HEALTH PRACTICES AND
SOCIAL STRATIFICATION
Chapter 6

HEALTH PRACTICES AND SOCIAL STRATIFICATION

Health is highly valued in all cultures. In order to maintain good health, every culture has prescribed certain practices, norms, values etc. for its members and proscribed those which are believed to be injurious to health. Since culture is all pervasive, every member of the society is expected to follow certain practices regularly in order to enjoy a healthy life. In the light of modern medical knowledge, these practices may be helpful, harmful or neutral for the health of an individual. Similarly, the social structure determines the position and status of its different sections and members resulting in manifestation of varying patterns of health behaviour due to differences in living conditions and group differences in cultural perceptions and life style. Thus, the culture and social structure of a community regulates the varying patterns in which health practices are observed at large. There can be purely individual variations due to one's own choice.

The observance of health practices differs from one stratum to another depending upon the degree of conformity to the norms. Some health practices are observed by most of
the members of the community cross cutting all sections while some are practised mostly by a section(s) of the rural community. This partly depends upon the fitness or congruence between the routine life situations of the different sections of rural community and the given patterns of health practices.

In this chapter, observance of different health practices among the different social groups is discussed. Broadly, three types of health practices are examined (1) practices related to personal hygiene, drinking and smoking (2) practices related to maternal and child care, and (3) food practices. Under personal hygiene care of teeth, body and hair are presented. Under maternal and childcare, actions related to diet, work during pregnancy and after childbirth, prenatal check up, weaning, etc. are described. Under food practices the intake of various food items is discussed.

The heads of the family in the sample households were interviewed to collect data on personal hygiene. For maternal and child care and food practices the wife of head of the household or any elderly female member in the sample households were interviewed.
This chapter is divided into two sections - the first section presents differential distribution of health practices in different caste/class groups. The second section on "Discussion" briefly examines the implications of the observed similarities and differences.

SECTION - 1

HEALTH PRACTICES

PERSONAL HYGIENE

Personal hygiene deals with the maintenance and promotion of individual health, both mental and physical, and involves him/her into certain practices which enable him/her to lead a healthy life. This forms the baseline for community hygiene.

Use of Twig, Tooth powder and Tooth paste

All the respondents were asked as to what material they regularly use for cleaning their teeth. It is found that majority of the members (84 per cent) use twig regularly. In rural areas, due to the availability of a large number of plants of different species in abundance, people mostly resort to plucking of small branches and use them for brushing their
teeth. It is not only convenient but also economical for them. In terms of its use by different social groups, small differences are, however, observed. The Low Caste group resorted to its use slightly more (89.5 per cent) than the High Caste group (77.5 per cent). On the other hand, among the class groups, the Low Class group used twig more often (93.7 per cent) than the High Class (75.4 per cent) group. By and large the class differential is slightly more than the caste differential indicating the negative trend of its greater use by the Low Caste and Low Class groups.

Other materials such as tooth powder and tooth paste are reported to be used by a small number (16 per cent) of respondents. While 6.5 per cent of the respondents reported the use of tooth powder, 9.5 per cent of the respondents reported use of tooth paste. As regards the use of tooth powder by different social groups, not much difference is observed. However, with regard to the use of tooth paste, some difference which is of interest is noted. Compared to the use of tooth paste by the Low Caste group (6.3 per cent) the High Caste group used it slightly more (14.3 per cent). On the other hand, among class groups the differential is much sharper. While only 2.1 per cent of the respondents of the Low Class group reported the use of tooth paste, 21.1 per cent of the High Class group respondents reported its use.
In general, there is a clear trend of greater use of tooth paste by the High Caste and High Class groups than the Low Caste and Low Class groups. The differential is sharper in class groups than in caste groups.

It is observed that while the Low Caste/Low Class groups are associated with greater use of twig, the High Caste and High Class groups are associated with greater use of tooth paste in addition to the use of twig. (Table 6.1 and Fig. 6.1) If use of tooth paste is considered a progressive change in health behaviour, then class status/membership plays greater role in this change than caste membership/status.

