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**SOCIAL MARKETING:
GENDER INFLUENCE ON ADOPTION OF HIV/AIDS PREVENTIVE MEASURES
IN MAIDUGURI METROPOLIS**

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Abstract:

A social marketing intervention would be effective only if it brings about positive social behaviour change in a target population, in this case; adoption of HIV prevention methods.

The study is a survey conducted in Maiduguri metropolis to examine the influence of gender on adoption of HIV/AIDS prevention methods. Specifically the study assessed the level of awareness on HIV/AIDS and assessed the peoples' protective behaviours. Data for the study were collected from both primary and secondary sources. A total of 300 questionnaires were distributed amongst the sampled respondents. The 283 instruments retrieved were analysed using Descriptive statistics. The findings were that, despite the level of awareness on HIV (70%), a person's gender has a significant influence on adoption of HIV/AIDS prevention methods with the female gender at a disadvantage. The study recommends amongst others for the proper marketing of HIV prevention tools that women can have control over.

Key words:

Gender, Social Marketing, Adoption, HIV/AIDS

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Introduction

The term *social marketing* was coined in the early 70s in a pioneering article by Philip Kotler and Gerald Zaltman. Most social marketing efforts are applied to: Improving public health (e.g. HIV/AIDS, polio eradication and malaria control), protecting the environment and contributing to communities. It is specifically intended to bring about social change (Lamprey and Price, 1998). Features of social marketing such as repeated exposure to prevention messages, use of incentives and audience segmentation distinguish it from traditional health promotion. Effective social marketing interventions should bring about positive social behaviour change in a target population which in this case is adoption of HIV prevention strategies.

Social marketing is a strategy used to influence human behaviour by using marketing principles and promoting behaviour as a product (Kotler and Armstrong, 2008). Social marketing has the potential to change attitudes and beliefs, and ultimately to bring about individual and social change. It has become increasingly popular among donor agencies and governments as a way of addressing serious health issues. Social marketing is perhaps the most popular framework for designing health behaviour change campaigns through the use of commercial marketing approaches. Research shows that average social marketing campaigns can influence about 5% of a population's behaviour (Cugelman, 2012). This 5% impact is a ballpark figure that varies from population to population, and from behaviour to behaviour. Although 5% may seem small, at the population level, small shifts in public behaviour can translate into large health impacts.

In trying to enhance protective behaviour, factors that affect consumer's acceptance of innovations have to be considered, such factors are: characteristics of the consumer and perceived characteristics of the innovation. For a good, service or idea to be adopted, consumers go through a series of stages from learning about the new product or idea to trying it and deciding whether to adopt it or reject it. Awareness is the first step to understanding, which may then lead to a desire to do something and make a difference. In the awareness stage, characteristics of the consumer such as; demographic (age, gender and level of educational), psychographic, and socio economic characteristics affect behaviour change. At the interest stage, the perceived characteristics of the innovation feature such as, perceived risks, compatibility, communicability and complexity. HIV/AIDS prevention methods are innovations to consumers who have not adopted these strategies. People may be aware of the strategies but have not done anything yet. It is the goal of social marketing to move consumers from awareness to desire and action. **Characteristics of individuals** do influence the adoption of innovations, they include; gender, marital status, age, educational level and income. The demographic factor **gender** was chosen for this study.

Acquired Immune Deficiency Syndrome (AIDS) has grave implications for the economic development of the nation (Irefin and Mala, 2010). The national HIV prevalence rate has grown steadily from 1.8% in 1991 to 5.8% in 2001; subsequent surveys in 2003 and 2005 revealed a slight downward trend to 5.0 and 4.4% respectively. This trend has somewhat stabilized in 2008 to 4.8% but showed a slight decline to 4.1% in 2010 (NACA, 2010). The rapid spread of the virus could be attributed to the low adoption of preventive measures. "A healthy nation is a wealthy nation". Healthier workers are more productive, a healthy workforce creates ample businesses and opportunities where-in goods and services are produced and consumed. A marketer will want a population that is alive, healthy and willing to patronize his business and not a population ravaged by the Human immunodeficiency virus (HIV) or any disease. The AIDS pandemic is a serious threat to marketers which must be halted urgently and treated seriously.

