

# Feed the Future Ethiopia Growth through Nutrition Activity - Learning Document “Key Health, Nutrition, and Agricultural Services in the Face of COVID-19 in Ethiopia: Lessons Learned”

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## Webinar Summary Report

As the COVID-19 pandemic continues to impact health and economics at a global level in both large and small ways, strong efforts have been made in Ethiopia to better understand the specific impacts on the health, nutrition and agricultural sectors. Even before the emergence of COVID-19, high-quality and timely healthcare services were often unavailable, inaccessible or unaffordable for a large part of the population. The COVID-19 pandemic is also expected to have short and long-term impacts on Ethiopian agriculture and its extension systems, causing setbacks in efforts to improve local food security. In light of this, recent research has been conducted by Growth through Nutrition Activity and IFPRI, to specifically assess changes in service provision during COVID and to inform ongoing and future support and recovery of health and agriculture services.

On February 3, 2021, the Growth through Nutrition Activity hosted a webinar event on the topic “Key Health, Nutrition, and Agricultural Services in the Face of COVID-19 in Ethiopia: Lessons Learned,” and presented and discussed some of the key findings from two recent studies investigating changes in the health and agricultural sectors and time use of Health Extension Workers (HEWs) before and after the beginning of the COVID-19 pandemic. The findings and discussions provided key lessons and recommendations to inform ongoing and future support and recovery of health and agricultural services. The webinar was attended by more than 75 participants from around the globe and contained two 20-minute presentations and a 45-minute Q&A session. In the first presentation, Dr. Abdulhalik Workicho from Tufts University presented some of the changes in key health and agricultural services in Growth through Nutrition supported woredas, comparing service performance before and during COVID. This was followed by a complementary presentation by Prof. John Hoddinott from Cornell University on changes in the time use of front-line health workers before and during the COVID-19 pandemic in rural Ethiopia. The Q&A session following the presentations gave participants the opportunity to ask questions and reflect on the presentations (Annex 1).

Dr. Abdulhalik began his presentation by giving a global perspective of the impact of COVID-19 on various health and agriculture services, referencing data from the 2020 WHO Pulse Survey (covering 109 countries worldwide). He reported survey findings that health service disruption was documented in all WHO regions at various levels (over 50% for Africa). The report also showed that almost half of WHO region countries reported partial disruptions in non-communicable disease and mental health services, followed by 30% of countries that reported partial disruptions in the reproductive, maternal, newborn, child, adolescent health and nutrition service groups; the highest percentage of reported disruptions were in routine immunizations, family planning and antenatal care. These figures are concerning as COVID has the potential to reverse some of the nutrition gains that have been observed globally over the past few years. Dr. Abdulhalik then shared background on the recent Tufts study which was conducted to assess key changes in essential health, nutrition and agricultural services in Growth through Nutrition supported woredas. He explained that the study, which covered 16 primary health care units (PHCUs), was conducted using quantitative data collection and 10 key informant interviews (KIIs) with Health Center heads, Health Extension Workers, Woreda Agriculture Office heads, and project Zonal Coordinators. The quantitative data collected from PHCUs covered routine service provision from the same three months in 2020 and 2019 (pre-COVID).

Results from the qualitative interviews indicated that service delivery and utilization were perceived to be affected both at study Health Centers (HCs) and Health Posts (HPs) by COVID-19. Fear of infection, community perception (mostly at HPs), lack of PPE and travel restrictions were the most frequently mentioned perceived causes for service disruptions at health facilities (closely matching the causes of service disruptions indicated in the WHO Pulse report). Almost all PHCUs reported implementing COVID mitigations strategies, the most common of which were COVID awareness campaigns for staff and community, and strong implementation of infection preventions put in place to improve service delivery and utilization implemented at both HCs and HPs. Other strategies, such as availing the use of medical supplies and PPE, using phone for virtual services, and rearranging workplace were mostly limited to HCs, while mobilization of volunteers was mainly implemented at health posts.

