Mental Health and Psycho-social Responses to COVID-19 in Ethiopia: Lessons learnt from the first year of the pandemic

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Abstract

COVID-19 has a wide range of effects on the mental health of the public, people in isolation, vulnerable individuals, and health workers. This article has collected reports from the Ethiopian national public health emergency operations center, the Federal Ministry of Health- Ethiopia and the Health Professionals Advisory Council and included direct observations from the responses to review the mental health and psycho-social responses of Ethiopia to the COVID-19 pandemic, to share experiences and provide policy recommendations. The worldwide effect of the COVID-19 pandemic on mental health and psycho-social aspects of the public, restrictions due to the State of Emergency in Ethiopia, the pre-existing resource limitations in mental health care and an increase in returnees with multiple needs had increased the need for mental health and psycho-social support of individuals affected by COVID-19 in Ethiopia. Multiple stakeholders from governmental institutions, professional associations and non-governmental organizations had come together to mitigate the impact. The response included training healthcare providers, preparing guiding documents, mental health messages to the public, and providing mental health and psycho-social support services to individuals admitted in quarantines and treatment centers as well as health workers. The inclusion of Mental Health and Psycho-social support in the emergency response has shown promising results in Ethiopia that can be adopted in the management of other public health emergencies. The effectiveness of mental health and psycho-social interventions relies on recognizing the need of mental health services and increasing metal health resource allocation. [*Ethiop. J. Health Dev.* 2021; 35(SI-4):00-00]

Key Words: COVID-19, Ethiopia, Mental Health, Psycho-social support

Background

The COVID-19 pandemic is an infectious disease that has challenged the health systems of many countries in the world since China first reported it in late in December 2019 (1). According to the Committee for the Coordination of Statistical Activities, "COVID-19 has turned the world upside down" (2). The impacts of the disease are reflected in every aspect of human interaction, including healthcare, economic, psychological, social, and mental health aspects of patients, their families, and the communities at large. Projections on the global economic impact of COVID-19 indicate that the gross domestic product worldwide may fall by 2% below the benchmark, which was 2.5% for developing countries (3). In emergencies like the COVID-19 pandemic, exacerbation of pre-existing problems like poverty, discrimination, and mental illness or new emergency induced problems such as separation from family, grief, etc. are expected to occur.

In Ethiopia, there have been planning and preparations underway through the Public Health Emergency Operations Center (PHEOC) before the COVID-19 outbreak since January 27, 2020. A Ministerial Committee coordinated this response, and the Federal Ministry of Health (FMoH) led the Public Health Emergency Taskforce (PHEM) on COVID-19 (4).

The first case of COVID-19 in Ethiopia was announced on March 13, 2020, just two days after COVID-19 was declared a world pandemic. A state of emergency was announced on April 8, 2020, which was operational till the end of August 2020. Measures such as complete school closure, partial closure of civil services, suspension of international flights and mandatory quarantine of travelers for 14 days were adopted (5). As of June 18, 2020, this period was reduced to 7 days for people who produced proof of a negative RT-PCR test for the previous three days from the date of arrival to Ethiopian airports or borders. Travelers coming to Ethiopia could stay in hotels for the expected 14 days if they could afford the financial costs. Others who could not afford it were given options to stay in quarantine centers established by the government, located mainly in health facilities, schools and university premises (4). After the State of Emergency was lifted, home-based isolation and care for confirmed cases with mild symptoms were initiated.

According to the World Health Organization (WHO) the mental health and psycho-social consequences of the COVID-19 may increase globally due to measures such as self-isolation and quarantine that were introduced to control the spread of the pandemic (6). Due to this, common mental disorders, harmful substance use, self-harm or suicidal behavior were expected to increase (6). In cognizant of the problem, the WHO extended its message for the general population, healthcare workers, team leaders or managers in health care facilities, carers of children, older adults, people with underlying health conditions and their carers, and people in isolation, to assist with the problem induced through isolation. The messages can be used in communications to support mental and psychosocial well-being during the COVID-19 outbreak (7). The United Nations (UN) had also given recommendations to include Mental Health and Psycho-Social Services (MHPSS) as one part of COVID-19 national emergency responses (8).

