Social Marketing Communications on AIDS: Views of Implementers in Ghana

Ernest Yaw Tweneboah-Koduah
University of Ghana

Nana Owusu-Frimpong
Ghana Institute of Management and Public Administration

Purpose of research: *This research contributes to social marketing literature by applying theories of behaviour change to social marketing intervention programmes on HIV/AIDS in Ghana.* ***Design:*** *A qualitative research method was employed to help understand the views of social marketing implementers in Ghana. The qualitative data analytic procedure is reported in a connected narrative approach, and all interviews were transcribed and analysed using thematic analyses.* ***Findings:*** *The implementers of social marketing intervention programmes on HIV/AIDS in Ghana do not utilise behavioural change theories/models. The authors recommend that social marketing professionals in Ghana should take steps to understand the relevance and application of behavioural change theories to design better intervention programmes tailored to the needs of Ghanaians.* ***Limitations:*** *This study is limited to only implementers of social marketing intervention programmes. Therefore, future research should seek to understand the views of people the implementers seek to change their behaviour.*

INTRODUCTION

The overwhelming majority of people with HIV live in Sub-Saharan African countries. The region has just over 10% of the world's population, but is home to 68% of all people living with HIV. The first case of AIDS in Ghana was diagnosed in 1986 and by the year 2004, approximately 400,000 Ghanaians were estimated to be HIV-positive (UNAIDS, 2004). In Ghana, the most recent sentinel surveillance done in 2011 indicated a national median HIV prevalence of 2.2% (GAC, 2012). The trend in the national median HIV prevalence in Ghana since 2000, shows that there has not been consistent decline of HIV prevalence in the country. The highest prevalence rate was recorded among the 40-45 age group in 2009, and 30-34 in 2011, of which 77% of those who died of AIDS in Ghana fall within the 15-49 age group (GAC, 2012). This is very worrying since the bulk of the nation's active human resource base fall into this age group (NACP, 2009). Since the search for drugs to reduce HIV new infections still continues and funding for Ghana's health sector continues to dwindle (GHS, 2009), Ghana needs to develop effective social marketing intervention programmes (SMI) to change HIV/AIDS-related behaviours.

LITERATURE REVIEW

Kotler and Lee (2008) define social marketing as a process that applies marketing principles and techniques to create, communicate, and deliver value in order to influence target audience behaviours that benefit society as well as the target audience. French, Fishbein (2000) argues that although there have been enormous progress in prolonging and improving the quality of life of those infected with HIV, there is still neither a cure for, nor a vaccine to prevent this disease. He asserts perhaps, and most importantly, that it has become increasingly clear that preventing the transmission and acquisition of HIV must focus upon behaviour and behaviour change. French et al., (2010) indicate that having an understanding of the use of theory (particularly behavioural theory) is important, as it can strengthen and enhance the development and delivery of SMI and, therefore, ultimately improve and strengthen their potential impact and effectiveness. Fraze et al., (2007), Maibach et al., (2002), and Thackeray and Neiger (2000) also posit that behavioural change theories can help social marketers to efficiently plan campaigns by adding theory-based campaign elements in addition to the social marketing framework. Kotler and Lee (2008) conclude that information on target audience, barrier, benefits, and competition will help deepen understanding but may not lead to behaviour change. It is, therefore, imperative to understand underlying behaviour change theories. Glanz et al., (2008) assert that a social marketing professional who understands the relevance of theory may be able to design better interventions tailored to the needs of his/her target audience. McDermott et al., (2005) conclude that the key defining features of social marketing approach - which include identifying a clear target group and tailoring the approach to match their requirements, removing the competition to behaviour change and emphasising the benefits - were often missing in most social marketing programmes. Andreasen, (1995) indicates that mass approaches are often ineffective because they must inevitably be too broad to speak to anyone in any great specificity.

