



Fertility Pattern and Reproductive Health of Harijan (Dalit) Community in Select Destinations of Assam

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Citation: Ms. Joyshree Phukon, (2024), Fertility Pattern and Reproductive Health of Harijan (Dalit) Community in Select Destinations of Assam, *Educational Administration: Theory and Practice*, 30(6), 1248-1257, Doi: 10.53555/kuey.v30i6.5480

ARTICLE INFO

ABSTRACT

Fertility refers to the natural capability to give birth, encompassing both the individual and population's capacity to produce viable offspring. In general, fertility is considered a biological phenomenon, however, in reality it is influenced by numerous factors beyond biology. These factors include Age at marriage, Education, Occupation, Family income, and others. This study aims to explore the fertility patterns and reproductive health conditions of married females in the Harijan (Dalit) community. Despite being legally recognized as Scheduled Castes and entitled to various opportunities, Harijan women continue to face substantial socio-economic challenges. Education may affect fertility by influencing the age at marriage. Additionally, Education can influence females' fertility decisions through increased contraceptive use. This paper aims to assess the influence of various factors on the Fertility and Reproductive Health of Harijan (Dalit) women of 8 randomly selected districts i.e. Tinsukia, Dibrugarh, Charaideo, Sivasagar, Jorhat, Golaghat, Nagaon and Kamrup (Metro) districts of Assam. Despite being legally recognized as Scheduled Castes and entitled to various opportunities, Harijan women continue to face substantial socio-economic challenges. This research seeks to provide reliable data on fertility levels and trends within this community, highlighting the factors affecting their reproductive health and offering insights for targeted interventions to improve their socio-economic and health outcomes.

Keywords: Fertility, Contraception, Harijan, Reproductive Health, Socio-Economic Challenges.

1. INTRODUCTION

The literal meaning of the word Harijans is children of God. In India, the people who belong to the bottom of Hindu Caste System are called Harijans. They were traditionally sweepers, washers of cloths, leather workers and those whose occupation was to kill animals. Originally called untouchables or pariahs, they were given the name Harijans by the father of Nation Mahatma Gandhi who worked for many years to improve their lives. Many now refer themselves as Dalits to indicate their oppressed position outside the Hindu society, legally the Indian Government groups them as "Scheduled Castes".

The Indian Constitution came to its effect in 1949. Till then the Harijans who constitute about 15% to 20% of India's population were subjected to discrimination and social restrictions as it was believed that their caste would pollute everyone who came into contact with them. Under the constitution, the Harijans were recognized as Scheduled Castes and tribes entitled to educational and vocational opportunities, as well as representation in parliament, however, widespread discrimination still exist.

Socio-Economic development of the state depends greatly on the development of all section of people. Harijans are recognized as low caste people. It is observed that preference for children is still very high among the Harijan community. The population of Harijan community has increased but their literacy rate and employment opportunity have decreased till now, as they are not educated are not in a position to provide employment to them. This present study was undertaken to collect some reliable information regarding fertility levels and trends, and the factors that are supposed to influence the Fertility Pattern and Reproductive Health of married females of Harijan community.

Fertility is the natural capability to give birth. Fertility means the actual bearing of children during a women's reproductive period i.e., roughly from 15-49 years, a period of approximately 34 years. Fertility is not totally

depending on biology of the couple, but there are several other factors such as-age at marriage, educational status of the wife and husband, occupation, economic condition, spacing of children etc. also effect on it.

Objectives

It is aimed to address the following objectives through this study

1. To study the fertility pattern and differential among females of Harijan (Dalit) community.
2. To study the reproductive health condition of females of Harijan (Dalit) community.

B. Review of Literature

Sarmah, R.N. (1999) in his book "Society in India an overview" express the disabilities of Harijans. He also mentioned different factors related to fertility i.e. education, female mortality, age at marriage, occupation etc. Ahuja, Ram (1999) in his book "Society in India" explain the institutionalized inequality in the caste system manifests its extreme form in the growth of completely segregated set of caste called "Untouchable Caste". Gandhiji designated them as "Harijans" or the children of God.

Kumar Raj (2003) in his book "Essays on Dalits" is a compilation where several authors have contributed on Dalit issues.

