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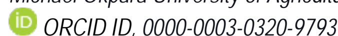
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CONSUMER MOTIVATION AND MULTILEVEL MARKETING ON HEALTH PRODUCTS

Abstract. *Multi Level Marketing (MLM) for healthcare product is one of the dramatic transformations that have emerged in contemporary times with varying behavioral responses. Its increasing acceptance in Nigeria is because people find it an alternative option to addressing diverse health concerns amidst other economic benefits. The study considered multilevel marketing in health with a key focus on the relationship between multilevel health products and continuance intention. Descriptive statistics and SEM statistical tool was employed in the analysis. This study therefore examines the issue of MLM and motivating factors and continued intention to engage in MLM in the health related product categories. An online survey was administered on 227 networkers of MLM in South-East, Nigeria. The data was analyzed using Structural Equation Modeling (SEM) and descriptive statistics. Result shows that Nature Renascence International (NRI), Longrich, and Norland are the major MLM brands. Other not popular brands are Edmark, Tianshi, AIM Global, Forever Living Products, Oriflame, and Neolife. However, the major challenge lies in getting down-liners / new people to register and be part of the MLM business. Analysis shows that wealth benefit is the major motivation to join an MLM despite the promises of health benefits. Specifically, wealth benefit is found to be significantly related to health benefit. The study also provides evidence that there is a nexus between wealth benefit and ethical concern. Also, wealth benefit has a significant effect on continued intention. The recommendation centers on policy-drive and regulation. An appropriate policy that addresses the establishment and operation of businesses that engages in MLM of health products is required. This is paramount in other to curtail unethical practices and sharp practices from MLM businesses. In addition, there is a need for proper regulation. The regulation is required to control*

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the use of unprofessional healthcare personnel in counseling and prescribing health drugs as well as targeting issues of false claims.

Keywords: healthcare products, emerging economy, independent advertisers, networking, pyramid scheme, distribution.

Introduction. Health is an important aspect of human life. This explains the high level of attention that has continuously led to policies, regulations and legislations to control the advertising of unhealthy products and practices (Ogba and Johnson, 2010). To date, healthcare has remained an area of interest to both individuals and government as exemplified by the COVID-19 pandemic. Despite interest in health issues, over the years, healthcare products have faced some levels of acceptance in some societies compared to others following the existence of some in-group factors and indigenous peoples' belongingness to a group that influences them (Oteh et al., 2021). The search for a cure and better health products has been driving people to move to different places in search of the cure for diseases and ailments (Bookman and Bookman, 2007). As a result, interest has increased in articles on healthcare leading to the inclusion of healthcare marketing in the academic curriculum (Stremerch, 2007). The rising interest in healthcare in Africa is often associated with the poor state of the healthcare system. Evidence shows that the healthcare system in Africa is underdeveloped as a result of poor governance and human resource challenges (Mack et al., 2015), low budgetary allocation to the health sector and financial barriers for accessing healthcare service with the poor bearing the greatest brunt (Uzochukwu et al., 2015). Other challenges include poor service integration (Romdhane et al., 2015), frequency of health workers' industrial strike because of the negligence of the sector (Essien, 2018), and shortage of human resources in healthcare (Oleribe et al., 2018). Most of the solutions to the problems are within human resources (Oleribe et al., 2019), opening economic opportunities for marketing of healthcare products by third party health care services and unlicensed institutions promoting healthcare products/services (Wortzel, 1976).

Multilevel marketing (MLM) in healthcare has been argued to be successful globally following its involvement in local health markets (Droney, 2016). Different names have been given to it such as network marketing (Dai et al., 2008) multilevel marketers (Aggarwal and Kumar, 2014), multilayer marketing (Rezvani et al., 2017), independent distributors (Keep and Vander Nat, 2014), and salespeople (Gregor and Gregor, 2013). However, the models are the same as it enables consumers to have the products without involving intermediaries (Selladurai, 2012); by contracting people to make face-to-face sales using a multilevel compensation structure (Albaum and Peterson, 2011). In recent time, MLM business has gained traction in Africa. The shift to Africa and other emerging economies is documented in extant literature. African market is seen as an attractive market owing to its huge consumption population leading to rapid expansion and increasing influx of new and great companies moving towards their revenue (NMC, n.d). Some of these MLM companies such as Oriflame, Longrich, Norland, and Forever Living Products have gained recognition and patronage in Nigeria. In essence, developments in healthcare services are putting healthcare marketers on a new pedestal (Awa and Eze, 2013). Marketers are finding MLM interesting to adopt. Distributors are using it to promote health products by positioning the health products as powerful medical products (Droney, 2016). The common baseline that is unique to each of these MLMs is an attractive promise of health enhancement and wealth creation (Hyman, 2007; Cardenas and Fuchs-Tarlovsky, 2018; Bradley and Oates, 2021). The attractive promises have elicited different reactions from people. Some consider it demanding given its networking nature and as a result, would not join. Others consider it to be exploitative on the ground of early entrants benefitting more than the late entrants. Consequently, consumers have a negative image of it (Msweli and Sargeant, 2001) despite the high demand and patronage for products marketed through MLM (Kustin and Jones, 1995). However, a consumer's negative image is established not to be universal (Muncy, 1993).

