



## A health equity critique of social marketing: Where interventions have impact but insufficient reach

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### ARTICLE INFO

#### Article history:

Available online 11 February 2013

#### Keywords:

Nepal  
Slum  
Hand-washing  
Ethnography  
Behaviour change  
Programme evaluation  
Qualitative research  
Intervention studies

### ABSTRACT

Health interventions increasingly rely on formative qualitative research and social marketing techniques to effect behavioural change. Few studies, however, incorporate qualitative research into the process of program evaluation to understand both impact and reach: namely, to what extent behaviour change interventions work, for whom, in what contexts, and why. We reflect on the success of a community-based hygiene intervention conducted in the slums of Kathmandu, Nepal, evaluating both maternal behaviour and infant health. We recruited all available mother–infant pairs ( $n = 88$ ), and allocated them to control and intervention groups. Formative qualitative research on hand-washing practices included structured observations of 75 mothers, 3 focus groups, and 26 in-depth interviews. Our intervention was led by Community Motivators, intensively promoting hand-washing-with-soap at key junctures of food and faeces contamination. The 6-month evaluation period included hand-washing and morbidity rates, participant observation, systematic records of fortnightly community meetings, and follow-up interviews with 12 mothers. While quantitative measures demonstrated improvement in hand-washing rates and a 40% reduction in child diarrhoea, the qualitative data highlighted important equity issues in reaching the ultra-poor. We argue that a social marketing approach is inherently limited: focussing on individual agency, rather than structural conditions constraining behaviour, can unwittingly exacerbate health inequity. This contributes to a prevention paradox whereby those with the greatest need of a health intervention are least likely to benefit, finding hand-washing in the slums to be irrelevant or futile. Thus social marketing is best deployed within a range of interventions that address the structural as well as the behavioural and cognitive drivers of behaviour change. We conclude that critiques of social marketing have not paid sufficient attention to issues of health equity, and demonstrate how this can be addressed with qualitative data, embedded in both the formative and evaluative phases of a health intervention.

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### Introduction

It is well established that many of the most intractable public health issues in poorer parts of the world could be prevented or ameliorated simply by changing people's behaviour: for example, hand-washing to prevent diarrhoea, bednets to protect against malaria, or condoms to stop the spread of sexually transmitted infections (Briscoe & Aboud, 2012). As highlighted in a recent special issue on behaviour change in developing countries (Aboud & Singla, 2012), the key to achieving improved health outcomes

lies in designing interventions grounded in theoretical models of behaviour change, good quality evidence, and an in-depth understanding of the target audience.

However, changing people's behaviour is notoriously difficult to do and there remain remarkably few examples of truly successful, sustainable and cost-effective programmes (Higginbotham, Briceno-Leon, & Johnson, 2001). Many interventions are poorly theorised, often based on the premise that educating people about potential threats to health will be sufficient to motivate a change in risk practices. While this approach may result in changes in knowledge and attitude, there is little evidence to suggest it translates into actual behavioural change (Loevinsohn, 1990). As more sophisticated behavioural models have developed, it is clear that new approaches to changing behaviour are needed, for example to extend beyond rational, cognitive drivers of behaviour.

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It is here that social marketing potentially has much to offer. A dominant paradigm in health promotion, social marketing “promotes the voluntary behaviour of target audiences by offering benefits they want, reducing barriers they are concerned about, and using persuasion to motivate their participation in program activity” (Kolter & Roberto, 1989: 24). It moves away from traditional health education models that simply tell people what to do, towards an approach that seeks to ‘sell’ the behaviour in question by convincing the target audience that it provides a solution to a problem they believe is important, and/or offers them a benefit they value (Grier & Bryant, 2005: 323). The first step in this process is uncovering and understanding people’s perspectives, preferences, and aspirations. As Curtis (2001: 76) asserted for hygiene prevention, ‘health is not the only motivation for healthy behaviour; other goals may be far more important.’ Identifying these other goals is a crucial part of discovering how best to promote novel social norms and behaviours.

Social marketing has been embraced by the public health community and widely utilised in low-income countries, particularly in relation to infectious disease control (e.g., sexual health, malaria, and hygiene). However, there remains a paucity of evidence regarding whether this approach is more effective than other types of behavioural intervention. Comprehensive and convincing evaluations of social marketing interventions undertaken in low-income countries are rare. Those that do exist tend to be narrowly focussed and exclusively quantitative in nature, relying heavily on sales data (e.g., condoms purchased) or self-reported changes in knowledge or behaviour (Price, 2001).