Deulkar Sita (2004) "Dalits Past Present & Future" explains that people have developed politically, socially, culturally, and economically, but an unfortunate section of our society is still forced to live under the same hostile circumstances. Dalits, the 'have nots' are supposed to be the most unfortunate section in our society, at the lowest strata.

Shankar Rao C. N. (2004) in his book "Sociology of Indian Society" states that the term "Scheduled Caste" is a politico legal one. The word 'Schedule' refers to a 'list' or 'table' out or scheduled a few of castes as the most inferior ones which requires some special attention. Their list of castes was designated as 'Scheduled Caste'.

Kaul, D.K. (2008) in his book "Dalits in rural India-challenges and opportunities" explains the caste system and Dalit movement.

Bhende A. Asha and Kanitkar Tara, (2010), in the book "Principle of population studies" explain the proximate determinant of fertility.

Jhansi S. C. (2010) "Women and Reproductive Health" studied on Reproductive Health of child and women.

Rao. G. Samba Siva and Rao A G Sankar (2015) "Status of Dalit Women" expresses that though India has all along been a male dominated society and women have never been given the equality status in socio-economic fields, the scheduled caste women have been tied the bottom of the hierarchy as sweepers and scavengers.

Baghel. Indu (2016) "Dalit women's movement in Modern India" critically examined the social, economic and political position of Dalit women and its overall impact on India's political system.

1. METHODOLOGY

Descriptive method is used to examine the fertility pattern and reproductive health condition of women of Harijan (Dalit) community of eight districts of Assam i.e., Tinsukia, Dibrugarh, Charaideo, Sivasagar, Jorhat, Golaghat, Nagaon and Kamrup (Metro). Both primary and secondary data are used for the analysis. For the collection of primary data, a multistage sampling technique is adopted. In the first stage, some districts of Assam have selected randomly. In the second stage the area of Harijan (Dalit) women inhabitant was considered from the selected districts. In third stage, Dalit women having at least one child have selected purposively from the scheduled area. Total sample size is 667.

The data thus collected will be subjected to suitable statistical analysis to draw conclusion. The collected data are processed through editing, classification and tabulation. The collected data are analyzed with the help of Tables and Diagrams. To study the fertility pattern of Dalit women fertility measures and Bongaarts Proximate determinants are used. The main source of the study is based on field study records.

Analysis

First Objective: to Study the Fertility Pattern and Differential Among Females of Harijan(Dalit) Community.

The fertility pattern within a community is influenced by a multitude of interrelated factors. Understanding these patterns is crucial for developing effective policies and interventions aimed at improving reproductive health and socio-economic outcomes. This study focuses on the Harijan (Dalit) community, a socio-economically disadvantaged group in India, to explore how various factors impact fertility rates.

To achieve this objective, the study considers various factors including age at marriage, educational attainment, economic status, occupation, economic category, and the use of contraceptives. Two key fertility measures, the Age-Specific Fertility Rate (ASFR) and the Total Fertility Rate (TFR), were also analyzed.

Age at Marriage

The age at which women marry significantly impacts fertility rates and trend. Early marriage often leads to a longer reproductive period, thereby increasing the likelihood of having more children. When childbearing starts before 20, the period available for childbearing lasts for approximately 24 years and the period of high

fecundity (lasting until around age 35) is 17 to 18 years long. Female married before 18 years have higher number of children than married after 18 years. A rise in the age of marriage can reduce fertility. Later marriage leads less female fertility. There is a strong relationship between child marriage and fertility. Women who marry at younger age are more likely to have higher total fertility.

Table-1-Distribution of women according to their age at marriage

Age at marriage	Frequency	Percentage (%)	Cumulative Percentage (%)
15-18	277	41.5%	41.5%
19-22	324	48.6%	90.1%
23-26	64	9.6%	99.7%
27-30	2	0.3%	100%
Total	667	100%	

Table-1 presents the distribution of women based on their age at marriage, providing insights into the trends and patterns related to fertility rates. A significant portion of the women, 277 out of 667, got married between the ages of 15 and 18. This group constitutes 41.5% of the total sample. Early marriage is often associated with higher fertility rates due to a longer reproductive period. The majority of the women, 324 out of 667, married between the ages of 19 and 22. This age group represents 48.6% of the total sample. Women marrying in this age range are still within the early years of their reproductive period, contributing to relatively high fertility rates, although potentially lower than those marrying even earlier. A smaller group of women, 64 out of 667, married between the ages of 23 and 26, making up 9.6% of the total sample. Marrying at this age is typically associated with lower fertility rates compared to earlier marriage, as the reproductive period is shortened. Only 2 women, representing 0.3% of the total sample, married between the ages of 27 and 30. This group is the smallest and represents the latest age of marriage within the sample. Marrying at this age is usually associated with the lowest fertility rates due to the further reduced reproductive period.

