

Editorial

COVID-19, a New Face with Old Contexts

David Alejandro Cabrera-Gaytán¹; Concepción Grajales-Muñiz²; Teresita Rojas-Mendoza³

¹ Master in Hospital Administration and Public Health, Specialist in Epidemiology, Surgeon. Mexican Social Security Institute, Mexico. david.cabrerag@imss.gob.mx; dcppreventiva@gmail.com. orcid: <https://orcid.org/0000-0001-5314-4786>. scopusid: 370073026002

² Master in Public Health, Surgeon. Mexican Social Security Institute, Mexico. concepcion.grajales@imss.gob.mx. orcid: <https://orcid.org/0000-0001-7923-53443>

³ Doctor in Senior Management, Specialist in Epidemiology, Surgeon. Mexican Social Security Institute, Mexico. teresita.rojas@imss.gob.mx. orcid:<https://orcid.org/0000-0002-6658-1739>

Undoubtedly, the COVID-19 pandemic has touched human life in its multiple dimensions: health, economy, social, cultural, education, tourism... in everyday life and in coexistence. In all of them, “incorporeality” and “tele-existence” have been the common denominator to provide continuity to our lives. Žižek [1, p. 12] reflects on the “new normality” (better said, a “pandemic neo-reality”), which “will have to be constructed on the ruins of our old lives”, so “getting rid of its consequences and returning to the way we did things before” [1, p. 12] is a global challenge with individual contexts because this pandemic has manifested that we are all in the same enraged ocean, but each in their own boat.

Global warning systems have fallen short. The story began in December 2019, in China, in 44 patients with pneumonia of unknown etiology [2]. However, history was being rewritten with publications about the presence of the virus from September and December 2019 in Italy [3,4], as well as in December of the same year in the United States of America [5]. Žižek formulated the defying question: “What has gone wrong in our system for the catastrophe to catch us completely off guard despite warnings from scientists?” [1, p. 12]. Julio Frenk and Octavio Gómez respond that “countries around the world, especially those with the greatest resources, neglected multiple calls from the World Health Organization and other multilateral, academic, and philanthropic organizations to enhance surveillance and response systems against global threats” [6].

History had been, in some ways, benevolent. Frenk and Gómez said that we have “been lucky” [6] in relation to emerging diseases due to respiratory viruses, because although they have been highly lethal, there has been little sustained transmission or high transmission with low lethality. In the last 20 years, avian influenza A(H5N1) events have occurred in humans, with a very high fatality rate (FT), which was expected (and which is still latent) to be the genesis of the new pandemic. In later years, severe acute respiratory syndrome was identified, with 10% FT and identified in several countries. Thereafter, in April 2009, in Mexico, the “worst” of health fears is revealed: an influenza strain, whose FT was low and easily transmitted from person to person; this pandemic lasted nearly a year and a half (on 29 June 2010, the Secretary of Health lifted the health alert. In 2012, the Middle East Respiratory Syndrome, (MERS) emerged with high FT of 34%, but with an R_0 lower than the unit. In 2013, influenza A(H7N9) appeared in China, which occurred in five epidemic waves, where the biggest was in 2017 [7,8]. A study published in 2016 revealed that the virus has higher pandemic risk than any new virus of influenza A [8]. The World Health Organization (WHO) has declared, on six occasions, in the last ten years, as a “public health emergency of international concern” diseases, such as influenza A(H1N1)pdm09 in 2009, the international propagation of poliovirus in 2014, the Ebola outbreak in Western Africa also in the same year, the 2015-2016 Zika epidemic, another Ebola outbreak during 2019 and, now, COVID-19 [9]. This whole component has been denominated “the new epidemic globalization” [10, p. 14].

Since the transmission of avian influenza, A(H5N1) in humans emerged, Mexico began monitoring and strengthening the Influenza Epidemiological Surveillance System (SISVEFLU, for the term in Spanish), and conducted diverse sectoral and academic meetings to create and update the national response plan for a possible influenza pandemic [11]. On 19 July 2006, the General Health Council published the “Agreement establishing preparation and response activities for an influenza pandemic” [12]. The Mexican Social Security Institute (IMSS, for the term in Spanish) began,

in 2006, preparing an action plan against the threat of a possible avian influenza epidemic, so on 30 August 2006, the Technical Council of the IMSS authorized, through Agreement 366/2006, the creation of an Institutional Strategic Reserve of Antivirals to ensure operations of essential services. However, the national and institutional manuscript was based on a distant threat in Asia, which would expand gradually to the world. The reality was overwhelming and astonishingly unexpected; the new influenza pandemic of the 21st century started in Mexico. Health authorities learned the importance of having timely information and communication systems, and coordinated within the sector.