Despite the efforts by donor agencies and the government, there has remained a low adoption rate by people. Social marketing may have created awareness for the strategies but the knowledge has not brought about significant influence on adoption rate. Are people unable to adopt due to other reasons? In terms of communicating to the public, are the right tools used and the right messages properly conveyed so that the public can have the right perception and better understanding of the strategies? In terms of behavioural change, do people lack the motivation to implement knowledge into sustained behaviour change?

Studies have been carried out on HIV/AIDS. Most of the research dwelt on its awareness, which includes awareness on the existence of the virus and knowledge about the disease (Odu and Akanle, 2008; Magnus and Gbekeji, 2009; Garbati, Abba, Kabrang, and Yusuph, 2011). Not much is known about social marketing of HIV/AIDS preventive measures and the challenges facing it in Maiduguri Metropolis. This leaves a knowledge gap. Bearing in mind the impact of HIV/AIDS, it is worthwhile to analyse the factors that affect the adoption of HIV/AIDS preventive measures specifically the influence of gender on behaviour change in Maiduguri metropolis. The main objective of

this study was to examine the influence of gender on adoption of HIV/AIDS preventive measures in the metropolis, while the specific objectives were to assess the level of awareness on HIV/AIDS by consumers in Maiduguri metropolis and to assess the protective behaviours of consumers living in Maiduguri metropolis. The study is relevant in terms of behavioural characters of the population and was limited to the age group of 15 to 65 years, the study focused on variables like gender, marital status, awareness and protective behaviours.

LITERATURE REVIEW/CONCEPTUAL FRAMEWORK

Social marketing and HIV/AIDS prevention

The main goal of social marketing is behavioural impact and so utilises evidence from commercial marketing and market research as well as social science research and segments the population according to demographics, behaviour and psychographics (beliefs, attitudes and opinions). Social marketers usually start by defining which behaviour they would like to change and why and sees personal motivation and barriers to behaviour change as particularly important to understand. Social marketing requires a clear understanding of competing behaviours, socio-economic, political and cultural conditions to develop strategies compatible with existing socio-economic and cultural values of the population where the strategies are applied (Hussain and Shaikh, 2005).

Social marketing can be applied to a variety of social problems. Fox and Kotler (1980) are of the view that its application is most appropriate when new information and practices need to be disseminated, when counter marketing is needed (gives the other side of the story) and when activation is needed. Most times people know what they should do but do not act accordingly. In such situations, social marketing aims to move people from intention to action.

Role of social marketing on preventive behaviour

Social marketing seeks to influence social behaviours not to benefit the marketer but to benefit the target audience and general society. Studies have shown that social marketing has made successes in various settings, these successes speaks much of its potential in addressing health behaviours and disease prevention. The technique has been used extensively in health programmes, especially for contraceptives and oral rehydration therapy (ORT) and used more frequently in the United States of America for such diverse issues as drug abuse, heart disease and organ donation (Weinreich, 2010).

Social marketing has been used to influence breastfeeding, hand washing, healthy eating, cervical screening, environmental impact, smoking cessation and physical activity (National Social Marketing Centre, 2006). Published evaluations in the sexual field suggest it has increased STI screening to heterosexual adolescents and condom use among adolescents (Bourne, 2011). In response to the HIV epidemic, social marketing programmes have made condoms accessible. Influence of social marketing particularly on condom use as an effort to fight the HIV/AIDS epidemic is one of the significant achievements of condom social marketing programmes. According to Barnes in a study on the impact of social marketing on HIV/AIDS, the sale of condoms has increased, these sales are a good reflection of condoms purchased and used. However, the HIV/AIDS prevalence has not declined. The marketing of condoms may not be sufficient compared to the demand for the condoms.

