In the reproductive age (15 to 44) the females are more in the 15 - 19 and 20 - 24 age groups and starts declining above 24 years of age. Sex Ratio (calculated as number of females per 1000 males) is around 1005.63. The sex ratio is much higher in the age group 60 and above (1382.97 females per 1000 males) followed by the age group 0-14 (1016.66) and 15-59 (960.41). 52.9 percent people are in the reproductive age group (15-59) while the infancy and childhood age group has around 40 percent and the older age groups have around 6.3 percent. The dependency of population is based on the fact that every member of a society is a consumer and only some are producer. The overall dependency ratio is 89.05. The child dependency and old dependency are 77.15 and 11.9 respectively. Old dependency ratio is more in village Salheghori, while child dependency is more and old dependency less in Jalda village.

5. DETERMINANTS OF HEALTH

Socio-economic status is an important determinant of health status. Mortality, morbidity and fertility are highest among the lowest socio-economic groups. Education is one of the important social determinants which influence individual attitude and behavior. Education also enhances the ability of individuals to achieve desired demographic and health goals. The study has indicated that 67 percent people are illiterate. Nearly 23 percent people have less than 5 years of completed education. A negligible percentage (4.76 percent) has come up to middle school. The distribution of male and female by education shows that the majority of the females (81.65 percent) are illiterate as compared to male (52.77 percent). Females have higher proportion of little or no education than males. 29 percent of males and about 16 percent of females are primary educated. A negligible percentage of females (1.19 percent) have come to middle school as compared to males (8.28 percent). The proportion of women who have never attended school declines steadily with age; from 95 percent for women in age the group of 25-34 to 78 percent for women age 15-24. The occupation structure of the villages are obtained from the study shows that nearly 62 percent families were earning their livelihood from wage labour followed by agriculture (19.5) and basketry (12.5). In the village Umaria, a large proportion (47.5 percent) of families primary occupation was based on basketry, because of its closeness to Achanakmar forest. Male members of the family collect bamboo from forest and females make baskets from it. 96 percent families of Jalda and 72 percent of Salheghori were earning their income from wage labour. This is because of great impact of Rashtriya Rojgar Garanthi Yojna. Distribution of land holding shows that about 28 percent of the families have 2 acres of land followed by 1 acre (26 percent). 7 percent families are landless. The percentage of land less family is more in the village Umaria and Jalda (19 percent). The important agricultural products are rice, pulses, oil seed and makka. They engage themselves in the occupation like basketry, wage labour, forest produce collection and agriculture. They collect fuel wood, wild fruits, flowers and seeds from the forest. Some of the wild fruits are *TENDU*, *MAHUA*, *KATHAL*, *DOOMER*, *JAMUN*, *MANGO*, *BER*, *PIYAR* etc. Some important flowers are *MAHUA* and *DHAWA*. Bamboo, *CHAROTA* and *KOSAM* are some important seeds that they collect. Distribution of yearly income of families shows that about 44 percent earn between Rs.10, 000 and 15,000, followed by (35 percent) in the income category of Rs. 5001 to 10,000. Only 15 percent families earn more than Rs 15,000 per annum. Mean family income comes to Rs 11,568.53 whereas mean income of Umaria, Jalda and Salheghori was found to be Rs 10,660.99,

14,604.04 and 11, 292.09 respectively. They depend on a number of occupations; despite this their income is meagre. 96 percent families engage themselves to forest produce activities and 94 percent to wage labour due to impact of Rashtriya Gramin Rojgar Garanthi Yojna and agriculture (91 percent).

6. DEVELOPMENT INDICATOR

In order to assess the living standard of the family information on household goods was collected. Bicycles are owned by 63 percent of the families, followed by clock (17 percent) and radio (16 percent). A small proportion of families possess items such a television, motorcycle, mobile telephone, electric fan and water pump. 99 percent of the families live in *KACHHA* house. The most common and improved source of drinking water for tribals are covered well and hand pump/ tube well. 84 percent of the families collect drinking water from improved sources. Well (52 percent) is the main sources of drinking water in those villages as compared to tube well/hand pump (32 percent). 16 percent families get their drinking water from non-improved sources such as uncovered well and surface water known as NALA. 23 percent families of Salheghori village collect their drinking water from non-improved source. Water borne diseases spread as endemic, causing much suffering and loss of human life especially among the children. Examples of such diseases are diarrhea, enteric fever and viral hepatitis which are most prevalent among the people of tribal areas. Smoke from solid cooking fuels include coal, char coal, wood, straw and grass as cooking fuel that generate smoke and has adverse effect on health when inhaled. 94 percent houses have no ROSANDAN (ventilator).

