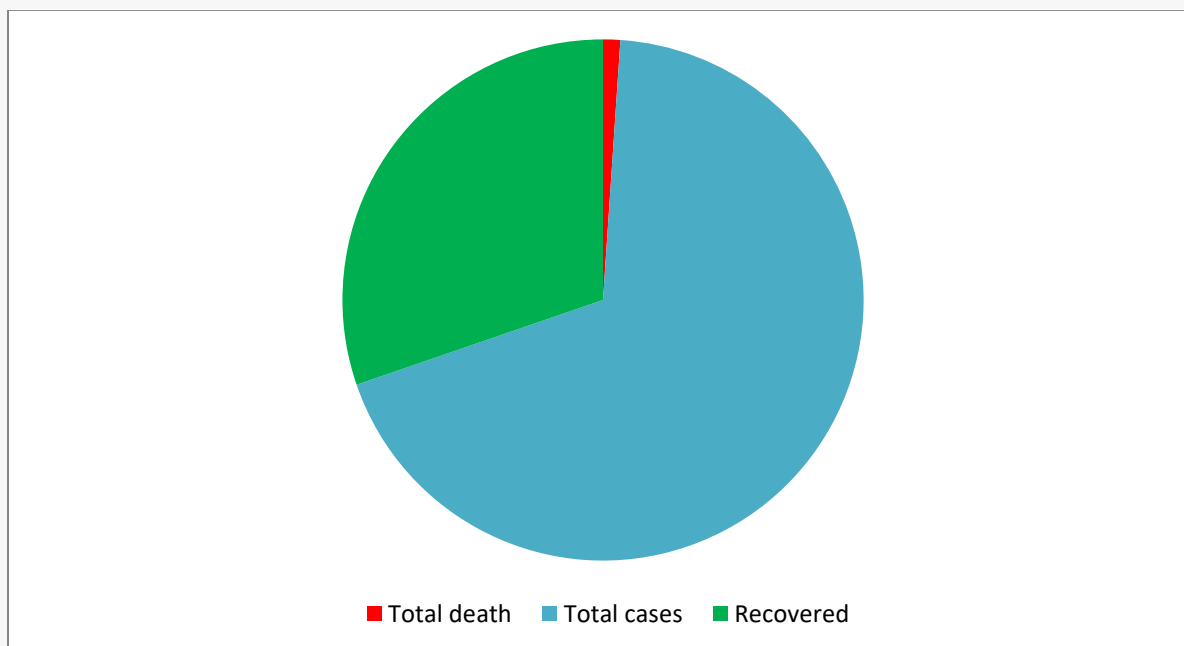


EPHI, National Data Management Center for health (NDMC)  
Quick update on COVID-19, 026

This update summarizes	Ethiopia's COVID-19 situation update
	Global and regional burden of COVID 19
	Effects of Dexamethasone on Days Alive and Ventilator-Free in Patients with Moderate or Severe Acute Respiratory Distress Syndrome and COVID-19: The CoDEX Randomized Clinical Trial.
	Long-term effects of COVID-19
	Impacts of COVID-19 on Reproductive and Maternal Health Care Services
	The impact of COVID-19 on mental, neurological and substance use services

**Ethiopia's COVID-19 situation updates**

As of October 8, 2020 there were a total of 80,895 COVID-19 cases and 1,255 deaths across the country. Compared to the cases and deaths reported a week ago, the cumulative cases have increased by 5% and deaths by 3%. So far 35,670 cases have recovered from COVID-19 (Fig 1). Of the 44,213 active cases, 245 are critical. The total number of tests stands at 1,321,160 showing a 3% increase compared to last week.