The quantitative component of the study looked at key maternal health and nutrition services at both HCs and HPs by comparing service performance for the same period in 2019 (pre-COVID) and 2020 (beginning of COVID pandemic). Findings indicated that almost all of the key maternal health and nutrition services at Health Centers showed a decline in performance in 2020 as compared to 2019, except for Iron/Folic Acid (IFA) supplementation which showed better performance in some of the months. This decline in performance is mostly observed during the beginning of the pandemic but showed some recovery, especially from April to May for some of the services such as deworming for women, IFA and antenatal care. The adopted COVID mitigation strategies were cited as a major explanation for the recovery from the initial decline in services. On the other hand, the study did not find much impact of COVID on key child health nutrition services at HCs. Vitamin A supplementation and under 5-yr-old child deworming and screening for malnutrition were examples of services that actually had mostly higher performance in 2020 (during COVID) as compared to 2019. At the Health Post level, a similar trend was seen, where maternal health and nutrition services seemed to be affected more than child health and nutrition services. In particular, services that involved group gatherings (i.e., pregnant women conferences, cooking demonstrations, etc.) were mainly affected since they could not be conducted as usual due to COVID social distancing restrictions. Additionally, child health and nutrition services that were lower at the beginning of the pandemic showed a slight improvement in April –May or June. One possible explanation for the recovery is the result of campaign activities or mitigation strategies that were put in place after the onset of the pandemic. Qualitative findings support some of these trends, with service providers noting the alarm and confusion at the beginning of the pandemic and noting the ways in which they then adapted service delivery to meet the new environmental context.

Dr. Abdulhalik also reported findings from agricultural service provision at various levels in the study areas, with the most affected activities being support provided by Agricultural Extension Workers (AEWs) followed by marketing and access to inputs activities. On the other hand, field-level agricultural activities (such as land preparation and weeding field crops) were the least affected as they don't conflict with social distancing or gathering restrictions. Disruption of the extension system, fear of infection, shortage of inputs and travel restrictions were some of the commonly reported perceived causes of disruption in agriculture services. Similar to the health sector, spreading COVID awareness was the major mitigation strategy that was implemented in most of the project woredas. The other mitigation strategies included provision of inputs by different institutions, use of SMS messaging, careful movement of labor, and use of model farmers. While most of Growth through Nutrition intervention activities were affected at the start of COVID,

they showed much improvement by June, with the exception of those requiring group gatherings, which only showed a small improvement. This is also reflected in the qualitative results where respondents highlighted the challenges of lack of inputs, marketing, and limitations on group gatherings, but also note some success in more recent support that had been received to help address these challenges.

In summary, the study shows that while it has been suggested that COVID would have a strong negative effect on both the health and agriculture sectors, and there have been some challenges, the systems have demonstrated a resiliency and quick recovery. Although some key service levels were lower in 2020 than 2019, this was not the case for all, and some even increased from the previous year despite the pandemic. Any disruptions seemed more pronounced the early months of pandemic, mainly March–April, with many showing improvement after May. In closing, Dr. Abdulhalik highlighted some of the creative strategies employed to modify service delivery and meet the challenges of COVID, which have been largely successful in mitigating the disruption of health, nutrition and agricultural services. While strategies such as increasing the number of smaller events and going door to door have been effective, they also may require additional resources (funding and supplies) to be sustainable.

The second presentation by Professor Hoddinott of Cornell University looked at the COVID-19 disruption on health and nutrition services by studying changes in the time use of health extension workers, comparing the pre-COVID and COVID periods. This ongoing study was conducted in four rounds: August 2019 (pre-COVID), February 2020, May 2020, and September 2020. The first round of the study was conducted using in-person interviews, whereas the others were conducted via phone. While all rounds examined health and nutrition services undertaken by HEWs, the latter two included qualitative questions focused on the amount of time HEWs spent on health and nutrition services.

Study findings show that the average number of days HEWs worked per month (24.5) did not change over the four reporting periods, however, the number of hours worked per day slightly increased from 8.0 hours (pre-COVID) to 8.4 hours (during the COVID-19 pandemic). This slight increase was not associated with any changes in the overall number or types of activities that HEWs reported undertaking. Most of the health and nutrition services remained stable in all rounds. Conversely, the time allocation by HEWs for various health and nutrition services changed significantly when comparing pre-COVID and during COVID; HEWs reported shifting time or allocating more time for COVID-related services, such as awareness creation and WASH activities. Some health and nutrition related activities associated with immediate threats to human life (severe malnutrition, HIV/AIDS) or those that can be accomplished quickly through campaigns (immunizations) were protected in HEW allocation and remained largely unchanged. HEWs also reported allocating a reduced amount of time to services that presented a less immediate threat to human life (complementary feeding counseling, growth monitoring) and/or more time intensive services (family planning).

