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Maternal and Child Survival Program

Faith Based Leaders Mobilizing Communities to Save Lives of Mothers and Newborns

A Synthesis Report

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Acronyms and Abbreviations

ANC	Antenatal Care
CBNC	Community Based Newborn Care
COMBINE	Community Based Interventions for Newborns in Ethiopia
EDHS	Ethiopia Demographic and Health Survey
FHG	Family Health Guide
FMoH	Federal Ministry of Health
HAD	Health Development Army
HC	Health Center
HEW	Health Extension Workers
HP	Health Post
iCCM	Integrated Community Case Management
KCP	Kebele Command Post
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
NEGA	Newborns in Ethiopia Gaining Attention
PHCU	Primary Health Care Unit
PNC	Postnatal Care
SBCC	Social Behavior Change Communication
sKCP	strengthened Kebele Command Post
SNL	Saving Newborns Lives
SNNPR	Southern Nations Nationalities and Peoples Region
TBA	Traditional Birth Attendant

Background

The State of Maternal, Newborn and Child Health in Ethiopia

While Ethiopia was able to make significant improvements over the past decade in improving the health of mothers, newborns and children, the maternal, newborn and child mortality rates are still unacceptably high. Figure1 shows the child mortality trend over the past decades in Ethiopia. Despite the significant achievements over the past decades, 1 in every 35 children dies within the first month of their life, 1 in every 21 children dies before celebrating the first birthday, and 1 of every 15 children dies before reaching the fifth birthday. Maternal mortality ratio stands at 412/100,000 Live Births, meaning for every 1000 live births, 4 women die during pregnancy, child birth or postpartum period[1].

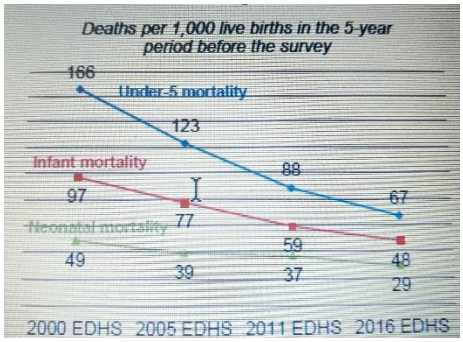

Figure 1: Trend in child mortality in Ethiopia

Box 1 and 2 Major causes of death for mothers and newborns.

Box 1: Causes of Maternal Mortality

- Excessive bleeding
- Sepsis (resulting from infections)
- Eclampsia (convulsions)
- Prolonged labor

Box 2: Causes of Newborn Mortality

- Severe infections
- Intrapartum related complications
- Preterm birth complications
- Congenital abnormalities

Barriers to seeking MNCH-CBNC care

Studies conducted by Save the Children[2] to document barriers to Maternal, Newborn and Child Health (MNCH) care in SNNPR[3], Oromia[4] and Amhara[5] and other similar studies[6] documented the following major barries for families seeking MNCH-CBNC care. Some of the barriers are related to the belief system and culture, some are related to access (physical, financial, social), and others are related to lack of information and knowledge.

- Belief that outcome of pregnancy is predetermined from God/Allah.
- Fear of 'evil eye' and of miscarriage.

[1] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.
[2] Save the Children conducted studies to identify barriers to MNCH-CBNC in SNNPR, Oromia and Amhara Regions through the Saving Newborn Lives and the MCSP-NEGA projects with the aim of using findings to improve program design and delivery.
[3] Rapid Assessment of Determinants, Factors and Opportunities to Early Pregnancy Identification, Focused Antenatal Care, Skilled Birth Attendance and Postnatal Care Service Utilization in Gurage and Sidama Zones of SNNPR . Addis Ababa: Save the Children. 2015.
[4] Rapid Assessment on Barriers to Early Pregnancy Identification, Focused Antenatal Care, Skilled Birth Attendance and Postnatal Care Service Utilization in East Shewa Zone, Oromia Region . Addis Ababa: Save the Children. 2015
[5] Barriers and Facilitators for early pregnancy identification, birth notification, antenatal and postnatal visits in Amhara Regional State, Ethiopia. June 2017. Unpublished report. MCSP NEGA.
[6] MCHIP. (2012). *Cultural Barriers to Seeking Maternal Health Care in Ethiopia: A Review of the Literature.* Addis Ababa: MCHIP.

- More trust in traditional rituals associated with pregnancy, childbirth and early neonatal period.
- Traditional beliefs that promote seclusion of mother and newborn in the early postpartal period.
- Women lacking autonomy and involvement in decision making.
- Limited physical access of health facilities, including difficult topography particularly for pregnant women.
- Inability to afford cost of services (direct as well as indirect cost, including cost related to transportation).
- Poor quality of health services in health facilities (perceived or actual based on previous experiences).