The common means of reaching people in MLM is word of mouth (Monteiro Grade, 2019) through periodic organized seminars, online communities, and word of mouth. The focus is often to exploit the personal relationships to make alleged medical products available and teach them to become informal medical experts with materials provided for them (Droney, 2016). This has raised a lot of concerns that hinge on legitimate means of making money (Albaum and Peterson, 2011; Ally, 2019), propagation of anyone being a salesperson (Hyman, 2008), sharing common features with pyramid schemes (Cardenas and Fuchs-Tarlovsky, 2018), and unethical approaches to health provisions. The health products are often classed as transformative (Droney, 2016) and regenerative (Nigerianorland, n.d.). One of the distinctive features of MLM is the distributor's selling of MLM products and consumption of the products as well (Albaum and Peterson, 2011) which often serve as their base of persuasive communication to convince recruits/distributors to join. However, the approach has been frequently scrutinized legally and criticized by people as a scam or pyramid scheme (Ally, 2019). A remarkable difference between pyramid schemes and multilevel marketing is in having products of real value to sell (Vander Nat and Keep, 2002). Multilevel marketing is a form of direct selling (Albaum and Peterson, 2011; Vander Nat and Keep, 2002; Ally, 2019) that involves non-store retailing on grounds of face-to-face communication between parties to the transaction (DSA, 2001) with a structure of different levels of compensation (Albaum and Peterson, 2011).

In Nigeria, the existence of MLM has driven people into the business model of MLM. Consumers are often swayed by its attraction of instant wealth while the distributors have often used alleged benefits of the health products to build relationship, recruitment and attract patronage (Sethi and Khinvasara, 2015). Some are alleged to have therapeutic efficacy from the use of botanicals in traditional medicine (Schiff et al., 2006) though the distributors mostly lack the proof over these presumptions they use to promote the health products (Cardenas and Fuchs-Tarlovsky, 2018). Some of these claims are spurious as there are no available evidence to support them leading to increasing consumer disaffection and disappearance of such brands in the market.

In contemporary times there are dramatic transformations in emerging economies with associated behavioural responses (Monteiro Grade, 2019). Part of these transformations has led to the rapid growth of MLMs in societies (Vander Nat and Keep, 2002) with some nations experiencing more adoption and diffusion than others. Extant studies show that ease and low cost of social media marketing as well as expansion in emerging economies are mentioned as plausible reasons (Deliema et al., 2018). The adoption of MLM in some African nations like Ghana is seen as higher social status given that it brings profit for distributors (Droney, 2016) while in some developed nations like the USA the purpose is to promote overall health, wellness and fill dietary nutritional gaps (Dickinson et al., 2014; Bailey et al., 2013). The focus of the study is on ascertaining the continued intention of consumers to engage in MLM in health or nutritional products amid associated ethical concerns.

Literature Review. In recent time, about 73% of individuals that participate in MLM face different fortunes as some lose money while some make gains (Dunion and Howerd, 2018). In an hour, the participants were found to make less than 70 cents (Laryea, 2018). In 2011 companies engaged in MLM accounted for 70% of direct sales (Albaum and Peterson, 2011). However, by 2021, 2.3% global direct sales was recorded year-by-year with 78.4% of global direct sales credited to the impact of top ten MLM companies (Gokul, 2021). In 2017 out of the top 20 MLM companies by global revenue 11 were devoted to health products (NMC, n.d.), targeting developing economies due partly to their health system development and consuming publics. Reports indicate that by 2020, MLM companies dealing on health products such as Natura cosmetics and Herbalife recorded improved revenue from previous years (Gokul, 2021). Nigeria is one of the attractive markets due to its large productive population. This is evidenced by the influx of several MLM in the Nigerian market (Tepede, 2011) and successes of other business models over the years (Dyer, 2011; Lee et al., 2016). The intense pressure on the Nigerian economy has led many businesses to device different models and strategies to survive. MLM serves this purpose using a network

of distributors to sell goods and services to people (Aggarwal and Kumar, 2014). The strategy revolves around structured compensation plans (Albaum and Peterson, 2011) which can come from mark-up of 40-50% (Coughlan and Grayson, 1998; Oladele and Laosebikan, 2019), commission on personal sales volume (Oladele and Laosebikan, 2019) and commission on group sales volume (Albaum and Peterson, 2011) with a commission on group sales volume appearing more complex in structure than the others (Coughlan and Grayson, 1998). This layer of compensation, empowering chains of command is seen as a key definition of MLM (Oladele and Laosebikan, 2019). In essence, money-making in MLM is from compensation for referrals and commission on sales compensation (Lee and Loi, 2016). Though there has been evidence of loss of interest of distributors of MLM with their brands; Nigerians seem to be patronizing new ones and dumping old ones. This smacks the promises of gains from these MLMs particularly following the assertion of NigeriaNorland (n.d.) on its ability to turn expenses into income. MLMs have an attraction of ease of creating a business at low cost because of low investment of time and money (MDP Partners, 2018). A deep understanding of compensation plan and incentives is critical to earning profit and remaining in the MLM business (Oladele and Laosebikan, 2019) given that monetary dimensions have been established in literature as a factor in motivating networkers to join MLM business (Lee and Loi, 2016; Lee et al. 2016). However, these platforms historically has high failure rate given the low entry and exit barriers (MDP Partners, 2018).