Without doubt, that pandemic was used to strengthen the, currently standardized, influenza epidemiological surveillance system. In 2009, The most difficult thing was to consolidate an information system while an online system was being developed by the IMSS, organization aligned with this sectoral surveillance, but which, given the captive population, has required using its own system in terms of information technologies. Said system is the Online Notification System for Influenza Epidemiological Surveillance (SINOLAVE, for the term in Spanish), which has provided its own success, like the characterization of the two epidemic curves of influenza A(H1N1)pdm09 in 2009; identification of two people with non-typed influenza, which was later determined to be A(H7N3), of avian origin in the Altos de Jalisco, during 2012 [13,14]; the “breaking” of the biennial cycle due to viral behavior in the 2016-2017 season, as well as in the 2017-2018 season (it was expected to be due to influenza A(H3)); the increase of cases in Guerrero during the 2013 interseason period, after the entry into the national territory of the meteorological phenomena “Ingrid” and “Manuel”; the unusual and unique increase during the 2018 interseason period, with cases of influenza A(H1N1)pdm09 in the Yucatan peninsula, and the change in predominant viral circulation in the 2019-2020 season, which started with predominance of influenza A(H3) between weeks 40 to 52 and influenza A(H1N1)pdm09 between weeks 1 to 10, to then identify SARS-CoV2. In all events, a growth curve has been presented and, from 2009 to 2020, the epidemiological surveillance system has adapted to the contexts and challenges that have emerged, with the updating of operational definitions, adaptation of diagnostic algorithms, and inclusion of variables related to contact history with other people and animals, which have been reflected in the SINOLAVE.

However, a contradictory situation was the creation of an alternate system (two surveillance systems already existed for respiratory diseases), parallel (duplication of activities) and centralized (in the country’s health jurisdictions operated by the governing body, and not by the medical units, which is where the information originates) for epidemiological surveillance of suspicious cases of COVID-19 in Mexico, through the COVID-19 online capture mask (which operated from March 4 to April 5, with retrospective capture), as well as focusing it as sentinel-type epidemiological surveillance, when registration systems already existed in the country since 2009 (the SISVEFLU, and the SINOLAVE in the IMSS) that have characterized and identified the behavior of the influenza virus and of other respiratory viruses for a decade [15-17]. In the end, that idea was abandoned and existing systems were adjusted throughout the pandemic, such as, for example, vaccination schedules, the clinical condition, second events, and diagnosis by rapid qualitative immunochromatographic tests of SARS-CoV2. [17], so it is a lesson learnt: use current systems and adapt them to the new need.

At the beginning of the pandemic, one of the mistakes by governments globally was underestimating the problem and ignoring the WHO warnings. Countries, like Brazil, the United States, Italy, Mexico, the United Kingdom, Russia, and Türkiye gave a late response [6]. These not only “trivialized the danger posed by COVID-19, [but also] disregarded medical advice” and even returned “to magical” [6] and religious thinking, pointed out and criticized by Ximénez-Fyvie [7].

Another government learning was to compare and take as a basis behavior with respect to the last pandemic presented by a respiratory virus: influenza A(H1N1)pdm09 [7]. Although there was insufficient information about SARS-CoV2, predictions or projections were made with preliminary data and several assumptions (susceptible population, attack rate, reproduction number, incubation period, duration of the disease, mathematical models, etc.) of what was happening in China with restrictive measures, which provided heterogeneity of results and scenarios. Previously, no precedent existed for a pandemic of immense magnitude due to a coronavirus; both prior events were of low transmission and the family of these viruses is also included in the common cold, which is self-limiting and benevolent. But the SARS-CoV2 was altogether contrary. As in 2009, restrictive, short-term mobility measures were implemented in the center of the country. In 2020, these measures were extended to the entire country, through state authorities and with more time, to be able to “reactivate” a “new normality”.

