



THE IMPACT OF COVID-19 ON MENTAL, NEUROLOGICAL AND SUBSTANCE USE SERVICES

RESULTS OF A RAPID ASSESSMENT IN THE AFRICAN REGION

8 OCTOBER 2020



World Health
Organization

REGIONAL OFFICE FOR
Africa

**The impact of COVID-19 on mental, neurological and substance use services:
results of a rapid assessment in the African Region**

© WHO Regional Office for Africa 2021

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment in the African Region. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

TABLE OF CONTENTS

| | |
|---|-----------|
| Acknowledgements | iv |
| Abbreviations | v |
| Executive summary | vi |
| 1. Introduction | 1 |
| 2. Methodology | 3 |
| 3. Results | 7 |
| 3.1 Mental health and psychosocial support response and coordination | 7 |
| 3.1.1 MHPSS as part of COVID-19 response plans | 8 |
| 3.1.2 Multisectoral MHPSS coordination | 9 |
| 3.1.3 Membership of the multisectoral coordination platform | 9 |
| 3.2 Impact on the use of mental, neurological and substance use services | 10 |
| 3.2.1 Inclusion of services for mental, neurological and substance use disorders in the list of essential health services | 10 |
| 3.2.2 Policies for access to essential services for mental, neurological and substance use disorders | 10 |
| 3.2.3 Access to services in the African Region, by setting and service category | 11 |
| 3.2.4 Stage of transmission and disruption of services | 12 |
| 3.3 Disruption of MNS-related interventions/services due to COVID-19 | 12 |
| 3.3.1 Level of disruption of MNS services | 13 |
| 3.3.2 Causes of disruptions in MNS-related interventions/services | 14 |
| 3.3.3 Disruptions, income groups, travel restrictions and availability of PPE | 14 |
| 3.3.4 Approaches to overcome disruptions in the African Region | 16 |
| 3.4 Surveillance and research concerning MNS disorders during the COVID-19 pandemic | 18 |
| 3.4.1 Data collection on MNS disorders or manifestations | 18 |
| 3.4.2 Studies related to the impact of COVID-19 on mental health | 18 |
| 4. Conclusion | 21 |
| Annex 1: List of responding countries in the African Region | 22 |

ACKNOWLEDGEMENTS

The survey was implemented by the Department of Mental Health and Substance Use (MSD), World Health Organization, Geneva. The guidance and conceptualization for the rapid assessment were provided by Dévora Kestel, Director, MSD; Tarun Dua coordinated the overall implementation; and Fahmy Hanna and Jorge Castro led the questionnaire design, data management, statistical analysis and preparation of the final global report.

In the African Region, we are especially grateful to Florence Baingana, WHO African Regional Advisor for Mental Health and Substance Abuse, and all colleagues in the NCD Management Team, ably led by Professor Jean Marie Dangou (Team Lead) and Olivia Endzandza (Administrative Assistant).

Finally, we thank all Member States that took part in the rapid assessment, allowing for the analysis and completion of this report.

ABBREVIATIONS

| | |
|-----------------|---|
| AFR | WHO African Region |
| AFRO | WHO Regional Office for Africa |
| AMR | WHO Region of the Americas |
| COVID-19 | coronavirus disease 2019 |
| EMR | WHO Eastern Mediterranean Region |
| EUR | WHO European Region |
| IASC | Inter-Agency Standing Committee |
| IST | Intercountry Support Team |
| MHPS | mental health and psychosocial support |
| MNS | mental, neurological and substance use |
| MSD | WHO Department of Mental Health and Substance Use |
| NCDs | noncommunicable diseases |
| NGO | nongovernmental organization |
| PPE | personal protective equipment |
| WB | World Bank |
| WHO | World Health Organization |
| WPR | WHO Western Pacific Region |

EXECUTIVE SUMMARY

The World Health Organization (WHO) has identified mental health as an integral component of the COVID-19 response. Its rapid assessment of service delivery for mental, neurological and substance use (MNS) disorders during the COVID-19 pandemic, on which this report is based, is the first attempt to measure the impact of the pandemic on such services at a global level. The data were collected through a web-based survey completed by mental health focal points at ministries of health between June and August 2020. The questionnaire covered the existence and funding of mental health and psychosocial support (MHPSS) plans, the presence and composition of MHPSS coordination platforms, the degree of continuation and causes of disruption of different MNS services, the approaches used to overcome these disruptions, and surveillance mechanisms and research on MNS data.

In total, 28 out of 47 or 60% of WHO Member States in the African Region submitted answers to the survey, compared with 67% across all WHO regions. Data were disaggregated by region, income group and stage of transmission of COVID-19. Further analysis of AFR-specific data was conducted for selected variables.

A remarkable majority of countries in the African Region, 96% (27 of the 28 reporting countries) as against 89% of responding countries globally, reported that MHPSS response was part of their national COVID-19 response plans. However, only 25% of these countries (compared to 17% at the global level) have ensured full additional funding for MHPSS covering all activities.

While 57% of responding countries in the African Region reported having an MHPSS coordination platform, 100% of these platforms included the ministries of health, compared with 65% globally.

Continuity of all MNS services was included in the list of essential health services in the national COVID-19 response plans of 64% of African countries that responded to the survey, compared with 51% of responding countries globally.

To understand government policies on access to a range of MNS services, the status of closure of existing services was checked across different categories and settings. A total of 10 services for

MNS disorders were included, such as inpatient and outpatient services at mental hospitals; outpatient and inpatient psychiatric and neurological units as well as treatment of substance use disorders at general hospitals; and services for MNS disorders in primary health care, residential, home and day care services at community level. About 17% of countries in the African Region reported that all services were fully open while 93% of countries globally reported disruptions in one or more of their services for MNS disorders. No country reported full closure of all services.

The trend for types of services disrupted differed. In the African Region, substance use services and school- and work-related mental health services were more impacted. At the global level, the following services were largely disrupted: school and workplace mental health services, mental health services for the elderly and child and adolescent mental health services. In the African Region, outpatient and inpatient services in mental hospitals were reported as having remained open in up to 80% of reporting countries; outpatient services and inpatient MNS services in general hospitals were reported as being open in 70% and 78% of reporting countries respectively. The most affected services were inpatient units for substance abuse in general hospitals and community-based services, although both were reported as fully open in over 50% of reporting countries.

Countries were also asked to report on disruptions (complete or partial) involving the delivery of specific MNS interventions. For the purposes of the survey, complete disruption was defined as more than 50% of users not served as usual, and partial disruption as between 5% and 50% of users not served as usual.

A surprising finding was that responding countries in the African Region reported the following as the least disrupted services: psychological and psychosocial support (only 14% fully disrupted), essential MNS drugs (14%) and emergency MNS services (18%). This was different at the global level where approximately 30% of countries reported some disruption in the management of emergency MNS manifestations (including status epilepticus, delirium and severe substance withdrawal syndromes), as well as in the supply of medications for people with MNS disorders.

The following were identified as the main causes of disruption at global and regional levels: a decrease in outpatient volume due to patients not presenting; travel restrictions hindering access to health facilities for patients; and a decrease in inpatient volume due to cancellation of elective care.

In the African Region, supply-side factors related to a lack of resources in health care systems were prominent. These included insufficient staff (46% AFR vs 32% global), unavailability of health products (43% AFR vs 23% global) and insufficient personal protective equipment (PPE) (43% AFR vs 28% global).

Countries have responded to the disruption of MNS services in multiple ways. The approaches being used are different between the global level and the regional level. In the African Region, prominence was given to the establishment of helplines and specific measures for infection prevention and control, and triaging. At the global level, up to 70% of countries responded by using telemedicine/teletherapy to replace in-person consultations (including use of any remote contact, such as telephone or video conferencing). Other measures at the global level are similar to those implemented in the African Region, including use of helplines for MHPSS (68%) and specific measures for infection prevention and control in mental health services (65%). While training in basic psychosocial skills for health care providers working in COVID-19 treatment centres was the most common approach in low-income countries (60%), it ranked fourth in the African Region, at about 37% of reporting countries. However, interventions such as task sharing through capacity building of general health workers seem to be underutilized in the African Region (43%).

Slightly more than half of responding countries (53%) were reported to be collecting data on MNS disorders or manifestations in people with COVID-19, and two thirds (66%) of them reported ongoing or planned studies related to the impact of COVID-19 on mental health. A gap was identified in the areas of substance use and neurological research related to the pandemic.

This report provides key insights into the extent of disruption of MNS services and measures being adopted in response, both at the global level and in the African Region. Certain limitations should be kept in mind when examining the results of this rapid assessment; these include the limitations

associated with self-reported data, particularly involving judgements often made by a single focal point.

The survey highlights the need to strengthen the monitoring of changes in service availability, delivery and utilization at country level, and to establish informed decision-making on required adaptations and strategies for MNS services during the pandemic. WHO's guidance titled *Maintaining essential health services: operational guidance for the COVID-19 context* includes specific adaptations and considerations for safe delivery and restoration of MNS services, covering emergency acute care, outpatient care guidance and other contexts.

KEY MESSAGES

In the African Region:

- MHPSS is recognized as an integral component of the COVID-19 response. Almost 100% of the responding Member States had included MHPSS in their response. They had also developed MHPSS plans, which for the most part were not funded.
- There were disruptions to MNS services, especially for alcohol and substance use disorders, at the primary health care and community levels.
- Countries adapted and responded to the disruptions by increasing the use of helplines to provide counselling and by strengthening specific measures for infection prevention and control and triaging.
- There is a need to strengthen the monitoring of changes in service availability, delivery and utilization at country level, and to establish informed decision-making on required adaptations and strategies for MNS services.
- Bigger investments are required to initiate/strengthen the use of newer technologies such as telemedicine and teletherapy.

