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The role of mother-in-law in preventing the mother-to-child transmission of HIV in South Asia  
(Bangladesh, India, Nepal, Pakistan)

Case study

Executive summary

In South Asian patriarchal societies, mothers-in-law have a strong influence on the uptake of health services. Understanding their role is important if we are to design and target effective community-based health promotion interventions. Several studies\(^1\) state the importance of focusing on mothers-in-law in interventions relating to maternal and child health as well as HIV prevention in young women and their babies. Senior family mostly make decisions about access to health care, and the ability of young women to make decisions is limited in several South Asian settings. This change through the life cycle points to mothers-in-law as a potentially important focus for intervention in relation to the maternal health of young married women. Therefore, health promotion and educational interventions to improve the use of health services (including PMTCT) by pregnant women should target not only future mothers, but also family members, particularly mothers-in-law where they control access to family resources.

However, in order to design effective intervention, social norms should be understood and addressed. Often, in South Asian countries, mothers-in-law have a negative influence on the decisions around accessing health care facilities and providers. The main factors leading mothers-in-law not to support/encourage ANC check-ups were expectations regarding pregnant women fulfilling their household duties, perceptions that ANC was not beneficial based largely on their own past experiences, the scarcity of resources under their control and power relations between mothers-in-law and daughters-in-law. In order to change mothers-in-law attitudes

\(^1\) The studies were cited throughout the paper.
towards uptake of perinatal health services by their daughters-in-law, several strategies were proposed, including re-categorization of mothers-in-law, reducing the empirical expectations, and promoting children’s right to health.

In order to implement the above-mentioned strategies, a number of interventions can be considered, like promoting the ‘good mothers-in-law’ concept through communication at all levels (personal, family, community, and mass media); community commitment and common pledge achieved through community discussion and community decision; design and promotion of informative materials and supportive messages directed to mothers-in-law; and a public campaign on children’s rights to health.
I. Introduction

With continuously increasing number of women, infants and children living with HIV every year, the HIV epidemic continues to dramatically affect their health, livelihood and survival across the region. In 2007, the estimated number of women living with HIV in South Asia is 620,000 and in East Asia and the Pacific is 810,000. In South-East Asia women account for about 40% of the people living with HIV, while in South Asia 30% of the adults living with HIV are women. In 2008, an estimated 84,000 pregnant women were living with HIV in East, South and South-East Asia, accounting for 6% of the total number of pregnant women living with HIV globally.

Prevention of mother-to-child transmission (PMTCT) programmes provide an important opportunity to implement highly effective interventions in resource-limited settings, and promote the health of mother and child. Without treatment, about half of these infected children will die before their second birthday. Without intervention, the risk of mother-to-child transmission (MTCT) ranges from 20% to 45%. Nevertheless, with specific interventions, the risk of MTCT can be reduced to less than 2% in non-breastfeeding populations, and to 5% or less in breastfeeding populations.

Most of the countries across Asia-Pacific implement a facility-based PMTCT programme, with antenatal care (ANC) and maternal, newborn and child health (MNCH) services in the center of the programme. Therefore, unavailability and/or low uptake of maternity services lead to low coverage of PMTCT programmes. Consequently, many initiatives were taken to make health services (including MNCH and PMTCT) accessible to all women, especially in marginalized areas, such as setting up services in local communities, providing free of charge services, providing transport incentives, implementing Female Community Health Volunteers (FCHVs) programme etc. In South Asia, many women do not utilize institutional care in spite of these initiatives, but the reasons for such low uptake are poorly understood. A mix of personal and service-related factors acts as critical barriers in accessing health services by pregnant women in South Asia. For example, lack of confidentiality, discrimination and negative attitudes of health care providers, poor communication between service providers, and low social status of women

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2 UNICEF. State of the World Children. 2009
are the major barriers to seeking health services by pregnant women. However, another significant obstacle is the role of mother-in-law as decision around fertility and pregnancy were shown to be normatively the husbands’ and older women's domain, with pregnant women being distanced from the decision-making process. Evidence from Bangladesh, India, Nepal and Pakistan suggests that mothers-in-law significantly affect uptake of health care services\(^4\). Therefore, the case study intends to examine in more detail the role of mothers-in-law in decision-making and uptake of ANC by their daughters-in-law.