In South Africa, an evaluation of a social marketing intervention targeted at gold miners showed significant increase in awareness and increase in the prevalence of condom use with partners during the intervention period. A further study carried out by the Zambia social marketing project evaluated sexual activities and condom use in Lusaka. The result of the study showed a strong association between a specific brand advertising and condom use. Social marketers are confident in their claims to be able to change behaviour and insist it must be used alongside other interventions to improve individual's health and well-being (Smith, UD).

Gibson, Zhang, Cassady, Pappas, Mitchell and Kegeles (2010), also showed the role of social marketing in stalling HIV/AIDS in a research they conducted which revealed that exposure to posters and the newsletter was associated with decreased injection risk among injecting drug users. Noar and Kennedy,(2009) also buttress the findings with evidence from several quasi-experimental designs that media campaigns can reduce rates of unprotected sex and increase HIV testing behaviours, although effects are typically short term. While such surveys represent important contribution to the literature on the effectiveness of social marketing programmes especially on creating awareness and making condoms available in many of the world's developing countries, encouraging their use is very

vital in the fight against HIV/AIDS. Social marketing programmes can do well in motivating individual behaviour change, but that is difficult to sustain unless the environment they are in supports such programmes.

Awareness on HIV/AIDS

Appropriate knowledge is a prerequisite for promoting prevention of HIV/AIDS. Lack of knowledge makes people vulnerable to HIV/AIDS infection. Comprehensive knowledge on HIV means knowing that consistent use of condoms during sexual intercourse and having just one HIV- negative faithful partner can reduce the chances of getting the AIDS virus.

According to Odu and Akanle (2008); Magnus and Gbekeji (2009) there is a relatively high level of awareness among people on the existence of the disease accompanied by a moderately high level of knowledge about HIV/AIDS route of transmission and the preventive measures of HIV/AIDS. However, in spite of the high level of awareness on HIV/AIDS, there exist widespread misconceptions. A significant number of studies have shown that there is a moderately high level of awareness and knowledge on mode of transmission and the preventive measures of HIV/AIDS but, the virus is still spreading. The disparity between knowledge and behaviour may be responsible for the continuing spread of epidemic. The finding of Odu and Akanle (2008) revealed that a high percentage of awareness was available among people. However, among those who were aware of the consequences of HIV infection, no serious preventive efforts were taken towards avoiding the infection. This is so because most people felt that they can never contract HIV/AIDS. An impact study conducted in India indicated an eighty percent increase in awareness of HIV/AIDS among the target group. Targeted communications have focussed on raising awareness among those groups deemed to be most at risk and promoting behaviour change (Noar and Kennedy, 2005). Garbati, Abba, Kabrang, and Yusuph, (2011), identified that in a recent knowledge, attitude and practice (KAP) pilot survey among both new and old students of the University of Maiduguri revealed a generally informed population on HIV/AIDS education. This, however, did not translate to an improved acceptance of HCT services. From the pilot survey, about 4.7% of a cross-section of the student population from the institution tested positive to the virus.

Influence of gender on behaviour change

The socio-demographic characteristics of individuals influence their health care seeking behaviour. Factors such as age, gender, level of education and income are significantly associated with knowledge and attitude which may affect adoption of prevention strategies (Folake, Adebayo, Anyanti and Ankomah, 2009).

The term gender refers to the roles, responsibilities, needs, interests and capacities of boys, girls, men and women. Gender is influenced by social and cultural factors and act as societal norms of masculinity and femininity (UNAIDS 1999). Gender dynamics are understood as the different roles, expectations, identities, needs, opportunities and obstacles that society assigns to women and men based on sex (UNFPA, 2002). Gender inequality is a key driver of the epidemic, it increases the personal and social vulnerability of women and girls and results in an increasing feminization of the global HIV pandemic. Girls and boys, women and men, have the same rights, potentials capacities; but discrimination against women based on socio-cultural norms often relegates them to lower status and values. Both men and women are victims of social construction of gender. Men's risk of HIV infection is primarily determined by their own behaviour, whereas, women's vulnerability to HIV infection is largely beyond their control. Women face a number of barriers to HIV prevention, testing and counselling, including embarrassment, fear of rejection, stigma, and partner's objection to testing, lack of accessible information, limited decision-making power, restricted mobility and child care responsibilities (Ali, 2009).