In conclusion, Professor Hoddinott explained that the changes in allocation of time by HEWs across activities were partly influenced by the need for outreach and training on COVID-19 and WASH, which reduced the total time available for other work normally undertaken by HEWs. This was due in part to the increase in pandemic-driven demand for certain activities, such as treatment of severe malnutrition, and because of restrictions on movement and gatherings that limited access for some services. The September

2020 data, however, showed that some activities with reduced allocation were already being restored; the next survey will provide additional information on whether this trend continues.

### Annex 1: Q&A Session

#### **Q1. Where are the 16 primary health care units located? Any notable differences between regions or health facilities?**

AW: The 16 primary health care units included in the study are from the project intervention regions mainly Amhara, Tigray, Oromia and SNNPR. The study did not disaggregate the data to look at regional variation or variation within health facilities (i.e., comparing one health post with the other or health center with the other).

#### **Q2. Did you see much variation between health facilities in their ability to cope with COVID and continue providing services? If so, any insights on the key factors affecting service provisions at the health posts?**

AW: As shown on the graphs, health posts' service provision was less effective as compared to health centers, except for ones that could be provided using outreach services such as Vit A supplementation, U<5 malnutrition screening and deworming. All other static services (i.e., antenatal care services, IYCF counseling of pregnant women) and services that require group gathering (i.e., demonstrations of complimentary food preparation) were highly compromised at health posts more so than at health centers. One important note is that there was also strong collaboration between Health Centers and Health Posts in the provision of outreach services.

#### **Q3. Did you know the factors that increase to the under-five child screening for malnutrition in the pandemic in 2020?**

A1. There are a number of services that actually showed service improvement in 2020. Some of these are Vit A supplementation, U<5 child malnutrition screening and deworming. The information gathered through the qualitative study indicate that some of the contributing factors for this increase include changing the provision of services from static to outreach services i.e., provision of some of these services during HEW house visits. In addition, the COVID mitigation strategies that were put in place at the health facilities helped to create demand for some of these services.

#### **Q4. Comparing the graphs in 2019 and 2020, what happened to key child health and nutrition services that showed significant drop in June 2020?**

AW: We usually see a drop in provision of services during June and July months due to the rainy season which can affect travel movement of clients to come to health facilities and HEW to provide the necessary services both at health posts and house to house. This is especially true for health facilities in rural parts of Ethiopia.

**Q5. Could you talk more about the creative strategies used in the healthcare system to mitigate service distribution during the pandemic?**

AW: Changing some of the static services to outreach services significantly helped to improve services provision. For example, HEWs conducted child growth monitoring, child malnutrition screening, etc., during house visits. The strong collaboration between health centers and health posts were also critical in the provision of outreach services to the community. Some of HEW also used telephone sessions to provide antenatal care advice.

**Q6. It's really interesting to see that the health extension workers time spent on COVID awareness campaign increased from May to September. Do you have any estimate of the actual amount of time per day or per week spent on COVID awareness raising, or any information on this integrated into existing activities?**

JH: Unfortunately, no, the surveys were conducted using telephone interviews, so they had to be very brief. In testing of the survey, we found that we could either get a broad overview or a lot of depth on a few specifics, but not both. Getting the amount of time spent on different activities was very time consuming so we decided we needed to just rely on the more qualitative information that was collected.

**Q7. What do you think accounts for the recovery or partial recoveries of activities that decreased initially in the pandemic? The time spent on COVID 19 awareness and WASH education seems to still increase between May and September 2020, but the health extension workers still have only a limited amount of time. Does this go along with the creativity and innovation of health extension workers that you mentioned that allowed the health extension workers to provide more services in spite of time constraints?**

JH: Yes, the HEW creativity and rethinking how to provide and adapt some of these services. Again, I want to stress that that's not something we can say definitively from the data we have, but I think is impressionistic based on the qualitative oriented conversations and also with some of the evidence from Dr. Abdulhalik provided.

**Q8. From the pre-COVID assessment, extension workers did not look at any time to address global or local outbreaks. Is this something that can be considered in the extension package for better emergency preparedness?**

JH: This is a good question. It is uncertain or unclear what the next great emergency might actually be. It is reasonable to expect in the next 10-15 years there could very well be some other type of emergency, but I don't think we can say at this point, "we should prepare for *this* type of emergency" because we just don't know what it is. But I suspect health systems might benefit from doing exercises of saying, supposing this general type of emergency occurs? And for example, half our health extension workers are taken out of service? Or supposing there are restrictions on movements in rural areas, how can we

respond? And begin to think out or game out how we might respond to those types of general threats to the delivery of health, primary health services. I suspect would be a useful exercise to undertake.