II. Discussion on social norms issues

*Who are the mothers-in-law in South Asia (categorization)*?

Mothers-in-law in South Asia hold much authority and influence over home activities. They are strong, powerful women, who have control over resources. When a woman becomes mother-in-law is the only time when authority is allocated to her. The hierarchy within family changes and the mother-in-law gains power over other women (daughters-in-law) and younger men. Most of the time, this anticipated power at a certain age acts like an incentive for women to strive for becoming a mother-in-law. Another reason for mothers-in-law to maintain the control over her son and daughter-in-law is the lack of alternative structures of social support and old age care. The fear of losing emotional economic support from sons makes her to act in an authoritative way, particularly with their daughters-in-law\(^5\). In addition, a young bride spends her time working with her mother-in-law in the home under her control and supervision. Mothers-in-law, by having daughters-in-law to work hard at home, have an opportunity to be freed much of the heavy labor of managing a household, which will allow them to get involved in other activities at community level and hence to become central figures not only in family, but also in neighborhood social relations\(^6\). In traditional South Asian families and communities, mothers-in-law are respected and should be obeyed.

A good mother-in-law understands the value of a good communication and relationship with her daughter-in-law. She understands her roles clearly and plays them accordingly, without being

\(^4\) Data included in the Demographic and Health Surveys (DHS) done in Bangladesh, India, Nepal and Pakistan

\(^5\) Jaan Valsiner. *Comparative cultural and constructivist perspective (Advances in Child Development Within Culturally Structured Environments)*. 1995

\(^6\) Development Research Centre on Migration, Globalisation & Poverty. *Staying Behind When Husbands Move: Women’s Experiences in India and Bangladesh*. 2009
authoritative. She is kind and treats her daughter-in-law with love and respect, like she would her own child. Moreover, she encourages her son to support his spouse, instead of worrying herself about her position in the family. Finally, a good mother-in-law recognizes the importance of health care for her pregnant daughter-in-law and her future grandchild. Therefore, she is always ready to give positive advice and encourage her daughter-in-law to access perinatal services.

**What is the script?**

Several quantitative and qualitative studies\(^7\) done in South Asia show that mothers-in-law play a significant role in decision-making process around fertility and access to health care services related to pregnancy, particularly ANC, delivery and infant feeding. In many countries of South Asia, mothers-in-law play a crucial role in the decisions around accessing health care facilities and providers. Findings from a study done in Nepal\(^8\) suggest that mothers-in-law sometime have a positive influence, for example when encouraging women to seek ANC, but more often it is negative.

Older women, especially mothers-in-law did not consider health care services essential during pregnancy and often discouraged their daughters-in-law from attending ANC and MNCH services in Bangladesh\(^9\), where only 37% of pregnant women receive antenatal care during pregnancy. Similarly, in India, the coverage of pregnant women with ANC is relatively low (only 77%)\(^10\). Of all women who do not attend ANC, 60% and 55.7% of rural and urban women respectively are not allowed by either their husband or the family. In Nepalese society, it is customary for senior women to occupy the top position in a hierarchical family network, exercising authority and power over daughters-in-law. In such patriarchal society, decisions about the management of pregnancy, childbirth and perinatal care usually come within the purview of older women, especially mothers-in-law. A study\(^11\) in Karachi, Pakistan, shows that

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\(^7\) The studies will be quoted when specific data will be presented


\(^10\) The National Family Health Survey

a woman’s mother-in-law have a strong influence on couple’s reproductive decision making. There is a significant association of women’s contraceptive use with their communication with mothers-in-law about reproductive matters. Unfortunately, this study did not specifically explore decision-making when higher levels of health care, such as antenatal care or institutional delivery, are required. On the other hand, a large-scale ethnographic survey exploring the gendered influences on women’s uptake of ANC services in Punjab, Pakistan, shows that the low coverage (33% of Punjabi women reporting use of ANC) is associated with strong influence of mothers-in-law in the decision making process regarding pregnancy. 

