

Lockdown or participatory health surveillance? Lessons from the Covid-19

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THIS ISSUE OF THE JOURNAL 'SAÚDE EM DEBATE' BRINGS CONTRIBUTIONS to understand the world of collective health at the critical moment of the 2020 Coronavirus pandemic (Severe Acute Respiratory Syndrome Coronavirus 2 – Sars-Cov-2), in which the disease caused by this virus was named Covid-19. In a previous editorial, 'Saúde em Debate' expressed the prediction that the success of the Chinese model would bring inevitable criticism to the Western model of mitigation and vertical state action without direct popular participation¹.

In the second half of March 2020, the indiscriminate closure of cities (Lockdown) was discussed in Brazil, as opposed to the Chinese and Korean experience of epidemiological surveillance by popular mobilization with organization and information by the base, selective closure, and maintenance of essential services such as health, food, and survival.

China was victorious. On March 3rd, 2020, the Chinese government released the first bulletin with no new cases of Coronavirus contagion. On the same day, Italy announced the death of more than 600 people, heading for the peak of the epidemic spread across the country after it started in the region of Lombardy, around the city of Milan.

Several films made in China during the surveillance and control actions revealed that entering and leaving condominiums, subways, buses, shopping venues in Wuhan were monitored by members of the Chinese Communist Party and members of Local People's Committees. These committees acted as local authorities under a central command, defining authorizations to go out for purchase of supplies and contacts of absolute necessity. One must keep in mind that essential need or service is a class concept according to which what is little for a minority is too much for many.

The control of departure, route, and arrival was done in China using social networking applications such as 'WeChat', reading of standard identification 'QR' codes by cell phones, centralizing information and analysis. The Chinese state service provided big data and computing infrastructure for collecting, storing, processing, and analyzing information to control the epidemic.

If a person in Wuhan demonstrated to be infected with symptoms or signs after riding in a specific subway car or shopping in a supermarket, they would be identified as to the time, route, contacts, and close people to be called in for examinations and surveillance.

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Not even George Orwell could have imagined a big brother so present with a capillary structure to control people and those carrying a lethal virus.

In the same period, mortality in Korea was 7.9 per thousand (0.79%) and affected mainly the elderly and conglomerate groups in homes for the elderly. In Italy, mortality reached over 9% and went on to killing babies. The upward graphs of cases and mortality in European countries and in Brazil made it possible to predict that, here, there would be a greater chance of reproducing the Italian model of dissemination of the Covid-19².

The similarity between Brazil and Italy comes from the implantation of the neoliberal model destroying public devices of health services and surveillance in Italy after 2010. What is the origin of the Italian tragedy of the Coronavirus^{3,4}? In 2020, Italy completed ten years of budget cuts. It is estimated that the country had a deficit of 56,000 doctors and 50,000 nurses. In addition, between 2015 and 2020, 758 Italian health establishments were closed, including clinics, polyclinics, health centers, and hospitals. This demolition of the public apparatus of health care and surveillance in Italy resulted from the practices called fiscal and budgetary 'austerity' of the states, required by the ECB-EEC-IMF 'Troika' (European Central Bank, European Economic Commission and the International Monetary Fund), which required governments to set aside most of the public budget to finance bank interest and public debt and limited investments, public services, and social security rights.

The 'austerity' that closed the Italian public health apparatus was similar to that which came to be applied in Brazil after the failure of the coalition government (2010-2015), the legal and parliamentary *coup d'état* (2016), and the fraudulent election of the ultra-right wing in 2018.

Similar ultraliberal programs took place at the same time in Chile, Peru, Argentina, Paraguay, Ecuador, Colombia, and Bolivia, forced by the pressure of international financial and diplomatic sanctions, by media propaganda campaigns during the elections, by parliamentary coups, or by the so-called 'hybrid war', overthrowing elected governments.

The Sars-Cov-2 pandemic or simply the 'new' Coronavirus of Severe Respiratory Distress Syndrome in 2019 flattened the drastic aggression of the ultraliberal model and exacerbated the capital accumulation crisis in order to force a real setback in the implementation of the 'austere States' of countries like The United Kingdom, Germany, and France.

