ASSESSING THE IMPORTANCE OF COUNSELLING AS A COMMUNICATION TECHNIQUE INPREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIVIN TWO SELECTED HOSPITALS IN KADUNA

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A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA, NIGERIA, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS (M.A) IN DEVELOPMENT COMMUNICATION,

DEPARTMENT OF THEATRE AND PERFORMING ARTS,

FACULTY OF ARTS,

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ZARIA, NIGERIA

DECEMBER, 2016

DECLARATION

I hereby declare that this dissertation titled '**Assessing the Importance of Counselling as a Communication Technique in the Prevention of Mother to Child Transmission of HIV in Two Selected Hospitals in Kaduna'** was undertakenby me in the **Department of Theatre and Performing Arts,** under the supervision of **Prof Steve Abah**and **Dr Victoria Lagwampa.** The information derived from the literature has been duly acknowledged in the text and list of references provided. No part of this dissertation has been previously presented for another degree or diploma at this or any other Institution.

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TANKO, Doris **Date**

CERTIFICATION

This Dissertation titled ‘‘**Assessing the Importance of Counselling as a Communication Technique in the Prevention of Mother to Child Transmission of HIV in Two Selected Hospitals in Kaduna’**meets the regulation governing the award of the degree of Master of Arts in Development Communication of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This Dissertation is dedicated to my children, Peter, Gabriel and Abraham and also to my husband, Abraham Tizhe Gabriel for constantly pushing me beyond my limits.

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I owe everything to God who gave me life and saw me through from the beginning to the end of this programme. To the department and Lectures for encouraging me to accomplish this despite all odds. Late Professors J. Z Okwori, S.A Kafewo, Dr. M Ayegba, their encouragement while alive can never be forgotten. My sincere gratitude goes to my supervisors, Professor Steve AbahandDr Victoria Lagwampa, and the post graduate coordinator Dr E Jegede, your guidance and patience through this research work has greatly impacted not only this research work but have influenced greatly my approach to academic pursuit, to work, and very importantly, to human relationship regardless of status.

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ABSTRACT

HIV/AIDS has remained a major threat to population health in developing countries and Nigeria in particular. The 2013 National Demographic and Health Survey (NDHS) says though mortality rates differ by zones, the under-five mortality rate for the ten-year period before the survey ranges from 185 deaths per 1,000 live births in North West Zone to 90 per 1,000 live births in South West Zone. Children living in rural areas are also more likely to die young than children in urban areas, with under-five mortality at 167 per 1,000 live births in rural areas, compared with 100 per 1,000 live births in urban areas. This mortality is associated with poor women education, low access neonatal health services, HIV infection and other factors. HIV infection having been identified as one of the causes of child mortality and a major health concern needs to be tackled. Government and non-governmental agencies have used various strategies to halt the rate of infection and eventual death especially in children. An integral part of the strategies employed is the prevention of mother to child transmission programmes which counselling is incorporated into. This research assessed the importance of counselling as a communication technique in prevention of mother to child transmission of HIV and took a holistic look at the process of counselling in two selected hospitals and how it has helped in combating MTCT. This research was conducted on 29 hospital staff of two hospitals with 19 from Saint Gerard's Catholic Hospital Kaduna in the Heart to Heart centres and 10 staff from Yusuf Dantsoho hospital Kaduna with an average patients of 439 assisted by a Non-governmental organisation Caritas Foundation of Nigeria and Centre for Integrated Health Programmes (CIHP) for Saint Gerard's and Yusuf Dantsoho Hospital respectively.Qualitative and quantitative mode of data collection was used in analysing the study and the research found out that majority of the patients were aware of their HIV status after counselling and counselling has been beneficial. That counselling helps to reduce stigma and discrimination. That HIV positive mothers have given birth to negative children due to their adherence to counselling services and that there has been an improvement in the health status of HIV positive mothers and their children.

In view of this research that was carried out in the two hospitals, there is the need to enhance the level of awareness with specific communication strategies; that being HIV positive is not a death sentence.

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CHAPTER ONE

1.1 Background of the Study

To state that HIV/AIDS remains a major threat to population health in Nigeria is an understatement, as it carries a heavy burden of the disease in Africa. Nigeria is the most populous country in Africa. Estimates based on the 2006 national census and an annual growth rate of 3.2%, puts the 2012 population at about 171 million. United Nations Population Fund (UNFPA, 2010).

Other reports from UNFPA, 2010 said the high population may be attributed to the high total fertility rate of 5.7%, a large percentage of women in the reproductive age group and a low contraceptive prevalence rate of 15% (National Population Commission 2009 and ICF Macro)

The 2013 National Demographic and Health Survey (NDHS) says though mortality rates differ by zones in Nigeria, the under-five mortality rate for the ten-year period before the survey ranges from 185 deaths per 1,000 live births in North West Zone to 90 per 1,000 live births in South West Zone. Children living in rural areas are also more likely to die young than children in urban areas, with under-five mortality at 167 per 1,000 live births in rural areas, compared with 100 per 1,000 live births in urban areas. This high mortality is associated with poor women education, low access to neonatal health services, HIV infection and other factors. The survey states that childhood mortality generally decreases as household wealth increases. Under-five mortality among poorer households (190 deaths per 1,000 live births) is more than twice that of children from the wealthiest households (73 deaths per 1,000 live births). Breastfeeding was nearly universal, with 97% of children being breastfed, although, only 13% of children under 6 months were exclusively breastfed. Health-care provision in Nigeria is a concurrent responsibility of the three tiers of government; the federal, state and local governments, which have broad responsibilities for tertiary, secondary and primary care respectively. The Federal

Government through the Federal Ministry of Health (FMOH) provides policy guidance and technical assistance to the 36 states and the Federal Capital Territory, Abuja. The FMOH also implement and /or monitor and evaluate National Health Programmes and Policies. In 2011, a census of available Health Facilities in Nigeria showed a total of 34,173, of which 30,098 (88.1%) are Primary Health-Care Facilities, 3,992 (11.7%) Secondary and 83 (0.2%) Tertiary.(Federal Ministry of Health, 2011).

Nearly 38% of these facilities belong to the private sector. Human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) is a major public health problem in Nigeria. Since the report of the first AIDS case in Nigeria in a 13-year-old girl in 1986, serial HIV sentinel surveys of pregnant women in the country recorded persistent high HIV prevalence. Though, with variations across the country, the national median sero-prevalence was 1.8% in 1991, 3.8% in 1994, 4.5% in 1996, 5.4% in 1998, 5.8% in 2001, 5.0% in 2003, 4.4% in 2005, 4.6% in 2008 and 4.1% in 2010 HIV infection among women of child-bearing age and mother-to-child transmission (MTCT) of HIV in Nigeria remain major health issues (Ezeanolue, Obiefuneetal, 2013). The statistics are startling. In 2009, according to the Nigerian National Agency for the Control of AIDS (NACA), about 1.72 million women and girls were living with HIV and AIDS with the highest prevalence rate of 5.6% among women in the age group 25-29 (NACA, 2011). In 2012, there were 110,000 new HIV infections among women aged 15-49 years in Nigeria, ranking the country second (next only to South Africa) among countries with the highest burden of new HIV infections among women (UNAIDS, 2013).

Nigeria is one of 22 countries that account for 90% of pregnant women living with HIV(Ezeanolue, Obiefune et al, 2013). In 2010, despite improved efforts dedicated to the prevention of mother-to-child HIV transmission (PMTCT), only 16.9% of pregnant women in

Nigeria were tested for HIV (NACA, 2012). The low rates of testing and treatment in Nigeria contributed to an estimated 75,000 HIV-infected infants in 2010 (Ezeanolue EE, Obiefune et al, 2013, WHO, 2011). In 2012, while these rates dropped, 60,000 new HIV infections occurred among children, now making Nigeria the country with the largest number of children acquiring HIV through MTCT (UNAIDS, 2013). Currently, Nigeria alone, "accounts for 30% of the burden of MTCT" [UNAIDS, 2011]. Without urgent action in Nigeria, UNAIDS suggests that the global target of eliminating new HIV infections among children by 2015 is unlikely to be reached (UNAIDS, 2013). It is 2016 and the global target has not been reached in Nigeria as HIV infection among children is still occurring. What were the measures put in place to achieve this target and since there are still cases of infection, could it be that the interventions are inadequate? What are the factors responsible for the new cases of infection?

The focus should be on what government has done and is doing to reverse this unfortunate situation. Nigeria has enacted so many laws and policies to guide a multi-sector response to the HIV/AIDS scourge. Such include: National Policy on HIV/AIDS, National Strategic Framework 2010-15, National Action Plan on Orphans and Vulnerable Children, National HIV/AIDS Prevention Plan, etcetera. Increased attention has been paid to prevention of mother to child transmission (PMTC) given that Nigeria contributes the highest percentage of 32% to the world gap in eradicating MTCT.

In 2012, World Vision International listed the components of the comprehensive PMTCT endorsed by WHO and UNICEF as:

1. Primary prevention of HIV among women of child bearing age.
2. Prevention of unintended pregnancies among women living with HIV
3. Prevention of HIV transmission from a woman living with HIV to her infant.

4. Provision of appropriate treatment, care and support to women living with HIV and their children and families.

The role of communication in the implementation of these components forms the basis of this study.The term development has formed an integral part of human existence. Okwori (2009) observes that; "But how did a concept whose origins can be found in biological theories become an imperative of how the lives of millions of human beings ought to be lived? …and why did the term 'Development' become the one to summarize the several goals and practices needed for the betterment of human life?"

One prominent word in the above quotation is 'betterment', it might not be wrong to say that the entire ideology behind development whether in biology or the theories of humanities is improvement in human condition.A lot have been said about development and theories. Schools of thoughts have emerged, which is a notable achievement in the development discuss to the wellbeing of human existence as theories and counter theories have sprung up either debunking or improving the other. The 'betterment' of human condition in the face of Human immunodeficiency virus (HIV) forms the background to this study. Family is an important unit in human existence, without procreation human existence will go into extinction. If this is challenged by the transmission of HIV, then communication should be used to minimize or eradicate the challenge posed by HIV.

Prof Ladan of ABU, Zaria (2008) says since the first AIDS case was reported in Nigeria in 1986 in a 13year old child, HIV prevalence has been on the increase, from 1.8% in 1991 to 4.5% in 1996 to 5.8% in 2001. However, there seem to be a decline to 5% in 2003 and 4.4% in 2005. He further stated that HIV and AIDS epidemic is closely accompanied by the growing unprecedented problem of orphans and vulnerable children as a result of rising number of deaths of one or both parents due to HIV or AIDS. These are further worsened by the

vulnerability of children through high maternal mortality, poverty, disease and Mother to Child Transmission (MTCT).

A report published by AVERT in 2012 put infections at 3.4million representing 3.7%, with prevalence at 3.1% stating that 70,000 new infections in 2011 were attributed to MTCT.

Furthermore, HIV prevention programme in Nigeria is built around three pillars; Education, Condoms and Media Campaigns and Public Awareness. Sadly, in this attempt to curtail MTCT, Only 18% of pregnant women have access to anti –retroviral drugs. Also, only 23% of schools provide life skills based HIV education, with only 25% of 15-24years correctly able to identify preventive ways of HIV in 2010. However, improvements in the uptake of HIV testing and counseling and scaling up access to the most effective anti –retroviral regiment (triple ARV regiment) has help to halt the rising number of children living with HIV.

According to the Federal Ministry of Health (2008), an estimated 360,000 children between the 0-14years are now living with HIV; with an annual birth rate of 6,081,000 per annum, 58% of pregnant women received antenatal care while 39% were assisted by skilled birth attendants at delivery in 2008.

The World Health Organization in 2010 reported that Nigeria with a population of about 150 million has 897 testing and counseling centres giving an average of 29.2 per 100,000 adults to a centre. A year later the number of centers remains the same, showing a decline in the health care facilities.The immediate causes of HIV are sexual transmission, transmission from mother to child and transmission through transfusions and sharing of blood and blood products.

The woman plays a pivotal role in the mother to child transmission of HIV besides other factors and if not properly handled can increase the epidemic.