Mother-in-law’s belief about pregnant women’s workload. Most mothers-in-law expected their daughters-in-law to work during pregnancy as they had worked themselves. In Nepal, there is a belief that working hard is part of the culture for pregnant women, implying that it was beneficial. Thus, mothers-in-law prioritize household work over their daughters-in-law’s health. As indicated above, in India and Pakistan, the mothers-in-law will use the opportunity of having their daughters-in-law working for the household to get themselves engaged in community activities and neighborhood social relations. Many South Asian women recognize that their mothers-in-law’s expectation that household work had to be done made it hard for them to go for ANC check-ups or other health care services without finishing tasks assigned to them.

“My in-laws and my husband scolded me. I thought it would be better not to go for check-ups than to hear criticism from them. I went for a check-up once in my previous pregnancy; I had to wait in the queue. They blamed me for going to see my friends for entertainment, leaving my household work undone” (Nepalese pregnant woman who does not use ANC services)

Mother-in-law’s perceptions and their own experiences of ANC and institution delivery. A theme emerging from both husbands’ and women’s accounts concerned mothers-in-law’s perceptions of the benefits of ANC and their own experience of pregnancy and delivery. ANC is viewed as a curative rather than preventative form of care. Most mothers-in-law believe that as

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12 Zubia Mumtaz and Sarah M. Salway. Gender, pregnancy and the uptake of antenatal care services in Pakistan. 2007
pregnancy is a natural state, there was no need to seek medical care and that ANC was only necessary when complications occurred. Often they rely on traditional medicine for any illness and there was no common history of attending ANC or institutional delivery. For example, in India, of the estimated 25 million deliveries that take place annually, approximately 41% occur in a health facility and the most frequently mentioned reason for not delivering in a health facility is that the husband or mother-in-law considers it unnecessary. Most mothers said that giving birth at home with assistance from a traditional attendant was a norm followed in their family and society\textsuperscript{15}. Childbirth being a natural process, there was no need to change the norm. Likewise, in Nepal, 81\% of births take place at home, many without skilled attendants. A home birth is the norm, assisted only by relatives or a local traditional birth attendant.

“My mother-in-law said that pregnant women didn't go for antenatal check-ups in the old days. She told me that she had all her children without any antenatal check-ups and all are fine. She questioned why different foods and antenatal check-ups are necessary for pregnant women. That's why I didn't go” (Nepalese pregnant woman who does not use ANC services)\textsuperscript{16}.

“I don’t know anything. I never went for check-ups during my pregnancies. If everybody is saying pregnant women should go for check-ups then my daughter in-law should go as well” (Nepalese mother-in-law)\textsuperscript{17}.

Mother-in-law’s power and control over resources. Even if sometimes supportive mothers-in-law helped their daughters-in-law to go for check-ups, they did not encourage hospital delivery because of the cost involved. Power and control over resources are interrelated. Traditionally South Asian mothers-in-law are powerful as they can access household resources through their close contact with the main family earners (either their husbands or sons). Because they don’t see immediate benefits from ANC, mothers-in-law consider the cost involved in preventive care as unnecessary. Women’s low status within households prevents them from keeping any income

\textsuperscript{17} Bibha Simkhada, Maureen A Porter, Edwin R van Teijlingen. The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study. BMC Pregnancy and Childbirth 2010
they might earn themselves, and, therefore, lack of access to resources is a major barrier, especially where mothers-in-law control household finances.

“My personal expenses were under the control of my mother-in-law and even my husband had to ask her for money” (Nepalese pregnant woman who does not use ANC services)\textsuperscript{18}.

**Empirical expectations:** ‘Tradition’ over generations. Most of the mothers-in-law in South Asia were badly treated by their own mothers-in-law (for the same reasons mentioned above) and therefore, they follow a similar behavior. Mothers-in-law treat their daughters-in-law defectively because this is their past experience and they think that all mothers-in-law in their community adopt the same negative attitude towards their daughters-in-law.

**Normative expectation with sanction:** Moreover, mothers-in-law act defectively because they think that the community expects them to act like that. A study done in India suggests that a woman who has had a bad relationship with her own mother-in-law may remember the hostility to which she was subjected and then may adopt a more human and sympathetic attitude towards her daughter-in-law\textsuperscript{19}. However, if they adopt positive attitudes and change their behavior, they might lose their prestige and authority within her family and community. There is no study done in Bangladesh, Pakistan or Nepal to suggest the same situation in the respective countries and, therefore, this remains an open question.