Fisbein and Cappella, (2006) and Morris and Clarkson, (2009) state that although an investigator can sit in her or his office and develop measures of attitudes, perceived norms, and self-efficacy, she or he cannot tell what a given population (or a given person) believes about performing a given behaviour. Thus, ultimately, one must go to members of that population to identify salient outcome and normative and efficacy beliefs. Once understood in this way, these beliefs can serve as the basis for messages and other interventions that can have an impact on the target behaviour through the mediating mechanisms (Weinstein et al., 2007; Kotler and Lee, 2008). McFadyen et al., (2003) state that social marketing provides a strategic planning framework comprising consumer research, segmentation and targeting, objectives setting and manipulation of the marketing mix may be able to design better interventions tailored to the needs of his/her target audience. In social marketing intervention programmes tailored to different populations to promote male circumcision in Johannesburg, Bridges et al., (2010) conclude that researching actual community perceptions prior to the implementation of social marketing campaign is critical, especially, with interventions which are culturally charged and physically invasive as HIV/AIDS testing and counselling.

Morris and Clarkson (2009) recommend that social marketing strategy must provide an environment that facilitates desired behaviour and removes or reduces competition. This process involves several steps and starts with understanding of the existing knowledge, attitudes and behaviour as well as the nature of competition (Morris and Clarkson, 2009). The extant literature suggests that lack of time (Lang et al. 2007) and lack of resources (financial and human resources) generally are a commonly cited explanation for lack of change (Lang, et al. 2007; Taylor and Beswick, 2005) by implementers and these cannot be resolved at the individual implementer level. Many of the issues identified as challenges to change at the implementers' level are, in fact, well beyond their control and require responses at a higher level (Gurses, et al. 2008). The current debate in social marketing literature, therefore, suggests that social marketers should not only use the intervention mix (4Ps) to influence only the downstream. Rather, they should also seek to influence the upstream (politicians and private sector) to help them overcome most of these challenges (Andreasen, 2006). Social marketing professionals and researchers have over the years addressed the challenges that social marketers have in creating campaigns that adequately addressed AIDS (Andreasen, 2001, 2006; Kotler, Roberto, & Lee, 2002). Social Marketing professionals once might

have seen their roles as working at a particular level of intention or employing a specific type of behaviour change strategy, it is now realised that multiple interventions at multiple levels are often needed to initiate and sustain behaviour change effectively (Glanz, et al., 2008). Niblett (2005) asserts that to achieve social marketing programme objectives, the interventions often create new awareness and new attitudes that facilitate change in the form of action. Strand et al. (2004) posit that social marketers are good at delivering ideas, creating awareness and positive attitudes and developing branding and position. However, there is a huge disconnect in converting that increased awareness and attitude change into behaviour change. Andreasen (2006) indicates that in this 21st century, an audience-centred social marketer thinks that if an intervention is not successful, it is not the target audience's fault. It is quite probable that the social marketer does not understand the audience well enough to create effective strategies.

Social marketing emphasises the need for campaign implementers to understand the people they hope to persuade and engage (Stead et al., 2007). In other words, using scientific methods to determine who the target audience is, what they know, how they behave, and what their attitudes, beliefs, and emotions are regarding campaign issues, is the first component of a social marketing program (Stead et al., 2007). Although social marketing experts have indicated a need to apply theories to optimize campaign effectiveness by implementers, the available data suggest that the utilisation of behavioural change theories/models in social marketing communications on HIV/AIDS in Ghana is limited. To fill this gap, this research seeks to determine the nature and extent of SMI on HIV/AIDS in Ghana, understand the views of implementers on social marketing intervention programmes and how they could employ theories of behaviour change to design effective social marketing campaigns for HIV/AIDS preventions in Ghana.

METHODOLOGY

A qualitative research method was employed to help understand the views of social marketing implementers in Ghana. An in-depth interview of two (2) directors each from Ghana Social Marketing Foundation, Ghana AIDS Commission, and National AIDS Control Programme were conducted. All the institutions charged with the responsibilities of designing and implementing SMI programmes on HIV/AIDS were contacted but one did not cooperate leaving us with the three institutions mentioned above. The qualitative data analytic procedure is reported in a connected narrative approach (Misler, 1990), and all interviews were transcribed and analysed using thematic analyses (Braun and Clark, 2006). This research adopts thematic analysis because it is widely-used in health education and promotion (Matthews and Ross, 2010), it offers an accessible and theoretically-flexible approach to analysing qualitative data that allow researchers to identify and analyse the main themes of data collected (Braun and Clark, 2006).