Iwuagwu (2009), defined the role of a woman in the African culture thus:

> In Nigeria, as in most African countries and cultures, a woman's worth and sense of fulfilment are often tied to her fertility and ability to bear children. Not being able to bear a child can be a traumatic burden for an African woman. HIV/AIDS has been documented to reduce the fertility of those living with the virus. Men are also under cultural and personal pressure to prove their manhood by fathering children; they in turn pressure their HIV positive partner to help them achieve their procreation goal. As if this is not enough, Women Living with HIV/AIDS are further weighed down by concerns about their own mortality and the associated fear of leaving orphaned child(ren). They are also consumed with the fear of infecting their baby during pregnancy, birth or breastfeeding. (Iwuagwu; 2009)

Challenges of PMTCT Programme in Nigeria

The PMTCT programme in Nigeria is besieged with a number of challenges not limited to the following ( ):

- Inaccurate knowledge of HIV-related issues by healthcare providers and the general public and the resultant pervasive stigma associated with the disease
- Poor political commitment and low resource allocation to the PMTCT at the state and local government levels
- Dependence on international donors for programme resources. Programme sustainability is therefore not guaranteed
- Implementing partners' preference to run the PMTCT programme as a vertical programme instead of integrating it into the existing Maternal and Child Health (MCH) structure
- Low level of male partner involvement in PMTCT, among others.

These challenges have resulted in very low programme coverage and possibly the part of the reason the global target of eradicating child infection by 2015 was not met.

In the face of these challenges, different governmental and non-governmental agencies deployed several communication strategies towards prevention of mother to child transmission

of HIV. Notable among the communication strategies are the counseling sessions and support group for infected patients in St Gerard's catholic Hospital Kakuri Kaduna and Yusuf Dan Tsoho Memorial Hospital Tudun Wada, Kaduna.

1.2 Statement of the Research Problem

HIV and AIDS over time became major health challenges, as a cure for the disease is yet to be found and rate of infection has been on the increase. Overtime infected population fell back to medication where available in the absence of a cure. The quest for prevention became imperative globally and communication strategies like the use of fliers, posters, billboards, radio and television programmes have been deployed to create awareness and subsequently to encourage prevention. Despite awareness created by the media and other agencies, the mention of HIV still sends shivers down peoples' spine. Some notable employers like the banking sectors, government agencies do not employ people infected. Some places of worship also segregate as infected members are deprived of certain privileges like marriage.

Specific communication strategies have been deployed like Health Talks, use of posters and fliers and counselling. But even with the communication approaches the rate of infection is not commensurate to efforts deployed to curb the infections as shown by available statistics. If adults are infected and in turn pass the virus to their unborn children who without cure might hardly live to celebrate their first birthday. UNAID 2013 reported that about 150,000 children became infected with HIV in 2015 because only 69-86% of women living with HUIIV had access to medicines to prevent transmission to their infants.

The problem arising from all these indicate that the communication strategies being employed to enlighten the general public to challenge their attitude towards sufferers and not to stigmatize them not working. Nor is the sensitization for prevention of transmission from mother to child

effective enough. The challenge therefore is that the communication approaches to address the issue of infection still remains to be properly understood and utilized.

1.3 Aim of the Study

The aim of this research is to assess the importance of counselling in combating mother to child transmission of HIV, taking a holistic look at the process of counselling in the hospitals and how it has helped in preventing mother to child transmission of HIV.

1.4 Objectives of the Study

The objectives of this research include the following:

a. To ascertain whether pregnant women are exposed to counselling in the two selected hospitals
b. To examine the mode of introducing pregnant positive mothers to PMTCT programme in the two selected hospital.
c. To determine whether counselling has encouraged pregnant women to participate in PMTCT programme in the hospitals.
d. To find out the level of awareness of pregnant positive women about PMTCT.
e. To ascertain if counselling has actually helped in reducing the rate of transmission of HIV from mother to child in the hospitals.

1.5 Research Questions

In line with the set objectives of the study, the following research questions were formulated in order to provide answers for the study,

a. Are pregnant women exposed to counselling in the two hospitals?
b. What are the ways in which pregnant women are introduced into PMTCT programme in the hospital?

c. Has counselling services encouraged pregnant women in the two hospitals to participate in its PMTCT programme?
d. What is the level of awareness of pregnant positive women on PMTCT?
e. Has counselling reduced the rate of transmission of HIV from mother to child in the hospitals?

1.6 Justification for the Study

According to Hulme and Turner (1990), it took all history until 1850 for the world's population to climb to 1 billion. By 1930, eighty years later, another billion had been added and by 1960 the world's population had surpassed the 3 billion mark. Furthermore, growth rate have slackened slightly but United Nations put current world population at 7 billion on October 31, 2011 and is expected to reach 8 billion in 2024.

Though world population is on the increase as stated above, it has both positive and negative impact with more of the negative in developing countries and the scourge of HIV contributes immensely in the effect of population in this region. This is seen in the number of youths (15-45 years) dying day in day out and the number of children orphaned. Therefore, a study which seeks to understand the barriers to communication and assess the importance of communication in the prevention of mother to child transmission of HIV would contribute to halting death from HIV-AIDS.

Furthermore, if positive pregnant women understand the need and ways of preventing their unborn children from getting infected with HIV, the study would have helped in reducing the rate of infection, the number of infected children and orphans and the family being an integral part of human existence would be healthier and better positioned.

Similarly, the outcome will provide insight into a healthier and better future for both the infected and affected. It will equally contribute towards achieving the national target in the battle against the pandemic. Then, this research would have been justified.

1.7 Scope of the Study

This study will constitute a reference material for further research by either the researcher or other researchers thereby forming a base for follow ups.

The scope of this research area is Saint Gerard's and Yusuf Dan Tsoho Hospitals, Kaduna. Saint Gerard's Catholic Hospital is a reputable missionary hospital in Kaduna south local government that has partnered with bothNational and International organizations in the fight against mother to child transmission of HIV /AIDS. As such enjoys the community's trust and confidence despite the fact that it is open to service to all comers from diverse backgrounds. It is one hospital that operates a friendship care centre and is renowned in testing and counseling of the public, especially pregnant women for antenatal.

Dan Tsoho Memorial Hospital on the other hand is a government hospital located in Tudun Wada in Kaduna North. Due to rampant cases and rate of infection of HIV, the hospital saw the need to run a PMTCT programme and with the help of non-governmental agencies like ICAP and CIHP (Centre for Integrated Health Programmes) began the programme in 2007. The PMTCT programme was sponsored by ICAP, a non-govermental agency as earlier mentioned at inception but is currently sponsored by Centre for Integrated Health Programmes (CIHP).

The study will undertake a critical analysis of communication and counselling options made available to HIV infected pregnant women in line with global best practices.

1.8 Operational Definition of Terms

CIHP- Centre for Integrated Health Programmes

AIDS- Acquired Immune Deficiency Syndrome

HIV- Human Immunodeficiency Virus

NDH- National Demographic and Health Survey

MTCT- Mother to Child Transmission

UNFPA-United Nations Population Fund

FMOH- Federal Ministry of Health

NACA- National Agency for the Control of AIDS

WHO- World Health Organisation

PMTCT- Prevention of Mother to Child Transmission of HIV

UNICEF- United Nations International Children's Emergency Fund

UNAIDS- United Nations Programme on HIV/AIDS

ICAP-

BCC- Behaviour Change Communication

STI- Sexually Transmitted Infection

IDU- Intravenous Drug Users

OVC- Orphans and Vulnerable Children

VCT-Voluntary Counselling and Testing

NGO- Non Governmental Organisation

MNCH- Maternal New-born and Child Health

ARV- Antiretroviral

ANC- Antenatal Care

PCN- Post natal Care

LMG- Leadership Management and Governance

PEPFAR-President's Emergency Plan for AIDS Relief

USAID- United States Agency for International Development

MSH-Management Science Health

LDP+- Leadership Development Programme Plus

FCT- Federal Capital Territory

EGPAF- Elizabeth Glazer Paediatric AIDS Prevention

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Development is an important concept which is becoming a global phenomenon (Servaes, 2001). The idea of development is conceptualised differently by different scholars while some scholars see it as a change in the society, others see it as advancement, improvement empowerment and progress (Serveas, 2002). For instance, Rogers (1969) asserts that it can only be given the rightful coloration in terms of change, new innovation and meanings it brings to the lives of the people. in line with the submission of Ake (2001) development means processes by which people create and recreate themselves and their life circumstances to realize higher levels of civilization in accordance with their own choices and values (Ake, 2001). From this context, development can be seen as multidimensional process involving major societal changes in terms of social structures, popular attitudes and national institutions, as well as the acceleration of economic growth, the reduction of inequality and eradication of extreme poverty.

Furthermore, Sen (1989) views development as encompassing the economic, political, social, cultural and environmentaldimensions. While economic and social progress and the elimination of poverty are the objectives ofdevelopment, it includes also freedom from fear and arbitrary arrest; free speech, free association and the right tovote and be voted for.However, development and communication have always been together since it is difficult to separate. It is therefore, pertinent to inculcate communication into this study.

2.2 The Concept of Communication

When people communicate with each other, they exchange various forms of meaning, such as ideas and information, through a common system of symbols. Typical communications can include writing in a diary, watching television, talking with friends, and speaking on the telephone. It has been estimated that people spend more time communicating than they spend on any other complex activity in life (Servaes, 2001). Human communication takes place on many levels, from the simplest interpersonal and small-group exchanges among friends to mass communication, as experienced in public speeches, magazines, or news broadcasts.

Communication is not limited to exchange between people. It also refers to activities that do not involve people for example; the word communication may be used to describe the ways that animals relate to each other. Similarly, it is often said that electronic devices communicate with each other. All such communication happen because participants in the process share an understanding of certain symbols and exchange them in a systematic or orderly way.

Communication is simply the act of transferring information from one place to another, a process of transmitting and receiving messages or information between a sender and a receiver(s), which usually involves feedback; this can be verbal or non-verbal. However, the sender must encode the message (the information being conveyed) into a form that is appropriate to the communication channel, and the receiver(s) then decodes the message to understand its meaning and significance.**Misunderstanding can occur at any stage of the communication process but e**ffective communication involves minimising potential misunderstanding and overcoming any barriers to communication at each stage in the communication process. Communication is an indispensable tool for daily existence. It is the engine that drives virtually everyman's activity.

2.2.1 Levels of Communication

There are various levels of communication but for the purpose of this study, four of them are discussed namely: Intrapersonal, interpersonal, personal and group communication. Understanding the various levels of communication is necessary in identifying where mother to child transmission can be assigned. It further explains the types of communication that exist when we are dealing with prevention of mother to child transmission of HIV.

2.2.2 Intrapersonal Communication

According to Langs, (1993) Intrapersonal communication involves communication with oneself. People normally communicate with themselves when they are alone in private or semiprivate places. When people talk to themselves aloud in crowded, public places, others find such behaviour strange.

It is observed that people communicate with themselves for a variety of purposes. They inform themselves by making grocery lists and by jotting notes of upcoming events on calendars. Before writing essays, they may inform themselves about how to proceed by making outlines. People also express feelings to themselves. Diary writing, for example, grows out of the human need to express feelings to oneself. People also address imaginative messages to themselves. They daydream and fantasize for pleasure. Students doodle creatively as they sit in class. Some people write poetry or prose that they never intend to share.

2.2.3 Interpersonal Communication

Interpersonal communication involves one-to-one exchanges between people. It is the most important and frequent context for communication. It is important because it is essential to forming and maintaining significant relationships between individuals (Langs, 1993).

Two types of interpersonal communication exist. The first is impersonal in nature. When people react to each other according to the role they are playing, the context is impersonal. For example, in the relationship between a customer and a clerk, the customer may say “I'd like this item,” and the clerk may say “That will be 79 cents.” The most important type of interpersonal context, however, is personal in nature. When people react to one another as unique human beings with special needs and interests, a personal context exists and close relationships may develop. Such things as attraction, self-disclosure, and trust seem to play important roles in establishing and maintaining long-term social relationships.

While most interpersonal communication involves face-to-face exchanges, telephone calls, e-mails, and letters are also forms of interpersonal communication. When friends and loved ones are separated by space, they still feel the need to communicate with each other. People use personal language and paralinguistic cues to convey friendship or affirm their feelings across distances. This aspect requires that mothers should be able to reflect the need to consciously practice how to prevent mother to child transmission according to the information that is made available to them. This kind of communication takes place within and it is a starting point for prevention exercise. This is important because without this phase, it can be difficult to achieve behavioural change.

