"Learning from Others"- The role social networks on child care knowledge and practices among mothers in Rural Odisha, India

Introduction

Health knowledge is a result of formal education (Caldwell, 1979; Glewwe, 1999; Frost *et al.,* 2005). In the large volume of literatures on the positive relationship between education – particularly maternal education – and child health, health knowledge, or knowledge of disease etiology and prevention, has been cited as an important intermediate mechanism linking maternal schooling to improved child health (Caldwell, 1979; Glewwe, 1999; Frost *et al.,* 2005). Although formal education and mass media campaigns are crucial in almost all settings, knowledge shared by friends and acquaintances through informal methods can in some cases carry greater weight or authenticity. So social networks are considered to be effective disseminator of knowledge and, more importantly this knowledge has led to positive changes in behaviour, for example in relation to family planning (Montgomery and Casteline, 1996; Casteline, 2001; Cleland, 2001; McNay *et al,* 2003).

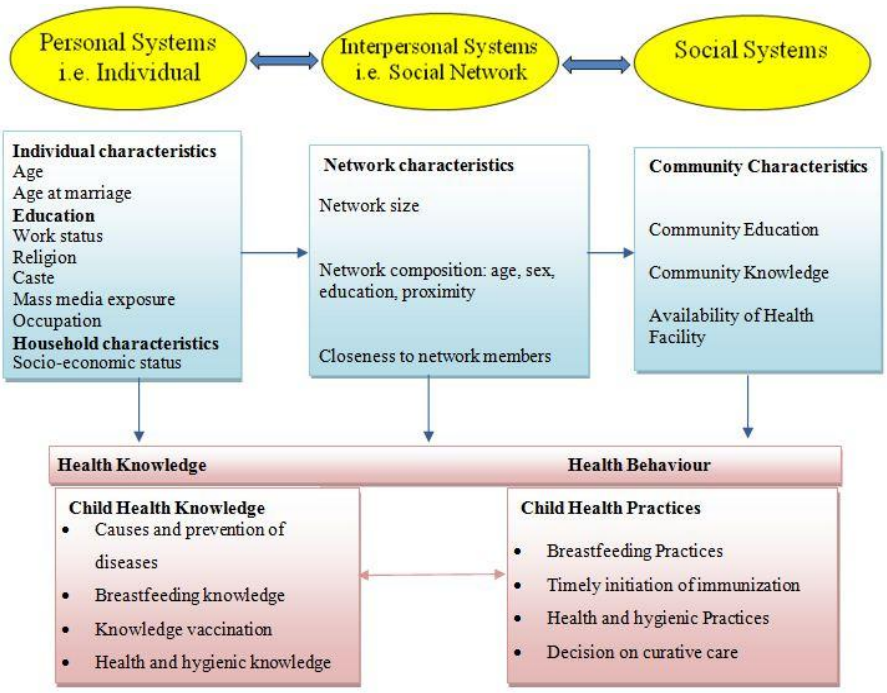
People are embedded in social relationships with other individuals through whom they learn about new ideas (innovations), in a process of diffusion. There is a large demographic literature about the diffusion of information and ideas about contraceptive use and fertility values via social networks (Casterline, 2001; Reed *et al.*, 1999), yet little research exists on social networks as mechanisms for the spread of knowledge about child health or health more broadly. One important contribution is a study in Guatemala on the diffusion of etiological beliefs about child diarrhea. Goldman, Pebley and Beckett (2001) found that, in addition to education and household economic status, social contacts, particularly interpersonal social contacts, influenced biomedical etiological beliefs. A recent review of the literature on grandmothers' roles in non-western societies revealed that grandmothers, in virtually all cultures and communities, have considerable knowledge and experience related to all aspects of maternal and child development, and that they have a strong commitment to promoting the well-being of children, their mothers, and families. (Aubel, 2005).

Conceptual Framework

Man/woman is a dynamic human being whose perceptions of objects, persons, and events influence his behaviour, social interaction, and health (King, 1971). King's conceptual framework includes three interacting systems with each system having its own distinct group of concepts and characteristics. These systems consist of personal systems, interpersonal systems, and social systems. The personal system that King speaks of refers to the individual. Individual age, education, work status, religion, caste, exposure to media determines perception and beliefs of human being. Interpersonal systems involve individuals interacting

with one another. King refers to two individuals interacting as dyads, three individuals as triads, and four or more individuals as small or large groups (King, 1981). These interacting groups are also important as they influence individual characteristics and directly health knowledge and behaviour of person. The social system has also manipulates individual characteristics and interpersonal relations as well as influencing health beliefs and behaviour.