Generally, there is a nexus between wealth and health (Cervellati and Sunde, 2011; Hansen, 2012; Salman and Atya, 2012). The argument is that in linear models wealth is positively related to health but in non-linear models, the relationship is inverse (Selman and Atya, 2012). Therefore, these arguments reinforce the impetus for network marketing in healthcare. The drive of a good number of MLMs such as Norland is building health and detoxifying the global ecosystem (Nigerianorland, n.d.) and Herbalife's focus on personal care products, nutrition, and weight management (Urban et al., 2013). Unfortunately, the patronage and consumption of these products vary from location to location (Cardenas and Fuchs-Tarlovsky, 2018). These products are often presumptuously believed to have therapeutic effects following the underlying contribution of botanicals in traditional medicine (Schiff et al., 2006). It is often on grounds like this that distributors and networkers promote the products. This is despite the suspicious toxicity of a good number of MLM's distributed dietary supplements and herbal products (Cardenas and Fuchs-Tarlovsky, 2018). Networkers often lay claims to usage and efficacy of it from personal usage to convince and motivate new intending networkers. This position of face-to-face conviction often seems to draw the attention of potential networkers who are motivated by promises of financial gain and nutritional health management. The main idea in this regard is to make powerful personal statements of the efficacy of the products in addressing their health challenges (Koehn, 2001) with the main intention of eliciting positive responses from invited people during seminar presentations. However, there are shreds of evidence of the successes of these persuasive communications. On other hand, there are indications of moral challenges raised by these health claims (Callahan and Jennings, 2002).

A critical aspect of MLM in health matters borders on ethics. In some cultures, the practice is accepted. The practice of using MLM strategy by medical professionals in selling health products in western culture is well documented (Cardenas and Fuchs-Tarlovsky, 2018). The key problems center on usurping the position of medical professionals in rendering healthcare services. The strategy of MLM networkers is the elevation of an individual's experience of personal use of health products to those experts in the medical profession (Koehn, 2001). In most instances, there is an existence of misrepresentation of the efficacy of the products following networkers' statements (Groß and Vriens, 2017). The aim is always to convince invitees of the benefits they are being offered during sales proposition meetings. A key risk in this regard is decision making without having complete and reliable information (Cardenas and Fuchs-Tarlovsky, 2018) given that autonomous decision making requires truthfulness and completeness of the information (Varelius, 2006). MLM networkers are often criticized to be unethical for hiding under the realities of

businesses to promote dreams of earning big, operating under illegal pyramid structure following discrepancy in earning between early entrants and late entrants to the business, and lack of proper and appropriate training to embark on such sales (Aggarwal and Kumar, 2014). MLM networkers are also associated with tendencies to engage in fraudulent and deceptive recruitment of other networkers (MDP Partners, 2018). Key ethical concerns in MLM strategy are on non-possession of expert knowledge on health products, lack of requirement to be health adviser or health networker, and presence of misleading impression of making people's lives better fused with the opportunity of making plenty money (Cardenas and Fuchs-Tarlovsky, 2018). This buttresses the assertions of Aggarwal and Kumar (2014) on MLM as a deceptive approach that influences cultural beliefs, social and personal needs rather than meeting consumer needs. In other words, extant studies argued that people in the upper class with wealth tend to behave unethically (Piff et al., 2012; Wang and Murnighan, 2012).

Methodology and research methods. In the first place, the hypotheses of the study include:

H1: Wealth benefit of multilevel marketing of health products is related to health benefit

H2: Wealth benefit of multilevel marketing of health products is related to ethical concerns

H3: Wealth benefit is related to continued intention toward multilevel marketing of health products

H4: Health benefit of multilevel marketed health products is related to ethical concerns

H5: Health benefit of multilevel marketed health products influence continued intention

H6: Ethical concerns influence continued intention of multilevel marketing of health products.

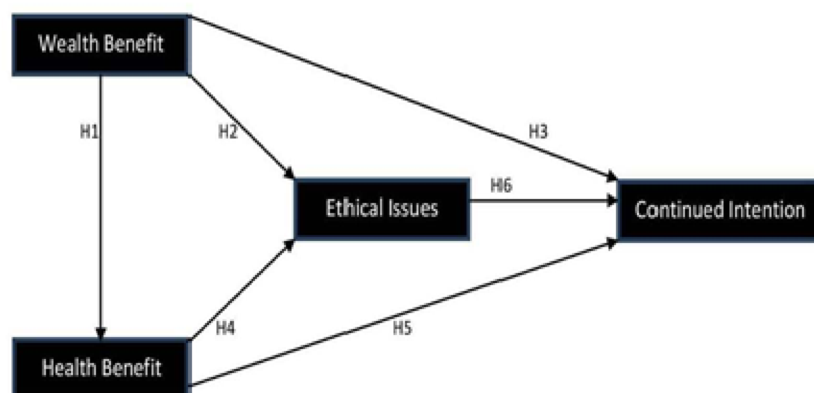

Figure 1. Proposed model of MLM on Health products continued intention

Sources: developed by the authors.