1

C H A P T E R O N E

INTRODUCTION

1. INTRODUCTION

In the African Region, the first case of coronavirus disease 2019 (COVID-19) was detected in Algeria on 25 February 2020. By 15 July 2020 (the midpoint of the rapid assessment), the updated figures in the African Region represented 3.9% of confirmed cases worldwide and 1.5% of global deaths. At that point in time in the African Region, there were a total of 503 122 confirmed cases and 8 607 deaths¹. As of 16 September 2020, the African Region had 1 120 722 confirmed cases and 24 244 deaths. While this appears to be an exponential rise, the figures still stand at 3.8% of global confirmed cases although the African proportion of deaths has risen to 2.6% of global figures². In mid-July 2020, thirty-three countries were experiencing community transmission, 10 had clusters of cases and four had sporadic cases, compared with mid-September when community transmission was recorded in 35 countries, clusters of cases in nine countries and sporadic spread in three countries.

There are direct and indirect consequences of COVID-19 on mental health, creating demand for services. COVID-19 presents risks for development, exacerbation and relapse of a range of mental, neurological and substance use (MNS) disorders. COVID-19 is associated with neurological and mental complications, such as delirium/encephalopathy, agitation, stroke, insomnia, loss of sense of taste and smell, anxiety, depression and Guillain-Barré syndrome. In addition to this, pre-existing mental and neurological conditions increase the risk of severe COVID-19 illness and/or death. Social distancing restrictions, countrywide lockdowns, closure of businesses that are considered “non-essential” and travel restrictions, among others, are also leading to increased levels of stress, anxiety and depression. The number of deaths recorded in a short period of time, the fear of contracting the illness and the fear of infecting loved ones all make this pandemic one that affects almost every single individual in one way or another.

Before COVID-19, mental health systems in the African Region were already challenged by weak governance structures, centralized and institution-based care

(often of poor quality), limited mental health services at community and primary health care levels, dire shortages of mental health human resources and chronic shortages of medications, to mention but a few. This is compounded by poor mental health literacy and mental health-seeking behaviours among the populations, including myths and misperceptions that lead to stigma and discrimination of people with mental health conditions.

Drawing lessons from the Ebola outbreak in West Africa and other complex emergencies such as the Boko Haram insurgency in north-east Nigeria, WHO included mental health and psychosocial support (MHPSS) as a key component of the COVID-19 response. Very early in the response, clinical guidelines were developed that included MHPSS; a guidance note was developed on the multisectoral MHPSS response; a children’s book, “My Hero is You”³ has been developed and translated into over 130 languages, including French and English, as well as 17 African languages and dialects⁴. A handbook on basic psychosocial skills for responders was developed and disseminated. The WHO African Region developed and disseminated guidance for Member States, including support for the establishment of MHPSS technical working groups (TWGs), as well as funding for MHPSS activities.

In order to track access to mental health services and determine the continuity of essential mental health services, a survey was carried out across all six WHO regions. This was the first attempt to measure the impact of COVID-19 on MNS services at a global level. The survey covered the existence and funding of mental health and psychosocial support plans, the presence and composition of mental health and psychosocial coordination platforms, the degree of continuation and causes of disruption, and surveillance and research on MNS data.

The survey results provide an overview of the impact of COVID-19 on MNS services and understanding of the reasons for disruptions. This information will inform planning and response to mitigate the effects by country and region.

¹ COVID-19 WHO African Region: External situation report 20, 15 July 2020

² COVID-19 WHO African Region: External situation report 29, 15 September 2020

³ IASC My Hero is You, Storybook for Children on COVID-19 <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/my-hero-you-0>

⁴ Acholi, Adhola, Amharic, Hausa, Igbo, IsiZulu, Juba Arabic, Kinyarwanda, Luganda, Lugbara, Lukhonz, Ndebele, Nuer, Runyankore, Swahili, Tigrinya (Ethiopia), and Tigrinya (Eritrea).



C H A P T E R T W O

METHODOLOGY

2. METHODOLOGY

The WHO Department of Mental Health and Substance Use (MSD) developed the survey “Rapid assessment of service delivery for mental, neurological and substance use disorders during the COVID-19 pandemic” in collaboration with the six WHO regional offices. The survey followed the template of a recent WHO survey on the impact of COVID-19 on noncommunicable disease (NCD) resources and services,⁵ but adapted its structure and scope to mental health. The survey was drafted in English and translated into French, Russian, Spanish, Chinese and Portuguese, and was launched in mid-June 2020.

Ministries of health were requested through WHO regional and country offices to appoint a focal point for completion of the survey. The focal point was encouraged to contact other experts in the country to obtain information relevant to answering the survey questions. Close contact with the focal points was maintained during their nomination and through submission of the questionnaire. WHO staff members in headquarters, regional and country offices were available to respond to enquiries, to provide additional guidance and to assist focal points in completing the survey questionnaire. In some regions and as requested, webinars were organized with focal points

to provide further information on the survey and to respond to frequently asked questions. The survey was web-based, using the LimeSurvey platform, and countries were strongly encouraged to use this method for submission. A Microsoft Word version of the questionnaire was made available whenever requested. Box 1 provides the thematic areas and questions of the survey. The full questionnaire is available in Annex 1.

Responses were received between 15 June and 15 August 2020, though a handful of responses were accepted after this date (see Annex 2 for the complete list of responding countries in the African Region). Fifty per cent of responses were received during the month of July. When the WHO Secretariat received a completed questionnaire, the team reviewed it for incomplete and inconsistent answers. Respondents were re-contacted and asked for clarification and corrections as appropriate, to ensure data quality. Data from the national questionnaire were downloaded directly from the web-based platform into a Microsoft

Excel database and analysed using the Statistical Package for the Social Sciences (SPSS) software.

Box 1: Survey thematic areas and questions

Mental health and psychosocial support (MHPSS):

- Q1. Is MHPSS response part of the national COVID-19 response plan?
- Q2. Do multisectoral MHPSS coordination platforms for COVID-19 exist?

Mental, neurological and substance use (MNS) services during the COVID-19 pandemic:

- Q3. Is ensuring continuity of services for MNS disorders included in the list of essential health services as part of your country's response during COVID-19?
- Q4. During the COVID-19 pandemic, what are the government policies for access to essential services for MNS disorders at primary, secondary and tertiary care levels?
- Q5. Which of the following interventions/services related to MNS disorders have been disrupted due to COVID-19?
- Q6. What are the leading causes of this disruption(s)?
- Q7. What are the approaches used to overcome these disruptions?

Surveillance and research concerning MNS disorders during the COVID-19 pandemic:

- Q8. Is the Ministry of Health collecting or collating data on MNS disorders or manifestations in people with COVID-19?
- Q9. Is there a planned or ongoing study related to the impact of COVID-19 on mental health/brain health/substance use in the country (by government or anyone else, whether stand-alone or as part of a broader survey)?

⁵ World Health Organization. The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment. Geneva, 2020. <https://www.who.int/publications/i/item/ncs-covid-rapid-assessment>



The analysis presented in this report is based on unweighted country data. Data were analysed by WHO region, by World Bank income group⁶ (based on classifications set in July 2020)⁷ and by stage of transmission in responding countries (as of the middle timepoint of the survey on 15 July)⁸.

Certain limitations should be kept in mind when examining the results of this rapid assessment. Firstly, it is vital to acknowledge the limitations associated with self-reported data, particularly involving judgements often being made by a single focal point. For some of the variables, it is not possible to compare self-reported responses with publicly available information due to the acute nature of the emergency and limited availability of data. While focal points were encouraged to consult with other stakeholders, especially other humanitarian responders, the extent to which a full range of consultation in each country has occurred is difficult to examine. Furthermore, this rapid assessment did not include other methods such as focus groups or interviews with key informants.

A further limitation is that most of the information provided relates to the country, thereby overlooking potentially significant variability within countries concerning, for example, rural versus urban areas or remote versus central parts of the country.

Another limitation is the weakness of pre-existing national information systems. As per the WHO

Mental Health Atlas 2017, only 37% of Member States regularly compile mental health-specific data covering at least the public sector.

Additionally, 29% of WHO Member States compile mental health data as part of general health statistics.¹ During the COVID-19 pandemic, we have had to rely on pre-existing information systems with their limitations to learn about the current impact on services.

Despite our best attempts to obtain information from all countries on all variables, some countries could not provide data for some questions, and others were simply unable to participate in the exercise within the time allowed. The most common reason for not participating in the exercise or for sending incomplete data was that focal points were engaged in the acute emergency response, as communicated by some countries and WHO country and regional offices. Also, the situation was changing rapidly in some cases, or the data available were sometimes difficult to use in reporting the information in the manner requested in the survey. This could lead to potential bias in interpreting data at group level, such as WHO regions or World Bank income groups. This survey will be an ongoing activity for WHO, to be repeated regularly and integrated with the pulse survey on continuity of essential health services during the COVID-19 pandemic.¹⁰

⁶ For operational and analytical purposes, economies are classified among income groups according to 2019 gross national income (GNI) per capita, calculated using the World Bank Atlas method. The groups are: low-income, US\$ 1 035 or less per capita; lower-middle-income, US\$ 1 036- US\$ 4 045; upper-middle-income, US\$ 4046- US\$ 12 535; and high-income, US\$ 12 536 or more.

⁷ World Bank. Country Classification; June 2020. <https://datahelpdesk.worldbank.org/knowledgebase/topics/19280-country-classification>

⁸ World Health Organization. Coronavirus Disease (COVID-19) Dashboard. Transmission classification (15 July 2020). <https://covid19.who.int>

⁹ World Health Organization. Mental Health Atlas 2017. Geneva, 2018

¹⁰ World Health Organization. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Geneva, 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

3

C H A P T E R T H R E E

RESULTS

3. RESULTS

This report includes the analysis of data from Member States in the African Region, sometimes including results from the global analysis, as this is important to get a sense of how the African Region compares with the rest of the World.

In total, 28 out of the 47 countries in the African Region completed the survey. For some of the results, only those countries that completed questions with validated answers were included, which is why the total number is not always 28.

