

Original Research Article

CHANGING CITIZENS' NEGATIVE ATTITUDE TOWARDS HIV/AIDS IN NIGERIA: THE POLICY THRUST AND COMMUNICATIONS STRATEGY

ABSTRACT

In this study, the negative attitude of some Nigerians which inhibits a total successful HIV/AIDS campaigns in the country is critically examined. This was motivated by the reported persistent high national prevalence rate of between 5% to 3.6% of this dreaded health problem over the past ten years. The study objectives were to: ascertain the effectiveness of communications' media being used in the HIV/AIDS campaigns in Nigeria; and determine the potency of the health policy in the country as tools for successful HIV/AIDS campaigns. The area of study was PortHarcourt city in the Rivers State of Nigeria, reputed as oil producing State with a high momentum of social life. The main instrument for data collection was structured questionnaire. Likert's 4-points scale and measure of central tendency was used in the presentation and analysis of the data. Results obtained indicate that the communications' media being used in the HIV/AIDS campaigns in Nigeria are quite effective; the health policy thrust in the country is also adequate for successful HIV/AIDS campaigns, however, some socio-cultural and religious factors, depending on the parts of the country inhibits peoples' acceptance of some of the anti-HIV/AIDS messages and products like condom. The study then recommended that school heads, corporate organization heads, religious and community leaders should be used to enhance the success of the campaign against stigmatization of people living with HIV in the country.

Keywords: Stigmatization, HIV/AIDS, Heath Policy, Marketing Communications, Nigeria.

1.1 Background to the study

Nigeria's country report show that HIV prevalence rate as at 2009 records was 3.9%, which is about 5.8million people in a country of over 170million people (CIA.gov, 2009)^[1]. The country is also amongst the list of 20 countries with worst cases of problem in the world and the 3rd largest in terms of population figures (see figure 1 for a clearer picture of this). In a study by Macro International, it was discovered that in spite of the campaigns in Nigeria, only about 10% - 16% of Nigerian girls between ages 15 – 24 use condom, while 46%-55% of their male counterparts do (Macro Internationally, 2009)^[2]. That puts the female population in the country at a greater risk of contracting the infection. According to the 2008 National HIV Sero-prevalence , Nigeria has an HIV prevalence rate of 4.6%. All the 36 states and FCT have HIV prevalence above 1% with 17 states having HIV prevalence greater than 5%.

40 This translates to about 2.95 people (1.2million men and 1.73 million women) living with the
41 virus in the country. The number of new infections is put at 323,000 adults and 57,000
42 children. Infection rates among young people aged 15-19 put at 3.3%; 20-24 at 4.6% and
43 25-29 at 5.6% are considered very high (UNFPA, 2009).^[3]

44 The HIV epidemic in Nigeria is said to be complex and varies widely by region. In some
45 states, the epidemic is more concentrated and driven by high-risk behaviours, while other
46 states have more generalized epidemics that are sustained primarily by multiple sexual
47 partnerships in the general population.

48 Youths and young adults in Nigeria are particularly vulnerable to HIV, with young women at
49 higher risk than young men. There are many risk factors that contribute to the spread of HIV,
50 including prostitution, high-risk practices among itinerant workers, high prevalence
51 of sexually transmitted infections (STI), clandestine high-risk heterosexual and homosexual
52 practices, international trafficking of women, and irregular blood screening (Douek and
53 Roederer, 2009^[4]; Weiss, 1993).^[5] According to UNAIDS (2014)^[6], in 2013 there were
54 around 24.7 million people living with HIV in sub-Saharan Africa. Women accounted for 58%
55 of the total number. There were also an estimated 1.5 million new HIV infections in sub-
56 Saharan Africa in 2013. Sub-Saharan Africa to which Nigeria belongs accounted for almost
57 70% of the global total of new HIV infections in 2013. In sub-Saharan Africa, 1.1 million [1.0
58 million – 1.3 million] people died of AIDS related causes in 2013. Treatment coverage was
59 only 37% of all people living with HIV in sub-Saharan Africa. 67% of men and 57% of women
60 were not receiving ART in sub-Saharan Africa in 2013. In Nigeria 80% of people do not have
61 access to treatment (UNAIDS, 2014)^[7].