Body bath/Head bath

In order to understand the keenness shown in maintaining the cleanliness of the body, all the respondents were asked as to what type of bath they take regularly - the head bath or body bath. According to customary usage in study area, body bath is referred to the one in which an individual takes bath without pouring water on the head. For head bath, one pours down water on his or her head and cleans the entire body. It is observed that majority (93 per cent) of the respondents resort to body bath and only a small number (7 per cent) take head bath. This pattern is more or less found in all the caste and class groups (Table 6.2).
FIG. 6.1 USE OF MATERIALS FOR CLEANING TEETH, BATHING AND HABITS OF DRINKING AND SMOKING IN CASTE AND CLASS GROUPS.
The respondents were further asked to report as to how regularly they take head bath—once in 2 days, once a week, once a fortnight, once a month and rarely. It is observed that majority of the respondents (54 per cent) reported taking head bath once in a week, followed by once a fortnight (18.5 per cent), once in a month (14.5 per cent) rarely (7.5 per cent). Only 5.5 per cent respondents reported head bath once in 2 days. However, there are notable differences in the frequency of observing this practice among the different social groups. While 62.2 per cent of the respondents belonging to the High Caste group took head bath once a week, only 31.2 per cent of the Low Caste group respondents resorted to this practice. Similarly, while 68.4 per cent of the High Class group respondents reported observance of this practice once a week, only 41.7 per cent of the Low Class group respondents observed this practice. It is interesting to observe that both the Low Caste and Low Class groups reported taking head bath less frequently, while both the High Caste and High Class groups resort to headbath far more frequently than the Low Caste and Low Class groups. This can be attributed partly to the greater consciousness of personal hygiene among the High Caste and High Class groups which is, to a certain extent, related to the observance of purity-pollution norms, rituals, and their daily routine (Table 6.3).
It was also observed that most of the adults working in fields take bath on their return from work in the evening. Those who are engaged in other occupations such as supervision of agricultural farms, business, governmental service, etc. take bath in the morning.

Material used for bathing

The respondents were asked to report the material they use commonly for bathing. It is interesting to note that only about half (51.5 per cent) of the respondents used soap. Only a negligible proportion of the respondents (1.5 per cent) reported using indigenous soap nut (Kunkudu kaya). Nearly half (47 per cent) of them are not using anything.

There are significant differences in use of soap among various social groups. While majority of the High Caste group respondents (58.2 per cent) reported use of soap, only 35.4 per cent of the Low Caste group respondents used soap. Similarly, while 70.2 per cent of the respondents belonging to the High Class group reported use of soap, only 38.5 per cent of the Low Class group respondents used soap. In contrast to this, majority of the Low Caste and the Low Class (about 62 per cent) group respondents have not used any material for cleaning their body while bathing. They simply pour water on
their body and rub it with their hands or may use coconut fibre sometimes. Thus, there is a clear trend of greater use of soap both by the High Caste and the High Class groups. It is further observed that the High Class group resorted to the greater use of soap (70.2 per cent) than the High Caste (58.2 per cent) group. On the other hand, about 2/3rds of both the Low Caste and the Low Class groups are not using any thing to clean their body while bathing. This itself indicates greater concern for bodily cleanliness among the High Caste and High Class groups than among the Low Caste and the Low Class groups (Table 6.4 and Fig. 6.1). Since class differences are notably larger than caste differences these practices appear to partly depend upon affordability and higher socio-economic status in addition to health consciousness and traditional concern for purity or personal hygiene.

Use of Hair Oil:

It is popularly believed that applying oil daily to one's hair keeps the head cool besides giving him/her a presentable appearance. The respondents were asked as to how regularly they apply oil to their hair (daily, once
in 2 days, once in a week, twice a week and rarely). In general, it is observed that a small proportion of respondents (16.5 per cent) apply oil to their hair daily. Most of them apply oil to their hair once in 2 days (44 per cent) or twice a week (20 per cent), followed by once a week (15 per cent) and rarely (4.5 per cent) (Table 6.5).

There are marked differences in regularity of this practice among the different caste and class groups. As the following table suggests (Table 6.6) while 71.4 per cent of the respondents in the High Caste group reported applying oil to their hair regularly (either daily or once in 2 days) only 39.5 per cent of the respondents in the Low Caste group reported so. Most of the respondents from the Low Caste group are irregular in this practice. Similar difference is observed in class groups also. While in the High Class group, 86 per cent reported applying oil to their hair regularly, in the Low Class group only 40.6 per cent of the respondents reported so. When comparing Caste and class groups, it is significant to note that although among the High Class group 86 per cent reported regular use of hair oil, while among the High Caste group only 71.4 per cent reported so. No such Caste-Class
difference among the Lower Caste/Class group is observed. In case of practices like using hair oil or combing, affordability is less important while concern for one's appearance in fitness with one's class status is more important. Such concern for appearance is perhaps itself a class related behaviour. In absence of such concern among the Low Class group we do not observe any caste-class difference.