On the other hand, an online survey design was adopted for the study. The questionnaire was pretested on 10 selected networkers of health products in order to elicit the variables and structure of the questionnaire. The questionnaire was designed under three sections of demographic information, knowledge of network marketing on health (with the inclusion of 2 filter questions – «Do you know about network marketing of health products» and «Have you participated in any network marketing on health products»), and questions on the major constructs of the study. The constructs specifically are on wealth benefit, health benefit, ethical concerns, and continued intention on network marketing of health products. 4 point Likert scale was used to measure the variables with 1 = strongly disagree to 4 = strongly agree. This is appropriate in cases when researchers want to eliminate the chance of misusing the midpoint (Chyung et al., 2017), minimize social desirability bias (Garland, 1991), and when respondents are comfortable with the subject matter (Johns, 2005). Thus, the choice is premised on sampled respondents

having experienced the network marketing of the health products. Cronbach Alpha coefficient was used to test the internal consistency of the items. It is the most commonly used measure (Taherdoost, 2016) and the most appropriate measure when Likert scales are used (Robinson, 2009). The validity of the instrument was conducted given that reliability is not sufficient without its combination with validity (Taherdoost, 2016). This implies that the reliability test requires validity (Wilson, 2010). Content validity was adopted by using 11 experts in the field to access the coverage and methodology. Each item was assessed using not necessary, useful but not necessary, and essential on 3 point scale. The approach taken was in line with the recommendation of Taherdoost (2016) and Lawshe (1975). Content validity ratio (CVR) proposed by Lawshe (1975) requires a linear transformation of the level of agreement on some panel experts rating of «essential» in a set of items (Taherdoost, 2016). The formula for determining the essential item is given as:

$$CVR = \frac{n_e - \left(\frac{N}{2}\right)}{\frac{N}{2}} \quad (1)$$

where: CVR = content validity ratio; $n_e =$ Number of panel members indicating "essential" (9); N = Number of panel members (11); 2 = constant.

The minimum value from 11 experts is 0.59 (Lawshe, 1975). The derived CVR of 0.636 indicates the acceptable validity of the instrument.

Snowball non-probability sampling technique was used. This was done by identifying networkers who used their online community and meetings to reach out to fellow networkers of health products. It is appropriate in situations where reaching a respondent will lead to reaching other respondents for the study (Onyeizugbe, 2013). Data was collected from Abia, Enugu, Ebonyi, and Imo State which are in the South East region of Nigeria. The reason for the choice of this region is because of the prevalence of networkers in the region. A total of 285 copies of the questionnaire were collected. After screening the questionnaire for irrelevant ones and incompleteness the final sample consisted of 227 forms.

Results. STATA 13 and SPSS 23 were the packages used in the analysis. Common method bias (CMB) was conducted using Herman's single factor. All the items were adjusted to one factor. 49.8% was explained which is below the 50% threshold (Yang et al., 2012). Thus, there is non-existence of CMB in the study. The exploratory factor analysis (EFA) used to assess the unidimensionality showed that the KMO (Kaiser-Meyer-Olkin Measure of Sampling Adequacy) at 0.924 and Bartlett's Test of Sphericity at 1744.157 (0.000) indicates sample adequacy and rejection of non-existing difference between correlation and identity matrix respectively. During the factor analysis, items that were below .60 were removed. This includes HB1 – opportunity to build my health is the main reason for network marketing of health products, HB3 – I see the opportunity of using to build health to be important in the society, ET3 – I do not doubt the presumptions of what the health products can do, and ET4 – It is okay to use the health products in addition to medically prescribed drugs by professional health practitioners. In addition to content validity, the internal consistency of items was checked while convergent validity was done through average variance extracted (AVE). The values of composite reliability exceeded the 0.70 threshold as recommended in literature (Verkijika, 2018). With AVE, the values met the threshold of 0.50 (Hair et al., 2014). See table 1.