According to the HIV/AIDS cluster report (2003), gender inequality often places females at considerable disadvantages in terms of their access to resources and goods, decision-making power, choices and opportunities across all spheres of life. WHO and UNAIDS (2008) estimates that women comprise 50 percent of people living with HIV globally. In sub-Saharan Africa, women constitute 60 percent of people living with HIV. The highest gender gap is recorded between young women and men between 15-24 years old (UNAIDS, 2008). Understanding why women and girls are more likely to become infected with HIV therefore falls into the domain of gender relations and gender inequality. Many factors contribute to creating and increasing gender inequalities, which in turn can affect the spread, prevention, care, support and treatment of HIV/AIDS. Some of the factors are:

a. Gender Based Violence: - This occurs in all societies and takes place in many forms. Violence has a variety of implications for HIV/AIDS, both in perpetuating the spread of HIV, and also worsening the impacts of the disease.

Domestic violence, when women are perpetrated by their partners, is the most common form of gender based violence. The threat of violence can influence a women's ability to negotiate when and how sex takes place and whether or not to use protective barrier, which in turn increases the risk of HIV transmission (Safaids and Oxfam, 2005). Gender violence can also be a punitive reaction to a positive HIV diagnosis within a relationship. Studies show higher HIV risk among people with history of gender based violence and higher rates of gender based violence among those who are HIV positive (Anderson, Cock and Shea, 2008). It is convincing that gender based violence is an important agent of HIV transmission.

b. Sexual Abuse and Rape: - Sex trafficking and harmful cultural practices occur worldwide and are examples of gender based violence that can substantially increase the risk for HIV/AIDS infection. A report in Lusaka, Zambia by victims support unit showed that almost half of married women aged from 15 years reported being battered or physically abused by their husbands. Most of the women who tested positive for HIV/AIDS claimed they were abused at some time in their lives (Ali, 2007). Gender based violence and rape of girls and women were all commonly cited as insurmountable barriers to the adoption of prevention methods (WHO/UNAIDS, 2006).

c. Economic Inequalities and Poverty:- This significantly contributes towards increasing gender inequalities. Limited access to, and control over economic assets can also contribute to the vulnerability of HIV infection in several ways, as it increases the likelihood of the inability of persons to negotiate safe sexual practices, exchanging sex for money and staying in a relationship that is violent and risky. In 2004, the horizons programme developed a collaborative research to explore how adults and youths in Kenya define and perceive the ABC terms and behaviours. The female respondents highlighted pressure to have sex, often due to economic hardships as a barrier to protection (USAID, 2008). Sexual exchange has become intrinsic to the economic survival and security of poor women in Africa. Economic crisis has driven many women to exchange sex for the means of subsistence for themselves and their families. Young girls are at particularly high risk, first because of their lack of access to economic resources, often presumed to be free of HIV by older men; they are targets of sugar daddies since their poor parents may be unable to pay their school fees and provide for other needs. Secondly, since African culture emphasizes female subordination they usually lack the courage to negotiate for safer sex (Obiona, 2008). Mahmud (2010) is of the view that due to poverty, young girls are forced to submit to sexual overtures. *Juye* is a popular Hausa term referring to a youth buying off what a girl is hawking at a go so as to befriend her. That way, most hawkers end up being raped or impregnated by the boys.