The data suggests a strong trend towards early marriage, with the majority of women marrying before the age of 23. Early marriage is linked to higher fertility rates, which is a common pattern in communities with lower educational attainment and economic status. Understanding these trends can help in formulating policies and interventions aimed at delaying marriage age, thereby potentially reducing fertility rates and improving the socio-economic conditions of the community

Educational Status

There is an inverse relationship between education and fertility rates. In countries where the percentage of literate individuals is high, fertility rates tend to be low. This correlation is evident in developed nations, which typically have lower birth rates compared to less developed countries. Educated individuals often prefer smaller families because they are more aware of the disadvantages of overpopulation and understand the significance of various family planning methods. They recognize the socio-economic and environmental impacts of having fewer children and are more likely to use contraceptives and other family planning devices to manage their family size responsibly.

Table-2: Distribution of respondents according to their Educational Status

		Frequency	Percentage	Cumulative Percentage
Valid	Graduate	1	0.1	0.1
	HS	2	0.3	0.4
	HSLC	42	6.3	6.7
	High School	319	47.8	54.5
	Primary	221	33.2	87.7
	Illiterate	82	12.3	100.0
	Total	667	100.0	

Source: Primary data

Table-2, provides a breakdown of the educational status of the respondents, illustrating the correlation between education and fertility rates. Only 1 respondent out of 667 is a graduate, representing 0.1% of the total sample. This very low percentage suggests limited access to higher education, which can impact fertility rates as higher educational attainment is often associated with lower fertility due to better knowledge and use of family planning methods and a tendency to delay marriage and childbearing. There are 2 respondents who have completed higher secondary education, making up 0.3% of the total. Similar to graduates, those with higher secondary education are likely to have lower fertility rates due to similar factors influencing educational attainment. A small group, 42 respondents, have passed the HSLC exam, constituting 6.3% of the sample. This level of education may still support some understanding of family planning but is less influential compared to higher levels of education. The largest group of respondents, 319 out of 667, have completed high school, representing 47.8% of the total sample. While this group has a relatively higher level of education, the fertility

rates may still be influenced by socio-economic factors and cultural norms. A significant portion, 221 respondents, have only completed primary education, accounting for 33.2% of the sample. Lower educational attainment is generally associated with higher fertility rates due to limited knowledge and access to family planning resources and a higher likelihood of early marriage. There are 82 respondents who are illiterate, making up 12.3% of the total sample. Illiteracy is closely linked to higher fertility rates as these individuals often lack awareness of and access to family planning methods, and may marry at an earlier age.

The insights from this table underscore the importance of improving educational opportunities, particularly for women, as a means to manage fertility rates and enhance overall socio-economic conditions within the community.

Economic Status

Economic conditions influence family planning decisions. Families with better economic status tend to have fewer children as they can afford to invest more resources in the upbringing and education of each child. The overall economic category of a household, including factors like income level and asset ownership, impacts fertility decisions. Lower economic categories often correlate with higher fertility due to the perceived economic benefits of having more children.

Table-3: Distribution of respondents according to their Monthly Family Income

Income level	Frequency	Percentage	Cumulative Percentage
3000-5000	75	11.2	11.2
5000-10000	481	72.1	83.4
10000-15000	54	8.1	91.5
15000-20000	25	3.7	95.2
20000-25000	24	3.6	98.8
25000-30000	7	1.0	99.9
30000 & above	1	.1	100.0
Total	667	100.0	

Source: Primary data

Table-3 reveals that majority of respondents (72.1%) fall within the income range of 5000-10000 INR per month. A smaller proportion of respondents (11.2%) have a monthly family income between 3000-5000 INR. Higher income brackets, such as 10000-15000 INR, 15000-20000 INR, and 20000-25000 INR, have fewer respondents, with percentages of 8.1%, 3.7%, and 3.6% respectively. Only a minimal number of families earn above 25000 INR per month, making up 1.1% of the total respondents. Lower-income families may have less access to family planning resources and healthcare services, which can result in higher fertility rates. Economic constraints can limit their ability to afford contraceptives or access reproductive health services. There may be a trend of larger family sizes in these communities as a result of limited economic opportunities and access to resources. Conversely, as income levels increase, there may be a trend towards smaller family sizes, driven by better access to education, healthcare, and family planning resources.