**Q9. Did the movement restriction of health workers and their ability to fulfill their job requirement?**

JH: I don't know the answer with certainty, but my impressionistic answer is initially the restrictions on movement also affected the health extension workers but over time, they began to work out ways of actually addressing the problem. They began to do house-to-house visits and substituted for large group meeting for delivering counseling or trainings. So, I think the short answer is that it had some initial effect but not necessarily a longer-term effect. The longer-term effects in terms of providing the services might have been much more about the ability to actually speak with larger groups people at once. The other part of this, individual travel restriction certainly had initial effects in terms of in terms of people's ability to access markets because a lot of places markets are closed down and that might have affected people's abilities to acquire foods, particularly foods they themselves don't produce in their own homes. The last point, the studies were done in rural areas, but we can't say anything about what happened in urban areas. In a general sense, in urban areas, the lockdowns for more severe restrictions on movement and people understandably living in crowded urban spaces much more concerned about contracting COVID. So what we have describes we think fairly well the landscape in rural areas, it would be wrong to assume that it would also be equally applicable to what happened to access to health and nutrition services in cities and towns (urban areas).

**Q10. Did extension worker have masks and guidance protocols about how to safely deliver house health and nutrition services?**

JH: In terms of masks and training protocol most of the health extension workers did receive training and protocols, but in terms of things like basic personal protective equipment, while it was available, it was not necessarily in the quantities that people, health extension workers, needed. So they would have masks that would last long and they weren't always able to get new ones (durable ones). For example, 90% of health extension workers reported they had a shortage of masks 30 days prior to the survey, about 60% said they were shortages of gloves. Similar things comply to medical gowns and soap. So the short answer is that there was training for many, but not all. There was protective equipment provided for many, and not all and in some cases, the shortages of those were great.

**Q11. What are the implication of these studies for the nutritional status of those vulnerable members of the country?**

AW: Our study which was taken at early stage of the pandemic (March –July) did not look at the nutritional status of children. At this point we cannot definitively says impact on nutrition status but given the impact of the pandemic on economy and health, we would expect to have impact on the nutritional status as well. But to say definitely we need to have more studies.

**Q12. In your opinion, what will be the impact of the relative disruption of nutrition and health activities on child and maternal malnutrition in Ethiopia?**

JH: The truthful answer is I think right now we just don't know. We know there have been some disruption of health services which we have tried to document. We know there have been disruptions to household economic activities that could also have effects on child and maternal nutrition, but it is going to be very difficult to disaggregate. But I think by time we get to later this year, we'll have a better sense of the overall effects of the pandemic on these types of outcomes. But going forward disentangling the effects which come through disruption to health services from those that come through another consequence of the pandemic is going to be a very difficult exercise.

**Q13. Any critical lessons in relation to nutrition during the pandemic?**

JH: Despite well-placed concerns about the impacts of this unprecedented crisis on the health sector, the first lesson is that grassroots, primary care level health care providers in Ethiopia and possibly other parts of the world, became enormously creative about how they responded and adapted to COVID. The examples by Dr. Abdulhalik of adapting some services provision from static services to outreach service, with the HEWs conducting house to house visit to create awareness of COVID, and taking along basic health supplies to deliver outreach services such as checking children for severe acute malnutrition, deworming etc., demonstrates some of that creativity. This indicates that we may have underestimated or not given enough credit to health extension workers and their ability to adapt when the pandemic started.

A second lesson is the importance of thinking in the future about more creatively about how some of these services can be delivered, particularly when they're going to be disruptions in the ordinary way in which they're done. Health Development Army, local health volunteers are a resource for example that could potentially take on some of the routine burden of health extension workers, freeing up more time for to provide more specialized activities. Also looking at to what extent are we now at a place where use of health care activities and resources is being constrained much more by the demand side (by individuals who are unwilling or unable to actually travel) as opposed to the in their provision by health extension workers and trying to understand that better would also be a useful lesson to learn as well.

**Q14: In terms of policy or interventions, which were the most impactful in terms of child and maternal nutrition, what can governments learn?**

AW: From the study that we have done, it was not designed in such a way to look at the effects of individual interventions or policies, so we cannot say from this study which is the most impactful. It does seem that the aggregated effects of all the mitigation strategies implemented together had results in improvement of services, and it seems likely that this has continued even beyond the study period, but we cannot specifically isolate one intervention to say it was the most impactful.