

Editorial

Strategies for Return to Normal Following COVID-19 Pandemic

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The COVID-19 epidemic has started to wane after the massive second and third waves of the disease in our country (Figure).¹ Nationwide deployment of preventive measures including widespread implementation of non-pharmaceutical interventions (masking, physical distancing, hand-hygiene, etc.) and a successful and massive vaccination campaign has resulted in control of the infection related morbidity and mortality and in declining case numbers and deaths in our country.²

The question in mind of everyone- scientists, medical epidemiologists, public health specialists, health care bureaucracy, and the public-now is: *Can we go back to normal or like it was before the epidemic?* Many public health specialists believe that we have added a new disease to the population which is more infectious and more severe than flu and such a scenario is unlikely to happen.³

Accordingly, the world pre-2020 no longer exists, although we may want it to, and may not exist in the foreseeable future. It is now clear that vaccines that have so far been developed are amazing, but the vaccine protection wanes with time, especially for symptomatic infection and the immunity from the infection also wanes. The Omicron variant of *SARS-CoV-2* has proven that high levels of antibodies in the population are no guarantee against high levels of illness.⁴

One strategy could be that we should accept millions of people getting sick once or twice a year despite the currently available vaccines or get the whole population vaccinated twice a year. The strategy of infection shall result in yearly disruption of education, business, and livelihoods for millions in India and billions globally. Professor Christina Pagel @chrishirp has commented

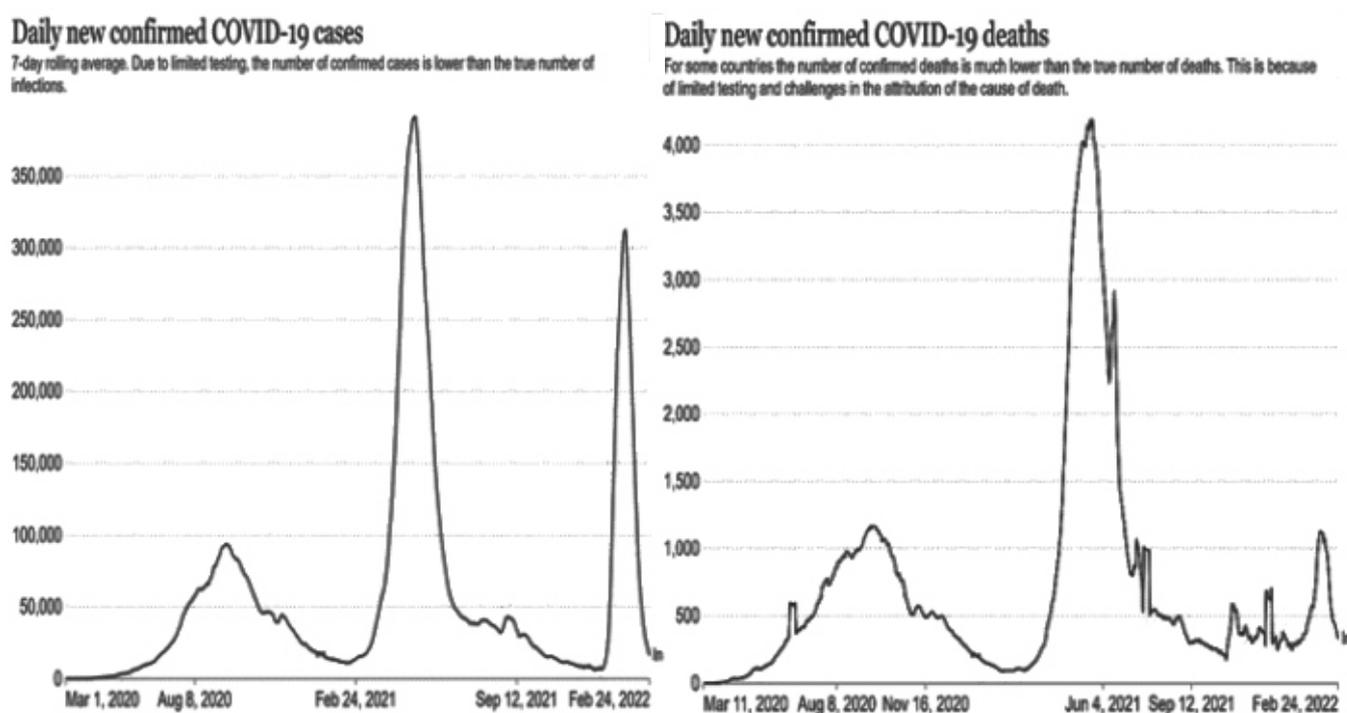


Figure: Waning COVID-19 epidemic in India: Cases and deaths.¹

that we cannot go back to pre-2020 status but we can safely go forward towards a healthier future if we can adapt to the future with learnings from the epidemic.³ Some of these learnings along with strategies for implementation are summarised in table below. Most of these strategies need a massive re-think on part of health bureaucrats and politicians. The strategies not only need a political will to implement but also a massive financial outlay and is a long-term project. However, we cannot wait indefinitely for the interventions.