2.2.4 Small Group Communication

Small group communication involves give-and-take exchanges between a relatively small numbers of people. A small group involves at least three but has no precise upper limit. The important thing is not how many people are involved but whether the people are aware of each other as individuals and are able to participate in the discussion.

Scholars often classify groups by function and it is important to note that example of functional groups include those that are organized for the purposes of learning, socializing, therapy, problem-solving, political action, and worship groups. Given the variety of functions, effective participation in groups requires a variety of skills.

The importance of this aspect of small group communication is evident where for instance in a gathering of mothers during immunization or workshop for breastfeeding mothers. Within this forum, a lot of information can be disseminated to nursing mothers on how to prevent transmission to children. This aspect can be very effective since it is done in smaller groups and there is the tendency to increase acceptability.

2.2.5 Mass Communication

Simpson (1986) States that Mass communication may be defined simply as messages transmitted through electronic or print media and directed at great numbers of people. Many features of mass communication distinguish it from other forms of communication. Mass communication messages are prepared by groups of people working for an organization, be they a staff working for a newspaper or a group of volunteers writing a press release for a service organization. A local television evening news programme, for example, involves the three or four people who are seen at the news desk, but it also involves many people who are never seen on camera (camera operators), script writers, engineers, business managers, and many others. Mass communication is also directed to a relatively large and anonymous audience "to whom it may concern." The message must appeal to a large number of people, or those producing it will not remain in business. Because of the expense of communicating to large audiences, nearly all forms of mass communication depend on some source of funding, be it through subscription, advertising revenue, or charitable support. Finally, the source of the message is remote—

separated from the audience by time or space. As a consequence, those being addressed do not attend to the message as intently as do those in the company of the message source. For example, television viewers generally feel free to talk to each other, leave the room to get a snack, change channels, or fall asleep.

It is important to note that mass media has been instrumental in disseminating information about mother to child transmission of HIV. It has actively involved radio, television and most recently the Internet. It effectiveness is a key factor that instigates it usage. With wide coverage, it has made information available even to the remote part of the rural areas. This is highly noticeable in the case of radio which is easier and affordable even to rural dwellers.

2.3 Communication and HIV

The concept of Communication is important in the prevention of mother to child transmission of HIV. Several HIV champagne have been initiated over the years and one of the central elements deployed to facilitated prevention is communication. In view of this, it is important to examine the concept of communication with the view to studying its role especially in preventing mother to child transmission in Kaduna State. According to Ifeyinwa (2012) understanding communication in relation to mother to child prevention of HIV is importance is very essential. She reiterated that in recognition of the all-important nature of communication:

> Virtually all the PMTCT guidelines released have strongly emphasized effective, efficient and well-articulated communication strategy geared towards creating and raising the awareness level of the public on PMTCT, to consequently stimulate positive attitudes and practices/behaviours. Communication has been at the heart of all PMTCT sensitization and mobilization efforts/campaigns which have utilized several channels such as radio, television, magazine and newspapers. Other channels include the use of health workers, religions leaders, friends, relatives etc, all geared towards effectively reaching the public with salient information on PMTCT.

The emphasis in the above submission is that for effective achievement of preventing mother to child transmission of HIV, salient information must be clearly passed across to the specific audience in such a manner that they understand the messages as well adhere to the instructions. The aspect of adherence to instructions on how to prevent the transmission is related to behavioural change and well as social mobilisation. In view of this, it can be said that ssocial changeis most commonly understood as a process of transformation in theway society is organized, within institutions and in the distribution of power withinvarious social and political institutions.(Figueroa, Kincaid, Rani& Lewis, 2002). Furthermore, Communication for social changeis a process of public and private dialoguethrough whichpeople define who they are, what they want and how they can get it.

> It is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-need and raise awareness of, anddemand for, a particular development objective. It involves enlisting the participation ofsuch actors, including institutions, groups, networks and communities, in identifying,raising and managing human and material resources, thereby increasing andstrengthening self-reliance and sustainability of achievements (Figueroa, et al, 2002:56).

On the other hand, Behaviour change communication (BCC) is aresearch-based consultative process of addressing knowledge, attitudes and practicesthrough identifying, analysing and segmenting audiences and participants inprogrammes by providing them with relevant information and motivation through well-defined strategies, using an audience-appropriate mix of interpersonal, group andmass-media channels, including participatory methods.BCC is an integral component of a comprehensive HIV/AIDS prevention, care and support programme. It has a number of different but interrelated roles. Effective BCC can:

- *Increase knowledge.*BCC can ensure that people get the basic facts about HIV and AIDS in a language or visual medium (or any other medium that they can understand and relate to).

- *Stimulate community dialogue*.That is to say,Effective use of BCC can encourage community and national discussions on the basic facts of HIV/AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours and risk settings, environments and cultural practices related to sex and sexuality, and marginalized practices (such as drug use) that create these conditions. It can also stimulate discussion of healthcare-seeking behaviours for prevention, care and support.

- *Promote essential attitude change***.** BCC can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, belief in the right to and responsibility for safe practices and health supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles and increasing the basic rights of those vulnerable to and affected by HIV and AIDS.

- *Reduce stigma and discrimination.*Communication about HIV prevention and AIDS mitigation can effectively address stigma and discrimination and attempt to influence social responses to them.

- *Create a demand for information and services.*BCC can spur individuals and communities to demand information on HIV/AIDS and appropriate services.

- *Advocate.*BCC can lead policymakers and opinion leaders toward effective approaches to the epidemic.

- *Promote services for prevention, care and support.* BCC can promote services for STIs, intravenous drug users (IDUs), orphans and vulnerable children (OVCs); voluntary counselling and testing (VCT) for mother-to-child transmission (MTCT); support groups; provide clinical care, social and economic support.

- *Improve skills and sense of self-efficacy.*BCC programmes can focus on teaching or reinforcing new skills and behaviours, such as condom use, negotiating safer sex and safe injecting practices. It can contribute to development of a sense of confidence in making and acting on decisions.

2.4 Health Communication

Health communication, which is defined as 'the study and use of communication strategies to inform and influence individual and community decisions that enhance health', is a core strategy for public health improvement. Health communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. Communication serves the purposes of: 1) initiating actions, 2) making known needs and requirements, 3) exchanging information, ideas, attitudes and beliefs, 4) engendering understanding, and/or 5) establishing and maintaining relations (U.S. Office of Disease Prevention and Health Promotion, 2004). Communication, thus, plays an integral role in the delivery of healthcare and the promotion of health.

According to Healthy People 2010 guidelines, health communication encompasses the study and use of communication strategies to informand influence individual and community decisions that enhance health. Itlinks the domains of communication and health and healthcare.

Health communication encompasses the study and use of communication strategies to inform and influence individual and community knowledge, attitudes and practices (KAP) with regard to health and healthcare.

Health communication can take many forms, both written and verbal, and can be directed toward individuals, communities or entire nations. In addition, health communication is an integral component of health promotion, health protection, disease prevention and treatment and is recognised as a core competency in public health and health promotion practice, playing a

pivotal role in achieving public health objectives (U.S. Office of Disease Prevention and Health Promotion, 2004).

The field represents the interface between communication and health and is increasingly recognized as a necessary element for improving both personal and public health. Health communication can contribute to all aspects of disease prevention and health promotion. The most obvious application of health communication has been in these areas of health promotion and disease prevention and reproductive health among women. Studies have uncovered improvement of interpersonal and group interactions in clinical situations (for example, between provider and patient, provider and provider, and among members of a healthcare team) through the training of health professionals and patients in effective communication skills (U.S. Office of Disease Prevention and Health Promotion, 2004).

Health communication initiatives must use the most effective and efficient strategies for the promotion, protection and maintenance of health through the use of the best available evidence at practice and policy level. Public health practitioners, programme managers and policymakers need to be aware of what is known about the strengths, weaknesses and costs of health communication interventions aimed at the prevention and control of communicable diseases so that impacts can be enhanced and opportunities maximised for strengthening evidence-informed action.

2.5 The Role of Health Communication

One of the major developments of recent years has been the "discovery" of the role that health communication can play (for good and bad) in determining individual and community health status. Effective communication can:

(a) Improve the health outcomes of acute and chronic conditions,

(b) Reduce the impact of racial, ethnic, disease-specific and socioeconomic factors in care, and

(c) Improve the effectiveness of prevention and health promotion.

Health communication has become an accepted tool for promoting public health. Health communication principles are often used today for various disease prevention and control strategies including advocacy for reproductive and health issues, marketing health plans and products, educating patients about medical care or treatment choices, and educating consumers about healthcare quality issues. At the same time, the availability of new technologies and computer-based media is expanding access to health information and raising questions about equality of access, accuracy of information, and effective use of these new tools.

The many roles that health communication can play have been highlighted by the Centres for Disease Control and Prevention. These roles include:

(a) Increase knowledge and awareness of a health issue, problem, or solution

(b) Influence perceptions, beliefs, attitudes, and social norms Prompt action

(c) Demonstrate or illustrate skills

(d) Show the benefit of behaviour change

(e) Increase demand for health service

(f) Reinforce knowledge, attitudes, and behaviour

(g) Refute myths and misconceptions

(h) Help coalesce organizational relationships

(i) Advocate for a health issue or a population group

Poor communication has a strongly negative impact on outcomes of some ones health and better communication can lead to improvements in prevention, motivation for behaviour change, and adherence to treatment.

Health communication programmes can affect change among individuals and also in organizations, communities, and society as a whole:*On Individuals:* The interpersonal level is the most fundamental level of health-related communication because individual behaviour affects health status. Communication can affect individuals' awareness, knowledge, attitudes, self efficacy, skills, and commitment to behaviour change. Activities directed at other intended audiences for change may also affect individual change, such as involving patients in their own care.On Groups: The informal groups to which people belong and the community settings they frequent can have a significant impact on their health. Examples include relationships between customers and employees at a salon or restaurant, exercisers who go to the same gym, students and parents in a school setting, employees at a worksite, and patients and health professionals at a clinic. Activities aimed at this level can take advantage of these informal settings.

2.6 Development Communication

According to Quebral(1973/72), development communication therefore is an organized efforts to use communications processes and media to bring social and economic improvements, generally in developing countries. He went further to state that the field emerged in the late 1950's amid high hopes that radio and television could be put to use in the world's most disadvantaged countries to bring about dramatic progress. Early communications theorists like Wilbur Schramm and Daniel Lerner based their high expectations upon the apparent success of World War II propaganda, to which academia and Hollywood had contributed immensely. He posited that World War II brought dozens of new, very poor, countries, left by their former colonial overseers with little infrastructure, education, or political stability. This situation was ripe enough to set the table for the kind of development that only the west can offer which is known as westernization or modernisation. Modernization was presumed to equate to Westernization, and to be a necessary prerequisite to meeting human needs. In line with this

ideology, the expectation was for the developing world to adopt the same kind of education, infrastructure and political structure of the developed world. In view of the above, it was widely accepted that mass media could bring education, essential skills, social unity, and a desire to "modernize." (Ongkiko, 1998).

However, development was seen as a top-down process, whereby centralized mass media could bring about widespread change. Producers of development media often failed to ask if the audience could receive the message. Television penetration in developing countries is minimal and radio penetration in the early days of development communication was light , again the failed to understand the message, a problem in countries with dozens of languages and dialects or even, act upon the message (with the necessary tools or other forms of structural support), and want to act upon the message. This was because it was based upon a propaganda model, development communications efforts were often seen as propaganda and distrusted.

Projects embodying these philosophies have enjoyed little success. In the 1970s and 1980s, a new paradigm of development communication emerged which better recognized the process of deliberate underdevelopment as a function of colonialism, the great diversity of the cultures involved, the differences between elite versus popular goals for social change, the considerable political and ideological constraints to change, and the endless varieties of ways different cultures communicate.

Some developing countries have demonstrated success in using satellite television to provide useful information to portions of their populations out of reach of terrestrial broadcasting. In 1975 and 1976, an experimental satellite communications project called SITE (Satellite Instructional Television Experiment) was used to bring informational television programmes to rural India. Some changes in beliefs and behaviours did occur, but there is little indication that

satellite television was the best means to that end. The project did lead to Indian development of its own satellite network. China has also embarked on an ambitious programme of satellite use for development, claiming substantial success in rural education. When television has succeeded as an educational tool in developing countries, it is only when very specific viewing conditions are met. For example, programmes are best viewed in small groups with a teacher to introduce them and to lead a discussion afterwards.