The National Community Based Newborn Care Program

The national Community Based Newborn Care (CBNC) program was launched in March 2013 following the successful implementation modality used by Save the Children's COMBINE (Community Based Interventions for Newborns in Ethiopia) research trial. The program was designed to be implemented using the integrated community case management (iCCM) program platform and in three phases over three years: Phase I covering seven learning zones in Amhara, Oromia, SNNPR and Tigray regions (primarily agrarian areas); Phase 2 covering the remaining zones in the four regions and Phase 3 to focus on the pastoralist areas of the country.

The CBNC package recognizes that essential newborn care requires a continuum of care provided at the household-health post-health centre and hospital levels; as well as the role of households as primary producers of their own health. The package was designed for implementation in Primary Health Care Units (PHCUs) along with appropriate referral systems linking communities to CBNC health services (components presented in Box 3). Based on evidence from the iCCM and the COMBINE research trial, the CBNC Implementation Plan promotes improving maternal and newborn care practices and care seeking through the Health Development Army (HDA) 1to 5 network, and empowering community mobilization approaches.

Box 3: Components of Community Based Newborn Care Package

- Early Identification of Pregnancy
- Provision of Focused Antenatal Care (ANC)
- Promotion of institutional delivery
- Safe and clean delivery including provision of misoprostol in case of home deliveries or deliveries at health post level
- Provision of immediate newborn care, including application of Chlorohexidine on cord
- Recognition of asphyxia, initial stimulation and resuscitation of newborn baby
- Prevention and management of hypothermia
- Management of pre-term and/or low birth weight neonates
- Management of neonatal sepsis/very severe disease at community level

With the aim of addressing the key barriers to seeking appropriate care and improved newborn care practices the Maternal and Child Program (MCSP)-

Newborns in Ethiopia Gaining Attention (NEGA) Project developed and implemented a comprehensive Social Behavior Change Communication (SBCC) strategy beginning in 2016. The strategy was designed to complement the MNCH-CBNC Demand Creation Strategy jointly developed by Save the Children's Saving Newborn Lives (SNL) and MCSP NEGA projects and being implemented in the 246 Save the Children CBNC implementation woredas advancing the CBNC package nationwide.

Engaging Faith-based Leaders in MNCH-CBNC

Traditional Roles of Faith-based Leaders in Setting Social Norms

Ethiopia is a very religious country with over 95 percent of the population belonging to the Christian (Orthodox Christian, Protestant or Catholic) or Muslim faith. Religion is highly intertwined with Ethiopian traditional norms and culture, and has a strong influence in the everyday lives of ordinary people. MCSP NEGA identified key common grounds that are inherent to the belief system and very appealing for faith-based leaders to engage in improving the lives of mothers and newborns (Box 4). The following are some of the key considerations on why we needed to engage faith-based leaders to advance the CBNC agenda.

Role Models: Faith-based leaders possess an ordained role of leadership in their institutions and communities, serving as role models of care and compassion. They shape social values and promote responsible behaviors that respect the dignity and sanctity of all life.

Community Spokesperson: Faith-based leaders are well situated to address social issues and have the capacity to bring communities together. As community spokespersons, they often are successful in mobilizing for positive social change. Once convinced, these leaders can play an important role in shifting their communities' beliefs, attitudes, and behavior related to MNCH, as they have already started to do for HIV.

Moral Influence: Their moral influence and extensive networks give them access to the most disenfranchised and deprived groups, those that international organizations and governments are sometimes less able to reach effectively.

Box 4: Common Grounds

- Dignity of every person is key in all religions, hence, faith-based leaders have the moral responsibility to prevent maternal and child death, and strive to transform societal or religious norms or practices that perpetuate maternal, newborn and child death.
- Nearly every major religion views life as a sacred gift from a divine creator or creating force(s). Promoting and maintaining good health in children is understood as an obligation in many religious traditions.
- Maternal and child death is a threat to family life and spiritual well-being. As young men and women fall ill and die, they often suffer spiritual anguish, social isolation and physical and economic hardship. They also leave behind grieving children, spouses and friends who call out faith-based leaders for comfort and practical guidance.
- Some attitudes and behaviors that are understood to be grounded in religion are, in fact, rooted in other social and cultural norms. These distinctions are important since harmful practices that are based on other cultural values can be challenged and redressed by religious actors.

They can also influence thinking, foster dialogue and set priorities for members of their communities.

Close Links: Faith-based leaders have close links to their communities which provide them with an opportunity to promote behavior change and address other cultural factors contributing to maternal, newborn and child mortality. Because they have more access to the family and personal spheres than most outside actors. Hence, they can serve as an important conduit of communication for social change and transformation.

