Care in the congregation

Dr Echezona Ezeanolue provides an insight into an intervention he is trialling in Nigeria. It aims to reduce mother-to-child transmission of HIV by reaching out to pregnant women in their places of worship.

Without effective interventions for the prevention of mother-to-child transmission (PMTCT) of HIV, what is the likelihood of a child contracting the infection?

The transmission rate approaches 30 per cent for infants born to a mother with HIV who did not benefit from available and effective antiretroviral drug interventions during pregnancy and labour, which subsequently provide the infant with antiretroviral prophylaxis early in life.

Why does PMTCT remain such a huge challenge, particularly in Nigeria, where you are currently working?

The goal of achieving an AIDS-free generation is unlikely to be reached if new infections persist among children. In 2014, an estimated 240,000 new infections occurred among children in Nigeria alone accounts for approximately 25 per cent of all new child infections. PMTCT efforts in Nigeria are therefore critical to achieving the global goal. However, there are many challenges to eliminating new infections, such as poor access to and stigma associated with testing, access to affordable care, limited health facility capacity for PMTCT and a low number of health professionals, among others.

One major issue in Nigeria is that many women are not effectively linked with healthcare facilities. Is this problem being addressed in your research?

Progress has been made in health facilities, especially in HIV counselling and testing, but with less than 35 per cent of pregnant women delivering in health facilities in Nigeria, this is only part of the solution. These issues are apparent when you recognise that a significant number of communities do not have a health facility in which to develop a PMTCT programme. Community-based approaches to create demand for testing and linking those identified with HIV to the health facilities that have PMTCT programmes will complement the progress made so far.

Think about our experience in the US: when we wanted to increase the number of people who received flu shots, we made them available at CVS Pharmacy, Walgreen and Walmart stores, in addition to doctors’ offices, because these locations are widely distributed and well patronised by the community. When we critically assessed communities in Nigeria (and most of Africa) looking for the equivalent of CVS, Walgreen and Walmart, the most widely distributed and highly patronised facilities in communities were worship centres such as mosques and churches.

Could you tell us more about the Healthy Beginning Initiative (HBI)?

HBI was designed as a feasible, acceptable and sustainable community-driven intervention culturally adapted and delivered by church-based health advisors (CHAs) to identify pregnant women, implement health interventions and support linkage to health services for women and their families. HBI uses the church, mosque or temple as a recruitment centre to identify pregnant women during prayer sessions. It implements an integrated approach to health screening and education during the baby shower reception, and uses the baby reception following infant baptisms as a follow-up to link both women and infants with health conditions to the health system.

What have been your major findings so far?

Results show that women and their male partners who attend churches that have adopted HBI have higher HIV testing rates - a crucial step in PMTCT. The study provides one more evidence-based intervention that is feasible, acceptable, sustainable and transformational in our effort towards an AIDS-free generation.

Where do you foresee as the next big steps in your work?

Congregation-based interventions are not a new phenomenon. The approach has been used in the US and other countries to improve immunisation rates, blood pressure monitoring, prostate screening, HIV testing and so much more. What makes the HBI innovative is the use of an integrated approach that is adapted to the culture. This is a major factor that could ensure the sustainability of programmes and interventions built on the HBI.

TO ACHIEVE AN AIDS-free generation, public health policy makers across the globe must focus on increasing the prevention of mother-to-child transmission (PMTCT) of HIV. When both mother and infant have access to appropriate testing and healthcare during pregnancy, delivery and postpartum, the chance of a seropositive woman passing the virus to her child stands at less than 1 per cent. But without such care, the risk of transmission rises to approximately 30 per cent. Efforts to improve PMTCT programmes must therefore focus on effectively linking pregnant women with well-equipped health services.

This is particularly true in Nigeria - a country that has one of the highest proportions of pregnant women living with HIV in the world, and yet where less than 50 per cent of these women are tested for HIV, less than 60 per cent receive antenatal care, and less than 50 per cent receive a healthcare facility. In light of such statistics, it is clear that clinic-based PMTCT interventions in Nigeria can only ever achieve limited effectiveness. Community-based alternatives are therefore urgently needed.

A FAST INTERVENTION

The Healthy Beginning Initiative (HBI) aims to fill this unmet need, providing vital information and access to pregnant women outside of the clinic. The Initiative is led by Dr Echezona Ezeanolue, Associate Professor of Pediatrics at the University of Nevada, Reno, and President of HealthySunrise Foundation, a non-profit dedicated to improving maternal-child health programmes. Community-based interventions that can be integrated with current health facility-based programmes hold promise in resource-limited settings.
such as Nigeria,” Ezeanolue explains. “Data have shown that pregnant women accept HIV testing when it is available and the transmission rate drops when mother and child are linked and retained in care.”

HBI works by targeting pregnant women in their places of worship – a choice grounded in the fact that around 90 per cent of Nigerians attend a religious service at least once a week, and can be applied throughout pregnancy and the postpartum period. Importantly, HBI meets the Feasible, Acceptable, Sustainable and Transformational (FAST) criteria. “The Initiative is feasible because it uses well-established infrastructure to deliver health interventions; it is adapted to be culturally acceptable by celebrating pregnancy and using an integrated testing approach that does not stigmatise HIV testing; it is sustainable because we don’t have to build new places of worship; and it is transformational because it is simple,” Ezeanolue elaborates.

CHURCH AND CLINIC
To assess the impact of HBI on PMTCT, Ezeanolue and his collaborators are conducting a cluster randomised trial comparing it with the conventional clinic-based approach. The primary aim is to evaluate the effect of HBI on HIV testing rates among pregnant women, while secondary aims include the evaluation of its effect on HIV testing among their male partners and the rate of PMTCT completion among seropositive pregnant women.

The trial is being carried out in churches across Enugu State in south-eastern Nigeria. Although the initial plan was to include 40 churches from four dioceses in the study, HBI proved so attractive to both churches and pregnant members of the congregation that all 200 churches in the dioceses were included. While this did result in some initial challenges, such as event overcrowding and limited supplies, it also served as a powerful demonstration of the popularity of this type of congregation-based approach.

Although the project is still ongoing, preliminary data indicate that pregnant women and their partners involved in HBI were more likely to be tested for HIV than their control group counterparts. Since testing is a crucial step to successful PMTCT, this finding provides evidence supporting the future development and expansion of the Initiative.

AN ADAPTABLE APPROACH
In terms of HIV reduction, HBI has the potential to be adapted and applied across a range of resource-limited, hard-to-reach populations, both in Nigeria and further afield. In light of the fact that, according to UNAIDS, 240,000 children were newly infected with HIV worldwide in 2013, any efforts that can be made to stem this tide are likely to have significant impact.

However, the possibilities represented by this approach are not limited to HIV; the HBI model could be used to tackle a range of maternal-child health problems, from perinatal depression and hepatitis B transmission to reproductive health and sickle-cell disease. Ezeanolue has plans to investigate these possibilities in the future: “We want to employ our new approach to tackle access to maternal health in resource-limited countries such as Nigeria, which has a population of 183 million people but only an estimated 150 psychiatrists,” he reveals.