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Many low and middle-income countries have developed innovative national mental health and psychosocial programs based on these recommendations. These included the provision of training for necessary psychological interventions mainly for community volunteers, health workers and law enforcement personnel. Other interventions include remote support through hotlines for patients, families and front-line professionals, technology-based mental health screening for the public, safety guidelines in Psychiatric Hospitals and online prescribing of Psychiatric medications (9).

Like many other countries globally, COVID-19 in Ethiopia introduced complex and multifaceted challenges, including economic, health, social and political impacts. The impact on the country's economic growth is predicted to face a significant challenge as measures to contain the spread of the virus affect the day-to-day living of citizens (10). An additional 2.2 million people in the country may fall under poverty due to the loss of income and unemployment associated with COVID-19 (11).

The need for mental health and psycho-social support has increased in the context of COVID-19 globally due to several reasons. These are the stressful nature of the pandemic, the large number of infections, mandatory quarantines, isolation from family and social connections, lifestyle changes, stigmatization, aggravated loss of livelihood, deaths, and many other challenges (12). Similarly, there are reports that a threefold increase was noted in the prevalence of depression in Ethiopia's community during COVID-19 (8). Most of the people who participated in a telephone interview after their quarantine or isolation due to COVID-19 revealed that they experienced stress during their isolation due to COVID-19. Their worries were mostly about being away from family and the probability of making their children infected or the loss of jobs or income (13).

The mental health and psycho-social services in Ethiopia before COVID-19 have been progressively scaled up (14) through training Psychiatrists, Mental Health Epidemiologists at Ph.D. level, Mental Health Practitioners and Clinical and Counseling Psychologists at M.Sc. level, Psychiatry Nurses at B.Sc. level, and Social Workers at Ph.D., MSW and BSW levels. The Mental Health Gap Action Program (mhGAP), supported by WHO, has also been adopted and implemented to train primary healthcare workers and health extension workers on the basic management of mental health disorders. Even though there is only one Specialized Hospital for mental healthcare in the country, there is a large emphasis on integrated services which promoted the opening of psychiatry wards in General Hospitals around the country (15). However, these services are feared to have been compromised due to COVID-19, as seen in many countries.

The pre-existing burdens on mental health and psycho-social care demands could be aggravated due to the COVID-19 pandemic in Ethiopia. For Ethiopia, which has a population of over 110 million people, there were only 82 psychiatrists. Most of them work in the capital city (Personal Communication from Ethiopian Psychiatric Association, Dr. Dawit Assefa, June 15, 2020). This has created a massive gap in the accessibility and quality of services and increased the patients' financial burden. The awareness of mental health in the community is low, and most people first visit traditional and religious service providers before going to mental healthcare facilities (14). There have not been any national or regional level mental health hotlines that can provide remote mental health care and referral services to the needy. The demands of COVID-19 increase such gaps in the mental healthcare service provision.

The considerable number of returnees coming in through different corners of the country during the pandemic has also increased the need for MHPSS services. From April 1 to December 22, 2020, over 42,600 returnees arrived in Ethiopia (16). During the government's mandatory quarantine period, returnees were required to stay at temporary quarantine centers in university dormitories and high schools. Returnees and deportees often needed essential mental health and psycho-social support because of the lack of basic needs, possible traumatic experiences, and having no means to communicate with their families. The combination of these factors had increased the need for MHPSS during COVID-19.

Although Ethiopia has faced several public health emergencies previously, the associated mental health and psycho-social support (MHPSS) needs, and responses have not been well documented. It is therefore important to document the mental health and psycho-social responses of Ethiopia during the initial period of the COVID-19 pandemic. The objectives of this article are to highlight significant experiences and to identify challenges that serve as a basis to improve future MHPSS responses in public health emergencies.

Methods

In this article, Ethiopia's national mental health and psycho-social support challenges and activities in the context of COVID-19 are reviewed based on the national data and reports from one year (March 2020 – March 2021) of the response obtained from the Federal Ministry of Health Ethiopia, the Ethiopian Public Health Institute and the Professional Associations' Scientific Advisory Council on COVID-19, as well as from direct observations from the researchers who had been involved in planning and implementing the responses. Collected data was re-organized to show the activities of the response.