Table 6.6
Regular and Irregular Practice of Oiling Hair in Caste and Class groups

<table>
<thead>
<tr>
<th>Frequency of applying oil to hair</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 98</td>
<td>71.4%</td>
<td>39.6%</td>
<td>86%</td>
<td>40.6%</td>
<td>60.5%</td>
</tr>
<tr>
<td>Regular</td>
<td>28.6%</td>
<td>60.4%</td>
<td>14%</td>
<td>59.4%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Irregular</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**DRINKING:**

Drinking is a social evil widely prevalent in rural areas. This habit not only drains off sizeable portion of their income but also affects the health of the individual
to the extent of incapacitating him either for a shorter period or for a longer duration depending upon the quantity and the frequency of liquor consumed. This in turn has a severe impact on the consumption pattern in the household sometimes leading to deprivation of essential items such as food, medicines etc. to the members in the family.

About one-fourth (24.5%) of the respondents in general reported that they drink. While only 3.1 per cent of the respondents belonging to the High Caste group reported having drinking habit, 58.3 per cent of the Low Caste group respondents reported this habit. Similar pattern is observed in class groups (High Class group 1.8 per cent and Low Class group 45.8 per cent). In other words, out of those who reported drinking habit, most of them belong to the Low Caste, Low Class groups. (Table. 6.7 and Fig. 6.1) It is possible that more respondents than the reported number are having this habit but did not actually report it due to the fear of getting them bracketed as drunkards.

To understand the extent of drinking habit prevailing in various social groups, the respondents using liquor were asked to report the frequency of their consumption of liquor—regularly (more than thrice a week), frequently (thrice or less than thrice a week) or occasionally (twice or once a month)
Among the Low Caste about 20 per cent admitted drinking regularly, 40 per cent frequently, while 40 per cent occasionally. In all, about 60 per cent of the drinkers in the Low Caste group drink liquor regularly or frequently while only 3 per cent of the drinkers in the High Caste group drink liquor regularly or frequently. When it comes to Low Class group, about 68 per cent admitted drinking liquor frequently or regularly. This suggests that regular drinking habit is admitted more in the Low Class group than in the Low Caste group. Drinking liquor is considered bad in the High Caste and any one indulging in this habit is looked down upon by the community (Table 6.8).

The type of liquor (sara or toddy) one consumes depends upon one's affordability and taste. There are few shops in the village which sell both sara and toddy. A large number of palmyra trees are available around the region for tapping toddy. Incidentally, Settibaljis (toddy - tappers) are the most populous group next to the Kammans, (the dominant caste of the village). Their main occupation is to tap toddy from palmyra trees and sell it in the market. They also engage in other occupations such as agricultural labour, construction work, etc.
All the drinkers were asked to report the type of drink they prefer. In general, about half (51 per cent) of the drinkers prefer toddy, 28.6 percent sara and 18.4 percent like both sara and toddy. Only 2.2 percent take other types of drink. Majority of the drinkers in the Low Caste group (60.7 per cent) reported drinking toddy. Only about 18 per cent of the Low Caste drinkers reported taking sara only while nearly 20 percent reported taking both of them. Similar pattern is observed in class groups also.

It is found that there are some provision shops in the village which sell whisky, rum, etc., stealthily at a premium for the rich and influential persons in the village. Being the head quarters of Mandal (Taluk), this village has a number of government offices. The officials and the rich usually patronise these brands.

As regards the quantity of liquor consumed, it is found that majority (53 per cent) of the drinkers usually take one unit only (Dokku). About 26.5 per cent take 2-3 units while 20.5 per cent take more than 3 units. This pattern is more or less the same among the Low Caste and the Low Class groups.

**SMOKING:**

Smoking is a very common habit among people in this village. Incidentally, tobacco is grown in this village and
in some villages around as a cash crop. There is no taboo associated with smoking as in case of drinking. About 78 per cent of the respondents reported smoking regularly. In both the High Caste and the Low Caste groups smoking is prevalent equally (about 75 per cent) Smoking is more prevalent among Low Class group respondents (84 per cent) than the High Class group respondents (70 per cent) (Table 6.9)

The extent of smoking further depends upon the number of cigars smoked per day usually. To understand this, all the smokers were asked to report the number of cigars they smoke generally per day. It is found that half of them smoke three to five cigars a day, followed by more than 5 (27 per cent), 2 cigars (15.5 per cent) and one cigar (7.7 per cent). About 81 per cent of the smokers in High Caste group smoke 3 or more cigars daily while only 70 per cent of the smokers in the Low Caste group do so. On the other hand, about 85 per cent of the smokers in the High Class group smoked 3 or more cigars daily. This is partly because of the affordability by the High Caste and High Class groups (Table 6.9)

In the Low Caste and Low Class groups, smoking by females and children is a common practice and they also smoke one or two cigars a day. On the other hand, smoking by females in the High Caste and High Class groups is a taboo and is looked down
upon. To understand the extent of smoking by females, all the respondents were asked to report whether any female member(s) in their household smoke. In general 21.5 per cent of respondents informed that female member(s) in their household do smoke. Both the High Caste and High Class group respondents replied in the negative. On the other hand 52 per cent of respondents in the Low Caste group and 43 per cent in the Low Class group informed that their female members do smoke.