Occupation

Occupation plays a significant role in determining a family's economic condition, which in turn affects fertility rates. Families of manual workers tend to have higher fertility rates, as they often view having more children as a way to increase the number of working hands and, consequently, the household income. In contrast, those engaged in white-collar jobs typically have lower fertility rates. In households where women are employed alongside men, fertility rates are also lower.

Among Harijan communities, many individuals are manual workers, and due to their poor economic conditions, they often see their children as potential income earners. This perspective contributes to higher fertility rates within these communities.

Table-4: Distribution of respondents according to their Occupation

	Frequency	Percentage	Cumulative Percent.
Business	3	0.4	0.4
Govt. Job	3	0.4	0.8
Housewife	293	43.9	44.7
Municipality Cleaner	116	17.4	62.1
Professional	2	0.3	62.4
Private Job	4	0.6	63.0
Wage Earner	242	36.4	99.4
Others	4	0.6	100
Total	667	100.0	

Source: Primary data

Table-4 details the occupational distribution of respondents, providing insights into how occupation correlates with fertility rates and trends within the community. A very small fraction of respondents, 3 out of 667, are engaged in business or government jobs, each representing 0.4% of the total sample. These occupations are generally associated with higher income and better access to resources, which often correlates with lower fertility rates due to a preference for smaller families and greater use of family planning methods. The largest group, comprising 293 respondents, are housewives, representing 43.9% of the total sample. Housewives typically rely on their spouse's income, and higher fertility rates may be observed in this group due to traditional roles and limited access to employment opportunities and family planning resources. A significant portion, 116 respondents, work as municipality cleaners, making up 17.4% of the sample. This occupation, often associated with lower socio-economic status, tends to correlate with higher fertility rates due to economic necessity and limited access to education and contraceptive methods. Only 2 respondents are professionals, representing 0.3% of the total. Professionals typically have higher educational attainment and income levels, which are associated with lower fertility rates. There are 4 respondents employed in private jobs, accounting for 0.6% of the sample. Similar to professionals, private job holders might have better access to family planning and a preference for smaller families, resulting in lower fertility rates. A substantial group, 242 respondents, are wage earners, constituting 36.4% of the total. Wage earners, often in manual labor or low-income jobs, are likely to have higher fertility rates due to economic pressures and the perceived benefit of having more children as potential earners. A small group, 4 respondents, fall into the 'others' category, making up 0.6% of the sample. This category includes various occupations that do not fit into the specified groups. The cumulative percentages show that the majority of respondents are housewives, wage earners, and municipality cleaners. These occupations are typically associated with lower socio-economic status and higher fertility rates. This is due to a combination of factors such as limited access to family planning resources, lower educational attainment, and economic strategies that favor larger families to contribute to household income.

The data suggests that occupation significantly influences fertility rates. Higher fertility rates are observed among housewives, wage earners, and municipality cleaners due to economic necessity and limited access to education and contraception. In contrast, those in business, government jobs, professional roles, and private jobs, who generally have higher socio-economic status, tend to have lower fertility rates. Understanding these occupational distributions and their impact on fertility can inform targeted interventions to improve access to education, family planning, and economic opportunities, ultimately contributing to better reproductive health and socio-economic outcomes within the community.

Adoption of Contraceptive Methods

Access to and use of contraceptives are crucial in controlling fertility rates. Increased use of family planning methods is directly linked to reduced fertility.