RESEARCH FINDINGS AND DISCUSSION

This section provides analysis for an in-depth interview of 6 directors from the institutions charged with the responsibilities of developing and implementation of social marketing intervention programmes on HIV/AIDS in Ghana.

TYPES AND OBJECTIVES OF SOCIAL MARKETING INTERVENTIONS ON HIV/AIDS IN GHANA

When asked to describe the objectives the implementers seek to achieve with social marketing intervention programmes, all the respondents indicated that the objectives of SMI on HIV/AIDS in Ghana are mainly to: (i) provide testing and counselling facilities and encourage people to know their HIV/AIDS status, (ii) encourage condom usage, (iii) reduce stigmatisation and discrimination among people living with HIV/AIDS, (iv) prevent mother-to-child transmission and (v) promote abstinence and faithfulness to one mutual partner, and create awareness on antiretroviral therapy. These findings are consistent with

McFadyen et al., (2003). Based on the findings above, the authors argue that the implementers of social marketing intervention programmes on HIV/AIDS in Ghana are in the right direction for identifying the behavioural goals they seek to achieve with their interventions.

All the directors interviewed revealed that the major challenge facing them is how to get people to know their HIV/AIDS status. This collaborates with the work of Strand et al. (2004) which conclude that social marketers are good at delivering ideas, creating awareness and positive attitudes and developing branding and position. However, there is a huge disconnect in converting this increased awareness and attitude change into behaviour change. Andreasen (2006) indicates that in this 21st century, an audience-centred social marketer thinks that if an intervention is not successful, it is not the target audience's fault. It is quite probable that the social marketer does not understand the audience well enough to create effective strategies. Based on the above findings, the authors posit that implementers of SMI on HIV/AIDS in Ghana must take steps to understand why the targeted population have not taken action to know their HIV status.

When asked to describe the nature of social marketing intervention programmes on HIV/AIDS, the response from a director of Ghana AIDS Commission shows the frustrations of the implementers as follows:

> "We have those that relate to services and those that relate to commodities like condoms, so taking services as an example, we have put in place a number of services for prevention, for care and treatment. For example a key service is testing and counselling. Now in this country only few, less than 10% of the population have tested for HIV which is very low. Meanwhile we have the testing facility in all health care facilities in the country so the question is why people are not accessing HIV testing facilities? What we believe to be the answer is the issue of stigmatisation. People feel that first if they get to know their HIV status, it might hasten their death. Secondly, some think that other people will get to know and they will be socially stigmatized. So mainly the testing we see in the hospital setting is more of diagnostic where people walk in after taking his/her problem and realizing that probably he/she might have something to do with HIV infection then they are asked to do the test. Sometimes you have young couples who want to marry and the church demands that they do HIV test. To see people on voluntary bases for testing is quiet limited but that is an area which is very critical for reducing HIV infection".

When asked why recent strategies/programmes have focussed much attention on HIV testing and counselling instead of their traditional ABC (Abstinence, Be faithful, and Condom usage) approach? A response from one of the directors at National AIDS Control Programme explains as follows:

> "AIDS is the disease stage so as much as we get people getting tested to know their status, they would not get sick only for them to go to the hospital then after everything has been done and the doctors can't find the cause, they tell them to go and do an HIV antibody test. By that time they would have reached the AIDS stage but if we sensitise them and they get tested early, then of course they will know they are HIV positive. At this early stage, they will be monitored and when they are due for their drug it will be given to them and they wouldn't even move to the AIDS stage. So that is the essence with all the noise going round *so that people will be aware of what is going on, go out there get tested".*

TARGETS FOR SOCIAL MARKETING INTERVENTION PROGRAMMES ON HIV/AIDS

Regarding the targeting of social marketing intervention programmes, the result reveals that all the implementers of social marketing intervention programmes on HIV/AIDS target the entire Ghanaian population. Though four of the directors interviewed recognise the difference in prevalence among some

groups and districts in Ghana, they do not design tailor-made intervention strategies/programmes for any particular group with the explanation that they do not see any significant difference between Ghanaians. When asked whether they have different intervention programmes for different target groups, the response provided by a director of Ghana National AIDS Control Programme affirmed majority position in their responses as follows:

> "Human beings are complex, but there are cross-cutting things which are fundamental which would affect everyone irrespective of who they are. It's only some tiny differences that you need to cater for. But in doing this, you will take a lot of things into consideration. Practically, one needs to do cost and benefits analysis. If we try to come up with different things for different target groups it may not be cost effective, in fact our resources would not even allow for that so we look at what is common and try to adapt. We would not tailor our messages to specific theory of behaviour models to influence different target audience because we realise that there are certain common things that run through the Ghanaian population".

When probed further whether the implementers intend to design tailor-made interventions for areas with high HIV/AIDS prevalence, majority indicated that they have no intention of doing that. The responses below by two directors at Ghana Social marketing foundation and Ghana National AIDS Control programme summarises the views of most implementers.

> "We don't because that is part of stigmatising and demographically or location specific things". "I told you that studying people behaviour would not produce any positive result that suggests to us that there are significant differences in behaviour across the country. So once you have that evidence what do you do with it? You don't have to necessarily move resources because you've noticed some individual change. They may not be significant, you know, statistically when you are doing social science, you rather move with statistical findings and conclusions. Though there are those differences, when we do the analysis it doesn't give us any impression that they are very significantly different and therefore by sight to sight we may not necessarily come out with something unique for let's say Agomanya as compared to let's say somewhere in Tarkwa".

However, two other directors from Ghana AIDS Commission shared a different opinion on the issue and indicated that they segment the population for different programmes. One of them provided the following response.

> "We target the general population but we segment the population. We have youth, we have women, we have children, the aged then we have sex workers, men who have sex with men even youth we break them into various groups. We have programmes for basic level students and when you take tertiary institutions they have a different package of programme. Out of school children also have their package of programme. So everybody is targeted but the information is organised in a way to meet the specific needs of the various segments of the population".

It was interesting to note from further discussions that even though, they target every segment of the population, they do not design a single social marketing intervention programme on HIV/AIDS to meet the specific needs of segments identified. Rather, they organised their interventions in a way to meet the needs of the various segments of the population. They sometimes communicate SMI in different native languages for some tribes in Ghana but with the same content. A director from Ghana National AIDS

Control Programme was worried about their inability to design tailor-made interventions and laments as follows:

> "Maybe I will start with my challenge; for me my challenge you know like I said earlier on is that we need to know our target group to tailor-made whatever information that goes to them, so where it's not tailor-made, it's like blanket something, like one cup fits all and it becomes a challenge. We think we are doing much but we end up not yielding much result because a generalised intervention might not go down well with everyone. That is my greatest challenge".

This confirms the research findings of McDermott et al., (2005) which conclude that the key defining features of social marketing approach - which include identifying a clear target group and tailoring the approach to match their requirements, removing the competition to behaviour change and emphasising the benefits - were often missing in most social marketing programmes. However, the findings of this research are inconsistent with the benchmarks of social marketing (Andreasen, 1995)

Regarding research findings to design effective social marketing intervention programmes on HIV/AIDS, the result found that most implementers utilise research findings to help them know what is happening in terms of the epidemiology; how many people are infected between the general population, who is being infected, what is the source of the infection and what are the barriers to change- for instance, what are preventing people from using condom. These findings collaborate with the conclusions of many (eg. Fisbein and Cappella, 2006; Morris and Clarkson, 2009) researchers who state that although an investigator can sit in her or his office and develop measures of attitudes, perceived norms, and self-efficacy, she or he cannot tell what a given population (or a given person) believes about performing a given behaviour. Thus, ultimately, one must go to members of that population to identify salient outcome and normative and efficacy beliefs. Once understood in this way, these beliefs can serve as the basis for messages and other interventions that can have an impact on the target behaviour through the mediating mechanisms (Weinstein et al., 2008; Kotler and Lee, 2008).

