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EDITORIAL

# COVID-19 actuality: From suicide epidemics in Asia to the responsibility of public authorities in the management of the crisis

After years of decline, the frequency of suicide is on the rise again in Asia, since the middle of 2020. The COVID-19 pandemic is not unrelated to it, because it generates a situation of chronic stress, loss benchmarks, difficulties in accessing neuro-psychiatric care, critical economic conditions, and widespread malaise.

The suicide of several media figures in Japan (mostly movie actors) prompted the government to take action, using some of the economic stimulus money to fund suicide prevention campaigns. It is especially women and young people under 30 who are affected by this ''suicide epidemic'' (probably due to the precarious situation of the students, the considerable increase in the mental burden on wives and mothers who are unable to attend, leaving the home, and an aggravation of domestic violence), but also children (primary and secondary school children)! The situation is all the more delicate in Japan since, traditionally, suicide is not experienced in a particularly negative way, relating to the concept of an honourable end, in the context of the seppuku of the political and military elite in the Edo and Menji period (samurai); moreover, psychological suffering was traditionally put aside or hidden for the benefit of the visibility of collective harmony [1].

In Thailand, different causes have the same consequences: the collapse of tourism and the growing number of bankruptcies have fuelled the anxiety of the population, while in terms of health (physical), the epidemic has been totally controlled with one of the lowest case fatalities in all of Asia. In this context, it is mainly male suicides, with a large proportion of students already weakened by the hyper-competitive nature of the university in this country and the obligation to succeed or perish [2]. Finally, the too great scarcity of access to neuro-psychiatric structures (already outside any pandemic, and even more because of COVID-19) has only made matters worse.

In South Korea too, the suicide rate among young women (20—30 years) increased by 40%, compared to the same period in 2019, with causes comparable to those in Japan [3]. The same happened in China [4], India [5], etc. Asia is not an isolated case [6]. What about in other cultural contexts? We call on health professionals to let us know, in their areas of practice, if such situations are also encountered, and what measures have been taken by public structures to limit their importance.

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While Iran is currently the country most affected by the COVID-19 pandemic in the Middle East [7], Iran's Supreme Leader (Ali Khamenei) publicly announced on January 8, 2021, and then posted on social media (Twitter) that his country officially banned the importation of western vaccines [8]. The alleged reason? The lack of confidence, and the certainty that ''these vaccines are used to infect people''. Mix in the rhetoric of conspiracy theory (the infamous chip that could spy on), ''genome modification'', etc. The move was denounced by the Iranian Medical Council, which called for any available vaccine as soon as possible, and facilitating its use for the entire Iranian population. To fight in a ''modern'' way against the pandemic, the political authorities of Iran have therefore decided to turn to ''non-aligned'' countries (Cuba, Russia), and to try to develop a vaccine themselves. Obviously, we can well regret the delay taken on the therapeutic plan, with a treatment whose objectivity, safety and efficiency have been recognised by neutral authorities (WHO). It is also surprising that Iran, itself the victim of an international embargo, has chosen to self-isolate in terms of health, endangering the survival of a large part of the population by a totally anachronistic obscurantism and mistrust.

In Brazil, two traditional leaders (Raoni Metuktire, from the Kayapo tribe; Almir Surui, from the Paiter-Surui tribe) filed a complaint on January 22, 2021 against the President of the Republic of Brazil (Jair Bolsonaro) and several of his ministers before the International Criminal Court [9]. The charges are multiple: crimes against humanity, murders, extermination, forced population transfers, enslavement, persecutions vis-à-vis the indigenous populations of the Amazon. Objectively, the policy of the populist president has been marked, since the start of his mandate (January 1, 2019) by the dismantling of government environmental protection agencies, an extension of deforestation, repeated violations of constitutional rights toward indigenous populations, and repeated racist statements. The voluntary use of toxic products in regions inhabited by these populations, and the systematic delay in dealing with the COVID-19 pandemic in these Amazonian territories, have been denounced by several international observers [10].

These two examples are revealing of the involvement of politics in the health life of a population, whether as a whole or in its minority. Dogmatic demands, more or less well-founded beliefs, racial theories, economic or commercial collusion, so many elements that directly or indirectly influence public health policy. What is the margin of freedom for governments? At what point should we move from the independence of a country to a duty of interference from other countries for humanitarian reasons? What is their level of responsibility? Are they accountable to the people who brought them to power, to an alleged universal morality or ethics, or to international authorities (not necessarily unanimously recognised)? Who makes the choices? Who judges? Who acts? The question is epistemological. In the meantime, patients pile up, and death does its job.

## Disclosure of interest

The author declares that he has no competing interest.

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