MHPSS Response for COVID-19 in Ethiopia

As part of the emergency response, Eka Kotebe General Hospital, the second-largest mental health service provider in the country with 150 beds dedicated to psychiatric inpatients before the outbreak of COVID-19 was repurposed entirely into the first COVID-19 dedicated treatment center. Its psychiatric services were transferred to another nearby building which is only limited to outpatient and emergency services.

As per the report from the Ethiopian Medical Association (EMA), an MHPSS team was created, as

part of the health professional associations' advisory council for the FMoH in March 2020. The MHPSS team was made up of academics and representatives from each of the professional associations of Psychiatry, Social Workers and Psychologists. The team's multidisciplinary nature helped to gain new perspectives, to prepare a list of guidelines and recommendations for the national MHPSS response. In addition to looking at international recommendations and published articles, experience sharing meetings were conducted with MHPSS responders from Italy and Nigeria to discover how professionals in their context provided MHPSS services.

A focal person was assigned in the PHEOC in the Ethiopian Public Health Institute (EPHI), as of April 2020, in the Case Management and Facility Readiness Section to lead the national MHPSS response. The Advisory Team and the PHEOC worked together to prepare several guiding documents such as "*Psychological First Aid Protocol for people in COVID-19 Quarantine and Isolation*", "*Self-care guide for healthcare professionals during COVID-19"*, "*Self-care guide for people staying in COVID-19 quarantine and isolation centers (Amharic)"*, and "*MHPSS services for Treatment, Isolation and Quarantine Centers during COVID-19*". Recommendations highlighted the importance of training healthcare workers on self-care, psychological first aid, and psychiatric considerations in treating patients with COVID-19. It also emphasized social workers, psychologists, and psychiatry professionals by identifying their specific roles and providing a referral mechanism.

The documents were followed by the transfer of some psychiatric nurses from other governmental hospitals to COVID-19 treatment centers, the recruitment of volunteer psychologists, social workers, psychiatry residents and Consultant Psychiatrists from the professional associations, following reports of large numbers of returnees in quarantine having suicidal behavior and aggressive behavior related to mental illness. Training was given to the newly assigned MHPSS staff and health professionals working in different quarantines and treatment centers on psychological first aid and self-care basics. The training was supported by the EPHI, EMA, WHO and International Organization for Migration (IOM). Since the number of professional volunteers was not enough to deploy for all centers, priority was given to 7 quarantine centers that accommodated deportees and returnees who could not afford to stay in hotels and had critical demand for MHPSS services. The rest of the centers were given contact details of a mobile emergency MHPSS team of volunteers, that could conduct Psychiatric Evaluation and proper follow-up management.

The services provided by the professionals in quarantine centers included providing general information on COVID-19 in quarantine, assessment of basic psycho-social needs, screening for prior and current mental health conditions, group and individual counseling for selected individuals and staff, acute management of suicidal patients and agitated patients with severe mental health conditions using emergency medications, and a referral to mental health service provision centers. Some of the professionals reported a fear of infection due to low provision of PPE and interaction with agitated patients who may not be able to follow COVID-19 precautions.

From April 15 until August 5, 2020, some 6,000 people in 7 quarantine centers in Addis Ababa were screened for mental health and psycho-social needs, of which 4,132 people received group counseling and guidance, and 936 people received individual counseling and guidance. After discharge, people with needs of shelters, those with disabilities, unaccompanied children, and women who had a recent history of gender-based violence were linked with local governmental institutions and non-governmental agencies in the different regions for continued social support.

In some centers, training on psychological first aid in local languages was provided to other health professionals, cleaners and security personnel working in the quarantine centers. The MHPSS professionals have collaborated with other experts from the Contact Tracing Team to jointly declare the test results to those who were found to be COVID-19 positive. This collaboration was found to help make sure that people feel supported while receiving their results and supporting a better yield of contact tracing. It assisted in decreasing the amount of people, who tried to escape, or from people attempting suicide from the centers after receiving their positive results.

