Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Asian Journal of Psychiatry 55 (2021) 102545

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Editorial

The bitter lessons of COVID-19: Acknowledging and working through many points of tension

At the end of each year, it is customary for the editorial team to provide an annual report to the Journal readership and outline plans for the next year. This transition from 2020 to 2021 feels vastly different from other years, however, and the annual tradition takes on a greater significance. A year ago, when I penned my editorial for the first Journal issue of 2020 (Tandon, 2020a) and articulated ambitious plans, little did I know of the calamitous year to follow and the devastation that a viral pandemic would inflict on the entire world. Through all of 2020, the lives of planet Earth's 7.84 billion human inhabitants were turned topsy-turvy, albeit in different ways and to varying extents. Although the first known case occurred in late 2019 and the disease received the name COVID-19 in February of 2020, it was not until the middle of March that the global scale of the infection was recognized and the World Health Organization declared it a pandemic. Since that time, over 82 million people have been infected with the SARS-CoV-2 virus and over 1.8 million have died from COVID-19. In an effort to control the spread of this contagion, lockdowns and quarantines were routine across the world, schools and colleges shut down, workplace closures frequent, stay-at-home restrictions widely implemented, and marked restrictions placed on all forms of travel and public gatherings. The world economy plummeted into its deepest recession in the modern era. Although there are some hopeful signs with an improved understanding of how to reduce contagion and the arrival of effective vaccines, the pandemic continues to wreak havoc with over 500,000 new infections and over 10,000 COVID-related deaths across the world *every day*.

As we bid 2020 good-bye and start a new year with a mixture of hope and trepidation, it is a good time to take stock. What happened? What did we do and how did we fare? What have we learned? Given the fact that COVID-19 continues to ravage our world, what should we do differently and what can we do better? It is prudent to examine these issues at a global level as also answer these questions more narrowly in terms of mental health and our profession and then more specifically with reference to our Journal. To be sure, the Journal was significantly impacted by the pandemic and its impact on mental health and the practice of psychiatry. The Journal experienced a four-fold increase in the number of submissions from 1,000 in the year 2019 to almost 4,000 in the year 2020. Of the 583 published articles in the year 2020, 227 (39 percent) were related to COVID-19 and mental health, a topic that did not exist prior to this year. In a March editorial (Tandon, 2020b), we had committed that the Asian Journal of Psychiatry would strive to play its role in the dissemination of good information relevant to COVID-19 and mental health. We did not realize how challenging that task would be. In an international healthcare crisis such as the COVID-19 pandemic, real-time dissemination of accurate information becomes critical in order to enable optimal healthcare and policy decision-making in a situation of urgency with substantial uncertainty, compelling the Editor to adjust the balance between comprehensive and speedy manuscript processing in order to make valid information available expeditiously (Tandon, 2020c). Over 2,000 submissions on the topic over a 9-month period strained our capacity and a large number of the manuscripts were of variable quality and relevance. Authors of potentially useful but preliminary or opinion-laden submissions were asked to condense their manuscripts into a more concise format such as Correspondence; the objective was to inform the readership of the less definitive nature of the contribution. We recognized that publishing a large number of Letters to the Editor would have downstream negative effects on Journal prestige such as lowering our Impact Factor (currently 2.53), but believed that this was the right course of action. The need for ultra-rapid manuscript processing and the relatively speedy publication of accepted manuscripts had predictable effects- many desirable and some less desirable. We published 227 articles on COVID-19 and mental health, significantly focused on contributions from and implications for countries in Asia. These publications included contributions from authors across 30 different Asian countries. Nine of the most highly cited articles on COVID-19 and mental health were published in our Journal (Ahmed et al., 2020; Banerjee, 2020; Goyal et al., 2020; Mamun and Griffith, 2020; Rajkumar, 2020; Roy et al., 2020; Tandon, 2020a,b, Zandifar and Badrfam, 2020); each of these has been cited over 100 times in the scientific literature. Less desirable consequences include the publication of a substantially larger volume of Correspondence and the inability to provide more detailed feedback to authors whose submissions were not accepted for publication. The Journal is making some necessary corrections and implementing plans first laid out at the beginning of 2020. While these changes and plans will be discussed in detail in the next editorial, let us examine how COVID-19 affected people around the world, how nations responded to it, what differences were observed in outcomes across the world with a particular focus on countries in Asia.