*Is this a social dilemma?*

As described in the paragraphs above, the current situation indicates that mothers-in-law in South Asia do not support their pregnant daughters-in-law to access health services, including ANC and PMTCT. The major benefit of this attitude is the power and authority that mother-in-law can have over her daughter(s)-in-law. The proposed solution is to have mothers-in-law supporting their pregnant daughters-in-law to access health services, including ANC.

In this case, the social dilemma occurs when a mother-in-law (or a small group of mothers-in-


\textsuperscript{19} Jaan Valsiner. *Comparative cultural and constructivist perspective (Advances in Child Development Within Culturally Structured Environments).* 1995
law) decide to change their behavior and support their daughters-in-law to access the perinatal services, including ANC and PMTCT, which will prove immediately sanction to the individual (or the small group). If only one or few mothers-in-law will make the change, she/they might loose the authority within her/their family and her/their prestige in the community, while the rest of mothers-in-law will be a little bit better off. If the entire community of mothers-in-law will adopt the change, it will produce a common good in the long run – e.g. healthier women and babies, higher prestige for mothers-in-law (who will have a better image as caring and affectionate figures) etc.

To change the social norm, the following three strategies can be considered:

- **Correct misperceptions or bad perception of mothers-in-law as careless, authoritative figures to decrease problem behavior and increase prevalence of new attitude (Re-categorizing mothers-in-law).** This intervention is aimed to change the categorization of mothers-in-law as caring women who support their daughters-in-law to access pre- and

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<th>Mothers-in-law supporting their pregnant daughters-in-law to access health services, including ANC</th>
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OTHERS

Mothers-in-law supporting their pregnant daughters-in-law to access health services, including ANC

Mothers-in-law NOT supporting their pregnant daughters-in-law to access health services, including ANC

- Correct misperceptions or bad perception of mothers-in-law as careless, authoritative figures to decrease problem behavior and increase prevalence of new attitude (Re-categorizing mothers-in-law). This intervention is aimed to change the categorization of mothers-in-law as caring women who support their daughters-in-law to access pre- and
postnatal health care services. The intervention is based on the principle that the change of emotional reactions of mothers-in-law toward their daughters-in-law will lead to a change in response to a specific situation and will induce positive shifts in their behavior. An affectionate, caring mother-in-law can become a mother figure for her daughter-in-law and a proud grandmother for her future grandchild. She will be loved, appreciated and respected by all, within her family and community. At the same time, she will involve other older women from community to adopt and reinforce the change because she will want loving and caring mothers-in-low for her own daughters.

- **Reduce or change the empirical expectations.** This is probably one of the most important strategies that can be adopted. According to Bicchieri, social convention theory predicts that specific strategies facilitate coordinated abandonment of a specific behavior/practice. Attaining stable coordinated abandonment of the bad practice (non-use of health care services by pregnant women) within a local community of people requires several steps. First, the greater part of the community (primarily mothers-in-law) must be involved in community discussion. Genuine community discussion and debate changes attitudes. Mothers-in-law and other family members must acquire awareness of the existence of an alternative (ANC attendance), and the alternative must become valued more highly than the current practice. Based on discussion/debate, a community decision is made. Second, the community commitment has to be publicized and a common pledge needs to be achieved. By making a pledge, community members exchange promises to cooperate (or reciprocate), and thus obtain a powerful norm of promise-keeping (because it puts at stake one’s social reputation for keeping commitments). A joint public pledge shifts empirical expectations among mothers-in-law from “NOT supporting their pregnant daughters-in-law to access health services, including ANC” to “supporting their pregnant daughters-in-law to access health services, including ANC.” Hence, making mothers-in-law to collectively agree to support their daughters-in-law to access health services (including PMTCT) will result in a public pledge and consequently – through commitment to move together in adopting the new behavior – in a common action.