Methods to develop and implement these strategies need a multisectoral approach as suggested by us earlier.⁵ In the document published in the journal *Health Research Policy and Systems* we focused on non-communicable disease and suggested a multisectoral approach for prevention and control of diseases such as cardiovascular diseases, hypertension, diabetes, and others to tackle the proximate and upstream risk factors: “..... prevention strategy entails a change in medical educational curriculum and improved healthcare delivery for control of risk factors-

Table: Some learnings from the COVID-19 epidemic and the way forward

Strategies	Implementation
1. Universal vaccination at worldwide (global) scale	<ul style="list-style-type: none"> • Aggressive vaccination strategy including home-based vaccinations. • Community health workers led initiative is crucial to implement this strategy, especially in low and lower-income countries of Africa, South Asia, Central, and South America.
2. Creation of infrastructure to support surveillance for new COVID-19 variants	<ul style="list-style-type: none"> • Telehealth based surveillance by empowering primary care community health workers. • Microbiological laboratories should be developed at district level hospitals with capacity for genomic surveillance.
3. Establish permanent surveillance units for similar virological illnesses	<ul style="list-style-type: none"> • Surveillance and diagnostic capabilities for other common air-borne viral diseases such as measles, chicken-pox, swine flu, etc. • Rapid diagnosis of variants of these respiratory pathogens. • Vaccine development and deployment.
4. Primary care to be treated as centre-of-excellence	<ul style="list-style-type: none"> • Create primary care as the most efficient models of healthcare with adequate manpower and financing.
5. Specialised clinics for the management of Long COVID Syndrome (LCS) or Post-Acute COVID Syndrome (PACS)	<ul style="list-style-type: none"> • Empowering medical centres to manage the plethora of long-term consequences of COVID infection. • Invest in evaluation, management and treatment for LCS and develop new treatments. • Club the LCS management centres with non-communicable disease surveillance and management centres in primary care.
6. Plan for future surges of COVID-19	<ul style="list-style-type: none"> • Continuous epidemiological surveillance systems. • Creation of rapid outbreak identification centres and detection of new variants. • Availability of large-scale testing and tracking capability. • Availability of high-quality masks and other protective gear. • Strategies for avoiding strict lockdowns.
7. Drug development and therapeutic research	<ul style="list-style-type: none"> • Investment for drug development using public-private collaborations. • Create resources for availability of high-quality medicines and vaccines to the poor and marginalised. • Efficient regulatory system to support clinical trials and drug approvals. • Availability of drugs at a subsidised and affordable costs in developing countries.
8. Clean habitable indoor air	<ul style="list-style-type: none"> • Creation of well-ventilated indoor spaces to promote particulate circulation and prevent deposition. • Technological innovations.
9. Social engineering strategies	<ul style="list-style-type: none"> • Reduce inequalities in health, housing, workplaces, education, and social support. • Create a resilient and just society.
10. The new normal for healthcare	<ul style="list-style-type: none"> • Masking indoors, especially for the vulnerable. • Continued masking by all the healthcare personnel. • Frequent testing and tracking. • Periodic vaccination: every 6-9 months.

smoking, hypertension, dyslipidemia, and diabetes. Secondary prevention involves the creation of facilities and human resources for optimum acute care and secondary prevention. There is need to integrate various policymakers, develop effective policies and modify healthcare systems for effective delivery of cardiovascular disease care”.

Similar ideas were reiterated for improvement of healthcare systems and to tackle the social and political determinants of health more recently in an article in the *Lancet*.⁶ “.... focus on social determinants of health in populations is important: political, economic, and social factors, principally unplanned urbanisation, illiteracy, poverty, and working and living conditions. Implementation of the UN Sustainable Development Goals can lead to major improvements in cardiovascular health, and adequate health-care financing and universal health care are important for achieving these goals” Both of these themes ring true in the context of COVID-19. These strategies are all the more important as it has been recently reported that COVID-19 kills more individuals belonging to low socioeconomic status (identified as low educational status) in India.⁷ Hope that our policymakers heed the suggestions.

REFERENCES

1. Ritchie H, Mathieu E, Rodes-Guirao L, Appel C, Giattino C, Ortiz-Ospina E, et al. India: Coronavirus pandemic country profile. Available at: <https://ourworldindata.org/coronavirus/country/india>. Accessed 25 Feb 2022.
2. Gupta R, Gaur K, Katoch VM. SARS-CoV-2 variants of concern and changing trends in COVID-19 in India and Rajasthan: Epidemiological perspective. *RUHS J Health Sciences*. 2021; 6:141-45.
3. Pagel C. When we can go back to normal or like it was before. Available at: <https://twitter.com/chrischirp/status/1491891791490125825>. Accessed 11 Feb 2022.
4. Madhi SA, Kwatra G, Myers JE, Jassat W, Dhar N, Mukendi CK, et al. Population immunity and COVID-19 severity with omicron variant in South Africa. *N Engl J Med*. 2022; doi: 10.1056/NEJMoa2119658.
5. Gupta R, Guptha S, Joshi R, Xavier D. Translating evidence into policy for cardiovascular disease control in India. *Health Res Policy Systems*. 2011; 9:e8.
6. Gupta R, Wood DA. Primary prevention of ischemic heart disease: populations, individuals and healthcare professionals. *Lancet*. 2019; 394:685-96.
7. Sharma AK, Gupta R, Baig VN, Singh VT, Chakraborty S, Sunda JP, et al. Educational status and COVID-19 related outcomes in India: Hospital based cross-sectional study. *BMJ Open*. 2022; 10:e055403.