62

63 Again, the greatest worry over the whole issue is the heart-rending stigmatisation and social
64 ostracism which people living with HIV/AIDS are saddled with in Nigeria. Some have been
65 banished by their communities, abandoned by their families, excommunicated by their

66 churches or sacked from their jobs, while those trading are refused patronage. Landlords
67 evict some from their homes, while others are shunned in the streets. For instance, a report
68 by the Ireland based Refugees Documentation Centre, Legal Aids Department and the
69 Research Directorate indicates that, in Nigeria, there is a strong stigma associated with
70 HIV/AIDS (This Day, 2008^[8]). The report confirms that the stigmatization and discrimination
71 of people infected by the virus is 'commonplace' in Nigeria. The discrimination is borne out of
72 the fact that both Christians and Muslims in the country see immoral behaviour as being the
73 cause of the HIV/AIDS epidemic. Hence, due to fear of stigmatization, many HIV/AIDS-
74 infected persons refuse being open about their infection (UNGASS, 2008^[9]). This
75 stigmatization and social ostracism consequently prevent many infected persons from
76 seeking medical care, thereby quickening their death, while others die out of frustration,
77 rejection, depression and neglect (International Union for the Scientific Study of Population
78 2005^[10]).

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80 Collaborating, the US Department of State country report on Nigeria also stated that there
81 was widespread discrimination against persons living with HIV/AIDS, which the public
82 consider a disease resulting from immoral behavior. Persons living with HIV/AIDS often lost
83 their jobs or were denied health care services. Public education campaigns have been
84 initiated in the past to reduce stigma and change perceptions of the disease notes the US
85 Department of State Bureau of Democracy, Human Rights, and Labor (2009)^[11], in its 2008
86 Human Rights Report on Nigeria, but these do not seem to have made any significant
87 change. Reports also had it that discrimination and stigmatisation of those with HIV is
88 widespread in Nigeria, especially in the private sector, and this makes it difficult for many to
89 declare their status for fear of losing their jobs (Immigration and Refugee Board of Canada,
90 2007)^[12].

91

The stigma associated with HIV/AIDS is also an important contributory factor to the spread of HIV/AIDS. The association of HIV with sex workers, men having sex with men and beliefs that attribute moral fault to people living with HIV/AIDS all contribute to the impact of stigma and often give rise to intolerance and discrimination. Stigma creates poverty, by turning the individual into an outcast (UNAIDS, 2014)^[13]. All these put to question, the effectiveness of the health policy trust and the communications' strategies used as social marketing tools in the HIV/AIDS campaigns in Nigeria, which is the main focus of this study.

1.2 Statement of the Problem

In spite of the behaviour change campaigns (BCC) in Nigeria, the national HIV prevalence rate had steadily increased from 1.8% in 1991 to 5.8% in 2001 with a decline to 5.0% in 2003 and 4.4% in 2005 and 4.9% in 2014. However, there is wide variation in the prevalence rate across age groups, geographic locations and occupations, due to varied socio-cultural and religious beliefs. 15 states have HIV prevalence rates above the national average of 4.4% with Benue State having the highest prevalence rate of 10%, while Jigawa, Ekiti and Oyo have the least prevalence rates of less than 2.1% (UNAIDS Country Report, 2013)^[14]. Furthermore, a prevalence rate of 5.2% was reported for the age group 15-24 years, with adolescent girls being three times more vulnerable than boys. Although the national average for HIV prevalence rate is 4.4%, Nigeria ranks third globally in terms of actual number of people living with HIV/AIDS, estimated at 3.86 million adults in 2007 (UNGASS, 2007).^[15] Behaviours driving the HIV/AIDS epidemic in the general population are said to include risky sexual behaviour (56.13% of women and men aged 15-49 years reporting having multiple sexual partners), high rate of unsafe sex practices and low condom utilization (35%). This is largely due to high sexual networking and unsafe sex practices (UNFPA, 2009)^[16]. This study is aimed at examining the effectiveness of the health policy thrust and communications' programmes used in the HIV/AIDS campaign in the country so far.

119 1.3 Study Objectives

120 The objectives of the study included:

- 121 i. To ascertain the effectiveness of behaviour change communications media being
122 used as tools for successful HIV/AIDS campaign in Nigeria.
- 123 ii. To determine the potency of health policy thrusts as tools for successful HIV/AIDS
124 campaign in Nigeria.