Table-5- Contraceptive Methods Adopted

	Frequency	Percent	Cumulative Percent
Condom	83	12.4	12.4
Natural	1	0.1	12.5
Pill	118	17.7	30.2
Tubectomy	9	1.3	31.5
Vasectomy	1	0.1	31.6
Total		31.6%	

Table-5 provides a breakdown of the contraceptive methods adopted by respondents, highlighting the prevalence and variety of family planning practices within the community. This data is crucial in understanding fertility rates and trends. A notable portion of the respondents, 83 out of 667, use condoms as their contraceptive method, representing 12.4% of the sample. Condoms are a widely accessible and non-permanent form of contraception, indicating an awareness and utilization of family planning resources among these respondents. Only 1 respondent uses natural methods of contraception, accounting for 0.1% of the sample. Natural methods, such as withdrawal or fertility awareness, are less reliable and indicate limited access to or preference for modern contraceptives. The most commonly used contraceptive method among respondents is the pill, with 118 users, constituting 17.7% of the sample. This suggests a significant portion of the community prefers a hormonal method of contraception, which is effective but requires regular access to healthcare services. There are 9 respondents who have undergone tubectomy, representing 1.3% of the sample. Tubectomy is a permanent method of contraception, indicating a firm decision to limit family size. Only 1 respondent has opted for vasectomy, accounting for 0.1% of the sample. This low number suggests a cultural or social reluctance towards male sterilization or a preference for female-centered contraceptive methods. The cumulative percentage of respondents using any form of contraception is 31.6%, indicating that a significant majority (68.4%) do not use any contraceptive methods. This has direct implications for fertility rates within the community.

The data shows that a considerable portion of the community is not using contraception, contributing to higher fertility rates. Among those who do use contraceptives, the pill and condoms are the most popular methods, reflecting a preference for non-permanent solutions that can be easily accessed and discontinued.

The low adoption rates of permanent methods like tubectomy and vasectomy suggest that there may be cultural, social, or informational barriers preventing their wider use. This reliance on non-permanent methods may also contribute to fluctuating fertility rates depending on the consistency and correctness of contraceptive use.

The distribution of contraceptive methods adopted by respondents indicates varying levels of access to and acceptance of family planning practices. To better manage fertility rates and trends, there is a need for increased education and resources to promote the benefits of contraceptive use and to address any cultural or social barriers that limit the adoption of effective family planning methods. Improved access to a variety of contraceptive options and comprehensive reproductive health education could lead to more informed family planning choices and potentially lower fertility rates within the community.

Measures of Fertility

There are different measures of fertility. In this study on fertility of Harijan community two types of measures are used i.e., Age Specific Fertility Rate (ASFR) and General Fertility Rate (GFR).

Age-Specific Fertility Rate (ASFR)

This measure provides insights into the fertility patterns of women at different age intervals, helping to identify specific age groups with higher fertility rates.

Total Fertility Rate (TFR)

TFR gives a comprehensive overview of the average number of children a woman would have over her reproductive lifetime, offering a clear picture of overall fertility within the community.

By examining these factors and their impact on fertility measures, the study aims to provide a detailed understanding of the fertility patterns and differentials among females of the Harijan (Dalit) community.

The Age Specific Fertility Rate (ASFR)

The Age Specific Birth rate is the number of births per 1000 women of given age per year.

It is calculated by using the following formula-

$$\text{ASFR} = \frac{\text{Births in specified age group}}{\text{Mid year women population of that age group}} \times K$$

The Age Specific Fertility Rate for women in the age group 20-24 in the study area during 2019-2020 is calculated as-

Number of live births to mothers of a specified age group in the population during 2019-2020 are-54

Number of women in the age group 20-24 during 2019-2020 are-155

Therefore, the Age Specific Fertility Rate for age group 20-24 during 2019-2020

$$= \frac{54}{155} \times 1000$$

$$= 348.39$$

The Age Specific Fertility Rate of 348.39 indicates that in 2019-2020 in the study area of select destinations of Assam, 348.39 births per 1,000 women took place in the age group 20-24. The Age Specific Fertility Rates for all the five-year age groups in the reproductive span for the study area during 2019-2020 are presented in Table-6

Table-6: Age Specific Fertility Rates for the study area during 2019-2020

Age group (1)	Number of births (2)	Number of Women (3)	Age specific fertility rate $\{(2) \div (3)\} \times 1000$ (4)
15-19	2	5	400.0
20-24	54	155	348.39
25-29	39	262	148.85
30-34	5	163	30.67
35-39	1	36	27.78
40-49	0	46	0
	101	667	955.69

Total Fertility Rate (TFR)

The Total Fertility Rate is a standard demographic indicator used internationally to estimate the average number of children that a woman would have over her childbearing years (i.e., age 15-49 years)

The Total Fertility Rate is the sum of the age specific fertility rates of women in each five years age group from 15 to 49. The procedure for computing the total fertility rate is illustrated in Table-6

From Table-6 Sum of column (4) = 955.69

Total Fertility Rate = $\{(955.69 \times 5) \div 1000\} = 4.78$

Age Specific Fertility Rates for the sample area in Assam during 2019-2020 are given in column 4 of Table-6.