Trusted and Credible: Faith-based leaders have credibility and trusted relationships with their communities and often have strong linkages with the most disadvantaged and vulnerable members. Their words and instructions are much respected and often fulfilled.

***Knowledge and Skills*:** Many faith-based leaders are skilled and influential communicators who can reach the hearts and minds of millions of people in ways that humanitarian actors cannot. They are educated and can interpret and address misconceptions related to religion as well as important social issues.

Sustainability: They will be there long after projects have phased out.

Leveraging Faith-based Leaders' Influence

Based on lessons from HIV/AIDS interventions in Ethiopia and experiences elsewhere, MCSP NEGA identified actions faith-based leaders can do that could significantly contribute to positive MNCH-CBNC practices, which in turn leads to positive maternal and newborn health outcome. To do this, they need to become as 'MNCH aware' as possible, this includes reading and internalizing information from the *Family Health Card*[7] and other relevant materials, as well as participation in discussion with HEWs and health workers whenever the opportunity arises. Box 5 presents some of the identified actions.

[7] The Family Health Guide is a national communication material with key messages related to MNCH-CBNC developed for low literate community by the FMOH and MNCH partners in 2011. It is a harmonized MNCH messaging tool for use by HEWs, HDAs and households across the nation. It is revised since with additional key messages and a full color version is in use since 2015.

Box 5: How can faith-based leaders contribute towards positive MNCH-CBNC practice in their communities?

- Clarify that cultural practices harmful to mothers and children are not part of religious beliefs and practices and advocate for their abandonment.
- Invite professionals (e.g. teachers, doctors, social workers) from religious communities to talk about MNCH-CBNC to their own members during worship services.
- Challenge attitudes that reject evidence-based health interventions for mothers and children such as institutional delivery, immunization and breastfeeding, early newborn care, early care seeking and facilitate changes in attitudes and practices. Work against the tradition of total seclusion of newborns during the postpartum period that could be detrimental to their wellbeing.
- Utilize religious media, such as radio and television networks run by religious organizations, to disseminate messages regarding MNCH-CBNC.
- Reinforce appropriate maternal and newborn care messages when they visit their God children during pregnancy or the postpartum period.
- Review spiritual writings, local sayings, beliefs and traditions that support maternal and newborn care. Air the facts and develop consensus on appropriate theological and ethical responses and systems of support.
- Raise discussions in mosques, churches, temples, *senbetes, mahbers,* Bible study groups and other places of worship, within faith-based leadership structures and in the broader community to help end maternal and newborn death.
- Invite HEWs or other public health professionals to share basic MNCH-CBNC related information to the congregation.

Approaches to Engaging Faith-based Leaders in MNCH-CBNC

The MCSP NEGA program employed two key approaches to engage faith-based leaders in improving MNCH-CBNC outcomes in their communities. This involved:

1. Facilitating faith-based leader engagement in the MNCH-CBNC demand creation activities, specifically, strengthening their membership and function within kebele level Kebele Command Post (KCPs) through a community empowering and capacity building process.

MCSP NEGA applied a community empowering, demand creation approach using a Community Action Cycle process to initiate MNCH-CBNC action at the community level. To institutionalize community MNCH-CBNC action, MCSP used the existing formal community leadership structure, the Kebele Command Post – KCP, to facilitate ownership, participation, effective implementation, resource mobilization, and monitoring of prioritized activities and their outcome. In consultation with KCPs, agreement was reached to expand membership to include key population groups – e.g., faith-based leaders, traditional birth attendants, other respected elderly community members, strong HDA leaders, as well as women and men who

have experienced poor MNCH outcomes and who were willing to share their experiences. As a result in all kebeles where the program was being implemented, faith-based leaders have become a key member of the 'strengthened' KCP working closely with the HEWs to promote positive MNCH-CBNC behaviors and practices, as well as counsel households and families to address harmful traditional practices, especially those related to childbirth and the early neonatal period.

2. Capacity building on key MNCH-CBNC barriers, practices and providing MNCH training to selected woreda level faith-based leaders from each project woreda such that (i) they support their fellow faith leaders engaged in the sKCPs; (ii) cascade what they have learnt to other faith leaders in the respective woredas to allow broader reach. This brief report mainly focuses on the second approach.

In addition to using faith-based leaders to reach communities and households with key MNCH message to improve positive behaviors and practices, MCSP NEGA considers this as critical to engaging men in MNCH given faith-based leaders are primarily male in Ethiopia.