125 1.4 Methodology

126 Survey research design was adopted for this study. For the area of the study, one
127 (1) Local Government was selected from each of the 36 States in Nigeria. The
128 justification for this selection was to achieve a fairly national representation. The
129 population of the study encompass people in the mobile age group of 15 years to
130 55 years, considered to be more sexually active in the population, and decision
131 makers, health workers and opinion leaders, giving us an estimated population of
132 76,033,000 mathematically deduced from Nigeria's current internationally
133 accepted population of 176 million people. The research frame included:
134 students, travelling traders, civil servants, politicians, drivers, commercial sex
135 workers in the country on one hand; and parents, health workers, community
136 leaders, health policymakers/implementers and school heads on the other hand.
137 The sample size was statistically computed using Taro Yamane's formula at 7%
138 margin of error and 93% level of confidence, giving us 204. The main
139 instrument for data collection was hard copy and electronic questionnaire
140 (Equestionnaire). The hard copies were hand-delivered and hand-collected, while
141 the electronic questionnaire version were via the Internet, especially to some

142 physically inaccessible places. Teachers in secondary schools across the country
143 were used in distributing and collecting the questionnaire. Proportionate criteria
144 was used to allocate the questionnaire to the 36 LGAs. The validity of the survey
145 instrument was done through content-validation, while the reliability was
146 confirmed through test-retest method. The main instrument for primary data
147 collection was structured questionnaire, while Likert's 4-points scale was used in
148 analysing the data.

149 **1.5 Review of Related Literature**

150 A number of theories and models that served as compass for better appreciation of this
151 study include: The transtheoretical Model of Behaviour Change. According to
152 Prochaska (1992)^[17], the transtheoretical model of behaviour change describes how people
153 modify wrong health behaviour or acquire a positive health behaviour. The central notion of
154 the model is the Stages of Change. The model focuses on the decision making of the
155 individual and the emotions, cognitions, and behaviour. It involves a reliance on self-report
156 (Velicer *et al.*, 1985)^[18]. The theory has been used to develop effective interventions to
157 promote health behavior changes in many developed nations.

158 For instance, Velicer *et al* (1998)^[19] pointed out that the model has been applied to a wide
159 variety of health behaviours. These include smoking cessation, exercise, low fat diet,
160 random testing, alcohol abuse, weight control, condom use for HIV protection, organizational
161 change, use of sunscreens to prevent skin cancer, drug abuse, medical compliance,
162 mamography screening, and stress management.

163 The model holds that individuals weigh the pros and cons of accepting any health offering or
164 changing their previous health habits (self-efficacy and temptation: the role of negative affect
165 or emotional distress, positive social situations and craving).

166 According to Prochaska (1992)^[20], this behaviour-change model offers an explanation of the
167 stages through which an individual will progress during a change in health behaviour. This
168 model is particularly associated with notions of 'relapse' behaviour, and has been used

169 widely in HIV/AIDS studies and campaigns. It divides behaviour change into the following
170 stages:

- 171 ▪ Pre-contemplation – lack of awareness of risk, or no intention to change risk
172 behaviour
- 173 ▪ Contemplation – beginning to consider behaviour change without commitment to do
174 anything immediately
- 175 ▪ Preparation – a definite intention to take preventive action in the near future
- 176 ▪ Action – modification of behaviour, environment or cognitive experience to overcome
177 the problem
- 178 ▪ Maintenance – the stabilisation of the new behaviour and avoidance of relapse.
- 179 ▪ This model was used as the basis for the US AIDS Community Demonstration
180 Projects, which targeted five at-risk populations in five US cities. Messages were
181 developed from the experiences of community members to model behaviour-change
182 steps, and messages were developed to target people considered to be at each of these
183 five stages (AIDSmap.com, 2012)^[21]. It imply that although behavioural-skills training is
184 generally a necessary part of an effective HIV-prevention programme, the provision of
185 information, although it does not effect change in itself, can prompt people to think about
186 changing and can help them maintain safer behaviour when they have made changes.

187 Again, the theory of reasoned action and planned behavior on the other hand (Ajzen &
188 Fishbein, 1980^[22]) states that adopting health protection behaviours are usually contingent
189 on (a) the perceived desirability of the behavior (i.e., positive attitudes and expectancies

190 about the behavior) and (b) the normative pressure to engage in the behavior (i.e., social
191 norms). The theory of planned behavior particularly adds that perception that the behavior is
192 easy also helps the individual to adopt it (i.e., perceived behavioral control). Supporting this
193 viewpoint, social–cognitive theory (Bandura, 1982)^[23] assumes that people will engage in
194 protective behaviour when they perceive that they are capable of doing so, because self-
195 efficacy is central to implementing behaviour. Bandura (1989)^[24] posits that people are more
196 likely to perform a behaviour once they acquire relevant knowledge and behavioural skills for
197 it.