When asked whether the implementers utilise some theoretical models to aid their design of SMI on HIV/AIDS, majority indicated that they do not employ such models. Two of them were quick to mention that they apply behavioural change models in designing their interventions but they were unable to describe the type of models employed. This suggests that most implementers of SMI on HIV/AIDS in Ghana do not employ behavioural change theories/models in planning their interventions irrespective of the fact that the existing literature indicates their usefulness in enhancing the effectiveness of any intervention. This is not consistent with the current argument for designing effective social marketing intervention programmes. Kotler and Lee (2008) conclude that information on target audience, barrier, benefits, and competition will help deepen understanding but may not lead to behaviour change. It is, therefore, imperative to understand underlying behaviour change theories. Glanz, et al., (2008) assert that a social marketing professional who understands the relevance of theory may be able to design better interventions tailored to the needs of his/her target audience. The authors contend that implementers of social marketing intervention programmes on HIV/AIDS in Ghana should understand and utilise behavioural change theory if they wish to design effective intervention programmes.

ENVIRONMENTAL FACTORS THAT HINDER THE ADOPTION OF SOCIAL MARKETING PROGRAMMES ON HIV/AIDS

The result reveals many economic and socio-cultural factors that could prevent Ghanaians from adopting social marketing recommendations on HIV/AIDS. In most cultures in Ghana, women do not discuss sexual issues with their partners. For this reason, women are rarely able to ask their partners to use condoms. The implementers are also of the view that fear of dying early for knowing one's HIV status and stigmatisation have prevented many for going in for HIV test. The implementers were also worried that people do not report rape cases which are major source of getting infected with HIV because they feel

they will be stigmatised or no one will marry them if it becomes public notice that they have been raped. Three of the directors interviewed see religion as one of the factors preventing some Ghanaians to adopt SMI on HIV/AIDS. They explained further that some religious groups in Ghana for instance do not understand why implementers should encourage people who are not married to use condom. Some believe that by encouraging homosexuals and young people who are not married to use condom or keep to one sexual partner, the implementers are leading them down to the moral turpitudinal road and therefore, there are people who object to what the implementers are doing. All the implementers mention economic factor as a major driving for preventing the adoption of social marketing recommendations on HIV/AIDS. An example from a director of Social Marketing Foundation describes the themes indentified from all the responses.

> "Economic factor in our part of the world is one of the driving forces. Students in the universities might know that it might not be too good to have sexual relationship with more than one man but for some they need to pay for their tuition fees, accommodation, buy credit for their mobile phones etc. Now she will think of the immediate consequences of being sacked from school or ejected from her room rather than looking at medium term/ long term of having HIV which might cripple her and kill her eventually and slip to the other side".

The director in question further cautioned and provided suggestions for Ghanaian environment to be conducive for SMI on HIV/AIDS.

> "Awareness alone cannot change people's behaviour if the environment doesn't support them. I think interventions have to be sustained for a longer time and more work has to be done on making the environment supportive of that change at the individual level".

The findings about existing factors preventing the adoption of SMI on HIV/AIDS by Ghanaians are consistent with a number of research conclusions in social marketing research. Morris and Clarkson (2009) recommend that social marketing strategy must provide an environment that facilitates desired behaviour and removes or reduces competition. This process involves several steps and starts with understanding of the existing knowledge, attitudes and behaviour as well as the nature of competition (Morris and Clarkson, 2009).

CHALLENGES IN IMPLEMENTATION OF SOCIAL MARKETING INTERVENTION PROGRAMMES

When asked to describe the challenges in implementation of social marketing intervention programmes, all the implementers indicate the following as the main challenges confronting them in their attempt to reduce new HIV infections: the donors of the social marketing intervention programmes on HIV are demanding tailor-made interventions as against the generalised interventions. They also indicated lack of adequate financing, health system barriers, procurement delays that sometimes lead to shortages of condoms and antiretroviral drugs, limitation of human resources, and media misrepresenting information on HIV/AIDS. The response below by a director from Ghana National AIDS Control Programme describes what implementers of SMI on HIV/AIDS see as health system barriers.