Table 1. Factor loadings, reliability, convergent validity, and descriptive statistics

Variable	Item	FL	CA	CR	AVE	$\bar{x}$	SD
Health benefit	HB2: It affords me the chance to build my health stronger and others HB4: I have been satisfied from using it to build my health and others	.815 .719	.848	.808	.51	3.14	.78

Continued Table 1

Variable	Item	FL	CA	CR	AVE	x̄	SD
Wealth benefit	WB1: Network marketing in nutritional products helps me build wealth WB2: I make money from it WB3: It is a good source of making money for me WB4: It provides me with extra source of income	.672 .751 .795 .640	.562	.742	.59	3.41	.55
Ethical concern	ET1: I don't doubt the efficacy of nutritional and health products ET2: I don't see MLM of health products as Ponzi scheme ET5: I believe networking health products is not wrong	.693 .727 .706	.668	.752	.50	3.48	.69
Continued intention	CI1: Given the chance, I'll do network marketing of health products CI2: I am open to continue doing network marketing of health product CI3: I am likely to continue network marketing of health products CI4: I intend to continue network marketing of health products	.838 .868 .949 .916	.934	.941	.80	3.30	.90

Note: FL: Factor loading; CA: Cronbach's alpha; CR: Composite reliability; x̄: Mean; AVE: Average variance extracted; SD: Std. deviation

Sources: developed by the authors.

Discriminant validity was conducted. Usually, it occurs when the pairs of latent variables share correlations that is less than 0.9 (Hair et al., 1995) and when there is a higher score of the shared variance of a construct and extracted variance against the shared variance of the construct and the model's constructs (Fornell and Larcker, 1981). These conditions were met in the study thus confirming the discriminant validity. See table 2.

Table 2. Inter correlation matrix and discriminant validity

	Wealth benefit	Health benefit	Ethical concern	Continued intention
Wealth benefit	**0.717**			
Health benefit	0.479	**0.768**		
Ethical concerns	0.468	0.644	**0.709**	
Continued intention	0.715	0.469	0.507	**0.894**

Note: Root of AVE on the main diagonal (in bold).

Sources: developed by the authors.

The sample characteristics show that 56.4% are female and 43.6% are male. Previous reports have indicated greater participation of women in MLM (Gocul, 2021). 4.4% were below 25 years, 57.3% were within the ages of 26 and 35 years, 37% were within 36 and 45 years, 1.3% were between 46 and 55 years; 96% has tertiary education and 4% has secondary school education.

The respondents identified some of the MLMs patronised by them. Nature Renascence International (NRI), Longrich, and Norland are the major ones going by the respective frequencies. Others that are used but not as much as the major three include Edmark, Tianshi, AIM Global, Forever Living Products, Oriflame, and Neolife. With this, there are several available MLMs within the location of the study that individuals patronize. See figure 2.

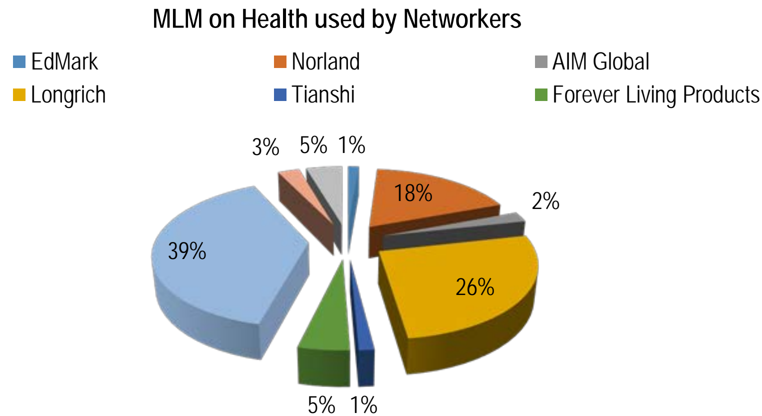

Figure 2. MLM on Health used by Networkers
Sources: developed by the authors.

However, the key reason for engaging in MLM is the offer of wealth benefit. A combination of health benefit and wealth benefit is attractive however the wealth dimension is the paramount drive for the individuals. The health benefit is merely an indication that it is a business. The attention is not really on the health benefit but on the ability to create wealth using MLM. See figure 3.

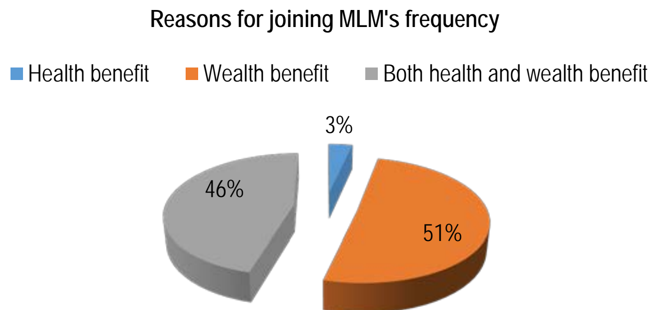

Figure 3. Reasons for joining MLM
Sources: developed by the authors.