Capacity Building for Faith-based Leaders

In order to reach to as many faith-based leaders as possible and create champions at the woreda level, MCSP NEGA worked closely with Zonal Health Bureaus to facilitate the selection of up to four faith-based leaders from each of the 135 project woredas. The identified faith-based leaders representing the main faith groups in the woredas were then brought together at their respective zonal towns for a one-day training (Table 1). Training workshops were structured based on the Faith-based leaders Engagement Guide developed by MCSP-NEGA. (Annex A).

Table 1: Faith-based leaders trained in MNCH-CBNC by Region.

Region	Planned	Achieved (%)
Tigray	56	124 (221%)
Amhara	168	157 (93%)
Oromia	168	71 (42%)
SNNPR	148	148 (100)
Total	**540**	**505 (94%)**

A series of training workshops were organized in the twelve (12) project zones and served as an opportunity to build consensus with faith-based leaders on reasons for engaging in MNCH-CBNC strategies for how to improve MNCH-CBNC outcomes in their communities, and how best to effectively work together as faith-based leaders. During the workshops, effort was made to learn from those faith-based leaders who had already been engaged in promoting positive

MNCH-CBNC practices. Discussions and presentations during the workshop built on images, anecdotes and quotations from the Bible and the Quran, in order to stimulate interest, harmonize common goals, and generate ideas for action.

> *"I have learned to view the problem of maternal and neonatal death from a new perspective. And I am looking forward to spreading the vital information parents need to know to protect mothers and babies from death".*
>
> *Sheik Nasr Arbisie, Alamata, Tigray Region*

Workshop participants were provided technical information on positive MNCH-CBNC family practices. Key strategies were also discussed around how to integrate MNCH-CBNC health promotion and action into their current religious practice. The highly interactive workshops were instrumental in building the confidence of the faith-based leaders to cascade their knowledge to other faith leaders in their respective woredas and implement practical actions in their communities and households in order to influence MNCH-CBNC behaviors and practices.

At the end of the training workshops participants were encouraged to develop their own plan of action as to what to do and how, depending on their local context. They were asked to document their MNCH-CBNC related activities to the extent possible to be able to share at a review meeting the following year.

Faith-based leaders Taking Action

The following case stories provide real-life examples of the actions undertaken by faith-based leaders to promote positive MNCH-CBNC behaviors and practices within their constituents, as well as sharing and advocating for improved social norms amongst other faith-based leaders in their communities.

Action: Taking Leadership: Cascading MNCH-CBNC knowledge within the Faith-based Community

Pastor Alemayehu Israel was one of the participants of the training workshop from SNNPR and here is his testimony.

"We [faith-based leaders] are the most trusted and respected members of the community. People turn to us for guidance on issues of family and personal matters. Often times, we are the first to be notified and consulted when families face health, livelihood, social and other problems. This puts us in a unique position to witness many incidents and events including the tragic ending of pregnancies and newborns. I myself have seen mothers and newborns dying from causes that could have

Figure 2: *Pastor Alemayehu Israel, SNNPR, Chencha Woreda; Photo Credit Gashahun Gebre*

been prevented" said Alemayehu Israel, Pastor of Chincha Worea Kalehiwot church and Secretary of Chincha Wereda Religious Institutions Forum.

Pastor Alemayehu continues: *"A couple of years ago, I was in Dita Wereda to minister the word of God in one of the local churches. One of the believers requested me to accompany him to a certain house and pray for an expectant woman. When we got there, the woman was in labor; and I advised her family to rush her to a health facility. However, they refused to do so for traditional and cultural reasons. When the woman failed to deliver after three days in labor, they agreed to take her to a health facility. Nonetheless, it was too late for both the mother and the baby to survive. I still feel the pain and anger it left in my life. Ever since then, I have always wanted to contribute my part to reduce the unnecessary death of mothers and newborns. However, I was not sure how to do it and what kind of messages to tell to my fellow believers until I was presented with the [training] opportunity."*

"In May 2016, MCSP NEGA offered a day long training to faith-based leaders from different woredas on issues of maternal and newborn health. The training equipped me with the information and tools I would need to promote healthy maternal and newborn behaviors and practices. It also helped me to have clarity of mind on the role religion plays in changing harmful traditional practices and what my role could be. The training and the subsequent discussion also helped me identify relevant verses from religious texts that enhances healthy maternal and newborn behaviors for my individualized counseling sessions, at sermons and public meetings. Overall, it equipped me with the knowledge and gave me confidence to reach out to my colleagues to share what I have learnt."

