COVID-19 Pandemic: Reflexions from East Europe

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Abstract

The pandemic of severe acute respiratory syndrome CoV-2 affected most countries and united the polarized world. In spite of sharing the experiences, the data show there are differences and specificities across regions. The number of infected persons and death toll show that wealthy, developed nations were not more prepared than low income, developing countries, to deal with major stress of the pandemic. The aim of this paper is to reflect on possible psychosocial causes of these differences. The emergency states were introduced rather early in countries of East Europe, with strict restrictive measures that seem to be critical. Mental health care considerably changed during the pandemic and was mostly neglected as was the usual somatic care of people, with intention to prevent collapse of not well-developed health system. There are many lessons to be learned from the pandemic. A long-term planning and management measures should be prepared for a possible second wave as well as for new outbreaks that might affect humanity. A particular emphasis should be paid on the importance of preservation of mental health, widely neglected during the pandemic, as well as to a comprehensive psychosocial approach to affected communities.

Keywords: *Consequences, COVID-19, east Europe, mental health care, social stress*

Introduction

The polarized world became united by the outbreak of severe acute respiratory syndrome CoV-2 virus affecting 213 countries and territories around the world. The pandemic has shown that "no man is an island entire of itself; every man is a piece of the continent, a part of the main," as John Donne wrote in his beautiful Meditation XVII (Devotions upon Emergent Occasions) back in 1624. In a massive "infodemic" during the pandemic, and an abundance of information one can easily access data about situation in each country of the world (https://epidemic-stats.com/). However, in spite of the pandemic uniting the world the data show there are differences and specificities across regions. The data of number of infected persons and death toll show that wealthy, developed nations were not more prepared than low income, developing countries, to deal with major stress of the pandemic. So far, the COVID-19 was under better control in the countries of the East Europe (including Western Balkan), except, unfortunately, in Russia, in which the number of infected people was increasing lately (about 10,000 new cases reported daily).

Possible Causes of Differences – East versus West

The unexpected paradox of better outcome of the pandemic in countries in East Europe may be explained by many factors. The pandemic management is conditioned by past cultural, ethical, sociohistorical experiences and established system of values. In the East Europe, many countries still have traditional and patriarchal organization of societies, with multigenerational households, most people live under modest condition, and are used to stressors of various kind. In spite of living in multigenerational households, the spread of the virus was not high in families. The international travel and exchange of tourists are less frequent and thus there were less imported cases. In addition to that, due to communist/socialist background in the past, it seems that people are more compliant to authorities and measures introduced by emergency states - a sense of collectivism and solidarity prevail instead of individualism of wealthy countries.

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The emergency states were introduced rather early in countries of East Europe, with strict restrictive measures, such as lockdown, physical distancing, and limited movement of people that seem to be critical. Another reason of a better outbreak outcome might be past disastrous experiences (wars, conflicts, UN sanctions, bombardment, political upheaval, and social transition).[1] The prolonged social stress and existential anxiety in the past probably made people of the Balkans and East Europe more prepared and less susceptible to the new crisis.[2] Having developed coping strategies in the midst of previous disasters might have caused higher resilience to psychosocial stressors (images of empty shops and hoarding of food were not seen in this region). An important fact is that primary health care is well developed, with health centers at the community, institutes for public health, including the fast establishment of primary COVID-19 centers at which people were triaged and when indicated referred to COVID-19 hospitals.

Although it is not a focus of this paper, it is worth noting that recently authors from Belgium postulated that the angiotensin-converting enzyme (ACE) D/I genotype distribution might affect the clinical course and partly explain the variable prevalence of the COVID-19 infection among continental European countries[3] and less infected people in East Europe.

Mental Health Care

Mental health care considerably changed during the epidemic. The services were focused on emergency cases and their hospitalization, while other people with mental health problems were treated per required need. Day hospitals and community centers were closed; the support was carried out through telephone consultations (some open for 24 h) by hospital staff or online by volunteer psychotherapeutic networks. The social isolation affects many people, especially those who are vulnerable and emotionally unstable, and consequences such as anxiety and depression are more pronounced in extraverted than introverted persons who are used to spend time in silence and solitude. Anecdotal experience of psychiatrists during epidemic has shown that hypersensitive, socially anxious people felt better in the lockdown than during the regular times. The crises endangering existence naturally cause existential fear and incidence of mental disorders and decompensations usually decrease. However, it is expected that after the end of the crisis many stress related disorders will appear both in general population and among patients with preexisting mental health problems.

Consequences

The measures implemented by states were to protect health systems with efforts to prevent their collapse (happening in Italy and Spain), and so far, they were successful in countries of East Europe. However, in spite of a better outcome of the COVID-19 outbreak in this world region, there were many problems. The health care was primarily focused on the prevention of spreading the virus and treatment of infected people, elective surgeries were postponed, and regular check-ups not carried out, which might affect both physical and mental health. One of the most important stressors was a loss of freedom of movement, the elementary human right, according to Article 13 of the UN declaration (https://www.un.org/en/universal-declaration-human-rights/). In order to prevent a collapse of already poor health systems, elderly people aged 65+ years were recommended to stay in isolation. In Serbia a unique, the strictest measure, included a total ban of leaving homes for them with threatened high sanctions as well as repeated curfew for the whole population, having being prolonged many times, from 12 to 86 h. That stigmatizing, discriminatory, dehumanizing measure imposed to elderly people is against dignity and self-esteem. While most of the 65+ people might have remained safe for now, due to their forced passivity and likely multimorbidity, both somatic and psychological consequences will probably be seen in near future, and victims will be uncountable. Isolating the elderly under excuse of caring for their well-being seems to be measure a social Darwinism – the strongest and youngest should survive. It has a strong impact on the psyche of each individual and a supposed intention to preserve life, can actually destroy it. Besides, what will happen to the elderly after the lockdown, when they return to everyday life without any immunity? They will still be the most vulnerable. Is a perpetual lockdown for them to be prescribed?

Lessons Learned

Lessons from this pandemic, with new knowledge and memories, should be helpful for future crises. There is a need to establish strategic, long-term, comprehensive planning and management measures, to redefine the needs and increase capacities of human, scientific, technological and material resources. A particular emphasis should be paid to importance of mental health, widely neglected during the pandemic, as well as to a comprehensive psychosocial approach to affected communities. Many organizations prepared guidelines for mental health care, not only focusing on responding to the current crisis and recovery after it, but also on preparedness and getting services ready in countries before the next emergency, as the WHO noted.[4] While the end of the first wave is on the horizon in many countries, it is to be seen whether the disastrous experience will be a valuable lesson for the future and how the so-called new normal life will look like. Hopefully, it will not lead to a dystopian brave new world.

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Conflicts of interest

There are no conflicts of interest.

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