The Covid-19 accelerated European measures to save the poor, to transfer income to informal workers and individual entrepreneurs, the sick, the elderly, and the children. Ultraliberal governments that argued that each person should save themselves began to distribute income to prevent death by starvation and acute illnesses and a wave pillaging and plundering.

The US government pressured Brazil to maintain ultraliberal policies while drastically modifying its domestic Minimum Citizen Income policy, promising to distribute a minimum monthly income to all poor Americans during the pandemic. This paradoxical political movement came to Brazil in convulsion at the rising peak of the pandemic, with 400,000 cases worldwide, and 2,200 in Brazil (3/25/2020)².

There were and still are people on the Internet defending the closing of borders with the deportation of travelers arriving from an epidemic area. It is inhumane, cruel, and epidemiologically ineffective. Closing borders is ineffective and authoritarian. It serves political and economic interests. We know that fascism does not prevent the migration of bacteria, viruses, toxic agents, smuggling, and authoritarianism. Quite the opposite. What must be done is to hire trained personnel for health surveillance and to increase the 'direct' popular participation in the right to notify, monitor the investigation, and learn about the outcome of the cases. To take in, treat if necessary, notify, investigate, and never close borders.

Travel restriction is a policy that requires departure and arrival control. It must be done with planned monitoring of necessities. People with a strict need to travel on state missions, cases of death, and logistical needs for trade in activities considered essential would travel knowing that, when leaving and arriving, they should undergo signs and symptoms control. In case of contact with the public, they would accept screening tests, if necessary, be in quarantine for the maximum incubation period – 14 days. In controlled circumstances, only people in search of repatriation would travel, those returning to their country of origin, people in search of international cooperation actions, study, migration, and work in activities also considered essential.

Italy, at the beginning of the pandemic, took a swing in the policy of social distancing⁴. Initially, it preferred to close its citizens within their old burghs, small towns in the North. Then, it decided to isolate the elderly and the poor to only later understand that the country should be stopped, allowing solely that people could leave the houses due to the need for food and medicine. Subsequently, they released departures and arrivals without the previous selective restrictions, and then returned again to the recommendations of social distancing. It is one thing to tell citizens not to leave their homes for 15 or 20 days and ask that only food and health materials circulate. It is another thing – and ineffective – to close cities, arrest migrants, and vote on laws in secret.

The social control model worked by statisticians and computer science scholars has as its starting point the current situation grading different levels of effectiveness of the ‘social distancing’ or the ‘stay home if you don’t want to kill others or get sick’.

Brazil sought to convince the population not to leave home. We may be successful in changing the model and reducing the speed of the epidemic with protection and ‘flattening the curve’. The people will be able to understand if we can achieve a result that brings us closer to China and South Korea and distances us from what happened in Italy. We hope that the working and poor population do not have to pay for the risk in crowded buses and subways in order to serve the class that can romanticize the quarantine.

Social distancing and universal testing of asymptomatic contacts are the explanations of South Korea’s success in blocking the emergence of new cases and reducing mortality to almost 100 times less than Italy.

There is no point in testing IGM levels five days after suspicious contacts, signs or symptoms. Rapid testing is required for carriers of viral particles. Brazil has scientific and technological capacity to manufacture diagnostic kits. The Federal University of Bahia and the Oswaldo Cruz Foundation have developed kits on laboratory bench that did not find financing for production in industrial plants. Public funding was lacking because of the ‘austere’ Constitutional Amendment 95⁵.

The success of universal testing has already mobilized even North American health workers. The internet list dedicated to public health called ‘spiritof1848’ has advocated universal testing in the USA since the end of February 2020, and the use of facial masks by people with the virus or sick people, preventing the spread to the 86% that will be asymptomatic (95% CI: [82% -90%]). Universal testing has allowed Korea to search for and isolate positive asymptomatic patients who are responsible for 55% of the transmission to new cases (95% CI: [46% -62%])⁶⁻⁸. What made a difference was to isolate positive asymptomatic patients. That in addition to the action of the gods of hygiene – water and soap.