"Soon after the date of the training, I summoned and oriented members of the Chencha Wereda Religious Institutions Forum members which comprises of Protestant, Orthodox, and Islam religions. The Forum agreed that saving the lives of mothers and children is in the best interest of every religion; and decided to contribute its part. Accordingly, the Forum issued a letter that requires its members to devote at least thirty minutes a month in their sermons to promote positive MNCH behaviors; and send a report to me on quarterly basis. This activity is also included in the Forum's annual plan of action which is shared with the Woreda Health Office and other relevant stakeholders. The Forum is now implementing the plan in all the branches (1 Mosque and 130 Orthodox and protestant churches). Faith-based leaders in our wereda have now started delivering key health messages enhanced by relevant verses from the scripture. They are also inviting health extension workers to convey appropriate messages to their congregations during religious gatherings. I pray and hope to intensify our efforts and end the tragic death of mothers and children in the near future."

Action: Integrating key MNCH-CBNC Information into Sermons

> "*In addition to promoting appropriate maternal and newborn health practices during sermons and religious festivities, I have also counseled many during my home to home visits.*" Kes Melakeselam Hailemnasie.

In the Embaalaje district of Tigray Regional State, Southern Zone, much progress has been made since MCSP NEGA started engaging faith-based leaders in improving the state of MNCH.

Kes Melakeselam Hailemnasie, 64 years old Orthodox Priest and head of Embaalaje Woreda Orthodox Churches Forum, participated in the training MCSP NEGA organized for faith-based leaders in Southern Zone of Tigray. He explains the training and what he did afterwards as follows.

"I participated in the training workshop for faith-based leaders in Embaalaje Woreda that was organized by MCSP NEGA. I can confidently say that the presentations and lively interactions with the facilitators and other participants in the training has equipped me with the knowledge required to educate community members on beneficial MNH practices", said Melakeselam. "It has also helped me to have a deeper understanding of the role we faith-based leaders can play to prevent maternal and newborn death."

Figure 3. *Kes Melakeselam using a family health guide to educate a mother who recently gave birth to a boy. Photo credit: Mesgena W/Gebriel*

Kes Melakeselam has reached more than 8,000 individuals with MNCH messages during regular sermons and other religious festivities using the Family Health Guide he received at the training workshop. He has also oriented his peers on the role they should play to improve the MNH situation in their community.

One of the beneficiaries from Kes Melakeselam's efforts is Abeba Mesele, a 21 year old mother of two. When she was pregnant with her second child, Kes Melakeselam approached her and taught her the importance of going to a health facility for antenatal checkup, delivering at a health facility and having early postnatal checkups. "*As a result, I took more than four antenatal facility checkups during my pregnancy, and gave birth to my baby at Adishuhu primary hospital. Upon returning from the hospital, I have informed the health extension worker in my kebele of my delivery and she visited me at home to check on me and my baby. Many thanks to Kes Melakeselam's advice, both my child and I are healthy",* said Abeba.

Action: Individualized Counseling and Support

Meria Haji Woyu, 18, is a high school dropout from Lemuna Bilbilo Woreda of Arsi zone in the Oromia region. An outstanding student fully supported by her strong single mother, Teyu Hawisho, she passed the regional exam in grade eight with an excellent score of 99.5%. But it was not long after Meria started enjoying her grade nine lessons that she got pregnant. At first, she did not know what to do, but then she took the news to her boyfriend. According to Meria, her boyfriend was very shocked and angry with her. Meria hid herself in her boyfriend's house for two days. When she went out of that house just for a bit, her boyfriend locked her out and left the village. Her mother was unable to bear the 'shame' Meria brought into her family. Her two brothers, who are still in bad terms with her, threatened to kill her unless she gets married to the man who got her pregnant. It was when she was at this desperate situation Haji Hassen Sikisa Andu, the local religious leader, stepped into her life.

Figure 4*: Meria Haji with her son in her village*
Photo credit: Zewge Abate

Haji Hassen Sikesa Andu has participated in the training workshop MCSP NEGA organized for faith-based leaders in Arsi zone. Following his training, he is proactively reaching out to families to educate them to avoid harmful attitudes and practices as well as promoting good ones. Here is Meria's story in her own words.

"My name is Meria Haji Woyu and I am 18. I live with my mother and siblings in Inqolo Gerjeda Kebele in Bilbilo Woreda of the Oromia region. Things were very bad for me last year. I was enjoying school in grade nine when I started seeing someone, something I never thought I would start that early. Worse, I got pregnant soon after and did not know what to do about it. I contemplated keeping this to myself and move on as if nothing happened. But, how long could a pregnant girl do that? I then decided to tell my boyfriend what happened.

He was very shocked and angry with the news. It looked like he was not part in this; but then he took me to his house nearby and I hid myself there for two days. When I came back from a brief walk the next day, I found my boyfriend's house locked. I realized he left the village, and he never contacted me ever since.

I had no option other than going back to my mother. When I told her about my situation, she was extremely furious. She said I was an embarrassment to the family. I did not expect her to be soft about this because, in our culture, having a baby without getting married calls for a serious condemnation. My two brothers behaved even worse. They persistently threatened to kill me unless I marry the man who got me pregnant.