d. Unequal access to preventive measures: - Research has shown a strong link between educational level and knowledge on HIV/AIDS (UNAIDS, 2006). In many parts of the world, more boys than girls have access to education and stay longer in school. This can affect their ability to access important information on how to protect them from HIV infection when they become sexually active or later in life. HIV prevention campaigns do not take into consideration HIV transmission within marriages. There is also lack of female controlled preventive measures. The only available tool is the female condom which is expensive and poorly marketed.

e. Unequal access to treatment: - Together with accurate information on prevention, equal access to treatment and care are crucial to slowing down the HIV/AIDS pandemic. Women are less likely to access treatment than men partly due to cultural norms which dictate that men's treatment is a bigger priority as they are seen as breadwinners. Economic dependency and affordability also play a role as poor women are less likely than poor men to be able to afford treatment even if the fees were substantially reduced (Keeping the promise, 2006).

The spread of HIV is rooted in poverty and gender inequality. Perhaps, this explains the predominance of HIV/AIDS in poor nations of the world. Addressing gender roles and power dynamics between men and women, and how they impact on sexual relations and decision-making, is critical for effective prevention and ultimately halting the HIV/AIDS pandemic.

f. Marital status: - Gender based power dynamics inhibits women's ability to negotiate issues related to sexual behaviour. The high levels of HIV transmission through sexual intercourse make negotiating safer sex indispensable. This is especially the case in married unions where women's status is compromised by social expectations, thereby increasing their vulnerability to HIV infection. A survey conducted by Federal Ministry of Health (2009) reveals that level of education to some extent affects the ability of married women to negotiate condom use with their partners. The gender reality of HIV/AIDS (2006) reports higher rates of infection among young married women than their sexually active unmarried peers in Kenya and Zambia.

Findings from the study suggest that within women, 80% of infections were among married women in monogamous relationships. The women reported that their husband utterly refused to consider using condoms or to even discuss the risks involved. Those that agreed to discuss convinced the women that their risk of infection was negligible. In most African societies, married couples do not use barriers during sexual intercourse for the sake of procreation.

METHODOLOGY

This study is a survey research; both primary and secondary sources of data were utilised. Primary data were obtained through questionnaire and oral interview. The secondary data were collected from existing sources in books, journals, and government reports. The study considered people between the ages of 15 to 65 living within the metropolis. A sample size of 300 respondents was drawn using stratified and convenience sampling techniques but, only 283 questionnaires were valid. The data were subjected to statistical analysis of Descriptive statistics and simple linear regression analysis using statistical package for social sciences (SPSS) version 16.

DATA PRESENTATION AND ANALYSIS

Data Presentation

Awareness on HIV/AIDS

Table 1: Frequency distribution of respondents' knowledge on transmission and prevention of HIV/AIDS

| Statements | Yes | No |
|---|---------|---------|
| Sexual relationship between males and females | 216(76) | 69(24) |
| Using unsterilized blades and needles | 150(53) | 133(47) |
| Mother to child | 199(70) | 84(30) |
| Maintain faithful HIV negative partner | 247(87) | 36(13) |
| Use condoms during sexual activity | 249(88) | 34(12) |
| Practice abstinence | 258(91) | 25(9) |
| Go for HIV test | 131(46) | 152(54) |

Source: Field Survey, 2011

Table 1 shows that 76% of the respondents say the virus is transmitted through sexual relationship between males and females, the remaining 24% say it is not transmitted through sexual relationship between males and females. This reveals that the respondents have a good basic knowledge on the transmission mode of the virus. It also reveals that 53% of the respondents know the use of unsterilized objects can transmit the virus while 47% of the respondents say the virus cannot be transmitted through sharp unsterilized objects. This distribution shows that many respondents are still not aware of this mode of transmission as just about half of the respondents are aware.