The sum of these age specific fertility rates (955.69), given at the bottom of the table, is multiplied by 5 because each age group consists of women of 5 different ages (for example, the age group 15-19 consists of women of 15,16, 17, 18, and 19 years). As the Total Fertility Rate is generally expressed per woman, the product (after multiplying the sum of the Age Specific Fertility Rates by 5) is divided by 1,000. Thus, in Table-6, the TFR observed for Harijan women in the study area of Assam during 2019-2020 was 4.78.

The Total Fertility Rate (TFR) for India as per the census 2011 was 2.4 per woman. According to data from National Family Health Survey-5 (2019-2021) India's total fertility rate dropped below the replacement level of 2.1 and currently stands at 2.0 and the fertility rate of Assam as per NFHS-5 is 1.9. The Total Fertility Rate (TFR) for the Harijan community in the study area is calculated to be 4.78, which is significantly higher than the TFR for India (2.0) and Assam (1.9) according to the National Family Health Survey-5 (2019-2021). This high TFR suggests that women in the Harijan community tend to have more children compared to the general population of India and Assam.

The elevated TFR indicates a need for targeted interventions to address the factors contributing to high fertility rates, such as education, access to family planning resources, and socio-economic conditions. Reducing the TFR to align more closely with national and regional averages could improve overall health and socio-economic outcomes for the Harijan community.

Second Objective: to Study the Reproductive Health Condition of Females of Harijan(Dalit) Community.

The primary aim of the second objective is to find out the impact caused by the factors that influenced the reproductive health conditions of Harijan women.

In this study to measure the reproductive health of women we use the following indicators.

1. Contraceptive Prevalence Rate

Contraceptive Prevalence is the promotion of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method being used. It is reported as a percentage with reference to women of respective marital status and age group.

The proportion of women of reproductive age who are using a contraceptive method at a given point of time-

$$\begin{aligned} \text{CPR} &= \frac{\text{No of women 15-49 using a contraceptive method}}{\text{Total no of women 15-49}} \times 100 \\ &= \frac{212}{667} \times 100 \\ &= 31.78\% \end{aligned}$$

Out of the 667 women surveyed, only 212 reported using contraceptive methods. Among them 83 females which accounts for 12.4% use condoms, 118 females amounting to 17.7% use pills, 9 females representing 1.3% have undergone tubectomy, and 1 female constituting 0.1% uses natural methods for contraception (Table-5). Only 31.78% of females from the Harijan community in the study area have adopted birth control practices. This indicates that the contraceptive prevalence rate among the Harijan community is significantly lower compared to the national level. (Contraceptive prevalence rate in the country as per NFHS-5 is 67%)

2. Antenatal Care Coverage

During the survey, the proportion of women who were attended at least once during their pregnancy by skilled health personnel for matters related to pregnancy is-

$$\begin{aligned} &= \frac{372}{667} \times 100 \\ &= 55.77\% \end{aligned}$$

As per NFHS-5(2019-20) of Assam, 50.7% of mothers had at least four antenatal care visits. It indicates that the antenatal care coverage among the Harijan community is significantly lower compared to the antenatal care coverage of Assam as a whole. (However, the ANC coverage in India has significantly improved from 51.6% (NFHS-4) to 59.25% (NFHS-5). Despite a national improvement in ANC coverage from 51.6% (NFHS-4) to 59.25% (NFHS-5), the Harijan community lags behind, highlighting the need for targeted health interventions.