Some respondents reported smoking cigarettes but their number is very small.

In this area there is a practice of smoking in which the smoker keeps the burning end of a cigar inside the mouth and this is locally known as 'Addapoga'. This is considered carcinogenic. 23 per cent of smokers resorted to Addapoga. The following table (6.10) shows that in both caste groups, about 20 ptr cent of smokers observed this practice. But in class groups, it is different. In the High Class group, only 8 per cent of the smokers reported using Addapoga, while in the Low Class group it is four times higher (32 per cent). On the whole, larger number of respondents in the Low Class (32 per cent) reported smoking Addapoga than any other group while a small number of respondents in the High Class (8 per cent) reported so. Thus, in observance of addapoga, the class differential is greater while the differential in caste
groups is negligible (see also Table 6.10 A in appendix). It is observed that most females who smoke resort to "addapoga" in greater frequency than the males.

Table 6.10

<table>
<thead>
<tr>
<th>Pattern of smoking in Caste &amp; Class groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern of Smoking</td>
</tr>
<tr>
<td>N=98</td>
</tr>
<tr>
<td>Burning end outside the mouth</td>
</tr>
<tr>
<td>Burning end inside the mouth</td>
</tr>
<tr>
<td>(Addapoga)</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

MATERNAL AND CHILD CARE PRACTICES:

MATERNAL CARE:

Maternal care is an important aspect of health care given to the expectant women in order to help them maintain good health both before and after delivery. It was aimed at facilitating delivery of a healthy baby and help the mother maintain good health.
Some of the health practices taken into account under maternal care are: Special diet given to women before delivery and after delivery, period of working outside the home say in fields by pregnant women and the period after delivery at which work outside the home is resumed and prenatal check-up. For maternal care, only those women (wife of head of a household) who have a child/children were interviewed. Out of the 200 sample households, only 190 women fulfilled the above criterion and the remaining 10 did not have any children. Of these ten, five belong to the High Caste group, one to the Middle Caste group and four to the Low Caste group. In terms of their distribution among class groups, two belong to the High Class group, three to the Middle Class group and five to the Low Class group.

Special care is taken normally in providing diet in the form of certain special items of food preparations, fruits, sweets etc. This depends upon the extent of consciousness in the family and its ability to provide them to the expectant women.

There is a differential pattern of observance of maternal care practices. In providing special diet before delivery, only 27.4 per cent of the households in the sample reported
observance of the practice. In other words, about 73 per cent of the households were not keen in providing special diet before delivery. While nearly 40 per cent of the households in the High Caste group reported providing special diet before delivery, it is only about 20 per cent of households in the Low Caste group observed this practice. On the other hand, the picture is still glaring in class groups. While majority of the households (55 per cent) in the High Class group provided special diet before delivery, it is only just 11 per cent of households in Low Class group (1/5th of the High Class group) which reported observance of this practice. The differential in class groups is sharper than in caste groups.

The picture is different when it comes to providing special diet after delivery. In general, nearly half (48.4 per cent) of the households in the sample observed this practice.

In the High Caste group, while nearly 60 per cent of the households reported observance of this practice, only 23 per cent of households in the Low Caste group followed this practice. Among class groups, while in the High Class group, about 60 per cent of the households reported observance of
this practice only about 35 per cent of households in the Low Class group followed this practice. The differential in caste groups is sharper than in class groups.

In general, it is observed that there is less consciousness in providing special diet before delivery than after delivery. Out of all social groups, only in the High Class group, majority of the households provided special diet both before and after delivery. In the Low Class group, while only 11 per cent of the households provided special diet before delivery, 34 per cent of households provided special diet after delivery. But in the Low Caste group only about 20 per cent of households provided special diet both before and after delivery. The Low Class group took greater care in providing special diet after delivery than before delivery while the Low Caste group showed the same extent of concern both before and after delivery. The High Caste group showed greater concern in providing special diet after delivery than before delivery (Table 6.11 and Fig. 6.2).