The survey was carried out between 15 June and 15 August 2020. The stage of COVID-19 transmission in responding countries was taken as the mid-point of the survey on 15 July 2020. Data were analysed by WHO region and by World Bank income category. The response rate varied across regions and income categories, as shown in the table below. As can be seen, considering all that was going on in Member States, Africa managed a 60% response rate.

Table 1: Response rate by WHO region and World Bank (WB) income group

| | | Total number of countries | Number of responding countries | Response rate |
|--------------|------------------------------------|---------------------------|--------------------------------|---------------|
| REGION | AFR (African Region) | 47 | 28 | 60% |
| | AMR | 35 | 29 | 83% |
| | EMR (Eastern Mediterranean Region) | 21 | 19 | 90% |
| | EUR (European Region) | 53 | 26 | 49% |
| | SEAR (South-East Asia Region) | 11 | 6 | 54% |
| | WPR (Western Pacific Region) | 27 | 22 | 81% |
| INCOME GROUP | Low | 31 | 15 | 48% |
| | Lower-middle | 46 | 33 | 72% |
| | Upper-middle | 60 | 44 | 73% |
| | High | 57 | 38 | 67% |

3.1 Mental health and psychosocial support response and coordination

The composite term ‘mental health and psychosocial support’ (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines in emergency settings to describe ‘any local or outside support that aims to protect or promote mental health and psychosocial well-being or prevent or treat mental health and psychosocial conditions’. The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies such as the

COVID-19 pandemic, including those working in health, social, education and community settings, as well as to ‘underscore the need for diverse, complementary approaches in providing appropriate support’¹¹. MHPSS is a cross-cutting matter of relevance to all emergencies and all sectors. While there is a need to have focused interventions with specific objectives and target groups, MHPSS applies a ‘whole-of-society’ and ‘whole-of-government’ approach.

¹¹ Inter-Agency Standing Committee. Reference Group on Mental Health and Psychosocial Support. Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak; March 2020. <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing>

3.1.1 MHPSS as part of COVID-19 response plans

In the African Region, 27 of the 28 responding countries (96.4%) reported that MHPSS response was part of their national COVID-19 response plans (Figure 1). However, only 26% of these countries had fully ensured additional funding for MHPSS response in the government budget for the COVID-19 response plan, while 37% responded that they had secured partial funding (Figure 2) and another 37% had no funding whatsoever. The lack of funding by countries is a major concern and may reflect the inability of these countries to implement their existing COVID-19 MHPSS plans and thus achieve their targets.

It is interesting to note that there is a trend for low-income countries to have MHPSS fully integrated in their multisectoral plans, while a higher percentage of higher-income countries do not have MHPSS

as part of their multisectoral coordination plans. However, higher-income countries had more funding fully or partially allocated to the plans that they had. The variation in MHPSS integration into COVID-19 response plans could be due to the African Region's experience of responding to complex emergencies. Since 2014, the African Region has been responding to the Ebola epidemic in West Africa, and on and off in the Democratic Republic of the Congo (DRC); as of 28 September 2020, the African Region was responding to a total of 116 ongoing events, including 104 outbreaks and 12 humanitarian crises¹². As the region with the largest number of pre-existing humanitarian crises, the African Region is more familiar with the integration of MHPSS into public health emergency responses.

Figure 1: MHPSS as part of COVID-19 response plans, by WHO region and WB income group

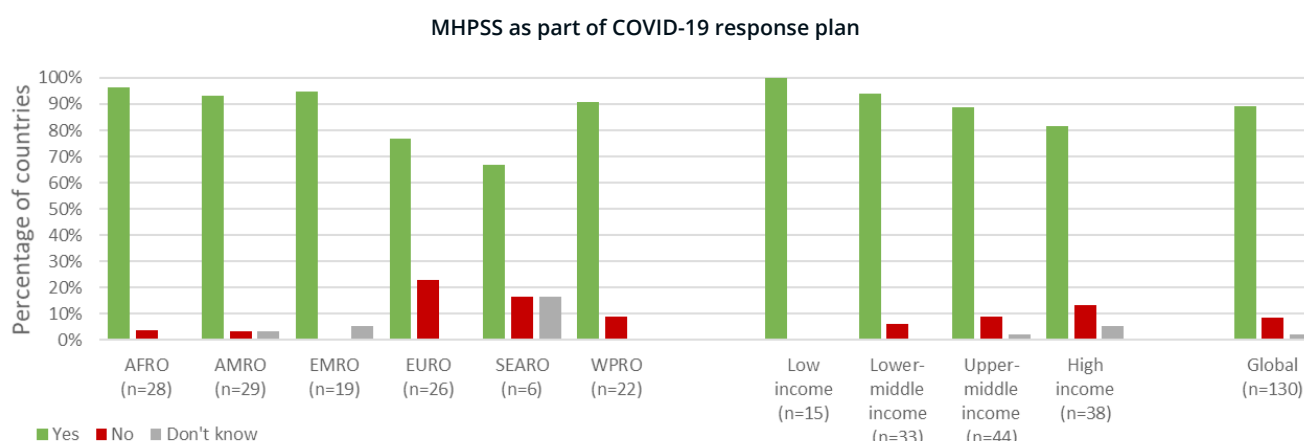
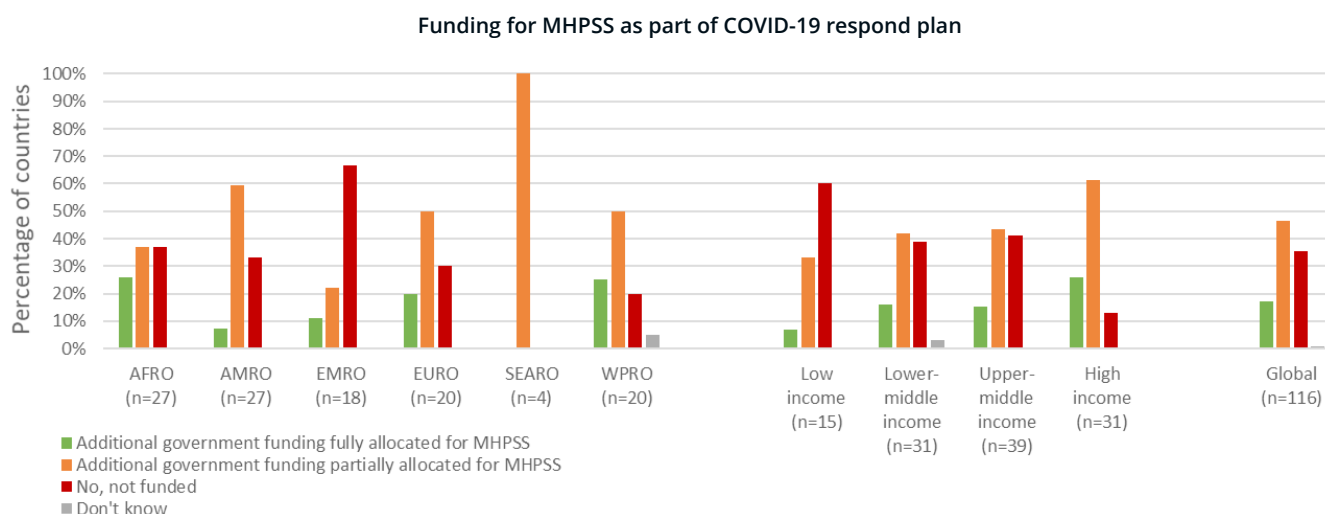


Figure 2: Funding for MHPSS as part of COVID-19 response plans, by WHO region and WB income group



¹² WHO Africa Weekly Bulletin on Outbreaks and Other Emergencies: Week 39/20

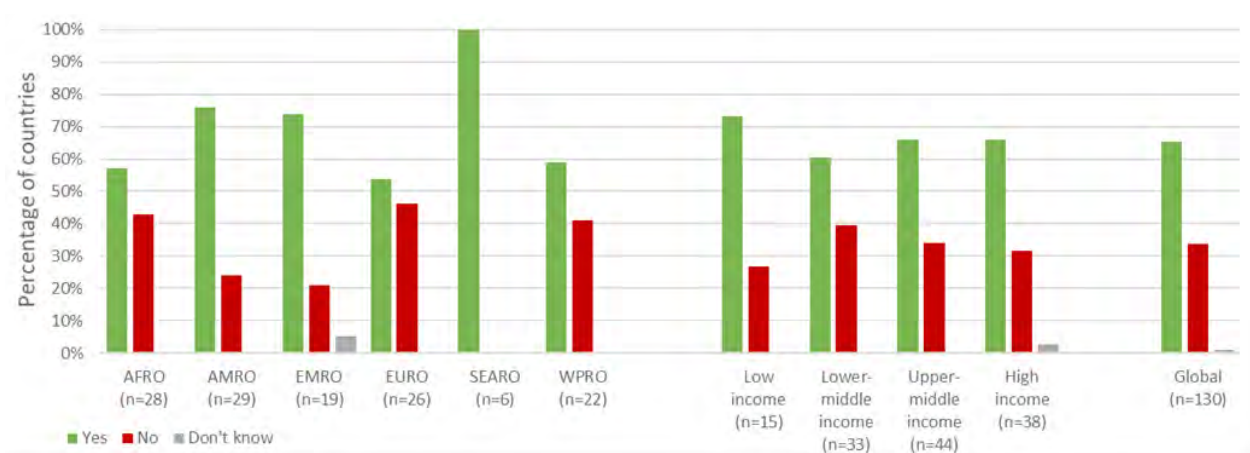
3.1.2 Impact on the use of mental, neurological and substance use services

While almost all reporting countries in the African Region had MHPSS in their COVID-19 response plans, only 57% of participant countries have a multisectoral MHPSS coordination platform for COVID-19 response (Figure 3). This implies that in some countries, MHPSS is being planned and delivered by one single entity, or by many partners, but without a coordination platform. The ministry of health is a member of the MHPSS coordination platform in 98% of reporting countries in the African Region, which is a good sign,

since we would want the ministry of health to lead the response, and the COVID-19 response to be built on the public health infrastructure.