3. Births attended by Skilled Health Personnel

During the survey, researcher found that out of 667 deliveries, only 492 were attended by skilled health personnel.

$$= \frac{492}{667} \times 100$$

$$= 73.76\%$$

As per NFHS-5(2019-20), 86.1% of births are attended by skilled health personnel. It indicates that the percentage of birth attended by skilled health personnel is considerably lower among the Harijan community compared to the overall percentage of births attended by skilled health personnel in Assam. This disparity indicates a need for improved healthcare access and support for the Harijan community to ensure safer childbirth practices.

4. Prevalence of Anemia in Women

Anaemia is a disorder characterized by a blood hemoglobin concentration lower than the defined normal level. The percentage of women of reproductive age screened for hemoglobin levels, with readings below 110g/l for pregnant women.

$$= \frac{429}{667} \times 100$$

$$= 64.32\%$$

As per NFHS-5 (2019-20), 54.2% of pregnant women aged 15-49 years are anaemic. It indicates that the prevalence of anaemia among women of the Harijan community in the study area is significantly higher compared to the percentage of anaemic pregnant women of Assam. This is significantly higher than the 54.2% prevalence of anemia among pregnant women in Assam according to NFHS-5 (2019-20). This higher prevalence highlights the urgent need for targeted nutritional and healthcare interventions in the study area among Harijan women.

5. Knowledge of HIV-related Preventive Practices

Biological changes caused by HIV, including systemic illness, stress, and weight loss, may affect the function of reproductive organs and result in infertility. Awareness of HIV/AIDS may affect fertility intentions of individuals in an entire population. Sex education is an effective strategy for reducing HIV related risk. There is absence of Knowledge of HIV related preventive practices among Harijans in the study area.

6. Number of Women received TT-1, TT-2 during pregnancy

In the study, out of 667 women surveyed, the distribution of the number of children they had is as follows: 162 women had 1 child, 292 women had 2 children, 140 women had 3 children, 53 women had 4 children, 12 women had 5 children, 7 women had 6 children, and 1 woman had 7 children (as shown in Table-7).

Table-7: Distribution of Women according to their Number of Children

Number of children per women	Number of females	Percentage (%)	Cumulative Percentage (%)
1	162	24.2	24.2
2	292	43.8	68.0
3	140	20.9	88.9
4	53	7.9	96.8
5	12	1.8	98.6
6	7	1.0	99.6
7	1	0.1	100%
	Total-667		

Among the 667 women surveyed, only 376 (56%) received TT-1, and 354 (53%) received TT-2 at the time of their first child. Similarly, 353 women (53%) received TT-1, and 334 women (50%) received TT-2 at the time of their second child (as shown in Table-8).

Table- 8: Number of Women received TT-1, TT-2 during pregnancy.

Birth order	Total No of Women with her children	TT-1	TT-2
1 st child	667	376(56%)	354(53%)
2 nd Child	505	353(53%)	334(50%)

The study highlights significant gaps in reproductive health among Harijan women. The distribution of children shows a trend toward larger family sizes, which can strain resources and affect health outcomes.

Furthermore, the relatively low percentages of women receiving essential tetanus toxoid (TT) vaccinations—56% for TT-1 and 53% for TT-2 at the time of their first child, and 53% for TT-1 and 50% for TT-2 at the time of their second child—indicate inadequate maternal healthcare coverage. These findings underscore the need for improved access to reproductive health services and education within the Harijan community to ensure better health outcomes for mothers and children.

7. ANC checkup for 1st Child and 2nd Child

Among 667 women 21 numbers have done 1time antenatal care (ANC) checkup, 349 numbers have done 2 times ANC checkup and 17 numbers have done 3 times ANC checkup at the time of 1st child. In the same way 18 numbers have done 1 time ANC checkup, 332 have done 2 times checkup and 21 numbers have done 3 times ANC checkup at the time of 2nd child. (Table9)

Table-9: ANC checkup for 1st Child and 2nd Child

Birth order	1 st time	2 nd time	3 rd time
1 st child	21	349	17
2 nd child	18	332	21

The survey indicates significant gaps in antenatal care (ANC) among Harijan women. Of the 667 women surveyed, only a small number received adequate ANC visits. For their first child, 21 women had 1 ANC checkup, 349 had 2 checkups, and only 17 had the recommended 3 checkups. Similarly, for their second child, 18 women had 1 ANC checkup, 332 had 2 checkups, and 21 had 3 checkups. These figures highlight insufficient ANC visits, which are critical for monitoring and ensuring the health of both mother and child during pregnancy. The findings point to the need for improved access to and awareness of comprehensive antenatal care services within the Harijan community to enhance maternal and child health outcomes.