A variety of types of organizations work with local governments to develop communications projects. The United Nations provides multi-lateral aid to governments. Non-profit non-governmental organizations (NGO) conduct development projects worldwide using U.N., government, or private funding, government agencies, such as the U.S. Agency for International Development (USAID) provide assistance to developing countries, but with political strings attached. There are three common types of development campaigns: Persuasion, changing what people do; Education, changing social values; and informing, empowering people to change by increasing knowledge. This third approach is now perceived as the most useful. Instead of attempting to modernize people, contemporary efforts attempt to reduce inequality by targeting the poorest segments of society, involving people in their own development, giving them independence from central authority, and employing "small" and "appropriate" technologies. The emphasis has shifted from economic growth to meeting basic needs.

In this new view of development, communication becomes an important catalyst for change, but not its cause. Local folk media, for example, is employed to reduces media's bias toward literacy and provide information in a traditional, familiar form. Development journalism provides people with information on change in their society, and works at the local level to

advocate change. Where mass media is now employed in developing societies, community newspapers and radio prove far more accessible and useful than television. The rapid spread of entertainment television in the developing world is proving to be more a disruption to traditional social structures than an agent of progress. One emerging genre of television does show promise for contributing to development. The telenovela, pioneered in Brazil, has demonstrated some success in disseminating "pro-social" messages. Such programmes are now being evaluated in many countries for their effectiveness in contributing to population control, health education, and other development goals.

It is important to note that development issues all over the world range from poverty, economy, physical or infrastructural developments, improve health, good governance, technological advancement and empowerment (Ogbe, 2016). Improve health is one of the major concerns of development especially in the developing nations like Nigeria. Poor health issues in developing countries have been a major development issues that has attracted several agencies and government. It has given rise to several interventions as well. Majorly, the MDG goal three is focused on health. In addition, health interventions have focused more on communication and as such the concept of health communication is a recurring concept in development communisation.

2.7 Mother to Child Transmission of HIV (MTCT)

The HIV crisis in Africa is headline news. Even in countries where leadership is ambivalent to treating adults, there is often clear commitment to PMTCT of HIV. In Africa, HIV infection rate among pregnant women ranges from 15 to 40% in the countries with the highest overall HIV prevalence, with women of reproductive age comprising over 55% of HIV-infected adults.

This overwhelming burden is carried by women and babies as well as families, society, and the health system'

The mode of transmission of HIV includes but not limited to blood transfusion of an infected person, un-protected sex with an infected person and mother to child transmission. Nasidi and Tekena inAjayi *et al* (2006) stated that women can transmit HIV to their babies in the utero, during birth, and through breastfeeding. Most infections are thought to occur at the moment of delivery (60% to70%), followed by transmission through breastfeeding (20% to 30%), and then transmission in the utero (less than 10%).without preventive intervention, approximately 25% to 40% of infants born to HIV positive mothers will contract the virus, also the mother-to-child transmission (MTCT) of HIV refers to the transmission of HIV from an HIV-positive woman to her child during pregnancy, labour, delivery or breastfeeding. MTCT is by far the most common way that children become infected with HIV (90 percent).

UNAIDS (2004) further stated that approximately 2.2 million children are currently living with HIV. Ninety percent (90%) of them became infected through mother to child transmission (MTCT) during pregnancy, delivery, and breast-feeding. This is also known as vertical transmission. The highest rates is found in African with a large population of women of reproductive age, high birth rates, a tradition of prolonged breastfeeding and a lack of effective interventions aimed at preventing Mother to Child Transmission Adewole et al, (2006**).**

Mother to Child Transmission of HIV represents a tragic dimension of the burden of HIV/AIDS particularly in resource constrained settings, where fragile and poorly funded health care systems hamper care and prevention efforts, as at least one third of HIV infected children in developing countries die within their first year of life.

In the absence of treatment, an infant's risk of acquiring HIV from a mother living with HIV/AIDS ranges from 15% to 30% among women who do not breast-feed their infants. The

risk of transmission increases when a woman has a higher viral load, or if an infant is directly exposed to the mother's infected body fluids during birth. If an infant born to an HIV-positive mother does not contract the virus during pregnancy or childbirth, studies estimate that the child has a 5–20% chance of acquiring the virus from the mother's milk if he or she is breastfed (UNAIDS, 2004). The most effective PMTCT treatments involve a combination of drugs with pregnant women with advanced HIV disease receiving combined therapy for their own health, as well as to prevent MTCT but a number of studies have shown that the protective benefit of drugs is diminished when babies continue to be exposed to HIV through breastfeeding (UNAIDS/WHO, 2005).Mothers are advised not to breastfeed whenever the use of breast milk substitutes (formula) is acceptable, feasible, affordable, sustainable and safe. However if they live in a country where safe water is not available then the risk of life-threatening conditions from formula feeding may be higher than the risk from breastfeeding (WHO, 2005).

For HIV positive women who choose to breastfeed, exclusive breastfeeding is recommended for the first months of an infant's life because a baby fed on infant formula does not receive the special vitamins, nutrients and protective agents found in breast milk and the cost of infant formula often puts it beyond the reach of poor families in resource poor countries, even if the product is widely available (UNAIDS/WHO, 2005). Many women also lack access to the knowledge, potable water and fuel needed to prepare replacement feeds safely, or simply have no time to prepare them.

From the above findings an infected mother can have a HIV free child if she adheres to certain guidelines, but how would she know about these guidelines or steps of prevention if she has limited knowledge and information?What approach has Nigeria as a nation taken to make PMTCT services available? The National HIV /AIDS Strategic Plan 2010-2015 says Nigeria has been steadfast in its commitment to strengthen its response to the HIV and AIDS epidemic

during the National Strategic Framework 2005-2009 period through the implementation of multi-sector comprehensive intervention programmes broadly clustered around complementary thematic areas of Promotion of Behavior Change and Prevention of New HIV Infections; Treatment of HIV/AIDS and Related Health Conditions; Support and Care for people living with and affected by HIV/AIDS; Policy, Advocacy, Human Rights and Legal Issues; Institutional Arrangements and Resource Mobilization and Application for the national response; and Monitoring and Evaluation Systems including research and knowledge management.

That the intent of the National Strategic Framework 2005-2009 to focus attention on HIV prevention as a top priority area with appropriate resources allocation is very clear. Anecdotal evidence from the implementation of the framework would, however, suggest expenditure on HIV/AIDS treatment was far greater than for prevention services. This may be a reflection of the fact that the unit cost of providing treatment services including drugs and laboratory services is far greater than that for HIV infection prevention services and therefore may not necessarily be a true reflection of the programme level of effort. More emphasis should have been on prevention rather than treatment, if new cases of infection are prevented fewer resources will be required to combat the epidemic. This prevention can be achieved through the process of communication.

2.8 Steps to Prevention of Mother to Child Transmission of HIV

World Vision, 2010 and the World Health Organization (WHO) issued guidelines for the prevention of mother-to-child transmission of HIV. The new guidelines recommend prolonged use of antiretroviral drugs (ARVs) during pregnancy and recommend that mothers living with HIV, or their infants, take ARVs while breast-feeding up to 12months to prevent HIV transmission. When implemented, these recommendations can reduce the risk of transmission

from 35 per cent to less than 5 per cent in breast-feeding populations, and from 25 per cent to less than 2 percent in non-breast-feeding populations. The guidelines will also ensure increased maternal and child survival.

The four components or prongs of the comprehensive PMTCT programme endorsed by WHO and UNICEF are:

1. Primary prevention of HIV among women of childbearing age
2. Prevention of unintended pregnancies among women living with HIV
3. Prevention of HIV transmission from a woman living with HIV to her infant.
4. Provision of appropriate treatment, care and support to women living with HIV and their children and families.

LilyKak, et al inan article titled 'Prevention Of Mother-To-Child Transmission Of HIV/AIDS Programmes' also buttress these four components endorsed by WHO and UNICEF which will also address issues of Maternal, New born, and Child Health (MNCH).

Component 1: Preventing HIV infection in women of reproductive age,

Component 2: Avoiding unintended pregnancy among HIV-infected women.

Component 3: Preventing transmission of HIV from an HIV-infected woman to her infant during pregnancy, labour, childbirth, and breastfeeding through:

• HIV counselling and testing

• Antiretroviral (ARV) drugs for prophylaxis

• Antiretroviral therapy (ART) for those who are eligible

• Safer infant feeding practices

Component 4: Providing follow up and care, support and treatment to HIV-infected women, their infants, and families.

Before pregnancy - Integration of PMTCT and maternal and newborn care begins before a woman becomes pregnant. It is critically important that young women have access to comprehensive and integrated reproductive health programmes to prevent both HIV infection and unintended pregnancy. Such an integrated programme would include counselling on safer sex practices and partner involvement, prevention of HIV transmission and other sexually transmitted infections (STI), prompt treatment of STIs, voluntary counselling and testing, disclosure to partners, and family planning services. This is different from what is obtainable as majority of women only go to health facilities when they are sick or already pregnant and it is mostly those who can afford medication.

During pregnancy and childbirth-Focused Antenatal Care (ANC) and early identification and treatment of maternal complications as well as early identification of maternal HIV status are central to integration. ANC services should incorporate family planning and birth preparedness, using messages specific to HIV-infected mothers. Among other essential interventions, integrated ANC should include detection and treatment of STIs, including syphilis, testing and counselling for HIV (opt out) and disclosure to partners, and counselling on infant feeding, birth preparedness, family planning, and prevention of HIV and STIs. During childbirth, integration should include minimal invasive procedures, use of the partograph, emergency obstetric care, universal infection precautions, and clean childbirth, active management of the third stage of labour, and counselling and testing for HIV (if not done earlier).

During the post-natal period, it is extremely important to ensure good care for the mother and newborn and continued PMTCT during this period of time. HIV counselling within PMTCT programmes is currently focused largely on the test result, with limited discussion about follow up care, reproductive health, prevention of HIV infections, and family planning. Early and regular follow up of infants can improve adherence to either exclusive breastfeeding or

replacement feeding and provide the opportunity to monitor nutritional status and growth (growth faltering is an early sign of HIV infection when other causes have been ruled out). Such follow up can also ensure immunisations and cotrimoxazole prophylaxis and facilitate referrals for prompt management and treatment of illnesses. Infection may also be reduced by improving breastfeeding techniques to decrease risks of breast inflammation and other conditions that may increase the chance of HIV transmission.

Newborn care can and must be linked with improved PMTCT follow up. Danger signs for newborn infections typically manifest themselves within 72 hours of birth. Newborns that have been born at home can be checked for signs of illness when they are brought back to the health care facility within 72 hours for nevirapine (ARV) prophylaxis. This visit also provides an opportunity for the newborn to be given his/her first immunisation and for the care giver to be counselled on newborn care at home. Just as ANC is an entry point for PMTCT, the delivery of BCG immunisation allows postnatal care to be delivered to both HIV-exposed and non-exposed newborns and their mothers. Routine HIV testing of babies at immunisation clinics could offer a second chance for mothers to learn about their own status and determine if PMTCT interventions have been successful, while the knowledge that infants are uninfected can be a strong motivating influence for mothers to optimise feeding practices, whether exclusively breastfeeding or providing replacement feeds with no mixing of the two methods. Thus, the post-natal period provides an opportunity for synergy between PMTCT and MNCH services and also links newborns and infants to child health services and paediatric AIDS programmes. While opportunities exist for PMTCT throughout the lifecycle, there are also opportunities for strengthening care throughout the various levels of service delivery. In order to understand the extent to which PMTCT and MNCH services are integrated.

WHO (2005) conducted a needs assessment in Uganda and Mozambique in 2004 aimed at identifying and addressing barriers to integration. The assessment found many gaps in the continuum of care and identified several opportunities for strengthening, in Zambia for example, linkage and integration with maternal, neonatal and child health are the hallmarks of the Zambian national PMTCT programme. The goals of the Zambian National PMTCT strategic framework include improvement in child survival and development through the reduction of HIV related infant and childhood morbidity and mortality, as well as a decrease in maternal mortality through the strengthening of antenatal, childbirth, and postnatal care services. The Reproductive Health Unit of the Central Board of Health coordinates and harmonises all partners' activities, integrates PMTCT into MNCH services, and links these programmes to youth-friendly services as well as Tuberculosis and HIV/AIDS programmes.