1. What Happened?

COVID-19 was a once-in-a-century pandemic in terms of the breadth and magnitude of its impact on mankind. What are the facts as we know them:

a) As of today, there have been over 82 million confirmed cases and 1.8 million deaths associated with COVID-19 across the world.
b) Although the pandemic originated in Asia (Wuhan, the capital city of the Hubei province in China), it disproportionately impacted countries in Europe and the Americas. With 58 percent of the world's population, Asia accounts for 25 % of the confirmed cases and 19 %

https://doi.org/10.1016/j.ajp.2021.102545

Available online 5 January 2021

of the worldwide mortality associated with COVID-19. In contrast, Europe has 9 percent of the world's population but 28 percent of both confirmed cases and COVID-19 associated deaths. The United States of America has 4 percent of the world's population but 25 percent of the world's cases and 19 percent of COVID-19 related deaths around the world.

c) In Asia, India has the largest number of confirmed cases (10 million) and COVID-19 related deaths (150,000) as of date. With a population of 1.35 billion (17 percent of the world's population), it accounts for 12 percent of confirmed cases and 8 percent of COVID-19 associated deaths around the world.
d) Across Asia, there is significant variation in density of reported cases (total cases/100,000 population) and COVID-19 related deaths (deaths/100,000). Countries in the middle east (Bahrain, Iran, Israel, Jordan, Kuwait, Palestine, Qatar) and those bordering Europe (Armenia, Azerbaijan, Cyprus, Turkey) have the highest number of reported cases and COVID-19 associated deaths per unit population.
e) China, where COVID-19 originated, officially reports a total of 87,000 confirmed cases and 4,600 COVID-19 associated deaths. A recent report, however, suggests that there had likely been over 500,000 cases in Wuhan itself.
f) The world witnessed negative economic growth, with the gross domestic product of most countries shrinking. China and a few countries in East Asia were notable exceptions.
g) Although the SARS-CoV-2 virus and resultant COVID-19 disease were identified in Wuhan city in December, 2019, the world was not apprised about this until late January, 2020 and it took another two months for the World Health Organization to declare it a pandemic. All through this pandemic, international organizations such as the WHO have played a very limited role.
h) Although we are into a new year, COVID-19 is still very much with us. Across the world, we still document over 500,000 new cases and 10,000 COVID-19 related deaths every day. Asia accounts for approximately 15 percent of these new cases and deaths, while the USA and Europe each account for 30–40 percent.
i) Multiple vaccines against the virus have been developed and approved. These are being rolled out across the world, although not in any coordinated manner. As of today, approximately 20 million individuals have received at least one dose of one of these vaccines; it should be noted that most of these vaccines require two spaced-out doses to be fully effective and our global population is 7,835 million people.

2. What can we learn from these facts?

Before we attempt to make sense of what has happened and draw lessons about what we can do better, it is important to first consider the veracity and relevance of these observations. Comparison of statistics across countries is problematic because of differences in methods of ascribing deaths to COVID-19, differences in rates of testing for SARS-CoV-2 infection, varying quality of data collection and aggregation, and questions about the accuracy of official reporting across countries. Despite these limitations, however, these are the facts we have. What do they tell us?

A) Relatively Better Outcome in Asia

Despite its origins in Asia, Europe and the Americas have been much more severely impacted by the COVID-19 pandemic, both in health and economic terms. Furthermore, the significantly poorer socio-economic conditions and less developed healthcare system should have predicted a greater impact in Asia. Finally, the much higher population density and large number of slums in Asia, physical distancing should have been much more difficult and that should have enabled easier spread of the virus there. How then does one interpret the relatively better outcomes in Asia as compared to Europe and the Americas?