The analysis also shows that 70% of the respondents know that mothers can transmit the virus to their children and 30% say it is not a mode of transmission. A high percentage of the respondents are aware of this mode of transmission which shows that they have in – depth knowledge on transmission mode. The analysis also show that majority of the respondents are of the opinion that to maintain a faithful and HIV negative partner is a good preventive measure against the infection while 13% do not agree. This shows that the respondents have a good basic knowledge on prevention of the infection. The study reveals that 88% of the respondents know condom is a protective barrier. However, only 12% say they do not know. This also reveals that majority of the respondents have basic knowledge on prevention of the infection. A high percentage of the respondents (91%) say they know that abstaining from sex can prevent HIV infection while the remaining 9% say it does not. The result shows 46% of the respondents are of the view that to have a HIV test is a protective measure while 54% of the respondents say it is not a protective measure. This analysis reveals that less than half of the respondents do not know knowing ones' status through a test is a prevention method.

Respondents' protective behaviours

The study sought to know whether the respondents had adopted any preventive measure by assessing their protective behaviours.

Table 2: Most popular preventive measure adopted by the respondents

| Options | Frequency | Percentage |
|-----------------|-----------|------------|
| Abstinence | 42 | 14 |
| Single partner | 25 | 9 |
| Condom use | 19 | 7 |
| Not adopted any | 197 | 70 |
| Total | 283 | 100 |

Source: Field survey, 2011.

The analysis on table 2 reveals that 70% of the respondents have not adopted any preventive measure while only 30% are protecting themselves. This clearly shows that the respondents are taking high risk by exposing themselves to infection through their risky behaviours.

Influence of gender on adoption of preventive measures

Table 3: Frequency distribution of influence of demographic characteristics on adoption of prevention strategies

| Statement | SD | D | A | SA |
|---|--------|--------|--------|---------|
| A man can demand for unprotected sex from his partner | 24(9) | 41(15) | 69(24) | 149(53) |
| Condoms are not for married couples | 29(10) | 30(11) | 77(27) | 147(52) |
| Women cannot ask for condom use for fear of beatings from partner | 28(10) | 38(13) | 77(27) | 140(50) |
| Women cannot ask for condom use because they fear their partners may leave them | 25(9) | 69(24) | 51(18) | 138(49) |
| If a man pays for intercourse, the woman should not ask for condom use | 49(79) | 53(19) | 83(29) | 98(35) |

Source: Field Survey, 2011

Table 3 shows that two-thirds (76%) of the respondents' agree that men can ask for sex without using condoms from their partners while one-third (24%) say their partners are not opposed to condom use. It can be seen here that majority of the respondents choice on using protection is negatively influenced by their partners. It also reveals that about 80% of the respondents are of the view that married couples should not use condoms while the remaining 20% disagree. The analysis again reveals that 77% of the respondents agree that women cannot negotiate condom use for fear of beating from their partners rest of the respondents do not support the statement. Also, about 65% of the respondents believe women fear desertion from their partners hence, the inability to negotiate condom use while the remaining 35% do not agree with the statement. The analysis further reveals that 64% of the respondents are of the view that once a man pays for intercourse then the woman should not ask for condom use. The remaining 36% of the respondents do not agree with the statement.

Discussion of Findings

Level of awareness on HIV/AIDS

The respondents' answers on modes of transmission and preventive measures of HIV scored high which show a high level knowledge on awareness. Over 80% of the respondents have comprehensive knowledge of HIV/AIDS; which is the consistent use of condoms and maintaining a faithful HIV negative sexual partner. It is discouraging however; that slightly more than 50% of the respondents know that to have a voluntary HIV test is a preventive measure. To know ones status is very important in the war against the virus. From this study, the level of awareness and knowledge on HIV/AIDS is high. The respondents were good at giving answers on modes of transmission of HIV/AIDS. This shows a higher level of deeper knowledge. This is in line with findings of Odu and Akanle (2008); Magnus and Gbekeji (2009); Noar and Kennedy (2009) Garbati et al. (2011).