Doctor Pérez Tamayo indicated: “If we are going to do something to change our pathology, it will only be from our ideas, from innovative social schemes, from brave political decisions [we would add: and with scientific evidence], from risky educational experiments, from dreams not yet dreamed” [18, p. 29]. Caring for people with COVID-19 has caused for single hospitals to be designated to care for these patients and has modified the course of care for people with other pathologies. Although the priority is attention to the pandemic, it becomes necessary not only to focus on it, but also on the direct long-term impact this disease could cause. In this sense, it is good to return to the words of Benach, Vergara and Muntaner: “the most important disease, its most devastating epidemic, is not tuberculosis, malaria

or AIDS, but health inequality” [19, p. 2]. Let us not forget that, at the beginning of the epidemic in Mexico, monitoring of the measles epidemic outbreak continued in several states, and between January 1 and April 2, 2020, 1,364 probable cases were reported, of which 124 were confirmed by laboratory [20].

It was reinforced that collaboration was needed from the health sector for timely diagnosis of cases, Therefore, the Central Epidemiology Laboratory of the IMSS obtained the release of the diagnosis on March 5, 2020, by the Institute of Epidemiological Diagnostics and Reference, after reviewing graphs of the positive controls and dilutions.

This pandemic has crossed more than borders; it has shown, again, the fragility of human beings in the face of a microbiological agent whose scope continues to be studied and understood. Sigerist expressed about tuberculosis that “it not only requires medical measures, but also broader economic and social measures” [...] the product of public health is ultimately political” [21]. In that sense, now is when we need solidarity convergence and a shared vision of politics and science; “it is *now* that true politics is needed” [1, p. 100]. Because this global phenomenon has left lessons, challenges, and defeats, expressed in human lives lost, well, “the worst that can happen to us, at the end of the pandemic, is that we allow the new world to be made in the image and likeness of COVID-19” [22, p. 12].

Mexico underwent the third COVID-19 epidemic wave (July to October 2021), characterized by affecting unvaccinated people (mainly young adults, adolescents, and pediatric population) [23]. The governing national vaccination policy against SARS-CoV-2 for COVID-19 prevention in Mexico, decreed by the federal government, was to start vaccination from older adults to younger ages, as well as inoculate health personnel who directly care for patients with COVID-19, and divide said policy into five stages [24]. It has been published that protection is greater with complete regimens, that is, with two doses, and at ideal times, depending on the biological type [25].

However, it has been revealed that vaccination has been slow in Mexico [26] and that the change in values and weights in the government’s epidemiological traffic light [27] (greater flexibility) causes increased mobility in the public space, favoring transmission among people and the country’s epidemiological context. Thus, the B.1.1.519 variant predominated during May and June 2021, while the Gama variant, since the beginning of the year, with a peak in June; but both were displaced by the Delta variant starting in July and continuing until October 2021 [28].

Half a year has passed since the start of vaccination in stage 1 (target population: older adults and health staff) with health authorities indicating that the number of hospitalizations and deaths has decreased in Mexico due to vaccination [29]; however, given these scenarios, the other hypothesis predicted is that the fourth epidemic wave will be of unvaccinated people and those previously vaccinated in stage 1, and even in stage 2.

The resilience we experience now depends on the strengths and weaknesses that each people has culturally; of seeing and analyzing in an attempt to reflect, because while, in some countries, COVID-19 has been a short wave (eastern countries), with the application of effective and timely health policies, with a responsible population response that allowed them return to “neo-reality” in a short time, in most others (especially Latin countries); on the contrary, as a result of health policies, a catastrophe is being experienced, with lacerating results, with ignominy towards science, insensitivity to the lack of resources to face this pandemic, indolence and ignorance of an incredulous people who now mourn their dead, without understanding what happened and who is to blame.

The consequences of the passage of COVID-19 through these countries will have repercussions in every setting. In health, we will have excess mortality and a reduction in the indicator of years of healthy life lost due to premature death or living with disabilities, which undoubtedly will bear consequences in various sectors, and in the day to day... and will inevitably lead us to a setback. This pandemic should leave us an advance in consciousness and legacies to the following generations, the COVID-19 generations.

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