8. 100% Iron and Folic Acid Users.

Among 667 women only 157 numbers of women used 100% Iron and Folic acid (IFA) at the time of 1st child and only 92 number of women used 100% Iron and Folic acid at the time of 2nd child. (Table:10)

Table-10: 100%Iron and Folic Acid users

Birth order	No of women with order of children	100% Iron and Folic acid users	Percentage
1 st child	667	157	23.5
2 nd child	505	92	18.2

As per NFHS-5(2019-20), percentage of mothers who consumed Iron Folic acid for 100 days is 47.5% and mothers who consumed 180 days or more when they were pregnant is 18.5%.

The survey reveals a concerning deficiency in the use of Iron and Folic Acid (IFA) supplements among pregnant Harijan women. Among the 667 women surveyed, only 157 (23.5%) used IFA supplements consistently during their first pregnancy, and even fewer, 92 women (18.2%), did so during their second pregnancy. Compared to the NFHS-5 (2019-20) data, where 47.5% of mothers in Assam consumed IFA for at least 100 days and 18.5% for 180 days or more, the Harijan community's utilization of IFA is significantly lower. This gap underscores the need for increased education and access to essential prenatal supplements within the Harijan community of Assam to improve maternal health and pregnancy outcomes.

9. Place of Birth

As per NFHS-5(2019-20), institutional birth rate is 84.1% and home births that were conducted by skilled health personnel are 2.6%. In this study institutional birth rate is 76.16% (Number-508) and home births are 23.84% (number-159). It indicates that the institutional birth rate among the Harijans community is significantly lower compared to the institutional birth rate at the state level (Table: 11)

Table-11: Place of Birth

	Total	Percentage	As per NFHS-5
Institutional birth	508	76.16	84.1%
Home birth	159	23.84	2.6%

The survey highlights significant disparities in birth practices among Harijan women in Assam compared to the state averages. The institutional birth rate among the Harijan community is 76.16%, which is lower than the state-level rate of 84.1% reported by NFHS-5 (2019-20). Additionally, 23.84% of births in the Harijan community occur at home, compared to 2.6% of home births conducted by skilled health personnel at the state level. This lower rate of institutional births and higher rate of home births indicate limited access to or utilization of healthcare facilities during childbirth within the Harijan community. Emphasizing the importance of institutional births and skilled care during home births is crucial for improving maternal and neonatal health outcomes in this community.

To improve the reproductive health of the Harijan community, we need to address systemic inequalities and barriers to healthcare access. Efforts should focus on improving healthcare, promoting reproductive rights and gender equality, raising awareness about family planning and maternal health, and addressing socio-economic factors to ensure fair reproductive health outcomes for everyone in the Harijan community.

2. DISCUSSION AND CONCLUSION

The study reveals that the fertility rate within the Harijan community of Assam is notably higher than that of other communities, and the reproductive health conditions are far from satisfactory. A significant factor contributing to this trend is the economic condition of the Harijan people, most of whom are manual workers. Due to their low economic status, children are often viewed as economic assets, leading to higher fertility rates. Education among Harijan women remains a major concern, with a large proportion being illiterate. The study found that 41% of the women were married below the legal age of 18, as per "The Special Marriage Act 1954" and "The Prohibition of Child Marriage Act 2006." Early marriage contributes significantly to higher fertility rates. Family planning is not widely practiced within the community due to illiteracy and a lack of awareness, resulting in large family sizes: 162 women had 1 child, 292 had 2 children, 140 had 3 children, 53 had 4 children, 12 had 5 children, 7 had 6 children, and 1 woman had 7 children.

Moreover, school dropout rates among Harijan girls are high, as they leave school to support their households and contribute to the family economy. This further perpetuates the cycle of illiteracy and ignorance regarding reproductive health and family planning.

To address these issues, it is essential to improve literacy rates among Harijan women. Education can play a crucial role in reducing early marriages, lowering fertility rates, and enhancing reproductive health awareness. By implementing and promoting educational programs and policies that focus on the development of reproductive health and family planning, it is possible to bring about significant improvements in the fertility patterns and overall well-being of the Harijan community.

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