Period of Working outside home before and after delivery:

Some women were engaged in agricultural labour, construction work etc. During pregnancy, women are permitted to work only upto a certain period so that they can maintain good health to facilitate an easy delivery. Out of those who are interviewed (190) only 61 women (32.1 per cent) reported
FIG. 6.2 USE OF SPECIAL DIET BEFORE AND AFTER DELIVERY, PHC AND OTHER AGENCIES FOR PRE-NATAL CHECK-UP IN CASTE AND CLASS GROUPS.
working in fields, construction work etc. Most of them belong to the Low Caste group. While in Low Caste group, 84.1 per cent of women were engaged in agricultural labour, construction work etc. outside their home, only 2.2 per cent of women in High Caste group were engaged in these activities. On the other hand, in High Class group no woman reported working outside the home. In contrast to this, 60.5 per cent of the women in the Low Class group reported engaged in these activities. Thus, we find that while no woman in the High Class group was engaged in work outside the home, nearly 84 per cent of the women in the Low Caste group were engaged in agricultural labour, construction work etc (Table 6.12).

Out of the pregnant women who worked outside their home 75.4 per cent worked till 7-9 months of their pregnancy followed by 23 per cent upto 4-6 months, and 1.6 per cent upto three months. Both in the Low Caste group (70.3 per cent) and in the Low Class group (76.4 per cent) majority of the women worked till 7-9 months of their pregnancy (Table 6.13).

To understand the pattern of resumption of work outside the home after delivery all the mothers who reported working during their pregnancy were asked to indicate the period when they resumed their work. In general, about 40 per cent of
mothers reported resumption of work within three months of
their delivery followed by 21.3 per cent in 4-6 months, 11.5
per cent in 7-9 months and 27.9 per cent after 10 months
of delivery. This pattern is found both in the Low Caste and
the Low Class groups (Table 6.14).

It is observed that women in the High Caste group are
not allowed to work in fields or in any other activity other
than household work as it is firmly believed that indulgence
in any such activity will invite stigma and disrepute to the
family. Eventhough one is very poor and the need to earn
money by way of working outside the home is felt, one is
hesitant to allow their females to do so because of the
ridicule likely to be received from their caste people. It
is found that only in rare circumstances, women are allowed
to work and that too, in the fields/houses of very close
relatives so that there will be less criticism from their
caste people.

In addition, the tradition in the dominant High Caste
group in this village (Kamma) also plays a significant role
in the work pattern. In this caste the females generally
own some amount of land given in the form of dowry at the
time of marriage by their parents. This land is cultivated
by their husbands or any other member in the family along
with the family's own share of land. He had to give her the money collected by selling the produce obtained from her share of the crop. She has exclusive right to spend this money the way she desires. Hence, the females in the High Caste group are having some source of getting money and therefore, they do not feel any need to go outside the home for work. Besides, the management of keeping buffaloes/cows and selling milk and milk products is largely done by females in the house. The proceeds of the sale of milk or milk products are generally kept by the females themselves. Thus, the economic independence coupled with the tradition in the group keeps the females in the High Caste engaged in household work mostly. (Out of the 98 . . . households belonging to High Caste Group, 83 belonged to Caste Kamma alone and the rest to Brahmin, Vysya and Kapu castes). Even in these castes, there is a strict observance of not allowing the females to work outside their home despite one's very poor economic position.

It is further enquired from well informed members of the dominant High Caste (Kamma) whether this pattern is found in all parts of the state. It is reported that females in their caste in other parts of the state - Krishna and Guntur districts especially - work as hard as males in the management of their
agricultural fields. The males in their caste are, therefore, left with enough time to engage themselves in other more rewarding occupations such as business, industry etc. However, the dominant High Caste people in this village consider them low in social status in view of their women being engaged in participation of work outside the home. As a result, they do not generally enter into any matrimonial alliance with them.