> "There are health system barriers; what we are doing may not necessarily be the priority, because the health sector has malaria, tuberculosis, HIV/AIDS and other diseases to deal with. Even if we see HIV/AIDS very serious they cannot abandon everything and come to us".

These findings are consistent with the extant literature which suggests that lack of time (Grol, et al. 2003; Lang et al. 2007) and lack of resources (financial and human resources) generally are a commonly cited explanation for lack of change (Jibawi, et al. 2008; Lang, et al. 2007; Taylor and Beswick, 2005) by implementers and these cannot be resolved at the individual implementer level. Many of the issues identified as challenges to change at the implementers' level are, in fact, well beyond their control and require responses at a higher level (Gurses, et al. 2008). The current debate in social marketing literature, therefore, suggests that social marketers should not only use the intervention mix (4Ps) to influence only the downstream. Rather, they should also seek to influence the upstream (politicians and private sector) to help them overcome most of these challenges (Andreasen, 2006).

EXTENT/COVERAGE OF SOCIAL MARKETING INTERVENTIONS ON HIV/AIDS

On the extent or coverage of SMI on HIV/AIDS in Ghana, all the directors interviewed assert that the coverage is nationwide. In other words, every Ghanaian has the opportunity of hearing/seeing SMI on HIV/AIDS irrespective of the location of the individual. However, some residents in Ghana might not receive the interventions on HIV/AIDS due to their inability to access some mediums of communications. It was clear from the responses that all the implementers have, national, regional, district, and sub district coordinators. The explanations provided by directors at Ghana AIDS Commission and National AIDS Control Programme summarise the main themes identified through the in-depth interview.

> "We are at the national level; our duty is to train counsellors as well as trainees, and these are from the 10 regions in Ghana. So whatever is done in greater Accra, it's the same that is done in the northern region, upper east or upper west. We have programme managers and they are the national officers and when you go to the regional level, we have regional trainers as well as regional counsellors. And it's not just the regional level, they are at the districts and the sub districts, even at the CHIP (community Health Post) zones."

> "I will say the whole country, National even up to district and sub district level. In the Ghana health service structure we go as far as the CHIP zones the lowest level. The rest I think will be determined by the person access to the media. Our interventions run on some of the media, so if you are in the country and you don't have access to television, then you will not get it. But we will try to carefully choose, for instance Ghana Television (GTV) which has a wider coverage".

The implementers indicated that although the awareness of HIV prevention among general populations is high, this knowledge has not adequately been translated to behavioural change. This is consistent with the conclusion of Strand et al. (2004). The authors postulate that the high awareness on HIV/AIDS is not associated with behaviour change because of the inabilities of the implementers to utilise behavioural change theory(s) and design tailor made interventions. Until they move from generalised to targeted interventions, they should not expect any positive impact on the behaviour of Ghanaians. It is important for implementers to understand the perceptions of Ghanaians if they want their interventions to have impact on their behaviours.

On the effectiveness of the various platforms for communicating SMI on HIV/AIDS in Ghana, all the respondents came to a conclusion that even though they use the available media, through research they have come to the realisation that the most effective of all the available mediums are radio and television.

PERCEPTION OF GHANAIANS ON HIV/AIDS

The thematic analysis found the following as the general perception of Ghanaians on HIV/AIDS. (1) Some Ghanaians still believe that HIV it's transmitted by supernatural powers, (2) Some still believe that is transmitted through mosquito bites, (3) some believe that when you urinate behind somebody's house

without permission or sleep with somebody's wife you will get HIV, (4) some people also believe that HIV/AIDS is religious, it is God-sent, it's a punishment or a curse from God because of that people prefer going to prayer camps instead of getting treatment from hospitals, (5) they believe that HIV is a death sentence, when you acquire HIV, it means you are dying or you will die soon, (6) for the youth some think that HIV is far away from them, (7) some think that AIDS is not a dangerous disease because one could live with it for a long period of time and (8) some believe in the social marketing recommendations on HIV/AIDS as means of preventing the epidemic. Researching and understanding the perceptions of Ghanaians on HIV/AIDS is consistent with Bridges et al., (2010). The authors assert that to influence Ghanaians to adopt recommendations of social marketing intervention programmes on HIV/AIDS, it is imperative that implementers address all the negative perceptions on HIV/AIDS.

