VIEW POINT

COVID-19 in Peru

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ABSTRACT

This article briefly describes the sanitary and mental health situation in Peru prior to the COVID-19 pandemic; the response measures taken by government authorities to confront them, analyzing their successes, errors, and limitations, and finally, some recommendations are made.

Key words: COVID-19, mental disorders, mental health, pandemic, public health, social confinement

INTRODUCTION

The COVID-19 pandemic has been having global effects, not only on health but also on all aspects of the lives of our nations. This pandemic had begun at the end of December 2019 in the city of Wuhan, China. At the time of writing this article, it had caused 17,918,582 infections and 686,703 deaths around the world¹ and in Latin America and the Caribbean, 5,048,322 infections and 209,405 deaths.²

Peru is a country with a population of approximately 33 million inhabitants. The pandemic is surprised by a precarious, fragmented, disintegrated, and inequitable national health system; a consequence of the abandonment of successive governments, the best expression of which translates into a share of only 2.2% of the national gross domestic product.² To this is added its emphasis on curative and promotional preventive carelessness, with abandonment of primary care.

It is in this context that on March 8, the “zero” case was detected in Peru. At that time, we had a little more than 3000 hospital beds and 276 intensive care unit (ICU) beds. Just a week later, the government declared a state of emergency, compulsory social confinement, and a curfew at night and Sunday all day and at the same time, social support measures for the poorest sectors.

Given the fragmentation of the health sector, a national command to combat COVID-19 was created, with the task of unifying health care. That has allowed that in just over 3 months, we have gone from 3000 to more than 15,000 hospital beds and 276 intensive care unit (ICU) beds.
hospital beds and from 276 to 1618 ICU beds. As this is insufficient, it is intended in a few weeks to increase to 20,000 and 2000 hospital beds and ICU beds, respectively. Despite these measures, the advance of the pandemic is enormous. As of the date of this report, there were 428,850 infected, 19,614 deaths, 13,743 hospitalized, 1416 in the ICU, and 294,187 patients discharged.[3] At the level of medical professionals, there are more than 100 deaths and more than 3000 infected. Nearly 2,404,046 samples have been taken between molecular and rapid tests.[3] The mandatory confinement was 108 days, being lifted not for health reasons, because the pandemic is far from being controlled and in the last 2 weeks, it has had a rebound, but for economic reasons. In fact, a significant sector of the population had long since no longer complied with the quarantine for various reasons.

The initial strategy designed by the government was apparently correct, an early and strict confinement and economic support for the sectors of poverty and extreme poverty. However, it was not taken into account that the employed population with informal employment in Peru was more than 70%,[4] and that therefore they live from what they work day to day and if they do not work, they do not eat. Another fact of reality that was not evaluated is the capacity of households to be able to preserve the food they buy because 47.5% of these do not have a refrigerator, according to Ipsos estimates with data from the ENAHO.[3] Another fact not taken into account is that according to the United Nations Development Program, of the 9 million households in Peru, 2.5 million live in overcrowded conditions and more than 500,000 households suffer from lack of access to water.[6] This reality made it difficult to demand from this population social distancing and handwashing, two important measures to avoid contagion. To this was added that when the government had to distribute the economic bonds to the vulnerable population, long queues were formed in the banks, being another source of contagion, because according to data from the National Institute of Statistics and Informatics, only 38% of Peruvians have a bank account.[5] It is then these structural problems explain part of the reasons why the measures taken by the government have not yielded the expected result. However, this does not mean that these have been a failure, but rather that they have limited their impact, they have definitely reduced their magnitude, and above all, they gave time for the health system to better prepare for the situation we are experiencing. To these structural problems that have limited the control of the pandemic, we should add the mostly hospital-based health approach of the strategy, since the centers and health posts that know and are close to the community have not been used, this would have made it possible to contact those infected and their environment to isolate and monitor them. Another error was the limited use of molecular tests because although more than 2,400,000 tests have been carried out to date,[4] most are rapid serological tests. Furthermore, there was a delay in control at airports and borders in the first weeks and later, a lack of control of agglomerations in the markets and public transport. From our point of view, these are the main errors in the control of the pandemic in Peru and that have limited its results.

MENTAL HEALTH AND COVID-19

Now, 6 months after the start of the pandemic, and with no clear prospects for its end, a look from public health shows the urgent need to take into account the cost of the pandemic on the mental health and well-being of people. Are the consequences on the mental health of the general population in social confinement being taken into account? The consequences on the mental health of the doctors and health workers facing this pandemic? The mental health of the people infected, hospitalized, or recovered from COVID-19 and their families? And the mental health of people with prepandemic mental disorders?

Nobody knows the real magnitude of mental health problems as a consequence of the pandemic. However, there are some studies of past epidemics and a few of the current pandemic – with obvious time constraints – that provide an idea of its repercussions on the mental health of the entire population.

MENTAL HEALTH AND COVID-19 IN PERU

In recent years in Peru, a process of mental health reform began, with a community focus, which has resulted in the recent adoption of the Mental Health Law and the creation of more than 150 community mental health centers (CMHCs). However, all these have been done vertically, without the participation of the civil society, specialized institutions in the area, and the community. The result has been to once again isolate mental health care from general health care because the CSMC have no relationship with the health centers of the first level of care. At the same time, support has been withdrawn from specialized hospitals, under the pretext of the “asylum,” ignoring the efforts that these institutions have been making to modernize, excluding them in practice from the “official” plans and programs, without, at the same time, generating the structures that replace their functions.