A referral system was set up for people with severe mental health problems who had aggression, severe agitation, or suicidal behavior. In Addis Ababa, a separate block in one of the quarantine centers named Dr. Aklilu Lema Sefere Selam Campus Temporary Quarantine/Isolation Center was set up with two M.Sc. level Psychiatry Mental Health Practitioners, one B.Sc. level Psychiatry Professional Nurse and one B.Sc. Clinical Professional Nurse. Volunteer psychiatrists were available on call for a consultation. Medication supply was arranged through St. Amanuel Hospital, the only mental health specialized hospital in Ethiopia and WHO. From April 15 to Sept 10, 2020, 125 individuals (77 women) have been admitted to this center. The individuals were diagnosed with different disorders, as indicated in Table 1 below. Once they completed their quarantine period and tested negative for COVID-19, they were provided with a referral to nearby centers which provided mental health services.

Table 1**. Psychiatric Diagnosis of people admitted to a separate COVID-19 Quarantine center for mental health needs. April 15 - Sept 10, 2020**

Diagnoses	Number	%
Schizophrenia	27	21.6%
Bipolar Disorders	22	17.6%
Major Depressive Disorder	23	18.4%
Post-Traumatic Disorder	21	16.8%
Brief Psychotic Disorder	24	19.2%
Catatonia secondary to other mental disorders	8	6.4%
Total	125	100%

A total of 20 people who tested positive for COVID-19 while they were in the separate quarantine centers between April 15 and Sept 10, 2020, were sent to Eka Kotebe General Hospital, one of the major COVID-19 treatment centers. It has a ward with 22 rooms, and 44 beds and was dedicated for the treatment of asymptomatic, mild, and moderate COVID-19 patients who had a severe mental illness that required treatment and close observation. Psychiatrists, Mental Health Practitioners and Psychiatry Nurses provided treatment and follow-up with the possibility for transfer to ICU as required**.**

On May 1, 2020, the FMoH established a multidisciplinary MHPSS team as part of the national PHEM taskforce that was tasked with expanding the MHPSS services to different regions and facilitating stakeholders' engagement. The team visited regional health bureaus, their PHEOC, and treatment and quarantine sites to establish local level support mechanisms to respond to the MHPSS needs. Multidisciplinary MHPSS administrative and field teams were then established in nine of the ten regions (except Benishangul Gumuz) and Dire Dawa City Administration with a monitoring and evaluation system. Currently, most of the central MHPSS team's activities are carried out in Addis Ababa, where 67% of COVID-19 infections in the country are reported (17). A multidisciplinary technical working group was established on September 21, 2020, in the FMoH to produce relevant and timely guidance, MHPSS documents and training manuals.

In collaboration with Packard Foundation and Jhpiego Ethiopia, training on stress management, burnout prevention, and leadership skills was conducted. A follow-up experience-sharing workshop was organized for MHPSS professionals and other health professionals working in quarantine and treatment centers in Addis Ababa and Oromia Region.

Representatives from 23 COVID-19 treatment hospitals country-wide were given implementation strategies to integrate MHPSS with other health services. Training was also provided for 20 COVID-19 hotline service providers in Addis Ababa on Tele counseling primary skills. MHPSS units in 52 private and governmental universities were also established in collaboration with the Ministry of Science and Higher Education, regional health, and education bureaus.

A close working relationship was created with members of a Technical Working Group (TWG) established by WHO, consisting of members from NGOs working on MHPSS in Ethiopia. There was also a collaboration with governmental institutions, including the Ministry of Peace, Ministry of Women Children and Youth Affairs and Ministry of Labor and Social Affairs, to reintegrate deportees and protect women and children.

Mainstream media engagement by MHPSS professionals had increased to cover various issues regarding mental health aspects of COVID-19 including social connectedness during physical distancing, MHPSS services in quarantines and protection of children from COVID-19. The PHEOC's risk communication and community engagement team collaborated with the MHPSS focal personnel to prepare educational materials in local languages and were transmitted through TV, radio, and social media; targeting children and parents with the support from UNICEF and Save the Children.

A clinic in Ethiopia reported a promising experience of providing Psychiatric services through online video conferencing and audio calls which were useful for their accessibility and reduction of fear of viral transmission despite encountering challenges such as poor internet connectivity (18).