At the global level, 43% of responding countries reported no MHPSS coordination platform. Global results suggest that this may be due to fragmentation of the MHPSS response in these countries, or a limited number of MHPSS multisectoral actors.

Figure 3: Multisectoral MHPSS coordination platform for COVID-19, by WHO region and WB income group

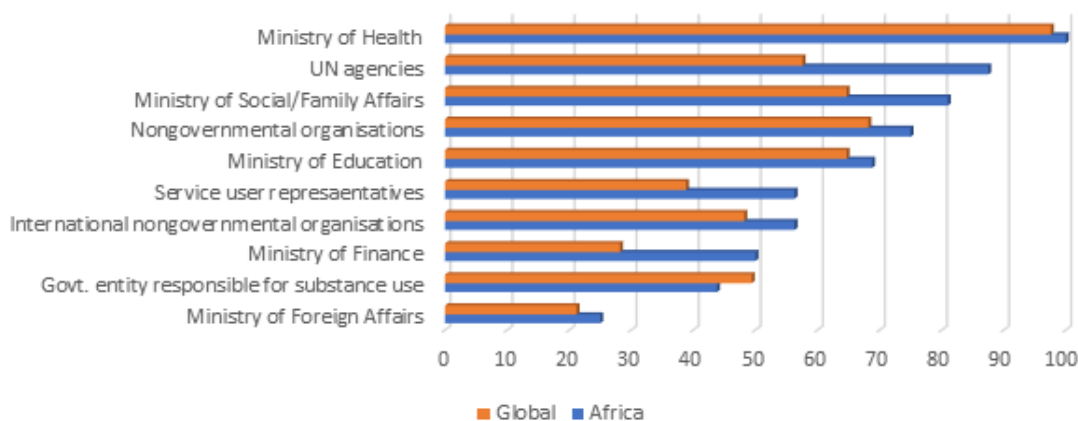


3.1.3 Membership of the multisectoral coordination platform

Both globally and in the African Region, the ministry of health is the predominant member of the MHPSS coordination platform, with 100% inclusion in the African Region. UN agencies are often co-Leads with the ministry of health, as reflected in Figure 4 below. The ministry of social/family affairs and the ministry of education are integral to the MHPSS

response. While the results show a promising and widespread existence of MHPSS platforms in most African countries, engagement with service user group representatives was reported in less than 40% of the platforms and engagement with the ministry of finance in only 28% for the African Region, and even less at the global level (Figure 4).

Figure 4: Global and African regional members of the multisectoral MHPSS coordination platform



3.2 Impact on the use of mental, neurological and substance use

Although the world is moving towards community-based services, in the African Region, psychiatric wards and general hospitals continue to provide the majority of MHPSS services. In addition, the African Region is one of the regions with the lowest public expenditure on mental health¹³. The Mental Health Atlas 2017 data¹⁴ show that government expenditure on mental health was less than US\$1 per capita in low- and lower-middle-income countries, and that

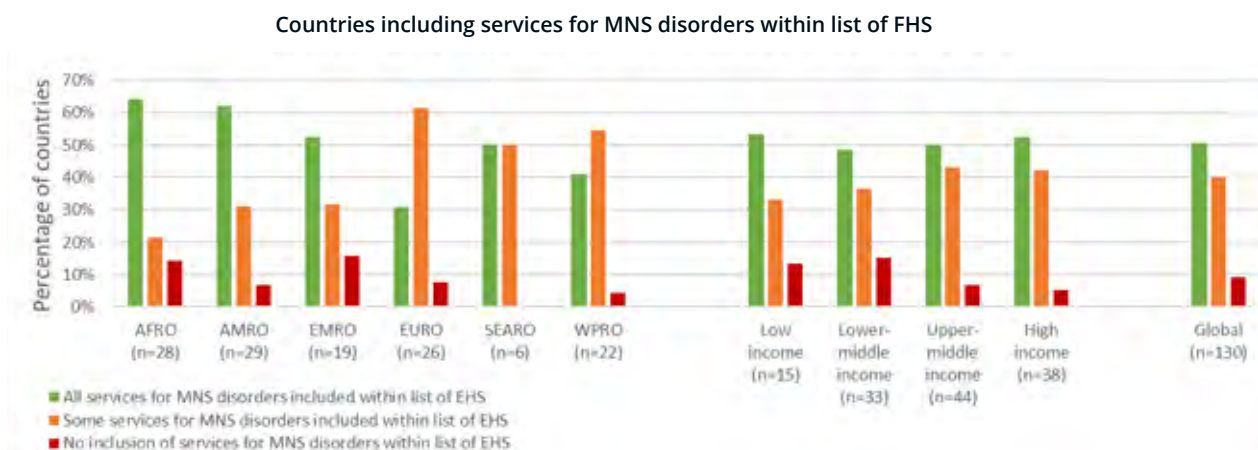
most of the mental health spending was going to mental hospitals, which are often located in larger cities and not accessible to the greater proportion of those who need care. During the COVID-19 pandemic, at a time when mental, neurological and substance use services are needed on a large scale, many countries are dealing with a challenging situation with scarce pre-existing resources and limited investment in these services.

3.2.1 Inclusion of services for mental, neurological and substance use disorders in the list of essential health services

Most participating African countries (64.3%) reported inclusion of all MNS services in the list of essential health services as part of their country's response during the COVID-19 pandemic, while 21% of them

reported inclusion of some MNS services, and 14.3% reported no inclusion of MNS services within essential health services.

Figure 5: Countries including MNS services in the list of essential health services, by WHO region and WB income group



3.2.2 Policies for access to essential services for mental, neurological and substance use disorders

Countries were also asked about national-level governmental policies regarding access to essential services for MNS disorders. These included various settings and categories, covering a total of 10 MNS services such as inpatient and outpatient services at mental hospitals; outpatient services, inpatient psychiatric and neurological units as well as treatment of substance use disorders at general hospitals; and primary health care, residential, home and day care services at community level.

In the analyses, countries were classified into three groups, namely: “All types of services fully open” when

every existing service was reported as fully open; “All types of services at least partially closed” where some services were reported as fully closed and some as partially closed; and “All types of services fully closed” if all existing services were reported as fully closed. No country reported full closure of all 10 categories of MNS services as described above. Approximately 18% reported services as fully open while 3% reported them as at least partially closed. The percentage of countries with all MNS services at least partially closed was significantly higher within the European Region, at 27%. At least partially closed services were reported from more high-income countries than from

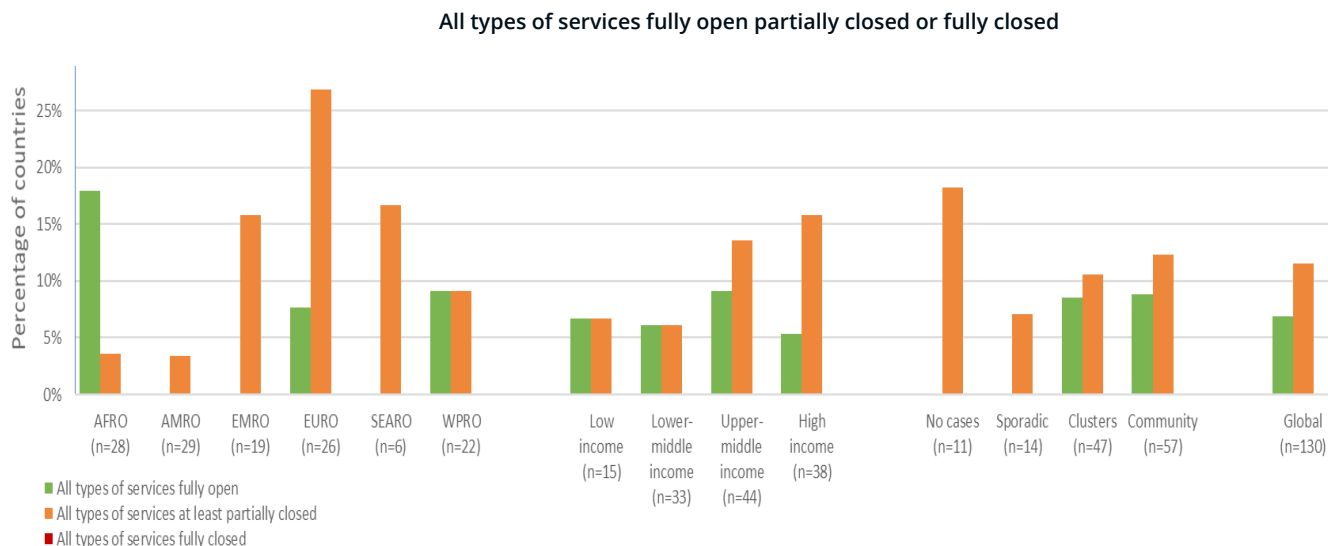
¹³ World Health Organization. Mental Health Atlas 2017. Geneva, 2018

¹⁴ World Health Organization. Mental Health Atlas 2017. Geneva, 2018

lower-income groups. This could be a reflection of the phase of the pandemic in which high-income countries were, compared with the African Region where the pandemic had a slow progression. Another reason for services being fully open in the African Region could be that most MHPSS services were provided

through psychiatric institutions and general hospitals, which had continued to provide services while community-based services were more likely closed or non-functional during the community-spread phase of the pandemic (Figure 6).

Figure 6: Status of all MNS services by WHO region, WB income group and Covid-19 transmission stage



Note: Bars not shown for “All types of services closed” since no country reported full closure of all 10 categories of service included in the analysis.