Respondents' protective behaviours

The study examined the protective behaviours of the respondents and it revealed that majority of the respondents were exhibiting high risk behaviours as 70% had not adopted any form of protection. Abstinence was the most popular form of protection for only 14% of the respondents; this clearly shows that the majority of the respondents are sexually active. It is very discouraging that only 7% were using condoms as a means of protection. This is in line with findings of Adedimeji et al. (2007); Odu and Akanle (2008); Adeokun (2008); Magnus and Gbekeji (2009); Asakun-Olarinmoye (2009) and Garbati et al. (2011) where most of the respondents were exhibiting high risk behaviours despite their awareness.

Influence of gender on adoption of HIV prevention strategies

More than half of the respondents are of the view that their male partners oppose to condom use as they most often refuse it and since they were not in a position to negotiate because they either did not want their partners to leave them because they help them financially or for fear of beatings. Once a man pays for intercourse, then the woman

has no choice but to comply with what he wants. This is in line with studies conducted by the Horizons programme (2004); Safaids and Oxfam (2005) and Anderson, Cock and Shea (2008). While a few of them said their partners understood and were not opposed to condom use. The study further revealed that majority of the men did not like the idea of using condoms.

The study also revealed that the marital status of individuals affect their protective behaviours. About 80% of the respondents are of the view that married couples should not use condoms; they believe condoms are not for married couples. The belief that married couples are supposed to procreate and have as many children as they can is still strongly held in the northern part of Nigeria. The issue of using condoms does not even arise for most of them. This shows that many people are not protecting themselves just because they are married. Findings from studies by the Gender reality (2006); Ambasa-Shisanya (2006); Ali, (2007) and Momoh, Moses and Ugiomoh (2007) all buttress the fact that use of condoms is significantly lower by married couples than single sexually active persons.

CONCLUSION AND RECOMMENDATIONS

Conclusion

After decades of fighting the dreaded HIV/AIDS in Nigeria, the country is yet to achieve much, especially in the area of prevention; which is attitudinal and behavioural change. Considering the fact that very little is known on the cure for the disease, the world needs to put more emphasis on prevention. The Nigerian Government, donor agencies, and other bodies have done a lot by using marketing communication in creating awareness for HIV/AIDS but have not achieved much success in behaviour change. Awareness for HIV has been raised but this awareness and knowledge on modes of transmission and prevention strategies have not caused a significant change in behaviour. Factors within individuals and their environment are responsible for the low adoption of HIV/AIDS prevention strategies. To bridge the gap between awareness and action, there is a need to move beyond awareness and to achieve sustained behaviour change. HIV/AIDS has no cure; the best option against the deadly virus is to protect oneself by adopting prevention strategies.

Recommendations

1. Traditional social marketing campaigns which employ mass-media advertising has created awareness for HIV/AIDS in the metropolis but has not achieved much success in behaviour change. This study recommends the use of social media interventions such as mobile applications, social media sites, email, text messages and sensor technologies. Both approaches should be combined and used to complement each other.

2. "Religious" and "Cultural" social marketing should be used where religious groups/leaders of all faiths and community leaders/elders are targeted and made to be integral part of the campaigns against HIV as these leaders can enhance the credibility of messages and promote their acceptance. They can be persuaded to promote cultural practices which can prevent HIV infection rather than those practices that are barriers to its prevention; these people are role models as they are opinion leaders whom people look up to.

3. HIV/AIDS prevention tools that women can control like the female condoms and microbicides should be properly marketed so that they are affordable and available. Social groups and networks (associations, clubs and organisations) should be targeted and involved in HIV control programmes. Social marketing interventions and approaches can be aimed at influencing members of the groups.

4. HIV test should be made compulsory before marriage in all communities. This can be achieved by enlisting opinion leaders (religious leaders and community leaders). This compulsory test should have a constitutional backing. Such marriages conducted without the test should not be recognised by the community.