198 Fishbein et al., (1992)^[25] observed that all of these theories imply that a number of different
199 intervention strategies must be used to change negative health behaviour to the positive
200 side. Each strategy requires different marketing communications techniques.)

201 HIV is a condition in humans in which progressive failure of the immune system allows life-
202 threatening opportunistic infections and cancers to thrive. Infection with HIV occurs by the
203 transfer of blood, semen, vaginal fluid, pre-ejaculate, or breast milk. Within these bodily
204 fluids, HIV is present as both free virus particles and virus within infected immune cells
205 (Sepkowitz, 200^[26], Kallings, 2008^[27]). In summary, these theories when professionally
206 applied will help health policy makers, planners and implementers in Nigeria, to understand
207 better the socio-psychological factors fertilizing the HIV/AIDS awareness and stigmatization
208 problems in the country and the best communications antidote for addressing the problems.

209 On the other hand, acquired immunodeficiency syndrome (AIDS) is a disease of the
210 human immune system caused by infection with human immunodeficiency
211 virus (HIV). During the initial infection, a person may experience a brief period of influenza-
212 like illness. This is typically followed by a prolonged period without symptoms. As the illness
213 progresses, it interferes more and more with the immune system, making the person much

214 more likely to get infections, including opportunistic infections and tumors that do not usually
215 affect people who have working immune systems (Brookins, 2012)^[28].

216 HIV is transmitted primarily via unprotected sexual intercourse (including anal and even oral
217 sex), contaminated blood transfusions, hypodermic needles, and from mother to child during
218 pregnancy, delivery, or breastfeeding. Some bodily fluids, such as saliva and tears, do not
219 transmit HIV. Prevention of HIV infection, primarily through safe sex and needle-exchange
220 programs, is a key strategy to control the spread of the disease (Sepkowitz, 2001)^[29].

221 There is no cure or vaccine; however, antiretroviral treatment can slow the course of the
222 disease and may lead to a near-normal life expectancy. While antiretroviral treatment
223 reduces the risk of death and complications from the disease, these medications are
224 expensive and may be associated with side effects (Sepkowitz, 2001)^[30].

225 AIDS is considered a pandemic—a disease outbreak which is present over a large area and
226 is actively spreading (Sharp and Hahn, 2011)^[31]. Mindful of its dangers, therefore, a lot of
227 public education and enlightenment campaign are going on in Nigeria to forewarn the
228 masses (Mershark, 2005)^[32]. A number of mass media, outdoor and traditional media of
229 communication are being used to advance the HIV/AIDS awareness campaign in Nigeria
230 and to enlighten the public against discrimination, but with little results in some quarters.

231 Bullmore (2007:3)^[33] defined advertising as any paid-for communication overtly intended to
232 inform and/or influence one or more people. Burnett (2008:17)^[34] says “Advertising says to
233 people, 'Here's what we've got. Here's what it will do for you. Here's how to get it.’ While
234 Ogilvy (2006:43)^[35] says “I do not regard advertising as entertainment or an art form, but as
235 a medium of information.” Thus, advertising is a form of communication used to persuade an
236 audience (viewers, readers or listeners) to take some action with respect to products, ideas,
237 or services. Most commonly, the desired result is to drive consumer/target publics' behavior

238 with respect to an offering. Advertising messages are usually paid for by sponsors and
239 viewed via various traditional media; including mass media such as newspaper, magazines,
240 television commercial, radio advertisement, outdoor advertising or direct mail; or new media
241 such as websites and text messages. This is unarguably one of the most potent tools to be
242 used for a successful rebranding campaign. Examples of above the line media are
243 newspapers, magazines, television , radio, billboards and the Internet (Brookins, 2012)^[36].
244 While examples of below the line advertisement media include direct mail, direct marketing,
245 seminars, workshops, symposia, public lectures, exhibitions and displays (McFarlin,
246 2012)^[37].

247 On the other hand, Squido (2009)^[38] reports that social marketing was “born“ as a discipline
248 in the 1970s, when Philip Kotler and Gerald Zaltman realized that the same marketing
249 principles that were being used to sell products to consumers could be used to “sell” ideas,
250 attitudes and behaviours. Kotler and Andreasen (2005:3)^[39] also see social marketing as
251 differing from other areas of marketing only with respect to the objectives of the marketer
252 and his or her organization. This technique has been used extensively in international health
253 programs, and is being used with more frequency in the United States at the national, state
254 and local levels for such diverse topics as HIV/AIDS, drug abuse, smoking, alcoholism,
255 exercise and human trafficking. So, social marketing has proved a very vital tool in health
256 communication campaigns.