Discussion

As to the authors' knowledge, there has not been documentation regarding the contributions made by MHPSS in prior health emergencies [before COVID-19] in Ethiopia from which experiences could be drawn. In the initial phase of the response to COVID-19, MHPSS was not considered part of the National Task Force. As a result, planning and providing MHPSS services in the preparation phase of the response was delayed. The emphasis on the need for MHPSS services increased due to reports of suicidal attempts and psychotic episodes in quarantine and a rise in the number of returnees who experienced mental and psycho-social challenges.

One of the primary tasks in providing MHPSS services in the emergency response was mapping and coordination (12). However, this assignment had a major challenge since no central team could coordinate NGOs, private health/social institutions, and governmental institutions working on MHPSS in the initial few months. Although these challenges were partially addressed as the MHPSS team was established under the support of FMoH, there were still concerns that further coordination among stakeholders was needed as MHPSS is a cross-cutting issue.

If the rate of infection outside of Addis Ababa rises and, as a result, the need for MHPSS increases in the regions,

the availability of MHPSS services comes into question since the Mental Health service coverage outside of Addis Ababa has been low even before the pandemic. Through the efforts made to establish MHPSS administrative and field teams in regional health bureaus, availability of trained local MHPSS professionals has been a challenge.

Many other countries such as Italy reported a concerning reduction of Psychiatric outpatient and inpatient services where psychiatric wards were repurposed for COVIID-19 related medical services (19). Similarly, the repurposing of a hospital, which predominantly gave Psychiatric services, into a COVID-19 center, raises the question of the continuity of essential mental health services in Ethiopia.

Provision of Personal Protection Equipment (PPE) for MHPSS professionals has also been a challenge. Clear guidance for PPE utilization in such cases was lacking. MHPSS professionals require better access to PPE since they may face an additional burden working with violent patients, and/ or suicidal patients who get into a physical altercation or require of injectable medications, which require the MHPSS professionals to have close contact with their patients (20).

Public health messaging about COVID-19 was generally provided but did not include messages regarding specific vulnerable groups, including those with mental illnesses and their families, those in long-term facilities, older people, those with disabilities, and children and women as per the recommendation of the WHO (7). Specifically tailored messages for these groups will need to be developed.

As the services for COVD-19 shift from quarantine and isolation centers to home-based services for mild and moderate COVID-19 (5) cases, it calls for a new system of integrated MHPSS service provision. Furthermore, if the death toll rises from severe cases, a system of culturally sensitive bereavement counseling and support is required for families and communities who could not undergo the usual traditional burial ceremonies.

Conclusion and Recommendation

MHPSS services in relation to COVID-19 in Ethiopia are commendable despite the delay in the response. As per the IASC recommendation, multi-sectoral collaboration has been used in Ethiopia which is a step in the right direction (12).

The response to the COVID-19 pandemic has highlighted the multidisciplinary teamwork and contribution of psychiatry professionals, other health professionals, psychologists, and social workers in providing the psycho-social support components of the MHPSS services (12). This contribution needs to be recognized and integrated into the health system to manage future challenges effectively as it has been highlighted in the national mental health strategy of Ethiopia (15).

The rise of COVID-19 infections and their related mental and psycho-social consequences would mean that it would be challenging to depend on in-person services. Therefore, the establishment of remote technology-based services and mental health hotlines may ease some concerns about the possibility of spreading infections to vulnerable individuals and provide the opportunity for broader access to the services (8). The use of remote mental health services was seen in other countries such as China, where online video, chat and telephone-based counseling was provided for patients, and/or people in isolation and health care workers (21).

The COVID-19 pandemic has amplified the deficits within Ethiopia's mental health system but has also provided opportunities to collaborate with different stakeholders. To continue to respond to the COVID-19 pandemic effectively and to effectively respond to future public health emergencies, an investment in the mental health system is essential as per the recommendations of the UN (8).

This article relied upon reports and has not used the collection of primary data. Therefore, the report may not have covered all responses that have been used. Additionally, a more in-depth look is necessary to assess the impact of the interventions in place and determine how the country’s mental health provision has been affected due to the COVID-19 pandemic.

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