*Fig. 1. Showing cumulative COVID-19 cases, recoveries and death as of October 08, 2020.*

## EPHI and FMOH COVID 19 response highlights of the week

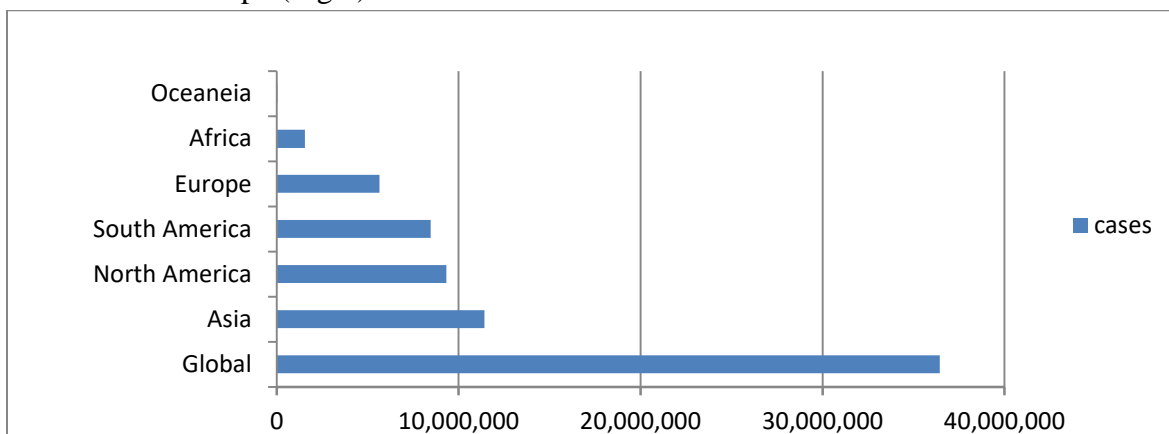
- Since Home Based Isolation and Care (HBIC) have started in Ethiopia, a total **20,715** COVID-19 confirmed cases have been followed as of October 08, 2020. Of which, 14,957 recovered and 5,770 cases are currently on follow up. Five COVID-19 related deaths have been reported 163 cases have been transferred to treatment centers while, 182 cases have been transferred from treatment centers to HBIC.
- Four days Home-Based Isolation and Care (HBIC) TOT for health professionals were completed on Oct 3, 2020 in Mekele city for 21 health professionals from Tigray region.
- As of October 05, 2020, a total of 14,350 Health Extension Workers and Health Extension Program supervisors from different region of the country are trained on mobile-based COVID-19 training.
- Four days Home-Based Isolation and Care (HBIC) TOT started on October 6, 2020 in Hawassa and Semera cities for 45 health professionals from SNNP and Afar regions.

### References

- [www.covid19.et/covid-19/](http://www.covid19.et/covid-19/)
- Public Health Emergency Operations Centers (PHEOC), Ethiopia
- [https://twitter.com/lia\\_tadesse](https://twitter.com/lia_tadesse)

## Global and regional burden of COVID-19

- Globally the total number of cases extends to 36,439,737 as of October 08, 2020. A total of 27,439,531 cases recovered and 1,061,239 people have died since the beginning of the outbreak. Globally, in a week time, from October 01, 2020 to October 08 2020, COVID-19 cases increased by 6.16% and deaths by 4.12%. Asia is the leading in terms of cases followed by North and South America. North America leads the number of deaths followed by South America and Europe (Fig 2).