(i) The younger average age of populations in most Asian countries compared to Western Europe and, to a lesser extent, the USA maybe one factor leading to lower mortality rates in Asia. But that cannot explain the significantly lower rates of confirmed cases. What did the richer countries with much better healthcare systems do wrong?
(ii) Containment strategies with isolation and contact tracing were much more vigorous across Asian countries than in most European countries and the United States. Even among Asian countries, efforts were more robust in East Asian countries than those in South and West Asia. The presence of a national healthcare system and a greater degree of state authority and control appear to be important determinants. What should the balance between individual freedom and privacy on the one hand and greater governmental powers be?
(iii) Across all countries, the elderly and those with comorbid chronic medical illnesses had the highest mortality. The disadvantaged (poor, minorities, migrants, etc.) in most countries had significantly worse outcomes- disparities in outcomes within nations often underlined existing disparities in health and healthcare. Amidst the increasing nationalism and majoritarianism across the world, how can minorities and migrants be better protected? With the shift to market-based capitalism across the world, how can the poor and other disadvantaged and vulnerable populations be better served?
(iv) The speed with which vaccines were developed has been spectacular. Multiple different vaccines have been developed and approved- USA (Biontech-Pfizer, and Moderna) and the United Kingdom (Oxford-AstraZeneca); both these are more individualistic and market-based economies with greater transparency and stronger incentives for entrepreneurship.
(v) Vaccines have also been developed in three Asian countries (China, India, and Russia) and are being distributed across the world. Despite the rapidity with which effective vaccines were developed, when the world's population will receive them is uncertain. So far, fewer than 20 million individuals have received a dose of the vaccine- that is 0.025 percent of the world's population! Will vaccine distribution be swift and equitable? Will its administration be efficient?
(vi) The role of the World Health Organization has been widely criticized and it is considered to have been ineffective in coordinating an effective global response to the pandemic. This global organization does not, however, have any intrinsic authority or power and only has the limited powers ceded to it by individual sovereign nations. How can the authority and abilities of transnational global organizations be enhanced?

B) Some Lessons to Learn

The pandemic exposed weaknesses in our public health preparedness and structure of our healthcare systems. We learned that we are all vulnerable and must share the global responsibility of addressing the worldwide shared vulnerability to infectious diseases with pandemic potential. We must recognize our common vulnerability, our weak existing global outbreak surveillance system, and virtues of an integrated global response. We need effective international organizations that are empowered to coordinate across nations. Accurate information needs to be shared across nations and mechanisms to enable this need to be strengthened. The focus needs to be on collective problem-solving and not in blaming and shaming. Accuracy of message should not be sacrificed at the altar of "controlled messaging" driven by nationalistic or political objectives. All of us have an important responsibility to combat conspiracy theories and rumors while promoting dissemination of accurate information of what we know, what we don't know, and what this information means. The pandemic has also exposed glaring health disparities and this should provide an impetus for reducing such inequities.

We cannot solve our problems with the same thinking we used when we created them- Albert Einstein

References

Ahmed, M.Z., Ahmed, O., Aibao, Z., et al., 2020. Epidemic of COVID-19 in China and associated psychological problems. Asian J. Psychiatry 51. Article # 102092.
Banerjee, D., 2020. The COVID-19 outbreak: crucial role psychiatrists can play. Asian J. Psychiatry 50. Article # 102114.
Goyal, K., Chauhan, P., Chhikara, K., Gupta, P., Singh, M.P., 2020. Fear of COVID-19: first suicidal case in India. Asian J. Psychiatry 49. Article # 101989.
Mamun, M.A., Griffiths, M.D., 2020. First COVID-19 suicide case in Bangladesh due to fear of COVID-19 and xenophobia. Asian J. Psychiatry 51. Article # 102073.
Rajkumar, R.P., 2020. COVID-19 and mental health- A review of the existing literature. Asian J. Psychiatry 52. Article # 102066.
Roy, D., Tripathy, S., Kar, S.K., et al., 2020. Study of knowledge, anxiety, and perceived mental healthcare need in Indian population during COVID-19 pandemic. Asian J. Psychiatry 51. Article # 102083.
Tandon, R., 2020a. Asian journal of psychiatry- beginning a new decade. Asian J. Psychiatry 47. Article # 101924.
Tandon, R., 2020b. The COVID-19 pandemic, reflections on editorial responsibility. Asian J. Psychiatry 50. Article # 102100.
Tandon, R., 2020c. COVID-19 and human mental health. Preserving humanity, maintaining sanity, and promoting health. Asian J. Psychiatry 51. Article # 102256.
Zandifar, A., Badrfam, R., 2020. Iranian mental health during the COVID-19 epidemic. Asian J. Psychiatry 51. Article # 101990.

Rajiv Tandon
Department of Psychiatry, WMU Homer Stryker School of Medicine, 1,000 Oakland Drive, Kalamazoo, MI, 49008, United States
E-mail address: rajiv.tandon@med.wmich.edu.