**Prenatal check-up**

Prenatal check up for pregnant women is necessary for maintenance of good health of both the mother and the baby. In general, nearly half or the pregnant women (52.6 per cent) reported to have no check up during their pregnancy (Table 6.15 and Fig. 6.2). Those women who had a prenatal check up consulted either the local PHC or other agencies such as private doctors, private maternity homes in towns etc. The analysis of the pattern of consultation of these health resources by the pregnant women show interesting results. In general, majority of them (66.7 per cent) visited PHC and the rest consulted other resources for pre-natal check up. However, there are significant differences in use of these health resources in caste and class groups. While in the High Caste group only 38.6 per cent of pregnant women had a prenatal check up at PHC, 87.5 per cent of pregnant women in
the Low Caste group had prenatal check-up at this health resource. In contrast to this, while only 12.5 per cent of pregnant women had prenatal check up at other agencies in the Low Caste group, 61.4 per cent of pregnant women in the High Caste had pre-natal check-up at other sources. Similar pattern is observed in class groups also. It is significant to note that while 76 per cent of pregnant women in the High Class group visited other agencies, only 5.3 per cent pregnant women in the Low Class group visited these agencies for prenatal check up. On the contrary, while about 95 per cent of the pregnant women in the Low Class group consulted PHC for prenatal check up, it is only 24.1 per cent in the High Class group. Thus, while the Low Caste and Low Class groups depended heavily on local PHC for pre-natal check up, the High Caste and High Class groups sought services from private agencies. The Low Class group (95 per cent) depended more on PHC than the Low Caste group (87 per cent). Similarly, the High Class group sought services from other agencies (76 per cent) in greater measure than the High Caste group (61 per cent). The wide differential in seeking services either from PHC or from other agencies in Caste and Class groups is due to one's economic position and their perception of services rendered in these agencies. The High Caste/High Class group women can not only afford the expensive medical care in private nursing homes
in nearby towns but also hold a 'not-so-favorable' image about the services rendered at local PHC. Absence of a lady doctor at PHC is also a factor in their seeking maternal care services outside the village. On the other hand, the Auxiliary Nurse Midwife (ANM) of local PHC belongs to the Low Caste group and this factor helps her to communicate better and to persuade the pregnant women of this group to seek services from PHC. In addition to this, lack of sufficient means to seek expensive care outside the village is another contributing factor that makes them visit PHC. Though some of them may also not have a favourable image about the services of PHC, they cannot help but to visit PHC due to their lack of sufficient means (Table 6.16).

CHILD CARE PRACTICES:

Under child care practices, weaning and age of the baby when solid foods were given were studied.

Early weaning practice reflects not only the health consciousness on the part of mothers but also the customs in the group. In general, nearly half (49.5 per cent) of the mothers started weaning when their babies reached the age of 9-12 months. About 20 per cent of mothers continued to breastfeed till their babies reached more than 2 years. About 14.2 per cent mothers weaned their babies between the age of 1 to 1½ years and about 12 per cent between the age of 1½ to 2 years.
There are significant differences in observance of weaning in different caste and class groups. While nearly 60 per cent of mothers in the High Caste group weaned their babies on their reaching 9-12 months, only 18.1 per cent mothers in the Low Caste group observed this practice. On the other hand, 45.4 per cent of mothers in the Low Caste group weaned their babies when they reached more than 2 years. Among class groups, while 60 per cent mothers in the High Class group weaned their babies when they were in the age of 9-12 months, about 40 per cent of mothers in the Low Class group observed this practice at the same age. However, 35.2 per cent mothers in Low Class group weaned their babies when they are more than 2 years old, while only 1.8 per cent mothers practised this in the High Class group. On the whole, while majority of the High Caste and High Class group mothers practised weaning when their babies reached the age of 9-12 months, most of the mothers in the Low Caste group (45.4 per cent) and the Low Class group (35.2 per cent) practised weaning when their babies were more than 2 years old. Of the Low Caste and Low Class groups, while 40 per cent of mothers in the Low Class group weaned their babies when they were in the age of 9-12 months only 18 per cent of mothers in the Low Caste group observed this practice. Thus, of all the caste and class groups, the Low Caste group practised weaning after a prolonged
period, that is after the age of 2 years of their babies. This itself reflects their lack of proper health consciousness and laxity in enforcing early weaning practice (Table 6.17).

As far as giving solid foods to babies is concerned it is observed that in general, 41.6 per cent of the mothers practised giving solid foods when their babies are 10-12 months old. More or less a similar percentage of mothers (39 per cent) gave solid foods to their babies below the age of 9 months. Thus, nearly 80 per cent of the mothers practised giving solid foods when their babies were below the age of 12 months. A small number of mothers (18.4 per cent) gave solid foods when their babies were more than one year old. This pattern is found more or less in all caste and class groups. However, in the Low Caste group, only 63.7 per cent of mothers gave solid foods when their babies were below the age of 12 months. In rest of the cases, they gave solid foods when their babies became more than 1 year old. Thus, in the Low Caste group, there is less consciousness in observance of accustoming the baby to solid foods early (Table 6.18).

As far as the use of baby foods such as Amul, Nespray etc. is concerned, very few mothers reported using them. Only 7 mothers out of 93 in the High Caste group and 1 mother out of
44 in the Low Caste group used them. Similarly only 6 out of
55 mothers in the High Class group used them. None of the
mothers in the Low Class group reported using them (Table 6.11).