257 Africa traditional media of communication on the other hand are the indigenous means of
258 communication by African community people amongst themselves. It includes
259 communication channels like talking drums, the folk songs, drama, festivals, town
260 criers, traditional wears, the artefacts, art works, paintings, stories, and among
261 others cultural architecture that reflects in the palaces, shrines, and African cities,
262 towns and villages (Ugboaja, 1985^[40]; Osho, 2011^[41]). It is the local means of
263 communication by the rural African people which essentially sustain their information

needs. Oramedia is also the enduring, sustaining and inevitable culture and tradition of the African people (Osho, 2011)^[42]. They are transmitted from one generation to the other. People grew up with them and get accustomed to them in their day-to-day interactions. Oramedia embodies both verbal and non-verbal means of communication and this makes it more appealing, affective, enduring, long-lasting in effect and understandable.

1.6 Data Presentation and Analysis

A report by Indexmundi (2009)^[43], says that in percentage terms Nigeria ranks 17th in Africa in HIV/AIDS Adult Prevalence Rate. But when this is translated to the country's estimated population of about 178million in 2012, that amounts to about 6,000,000 people, thereby putting the country as the third largest in the world in population terms. This is a huge challenge to the country's health initiatives.

The respondents' demographic data in table show that 57.35% of them were male, while 42.65% were female; 19.12% were in the age bracket of 21 to 30 years, 32.84% in the age range of 31 to 40 years; 25.98% in the age range of 41 to 50 years, while 22.06% were 50 years or above. 11.27% had only O'Levels qualifications, 23.04% had National Diplomas or equivalents, 38.73% had 1st Degrees, while 26.96% had Masters or Ph.Ds.

This part is based on 4-points Likert scale for the analysis.

Decision Rule

Reject, if Mean < 2.50 (Reject if Mean is equal to or less than 2.49).

Accept, if Mean > 2.50 (Accept, if Mean is equal to or greater than 2.50).

Test of Objective 1: To ascertain the effectiveness of behaviour change communications media being used as tools for successful HIV/AIDS campaigns and anti-stigmatization in Nigeria.

S/N	Questions	SA	A	D	SD	Mean	Decision
1	Communications above-the-line media tools of radio and televisions used were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria	86 (344)	103 (309)	10 (20)	5 (5)	3.32	Agreed
2	Communications above-the-line media tools of newspapers and magazines used were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria	51 (204)	127 (381)	15 (30)	11 (11)	3.07	Agreed
3	Communications above-the-line media tools of billboards and Internet were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria	49 (196)	135 (405)	12 (24)	8 (8)	3.10	Agreed
4	Communications below-the-line media tools of direct mails, door to door visitations and churches/market place visitations were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria	71 (284)	111 (333)	17 (34)	5 (5)	3.22	Agreed
5	Communications below-the-line media tools of public lectures and displays were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria	62 (248)	83 (249)	28 (56)	30 (30)	2.86	Agreed
6	Communications below-the-line media tools of seminars, workshops and symposia were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria	60 (240)	101 (303)	19 (38)	24 (24)	2.97	Agreed
	Grand Mean = 3.09					3.09	Agreed

291 **Source: Field Survey, 2014.**

292 Data displayed on table 3 above indicate that with a cumulative Grand Mean of 3.09, this
293 indicates a rejection of the null-hypothesis and acceptance of the alternative hypothesis that
294 the behaviour-change communications' media used as tools for the HIV/AIDS campaign in
295 Nigeria were significantly effective.

296

297 **Table 4: Test of Hypothesis 2:** To determine the potency of health policy thrusts as tools

298 for successful HIV/AIDS campaign in Nigeria.

S/N	Questions	SA	A	D	SD	Mean	Decision
7	The health policy programmes in place are significantly adequate	64 (256)	86 (258)	19 (38)	35 (35)	2.88	Agreed
8	The health policy programmes in place are quite anti-HIV	65 (260)	79 (237)	31 (62)	29 (29)	2.88	Agreed
	Grand Mean = 2.88					2.88	Agreed

Source: Field Survey, 2014.

Data displayed on table 4 reflect that 150 respondents agreed that the health policy programmes in place in Nigeria are quite adequate and significantly potent as tools for successful HIV/AIDS campaign in the country. With a Grand Mean of 2.88, this indicates a rejection of the null-hypothesis and acceptance of the alternative hypothesis.