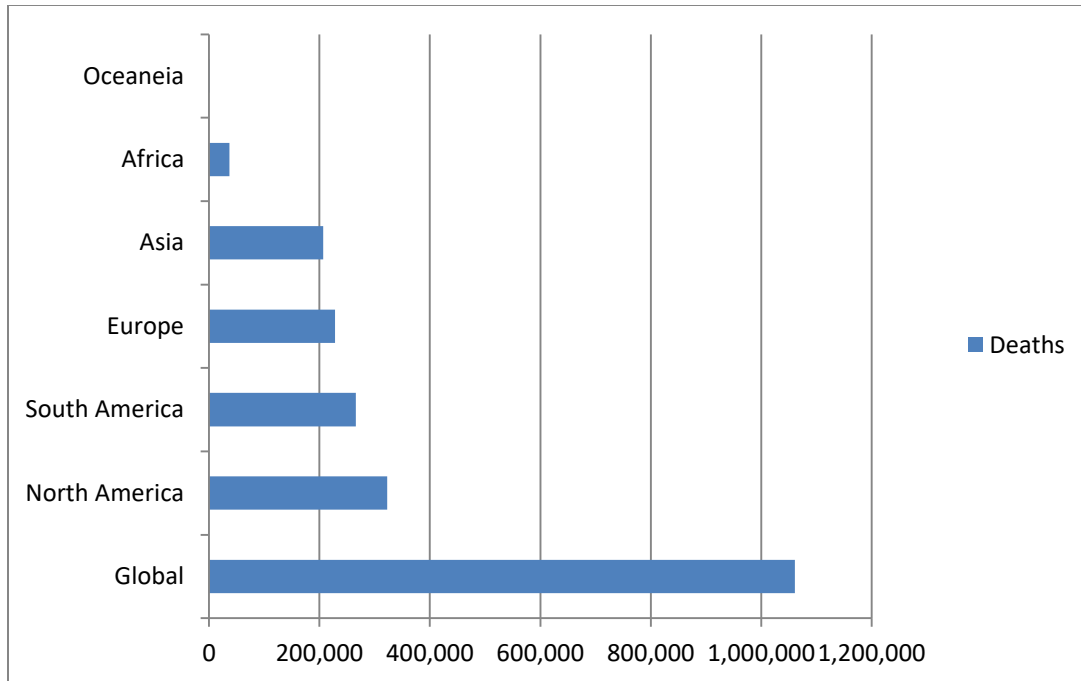
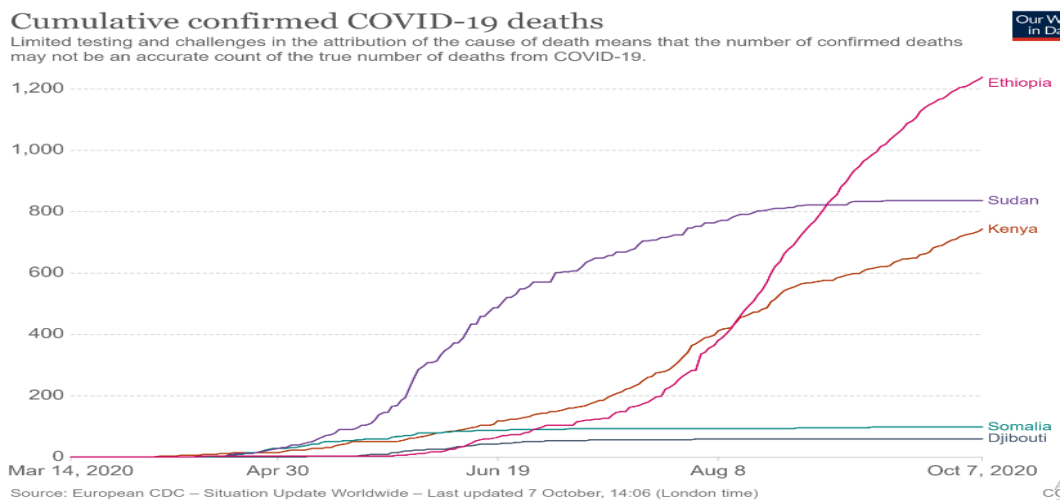
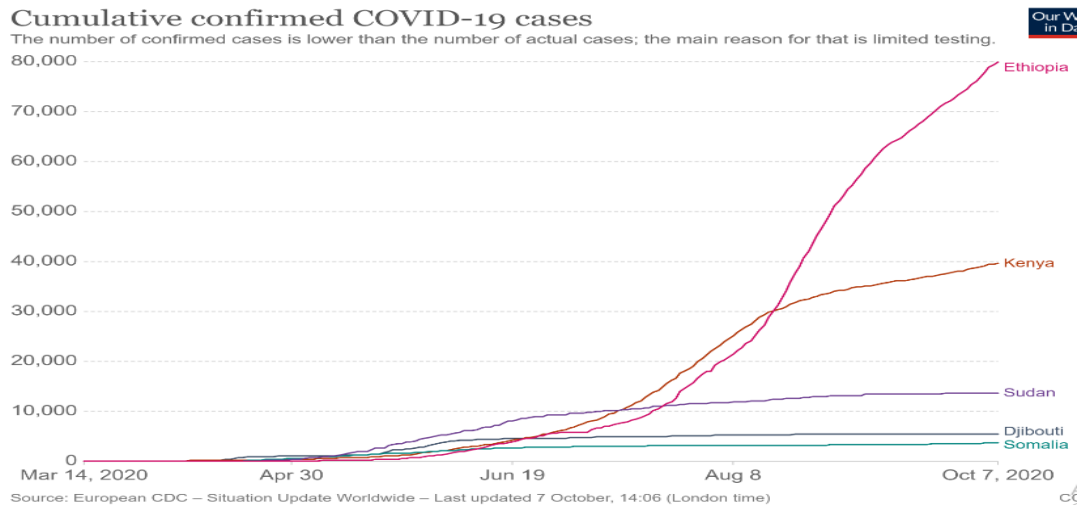


Fig 2. Global cases (top) and deaths (bottom) reported as of October 08, 2020.