**FOOD PRACTICES:**

In order to estimate the calorie intake in different
social groups, data were collected on consumption of food items
such as rice, wheat, sugar (including jaggery), oil, pulses and
non-vegetarian food items such as meat, fish, egg, etc. In
each household, the lady of the household or any other female
member involved in cooking in the household was asked as to
how much of these items were required for a week for consumption
in the family except rice for which daily requirement was
estimated because of the convenience in recall. All members
of the household belonging to different age groups and sex
were converted into standard consumption units by using the
table in the book "Nutritive Value of Indian Foods", National
Institute of Nutrition, Hyderabad 1984. The following
classification has been adopted in this study:

<table>
<thead>
<tr>
<th>Category</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (Male)</td>
<td>1.2</td>
</tr>
<tr>
<td>Adult (Female)</td>
<td>0.9</td>
</tr>
<tr>
<td>Adolescents (12-21 yrs)</td>
<td>1.0</td>
</tr>
<tr>
<td>Children below 12 yrs.</td>
<td>0.6</td>
</tr>
</tbody>
</table>
The quantity of different items of food consumed per day in the household was divided by the number of units in the household to obtain per unit per day consumption of the various items of food. By using the caloric value of foods (NIN, 1984) the items were converted into calories. For non-vegetarian food items, half of the total quantity of consumption is treated as fish and meat and the remaining half as egg since it was found difficult to obtain data precisely.

It was found difficult to obtain data on milk consumption precisely since most of the households in the poor sections of the community used milk and the milk products either irregularly or bought them for small amounts of money such as 25 NP, 50 NP etc. Similarly, data regarding the use of vegetables was also found difficult to obtain precisely.

The following table (6.19) shows that in general, each unit in the sample consumed 2241 calories per day. There is marginal differential consumption of calories per unit per day in different social groups. While the per unit per day in take of calories found highest in the High Class out of all social groups, it is the lowest in the Low Class group. Of the High Caste/High Class groups it is the High Class which is having slightly better calorie intake. The Low
Caste and Low Class groups are having more or less similar intake of calories per unit per day (Table 6.20 and 6.21).

Table 6.19
Consumption of calories in Caste and Class Groups

<table>
<thead>
<tr>
<th>Item</th>
<th>Calories</th>
<th>Per unit consumption of calories per day in Caste and Class groups</th>
<th>Average per unit consumption per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>1797</td>
<td>High Caste</td>
<td>2287</td>
</tr>
<tr>
<td>Wheat</td>
<td>35</td>
<td>Low Caste</td>
<td>2225</td>
</tr>
<tr>
<td>Pulses</td>
<td>59</td>
<td>High Class</td>
<td>2381</td>
</tr>
<tr>
<td>Oil</td>
<td>187</td>
<td>Low Class</td>
<td>2217</td>
</tr>
<tr>
<td>Suagar(Jaggery)</td>
<td>119</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egg, Fish, Meat</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2241</td>
</tr>
</tbody>
</table>

Broadly, the Low Caste and Low Class groups have less consumption of calories (2217-2225) per day per unit than the High Caste and High Class groups (2281-2287). This indicates a broad trend of nutritional status in the Low Caste/Class and the High Caste/Class groups. Since all the items of nutrition
could not be taken into account due to methodological problems, the results could only indicate broadly the trends in nutritional status in different groups. It may largely be inferred that the Low Caste/Low Class groups have poorer nutritional status than the High Caste and High Class groups.

Table 6.22

<table>
<thead>
<tr>
<th>Item</th>
<th>High Caste</th>
<th>Low Caste</th>
<th>High Class</th>
<th>Low Class</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>1756</td>
<td>1899</td>
<td>1775</td>
<td>1903</td>
<td>1797</td>
</tr>
<tr>
<td></td>
<td>(76.8%)</td>
<td>(85.3%)</td>
<td>(74.5%)</td>
<td>(86.0%)</td>
<td>(80.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>531</td>
<td>326</td>
<td>606</td>
<td>314</td>
<td>445</td>
</tr>
<tr>
<td></td>
<td>(23.2%)</td>
<td>(14.7%)</td>
<td>(25.5%)</td>
<td>(14.0%)</td>
<td>(19.8%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2287</td>
<td>2225</td>
<td>2381</td>
<td>2217</td>
<td>2242</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

It is interesting to note from the table that the percentage of consumption of calories drawn from rice and other items out of total intake of calories is more or less the same in the High Caste and the High Class groups (Rice nearly 75%, other items nearly 25%). Similarly, the percentage of calories
drawn from rice and other items out of total intake of 
calories is more or less the same in the Low Caste and Low 
Class groups (Rice nearly 86%, other items nearly 14%). 
Further, of the total consumption of calories, the Low Caste 
and Low Class groups have drawn more calories from rice (86%) 
than the High Caste and High Class groups (75%).