This does not imply that the Networkers do not encounter challenges. An open ended question was used to harness the challenges experienced by networkers. The focus of the question was on difficulties they encounter that could lead to regret and impact their activities on network marketing of health products. The different challenges were summarised in table 3. The challenge is more on getting down-liners/ new people to register and be part of the MLM business. In addition, another serious angle is selling the health products that are advertised by the Networkers. In this aspect, they sometimes regard themselves as independent advertisers or marketers. This important challenge implies that despite the evidence of disease in a person, trust in the health product could be a hindrance. However, a cause of the sales challenge in the study is attributed to the costly nature of the health products. At 14%, the products were deemed costly by networkers who as well are consumers of the products as shown in extant literature. An insignificant number considered the challenge to stem from poor arrival of health products, wrong management of MLM chain, non-realistic nature of MLM as a business, unethical thoughts about engaging in the business, and consideration of the MLM by individuals as a Ponzi/pyramid scheme. Notwithstanding, 6.6% of individuals believe that they have no regrets about the business. In other words, both registrations of new down-liners and selling of the health products are critical in succeeding as Multi-level marketers of health products. Realistically, the result provides an insight to the nascent stage of MLM in Nigeria, and the poor diffusion level. This is because despite the 18.2% increase compared with the previous year there is only a meager 1% contribution of MLM from Africa/Middle East to the global direct sales when compared with the other regions. The report by Gocul (2021) buttresses this point. See table 3.

Table 3. Challenges of participating in MLM

Challenges	Frequency	Percent
Getting a down-liner	87	38.3
Getting people to buy the health products	62	27.3
Had no regrets	15	6.6
It is a pyramid scheme	4	1.7
Not ethical	1	0.4
Not realistic	22	10.0
Products are too costly	32	14.1
The products do not work	1	0.4
The products do not arrive on time	1	0.4
Wrong management	2	0.9
Total	227	100

Sources: developed by the authors.

In exploring this dimension in the study, 65.6% of the networkers expressed their regret over MLM business in health while 34.4% had no regret. This buttresses the impact of the challenges of the business on the networkers, particularly with the demand of registering new down-liners and selling products to make money out of the advertised products. See figure 4.

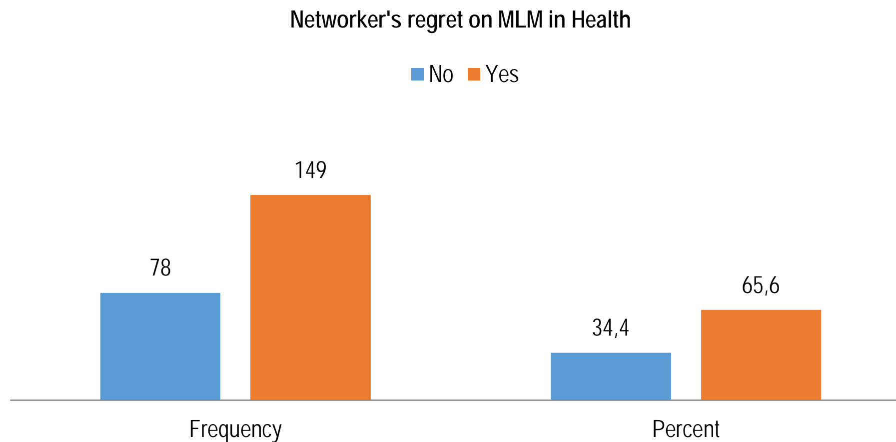

Figure 4. Networker's regret on MLM in Health

Sources: developed by the authors.

In analyzing the proposed hypotheses, structural equation modeling (SEM) was used to conduct the path analysis. The fit of the proposed model was tested using a set of goodness-of-fit indices. All the values of the respective index are below the required threshold thereby indicating a good fit of the model. See table 4.

Table 4. Goodness-of-fit indices

Fit indices	Threshold	Value in the model	Reference
$\chi^{2/df}$	<5	0.00	Bentler and Paul (1996)
RMSEA	<0.08	0.00	Hu and Bentler (1999)
CFI	>0.90	1.00	Bentler and Paul (1996)
TLI	<0.90	1.00	Schumaker and Lomax (2016)
SRMR	<0.08	0.00	Pituch and Stevens (2016)
R^2(Health benefit)		0.23	
R^2(Ethical issues)		0.45	
R^2(Continued intention)		0.55	

Notes: $\chi^{2/df}$ – normal chi-square/degrees of freedom; RMSEA – Root mean square error of approximation; CFI – Comparative goodness of fit; TLI – Tucker-Lewis index; R^2 = Coefficient of determination

Sources: developed by the authors.

The structural loads of the model were evaluated and the statistical significance indicates that not all the paths are significant. Table 5 and figure 5 show the overall result of the assessed paths. In the first place, H1, H2, and H3 were from wealth benefit. The importance of wealth benefit is highlighted by its significant effect on the paths. Specifically, wealth benefit is found to be significantly related to health benefit (β = 0.48; p = 0.00) which is consistent with earlier studies (Salman and Atya, 2012). The relationship between wealth benefit and ethical concern is confirmed (β = 0.21; p = 0.00) and consistent with extant studies (Wang and Murnighan, 2014; Zagorsky, 2017). Also, wealth benefit has a significant effect on continued intention (β = 0.60; p = 0.00). H4 and H5 were from health benefit. With H4, there is a significant relationship between health benefit and ethical concern (β = 0.54; p = 0.00) which confirms the argument of Callahan and Jennings (2002) about moral grounds in health. H5 is rejected (β = 0.06; p = 0.31). H6 is significantly related to ethical concern (β = 0.19; p = 0.00). See table 5 and figure 5.

