JN.1 becomes dominant COVID-19 strain across the US, fueling winter wave of mass infection

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On Friday, the US Centers for Disease Control and Prevention (CDC) updated its SARS-CoV-2 genomic surveillance variant proportions, with data obtained over the past two weeks, showing that the Omicron JN.1 subvariant accounted for 44.2 percent of all sequenced cases and is now dominant across the US.

Variant trackers and data scientists agree that the rise of JN.1 to dominance in the US will only fuel the country's eighth wave of mass infection in the weeks ahead. This could soon cause the second-highest number of COVID-19 cases of any wave so far, excluding only the initial Omicron wave exactly two years ago. It is not yet clear how high JN.1 will push hospitalization and death rates, but data from the "bellwether state" of New York are very concerning, with hospitalizations rising 36 percent over the past week after JN.1 became dominant.

JN.1 is now the dominant variant globally, causing spikes in infections, hospitalizations and now deaths in a growing number of countries. Some European countries, including Germany, the Netherlands and Denmark, have recorded all-time highs in COVID-19 wastewater levels, surpassing even the peaks reached during the first Omicron wave two years ago.

The case of Singapore is important to highlight as it provides a window into what the US and other regions can expect in the course of just a few weeks. The strain quickly rose in prominence and dominated other strains of SARS-CoV-2 by early December.

Singapore's Ministry of Health has reported a steady rise in COVID-19 hospitalizations due to JN.1, despite having a population that has been highly vaccinated and boosted. The number of COVID-19 cases has more than quadrupled in the past month, while hospitalizations have jumped from 136 in late November to 560 in their latest update. Public health authorities have issued pleas for citizens to don masks again and are reviewing health system utilization to assure bed capacity remains available for the infected.

In Malaysia, the government has reactivated the Heightened Alert System to better respond to developments. Cases have nearly doubled since early December. Thailand and Indonesia are also issuing similar advisories to their respective population.

On Tuesday, the World Health Organization (WHO) had to acknowledge the threat of JN.1 by designating it as its own "variant of interest" independent of its parent BA.2.86 (nicknamed "Pirola"). In its press release, the organization recommended that all people "Wear a mask when in crowded, enclosed, or poorly ventilated areas, and keep a safe distance from others, as feasible" and "improve ventilation."

Significantly, for healthcare workers and facilities, the WHO advises "universal masking in health facilities, as well as appropriate masking, respirators and other PPE for health workers caring for suspected and confirmed COVID-19 patients." They also suggest "improve ventilation in health facilities."

Needless to say, these basic public health measures are not being implemented in the overwhelming majority of healthcare facilities. As with the United Nations' toothless resolution calling for a ceasefire in Israel's genocide of the Palestinian people, the WHO's advice falls on deaf ears, as the world's ruling elites are inured to the mass death and suffering of their populations.

Nevertheless, in some health systems in Pennsylvania, Washington, Massachusetts, New Jersey and other states, administrators are doing the bare minimum of bringing back mask mandates in an attempt to slow the spread, especially among staff and patients.

Dr. David Christopher, an emergency room physician in Northeast Ohio, who has seen his ER being overrun with patients with respiratory illnesses, wrote on X/Twitter, "My hospital is finally reinstating COVID PCR testing on every patient being admitted which should give you a clue as to how bad things are getting again yet most people are totally oblivious while plague coughing is everywhere."

Recent studies have shown that the particular mutation distinguishing JN.1 from its parent BA.2.86, L455S, has given it significant immune-evading capacity. A research group headed by Yunlong Richard Cao of Peking University is one of the few groups conducting real-time studies on the emergence of these new strains of Omicron. Summarizing its latest finding on JN.1 in a *Lancet* report, they noted:

> JN.1, by inheriting BA.2.86's antigenic diversity and acquisition of L455S, rapidly achieved extensive resistance across receptor binding domain class 1, 2, and 3 antibodies, and showed higher immune evasion compared with BA.2.86 and other resistant strains like HV.1 and JD.1·1, at the expense of reduced human ACE2 binding. This

> evolutionary pattern, similar to the previous transition from BA.2.75 to CH.1.1 and XBB, highlights the importance of closely monitoring strains with high human ACE2 binding affinity and distinct antigenicity, like BA.2.86 and BA.2.75, despite their unremarkable immune evasion capabilities. Such strains could survive and transmit at low levels since their antigenic difference would allow them to target distinct populations compared with dominant strains and have the potential to quickly accumulate highly immune-evasive mutations at the cost of human ACE2 binding capabilities.