Intervention success is judged by many criteria: these include impact, reach, sustainability, cost effectiveness, acceptability, and equity. The process of evaluation is thus multi-dimensional, requiring a mixed-methods, ‘qual-quant-itative’ approach to fully capture all relevant dimensions of evidence. Careful and detailed qualitative research is at the heart of a social marketing approach: to identify what needs to be communicated, in what way, to whom, and through which channels in order to achieve a change in key behaviours (Biran et al., 2005: 213). But to-date, qualitative research is recognised as crucial only to the formative stages of intervention development; it is valued as a critical step in understanding how to shape and deliver a health intervention, but its importance beyond such *formative* stages is often overlooked.

In-depth contextual data in the *evaluative* stages are often conspicuously absent. When so many interventions are focussed on changing norms and behaviours, such limited qualitative analysis seems curious. It is now well recognised that “public health problems are embedded within a range of social, political and economic contexts” (Moffat, White, Mackintosh, & Howell, 2006: 28). Despite calls for the inclusion of qualitative data (Donnovan et al., 2002), few evaluations provide details on the implementation process or wider context that might be critical to its impact (Roen, Arai, Roberts, & Popay, 2006). Evaluations remain largely focussed on ‘hard outcomes’, with a paucity of qualitative work that seeks to capture local responses to intervention programmes. Nor has there been adequate exploration and critical reflection of the unintended consequences and potential harms that may arise from interventions (Kleinman, 2010), especially those that specifically aim to shift social norms.

In the field of behavioural health, researchers have thus accumulated expertise with respect to measuring attitudinal or behavioural change following a specific health intervention; however, they are often left with a ‘black box’ as to how exactly this was (or was not) achieved. Some key questions – what works, for whom, in what circumstances, in what respects, and how (Pawson & Tilley, 2006) – often remain poorly answered.

In this paper, we critically reflect on the success of a community-based hygiene intervention and the insights gained through long-

term qualitative research embedded in programme evaluation. Our intervention targeted maternal hand-washing behaviours in the slums of Kathmandu, Nepal. We capitalized on the ‘lessons’ learnt of previous community-based hand-washing interventions in developing countries (especially Curtis et al., 1997, 2001). Thus we focussed attention on the psychosocial determinants of behavioural change, informed by the Theory of Planned Behaviour (Fishbein & Ajzen, 1975). Additionally, we capitalized on insights derived from careful studies of the drivers of hygiene behaviour, targeting what Aunger et al. (2010: 384) called ‘motivated behaviours’ – behaviours that “occur in response to a need, or perceived discrepancy between an aspect of a person’s current state and an ideal state” to create a demand for hygiene. In this way, we incorporated strategies from social marketing to ‘sell’ hand-washing behaviours to mothers caring for young children. The impact of this intervention, regarding ‘hard outcomes’ (namely, maternal hand-washing practices, child morbidity, and growth) is reported elsewhere (Langford, Lunn, & Panter-Brick, 2011). We focus this paper on qualitative data collected in the formative and evaluation phases of the intervention. We present these data to evaluate both the power of a social marketing approach and its limitations.

## Methods

Ethical approval was formally obtained from both the Nepal Health Research Council and Durham University’s Research Ethics Committee. Verbal informed consent was gained from all participants and slum community leaders.

### Study design

The study was conducted in the eight largest slums of Kathmandu, randomised to either intervention or control groups, on the basis of the most recent demographic data available (Shrestha & Shrestha, 2005). We purposively chose the largest slum settlements in order to maximise sample size, leaving aside small settlements where intensive observation and repeated measures would be too logistically difficult over the year of study. Our target population consisted of mothers caring for infants 3–12 months old, the first year of life being the age range most relevant to monitor changes in child growth and morbidity outcomes. Our sample was small, but comprised of all available mother/infant pairs ( $n = 88$ ) living in the slums. Eligible participants were identified from house-to-house surveys, intensively recruited, and invited to an information meeting; all agreed to participate. Mothers were also offered a small gift (200 rupees, approximately £1.50) for growth measurements and time compensation. Having recruited a total sample of mothers with infants, we divided our work between areas assigned to intervention ( $n = 45$ ) and control ( $n = 43$ ). We worked intensively with this sample over one year, as the primary aim of our study was to produce good-quality repeated measures on infant health outcomes, pre- and post-intervention.

The study was carried out during 2005. We conducted formative research for four months, and implemented the intervention for six months with continuous evaluation. The lead author (RL) conducted participant observation throughout this period, and led the intervention with the help of two research teams: one responsible for the intervention’s design and implementation, the other responsible for survey evaluation. The first team included two Nepali research assistants, to assist with focus groups and interviews, and five well-known and respected women from the slums, recruited to be Community Motivators (CMs) taking prime responsibility for program implementation. The second team comprised ten Nepali field workers, trained to conduct structured observations and administer weekly child morbidity surveys; to

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