Table 5. Hypotheses testing

Hypotheses	Standardised estimates	Standard error	t-value	p-value	Conclusion
H1: Health benefit←Wealth benefit	.48	.05	9.95	0.00	Supported
H2: Ethical concern←Wealth benefit	.21	.06	3.74	0.00	Supported
H3: Continued intention←Wealth benefit	.60	.04	13.7	0.00	Supported
H4: Ethical concern←Health benefit	.54	.05	10.9	0.00	Supported
H5: Continued intention←Health benefit	.06	.06	1.02	0.31	Not supported
H6: Continued intention←Ethical concern	.19	.06	3.15	0.00	Supported

Sources: developed by the authors.

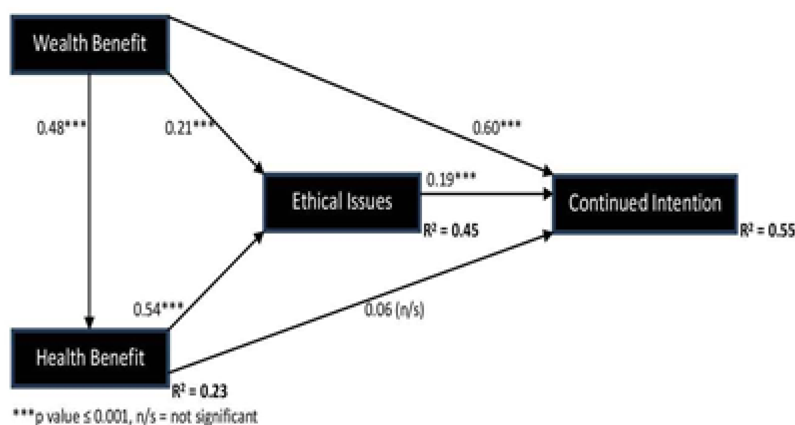

Figure 5. Results of Proposed model

Sources: developed by the authors.

Conclusion. The study considered multilevel marketing in health with a key focus on the relationship between multilevel health products and continuance intention. Descriptive statistics and SEM statistical tool was employed in the analysis.

In the first place, there are strong indications of the presence of several multilevel marketing companies in Nigeria dealing with health products. All of them have at least one percent patronage from networkers. However, Nature renaissance international (NRI) and Longrich products are the most patronized amongst the available ones. The higher patronage could stem from the better structure of the network, the price of the health products marketed, or the efficacy of the health products. These are the grounds that multilevel marketers considered to be unique. However, the patronage level indicates that certain advantages drive people to join specific MLM than others. In this regard, the key advantage is anchored on the chance of making more money – wealth benefit. The wealth benefit is the key driver rather than the acclaimed promises and efficacy of the health products that are marketed. This is possible in a developing nation such as Nigeria where the general poverty level is high. Thus individuals will seek any option they consider viable and legal to make extra money. Importantly, joining the networking platform does not immediately translate to success and ease of making money. Evidence from the data indicates that there are ominous challenges associated with multilevel marketing of health products. The challenges vary but the key ones are getting a new person (down-liner) to register as well as motivating people to buy the health product. Though some of the product prices are considered to be a hindrance because of the price, the challenge of convincing someone to join a network platform is considered to be the key hindrance

in making wealth and progressing in the business. This has often contributed to regrets by the individuals that join intending to make wealth. Essentially, a good number of networkers expressed their regret in associating with some of the MLM businesses. These regrets are often anchored in not being able to recover invested money, the task of convincing and registering new persons in the business, or the challenges of finding and selling the health products which come with prescription on usage. In any case, the regrets are pointers that the management of the structure is flawed, and not all products are meant to be operated in MLM structure.

On the other hand, the proposed model was checked for goodness-of-fit and analysed using SEM approach. The fit indices of the proposed model were within the recommended threshold thus indicating that the model is a good fit. The analysis of the paths shows that all the paths were significant except the relationship between health benefit and continued intention. Specifically, wealth has often been associated with health. In the study, it has the most significnt effect on continued intention. The significance of the result indicates that the chance of making more money directly influences health. This can be traced from the dimension of the networkers being users of the product as well. In most instances, the newly registered networkers are encouraged to use the products to be able to tell others the effect it has on health. In essence, the more the chance of convincing others of the health benefits consequent upon their earlier usage, the more the chance of making money.

Secondly, with the wealth benefit being the primary aim of joining any MLM business, the pecuniary interest is seen to have an association with ethical concerns of marketing health products using the approach. Extant studies indicate that wealth is associated with ethical concerns on a linear model (Salman and Atya, 2012). The implication is on the abuse by the personnel administering the prescription who in most cases are not healthcare practitioners and lacks expert knowledge on health products (Cardenas and Fuchs-Tarlovsky, 2018). The significance of the path between wealth and health buttresses this point. As the persevering ones grow in the business they hide under the realities of the business to promote the health product and dreams of earning big money (Aggarwal and Kumar, 2014). The issue lies in unethically misleading people with a false impression of making their lives better and making big money (Cardenas and Fuchs-Tarlovsky, 2018).