CONCLUSIONS AND MANAGERIAL IMPLICATIONS

First, the research concludes that implementers of social marketing intervention programmes on HIV/AIDS target the entire Ghanaian population and do not design tailor-made intervention strategies/programmes for any particular group, not even for areas with high HIV/AIDS prevalence in Ghana. Though the implementers do research to understand their targeted population, they do not tailor made their interventions to suit their audience. The managerial implication is that getting customer insight through research by implementers and not utilising the information to design a tailor made interventions will render the interventions ineffective. Therefore, to design effective SMI programmes on HIV/AIDS in Ghana, the implementers should target different segments of the Ghanaian population with tailor-made interventions since mass approaches are often ineffective and inevitably, too broad to speak to anyone in any great specificity. The criteria of segments selection could be based on prevalence of the disease, significant difference between Ghanaians, and implementers' ability to reach the audience.

Second, on employing behavioural change theories to plan HIV/AIDS intervention programmes, the research concludes that implementers of social marketing intervention programmes on HIV/AIDS in Ghana do not utilise behavioural change theories/models. The authors recommend that social marketing professionals in Ghana should take steps to understand the relevance and application of behavioural change theories to design better intervention programmes tailored to the needs of Ghanaians. This will sustain the interest of their financiers who are interested in financing tailor-made interventions.

Third, regarding challenges confronting implementers of SMI programmes on HIV/AIDS in Ghana, the research found many challenges. The managerial implication is that, the challenges could limit the implementers from fulfilling their mandates assigned to them by Ghana government. However, many of the issues identified as challenges to change at the implementers' level are, in fact, well beyond their control and require responses at a higher level. Therefore, the authors recommend that implementers should not only use SMI programmes to influence the downstream (individuals) to change their HIV/AIDS related behaviours. Rather, they should also seek to influence the upstream (policy makers, politicians, organisations and community leaders) to help them overcome most of the challenges.

Finally, the research found that majority of implementers are of the view that most Ghanaians have seen or heard SMI on HIV/AIDS. However, SMI programmes designed to change HIV/AIDS related behaviours of Ghanaians have, generally, been ineffective. The managerial implication is that if an intervention is not successful, it is not the target audience's fault. It is quite probable that the implementers do not understand Ghanaians well enough to create effective strategies. Therefore, implementers of social marketing intervention programmes on HIV/AIDS in Ghana should ascertain why most Ghanaians have not taken action to know their HIV status, for instance. This can be done by utilising research findings and application of behavioural change theories to design intervention programmes on HIV/AIDS to convert increased awareness and attitude change into behaviour change. This study is limited to only implementers of social marketing intervention programmes. Therefore, future research should seek to understand the views of people the implementers seek to change their behaviour.

REFERENCES

Andreasen, A. R. (1995). *Marketing Social Change: Changing Behaviour to Promote Health, Social Development, and the Environment.* A Wiley Imprint, 989 Market Street, San Francisco, CA 94103-1741.

Andreasen, A. R. (2001). *Ethnics in Social Marketing.* Washington, DC: Georgetown University Press.

Andreasen, A. R. (2006). *Social Marketing in the 21st Century*. Thousand Oaks, CA: 91320, Sage.

Braun, V. & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Bridges, J. F. P., Searle, S. C., Selck, F. W., & Martinson, N. A. (2010). Engaging Families in the Choice of Social Marketing Strategies for Male Circumcision Services in Johannesburg, South Africa. *Social Marketing Quarterly*, 16(3), 60-76.

Fishbein, M. (2000). The Role of Theory in HIV Prevention. AIDS Care, 12, 273-278.

Fishbein, M. & Cappella, J. N. (2006). The Role of Theory in Developing Effective Health Communications. *Journal of Communication,* 56, S1-S17.

Fraze, J. L, Rivera-Trudeau, M, McElroy, L. (2007). Applying Behavioural Theories to a Social Marketing Campaign. *Social Marketing Quarterly*, 13 (1), 2-14.