Figure1: Conceptual framework



Rational of the Study and Objectives

Social learning and social influence (or social pressure) through interpersonal channels have been thought to play a major role a myriad of demographic phenomena including the acceptance and use of contraceptives, the pace of family building, morbidity, migration decisions and the use of medical services. As such, network influences have potentially important policy implications for the implementation of a wide variety of public health initiatives. Like most knowledge acquisition, it is likely that people learn about health through not just one, but through a variety of reinforcing (and perhaps contradictory) means (Andrzejewski et al, 2009). Although broad theories and literature exist on learning through these various mechanisms, comparatively few authors have directly theorized or addressed learning about children's health, diseases, and prevention. Much of the demographic literature from the developing world is related to the spread of knowledge about contraception and fertility change, not about knowledge of children's health or health knowledge generally.

Therefore, the present study tries to find out role of social networks in mothers' health knowledge and child care practices of mother. The present study will be carried out in the

rural area of the state of Odisha. The state is lying behind not only in terms of demographic achievement but also in socio-economic achievement, performance of the state is not satisfactory as a whole. The state has experienced high level of infant and child mortality since long back. According to the recent bulletin of Sample registration System (SRS)-October 2009, Odisha has the second highest IMR with 69 of them dying per 1000 livebirths which is the second highest among all the states of the country after Madhya Pradesh. Moreover, in rural areas this rate is quite high with 71 children per 1000 live births died before completing one year of their birth.

Methods and Material

The present study will use both quantitative and qualitative primary data collected from the rural Jajapur district of Odisha (formerly known as Orissa), an eastern state of India. The data was collected in between the month of April 2012 to June 2012 for author's PhD research work. For quantitative data collection, a multi-stage sample design was adopted for primary data collection. There were four stages: Census sub-district, villages, households and women. Dharmasala sub-district which is a rural setting (100% rural population) was selected purposively. To make sure the sample represents from heterogeneous facility, four villages with sub-center (lowest health facility in Indian health system) and four villages without sub-center were selected. The villages were selected on the basis of literacy level and number of 0-6 population in 2001. Women with at least one under-five children were considered as eligible respondent. For more than one eligible women Kish table was used to select respondent.

A structured interview schedule was used to collect information on basic household information, social networks and child health knowledge as well practices. The total number of respondents were 379 from the selected villages-Aurangabad, Daulatpur, Panturi, Madhupurgarh, Pakhar, Subhadrapur, Odiso and Sana Nahangarara. In the social networks sections of the schedule women were asked to name the individuals, within and outside the household whom they talk most. Mothers will be asked about characteristics of the network member like sex, age, education, occupation, proximity and the social support i.e. both emotional and financial they provide to enhance the child health. Details of six best network members were recorded on how they are useful to women's health knowledge and child care practices. About 40 in-depth interview were collected from the villages. Both bivariate and multivariate techniques were used for the present study. IBM SPSS 20 was used for quantitative data analysis.

Preliminary Findings

- The size of network is directly associated with age, autonomy and children ever born of women. With increase in age and autonomy women's network size increase whereas education and economic status the network size goes down.
- Young mother's networks are restricted to husband's and maternal family most of the time. It is only after birth of first child women are allowed to speak outsiders.
- Women with better education and from upper caste families are more likely to talk to educated and upper caste people in the community.
- Size of network has no association with child health knowledge.
- Better educated network members are more likely to speak about modern medicine methods whereas aged and uneducated members mostly advice them about traditional ritual and culture.
- The qualitative data shows that mother-in-laws are the most influential persons for traditional rituals and herbal medicines.
- A woman from poor household generally prefers herbal medicine and medicines from medical stores rather than going for doctors and professional modern medicine practioners.
- In each villages, there are at least two persons other than health personals who helps and advices for treatments.
- Multivariate analysis shows educated network members, caste, religion and economic status are important to health knowledge of an women.

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