It is these conditions that explain why the response of the Peruvian State, to address mental health problems during this pandemic, has been late, limited, and fragmented.

The central government, through the executive directorate of mental health, during this period of pandemic has issued the following documents:

- “Technical guide for the mental health care of the affected population, families, and community due to
the COVID-19 pandemic,” which establishes that in the face of the COVID-19 pandemic, all public health institutions and private institutions incorporate mental health care into their intervention plans and strategies. For this, technical criteria and procedures for the care and self-care of the mental health of the population are established; the timely diagnosis of people with mental health problems and guidelines for developing a plan of therapeutic interventions and continuity of care; and finally, the guidelines for mental health care in people affected by COVID-19, as well as the accompaniment of their relatives, and the relatives of the deceased in the present context.[9]

- “Technical guide for the mental health care of health personnel in the context of COVID-19,” aimed at reducing the impact on the mental health of health personnel who provide care to people with a suspicion or diagnosis of COVID-19 infection. To do this, it describes the guidelines for the care and self-care of the mental health of the staff, focused on the institutional organization for the promotion of healthy work environments, the promotion of self-care, psychosocial support strategies available in the workplace and at a distance, identification of mental health problems, and management for intervention and recovery.[8]

- “Health directive that establishes provisions to provide information and psychosocial support to hospitalized patients with COVID-19 infection and their families,” which contains the procedures, provisions, and communication channels for psychosocial support to hospitalized patients with COVID-19 infection and their relatives.[10]

All these documents have the common denominator of containing guidelines and actions that are generally technically correct, but with serious implementation problems in reality, as a consequence of their verticality of origin, fear of the participation of the civil society and the population, and their. The intention is to focus exclusively on CMHCs, excluding the other components of the health services network, in particular the specialized institutions that concentrate on an important part of the service offered. CMHCs are recently created institutions, so they do not have the technical capacity, the human and logistical resources, and the experience for the magnitude of the task. In a kind of voluntarism, paternalism, and messianism, wishes are confused with reality.

The result is a fragmented and therefore inefficient response; on the one hand, the Ministry of Health, through the CSMC, without connection with the health centers and posts, but in the same sector, the psychiatric hospitals, the mental health institute, and the specialized services of the general hospitals responding independently. In the same way, the Social Security (EsSALUD), the Health Services of the Armed Forces and the Police, and the private sector, are working with enthusiasm, but without any coordination. The response has been mostly focused on teleconsultation and some orientation campaigns directed at the community. For its part, emergency care has been resolved by psychiatric hospitals despite not being taken into account the official discourse.

The situation of medical and health personnel is difficult, since they have to work with a greater risk of being infected and transmitting them to family, friends, and other people at work; with insufficient and uncomfortable protective equipment; in situations of overflow in the care demand and forced many times to make complex decisions, in a short time, which generate ethical and moral dilemmas. Faced with this situation, there has not been a satisfactory response from the state, beyond documents that they are not put into practice. Given this situation, the Peruvian Psychiatric Association in alliance with the Medical College of Peru has established a program of mental health care for doctors and relatives that has been running since May.

In what corresponds to the research area, there are several projects that have been running whose results are not revealed.

Finally, I would like to point out a series of lessons that we have been learning in the face of the pandemic and that governments and the population should keep in mind:

- The pandemic has exposed the precariousness of our social, economic, and political structure. It has dramatically made evident our shortcomings, the terrible inequality, and inequity in our society and how the state has not been built at the service of the majority. Hopefully, we have learned the need to build a more just and supportive society, at the service of the common good
- It is in the health system where our structural problems as a country have been most clearly reflected. Decades of abandonment, of disinvestment, and of demotivation in human resources policy have made the sector precarious, and this has been taking the toll on us. There is no right to health without investment and prioritization of public health
- Given the global and complex nature of the problem generated by the pandemic, the response strategy must be comprehensive; each of the components of the health, economic, and social measures are important, but not very effective if they are applied partially or in isolation
- In the design and implementation of measures to combat the pandemic, the active participation of academia, civil society, and the population must be favored
- There is no health without mental health, which requires that interest not only be focused on ICU beds, oxygen, drugs, and hospitalization but also on what
happens in the subjectivity and behavior of individuals, families, and social groups

- Recent international experience leaves no room for doubt, the great impact that the pandemic has been causing on the mental health of the population, and its repercussions in the medium and long term, which they have called the “Fourth Wave.” This requires that the response to this challenge has to be comprehensive and participatory, in which the following four fronts are clearly identified: the general population, patients with COVID-19 and their families, health personnel and their families, and patients with mental problems.

- The COVID-19 pandemic has been putting doctors and health professionals in an unprecedented situation, making difficult decisions and working under extreme pressure. This has led to what some have called ethical or moral dilemmas. This requires the immediate need for protection measures, incentives, and training for health personnel. Speeches are not needed, but effective and real measures.

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