- USA has recorded the highest number of cases (7,776,796 cases, 216,7788 deaths) that accounts 21.3% of the total global cases and carried 20.43% of global deaths as of October 08, 2020.
- India became the 2nd in terms of cases following USA. The number of cases in India has increased in a week time by 8.29% (6,312,584 to 6,835,655) and deaths by 6.94% (98,708 to 105,554).
- The number of cases in Brazil has increased by 3.92% (4,813,586 to 5,002,357) and deaths by 3.16% (143,962 to 148,304) in a week time.
- Russia has continued reporting the highest number of cases in Europe, with 1,260,112cases.
- Colombia ranked 5th in the world with 877,683 cases in a week time.
- The line share of Africa to the global COVID-19 pandemic has still been low (only 4.24% of the global cases and 3.5% of deaths as of October 08, 2020). However, within the continent the number of cases has increased by 3.7% in a week time (1,489,711 to 1,545,312 cases). Similarly, the total number of deaths in Africa has increased from 35,922 to 37,154 showing a 3.43% increase in a week time.
- South Africa ranked 10th worldwide in terms of cases and leading in the continent with 685,155 cases and 17,248 deaths. Morocco (140,024cases, 2,439 deaths), Egypt (104,035 cases, 6010 deaths), Ethiopia (80,895 cases, 1,255 deaths), and (Nigeria (59,738 cases, 1,113 deaths) are the most four leading countries next to South Africa in reporting COVID-19 cases in the continent as of October 08, 2020. (See table below).

Africa	October 1		October 8	
	Cases	Death	Cases	Deaths
South Africa	674,339	16,734	685,155	17,248
Morocco	123,653	2,194	140,024	2,439
Egypt	103,198	5,930	104,035	6,010
Ethiopia	75,368	1,198	80,895	1,255
Nigeria	58,848	1,112	59,738	1,113

- In East African, COVID-19 cases and deaths have shown fast progress. In a week time, COVID-19 cases and deaths were 5% and 3% in Ethiopia and 3.6% and 5.2% in Kenya. As of October, Ethiopia and Kenya continued to be the major drivers of the COVID 19 burden in east African countries. The epidemic appears plateauing in Sudan showing only 0.2% cases and zero deaths and in Djibouti 0.1% cases and zero deaths. Similarly, 4.4% cases and zero deaths reported in Somalia in a week time.



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2. Worldometer, Corona Virus <https://www.worldometers.info/coronavirus/>
3. Africa CDC: COVID 19 Surveillance; <https://au.int/covid19>
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### **Effects of Dexamethasone on Days Alive and Ventilator-Free in Patients with Moderate or Severe Acute Respiratory Distress Syndrome and COVID-19: The CoDEX Randomized Clinical Trial.**

