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Saas, *bahu* and ASHA: Information diffusion in rural Bihar

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The National Health Mission has induced substantially improved Maternal and Child Health (MCH) outcomes in India. The role of the ASHA workers in this transformation has been well documented in many studies. A recent study, however, points out two important constraints to their outreach activities. One is their failure to influence educated women, and those from affluent households; the second is that mothers-in-law (*saas*) act as mediators in the interaction between ASHAs, and women of reproductive age. The latter has both positive and negative consequences, that need to be explored in greater details.

Background

At the start of the millennium, improving MCH outcomes was one of the major challenges facing South Asian countries, including India. Despite impressive economic performance, India failed to attain the Millennium Development Goals with respect to reducing maternal, infant, and child mortality. Other MCH indicators, including nutritional outcomes, too, were poor. Further, there was considerable regional variation in these indicators, with states like Bihar lagging behind.

Demographic and health indicators	1992-93		2005-06	
	Bihar	India	Bihar	India
Infant mortality rate	89.2	78.5	61	57
Under 5 mortality rate	127.5	109.3	84	74
Total fertility rate	4.0	3.4	4.2	3.0
Percentage of mothers with at least 3 ANC check-ups	30.7	43.8	14.5	42.8
Percentage of women adopting modern contraception methods	18.5	33.1	26.8	45.3
Percentage of institutional deliveries	12.1	25.5	18.6	31.1
Children exclusively breastfed (0-5 months)	51.6	51	27.3	48.3

In 2005, therefore, the Ministry of Health and Family Welfare announced a flagship program called National Rural Health Mission. This programme, later renamed National Health Mission, was successful in improving the health scenario. One of the key components responsible for the success of the programme was the introduction of Accredited Social Health Activists (ASHAs).

ASHAs are local women, recruited as grass root level health workers. They were given the responsibility of motivating behavioural change through the dissemination of awareness about MCH issues. In Bihar, the efforts of ASHAs were supplemented by the Health and Nutrition Strategy of JEEViKA. This strategy targets Self Help Group members under JEEViKA. Community Mobilisers (CMs) intends to spread awareness among JEEViKA members through monthly meetings. These two strategies have led to an improvement in MCH outcomes.

Objectives

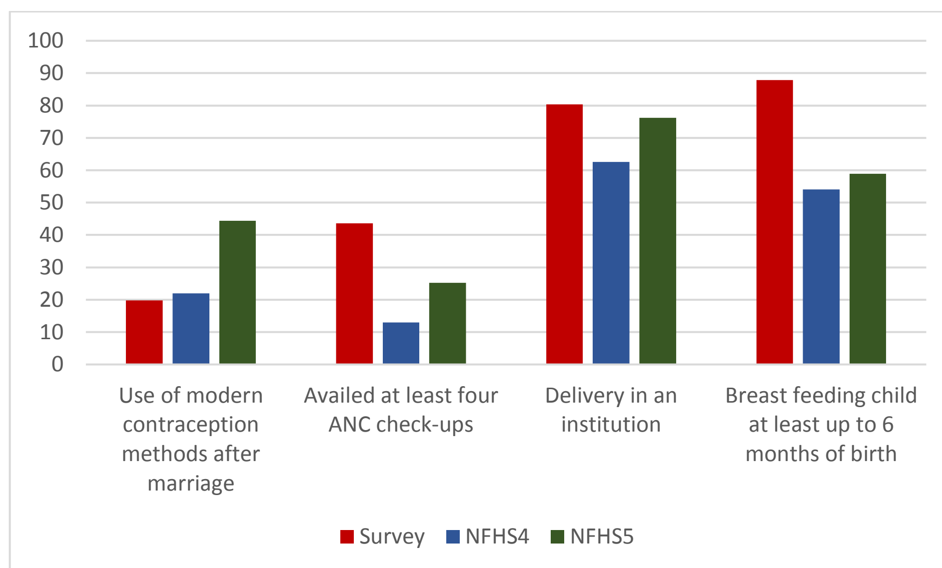
The attempts at behavioural change have created networks of information dissemination within the community; they have also generated exogenous peer effects. Our study seeks to examine whether ASHAs have been successful in reaching out to rural households and motivating them to adopt recommended MCH practices. The study examined the following research questions:

- What are the adoption levels of MCH practices like availing Ante Natal Care (ANC) services, seeking protection against anaemia and neonatal tetanus, institutional delivery, utilising Post Natal Care (PNC) services, exclusive breastfeeding of children between 0-5 years, and complementary feeding of children aged 6-36 months?
- Is there any peer effect?
- Who has motivated such changes?
- What are the characteristics of networks formed to disseminate information about MCH practices?