3.2.3 Access to services in the African Region, by setting and service category

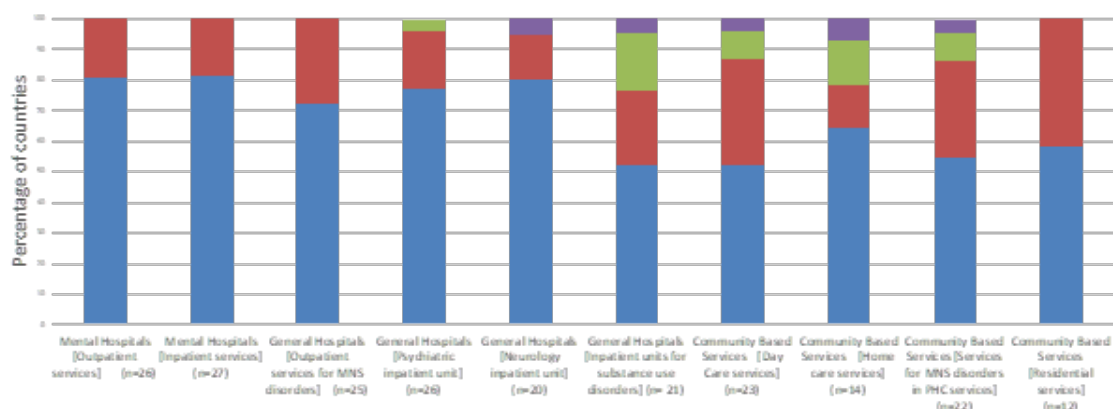
When looking at each of the 10 different categories of service, there were marked differences in the type of services affected by closure, with outpatient and community-based services being predominantly more affected (Figure 7).

In the African Region, approximately 80% of responding countries reported that both inpatient and outpatient mental health services remained open. This rate was slightly lower for inpatient services at general hospitals (77%) and much lower for general hospital out-patient services (72%). Inpatient units for substance abuse saw the highest number of countries reporting closure (19%), followed by community-

based homes (14%). Closure of inpatient services at the global level showed a similar trend.

Around 41% of countries reported either partial or complete disruption of home or community outreach services (including social care services) for people with MNS disorders. For community-based services, only residential and primary health care services were open in more than 31% of countries, while day care services were open in over 64% of countries. These results must be interpreted cautiously as the total number of reporting countries was very small in some instances.

Figure 7: Policies for access to essential MNS services, by setting and service category



Note: The difference in the denominator seen in Figure 7 is because in some countries, these services are either non-existent or information is not available¹⁵.

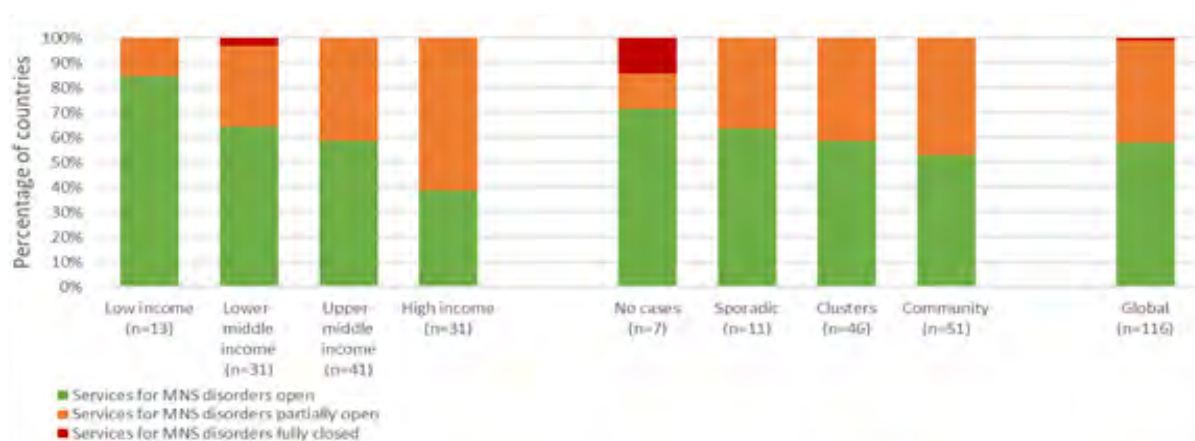
The recent WHO pulse survey on continuity of essential health services included one overlapping item on treatment for mental health disorders, which was reported to be disrupted in 61% of countries,

with 3% of those countries reporting severe/complete disruptions¹⁶. The type of treatment service, however, was not defined in the pulse survey.

3.2.4 Stage of transmission and disruption of services

Disruptions in outpatient services at mental hospitals seem to be linked to the stage of transmission of the virus, with countries in the community stage showing the highest level of disruption. See Figure 8 below.

Figure 8: Policies for access to outpatient services for MNS disorders at mental hospitals, by WB income group and COVID-19 transmission stage



3.3 Disruption of MNS-related interventions/services due to COVID-19

Countries were also asked about the level of disruption. Countries were also asked about the level of disruption of 16 specific MNS-related interventions or services (table 2), defining complete

disruption as more than 50% of users not being served as usual and partial disruption as between 5% and 50% of users not being served as usual. We also looked at the level of disruption combined across the

¹⁵ At mental health hospitals, 10% of countries did not report on policies for inpatient services for MNS disorders and 11% for outpatient services; at general hospitals, 9% of countries did not report on policies for psychiatric inpatient units, 24% for neurology inpatient units, 20% for inpatient units for substance use disorders, and 9% for outpatient services; at community-based level, 33% did not report on residential services, 20% on primary health care services, 37% on home care services, and 27% on day care services.

¹⁶ World Health Organization. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Geneva, 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

16 specific MNS-related interventions/services. In the analysis, “disruption in at least 75% of MNS-related interventions/services” was defined as 12 to 16 of the

specific MNS-related interventions or services being reported as either completely or partially disrupted.

Table 2: List of specific MNS-related interventions / services

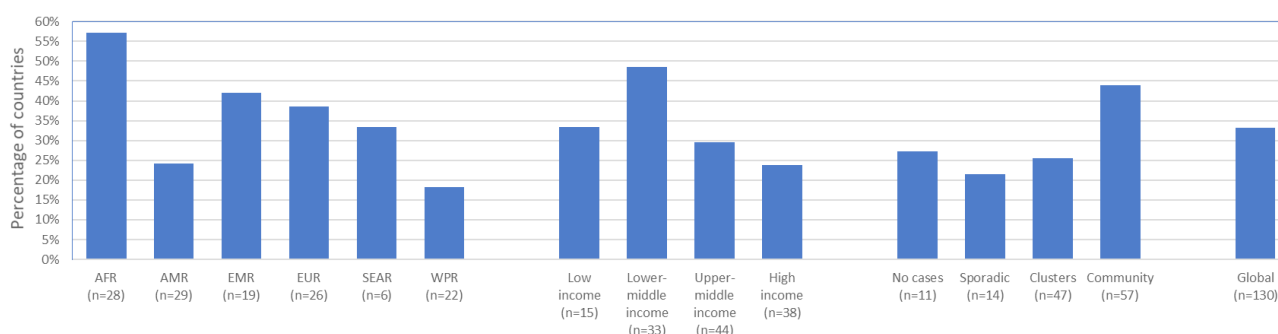
| |
|---|
| a. Management of emergency MNS manifestations (including status epilepticus, delirium, severe substance withdrawal syndromes) |
| b. Psychotherapy/counselling/psychosocial interventions for MNS disorders |
| c. Medicines for MNS disorders |
| d. Psychosocial interventions for caregivers of people with MNS disorders |
| e. Home or community outreach services (including social care services) for people with MNS disorders |
| f. Mental health interventions during antenatal and postnatal period |
| g. Services for children and adolescents with mental health conditions or disabilities, including developmental disabilities |
| h. Services for older adults with mental health conditions or disabilities, including dementia |
| i. Diagnostic and laboratory services for people with MNS disorders |
| j. Surgery for neurological disorders (e.g. epilepsy) |
| k. School mental health programmes |
| l. Work-related mental health programmes |
| m. Suicide prevention programmes |
| n. Overdose prevention and management programmes (e.g. naloxone distribution) |
| o. Critical harm reduction services (e.g. needle exchange programmes, outreach services) |
| p. Opioid agonist maintenance treatment of opioid dependence (with methadone or buprenorphine) |

3.3.1 Level of disruption of MNS services

In almost one third (33%) of countries, at least 75% of MNS-related services were completely or partially disrupted. This percentage was especially higher in the African Region (57%) and in countries in the

community stage of transmission. High-income countries showed a much lower level of disruption (24%) compared with the other income groups (Figure 10).

Figure 9: Disruption in at least 75% of MNS-related interventions/services, by WHO region, WB income group and COVID-19 transmission stage



Importantly, some life-saving emergency and essential MNS services were reported as being disrupted: approximately 30% of reporting countries at the global level reported disruption in the management of emergency MNS manifestations (including status epilepticus, delirium and severe substance withdrawal syndromes), and in the supply of medications for people with MNS disorders (Figure 10).

Prevention and promotion of mental health services and programmes were most severely affected and disrupted. Almost two thirds of school mental health or workplace mental health services were fully or partially disrupted. In the African Region, there were countrywide school closures; some countries have not reopened schools, even as late as the end of September 2020.

This would imply that school-going children, while being protected from COVID-19, were nonetheless unable to access mental health prevention or promotion services.

Among the interventions or services related to substance use, critical harm reduction services were completely disrupted in 30% of reporting countries and partially disrupted in 35%, globally; opioid agonist maintenance treatment of opioid dependence was completely disrupted in 27% of countries and partially disrupted in 18%; and overdose prevention and management programmes were completely disrupted in 21% of countries and partially disrupted in 32%. In the African Region, three of the top five most disrupted services were related to treatment of substance

use disorders, namely: opioid agonist maintenance treatment (completely disrupted in 58% of countries), critical harm reduction (completely disrupted in 47% of countries) and overdose prevention (completely disrupted in 40% of countries). (Figure 11)

At a time when they are highly needed, mental health services for the most vulnerable were reported to be disrupted. In the African Region, school mental health services were the second most disrupted service with 56% of reporting countries indicating complete disruption.

Both globally and in the African Region, management of emergency MNS disorders as well as medicines for MNS disorders were the least disrupted overall.