I wanted to take my own life because everything that was happening in my life was beyond what I was able to take as a young schoolgirl. I was already looking for poison to put in my food when Haji Hassen came to our house. Like many in the community, he heard my story. He took a long time counseling me and my mother. First, I was not listening from the heart. I told him not to waste his time and the only thing that would set me free from my burden was death. He was shocked to hear me say these things. He told me how, more than anything else, taking one's own life is condemned in our religion. He also promised me to find me a job so I can raise my child well. Gradually, he managed to calm me down and his frequent visits made a difference in my thinking. Following his persistent counseling on the importance of doing check-ups in health facilities, I started to receive antenatal care in the local health post. He also convinced my mother to take care and be protective of me and my baby. But my two brothers would not listen to anyone. They are still cross with me.

Figure 5: *Meria with her son (center) and her mother (right) with Haji Hassen Sikisa Andu (left). Photo credit: Zewge Abate*

Now I am a very happy mother. My son was born at home, but I took him to the health post for vaccination and medical check-up. I know school is my thing, and I will get back to it next year. My mother supports my plan and she pledged to take care of my baby while I go to school. I wouldn't have been where I am now if it was not for the support and counseling I received from Haji Hassen", said Meria.

Action: Going beyond Education to Sharing of Resources

Nuruya Reda, 25 and a mother of two, livers in Gerjele Kebele with her husband Hussein. The Kebele is found 15Kms south east of Alamata town in Southern Zone of Tigray region. The area is known for its harsh terrain and it lacks in access to modern ambulance services severely limiting physical access to modern health facilities.

In December 2016, Nurya was home alone when she started to have labor pains and started to bleed. Nuruya suspected that she could be in trouble but unfortunately there was no way that she could walk to a health facility. While contemplating what to do, she was visited by the God-send Sheik Nasr, a 43 year old religious leader who participated in the MCSP NEGA faith-based leaders training workshop. The Sheik had already acquired knowledge on identifying danger signs during pregnancy, labor and postnatal periods which was discussed as part of the training.

The Sheik, who makes a living driving a horse ridden cart, saw that Nurya was in trouble and used his cart as an ambulance to drive her to the nearest health facility where she stayed in labor for eight hours. She was then transferred to Alamata Hospital with a modern ambulance and she gave birth to her son Kubra. If Nuruya had not been lucky to be visited by the Sheik at the right time and taken to the health facility, the outcome may not have been positive.

Figure 6: Sheik Nasr discussing key MNH messages with Nuria and Hussein using the Family Health Guide. Photo credit: Mesgena W/Gabriel

"I have learned to view the problem of maternal and neonatal death from a new perspective. I look forward to spreading the vital information parents need to know to protect mothers and babies from death", said Sheik Nasir Arbisie.

The Sheik didn't stop his support even after she gave birth. After baby Kubra Hussein was born, Sheik Nasr Arbisie visited her three times a week to provide counseling and check on the condition of both mother and newborn. *"Sheik Nasr Arbisie explained to me about the danger signs of newborns that I should be keeping an eye on and seek immediate medical care if I happen to see any of them in my baby*", said Nurya, breastfeeding her son. *"I am glad that I met Sheik Nasr who is very patient in explaining to me and my husband everything about newborn health after my baby was born"* she added.

Since 2016, faith-based leaders from Raya Alamata woreda in Southern Zone of Tigray Region have helped disseminate key MNH messages that promote healthy maternal and newborn care practices to many pregnant women and mothers. After participating in the training workshop, not only did the faith-based leaders promote and support positive MNH behaviours and practices, but also organized themselves to volunteer in donating blood when it is required to save lives of women and babies.

Experience Sharing Amongst Faith-based Leaders

About a year and quarter after the initial training workshop, MCSP NEGA jointly with the respective zonal and woreda health offices, organized zonal level faith-based leaders experience sharing workshops with the aim of:

i) hearing from them and what they have been able to do over the past year,
ii) bottlenecks and challenges they may have faced,
iii) discuss strategies on how they can sustain their work going forward

Table 2 (below) provides a summary of review meeting participants by region. A total of 449 (83% of the faith-based leaders who participated in the initial training) participated in the review meetings.

Table 2: Number of faith-based leaders' participants in zonal review / experience sharing workshop, by region.