To seek the answers to these questions, a primary survey of 2250 women who had at least one child aged less than 36 months was conducted in six districts of Bihar, viz. Begusarai, Katiahar, Muzzafarpur, Nalanda, Purba Champaran, and Saharsha. It was supplemented by Focus Group Discussions (FGDs), and analysis of information networks using social network analytic methods.

Findings

Analysis of our data, and results from the last two rounds of National Family Health Surveys show that MCH outcomes have improved in Bihar in recent years. Our analysis also reveals that there is a peer effect, with the behaviour of one person being influenced by the behaviour of other community members.



It was observed that ASHAs were the main motivators underlying the change. This is in consonance with similar global studies showing that women, even when briefly trained, can successfully increase the coverage of healthcare, particularly if they are locally recruited and made accountable to the local clients.

Mapping the information diffusion network revealed a hierarchical network, with the ASHA at the top. Interaction was mostly restricted within the family. It was observed that the *saas* played a very crucial role as the gatekeeper through which ASHA was able to interact with the daughter-in-law (*bahu*).

> "*Before taking any decision we need to consult our guardian... Now it is true that our husband is our guardian. But, within the household domain, our guardian is the saas. We have to inform her and discuss all these issues before finalizing anything. ... Our husbands are busy with their work, and so they don't have time to guide us or understand what we need. On the other hand, our saas mostly stay at home with us and are more aware of the details of our personal life. Further, these are women-related*

> *issues; so a female guardian, like my saas, is better placed to take care of these matters*".

Acknowledging the power relations existing within the families, ASHAs involved the *saas* in the interaction with *bahus*. This reduced friction, enabled the ASHA to influence the *saas*, and established a channel of communication between the ASHA and *bahu*, their target.

In contrast, the contribution of the Health and Nutrition Strategy (HNS) of JEEViKA in inducing behavioural change is less apparent. As JEEViKA members and their family view the group primarily as an institution enabling more efficient management of household finances, they pay subscriptions regularly. But, as JEEViKA members admitted, "*We do not attend HNS meetings regularly*". In fact, more than half of the respondents had attended three or even lesser HNS meetings in the six months preceding the survey. Restrictions on movement outside the household, domestic chores, and the need to look after their children are the causes cited for their absenteeism. In such cases, the *saas* pays the subscription, and even attends the meetings: "*I don't generally move out from the house; beside this, my child is very young, and I have to take care of her … so my saas attends JEEViKA meetings*". The information provided in the HNS meetings proceeds through the mother-in-law, who may control the information provided to the *bahu*. Unlike the three-way interaction between ASHA, *bahu* and *saas*, the dialogue in JEEViKA meetings is only between the Community Mobiliser and the *saas*. The absence of the *bahu* in the deliberations implies that that the power of the *saas* as gatekeeper increases. The information passes through the *saas* who may use her gatekeeper's role to distort the information, or simply withhold it, to ensure that the *bahu* adheres to traditional family norms about fertility and MCH practices.

An unexpected finding relates to the association between education and economic status of the family, and MCH outcomes. Education, particularly that of women, and poverty alleviation are expected to increase awareness, acting as major drivers to improve MCH outcomes through behavioural change. Our study found that a relatively lower proportion of educated women, and women from families with high asset holdings adhered to the recommended MCH norms. It was also observed that ASHAs were more unsuccessful in reaching out to such women. FGDs revealed antagonism between ASHAs and affluent and upper caste women; ASHAs reported that the latter believed they knew everything and sought health care from private facilities:

> *"What will we explain to people who believe they know all? The upper caste feel that they have money, and so they need not avail of any government facilities. So we visit them just to share the check-up dates"*

As a result, ASHAs visited such households only to maintain records.

Sign posts for the future

The observed success of the ASHA workers in generating behavioural change may be attributed to their strategy of involving mothers-in-law in the discussions and motivating

campaigns. This has mixed consequences. In some cases, the mother-in-law has been very supportive and assisted her daughter-in-law to avail ANC services. But there are also many instances when the message of the ASHA has clashed with the traditional norms reinforcing notions of large families. Policy intervention must be directed to address the challenge posed by inter-generational power relations between women, and aim to tackle potential misalignment of preferences between the two generations. In case of the HNS strategy, attendance of younger women of reproductive age needs to ensured.

Our study highlights the fact that improvement of MCH outcomes is not a matter of merely health and awareness, but incorporates a gamut of issues like economic empowerment, agency in the household domain, access to social support systems, and capability to tap social networks. Addressing all these issues is a complex task. It calls for the introduction of a unique, multi-pronged strategy, co-operation between multiple stakeholders, including gatekeepers to the household domain, taking into consideration the convoluted cultural realities of the caste-ridden patriarchal society of the state.