1.7 Summary of Result

After the secondary and primary data analysis, the following results were obtained:

- i. Communications media tools of radio and televisions used were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria.
- ii. Communications media tools of newspapers and magazines used were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria.
- iii. Communications media tools of billboards and Internet were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria
- iv. Communications media tools of direct mails, door to door visitations and churches/market place visitations were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria.
- v. Communications media tools of public lectures and displays were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria.
- vi. Communications media tools of seminars, workshops and symposia were significantly potent as tools for successful HIV/AIDS campaigns in Nigeria.
- vii. The behaviour-change communications' media used as tools for successful HIV/AIDS campaign in Nigeria were also significantly effective.

viii. The health policy programmes in place were significantly potent as tools for successful HIV/AIDS campaign in Nigeria.

1.8 Discussion

This study revealed that the communications media tools of radio and televisions, newspapers and magazines, billboards and Internet, public lectures and displays, seminars, workshops and symposia, direct mails, door to door visitations and churches/market place visitations, used were significantly effective as tools for successful HIV/AIDS campaigns in Nigeria. Unfortunately, however, it could be seen that the effectiveness was more in the reduction of HIV prevalence amongst the populace, but, have not done much in the area of reducing stigmatization attacks against the victims. Consequently, this stigmatization worsens the HIV prevalence rate, by fuelling acts of denials and making people afraid to go and ascertain their HIV status, or even go for treatment or counseling when they do.

The study also revealed that the health policy programmes in place were significantly potent as tools for successful HIV/AIDS campaign in Nigeria. However, a greater quantum of this policy, resources, time and efforts are devoted towards HIV prevention and treatment, while little is done about cares, well-being and citizens' treatment of the people living with HIV/AIDS which has largely remained in the negative.

In a new national survey conducted by the federal government for the 2012 National HIV/AIDS and Reproductive Health Survey-Plus (NARHS Plus), it was reported that Nigeria's HIV/AIDS prevalence rate dropped to 3.4 per

cent in 2012. However, a State by State analysis shows that some of the States in the country are still within the dangerous rates of above 10% of their population. For instance, Rivers State leads other states in the country with a prevalence rate of 15.2 per cent. Taraba State ranked second with a prevalence rate of 10.5 per cent; followed by Kaduna State with 9.2 per cent. Nasarawa State has 8.1 per cent while the Federal Capital Territory (FCT) 7.5 per cent. Ekiti State however has the least prevalence rate of 0.2 per cent, Zamfara 0.4 per cent, Bauchi 0.6 per cent and Ogun 0.6per cent.

The Federal and State Governments in conjunction with international and local NGOs have been doing a lot to surmount the scourge. For instance, under the National Action Committee on AIDS (NACA) programmes people are counselled nationwide, in collaboration with development partners. In collaboration with UNICEF, 50 religious leaders were trained as master trainers for HIV counseling; 200 health workers were trained on the Prevention of Mother to Child Transmission (PMTCT) in 2013. HIV Counseling and Testing sites are being set up all over the country. However, one problem that seems to have defied all solutions is the problem of stigmatisation and social ostracism of people living with HIV/ AIDS. This calls to attention, a revisit and review of the social-marketing strategy being used to achieve a positive behaviour-change amongst the citizens, through an injection of more traditional and culture-centred techniques.

1.9 Conclusion

Millions of lives are being lost globally from the HIV/AIDS pandemic. This very health problem constitutes a drain to many countries' lean financial resources, especially in Sub-Saharan Africa with poor economic bases. Preventive medicine is the best answer

to the problem, through well-planned, multi-media social communications' campaigns designed to improve public awareness over the problems as this study testifies.

1.10 Recommendations

A combination of conventional media and traditional communications media should be used to enhance the success of the HIV/AIDS social marketing campaign in Nigeria.

Particular emphasis and priority should be given to the use of traditional media (oramedia) in order to effectively reach the country's rural people that constitute over 70% of the population.

Health policy and communications experts should be involved in the packaging and execution of the social marketing programme initiatives.

All the relevant stakeholders and opinion leaders in the country like traditional rulers, religious leaders, students' union leaders, town union leaders, market association leaders, heads of schools/institutions and professional association leaders should be carried along in the campaigns.

The social marketing campaigns should also inculcate messages aimed at educating the populace to stop the stigmatisation of people living with HIV, in order to reduce the problem of denials amongst the populace.

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