- Acute respiratory distress syndrome (ARDS) due to COVID-19 is associated with substantial mortality and use of health care resources. Dexamethasone use might attenuate lung injury in these patients.
- Multicenter, randomized, open-label, clinical trial conducted in 41 intensive care units (ICUs) in Brazil.
- Patients with COVID-19 and moderate to severe ARDS, according to the Berlin definition, were enrolled from April 17 to June 23, 2020. Final follow-up was completed on July 21, 2020.
- The trial was stopped early following publication of a related study before reaching the planned sample size of 350 patients.
- Twenty mg of dexamethasone intravenously daily for 5 days, 10 mg of dexamethasone daily for 5 days or until ICU discharge, plus standard care (n=151) or standard care alone (n = 148).
- The primary outcome was ventilator-free days during the first 28 days, defined as being alive and free from mechanical ventilation.
- Secondary outcomes were all-cause mortality at 28 days, clinical status of patients at day 15 using a 6-point ordinal scale (ranging from 1, not hospitalized to 6, death), ICU-free days during the first 28 days, mechanical ventilation duration at 28 days, and Sequential Organ Failure Assessment (SOFA) scores (range, 0-24, with higher scores indicating greater organ dysfunction) at 48 hours, 72 hours, and 7 days.
- A total of 299 patients (mean [SD] age, 61 [14] years; 37% women) were enrolled and all completed follow-up. Patients randomized to the dexamethasone group had a mean 6.6 ventilator-free days (95% CI, 5.0-8.2) during the first 28 days Vs 4.0 ventilator-free days (95% CI, 2.9-5.4) in the standard care group (difference, 2.26; 95% CI, 0.2-4.38; P = .04).
- At 7 days, patients in the dexamethasone group had a mean SOFA score of 6.1 (95% CI, 5.5-6.7) Vs 7.5 (95% CI, 6.9-8.1) in the standard care group (difference, -1.16; 95% CI, -1.94 to -0.38; P = .004).
- There was no significant difference in the pre-specified secondary outcomes of all-cause mortality at 28 days, ICU-free days during the first 28 days, mechanical ventilation duration at 28 days, or the 6-point ordinal scale at 15 days.

- Thirty-three patients (21.9%) in the dexamethasone group vs 43 (29.1%) in the standard care group experienced secondary infections, 47 (31.1%) vs 42 (28.3%) needed insulin for glucose control, and 5 (3.3%) vs 9 (6.1%) experienced other serious adverse events.
- Among patients with COVID-19 and moderate or severe ARDS, use of intravenous dexamethasone plus standard care compared with standard care alone resulted in a statistically significant increase in the number of ventilator-free days (days alive and free of mechanical ventilation) over 28 days.

## Reference

- Tomazini BM, Maia IS, Cavalcanti AB, et al. Effect of Dexamethasone on Days Alive and Ventilator-Free in Patients With Moderate or Severe Acute Respiratory Distress Syndrome and COVID-19: The CoDEX Randomized Clinical Trial. *JAMA*. 2020;324(13):1307–1316. doi:10.1001/jama.2020.17021

## Long-term effects of COVID-19

### Persisting Symptoms

- Most people with COVID-19 experience mild symptoms or moderate illness.
- Approximately 10-15% of cases progress to severe disease, and about 5% become critically ill.
- Typically, people recover from COVID-19 after 2 to 6 weeks.
- For some people, some symptoms may linger or recur for weeks or months following initial recovery. This can also happen in people with mild disease. People are not infectious to others during this time.
- Some patients develop medical complications that may have lasting health effects. Pulmonary, cardiovascular, neural and emotional complications are common insignificant proportions of affected patients.
- Evidence from previous coronavirus outbreaks, especially the severe acute respiratory syndrome (SARS) epidemic, suggests that these effects can last for years.



Figure 1. Recovery period after COVID-19

- Lasting health effects or symptoms which may persist as per the study in the U. S. include:
  - ➡ Fatigue
  - ➡ Cough, congestion or shortness of breath

- ➡ Loss of taste or smell
- ➡ Headache, body aches
- ➡ Diarrhea, nausea
- ➡ Chest or abdominal pain
- ➡ Confusion

- In this study 35% had not returned to their usual state of health when interviewed 2–3 weeks after testing. Among persons aged 18–34 years with no chronic medical conditions, one in five had not returned to their usual state of health.