Region	Plan	Achieved
SNNPR	190	188 (99%)
Oromia	74	60 (81%)
Amhara	157	125 (80%)
Tigray	28	110 (393%)*
Total	449	483 (107%)

In Tigray, informed by the MNH actions faith-based leaders have started taking after the training, the Zonal Health Bureaus requested MCSP NEGA to involve additional faith-based leaders that didn't participate in the initial training from the project woredas and kebeles. The cost related to the additional participants was covered by the respective woredas /zones. The workshops were opportunities to review progress, share experiences, renew commitment and build consensus on the way forward. At the workshops, it was learnt that nearly all faith-based leaders that participated in the training workshops last year have implemented some MNCH actions in their respective woredas and communities, mostly educating on positive MNH behaviors and practices during religious gatherings and through home visitation of followers, particularly of pregnant women.

Figure 7: *Kes Yalew sharing his experiences during review meeting at Debre Tabor, South Gondar Feb. 22, 2016; Photo credit: Jimmy Teshome*

Zonal and woreda health office representatives in the workshops reported that the faith-based leaders work and teachings in MNCH has gained significant acceptance from the community; their peers; and health facilities and offices. They confirmed that the faith-based leaders have been consistently using the Family Health Guide (FHG) they were provided during the training workshop as their "bible" while discussing MNCH in the communities and at households. A

large proportion of the faith-based leaders demonstrated very good knowledge of appropriate MNCH behaviors during the knowledge assessment session conducted using the MNCH knowledge assessment brochure developed by MCSP NEGA (see Annex B for brochure).

The faith-based leaders indicated that, now that they have experienced what they can do in MNCH and the small changes they can bring about, they want to continue to contribute their share to prevent unnecessary deaths of women and children. As a way forward, the faith-based leaders requested the zonal and woreda health office representatives to initiate a support for them through providing guidance in action planning and consider collating reports of their work so that their contribution is recognized.

Informed by the key challenges participants discussed in the workshops, the joint action plans focused on reporting and working relationships with the woreda health offices, both of which are critical to ensure faith-based leaders' continued engagement in MNCH beyond the project phase-out. At the end of the workshops, joint action plans were prepared based on the experiences, lessons learned and agreements reached with the Woreda and Zonal Health office heads.

Institutionalizing Faith-based Leaders' Engagement in MNCH-CBNC

Institutionalization of faith-based leaders' role in MNCH within existing structures was considered from the design stage. As such, MCSP NEGA facilitated the inclusion of faith-based leaders in the sKCP membership. The strengthened KCP with inclusion of representatives from key community groups is considered among the key MCSP NEGA 'legacy' HEWs, health center and woreda health office leadership identified. HEWs often refer to the sKCP as *"obtaining more legs to reach every corner of the kebeles"*. Zubeyda's story below is one example.

Zubeyda Musa, 27, is a HEW at Ufra Agamsa Kebele Health Post in Sire Woreda of the Oromia region. Among other things, her work involves continual counseling of mothers to seek MNCH services available at different levels. She said her engagement with the community in this regard has been more successful after MSCP NEGA program started to be implemented in 2015. She appreciates the approach to demand creation that has helped to leverage local community members and improve their maternal and newborn care-seeking behavior.

Figure 8: *Zubeyda Musa, HEW at Ufra Agamsa Health Post, explaining the Community Action Cycle poster that the sKCP got printed for use during the 'demand creation' experience sharing event they organized for other kebeles in the woreda. Photo credit:*

Zubeyda's story in her own words:

"My name is Zubeyda Musa. As a health extension worker in Ufra Agamsa Kebele Health Post, I have used various platforms to teach the community in my reach about the importance of neonatal and postnatal care. I go to community meetings organized by the Kebele administration and use the opportunity to provide health education. Upon invitation of faith-based leaders, I even went to religious congregations to promote delivery at health facilities, which are very important in reducing death in mothers and newborns. I am the secretary of the Kebele Command Post, a platform we use to raise community awareness of maternal, newborn and child health services and their contribution to reducing incidents of maternal and newborn death. I like the way the Kebele Command Post has lately been reorganized for better results.

Previously, the Kebele Command Post had members mainly from government structures. These included health extension workers like myself, the local school director, the Kebele Chairman, a representative from the office of Women and Children's Affairs and so on. The Committee worked towards creating community demand for health services, among many other endeavors to ensure community development. But the Command Post was very stretched to properly deal with health matters and also lacked key members from grassroots.

When the MSCP NEGA program came with a guideline for effective community intervention and strengthening Kebele Command Post structure, I started to enjoy better conversations with faith-based leaders, community elders, health development army leaders, and mothers with previous maternal health or ill-health experience who have all now become members of the Kebele Command Post. This has led to better results because of the stronger relevance of these additional members for the community. For instance, instead of me addressing a religious mass about the use of maternal, newborn and child health services, I now get help from a religious leader like Sheik Musa Asabel who is on the strengthened Ufra Agamsa Kebele Command Post. He is a very respected and trusted member of the community; people listen to his words and teachings. In a religious setting, people trust his words more than mine. Similarly, mothers on the Committee, who had unfortunate birth experiences can send strong message to women who are reluctant to seek maternal health services. I believe the active participation of the newly added members of the Kebele Command Post has significantly strengthened the platform and improved our performance particularly in creating community demand for MNCH services. They are practically acting as 'additional legs' for the HEWs reaching every corner of the kebele we might have difficulty getting to. I am confident that the strengthened Kebele Command Post will continue to actively engage in health matters in the community.