South Korea demonstrated creativity with improvised masks to avoid human contact with aerosols of saliva and human secretions in public transport, even those with reduced capacity. In the absence of sufficient industrial production, they used everything from

tights, pieces of cloth; scraps of paper towels, even cups of bras tied to the face. It became an international joke, but it worked.

In March 2020, Brazil still does not have a mobilization and contingency plan for social distancing and collective and individual protection measures. Only with the Minimum Citizen Income could it prevent the economic death of the popular economy, starvation, and violence. If nothing is done, those who do not catch the Coronavirus will catch the ‘*Guedesvirus*’ of bankruptcy, poverty, and a lack of money for rent, food, electricity, water, and everything that ultraliberals have privatized or want to privatize.

Although Brazil does not have an epidemiological health control model, whether vertical or participatory, the country has a set of authoritarian epidemiological laws, which allow the federal government to apply draconian measures without consulting and without allowing actions to defend regional or local interests⁹.

The best lists of essential needs and rights of the working population under quarantine and social distancing appeared in the manifesto of the ten Brazilian Union centrals and in the ‘16 questions from the slums’ published by the urban periphery movement^{10,11}.

The Brazilian Center for Health Studies (Cebes) has guided its action of studies and translational scientific exchange between the sectors of health, economy, law, popular education, and others, with the interface formalized in the forums of institutions such as the National Health Council and the National Fronts, created to fight for health and for life^{12,13}.

The discussions in the various instances of the Cebes and the content of its journal ‘*Saúde em Debate*’ aim to denounce that the strategy of mitigating to await the immunization of the ‘herd’ (group immunity) has proved ineffective in Iran and in Italy. The cost of human lives was due to the very high rate of reproduction (R_{zero} or R_0) that led to serious cases of babies, children and young people, besides elderly adults, with concomitant diseases. This experience did not exist in January because of the low severity rate and proportion of asymptomatic patients, which was unknown in January 2020.

Personal protective equipment has proven to be useless or to require several layers of protection, which make them unfeasible for use in the primary care network, due to the high costs of disposal and cleaning, and unavailability due to the volume of demand with the very high number of cases. The extent of this demand was also not yet known in January 2020, and became a concrete reality after the Coronavirus arrived in the Middle East and Europe, in March of the same year. The impact of it was the extremely high mortality of nurses, assistants, and doctors in Italy, even harming the attendance of hospitals that were dismantled and without staff, with the sickening and death of a high number of health professionals.

After understanding the speed of reproduction ($R_0 = 2.5$), the high rate of asymptomatic transmitters (86%), the persistence of the virus for up to several days on furniture, hospital waste, and objects for individual and community use (‘fomites’ in the health dialect), the inability to reverse the acute inflammatory condition in critically ill patients who are admitted to the Intensive Care Unit (ICU), even with mechanical ventilation for up to 20 consecutive days, have changed the scenario in Europe. They have also made Trump and Bolsonaro’s strategy of letting many people die so as not to paralyze the economy equally unsustainable.

We also denounce the strategy of liberating non-essential trade and activities as criminal, putting the working population at risk, in the expectation that the epidemic will be extinguished and admitting the increase in mortality of many poor people from the peripheries, who will not have access to the means that can save their lives, such as access to the ICU of the few hospitals that will be equipped.

The strategy of planned suppression was imposed after the dissemination of scientific

knowledge on the experience of China, South Korea, Iran, Italy, Germany, and The United Kingdom. The model adopted in the US, which suffers much resistance even there, is a murderous model of colonialist imperialism that imposes mitigation measures with commercial and banking liberation. The Brazilian government has sought to imitate such strategies since the beginning of the year 2020. If the ‘liberate all’ strategy wins here, we will know that the implication will be to send the people to die so that the economy, the investors, and financiers may profit, as it always happens.

Collaborators

Corrêa Filho HR (0000-0001-8056-8824)* is responsible for elaborating the manuscript. Segall-Corrêa AM (0000-0003-0140-064X)* contributed to the revision of the manuscript.

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