



Synthetic social support: Theorizing lay health worker interventions

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ABSTRACT

Levels of social support are strongly associated with health outcomes and inequalities. The use of lay health workers (LHWs) has been suggested by policy makers across the world as an intervention to identify risks to health and to promote health, particularly in disadvantaged communities. However, there have been few attempts to theorize the work undertaken by LHWs to understand *how* interventions work. In this article, the authors present the concept of ‘*synthetic social support*’ and distinguish it from the work of health professionals or the spontaneous social support received from friends and family. The authors provide new empirical data to illustrate the concept based on qualitative, observational research, using a novel shadowing method involving clinical and non-clinical researchers, on the everyday work of ‘pregnancy outreach workers’ (POWs) in Birmingham, UK. The service was being evaluated as part of a randomized controlled trial. These LHWs provided *instrumental, informational, emotional* and *appraisal* support to the women they worked with, which are all key components of social support. The social support was ‘synthetic’ because it was distinct from the support embedded in spontaneous social networks: it was *non-reciprocal*; it was offered on a strictly *time-limited* basis; the LHWs were *accountable* for the relationship, and the social networks produced were *targeted* rather than spontaneous. The latter two qualities of this synthetic form of social support may have benefits over spontaneous networks by improving the opportunities for the cultivation of new relationships (both strong and weak ties) outside the women's existing spontaneous networks that can have a positive impact on them and by offering a reliable source of health information and support in a chaotic environment. The concept of SSS can help inform policy makers about how deploying lay workers may enable them to achieve desired outcomes, specify their programme theories and evaluate accordingly.

In this article, we present the concept of ‘synthetic social support’ (SSS) and critically appraise its value within healthcare systems. We illustrate the concept by documenting and theorizing the work done by lay health workers (LHWs) in maternity care (trained, but not professionally qualified, people known locally as ‘Pregnancy Outreach Workers’ or POWs) in the city of Birmingham in the UK. This intervention can be seen as part of a broader trend internationally to employ trained, lay (non-professional) people to support the achievement of health and other public policy goals, such as within housing, families and communities or security policy (Singh and Chokshi, 2013). The POW service was evaluated using a randomized controlled trial (RCT) to explore whether the introduction of a POW intervention in addition to usual maternity care would have an impact on attendance at antenatal clinics or on postnatal depression. However, interpreting the results of the trial and what the policy implications of it were was more challenging because of the lack of a defined programme theory on the part of the commissioners or providers of the service. It is common –

and problematic - that complex interventions such as this remain a ‘black box’ (i.e. with unknown mechanisms) in effectiveness studies. Therefore, as part of the programme of research, we conducted a theoretically-informed qualitative investigation into the everyday work that the POWs undertook and have developed the concept of synthetic social support to theorize lay health work. We discuss the potential value of providing synthetic social support as an intervention to address poor health outcomes in (deprived) communities and invite future research to test and extend this middle range theory.

1. Background

1.1. The rise of lay/community health workers to deal with health risks and health inequalities

There have been calls to widen the public health and primary care workforce beyond health professionals (WHO, 1978; RSPH, 2015) and,

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internationally, there has been a rise in the number of interventions that utilise LHWs to support people with poor health outcomes (Department of Health, 2004; Singh and Sachs, 2013). At the heart of many of these interventions are attempts to operationalise epidemiological knowledge about health risks, by identifying ‘at risk’ individuals or communities and attempting to reduce health inequalities, improve health outcomes or both, preferably at low cost (Singh and Chokshi, 2013). While a decade ago evidence of effectiveness of LHWs was considered ‘promising’ but low quality (Lewin et al., 2005; Rhodes et al., 2007), the evidence is now much stronger for ‘childhood undernutrition, improving maternal and child health, expanding access to family-planning services, and contributing to the control of HIV, malaria, and tuberculosis infections’ (Perry et al., 2014: 399) although there still many question unanswered about their role, effectiveness (Gilmore and McAuliffe 2013) and cost-effectiveness (Jack et al., 2017).

1.2. Social support and health outcomes

It is well established in the literature that there is a relationship between social support and mental and physical health outcomes, including both self-reported and objective health measures (Berkman et al., 2000; Christakis and Fowler, 2007; Cohen, 1988; Durkheim, 1951; White et al., 2009), although the mechanisms are still being explored (Uchino et al., 2012). The link has also been identified in studies related to childbearing and childrearing, with particular emphasis on the support a woman receives from her partner and family (Collins et al., 1993; Ma et al., 2015; Mirabzadeh et al., 2013; Morikawa et al., 2015; Oakley, 1992), although there is still much work to be done around specific outcomes, such as pre-term birth (Hetherington et al., 2015). Generally the literature cites the positive effects of social relationships and social integration, although there is also potential for negative social relationships (abuse, neglect, prejudice) and excessive social control (over-regulation and surveillance of individuals). It is not a straightforward process to measure social support, not least because there is a distinction between the subjective perception of social support and levels of ‘objective’ enacted support (Hogan et al., 2002). Decisions about what and when to measure social support may depend on whether the focus of the study is on proximate and psychological pathways to health or on the social-structural influences on health. During pregnancy, greater latent, perceived and received social support have been linked to better birth outcomes (Collins et al., 1993; Feldman et al., 2000) and so professional care is particularly valuable when community and family networks are poor (Perry et al., 2016). Most studies focus on embedded social networks, or ‘social capital’, theorizing social support (or lack of it) as something largely durable (Alvarez et al., 2017). It is much less clear from the literature whether providing additional social support (rather than professional care) as a time-bound ‘intervention’ can improve health outcomes and, if so, how and at what cost (Johnson et al., 2000; Rowe et al., 2005).