Figure 10: Disruption of MNS-related interventions/services due to COVID-19 at the global level

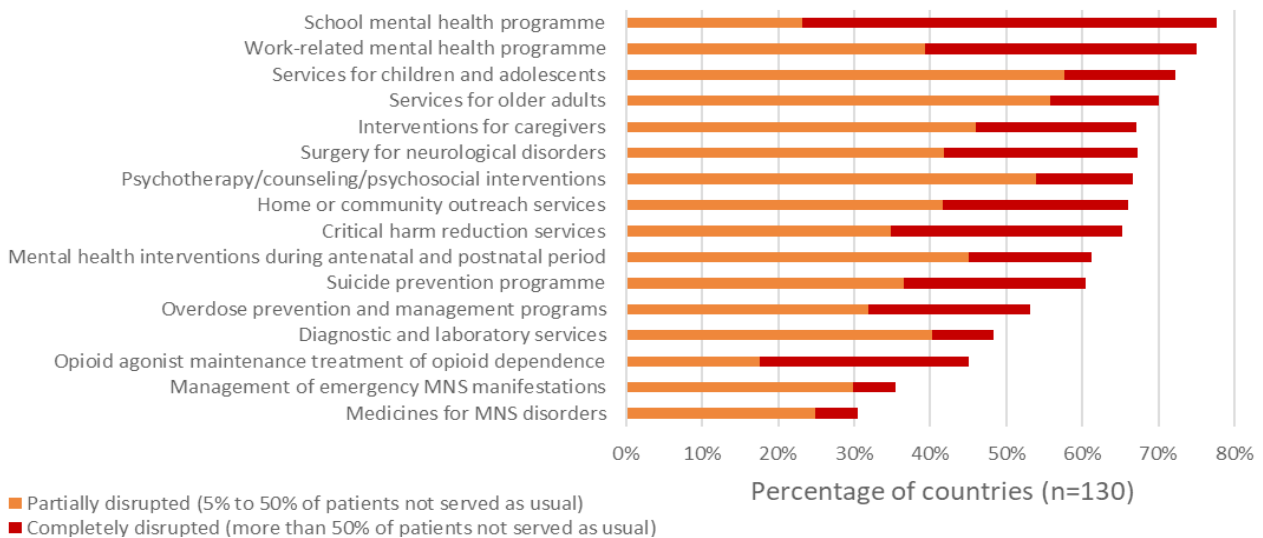
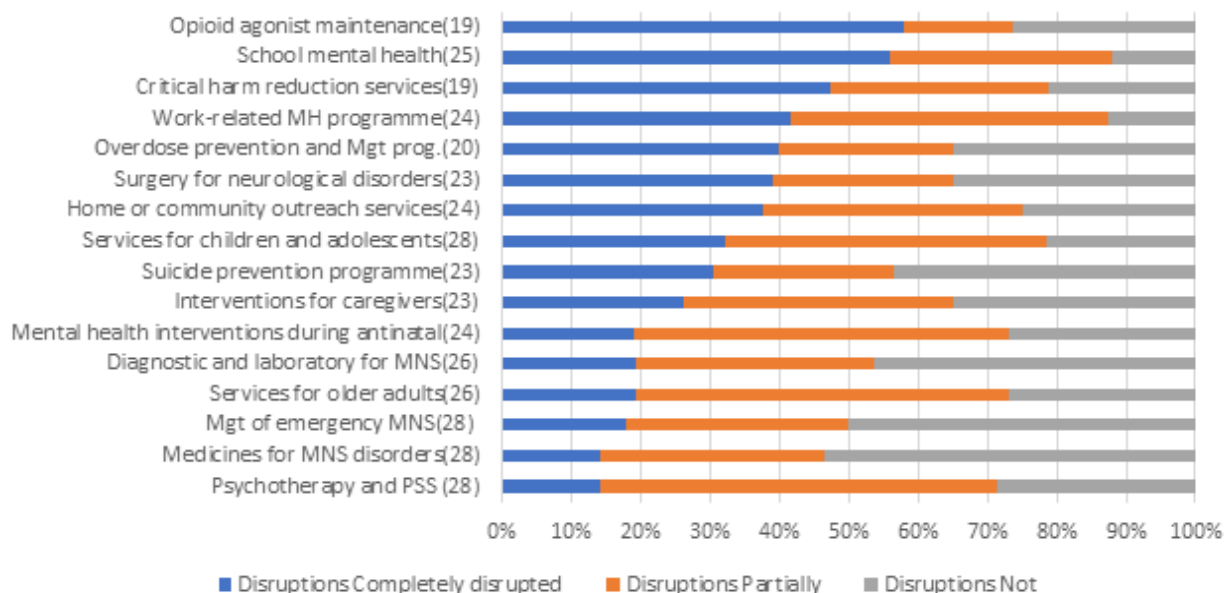


Figure 11: Disruption of essential services in the African Region



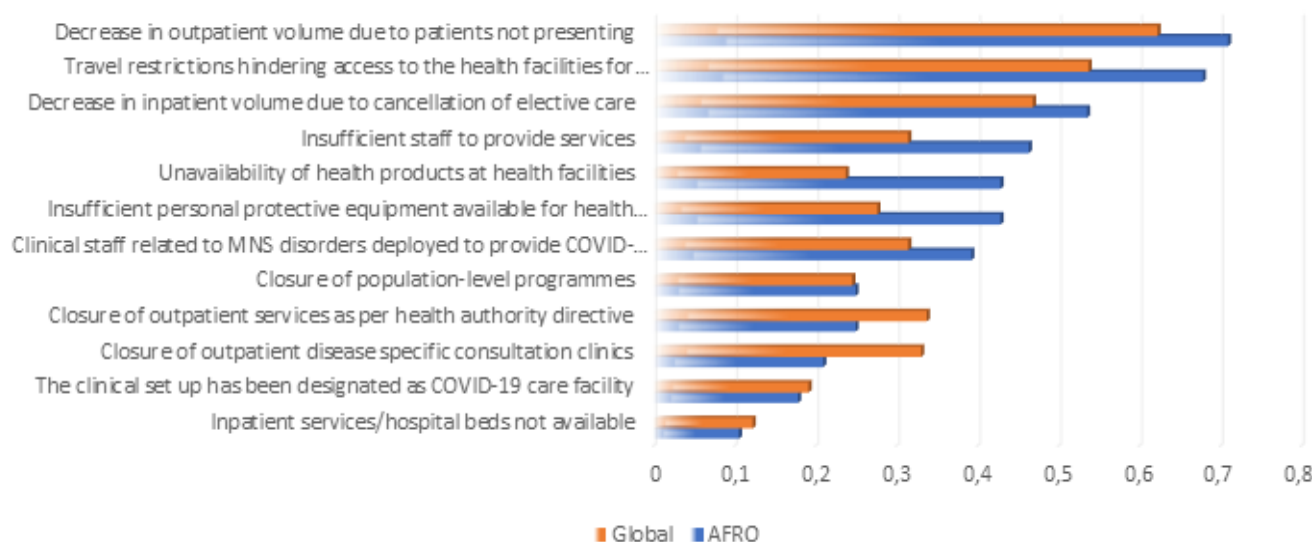
3.3.2 Causes of disruptions in MNS-related interventions/services

The survey not only included questions on disruptions of MNS-related interventions and services but also on the main causes of the reported disruptions. The leading causes of disruption both at the global and African Region levels were: a decrease in outpatient volume due to patients not presenting (62% global vs 71% AFR), travel restrictions hindering access to health facilities (54% global vs 68% AFR) and a decrease in inpatient volume due to cancellation of elective care (47% global vs 54% AFR) (Figure 12). COVID-19 magnified the existing limitations of the African Region's health and mental health systems, including insufficient staff (46% AFR vs 32% global), unavailability of health products (43% AFR vs 23%

global), insufficient personal protective equipment (43% AFR vs 28% global) and redeployment of mental health staff (39% AFR vs 31% global).

Indeed, the same leading causes of disruption were identified in the recent WHO pulse survey on continuity of essential health services, as a combination of demand factors on the one side, such as patients not presenting to outpatient care or perceptions that government or public transport lockdowns were hindering access, and on the other side supply factors such as cancellation of elective care or redeployment of clinical staff to provide COVID-19 relief.¹⁷

Figure 12: Causes of disruption at the global and African regional levels



3.3.3 Disruptions, income groups, travel restrictions and availability of PPE

Globally, when data were disaggregated across income groups, travel restrictions were reported as the most common cause of disruption in 73% of low-income countries (Figure 13). Travel restrictions, together with limited availability and closure of community-based mental health services closer to where people live, can potentially lead to adverse outcomes for people with MNS disorders.

Additionally, the income levels of countries can be correlated to availability of PPE. In 28% of the countries, respondents reported insufficient supplies of personal protective equipment (PPE) available for health care providers to provide services at mental health facilities. This was reported most frequently in the African Region (43% of countries) (Figure 14).