Today, PMTCT services are integrated in all 72 districts. PMTCT has strengthened the safe motherhood programme by utilising PMTCT funds to support systems for safe motherhood services such as the provision of tetanus toxoid immunisation, malaria and anaemia prophylaxis, postnatal care (PNC), and family planning. The Staff at different service delivery points has been oriented to provide information and refer clients across services, and integrated tools and job aids have been developed and demonstrated to staff, including the safe motherhood register, maternity counselling job aids, mother's birth preparedness cards, mother's cards, and child's cards. The integrated antenatal and postnatal registers record indicates when women should be followed up for infant feeding counselling and checking the infant's HIV status. This targeted approach has allowed some facilities to initiate 6 and 18 month follow up, despite being short-staffed. The programme is also utilising traditional birth attendants who have been trained in essential newborn care in two peri-urban districts. The

traditional birth attendants promote PNC by encouraging women to visit health facilities within 72 hours after childbirth and through breastfeeding support groups.

Similarly, in Nigeria over the past year, the Leadership, Management and Governance (LMG) Project helped support the PLAN-Health Nigeria project, funded by PEPFAR through USAID and managed by Management Sciences for Health (MSH), to pilot Leadership Development Programme Plus (LDP+), which focuses on empowering teams to improve PMTCT results. The programme also emphasizes new approaches tied in to country ownership, national health priorities, and specific health indicators.

LDP+ was piloted in the town of Gwagwalada, Nigeria. The Gwagwalada Council is one of the six Local Government Area Councils of the Federal Capital Territory (FCT) of Nigeria. LMG and PLAN-Health worked with the Gwagwalada Council, which selected 20 participantstwo from each of the 10 facilities providing PMTCT services in the areato form 10 teams to participate in the LDP+. Together, the teams decided to address PMTCT and focused on improving some standard indicators such as number of new antenatal care (ANC) clients; number of pregnant women tested for HIV, counselled and received their results; and the number of HIV-positive women. The programme ran from October 2012 to May 2013. During this time, the teams worked within their facilities to create a vision of improved results around PMTCT, align stakeholders around this vision, implement their action plans, and share learning with other teams to identify the most useful local interventions and activities. The teams also received coaching in the areas of monitoring, evaluation, and reporting.

The Zambian approach to PMTCT is exhaustive; it went further to even pay visits to mothers at home after delivery. Counselling during which communication takes place also plays a major role as mothers are not only counselled on HIV status alone but even feeding of their infant.

The article similarly observes that PMTCT services exist in most African countries, but coverage is limited and utilisation of services varies between and within countries. In 1998, the first pilot projects were initiated to demonstrate the feasibility of PMTCT programmes in high-prevalence countries. In 2004, just ten percent of women were tested for HIV through PMTCT services, and only 8.7 percent of HIV positive pregnant women received ARV prophylaxis globally. In East and Southern Africa, where these services are most needed, 17 percent of HIV-infected women were identified as such through PMTCT HIV screening; HIV-free child survival requires clear strategies for protecting children from all major causes of death, not just HIV infection. In many countries affected by HIV coverage of care is low at crucial times for both MNCH services and PMTCT programmes. This results in the characteristic cascade of diminishing service utilisation and delivery of interventions at the most crucial time. Continuity of care for individuals is an additional challenge affecting the quality of both MNCH and PMTCT services. Data from a project in Mozambique illustrate this major constraint to both MNCH and PMTCT. The high uptake of at least one antenatal care (ANC) visit (69 percent) in sub-Saharan Africa suggests that and only 11 percent of the projected total of HIV infected pregnant women received ARV prophylaxis. In West and Central Africa, the coverage is even lower: only three percent of infected women were identified, and just one percent received ARV prophylaxis. This deficit does not include women who become infected during pregnancy, when women appear especially prone to becoming infected – some reports suggest that in high HIV prevalent settings, up to 5% of pregnant women may become infected. The deficit also does not include women who were tested for HIV in the very early stages of infection, when anti-HIV antibodies are not yet detectable (the window period), and might have been identified only through repeat HIV testing at 36 weeks or later. Thirty-nine sub-Saharan countries have

implemented PMTCT programmes, however, only two countries, Botswana and Mauritius, have achieved universal coverage.

To completely eradicate HIV/AIDS in children form ages 0-15, general understanding from readings has divided this into two; the first is when the baby is still in the mother's womb and the other is during /after birth. When the baby is still in the womb, studies have shown that the mothers can take ATR drugs at different stages of pregnancy to prevent transmission to her baby. During birth, the mother can opt for a caesarean section for the delivery of her baby and subsequently breastfeed exclusively for 6 months then stop breastfeeding and introduce formula and other solid food. This has proven to be very effective.

The article also went further to buttress on antiretroviral therapy by observing thus:

Antiretroviral therapy: The new WHO PMTCT guidelines for ARV drug prophylaxis recommends giving HIV-infected pregnant women the drug azidothymidine (AZT) from 28 weeks, combined with single-dose nevirapine at birth to the mother and infant. Ideally, mothers should receive one week of further treatment of AZT and 3TC post-natally in order to reduce the likelihood of developing viral resistance to Nevirapine.These regimens, although very effective in clinical trials, have not been implemented at scale in high HIV prevalence settings. Experience within routine health systems is therefore lacking, and whether an integrated antenatal and post-natal care package can be successfully crafted to improve availability, sustainability and adherence to these prophylactic regimens is yet to be learned.

Key drivers of the HIV epidemic in Nigeria include low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and

debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.Looking at the third component mentioned above which advocates for Prevention of transmission of HIV from an HIV-infected woman to her infant during pregnancy, labour, childbirth, and breastfeeding through HIV counselling and testing, Antiretroviral (ARV) drugs for prophylaxis Antiretroviral therapy (ART) for those who are eligible, Safer infant feeding practices, it may not be out of place to mention here that counselling is central to the entire process of PMTCT. Pregnant women will have to be counselled before testing to find out their HIV status. If positive, it is hitherto seen as a death sentence in all parts of the world, however if the four components of PMTCT are implemented and communication (counselling) takes the lead, positive pregnant woman will get to find out that it is not actually a death sentence. It is through same counselling that such woman will be educated on medication, options available during childbirth and breast feeding.

Our review of the literature provide evidence to suggest that appropriate implementation of viral and information dissemination could go a long way towards achieving the prevention of HIV transmission from HIV infected mothers to their infants, and the provision of care and support for HIV infected mothers, infants and family members. Findings will lend support to the idea that well informed mother interventions focused on the factors that nurture the individual including family contexts is crucial to the success of PMTCT service uptake such as HIV testing, infant feeding choices, and adherence to ARV's. Finally, while we examine the role of information dissemination, this work will also make the case for communication as an intervention research, very little is known about communication as a form of combating the spread of PMTCT as this is an important area of future research.

2.9 HIV Counselling and Testing

HIVCounselling andTesting(HCT)isagatewaytovariousHIVprevention,treatment, careand supportservicesincludingPreventionofMothertoChildTransmission(PMTCT)ofHIVAccording to NACA, (http://www.naca.gov.ng/article/hct-hiv-counseling-and-testing visited on 30/08/2016), HIV Counselling and Testing (HCT) is the service rendered to an individual in order for him/her to know his HIV status, which could be either positive or negative and is usually confidential. Similarly, aside being the entry point to prevention, treatment, care and support, HCT contributes to the reduction of stigma and discrimination.

HCT is done in three distinct components, pre- test counselling before the blood is taken and this is meant to prepare the individual for the test and assess the risk level to HIV virus the person possessed. Also, it helps one to anticipate the result, whether it turns out HIV positive or negative. The second component is the taking of blood sample and test by using rapid test kits and lastly is disclosure of result, counselling and referrals, depending on the outcome of the result.

HCT is an integral part of HIV/AIDS and PMTCT. Without HCT, diagnosing HIV may not be possible except when an individual comes down seriously with some of the known symptoms of the disease which is usually associated with full blown AIDS and might be difficult to manage and control the disease. The National Agency for the Control of AIDS is using all strategy available to increase HCT uptake in the country. Provider Initiative HCT strategy is being introduced to most government funded hospitals to ensure that all patients that come in to health facility have access to HCT services at no cost.

2.10 The Importance of HIV Counselling and Testing

i. HCT helped millions of people to know their status, either positive or negative.

ii. HCT helps in preventing the spread of HIV.

iii. HCT allows the public to have access to medical care when tested positive.

iv. HCT educates people who tested negative on the ways to stay negative and for a positive test result, how to live positively without infecting others.

v. HCT provides critical information about HIV and the testing process.

vi. HCT gives information about how HIV is transmitted and how the public can protect themselves from infection.

vii. It also educates the public to know that HIV testing should be done regularly.

Similarly, testing for HIV is the gateway to prevention, care and treatment. HIV testing and counselling should be routine test for every Nigerian, as this is the surest way to guarantee an HIV free generation.

2.11 Guidelines for HIV Counselling and Testing

HCTis anentrypointforprevention, treatment,careandsupport services,however, demandforandsupplyofthisessentialservicehascontinuedtobelowdueto:

Stigmaanddiscrimination, lowawarenessandmisconceptions and lowcoverageandpooraccesstoHIVtreatment,careandsupportservices.

ThusdemandcreationforHCTserviceisstillaconsiderablechallenge.Thisiswhythe countryisutilizingmultipleapproachesincludingtheclient-initiatedcounsellingandtesting andprovider-initiatedcounsellingandtesting.

2.11.1 Theclient-initiatedapproachisthetraditionalVoluntaryCounsellingandTesting(VCT) inwhichanindividualvoluntarilyseekscounsellingandtestingservices.ThisapproachisofferedinallHC Tsettings.

2.11.2 Theprovider-initiatedcounselling andtesting (PICT)approachallowsthehealth careprovidertorecommend HCTroutinelytoclients/patientsasastandardcomponent

ofmedicalcareinthefacility. Two strategiesare commonlyusedinProvider-initiatedapproach, they are“Opt-out”–HIVtest whichisroutinelyrecommendedandprovidedto eachpatientand thepatientisinformedofhis/herrighttorefuse thetest. “Opt-in”–HIVtestisrecommendedandofferedtoeachpatientandthepatient explicitlyconsentstoreceivetheHIVtest.

NigeriahasadoptedtheOpt-outstrategytoboostaccesstoHCTwithinselectedclinical settings.TheOpt-out strategyisusedas partofbasiccareforante-natalclinicclients,all patients withtuberculosis(TB),sexuallytransmitted infections(STIs)andHIV-related diseases. Universalhumanrightsrequirementsforconfidentiality,consentandcounsellingmustbe respectedandupheld.

ThefollowingHCTservicedelivery models already in practice in the country incorporate both client-initiated and provider-initiated approaches. They are Standalone, Integrated Health Facility and Mobile/Outreach.

2.11.3 StandAloneModel

Stand-aloneservicesareprovidedinsites otherthanthehealthfacilities. Theyareusually situatedoutsidethehealthfacilities.Insomecases,thesesitesprovideadditionalHIVand AIDScareandsupportservices.StandAloneprovidesclientinitiatedHCTservicestothe generalpopulacewhovoluntarilyaccessit,forexample,thesexuallyactivemaleyouths

2.11.4 IntegratedHealthFacilityModel

Integrated servicesareprovided withinhealthfacilitiese.g.maternal andchildhealth (MCH),STI,TB,FPandout-patientclinicsas wellasforin-patients.Theseprovideboth theclientinitiatedandproviderinitiatedHCTservices.

2.11.5 Mobile/OutreachModel

Mobile/OutreachHCTservicesareprovidedforspecialpopulationssuchasHardtoReach (fishermen,nomads, women inpurdah, people livinginremote areas),MostatRisk Populations(MARPs)suchashighlymobilepopulations, longdistancetruckdrivers,MSM, IDU,SW,people whose work schedulemakesitdifficultforthem toaccessservices (factoryshiftworkers),and thoseincarcerated(prisoners).Thismodelprovidesboththe clientinitiatedandproviderinitiatedHCTservices

2.11.6 RoleofthePrivateSector

TheprivatesectorisamajorHCTserviceprovider,particularlyforthosewhocanaffordto payfor services,havemedicalinsuranceorfor employees/familiesprovidedwithmedical services.Companies,organizations,privatehospitals,FBOsandNGOs,providethis service,utilisinganyoracombinationofthemodelsdescribedabove.However,linkage andreferraltoothercareandsupportservicesneedstobeinstitutionalized.