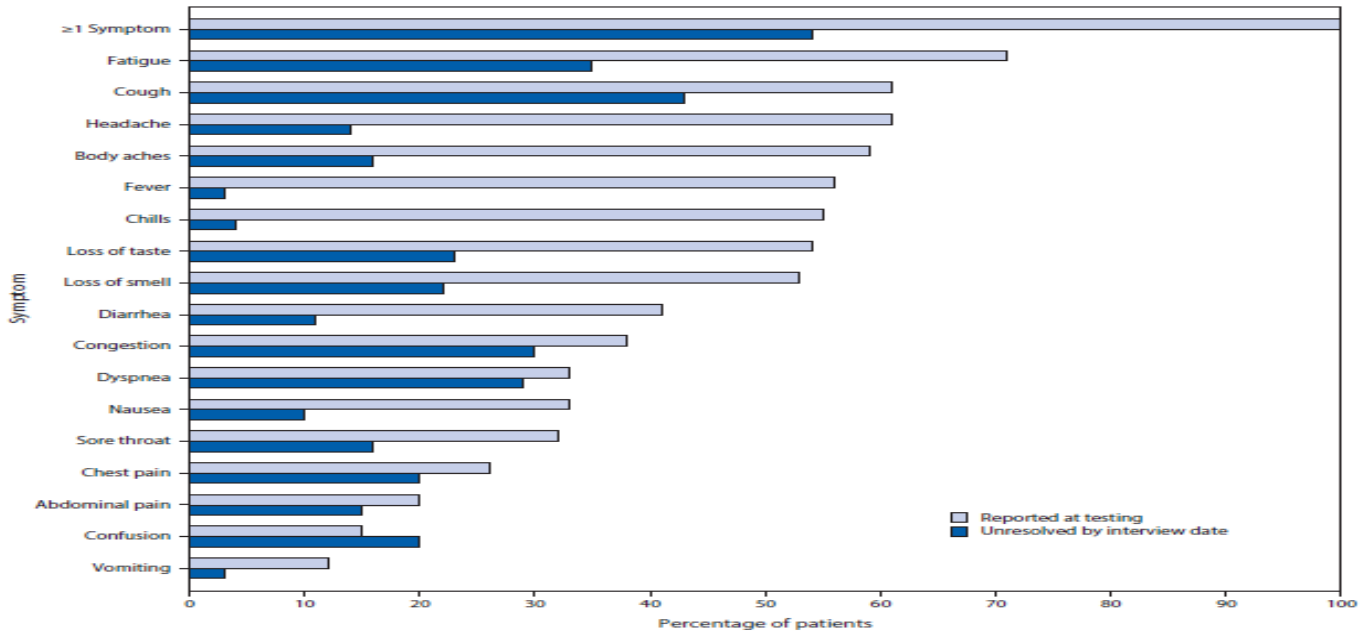


Figure 2. Self-reported symptoms at the time of positive SARS-CoV-2 reverse transcription–polymerase chain reaction (RT-PCR) testing results and unresolved symptoms 14–21 days later among outpatients (N = 274), United States, March–June 2020

## Management

- Management of covid-19 after the first three weeks is currently based on limited evidence
- Approximately 10% of people experience prolonged illness after covid-19
- Many such patients recover spontaneously (if slowly) with holistic support, rest, symptomatic treatment, and gradual increase in activity
- Home pulse oximeter can be helpful in monitoring breathlessness
- Indications for specialist assessment include clinical concern along with respiratory, cardiac, or neurological symptoms that are new, persistent, or progressive

## Implications

- These long-term conditions, therefore have the implications for public health practice that COVID-19 can result in prolonged illness, even among young adults without underlying chronic medical conditions. Thus, effective public health messaging targeting these groups is warranted.

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4. Marshall. M. COVID-19’s lasting misery. *Nature*, Vol 585 17 September 2020.

## Impacts of COVID-19 on Reproductive and Maternal Health Care Services

- Studies indicates that health services have been partially or completely disrupted by COVID-19 pandemic. The pandemic has continued disrupting the health system globally and particularly in low-income countries. Among essential health care services disrupted includes maternal and child health service such as family planning, delivery, immunization, and other non-communicable disease essential treatment.
- This caused as result of health staff working in this area partially or fully reassigned to support of COVID-19 services, allocate funding from the government budget to national COVID-19 response plan.
- Sexual and reproductive health services are amongst the highly affected essential health care services. For instance, according to a case study report in Tertiary health care facility in Ethiopia deliveries and immediate postpartum FP have decreased by 28% and 67% respectively during the pandemic compared to the same months last year.
- Overall, the number of clients presenting for family planning was reduced by 27%. In addition to this safe abortion services and comprehensive abortion care were reduced by 16.4% and 20.3% respectively. Moreover, family planning service utilization among safe abortion and post-abortion clients were reduced by 40.6%, and 39.7% respectively.
- Likewise, the Guttmacher survey shows reproductive health services are affected more as compared to other health service in developing countries. The impacts summarized into categories, including childbearing preferences, access to contraception and other reproductive health services, attitudes towards contraception and intimate Partner Violence.
- More than 40% of women reported the change in their plans about when to have children or/and how many children to have in this COVID 19 era. These changes were more common among women with no child.
- Woman who deserve services may have avoided available in-person healthcare due to fear that they or a family member would be exposed. One third of them had to delay or cancel an appointment or had trouble getting their contraceptive.
- In addition to this increased stress and uncertainty of the pandemic may have exposed some women to intimate partner violence. Stay-at-home orders and social distancing have made it harder for people experiencing IPV to obtain support and resources.