¹⁷ World Health Organization. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Geneva, 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

Figure 13: Travel restrictions hindering access to health facilities, by WB income group

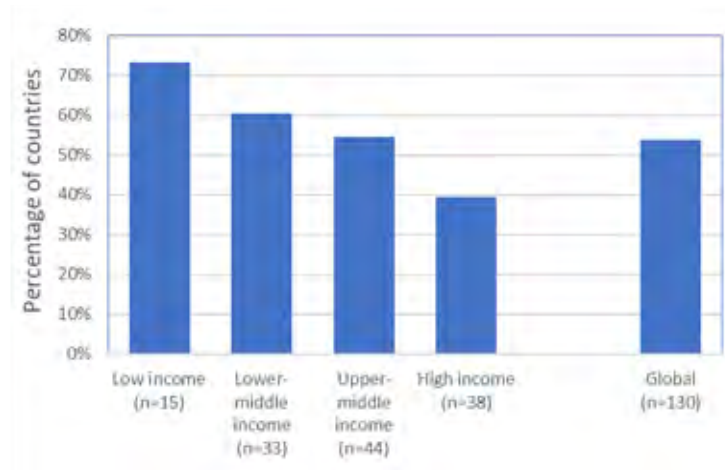
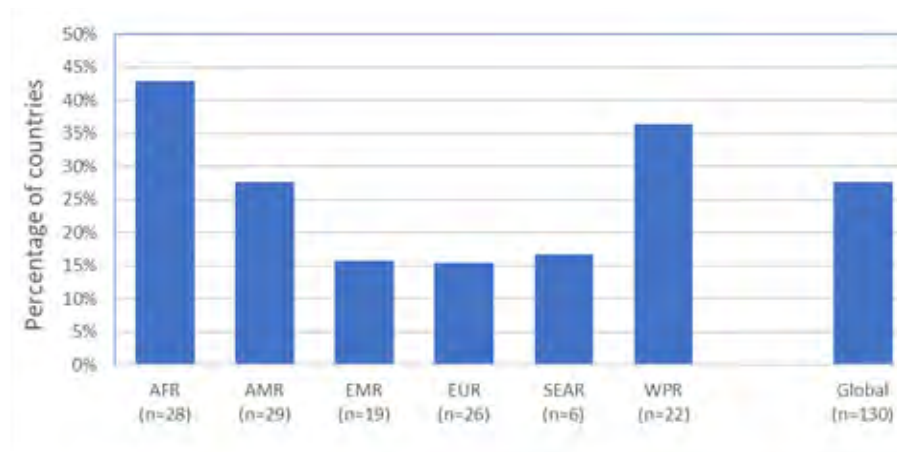


Figure 14: Insufficient PPE available for health care providers to provide services, by WHO region



3.3.4 Approaches to overcome disruptions in the African Region

Countries responded via a checklist on approaches being used to overcome service disruptions for the management of MNS disorders and to provide mental health and psychosocial support. A country could check multiple options.

The results are presented in Figure 15 below. The most frequent measures applied to overcome the disruptions were similar globally, although the frequency differed. The three most frequent measures reported were: establishing helplines (50% AFR vs 68% global); specific measures for infection prevention and control in mental health services (50% AFR vs 64% global); and triaging to identify priorities (50% AFR vs 49% global). There were marked differences in the frequency of deployment of telemedicine/teletherapy to replace in-person consultations (32% AFR vs 70% global) and in the use of self-help and the digital format of psychological interventions (36% AFR

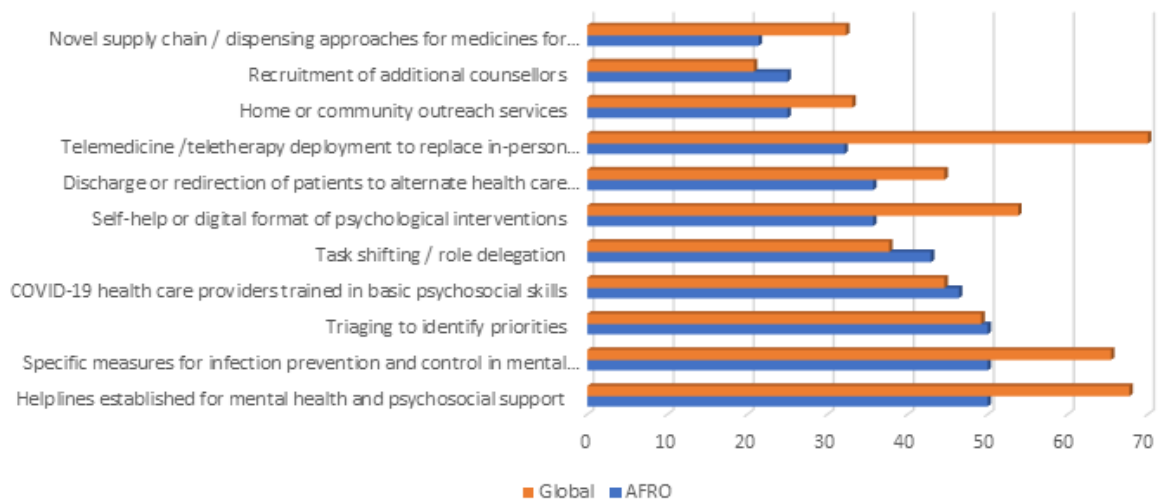
vs 54% global).

At the global level, the findings regarding the frequency of telemedicine are consistent with the recent WHO pulse survey on continuity of essential health services, which also identified telemedicine among the most frequent approaches¹⁸.

Recruitment of additional counsellors and new dispensing approaches for medications were among the least reported approaches, both globally and in the African Region. In the African Region, it may well be that health systems are already strained and cannot scale up human resources, and changing the management of the medicine supply chain is an involved and complex process which cannot be completed in the period of an emergency (currently less than nine months).

¹⁸ World Health Organization. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Geneva, 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

Figure 15: Approaches for overcoming disruptions in MNS-related intervention/services



Training in basic psychosocial skills for health care providers working in COVID-19 treatment centres was the most frequently used approach among the low-income group, reported in 60% of countries (Figure 16). The use of technology in overcoming service delivery disruptions varies by income group. While

more than 80% of high-income countries reported deployment of telemedicine/teletherapy to replace in-person consultations, or the use of helplines, both modalities were used in fewer than 50% of low-income countries (Figure 17).

Figure 16: Approaches for overcoming disruptions in MNS-related intervention/services among the WB low-income group

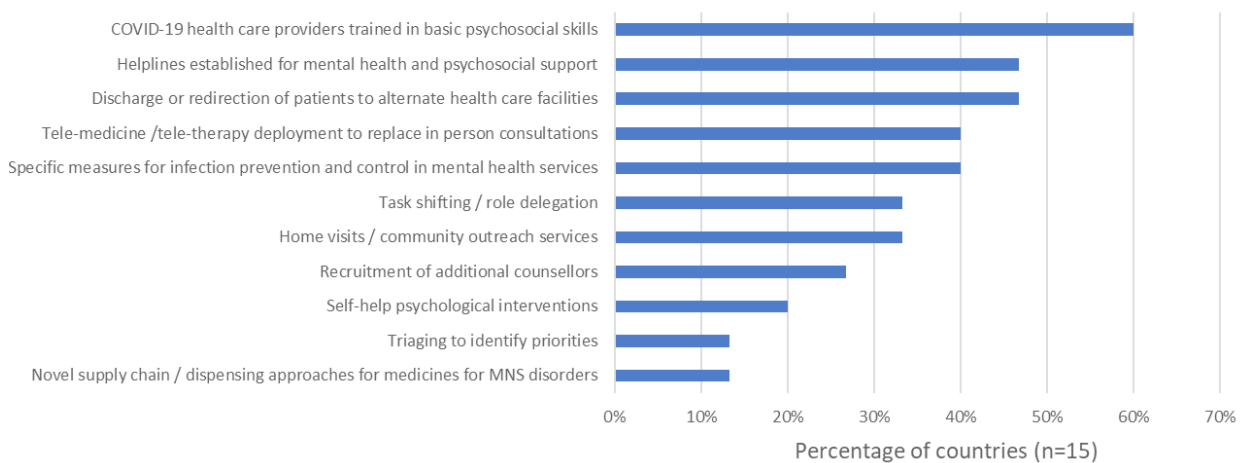
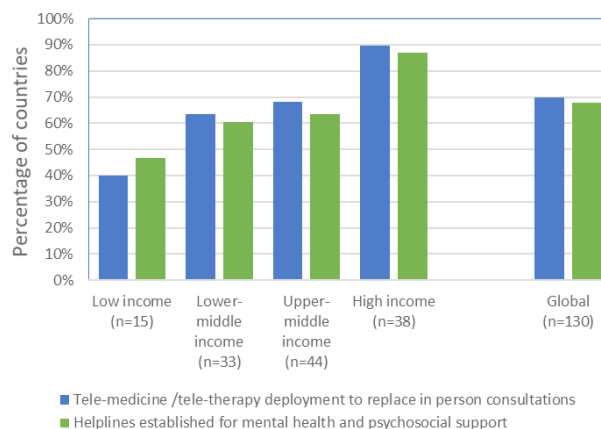


Figure 17: Use of technology in overcoming service delivery disruptions, by WB income group



3.4 Surveillance and research concerning MNS disorders during the COVID-19 pandemic

Information, evidence and research are critical ingredients for appropriate mental health planning and response during any emergency, especially in novel situations such as the COVID-19 pandemic. The generation of new knowledge through research enables plans and actions to be based on evidence

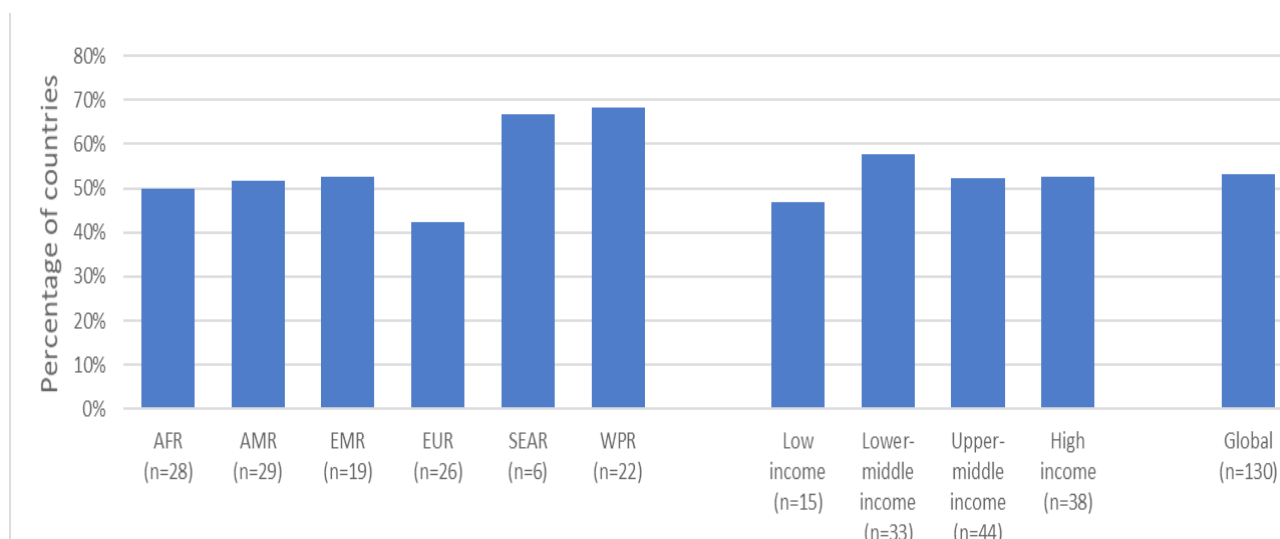
and best practice, and the availability of timely and relevant information or surveillance frameworks enables implemented actions to be monitored and improvements as well as gaps in service provision to be identified.