2.12 Understanding the concept of mother to child prevention of HIV in the context of Communication for Development

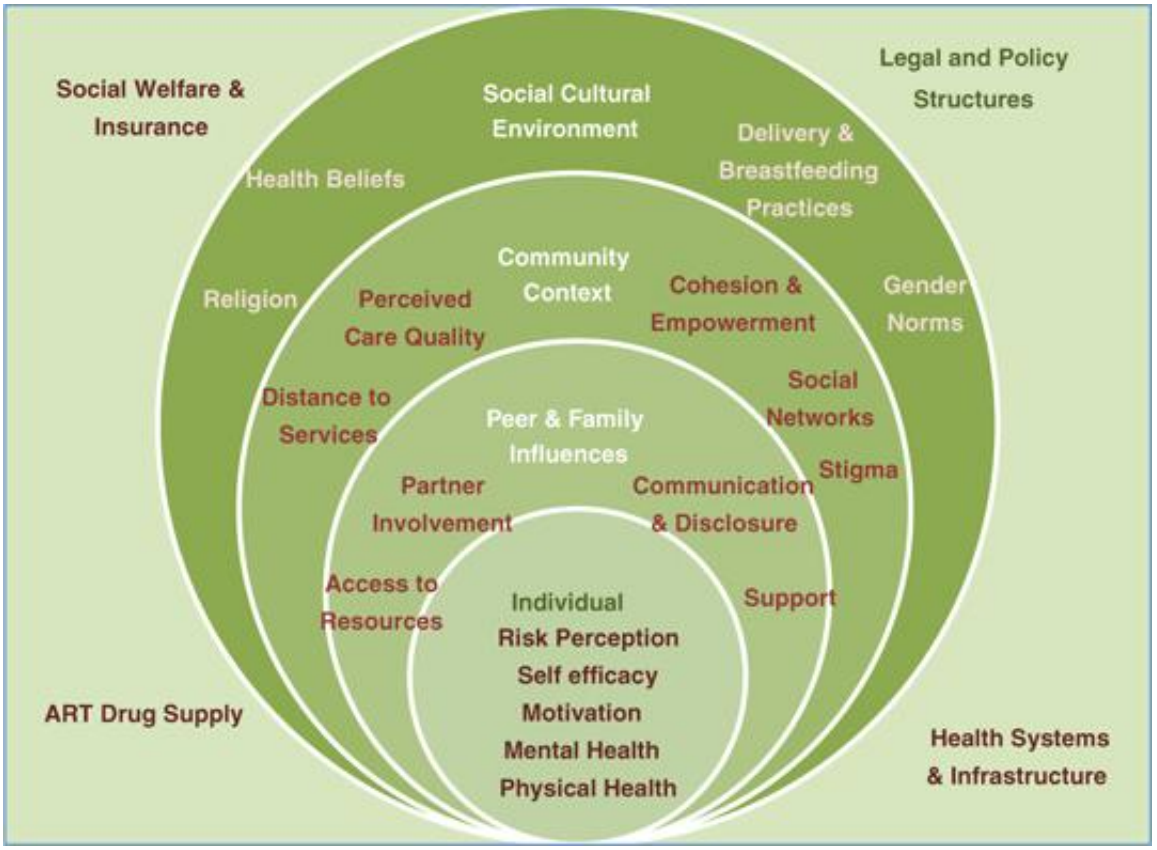
Since development is about the wellbeing of people, preventing mother to child transmission of HIV is paramount. The need to prevent mother to child transmission is important because the probability of under-five children surviving is low especially in the developing world. Therefore, if it is not adequately taken care of using communication strategies, it can affect the population of active citizens of a nation, which is tantamount to reducing GDP. It is in view of this that prevention of mother to child transmission of HIV is a development issue. WHO and other related health agencies who have taken up the responsibility of encouraging public health know the importance of the youth in a nation that most health interventions are targeted at them.

The youth constitute the active population and they are also worst hit by the HIV pandemic. The use of different modes of communication to reach them is paramount

2.13 Theoretical Framework

The theory that informs this work is the Social ecological framework for barriers to PMTCT. Health outcomes are increasingly recognized as being shaped less by individual's behaviour and more by the wider environments in which people live and make choices, influenced by family and peers, local beliefs and values, cultural norms and practices and political and economic circumstances (CSDH 2008 and Diez Roux 2004). The use of social ecological frameworks illustrate inter-relationships between proximate and distal determinants of health (Diez Roux (2004); Feldacker, Ennett and Speizer (2011) have been found useful in understanding HIV treatment adherence and programme retention (Mugavero, Norton and Saag, 2011). They demonstrate the way in which an individual's behaviours and health outcomes are nested within different levels of social organization, visually depicted as overlapping concentric circles, through which pathways of influence can take multiple routes.

Social ecological framework for barriers to PMTCT



The framework above illustrates the social ecological framework developed to guide the literature review, in keeping with recent approaches used to identify and synthesize available evidence driven by theoretical models rather than specific research questions. Each of the barriers to seeking, obtaining and remaining in PMTCT care, as summarized previously, has been situated at the level of social influence where it is most likely to operate. Individual pregnant women remain at the core of the framework, but their choices are embedded within multiple layers. Furthermore, this is to say that for every HIV positive individual or pregnant woman, the health status is not determined exclusively by the individual but also driven by other factors like the health system and infrastructure, availability of antiretroviral drugs and supply, access to resources, access to communication, partner involvement, peer and family influence, stigma and disclosure.

The study used this framework to develop review strategy for identifying community-based approaches implemented in developing countries to address one or more barriers along the PMTCT care continuum. Similar conceptually driven reviews have been conducted to understand determinants of access to services for sexual and reproductive health. The aim was to consider interventions at each level, although the focus was on the three middle circles of the framework (peer and family influences, community context and the socio cultural environment) as these seemed most amenable to being addressed through existing partnerships between biomedical service providers and civil society organizations, yet went beyond activities targeted at individual knowledge, attitudes and behaviours.

Community-Based Approaches

Extensive consultation with EGPAF staff throughout the organization, particularly in country-level programmes, as well as with other stakeholders, for example, partner institutions, civil society organizations, researchers in the field of pediatric HIV/AIDS care and representatives from donor agencies, led to adoption of the following working definition of community-based approaches to PMTCT: strategies and interventions to improve health behaviour and outcomes that are delivered outside of formal health settings including primary, secondary and tertiary medical facilities.

These could have a range of aims (e.g., increasing contact with individuals or empowering whole communities) but needed to explicitly target community members, their local civil or traditional authorities/leaders or traditional health providers outside the formal health sector. There was some ambiguity surrounding interventions where clinical services expanded to provide outreach, support or non-medical assistance (such as food supplementation) into the community. The researcher decided to define activities delivered outside facilities as

“community-based” regardless of how they were administered but not those where community members had to attend a clinic or health centre in order to receive the additional support.

According to National HIV /AIDS Strategic Plan 2010-2015, significant progress has been made in the fight against HIV and AIDS since the "United Nations declaration of Universal Access" in 2005.The population of PLWHIV has leveledoff at 33million people with about 4million receiving ART globally. Nigeria remains one of the most burdened nations with about 3million people living with the disease. Despite mounting a vigorous and sustained response, the HIV/AIDS epidemic has remained a major challenge and obstacle to the attainment of national development goals including the MDGs and the vision 20/20. All these underscore the importance of communication.

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CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

By definition, research means the careful investigation of a subject in order to discover or revise facts, theories, or applications. Thus, it implies how other researchers have approached a problem and how a new problem is to be treated systematically. Furthermore, research blends ideas and attitudes or findings of others to elicit a given scholarly work under study (Muller, cited in Okoh 2002). To Leeds, (quoted in Okoh 2002: 13), it is a procedure by which we attempt to find systematically, and the support of demonstrable fact, the answer to a question or the solution of a problem.

However, in development communication, research is seen in relation to interpretative approach to action research because the concern is about community development. Thus, in action research, the activity of naming and framing problems takes the form of cooperative inquiry into the situations of both researcher(s) and practitioner(s). For this reason, its purpose is one of widening the understanding rather than "discovering" knowledge. Jacobson and Servaes (1999) state that:

> 'The subjects involved in this kind of inquiry need to become aware of their situatedness… where actors create a new reality by reflectively questioning their assumptions, prejudices, interests, and distortions that underlie their… development process.'

Simply put, research here implies the idea of participatory communication which focuses, instead, chiefly on communication among local community members engaged in development effort. Thus, it has been used to refer to communication between community members and outside experts, academics, and field workers, but in such instances information transfer is de-

emphasized and the process of dialogue among participants is instead emphasized (Jacobson and Servaes 1999: 265).

In this chapter, the study adapted a methodology that revalidated the processes of prevention of mother to child transmission of HIV, which seeks to investigate the application of counselling techniques in the prevention of the epidemic from a mother to her child(ren).

A methodology based on participatory processes is used as a field study mechanism to re-examine the key issues. This is why the field method employed interviews and the administration of questionnaire with specific mind bugging items answered by the respondents who are HIV positive mothers and also the hospital administration responsible for such patients.

3.1 Research Design

This research is designed to collect qualitative and quantitative data for the study. Qualitative research is characterised by its aims, which relate to understanding some aspect of social life, and its methods which in general generate words, rather than numbers, as data for analysis.

For researchers more familiar with quantitative methods, which aim to measure something (such as the percentage of people with a particular disease in a community, or the number of households owning a bed net), the aims and methods of qualitative research can seem imprecise. This research method gives detail descriptions and explanations in narrative form; with constructive criticism of the phenomenon under study rather than providing and analyzing statistics. Furthermore, qualitative analysis justifies communication as a catalyst to development is better driven by experts and practitioners who work to sustain intervention programmes among target communities. In the process, qualitative analysis identifies associations with and between contributing factors for even development amongst them.

The basic sources for qualitative analysis here were books (both hard and soft copies) on HIV /AIDS, communication, community relations and views on its prevention and communication processes; recorded opinions /or social realities as put forward by key informants during field studies, newspapers and magazines publications as well as articles from Journals, which analysed and elicit communication practices in relation to prevention of mother to child transmission of HIV.

Quantitative Research is the systematic empirical investigation of observable phenomena via statistical, mathematical or computational techniques (Wikipedia 2016). Thus, this information as collected, analysed, interpreted, and presented will serve as the quantitative analysis of the study. Thus, quantitative research will carter for operational definition of variables, measuring problems and answering research questions about contributing factors among key assumptions of the research study. Specific issues that concern quantitative research are respondent's opinion, beliefs, and noticeable practices which are said to be at variant with standard rules or expected norms in the given context. They serve in generating statistical data which are either descriptive or inferential. This will aid or assist us in drawing conclusions about the wider population of the study.

Population of the Study

The population consisted of 29 hospital staff from the two selected hospitals with 19 from Saint Gerard's Catholic Hospital Kaduna in the Heart to Heart centre and 10 staff from Yusuf Dantsohohospital, Kaduna. Both centres have a total of 439 patients and are run by NGOs (Caritas Foundation of Nigeria) and ICAP for Saint Gerard's and Dantsoho Hospital respectively.

The population of the study is represented in Table 3.1.

Table 3.1 Population of the Study

S/N		No of patient	No of hospital staff	Total
1	St. Gerard's	53	19	62
2	Yusuf Dantsoho	386	10	396
	Total	**439**	**29**	**458**

Source: Statistics of patients and hospital staff 2015

3.2 Sample size and Sampling Procedure

The sample of patients for the study 57 for Saint Gerald Catholic Hospital and 191 for Yusuf Dan Tsoho Hospital making a total of 248 and this is in line with Krejcie and Morgan (1960) Table for determining sample size from a given population. For the hospital staff, since their numbers are very few, the study made use of all the hospital staff. The total sample of the patients and hospital staff summed up to 261 for the study. Purposive sampling procedure was used in choosing the samples for the study. The sample for the study is presented in Table 3.2 below:

Table 3.2 Sample of the Study

S/N		No of patients	No of hospital staff	Total
1	St. Gerard's	57	19	63
2	Yusuf Dantsoho	191	10	201
	Total	**248**	**29**	**261**

3.3 Instruments for Data Collection

The instruments used for data collection included interviews and questionnaire. The questionnaire is divided into sections A and B. Section A of the questionnaire provides the bio-

data of respondents, while Section B provided data for the research questions of the study. Section B contains questions with choices on a two-point scale ranging from Yes or No and Better or Not Better.

