Letters to the Editor

To the Editors:

The emergence of a pandemic H1N1 strain in Mexico, and its appearance within weeks in the USA and Canada, was unexpected. Nevertheless, as noted in the article "Faceoff: Cuba vs H1N1 Influenza" by Gail Reed (*MEDICC Review*. 2010,12(2):6–12), ". . . as luck would have it, H1N1 has been mild thus far. Just a rehearsal." Thus, it becomes essential for all countries to share their "lessons learned" so that the responses to the next, perhaps more severe, pandemic will be both effective and rational.

Cuba already had an integrated plan in place for avian flu involving 15 ministries. How that plan evolved, and which interventions worked and which did not, contribute important evidence to our knowledge base. Several of the 7 Cuban strategies listed by Reed merit additional comment.

In response to early Mexican data suggesting high mortality from the virus, many countries—Cuba among them—hurriedly implemented measures to attempt to delay the virus's entry, including flight cancellations, airplane captains' reports of illness on board (a requirement of the International Health Regulations), screening of arriving passengers, and various degrees of isolation for passengers with positive results. Given that H1N1 illness was mild and that there was an asymptomatic incubation period, it is difficult to determine if any of these measures were effective.

Screening measures, for example, can be costly in terms of personnel and equipment, and the cost per confirmed case may be high. The Cuban data reinforce my conviction that screening does not ultimately stop infectious disease at the border, and resources devoted to it might better be utilized for interventions to limit spread in the population. Reed notes that over 266,000 persons were screened, yielding only 10 confirmed cases (about 4 per 100,000) and another 140 false positives requiring follow-up. In the end, these measures did not keep H1N1 out of Cuba, and it is difficult to document if the efforts even delayed the arrival or spread of the virus there.

Cuba's capacity for community mobilization is quite extraordinary and it contributed to curtailing the spread of the virus. Once again, we see that interventions requiring public cooperation can only be successful when the public's trust is maintained through timely and accurate information. Early and persistent public education with reliable information about special high risk groups guided the actions of persons in these groups.

Cuba's ability to achieve collaboration between the clinical care community and the public health community is a lesson well worth remembering. In many countries, these two operate quite independently. The health care sector is often the source of critical data (e.g., numbers of patients, severity of illness, number of deaths, treatment successes, etc.) for shaping public health policies and strategies. But for effective information flow, seamless cooperation between the clinician and the public health expert is a must. As noted by Reed, Cuba has a strong integrated health care system with accessible primary health care. The family doctors and nurses, and community-based polyclinics not only provided care, but also implemented public health interventions and provided epidemiological data. As a result, there was consistent access to reliable epidemiological information nationally.

Further detailed analysis by Cuban authorities of the strategies and measures adopted, and publication of the results, will surely generate additional lessons of interest to the global community.

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