Engaging Ethiopian Orthodox priests and Health Development Army members to improve newborn and infant health behaviors

Leading Advancements in the Uptake of Newborn Community Health (LAUNCH)

Building on progress, addressing remaining gaps

Ethiopia has made important progress in maternal and child health, while continued support is still needed for newborn and infant health behaviors.

1 in 26
Infants died before their first birthday

57%
Exclusive breastfeeding up to 6 months

30%
Received basic immunization

2 in 5
Children under 5 are stunted

Source: EDHS 2024–25 Key Indicators Report.

The idea: What LAUNCH tested

Pairing Priests + HDA members

Maternal and infant health education

- Home visits during pregnancy, postpartum, baptism, and routine family support
- Community gatherings

Trial: community cluster-randomized trial in Gondar Zuria Woreda, Central Gondar Zone, Amhara; outcomes measured at 6 months.

Key results

68%
Feasible reach
Mothers received education from both priests and HDA members at least once.

+46%
Exclusive breastfeeding improved
Mothers were more likely to exclusively breastfeed at 6 months (RR=1.46; p=0.001).

Other outcomes did not change
No clear effect on growth, vaccination, malnutrition, illness, or care-seeking by 6 months.

What this means for policy and implementation

Use trusted local actors
Priests and HDA members can support behaviors shaped by trust, family norms, and social support, such as breastfeeding and newborn care.

Broader child health gains require education plus system support.
Behavior change alone may not be enough: some outcomes also depend on food, supplies, and service quality

Priest–HDA collaboration is feasible and can improve selected newborn and infant health behaviors, but broader impact may require stronger system support.

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LAUNCH STUDY · SCALE-UP EVIDENCE

What is needed to scale LAUNCH?

Who are the central actors to engage? How ready are stakeholders to scale LAUNCH?

A survey of 131 maternal and child health (MCH) stakeholders mapped working relationships across federal, regional, zonal, and woreda levels. The analysis identified central actors and assessed readiness and capacity to scale LAUNCH.

Most central actors identified

Position	Level	# connection
Director for MCH	Regional	64
Safe motherhood officer	Regional	59
Acting Lead Executive Officer	Federal	39
Desk Lead	Federal	39
Deputy Head for MCH	Regional	37
MCH case team leader	Regional	31
Child health & Nutrition	Zonal	29
Expert	Federal	26
Mother & Youth Officer	Zonal	26
Head	Regional	25
EPI technical assistant	Zonal	20
Desk Lead	Federal	16
Immunization officer	Regional	15
MCH TA	Regional	13

Central actors may be useful entry points for engagement, coordination, and buy-in

How ready did stakeholders feel? (scores 1-5)

Average stakeholder scores

Readiness to scale LAUNCH 3.9 / 5

Current capacity to implement 3.8 / 5

Where readiness was lower? Was readiness relational?

- Regional staff reported lower capacity than federal counterparts
- Staff with postgraduate degrees showed lower readiness scores
- Central actors shared similar readiness levels with their immediate networks

What communities and leaders told us: qualitative findings

20 in-depth interviews · 6 focus groups · Community to Ministry of Health level

What should be kept?

- Identify and engage trusted local influencers.
- Ongoing capacity strengthening to implementers.

What should be added?

- Incentives and communication materials to strengthen implementer motivation.
- Education should be linked with social support and referrals for vulnerable households.

What conditions are needed for scale-up?

- LAUNCH is acceptable and feasible within existing structures.
- Government ownership and financing are critical.
- Health services must complement education.

"We may forget if supportive supervision is not provided... we don't work unless we are supervised." (HEW, FGD-4)

".....we educate them but they are unable to meet the basic needs of their families." (HDA member, FGD-1)

Recommendations for scaling the LAUNCH model

Strengthen implementation capacity
Refresher training, supportive supervision, sustainable incentives, and communication materials.

Adapt influencer selection to local context
Engage trusted local figures based on community input and local religious or social structures.

Pair education with social support
Link counseling to referrals and practical assistance for vulnerable households.

Institutionalize within government systems

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