1.3. Risk society and the everyday practices of lay health workers

The guiding theoretical framework that we adopted for this study enabled us to explore non-professionalized work in a medically-dominated field of practice (i.e. public health in a high-income, Western society). Risk logics now dominate much of public policy (Beck, 1992, 2000; Giddens, 1991), including the public health system where prevention strategies based on epidemiological knowledge and evidence-based medicine prevail (Petersen and Lupton, 1996) and where notions of professional discretion have been replaced with administrative notions of control, efficiency and guidelines for practice. However ‘risk’ is a complex concept to grasp for both professionals and lay people (Adam et al., 2000; Lupton and Tulloch, 2002), and there is only limited theorization of the practice and tensions of real-life work that is shaped by the risk society, or ‘risk work’ (Horlick-Jones, 2005; Power, 2016; Veltkamp and Brown, 2017), and particularly how the disjunctions

between population-based knowledge of health risk and the individual facing an uncertain future are managed by street-level workers (Gale et al., 2016).

Where there have been qualitative evaluations of social support interventions, these tend to focus on patient experience (e.g. Dadich et al., 2013; Finn et al., 2008; Kozhimannil et al., 2016), and there have been few studies that explicitly attempt to describe or theorize the nature of the work undertaken, despite policy calls for greater understanding of ‘competencies’ (Malcarney et al., 2017). Conducting this kind of research requires in-depth studies of practice in context and the development of middle range or substantive theories (Glaser and Strauss, 1967; Merton, 1968: 39) to help explain practices (Gale et al., 2016).

The terms ‘lay’, ‘peer’, ‘community’, ‘outreach’ are often used interchangeably to describe non-professionally trained health workers. LHWs occupy a liminal space between professional and peer. The perceived ‘closeness’ or ‘identification’ with the local community is often part of the characteristics desired for employment, making them better placed, it is argued, to mediate between ‘the community’ and health professionals (DH, 2004). Nevertheless, there is a distinction between paid work, and volunteer self-help or ‘befriending’ projects (Gray, 2002). Their closeness to the community raises questions about the scope of their work if it moves beyond the tight boundaries of implementing medical guidelines (Mathers et al., 2017).

In mental health, ‘case management’ has become a popular concept, that emphasizes the importance and challenge of proactive attempts by the case manager to *co-ordinate* the support from multiple professionals as well as family and community networks (Perry et al., 2016; Pescosolido et al., 1995). However, although there are a number of different models of case management, it is usually based around managing long-term conditions (Ross et al., 2011), rather than primary prevention.

Another important concept in this discussion is social capital, which has been used to frame interventions, and is often used as an:

‘umbrella concept, in which social resources (social capital components) are grouped into dimensions: social networks, social contacts and participation belonging to the structural or objective aspects; and social support, sense of belonging and trust corresponding to the cognitive or subjective aspects. Moreover, depending on the directions of social ties, social capital is defined as bonding (intragroup ties between members sharing common characteristics), bridging (ties between heterogeneous groups) or linking (relationship between people who possess unequal wealth, power and status)’ (Coll-Planas et al., 2017: 663).

However, this concept is too broad for our purposes and we felt that the concept of social support was more helpful for explaining tangible everyday practices. While we explore and critique the concept of social support in the findings below, it is useful to highlight that we drew on existing conceptual literature on social support, in particular its components (instrumental, emotional, appraisal and informational support) and its context (the social structure and climate), to direct our analysis (see below).

Our use of the adjective ‘synthetic’ to describe the type of social support practised by LHWs has a useful double meaning for our new concept. The meaning of a ‘synthetic’ product, substance or action is one that is not genuine but is made to imitate a natural product, but synthetic also means something that has taken components from elsewhere that have then been synthesized to create something new and more appropriate for the purpose required. In our study, we established that to a large extent the work that the POWs were being paid to do was ‘social support’ in a harsh social environment characterised by health inequalities but that this was different from the social support women received from their spontaneous and embedded networks of family and friends in important ways. We must be clear that we do not mean to imply by the term ‘synthetic’ that it is the opposite of ‘authentic’ and

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