Interviewing is a conversational practice where knowledge is produced through the interaction between an interviewer and an interviewee or a group of interviewees. Unlike everyday conversations, the research interview is most often carried out to serve the researcher's ends, which are external to the conversation itself (to obtain knowledge about a given topic or some area of human experience). In most cases, research interviewing involves a "one-way dialogue" with the researcher asking questions and the interviewee being cast in the role of respondent. The qualitative research interview has become one of the most widespread knowledge-producing practices across the social scientific disciplines.

The interview conversation was introduced by a briefing in which the interviewer defined the situation for the participant and informed him or her about the purpose of the interview. Usually, the interviewer has prepared an interview guide in which the research questions are given a form that renders them suitable to be posed directly as interview questions.

The usage of interview in this research is necessitated by the need to afford some respondents the opportunity to air out their views and opinions concerning the issue in question that were not captured or provided for in the structured questionnaire.

3.4Procedure for Data Collection

The researcher visited the two hospitals and administered the copies of the approved questionnaire at their respective Heart to Heart centres to the hospital staff and patients. The

responses were collated and analysed. Conclusions were drawn from the result and solutions proffered were communicated in plain English language for easy understanding.

3.5Procedure for Data Analysis

Copies of well-articulated questionnaire were administered to 458 patience of St Gerald Catholic Hospital and Yusuf Dan Tsofo Hospital with a view to retrieve vital information required for the purpose of the research work. The responses were analysed using percentage application.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents the data and analysed the results. A total of 248 responses representing 80.1% of the total sample of respondents, formed the data analysed in this study. The first section presents the bio data variables analysis by means of frequencies and percentages, while the second section answers the research questions. The third section outlined the major findings of the study and the last section discussed the findings of the study.

4.1 ANALYSIS OF BIO DATA VARIABLES FOR PATIENTS

Table 4.1.1: Distribution of respondents according to sex

Variable	Frequency		Percentages
	St. Gerard's Catholic Hospital	Yusuf Dantsoho Hospital	
Male	0	0	0
Female	39	209	100
Total	**39**	**209**	**100.0**

Source: Field Survey, 2015

From data presented in Table 4.1.1, it was revealed that there were no male respondents that participated in the study, representing 0% and a further 39 females for Saint Gerard's Catholic hospital and 209 female respondents for Yusuf Dantsoho Hospital making a total of 248, representing 100% of the population of the patients and the hospital staff.

Table 4.1.2: Distribution of respondents according to age

Variables	Frequency	Percentages
20 - 25 yrs	17	6.9
25 – 30 yrs	122	49.2
30 and above	109	43.9
Total	**248**	**100.0**

Source: Field Survey, 2015

Details of the data presented in Table 4.1.2 above revealed that 17 respondents were within the age bracket of 20 to 25 years representing 6.9% of the total responses and another 122 respondents were within the age bracket of 25 to 30 years representing 49.2% of the total respondents, while 109 respondents were within the age bracket of 30years and above representing 43.9% of the total responses. This indicates that majority of the respondents fall within the age bracket of 25 years to 30 years and this is considered the most active in child bearing age bracket.

4.2 Answering of Research Questions

What are the major counselling processes used in hospitals to help infected mothers prevent MTCT and coping with the backdrop of stigmatization?

In answering research question one; questionnaire items had sub question items which were designed to elicit responses from the respondents. These questionnaire items and responses are discussed below.

Were you counselled before finding out about your HIV Status? Responses to this questionnaire item is summarized and presented in Table 4.2.1 below:

Table 4.2.1: Summary of responses on HIV status of respondents before counselling

S/No	Variable	Total Responses	Percentage
1	Yes	187	75.4
2	No	61	24.6
	Total	**248**	**100**

Source: Field Survey, 2015

The data presented in Table 4.2.1 above indicate that 187 respondents representing, 75.4% of the total responses had counselling before finding out about their HIV status while 61 respondents, representing 24.6% of the total responses did not attend any counselling session before finding out their HIV status. This shows that most of the respondents were aware of their HIV status through counselling.

Was the counselling helpful?

Responses to this questionnaire item are summarized and presented in Table 4.2.2 as can be seen below

Table 4.2.2: Summary of responses on the helpfulness of counselling to respondents

S/No	Variable	Total Responses	Percentage
1	Yes	190	76.6
2	No	58	23.3
	Total	**248**	**100**

Source: Field Survey, 2015

The summary of responses from respondents on the helpfulness of counselling revealed that 190 respondents, representing 76.6% of the total responses were of the opinion that counselling sessions actually helped them, while 58 respondents, representing 23.3% of the total responses were of the opinion that the counselling sessions did not help them in any way. This revealed that counselling sessions were of tremendous importance and helped most of the respondents in coping with HIV.

How did you feel before counselling?

Responses to this questionnaire item are summarized and presented in Table 4.2.3 as can be seen below

Table 4.2.3: Summary of responses on the feelings before counselling by respondents

S/No	Variable	Total Responses	Percentage (%)
1	Better	39	15.7
2	Not better	209	84.3
	Total	**248**	**100**

Source: Field Survey, 2015

From data presented in Table 4.2.3 39 respondents representing 15.7% of the total response were feeling better before the counselling session while on the other hand, 209 respondents representing 84.3% of the total responses were not feeling better before the counselling session. This indicates that majority of the respondents were sad and not feeling better before the counselling session.

How did you feel after the counselling Session?

The summary of responses to this questionnaire item are summarized and presented in Table 4.2.4 as can be seen below:

Table 4.2.4: Summary of responses on the feelings after counselling by respondents

S/No	Variable	Total Responses	Percentage(%)
1	Relieved	217	87.5
2	Not relieved	31	12.5
	Total	**248**	**100**

Source: Field Survey, 2015

Table 4.2.4 data revealed that 217 respondents representing 87.5 of the total response were feeling much better after the counselling session while only 31 respondents representing 12.5% of the total responses were still feeling bad. This indicates that the counselling session was of tremendous importance to the patients for it helped enliven their spirits and also boosted their morale.

Have you given birth after you discovered your HIV Status?

Responses to this questionnaire item are summarized and presented in Table 4.2.5 as can be seen below

Table 4.2.5: Summary of responses on giving birth to children after knowing their HIV status by respondents.

S/No	Variable	Total Responses	Percentage
1	Yes	161	64.9
2	No	87	35.1
	Total	**248**	**100**

Source: Field Survey, 2015

The responses in Table 4.2.5 revealed that 161 respondents representing 64.9% of the total responses gave birth after knowing their HIV status and 87 of the respondents representing 35.1% of the total responses did not give birth to children after knowing their status. This shows that after counselling, the patients must have learned that they can still give birth to healthy children free from HIV.

If yes, what is the status of your child

Summary of responses to questionnaire item is presented in Table 4.2.6 as can be see below.

Table 4.2.6: Summary of responses on the Child's HIV status by respondents.

S/No	Variable	Total Responses	Percentage
1	Positive	78	48.4
2	Negative	83	51.6
	Total	**161**	**100**

Source: Field Survey, 2015

Seventy-eight respondents, representing 48.4% of the total responses gave birth to children that tested positive to HIV while 83 of the respondents, representing 51.6% of the total responses

gave birth to children that tested negative to HIV test. This trend could be due to the counselling the mothers received and techniques they can use to give birth to children who are HIV negative.

Has PMT Counselling helped in prevention of transmission?

The summary of responses to this questionnaire item are summarized and presented below.

Table 4.2.7: Summary of responses on the effectiveness of PMT counselling on HIV transmission.

S/No	Variable	Total Responses	Percentage
1	Yes	234	94.4
2	No	14	5.6
	Total	**248**	**100**

Source: Field Survey, 2015

The data presented in Table 4.2.7 revealed that 234 respondents, representing 94.4% of the total responses answered in the affirmative that PMT counselling has had a positive effect on them while 14 respondents, representing 5.6% of the total responses answered negatively that PMT counselling has not had any effect on them. This goes to show that PMT counselling has a positive effect on the patients and should be continued since it helps the patients in coping with the disease.

4.3 SUMMARY OF RESPONSES FROM THE HOSPITALS STAFF

Table 4.3.1: Distribution of staff respondents according to sex

Variable	Frequency		Percentages
	St. Gerard's Catholic Hospital	Yusuf Dantsoho Hospital	
Male	5	2	24.1
Female	14	08	75.9
Total	**19**	**10**	**100.0**

Source: Field Survey, 2015

From data presented in Table 4.3.1 it revealed that there were 7 male respondents that participated in the study representing 24.1% and a further 22 female staff, representing 75.9% of the total respondents. This shows that majority of the respondent staff were female.

Table 4.3.2: Distribution of Staff respondents according to age

Variable	Frequency	Percentages
20 - 25 yrs	07	24.1
25 – 30 yrs	12	41.4
30 and above	10	34.5
Total	**29**	**100.0**

Source: Field Survey, 2015

Details of the data presented in Table 4.3.2 above revealed that 07 respondents were within the age bracket of 20 to 25 years, representing 24.1% of the total responses and another 12 respondents were within the age bracket of 25 to 30 years representing 41.4% of the total respondents and a further 10 respondents were within the age bracket of 30years and above

representing 34.5% of the total responses. This indicates that majority of the respondents fall within the age bracket of 25 years to 30 years.

Does your hospital have PMTCT Programme?

The summary of responses to this questionnaire item are presented in Table 4.3.3

Table 4.3.3: Summary of responses on the availability of PMTCT programme in selected hospitals

S/No	Variable	Total Responses	Percentage
1	Yes	29	100
2	No	00	00
	Total	**29**	**100**

Source: Field Survey, 2015

The data presented in Table 4.3.3 indicate that 29 of the staff respondents answered in the affirmative that the two hospitals have PMTCT programmes and this represent 100% of the total responses.

Are you aware of the components of PMTCT?

This questionnaire item seek responses from the hospital staff who are in the heart to heart centre whether they have an idea of the components of PMTCT and the responses to this questionnaire item are summarized in Table 4.3.4 as can be seen below:

Table 4.3.4: Summary of Responses on staff Awareness of the Four PMTCT Programme Componentsin their Hospitals

S/No	Variable	Total Responses	Percentage
1	Yes	20	68.9
2	No	09	31.1
	Total	**29**	**100**

Source: Field Survey, 2015

From the data presented in Table 4.3.4 above, 20 respondents, representing 68.9% of the total responses are aware of all the components of the PMTCT programme in the hospitals. A further 9 staff of the heart to heart centre were not fully aware of the components of the PMTCT programme. The reason given is that they were newly transferred from different departments and some were new employees still undergoing training and orientation on the various aspects of the PMTCT programme. From the responses given and summarized in Table 4.3.4 above, it shows that majority of the staff in the centres were fully aware of the components of the programme and that is why they have recorded high level of success in executing the programme in the two centres.

Twenty (20) staff were able to mention all the components of the PMTCT programme and 5 of the remaining staff were able to mention three of the components and 4 were able to mention only two. Those that were not able to mention all the four components were still at the various stages of learning or being introduced into the PMTCT programme fully.

Does your hospital apply these components in its PMTCT programme?

This questionnaire item seeks answers from the staff of the centres in the hospitals whether the hospitals apply the four components of PMTCT programme. The summary of responses is presented in Table 4.3.5 below.

Table 4.3.5: Summary of responses on whether the four PMTCT Programme component are applied in selected hospitals

S/No	Variable	Total Responses	Percentage
1	Yes	29	100
2	No	00	00
	Total	**29**	**100**

Source: Field Survey, 2015

The data in Table 4.3.5 indicates that 29 staff, representing 100% of the total responses of the Heart to Heart centres in the two selected hospitals stated in theaffirmative that all the four components of the PMTCT programme are usually applied in their hospital. This has led to tremendous success being recorded in the two centres with positive results on the part of the patients.

What type of counselling technique does your hospital use?

Responses to the counselling techniques being used in the various hospital are summarized and presented in Table 4.3.6.

Table 4.3.6: Summary of responses on counselling techniques being applied in the selected hospitals

S/No	Variable	Total Responses	Percentage
1	One on one counselling technique	27	93.1
2	Group counselling technique	02	06.9
	Total	**29**	**100**

Source: Field Survey, 2015

The data presented in Table 4.3.6 revealed that 27 respondents, representing 93.1% of the total responses indicated that their hospitals apply one on one counselling technique on patients in the various heart to heart centres, while 2 respondents representing 6.9% of the total responses indicate the use of group counselling especially for couples who are HIV positive so that they can live normal. This reveals that one on one counselling is being applied in Heart to Heart centres, since one of the principles of good counselling is confidentiality.