7. HEALTH INDICATOR

7.1 AGE AT MARRIAGE

The mean ages at currently married men was 19.3 and women 16.4. The mean ages at marriage of men were higher in village Umaria (21.5) than Jalda and Salheghori (18.7). The mean age at marriage of women were high in Jalda (17.3) followed by Umaria (16.6) and Salheghori (16.10). Nearly 90 percent boys and girls in three villages got married below the minimum legal age at marriage; i.e. before attaining the age of 18 for the female and the age of 21 years for male. All the men of Jalda and Salheghori village and all the women of Umaria and Salheghori village got married below the minimum legal age at marriage.

7.2 FERTILITY

As per NFHS-3 crude birth rate (CBR) for India and Chhattishgarh was 23.1 and 22.7 respectively. For the rural areas it was 25 and 24.2. As per study of the villages inhabited by the Baiga, their CBR was found to be 40. In high fertility situation CBR will be excess of 30 births per 1000 population. CBR was highest in Jalda (65), followed by Umaria (42) and Salheghori (34). General fertility rate (number of live birth per 1000 female population between the ages of 15-44) among them estimated to be around 185. Jalda indicated the highest level of GFR (333) and Salheghori lowest level (151). Age specific fertility rate for age 20-24 and 25-29 is much higher. The peak age of child bearing is 20-24; with steady decline in fertility rate thereafter. The age at which women start child bearing is an important demographic phase and determinant of fertility. The lower age at first birth is an indicator of higher fertility. More than 43 percent women became mother before ages 18. 42 percent mother gave first birth by age 18-20. More than eighty percent mother gave birth to the first before reaching 21 years of age. Nearly 55 percent and 32 percent women became pregnant 1 to 3 times and 4-6 times respectively. The total number of all ever married women are 270, while number of mothers are 246 (91 percent). Nearly 6 percent ever married women are infertile, who have not experienced pregnancy till the time of study. Umaria were reported to have highest percentage of infertile women (12 percent). About 3 percent of the ever married women experienced first time pregnancy during the study. The types of outcome of pregnancy are live birth, still birth, spontaneous and induced abortion. There are 890 number of pregnancies of which about 97 percent are live births. The total 1.5 percent still birth of the total pregnancies was found. The percentages of pregnancies that have ended as spontaneous and induced abortion are 1.3 percent. The still birth are more in Umaria village while spontaneous and induced abortion more in village Salheghori. It also estimated that 52 percent women had 1 to 3 numbers of children ever born followed by 4 to 6 children ever born (32 percent). Seven percent women had more than 6 children ever born which were quite higher in Jalda (16 percent). The total of 97 percent live birth of the total pregnancies was found among the mothers. Around 3 percent of the pregnancies ended up in reproductive wastage. Around 75 percent of the total pregnancies are surviving till the time of field work. Around 23 percent dead children of the total pregnancies were found. The dead children of total pregnancies were more in village Jalda (31 percent).

7.3 MORTALITY

The total number of death during a year was 35, out of which maximum death was found below the age of fifteen (51 percent). The Age specific mortality rate in the age 0-14

was 24.79. In the first year of birth nearly 23 percent died of which 11 percent were in the age group of 1-4. The mortality of women was more in their reproductive age 15-44 (33 percent). Perinatal mortality is sensitive indicator of health status of the population. The perinatal mortality (PNMR) is considered as indicator of obstetric care. The study has indicated that the PNMR among Baiga is 127. Umaria has the highest level of PNMR (200). According to NFHS-3 perinatal mortality of India is estimated to be 49 and neonatal mortality (NN) is 39. As per study the neonatal mortality among Baiga is 99. NN is highest in Umaria. As per NFHS-3 the infant mortality rate (IMR) for India was 57. The study indicates the highest IMR (113) among the Baiga. As per NFHS -3 under-5 MR of India was 74. As per study U-5MR are 155. The study indicated crude death rate of the Baiga to be 20. Crude death rate over 15 per 1000 population has considered as high. CDR was reported high in village Salheghori. Death rate due to different diseases indicated that death due to diarrhea was more (2.81) as compared to jaundice (1.68) and malaria (1.68).