## References

- Tolu, Lemi Belay, et al. "Effect of covid-19 pandemic on safe abortion and contraceptive services and mitigation measures: a case study from a tertiary facility in Ethiopia." *Ethiopian Journal of Reproductive Health* 12.3 (2020): 6-6.
- Lindberg, Laura D., et al. "Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences." Guttmacher Institute, June 24 (2020).

## The impact of COVID-19 on mental, neurological and substance use services

- Throughout the world, people are affected by Mental, Neurological and Substance (MNS) disorders, at staggering rates. In many contexts, appropriate and evidence-based treatment is lacking and people with mental health conditions experience severe human rights violations, discrimination and stigma. In conflict and other humanitarian settings, where mental health conditions are especially common, these issues are even more pronounced. Yet, despite this, investment in mental health remains extremely limited, characterized by a lack of resources and services and a large treatment gap, especially in resource-limited settings.
- There are direct and indirect consequences of COVID-19 on mental health conditions, leading to increased demand for services. In addition, health systems around the world are challenged, leading to the disruption of delivery of essential services, especially for the most vulnerable populations. Major stressors such as the COVID-19 pandemic represent risk factors for the development, exacerbation and relapse of a range of MNS disorders.
- Furthermore, COVID-19 itself 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. People with pre-existing mental, neurological or substance use disorders are also more vulnerable to SARS-CoV-2 infection – they may stand a higher risk of severe outcomes and even death.
- The disruption of care for MNS disorders can be life-threatening, for example for treatment for epilepsy, unaddressed suicide risk, unmanaged opioid dependence leading to overdose, and severe alcohol withdrawal syndromes. Additionally, not managing MNS disorders will hinder people’s recovery from COVID-19 through the potential inability of those living with mental disorders (either before, during or after the pandemic) to work or being trapped in a cycle of poor mental health and poor reintegration into communities.
- The World Health Organization (WHO) has identified mental health as an integral component of the COVID-19 response. Mental health and psychosocial support (MHPSS) should be treated as an integral and cross-cutting component in public health emergency responses as part of a range of pillars/domains, such as case management, risk communication and community engagement, the continuation of health services, coordination within countries, and operations (e.g. staff support). Mental health is an integral

part of universal health coverage and is crucial to the overall recovery of individuals, communities and countries after emergencies.

- Tracking access to health services during the pandemic is critical in order to achieve the optimal balance between fighting COVID-19 and maintaining these services. WHO's recent pulse survey on continuity of essential health services during the pandemic provides insights and perspectives on its impact on up to 25 essential health services in countries and how countries are adopting strategies to maintain essential services.
- In order to further understand the impact of COVID-19 on service delivery for MNS disorders, a specific survey was sent to designated mental health focal points in ministries of health of all Member States. The survey was conducted from June to August 2020 among 130 countries across six WHO's regions.
- 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 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.
- Innovative methods are being applied in many countries through tele-services and helplines; however, limited resources are a challenge to using these tools in lower-resource settings. Training in basic psychosocial skills for health care providers working in COVID-19 treatment centers was the most common approach in low-income countries. Generally speaking, however, interventions such as task sharing through building the capacity of general health workers seem to be underutilized.
- 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. As the pandemic continues, even greater demand will be placed on national and international mental health programmes that have suffered from years of chronic underfunding. Spending 2% of national health budgets on mental health is not enough. International funders also need to do more: mental health still receives less than 1% of international aid earmarked for health. This all highlights the need for more money for mental health. 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 *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 mental health service delivery and utilization is needed.

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