Has it been helpful?

This questionnaire item seeks to understand whether the counselling technique applied has been helpful to the patients and the summary of the responses are presented in Table 4.3.7 below.

Table 4.3.7: Summary of responses on whether the counselling technique has been helpful in selected hospitals

S/No	Variable	Total Responses	Percentage
1	Yes	25	86.2
2	No	4	13.8
	Total	**29**	**100**

Source: Field Survey, 2015

The responses on whether the one on one counselling technique applied to patients in the hospitals has been helpful indicate that 25 respondents, representing 86.2% of the total responses answered yes, that the counselling technique has been of tremendous help to the patients. Another 4 respondents, representing 13.8% of the total responses answered no to this research questionnaire item. The overall responses show that the counselling techniques applied in hospitals have been successful and has also helped patients to live normal lives.

Does it have any disadvantage(s)

The summary of responses to this research questionnaire item is presented in Table 4.3.8 as can be seen below.

Table 4.3.4: Summary of responses on whether the counselling havedisadvantage(s) of the counselling technique in selected hospitals

S/No	Variable	Total Responses	Percentage
1	Yes	20	68.9
2	No	09	31.1
	Total	**29**	**100**

Source: Field Survey, 2015

Responses above shows that 20 respondents representing 68.9% indicated that they are aware of the disadvantages of the counselling technique in use in the selected hospitals, while only 9 respondents representing 31.1% are ignorant.

During an interview with the nurse in charge of the Heart to Heart centre in St Gerald's Hospital, it was revealed that one of the major hitches encountered during counselling sessions is language barrier as some patients that come from rural areas cannot communicate with counsellors effectively. The health workers resolved to looking for a third party that can interpret at the spot

or give out contacts and ask the patient to call when the get home and find a relative who can communicate effectively order to understand their prescription and drug administration.

Furthermore, Traditional and cultural beliefs have also been identified as one of the major setback in PMTCT. Most patients will rather conform to traditional methods of breastfeeding for example rather than stick to global best practice given in the hospital.

4.4 Discussion of Findings

From the data presented and analysed, it is revealed that majority of the respondents were aware of their HIV status after counselling and majority of the respondents actually benefitted from the counselling process. This is in line with NACA's report which states that HIV Counselling and Testing (HCT) are the services rendered to an individual in order for him/her to know his HIV status, which could be either positive or negative and is usually confidential. Similarly, aside being the entry point to prevention, treatment, care and support, HCT contributes to the reduction of stigma and discrimination.

From the study it was found out that many HIV positive mothers gave birth to healthy children who are HIV negative and this was due to adherence to the communication and counselling services offered in the Heart to Heart centres in St. Gerard's Catholic hospital and Yusuf Dantsoho hospital in Kaduna where there are PMTCT programmes for pregnant HIV positive mother. This finding is also an improvement over UNAIDS (2004) findings which concludes that approximately 2.2 million children are currently living with HIV. Ninety percent (90%) of them became infected through mother to child transmission (MTCT) during pregnancy, delivery, and breast-feeding which is also known as vertical transmission. The highest rates is found in African with a large population of women of reproductive age, high birth rates, a tradition of prolonged breastfeeding and a lack of effective interventions aimed at preventing Mother to Child

Transmission Adewole et al, (2006**).**If this finding is anything to go by, the figures will drastically reduce since more women through counselling are now having HIV negative children.

Furthermore, the PMPTCT programmes in the two hospitals under review have been a success and have actually led to more pregnant mothers attending counselling sessions which have actually improved upon the health of the mother and the new born babies. This study found out that, more new born babies who are born by HIV positive mothers are HIV negative. This is also in adhering to the third and fourth components of comprehensive PMTCT programme endorsed by WHO and UNICEF as buttressed by LilyKak, et al in an article title 'Prevention Of Mother-To-Child Transmission Of HIV/AIDS Programmes'which are; **Component 1.**Preventing HIV infection in women of reproductive age, **Component 2.**Avoiding unintended pregnancy among HIV-infected women. **Component 3.**Preventing transmission of HIV from an HIV-infected woman to her infant during pregnancy, labour, childbirth, and breastfeeding through HIV counselling and testing, Antiretroviral (ARV) drugs for prophylaxis, Antiretroviral therapy (ART) for those who are eligible, Safer infant feeding practices and **Component 4.**Providing follow up and care, support and treatment to HIV-infected women, their infants, and families.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study is divided into five chapters with chapter one being the background to the study, the statement of the research problem, the objectives and the research questions. Chapter two consists of review of related literature and the theoretical framework,while chapter three specifically deals with the research design, population, sample and sampling technique, the instruments for data collection and methods, methods of data presentation and analysis. Chapter four of the study mainly deals with the presentation of data collected followed by analysis and discussion of findings. While the fifth chapter of the study contains the summary, conclusion and recommendations which are based on the findings of the study.

5.2 Conclusion

Since more pregnant women who are HIV positive are attending the counselling session it can be concluded that the pregnant women of that category have realized the importance of counselling and are ready to be attending such sessions because of the benefits they derive from that.

The one to one counselling technique being the communication strategy employed by most hospitals gives most patients the confidence to be attending such sessions. Therefore, it can be concluded that the communication strategy employed in most Heart to Heart centres is very effective and should be encouraged since it gives the counselee the confidence and confidentiality. As such more efforts should be put in devising better one to one counselling techniques by hospitals.

Most hospitals are using the PMTCT technique in preventing mother to child transmission of HIV. This can be seen in the number of healthy children being born by HIV positive mothers. This entails that more hospitals staff should be trained in the four PMTCT techniques to ensure greater efficiency in the programme in hospitals.

5.3 Recommendations

The study, therefore, makes the following recommendations based on the findings:

i. Research has shown that people are aware of HIV/AIDS, however the stigma associated with the disease is prevalent among the population and this can be attributed to 'negative publicity'. Therefore agencies responsible both government and private should further reiterate the level of awareness with specific communication strategies geared towards enlightening people that being HIV positive is not a death sentence but that one can live a normal life and have HIV negative child(ren).

ii. Since positive pregnant women are in dire need and deserve such a programme, the Federal Ministry of Health should integrate PMTCT programmes into hospitals rather than leave it in the hands of NGOs alone, this will aid programme sustainability in all government hospitals with rural areas inclusive.

iii. This research also recommends language training to hospital staff in HIV departments, at least the basics of the local languages of the communities in which the hospital is situated will help aid communication between patients and health workers.

iv. Traditional and cultural beliefs have been identified as a barrier in achieving PMTCT, therefore traditional institutions should be used as a medium for information dissemination for effective PMTCT programme

v. To sustain the momentum for both government and private hospitals engaged in PMTCT, an incentive can be introduced by government and donor agencies in the form of constant and un-relenting supply of drugs and information on future breakthrough in the field of HIV and PMTCT.

vi. Above all, Government should develop the political will to fund their part of the bargain alongside their international partners, unlike what obtains currently. The frame work for HIV/AIDS should be followed strictly as every single transmission from a mother to her child is a major setback and preventable. If more attention is given to prevention, less funding will be needed for treatment.

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Appendix I

QUESTIONNIARE FOR HOSPITAL STAFF

Research Questionnaire

Dear Sir/ Mr/ Madam/ Miss

The researcher is a student in the Department of Theatre and Performing Arts, Ahmadu Bello University, Zaria of Nigeria, conducting a research on 'Assessing The Importance of Counselling as a Communication Technique in the Prevention of Mother to Child Transmission of HIV in Two Selected Hospitals in Kaduna'

Kindly assist in filling- in the questionnaire with necessary information. All information will be held in utmost CONFIDENTIAL and used strictly for the purpose of this research.

Sincere and candid response to the questions will be highly appreciated.

Thank you

Doris Tanko

SECTION A:Personal data of respondents (Please tick as appropriate)

1) Gender: Male ☐ Female ☐

2) **Age**: 20-25 ☐ 25-30 ☐ 30-35 and above ☐

SECTION B

Indicate your answer by ticking any of the following options.

1. Does your hospital have a PMTCT programme? Yes( ) No( )
2. Are you aware of the four components of PMTCT? Yes( ) No( )
3. If yes to question 2, can you mention them?

a)……...

b)……..

c)……...

d)……...

4. Does your hospital apply these components in its PMTCT? Yes ( ) No ( )
5. How does the hospital apply these components in its PMTCT? .....

   ……

   ……

   ……..

6. What type of counselling technique does your hospital use? (a) One on one counselling technique ( ) (b) Group counselling technique ( )
7. Has it been helpful? Yes ( ) No ( )
8. Does it have any disadvantages? Yes ( ) No ( )
9. If yes to question 8, can you mention the disadvantage(s)? ……

   ……

   ……..

10. Are there other techniques used by your hospital? Yes ( ) No( )
11. If yes to question 10, what are they? ……

    ……

12. How would you rate them with counselling? Better ( ) Not Better ( )
13. How many new HIV positive pregnant mothers do you attend to in a month on the average? ……..

14. Do all of them come back for PMTCT programmes? Yes ( ) No ( )

15. If no to question 14, what do you think is responsible for those who do not come back?

    .....

16. Suggests ways on how you think counselling in PMTCT programme can be improved?

    ……

    ……

    ……

    ……..

Appendix II

QUESTIONNIARE FOR PATIENTS

Research Questionnaire

Dear Sir/ Mr/ Madam/ Miss

The researcher is a student in the Department of Theatre and Performing Arts, Ahmadu Bello University, Zaria of Nigeria, conducting a research on 'Assessing The Importance of Counselling as a Communication Technique in the Prevention of Mother to Child Transmission of HIV in Two Selected Hospitals in Kaduna'

Kindly assist in filling in the questionnaire with necessary information. All information will be held in utmost CONFIDENTIAL and used strictly for the purpose of this research.

Sincere and candid response to the questions will be highly appreciated.

Thank you

Doris Tanko

SECTION A:Personal data of respondents (Please tick as appropriate)

1) Gender: Male ☐ Female ☐

2) Age: 20-25 ☐ 25-30 ☐ 30-35 and above ☐

SECTION B

Indicate your answer by ticking any of the following options.

1. Were you counselled before finding out about your HIV status? Yes ( ) No ( )
2. Was counselling helpful? Yes ( ) No ( )

3. How did you feel before counselling? Better ( ) Not better ( )
4. How did you feel after counselling? Relieved ( ) Not relieved ( )
5. Have you given birth after you discovered your HIV status? Yes ( ) No ( )
6. If yes, what is the status of your child? Positive ( ) Negative ( )
7. Has (PMTCT) counselling helped you in prevention of transmission? Yes ( ) No ( )
8. Generally, would you say (PMTCT) counselling has helped in your knowledge of HIV?

   Yes ( ) No ( )
9. Suggest ways you think (PMTCT) counselling can be improved……

   …….....

   .....

Appendix III

Table for obtaining a sample from a given population

Required sample size, given a finite population

N-----n	N----- n	N----- n	N----- n	N----- n
10-----10	100-----80	280-----162	800-----260	2800-----338
15-----14	110-----86	290-----165	850-----265	3000-----341
20-----19	120-----92	300-----169	900-----269	3500-----346
25-----24	130-----97	320-----175	950-----274	4000-----351
30-----28	140-----103	340-----181	1000-----278	4500-----354
35-----32	150-----108	360-----186	1100-----285	5000-----357
40-----36	160-----113	380-----191	1200-----291	6000-----361
45-----40	170-----118	400-----196	1300-----297	7000-----364
50-----44	180-----123	420-----201	1400-----302	8000-----367
55-----48	190-----127	440-----205	1500-----306	9000-----368
60-----52	200-----132	460-----210	1600-----310	10000-----370
65-----56	210-----136	480-----214	1700-----313	15000-----375
70-----59	220-----140	500-----217	1800-----317	20000-----377
75-----63	230-----144	550-----226	1900-----320	30000-----379
80-----66	240-----148	600-----234	2000-----322	40000-----380
85-----70	250-----152	650-----242	2200-----327	50000-----381
90-----73	260-----155	700-----248	2400-----331	75000-----382
95-----76	270-----159	750-----254	2600-----335	100000-----384

Source: Krejcie and Morgan (1970:608) in Hill (1998).
Where N= Population size, and n= sample size required.