In another report awaiting peer review by the same group, they underscored the dangers posed by SARS-CoV-2's continuous evolution and the fatal flaws of a vaccine-only strategy. They found that a L455F+F456L mutation known as "Flip" on the receptor binding domain (RBD) of the virus inherently improves its receptor binding properties while maintaining its immune-evasive characteristics.

They wrote, "The enhancement of receptor binding increases the potential for the virus to further accumulate immune evasive mutations." In their conclusion, they warned, "the evolutionary potential of SARS-CoV-2 RBD is still high and should not be underestimated."

Ushering in the holiday seasons and entering the fifth year of the pandemic, such shifts in the genetic make-up of SARS-CoV-2 were not unexpected. They are part and parcel of the virus's ability to consistently find new mechanisms to advance its own evolution using billions of human hosts, as detailed in a recent Substack piece by Drs. Arijit Chakravarty and T Ryan Gregory.

The corporate media continuously minimizes the risks of COVID-19 by noting that health system usage and deaths are no longer at levels seen in the first two years of the pandemic. However, this does not take into account the immense societal impacts of Long COVID, often termed "the pandemic within the pandemic."

Not a single mainstream outlet has reported a highly significant interview with three of the world's leading experts on Long COVID—Drs. Ziyad Al-Aly, Akiko Iwasaki and Michael Peluso—in which each stated that they continue to remain disciplined with masking in indoor public spaces in order to avoid Long COVID.

More so than any previously studied pathogen, SARS-CoV-2 has been shown to persist in myriad body tissues for unknown duration. Thus, in a recent discussion with the WSWS, Arijit Chakravarty conceptualized the ruling elites' policy of "forever COVID" in a two-fold manner: through unending waves of mass infection, which will entail repeated annual reinfections for the great bulk of the population, untold masses are being seeded with SARS-CoV-2, potentially persisting in them *forever*. The implications of this policy are deeply disturbing, with ever-broader sections of society becoming debilitated and dying with each new wave of mass infection.

In an opinion piece published this week in the *British Medical Journal*, the scale of this "mass disabling event" was given further measure. According to the UK Office for National Statistics (ONS) Infection Survey, by the end of March 2023 (at which point the ONS discontinued this vital service), some 1.7 million people were experiencing Long COVID, 40 percent of whom had caught COVID-19 in the last two years (Omicron phase).

Extrapolated for the global population, this would mean that roughly 200 million people were then suffering from Long COVID. According to the ONS data, only 31 percent of those who still had symptoms after 12 weeks recovered within a year of their infection, the report noted. Tens of thousands of UK residents, and millions globally, have had persistent symptoms lasting for more than three years.

Despite the accumulated knowledge of post-viral syndromes and their impact, there is no impetus from within the capitalist political establishment to fund large, well-designed trials to evaluate potential treatments for Long COVID and related illnesses. As the authors noted:

> Post-viral syndromes are nothing new. We already knew of the significant ongoing burden of disease in many infected with SARS-CoV-1 almost 20 years and MERS over 10 years ago. The chances that another new coronavirus like SARS-CoV-2 which causes significant long-term morbidity should have been a consideration from the very beginning of the pandemic. It should have been explicitly factored into the debates on policies.

The evolution and rapid global spread of JN.1 epitomize the complete failure of capitalism to address the pandemic. The international working class must study and take heed of the ongoing dangers posed by the virus and fight for a preventative strategy against COVID-19 and other public health threats. Fundamentally, what is required is the eradication of capitalism to ensure that a socialist society is built by workers themselves to tackle these and all other urgent problems facing humanity.