SECTION II

DISCUSSION

In the previous section, the influence of social 
stratification in observance of some selected health practices 
related to personal hygiene, smoking, drinking, maternal and 
child care and food has been presented. In this section, the 
relative influence of caste and class in observance of these 
practices is discussed. While some health practices are 
observed by all caste and class groups more or less in equal 
proportion, other health practices are observed in different 
proportions in the caste and class groups.

Health practices such as the use of toothpowder, taking 
head bath, body bath and extent of smoking (cigars 3-5) have 
been observed by all the caste and class groups more or less 
in the same proportion.
In observance of rest of the health practices studied it is found that either the High Caste group observed a particular health practice more frequently than the Low Caste group or vice versa. Same is the case with the class groups as well.

Some health practices have been observed by a particular caste or class group only. On the other hand, some health practices have been observed by both the caste groups in more or less equal proportion.

It is found that the High Caste and the High Class groups observed the following health practices, which are beneficial to maintenance of good health, more frequently than the Low Caste and Low Class groups respectively. These are: (1) use of tooth paste (2) regularity in taking head bath (3) use of soap (4) regularity in oiling hair (5) taking special diet both before and after delivery (6) visiting other agencies (private lady doctors or nursing homes in nearby towns) for prenatal check up and (7) comparatively early weaning at the age of 10-12 months of the baby.

Similarly, the Low Caste and the Low Class groups observed certain health practices, some of which are conducive to illhealth, in greater measure than the High Caste and the
High Class groups. These are: (1) Use of twig (2) Irregularity in taking headbath (3) Not using any material for cleaning the body at the time of bath (4) Irregularity in oiling hair (5) Drinking (6) Working in fields or any other activity outside home by pregnant women upto 7-9 months of their pregnancy mostly (7) resumption of work by the new mothers outside the home within three months after delivery largely. They depended mostly on local PHC for prenatal check up. Greater amount of calories out of the total consumption of calories is drawn from rice in these groups. Their intake of calories is less than the High Caste/High Class groups.

Some health practices have been observed by either a particular caste or class group in greater frequency than others. These are:

1. The High Class group had slightly greater prenatal check up than the High Caste group.

2. The Low Caste group women observed weaning mostly when their babies are around 2 years old than the High Caste women who observed weaning when their babies are 10-12 months old.

3. The Low Class group practised "addapoga" more frequently than the Low Caste group.

4. The Low Caste group visited PHC for prenatal check up slightly in greater measure than the Low Class group.
Some health practices have been observed by both caste and class groups more or less in the same proportion. The High Caste and the High Class groups observed the following practices in more or less equal measure:

1. Very few (or no woman) reported working outside the home;

2. Weaning was observed when their babies are 9-12 months old;

3. Negligible (less than 3 per cent) drinking.

The following health practices have been observed by the Low Caste and the Low Class groups in more or less equal measure:

1. Use of soap and

2. per unit per day consumption of calories.

The practice of Addapoga has been observed in equal measure by both the High Caste and the Low Caste groups.

It is of interest to note that while the High Caste and the Low Caste groups have observed some health practices more or less in equal proportion, the High Class and the Low Class groups have not observed any health practice in more or less equal proportion.
By and large, it is seen that the High Class group is associated with observance of health practices in a measure which is conducive to better health in comparison to the High Caste group. These practices are (1) use of tooth paste (2) use of soap (3) regularity in taking head bath (4) regularity in oiling hair (5) less use of 'addapoga' (6) providing special diet both before and after delivery to women (7) greater prenatal check up (8) visiting private doctors/nursing homes in nearby towns where better facilities are available for prenatal check up and (9) negligible drinking.

On the other hand, neither the Low Caste group nor the Low Class group is distinctly ahead of each other in observance of health practices conducive to better health. Each one of them observed certain practices in a measure which is conducive to better health to a certain extent. The Low Class group is ahead of Low Caste group in taking head bath regularly, and providing special diet after delivery. The Low Caste group provided special diet before delivery and prenatal check up in greater measure. However, certain health practices which are injurious to health are found practised in greater measure by either of these groups. While the Low Class group uses 'addapoga', more frequently, less pre-natal check up, less special diet before delivery than the Low Caste group, the Low Caste group drinks liquour in greater measure than the Low Class group.
In general, both the High Caste and the High Class groups observed these health practices in such a measure which is conducive to better health. In all, it is found that the High Class group observed health practices in a greater measure which is conducive to better health than all other groups - High Caste, Low Caste and Low Class. In the Low Caste and Low Class groups only some practices observed by them are conducive to better health. It can be, therefore, inferred that as one's class status improves, one's health status is also likely to improve.