CONCLUSION

The health of Indian population has improved over the past fifty years according to different health indicators. “The infant mortality rate (IMR) has fallen from 148 to 71 per 1000. The Crude Birth Rate (CBR) has declined from 41 to 25 and Crude Death Rate (CDR) fell from 25 to under-9” (Gupta, 2002). Let me bring out the fact that IMR, CBR and CDR among Baiga reported as 113, 40 and 20 as per study which is higher than the national level. The present study has established the poor health status of the Baiga as per health indicators and some health statistics. The total Baiga population in Bilaspur district was 17,130 in 1981 census and 23,223 in 1991 census. Now it is 24,218 according to Baiga Vikas Abhikaran. The figures indicate that their population is not growing enough. Primitive health practices, economic and socio-cultural factors are possibly responsible for fertility and mortality pattern which determine their growth. Presently Government is providing health care services through the network of primary health centre, sub centre and community health centre. But they always believe in their traditional method of health care services. A number of studies pointed out that the tribal always go for indigenous practices for treatment because of which health workers have failed to introduce modern health care programmes in tribal areas. The study indicates that Crude Death Rate among Baiga was 20. CDR over 15 per 1000 population should be considered high. The mortality of child (below the age of fifteen) was more than other age group. The Age Specific Mortality Rate was about 25 in the age group 0-14. The mortality of women was more in their reproductive age group 15-44. Perinatal

Mortality (PNMR), Neonatal Mortality (NN), Infant Mortality (IMR) and under- 5 Mortality Rate (U-5MR) are the sensitive indicators of the health status of any population. The PNMR is considered an indicator of obstetric care. The causes of NN are low birth weight, birth injury and infection. The causes of IMR are malaria, diarrhea and pneumonia. The study indicates high level of PNMR (127) and NN (99) among Baiga. IMR and U-5MR were also reportedly very high (113 and 155). High level of PNMR (Still Birth and No of death up to 7 days) and NN (No of death from the age 0 to 28 days) may be related to antenatal care (ANC). ANC refers to pregnancy and delivery related health care. The study has indicated that nearly 58 percent women not received ANC during pregnancy for their most recent live birth at the time of field work. The lower utilization of maternal and child health care services during the pregnancy and delivery and after the delivery may be the possible a reason of high PNMR, NN and IMR. The persistence of high level of PNMR, NN and IMR are also strongly associated with age at marriage and age at first birth. It has been observed during the study that 90 percent men and women got married before attaining the legal age of marriage. The study has also showed that 43 percent women became mother before attaining 18 years of age. The lowest educational achievements and poor economic status are strongly correlated with PNMR, NN and IMR. Economic status is an important determinant of health status. The majority of Baiga family engage themselves in the traditional and lowers paid occupation like basketry, wage labour, forest product collection and low yielding agriculture. The study has indicated that the annual income of the family from these occupations is very low. The level of literacy is the most important indicators of health status of the tribal communities. It has a positive effect on the use of health care services. Women's education contributes to infant mortality and also influences their fertility behavior. The study has indicated that most of the Baiga females and males are illiterate. While a negligible percentage of male and female have completed five years of schooling. Fertility and Mortality are high among them because of their lower economic and educational status. The highest level of Perinatal, Neonatal and Infant mortality may be because of their lowest educational achievements and poor economic status. Therefore, there is an urgent need for socio-economic empowerment. It is also necessary to make them aware of modern health care services. Sensitization programmes for reproductive health have to be launched in the villages through video films and street plays. For this the local medicine men and magico-religious specialists must be taken into confidence.

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