REFERENCES

- Ali, N. M. (2007). Hidden in the Meali Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia. *New York: Human right watch. Vol.19 (18 A)*.
- Anderson, N., Cockcroft, A., & Shea, B. (2008). Gender based violence and HIV: relevance For HIV prevention in Hyper endemic counties of southern African. *Wolters Kluwer Health, Vol. 22, (4)*
- Bourne, A. (2011), Social Marketing and HIV Prevention. Making it Count Briefing Sheet 6. *Sigma Research at LSHTM*.
- Cugelman, B. (2012). Why Digital Behaviour Change Interventions will transform Public Health. *Ontorio health promotion E-Bulletin, volume 754*.

- Folake, R., Adebayo, S.B., Anyanti, J. & Ankomah, A. (2009). The society for Family Health, Garki, Abuja. Public.med.gov.
- Fox, K.F.A. & Kotler, P. (1980), The Marketing of Social Causes: The First 10Years. *Journal of Marketing*. Volume 44. Number 4.
- Gibson, D. R, Zhang, G, Cassady, D, Pappas, L, Mitchell, J & Kegeles, S.M. (2010). Effectiveness of HIV Prevention Social Marketing with Injecting Drug Users, *Am Public Health*. V. 100(10).
- Garbati, M.A, Abba, A . A, Kabrang, D.N and Yusuph, H. (2011). HIV/AIDS in Northeastern Nigeria: A review. *Journal of Infectious Diseases and Immunity Vol. 3(10)*, pp. 176-182, 15 October, 2011 Available online at <http://www.academicjournals.org/JIDI> ISSN 2141-2375.
- Hussain, S. & Shaikh, B. T. (2005), Stalling HIV through Social Marketing: prospects in Pakistan. *J Pak Med Assoc*, vol. 55, No. 7.
- Keeping the promise, (2005). *An Agenda for Action on women and AIDS*. www.hrw.org/english/docs/2008/05/05/global.18753.htm
- Kotler, P & L, N.R. (2008), Social Marketing: Influencing Behaviour for Good, *Social Marketing Services Inc*.
- Kotler, P. & Zaltman, G. (1971), in Fox, K.F.A & Kotler, P. (1980), The Marketing of Social Causes: The First 10Years. *Journal of Marketing*. Vol. 44. No 4.
- Magnus, O.O. & Gbekeji, J.O. (2009). Analysis of Spatial Awareness of HIV/AIDS Among Student of Tertiary Institutions in Edo State, *Nigeria, Etho-Med* 3(2).
- Mahmud, M.U. (2010). A Study of the use of Radio in HIV/AIDS Mitigation in Four Local Government Areas of Kaduna State. *MAJASS*. Vol.8 No.2.
- Momoh, S.O. Moses, A.I, & Ugiomoh, M.M. (Sept 2007). Women and HIV/AIDS Epidemic: The Issue of College Age Girl's Awareness in Nigeria. *College Student Journal*.
- National Action Committee on AIDS (NACA). (2009 & 2010). *National HIV/AIDS Statistics*. Federal Ministry of Health.
- Obiona E.E. (2008). Exploring the culture context of HIV/AIDS pandemic specific in a Nigerian Community: Implication for culture specific prevention Programmes. *Anthropologist*, 10 (4).
- Odu, B. K. & Akanle, F.F. (2008). Knowledge of HIV/AIDS and sexual Behavior among the Youths in South West Nigeria, *Humanity and Social Science Journal* 3(1), Idosi Publications.
- UNAIDS, WHO, AIDS Epidemic Update: December 2, 2002. *Geneva Joint United Nations Programme on HIV/AIDS*
- United Nations Action on Aids Programme (2006). *Reports on Global HIV/AIDS Epidemic, Genera. Switzerland*.
- USAID, (2009). *Gender-Related Barriers of Post Exposure Prophylaxis (PEP) Policies for Sexual Assault*. Retrieved on 11/11/2011.
- Weinreich, N.D. (2010). *What is Social Marketing?* Social Marketing Institute. <http://www.socialmarketing.org/what-is.html>
- WHO/UNAIDS, (2006). *AIDS Epidemic Update: Special report on HIV/AIDS*.

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