After years of hard work through various platforms, not least the strengthened Kebele Command Post, I am now happy to see so many mothers show no reluctance anymore to go for antenatal and postnatal care as well as institutional delivery. It is like a dream come true for me that influential community members like Sheik Musa Asabel are convinced themselves on the difference MNCH services make in reducing maternal and newborn mortality and morbidity and are educating the community about it."

Over the course of the project period, MCSP NEGA has observed other signs of possible sustainability of faith-based leaders' engagement at least in the medium term. During the various experience sharing and project hand over workshops organized jointly by MCSP NEGA and zonal and woreda counterparts, many zonal and woreda health office leaders indicated the demand creation and community empowerment strategy as an 'innovative' and important strategy that helps in addressing major bottlenecks in service utilization.

"The project [MCSP NEGA] has done an outstanding job by introducing such a strategy that augments participation and sense of ownership. The strategy has also helped to create a platform which brings together the health system and community based structures, including faith-based leaders who are very trusted in our communities, to work together to address key MNCH problems identified by the communities themselves. The strategy can help us mobilize the community for other health issues, beyond MNCH. We are not working hard to replicate the intervention in other kebeles." Ato Simon Sidamo, Head of Demele Health Center, Gamo Gofa Zone, SNNPR.

After receiving positive feedback on the important community MNCH-CBNC counseling and education work of faith-based leaders, the regions of Tigray and Oromia Zonal Health Bureaus extended invitations for the participation of faith-based leaders', who were previously not part of these important learning meetings, in the experience sharing meetings. Zonal health leadership also began to actively work with faith-based leaders to develop their role in MNCH-CBNC health promotion, including working with HEWs in their respective kebeles, educate communities and families on key MNCH-CBNC practice.

Lessons Learned and Conclusion

Engaging faith-based leaders in MNCH was not systematically integrated in the original MCSP NEGA project design. The MCSP NEGA team recognized its importance once program implementation begun and continued to learn how intertwined religion and traditional/cultural practices around birth and early postnatal periods are. During the visit of the project Chief of Party to Waghimra at the start of the project, the Zonal Health Bureau Head said *"you cannot address the deep rooted attitudes, behaviors and practices related to birth and early neonatal period in this community without engaging faith-based leaders. You have to first convince them and the community."* Such conversations, experience from CBNC Phase I zones and review of studies informed MCSP NEGA's strategy to engage faith-based leaders. As it was not part of the original design, this activity did not have dedicated funding; and it was not found to require a lot of resources after all.

The major lessons learnt are:

- Zonal and Woreda Health Offices are very keen to take on simple, replicable and scalable approaches that can address MNCH service utilization bottlenecks. By and large, the approach to engage faith-based leaders was readily accepted and was rolled out jointly by MCSP NEGA and respective zonal/woreda health offices.
- As engaging faith-based leaders for health promotion falls within the responsibility of the health offices, health managers and providers need to have the capacity to facilitate tailored training for the faith-based leaders.
- The faith-based leaders' training package needs to be well prepared: it will need to be easy to understand using simple concepts, needs to take into consideration the values and belief systems of the different faith groups, and has to be concise. Considerable planning should also go into how it is delivered to participants: it should be very participatory/interactive and use examples from the Holy Books.
- As they are often the first point of contact when serious health problems are faced in the communities and households and are expected to provide advice/guidance, faith-based leaders are very eager to learn about what is the right thing to say to families. The FHG is very much appreciated as a key resource and reference as it has many of the key messages in a simple and easy to understand way.

Conclusion

Engaging faith-based leaders has multiple benefits including creating a large pool of educated and influential MNCH-CBNC role models that are likely to display and implement positive MNCH-CBNC behaviors and practices in their own families. In addition, faith-based leaders are able to work effectively with their constituent to promote key MNCH-CBNC messages because of their trusted and respected roles in communities. Working with faith-based leaders in Ethiopia has the potential to create an enabling environment for positive normative and social change leading to improved maternal and newborn outcomes.

Annex A: Faith-based leaders Engagement Guide

Annex A-Faith Based Leaders Enga

Annex B: MNCH Knowledge Assessment Brochure (Amharic)

Annex B - MNCH Knowledge Assessm