3.4.1 Data collection on MNS disorders or manifestations

Data are needed to monitor trends and improve the quality of services during the pandemic through informed decision-making. However, as shown by this survey, more than 40% of health ministries globally are not collecting any data on MNS disorders or

manifestations in people with COVID-19; in the African Region, the proportion is 50%. Among low-income groups, only about 48% of countries were collecting such data (Figure 18).

Figure 18: Data collection on MNS in COVID-19 patients, by WHO region and WB income group



3.4.2 Studies related to the impact of COVID-19 on mental health

Countries were also requested to report on any planned or ongoing study related to the impact of COVID-19 on mental health/brain health/substance use in the country, either by government or other stakeholders. In all, 66% of countries reported studies related to the impact of COVID-19 on mental health, brain health or substance use, with the most frequent

type of study being on mental health impact (65% of countries). Across income groups, 80% of high-income countries reported carrying out studies on mental health impact. The number of countries globally conducting research on neurological or substance use disorders was much lower (5% and 15% respectively) (Figures 19 and 20).

Figure 19: Studies related to the impact of COVID-19 on MNS, by WB income group

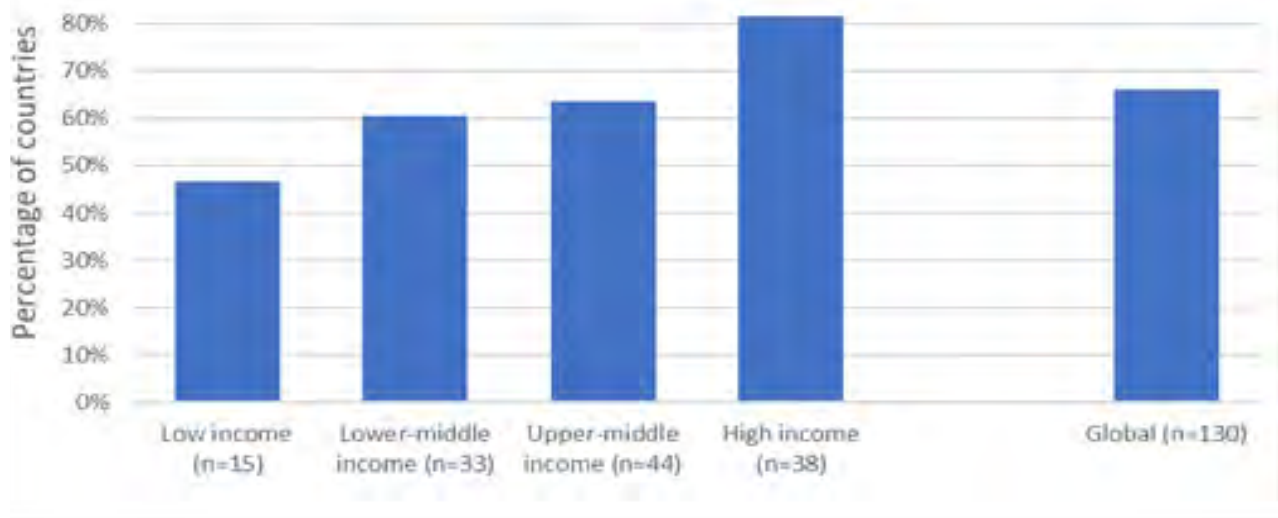
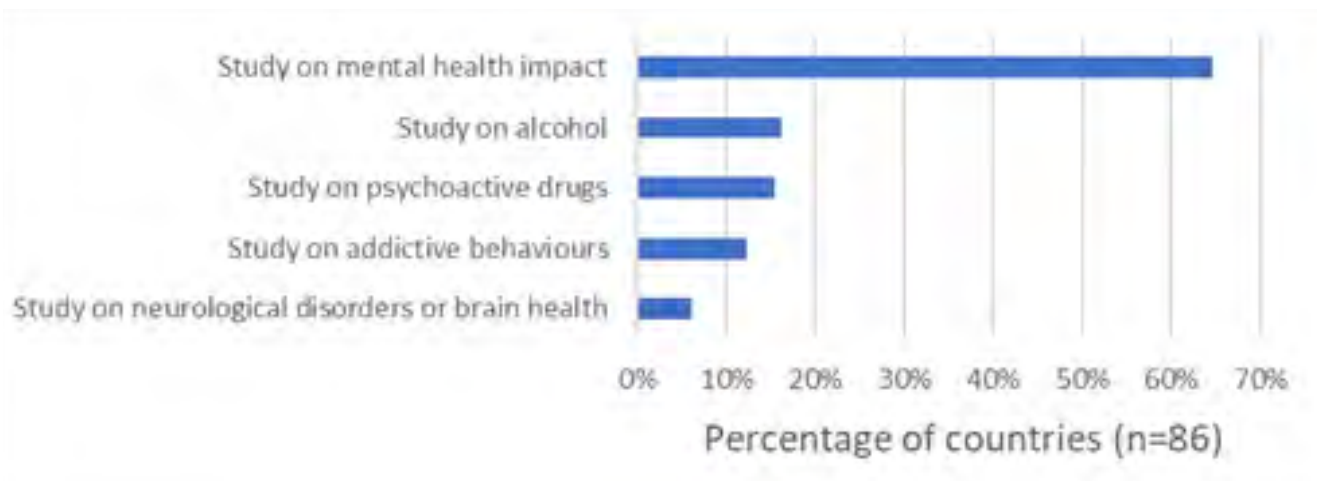


Figure 20: Type of study related to the impact of COVID-19



4

C H A P T E R F O U R

CONCLUSION

4. CONCLUSION

This survey provides insights from mental health focal points within ministries of health on the extent of disruptions to services for mental, neurological and substance use disorders, and an indication of their experience in adopting strategies to mitigate the impact on service provision. There were differences in the type of services disrupted, with already scarce outpatient and community-based mental health services predominantly more affected. Mental health prevention and promotion programmes felt the most severe impacts at a time when countries need them the most.

While acknowledging the limitations of such a survey, including the limitations of a self-reported questionnaire, the results, however, indicate that if robust health systems can be rapidly overwhelmed and compromised, the impact on the weaker health systems in the African Region is even more pronounced.

Innovative methods are being applied in many countries through teleservices and helplines; however, limited resources are a challenge to using these tools in lower-resource settings. Tools such as task sharing through capacity building of general health workers seem to be underutilized, probably due to lack of funds for training and payment of allowances to the deployed, repurposed personnel.

Although global advocacy for mental health inclusion in COVID-19 responses has resulted in better

integration into plans, multisectoral coordination platforms and regular data collection, there is still a gap in the financial and human resources allocated to integrate mental health into the emergency response, which constitutes a significant challenge and a barrier to the continuity of services.

The COVID-19 pandemic emphasizes the value of including MHPSS not only in response to emergencies and recovery, but also before emergencies through integrating measures into preparedness plans and efforts.

WHO's interim guidance document *Maintaining essential health services: operational guidance for the COVID-19 context* includes a section with specific adaptations and considerations for safe delivery of MNS services covering emergency acute care, outpatient care guidance and other contexts.

While many countries are implementing WHO-recommended strategies to mitigate disruptions to services, more information is needed to identify which approaches work in different settings during the different phases of the pandemic. Decisions about the nature and timing of adaptations to service delivery must be informed using accurate and timely data. As the pandemic is likely to ebb and flow over the coming months, real-time monitoring of changes in service delivery and utilization is needed.

ANNEX 1: LIST OF RESPONDING COUNTRIES IN THE AFRICAN REGION

WHO Member States

| | Member State | Responding focal point |
|----|--------------------------|-------------------------------|
| 1 | Algeria | Mohamed Chakali |
| 2 | Benin | François Agossou |
| 3 | Botswana | Moagi Gaborone |
| 4 | Burkina Faso | Marie Emmanuelle Zouré |
| 5 | Burundi | Jérôme Ndaruhutse |
| 6 | Cabo Verde | Aristides Delgado da Luz |
| 7 | Cameroon | Justine Laure Menguene Mviena |
| 8 | Congo | Rosalie Likibi-Boho |
| 9 | Côte d'Ivoire | Anna-Corinne Bissouma |
| 10 | Equatorial Guinea | Ana Bella Ekiri Nguie |
| 11 | Eritrea | Theodros Tekeste |
| 12 | Ethiopia | Dereje Assefa Zewude |
| 13 | Ghana | Akwasi Osei |
| 14 | Guinea | Kemo Soumaoro |
| 15 | Kenya | Simon Njuguna, Mercy Karanja |
| 16 | Liberia | Angie Tarr Nyakoon |
| 17 | Madagascar | Glenn Torrencelli Edosoa |
| 18 | Mali | Cheickna Tounkara |
| 19 | Namibia | Magdalena Didalelwa |
| 20 | Nigeria | Benjamin Aiwonodagbon |
| 21 | Senegal | Jean Augustin Diégane Tine |
| 22 | Seychelles | Gina Michel |
| 23 | Sierra Leone | Kadiatu Savage |
| 24 | South Africa | Ad Shiba |
| 25 | South Sudan | Joseph Mogga |
| 26 | Togo | Kolou Dassa |
| 27 | Zambia | John Mayeya |
| 28 | Zimbabwe | SM Chirisa |



World Health
Organization

REGIONAL OFFICE FOR

Africa