French J. & Blair-Stevens, C. (2010). *Key Concepts and Principles of Social Marketing*. In J. French, C. Blair-Stevens, D. McVey and R. Merritt (eds), Social Marketing and Public Health: Theory and Practice, Oxford University Press, Great Clarendon St. Oxford OX2 6DP.

Ghana AIDS Commission (2012). Ghana Country AIDS Progress Report.

Ghana Health Service (2009). Annual Report, Accra, Ghana.

Glanz, K., Rimer, B.K., & Viswanath, K. (2008). Health Behaviour and Health Education: Theory. Research and Practice. A Wiley Imprint, 989 Market Street, San Francisco, CA 94103-1741.

Gurses, A. P., Seidl, K .L., Vaidya ,V., Bochicchio, G., Harris, A. D., Hebden, J., & Xiao, Y. (2008). Systems Ambiguity and Guideline Compliance: A Qualitative Study of how Intensive Care Units Follow Evidence-Based Guidelines to Reduce Healthcare - Associated Infections. *Quality and Safety in Health Care*, 17(5), 351–359.

Kotler, P. & Lee, N. R. (2008). *Social Marketing: Influencing Behaviours for Good* (3rd Ed). Sage Publication, Inc. 2455 Teller Road. Thousand Oaks, California 91320.

Kotler, P., Roberto N. & Lee, N. (2002). *Social Marketing: Improving the Quality of Life*. Thousand Oaks, CA: Sage.

Lang, E.S., Wyer, P. C. & Haynes, R. B. (2007). Knowledge Translation: Closing the Evidence-to-Practice Gap. *Annals of Emergency Medicine*; 49(3), 355–63.

Maibach, E., Rothschild, M.L. & Novelli, W.D. (2002). *Social Marketing*. In K. Glanz, B.K. Rimer, and F.M. Lewis (eds), Health behaviour and Health Education: Theory, Research, and Practice. San Francisco: Jossey-Bass.

Matthews, B. & Ross, L. (2010). *Research Methods: A Practical Guide for the Social Sciences*. Pearson Education Limited, Edinburgh Gate, Harlow, Essex CM20 2JE, England.

McDermott, L. M., Stead, M. & Hastings, G. B. (2005). What is and what is not Social Marketing: The Challenge of Reviewing the Evidence. *Journal of Marketing Management*, 5(6), 545–53.

Misler, E. (1990). Validation in inquiry-guided research: the role of examplars in narrative studies. *Havard Educational Review*, 33 (1), 415-42.

Morris, Z. S. & Clarkson, P. J. (2009). Does Social Marketing Provides a Framework for Changing Healthcare Practice? *Health Policy*, 91, 135-141.

National AIDS Control Programme (2009). HIV Sentinels Survey Report, Ministry of Health, Accra.

Niblett, G. R. (2005). Stretching the Limits of Social Marketing Partnerships, Upstream and Downstream: Setting the Context for the 10th Innovation in Social Marketing Conference. *Social Marketing Quarterly*, 11(3), 9-15.

Stead, M., Hastings, G. & McDermott, L. (2007). The Meaning, Effectiveness and Futures of Social Marketing. *Obesity Reviews*, 8(Suppl. 1), 189–193.

Strand, J., Rothschild, M.L. & Nevin, J.R. (2004). "Place" and Channels of Distribution. *Social Marketing Quarterly*, 10(3), 8-13.
Thackeray, R. & Neiger, B. (2000). Establishing a Relationship between Behaviour Change Theory and Social Marketing: Implication for Health Education. *Journal of Health Education*, 3 (6), 331-35.
Taylor, F. & Beswick, A. (2005). Audit of Cardiac Rehabilitation in Light of the National Service Framework for Coronary Heart Disease. British Journal of Cardiology; 12, 50–52.
UNAIDS (2004). AIDS Epidemic Update. Joint United Nations Programme on HIV/AIDS and World Health Organization. Information Production Unit, Geneva, Switzerland.
Weinstein, N.D. (2007). Misleading Tests of Health Behaviour Theories. *Annals of Behavioural Change Medicine,* 33 (1), 1-10.