- **Promote children’s right to health (‘human rights discourse’).** In 2008 and 2009, two campaigns were initiated in Lao PDR and Vietnam to involve men in preventing the

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mother-to-child transmission of HIV. One of the major drivers of the campaigns was the
caring attitude of fathers-to-be for their future baby. Although evaluations of these
campaigns are on the way, anecdotal data from service providers indicate that most of the
men reacted positively and became more involved in PMTCT interventions when the
health of their future children’s was linked to their own risk behavior. Similarly,
promoting the children’s right to health can trigger off mothers-in-law attitude toward
pre- and postnatal care. In many Asian societies, grandparents (grandmothers especially)
have a respected role as elders in the community. Previous studies\textsuperscript{21} have found
expectant grandmothers to anticipate greater satisfaction from their new role and to place
more emphasis on how much they wish to be a central part of the grandchild’s life.
Furthermore, in South Asia, grandmothers are more likely to care for their grandchildren
and find a personal sense of biological renewal in her role. Therefore, presenting the
access to life-saving health information, interventions and services of daughters-in-law as
an opportunity for having healthy and beautiful grandchildren can be a useful strategy to
change the mind set of mothers-in-law. Using the children's rights discussion to suggest
that part of their role is to secure the wellbeing of their grandchildren and to educate them
on the benefits of pre-natal care may shift (re-categorize) the problem from mother-in-
law/daughter-in-law power relations with regards to housework, to family responsibilities
towards children. In addition, this strategy may help to emphasize their role to secure the
wellbeing of their grandchildren.

III. Proposed interventions to change the social norm

Based on analysis described above, some of the initiatives that can be designed implemented to
change the social norm include the following:

1. Redefine the concept of being mother-in-law and promote the model of a ‘good mother-
in-law’ (as it was described at page 3; see categorization). Communication at all levels –
personal, family, community, and mass media – can play a major role in promoting the
new concept. This can be the key process in re-categorizing mothers-in-low, opening the
local cultures to new ideas and changing norms regarding family dynamic. An
alternative solution will promote the maintenance of mothers-in-low’s authoritative

position in their families, but using their power to offer advise to their daughter-in-laws and influence their health-seek behavior.

An innovative approach will be to advocate at community level to drop the term ‘in-laws’ (both mothers-in-law and daughters-in-law). This will allow them to have a mother-daughter relationship, with older women adopting a protective and caring attitude towards the younger women. However, in a context with strong power dynamics (like South Asia), this approach will be extremely difficult to be implemented.

2. Community discussion, community decision and community commitment. In this regard, the best strategy might be the use of social networks to discuss with mothers-in-law their issues, their everyday lives, problems, families and eventually the importance of antenatal care for their daughters and daughters-in-law can be the best strategy. Women in South Asia are traditionally more open to discussing their concerns with other women and, thus, through creating relationships, mothers-in-law can be involved in discussion around ANC, institution delivery and post-partum care. These discussions can result in common pledge and commitment to move together in adopting the new attitude/behavior. A social network analysis will contribute to identifying the key family and/or community members whom mothers-in-law trust and involve them in various interventions\(^\text{22}\). Social networks of mothers-in-low might consist of their husbands, sisters and sisters-in-law, other old women in the community (including traditional birth attendants, and traditional healers). Identification and mapping of individuals who are part of the ‘gossip’ network should be researched in order to get a complete picture of interaction of mothers-in-law at community level. However, besides the members of the network, the quality of mothers-in-law's inter-personal ties (within the social network), particularly with their husbands, might be important in changing the social norm. The snowball research methodology would be probably the most appropriate approach to investigate the social network.

3. Design and promote informative materials and supportive messages directed to mothers-in-law. Offering correct information and educating mothers-in-low regarding the importance of perinatal care (including PMTCT services) as well as providing them various services (e.g. HIV or infant feeding counseling) can lead to a positive change of their attitudes. This approach have had demonstrated impact in other countries in the world, such as Tanzania\(^\text{23}\).


\(^{23}\) USAID. Testing a PMTCT infant feeding counselling programmes in Tanzania. 2007
4. Initiate and promote a campaign on children’s rights to health. This type of intervention capitalizes on the value of children in South Asia as well as on the importance of role of mothers-in-law as expectant grandmothers and aims to present the access to services of daughters-in-law as an opportunity for having healthy children. Mothers-in-law, being more concerned with their future grandchildren’s health and wellbeing, can adopt a caregiver role and encourage their daughters-in-law to use the pre and postnatal services.

The proposed interventions may be combined as some of them to achieve short- and long-term goals. For example, it's possible that promoting the idea of grandmothers protecting their grandchildren would be an easier short-term intervention, while the intervention of re-conceiving the mother-in-law/daughter-in-law relationship might be a longer-term endeavor, which may be worth it for reasons beyond HIV prevention.