Thirdly, with further wealth generated, the chance of continuing in the business is established. This is because of the ability to generate extra income through advertising and selling of the health products, the accruing financial percentage invested by down-liner, and progress in the MLM structure. In essence, wealth benefit is established to be significant in continuing in the business. Mostly, in developing countries where there is a high poverty level, the chance of individuals in the nation embarking on anything to make money and satisfy themselves will not be wasted.

Fourthly, the relationship between health benefit and ethical concern indicates the existence of a direct relationship. This supports studies on ethical issues of public health. In this regard, the health issues relate to the worry about the expertise of networkers selling, counseling, and prescribing the health products, the authenticity of the health products, and the proof of its efficacy amid claims of networkers on its efficacy. This informs the reason for challenges in selling the health products because the ones selling and prescribing the usage are not professional healthcare personnel. The implication is that there is a concern on the side of buyers about the ethical perspective of networkers' intention – selling to make money or selling to help the individual get healed. Topical issues on public health and ethics indicate the worrying curve associated with the two factors (Callahan and Jennings, 2002).

Fifthly, the empirical support of the relationship between ethical concern and continued intention indicates the impact of ethics on multilevel marketing of health products in a developing country. The morality behind multilevel marketing of health products can determine the decision to continue on the MLM business. Specifically, when MLM on health products is considered as a business that has products to sell and operated accordingly as specified, there is the chance of less number of people not viewing it as a

Ponzi or pyramid scheme. These are often one of the key views individuals consider before joining. In other words, when the business is operated morally and ethically there is a greater chance of individuals continuing in the multilevel marketing of health products.

Conclusively, multilevel marketing of health products in a developing Africa country like Nigeria is majorly influenced by wealth benefit despite the promises of the efficacy of the health product, the presence of challenges, and the ethical dimensions. Clearly, in other to continue on the business, it must offer a clear path of making real money through the selling of health products.

On the other hand, one of the key recommendations as a result of the findings of the study is that of policy-drive and regulation. An appropriate policy that addresses the establishment and operation of businesses that engage in MLM of health products is needed. This is paramount in other to curtail unethical practices and sharp practices from the MLM businesses. In addition, there is a need for proper regulation. The regulation is required to control the use of unprofessional healthcare personnel in counseling and prescribing health drugs as well as targeting issues of false claims.

However, the study had some limitations which specifically border on the methodology. The cross-sectional design and non-probability sampling technique limit the study in having a better insight that a longitudinal study can provide.

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Мотивація споживачів та багаторівневий маркетинг здорових продуктів

Багаторівневий маркетинг в сфері здорових продуктів зазнав трансформаційних змін через поведінкові реакції споживачів. Зростання його популярності в Нігерії пояснюється тим, що люди вважають його дієвим альтернативним варіантом вирішення різноманітних проблем зі здоров'ям, що слугує важливим підґрунтям для популярності продуктів здорового сегменту разом з безумовними економічними перевагами для продавців. У дослідженні авторів аналізуються різні аспекти багаторівневого маркетингу у сфері охорони здоров'я із зосередженням уваги на визначенні зв'язку між багаторівневими медичними продуктами та стимулами споживачів до подальшої купівлі таких товарів. Дослідники використовують описову статистику та статистичний інструмент SEM. Окрему увагу приділено аналізу мотиваційних факторів займатися бізнесом у сфері здорових продуктів. Авторами проведене онлайн-опитування 227 представників багаторівневих мереж здорових продуктів у південно-східних регіонах Нігерії. Результати аналізу показують, що Nature Renascence International (NRI), Longrich і Norland є основними брендами багаторівневих мереж у сфері здорових продуктів країни. Інші бренди менш популярні (Edmark, Tianshi, AIM Global, Forever Living Products, Oriflame і Neolife). Виокремлено основну проблему бізнесу, яка полягає в складності залучення спеціалістів з нижнього рівня / нових людей реєструватися та стати частиною такого виду діяльності. Аналіз показує, що матеріальні доходи є основною мотивацією приєднатися до мереж, незважаючи на обіцянки користі для здоров'я. Зокрема, з'ясувалося, що користь від статків значною мірою пов'язана з користю для здоров'я. Дослідження також надає докази того, що існує зв'язок між вигодою від статків і етичними занепокоєннями. Крім того, вигода має значний вплив на наміри до продовження співпраці. Рекомендації авторів зосереджені на політиці та регулюванні. Автори пропонують інструменти відповідної політики, яка стосується створення та діяльності підприємств, які займаються МЛМ товарів для здоров'я. Це має першорядне що мають значення для припинення неетичних практик з боку компаній багаторівневих мереж у сфері продажу здорових продуктів. Крім того, необхідне відповідне регулювання. Потрібним є розроблення положення для контролю за використанням непрофесійного медичного персоналу для консультування та призначення медичних препаратів, а також для боротьби з неправдивими рекламаціями.

Ключові слова: продукти у сфері охорони здоров'я, економіка, що розвивається, незалежні рекламодавці, мережа, піраміда, розподіл.