Can social marketing combat sorcery?

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Introduction

We describe several significant barriers to behaviour change in developing countries that must be taken into consideration when developing social marketing interventions. Over 80% of the world's population live in developing countries (Aboud, 2012), with large rural populations, poor health and transport infrastructures, and low per capita incomes, resulting in low life expectancy and significant health problems (Thornton, 2009). For example, 30% of Papua New Guineans live on less than $1 per day (Government of PNG); 3/5 of the Bangladeshi population live below the poverty line (Rahman, & Chowdhury,2007). Literacy rates in countries such as these are low; estimated at approximately 50% overall, but lower for women (Duncan, 2011; Chowdhury & Bhuiya, 2004). Information sources are thus heavily dependent on verbal communication, including repetition of traditional beliefs. Alleviating hunger is a Millennium Development Goal (MDG), with evidence that many signatories are encountering problems in achieving the targets set (Peterson, 2009). Malnutrition is directly responsible for over 300,000 deaths per annum globally and indirectly for 50% of the deaths of young children (Müller & Krawinkel, 2005). Malnutrition results in growth retardation in early childhood, decreased intellectual development and functional impairment that leads to reduced work capacity later in life (Rahman & Chowdhury, 2007). Behaviour change interventions are noted as cost-effective ways of improving nutrition such as changing food allocations within households or the way food is prepared and served (Horton et al., 2008). However, the impact of these interventions on changing beliefs about the sources of ill-health – including sorcery – is un-researched.

Method

We conducted a structured literature review, drawing on academic literature, governmental documents and grey literature as part of prior pilot research in Bangladesh and in preparation for pilot research within Papua New Guinea which will inform future Social Marketing-based interventions. Lessons learned in these countries, including whether and in what ways social marketing can combat traditional beliefs in sorcery as a cause of ill-health will have application to interventions in other developing countries, recognising cultural, religious and infrastructure differences.

Results

It is important to recognise and work within the existing health systems of these countries, recognising that 'traditional' indigenous health practices vary across regions and co-exist alongside bio-medical science models and, for Papua New Guinea, Christian beliefs (Davy & Patrickson, 2012) and for Bangladesh, Islamic beliefs (Faruque et al., 2008). In these, and many other countries, there are widespread beliefs that serious illness, including infectious diseases such as tuberculosis and HIV / AIDS involves supernatural forces such as sorcery resulting in low success rates for health promotion activity (Ongugo et al., 2011; MacFarlane, 2009; Dundon & Wilde, 2007). Behaviour change approaches must recognise these beliefs.

A range of less dramatic cultural and social structure barriers also exist in developing countries. For example, there are a number of folk-beliefs in Bangladesh that are currently significant barriers to improving maternal and infant nutrition. These include beliefs in 'eating down' (i.e. women should eat less during pregnancy) with evidence of supplementary food being eaten by others or being eaten in place of a normal meal (White, 2009) and of avoiding meat, fish and eggs during pregnancy (World Bank, 2005). While harmful beliefs

such as these are declining, lack of resources remains a significant barrier to women being able to eat more. In Papua New Guinea, pregnant women and their husbands are required to comply with certain prohibitions, stemming from traditional beliefs particularly in relation to 'acceptable' food; and it is believed that defying these will result in "adverse consequences for the health of the mother and child" (Whittaker et al, 2009:104).

Maternal autonomy has been identified as a key factor in improving child nutrition and health in other developing countries (Dancer & Rammohan, 2009). In Bangladesh, mothers are not the main decision makers for nutrition-related practices; mothers-in- law have substantial influence on domestic matters, reinforcing traditional practices; further, men rather than women frequently do household shopping (White, 2009). There is evidence from other countries such as Laos of misuse of products such as coffee creamers where powdered milk is not available or affordable (Barennes et al. 2008); warnings printed on packaging are of little use given low literacy rates in developing countries. Parental smoking is also directly associated with malnutrition. For example, Bangladesh has relatively high smoking rates, with 48% of men and 21% of women smoking and more than twice as much being spent on cigarettes than on clothing, housing, health and education combined coupled with evidence of expenditure on tobacco rather than food when choices are made (Best et al., 2007), a problem not restricted to this country (Block et al., 2009).

Research strategies for data collection is challenging in these countries, with cognitive interviewing, i.e. the verbalisation of thoughts, feelings, interpretations and ideas that come to mind while answering questions being better suited than conventional questionnaires and structured interviews being better suited for use with populations who face literacy challenges and strong oral rather than written cultures (Rosal et al., 2003). Recruitment of research participants is also challenging; for example, the concept of research benefiting people who are not part of the same tight clan ('wantok') system is both alien and culturally inappropriate in Papua New Guinea (Thornton, 2009). Appropriate theoretical foundations need careful consideration. While theory-driven approaches have been found to lead to more persuasive messages across a range of socio-economic groups in western countries (Schneider, 2006), there is debate within the extant literature regarding the appropriateness of western-originated concepts and whether western-originated methods can be modified to be contextually grounded in the specific context under study (Siddique et al., 2011).

The choice of communication channels is obviously important; the rural environment presents challenges, both in terms of the restrictions imposed on the use of printed material due to low literacy levels discussed earlier, but also due to the low penetration of other mass media forms. Mobile phone coverage is improving in developing countries, but a lack of mains electricity in rural areas limits battery recharging; solar energy is increasingly used to recharge batteries (Sovacool & D'Agostino,2012). Mobile phones can also be also perceived as a community rather than individual resource (Watson, 2012) which may impact the nature and framing of messages delivered via this medium.

Conclusion

Education alone will not be sufficient to overcome traditional beliefs if there is not support from other family and community members. Change agents or catalysts for change and empowered leadership, community involvement and provision of visual tools have been found to be successful in past health promotion interventions (Ashwell & Barclay, 2009). Information provision is necessary, but not of itself sufficient to change behaviours, and the role of household and community members in encouraging behaviour change will be paramount. The role of traditional beliefs, including sorcery, and their potential conflict with religious and medical beliefs must be recognised and respected; how their role in hindering or enabling social marketing behaviour change interventions requires considerable research.

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