

SHIFTS



World Health
Organization

REGIONAL OFFICE FOR South-East Asia



SHIFTS

THE COVID-19 PANDEMIC: SHIFTING THE
WORLD AND SHAPING ITS RESPONSE



“SHIFTS” – The COVID-19 Pandemic: shifting the world and shaping its response

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Preface

Eight months into the COVID-19 pandemic, more than 20 million people have suffered the disease and almost 750 000 lives have been lost. 2020 will be remembered as a pivotal year in human history. Never in living memory has a virus held the entire world captive in such a manner. The pandemic has revealed to us both the depths of human vulnerability and the strength of human resilience. It has transformed the way we live and work in a fundamental manner. It has transformed life as we know it. That is why we have called this book “Shifts”.

Since 2014 Member States of the WHO South-East Asia Region have strengthened emergency risk management as one of the Region's Flagship Priority Programmes. Achieving full compliance with the International Health Regulations (2005) has been a key area of work, and significant progress had been made prior to the emergence and spread of COVID-19. In recent years, and in the early months of the pandemic, WHO has supported countries to build capacity in field epidemiology, laboratory skills, clinical management and risk communication among other priority areas. The Region has never been more ready to tackle a challenge as immense as COVID-19.

But the scope of the challenge must be appreciated. The virus is novel. Responders from across sectors have had to learn and adapt at an unprecedented pace. They have had to procure and transport critical resources – human and otherwise – at a time of rolling “lockdowns” across the world. They have had to engage and inform the public on how to protect themselves and adjust to the new normal. They have had to counter stigma directed at returning and

internal migrants, and even health workers. And they have had to revive and maintain essential health services to ensure all people can access the health services they need to detect, manage or treat all other health conditions, whether diabetes, hepatitis or HIV.

Countries in the Region continue to adapt to the many challenges they face, in the spirit of the Region's "Sustain. Accelerate. Innovate" vision.

Triaging and task-shifting; leveraging the potential of telemedicine; developing novel supply chains and medicine dispensary options; and better engaging the private sector and communities have all achieved a measure of success in the provision of routine medical care. Policymaking and planning has shifted almost completely online.

The WHO Solidarity trials continue to coordinate the research and development of novel vaccines, therapeutics and diagnostics, while the WHO-supported COVAX Facility and Access to COVID-19 Tools (ACT) Accelerator will help ensure equitable access for all. WHO and national responders continue to identify and implement innovative ways to counter what is an "infodemic" of mis- and disinformation that endangers whole communities and countries.

COVID-19 has not only underscored the critical interdependence of achieving both universal health coverage and health security, but also between health, the economy, the environment and other social sectors. Health is indeed

wealth, and we must ensure that health sector funding is prioritized moving forward. By increasing investments in primary health care and pandemic preparedness among other priorities, leaders from across sectors will secure their country's progress in all areas of sustainable development.

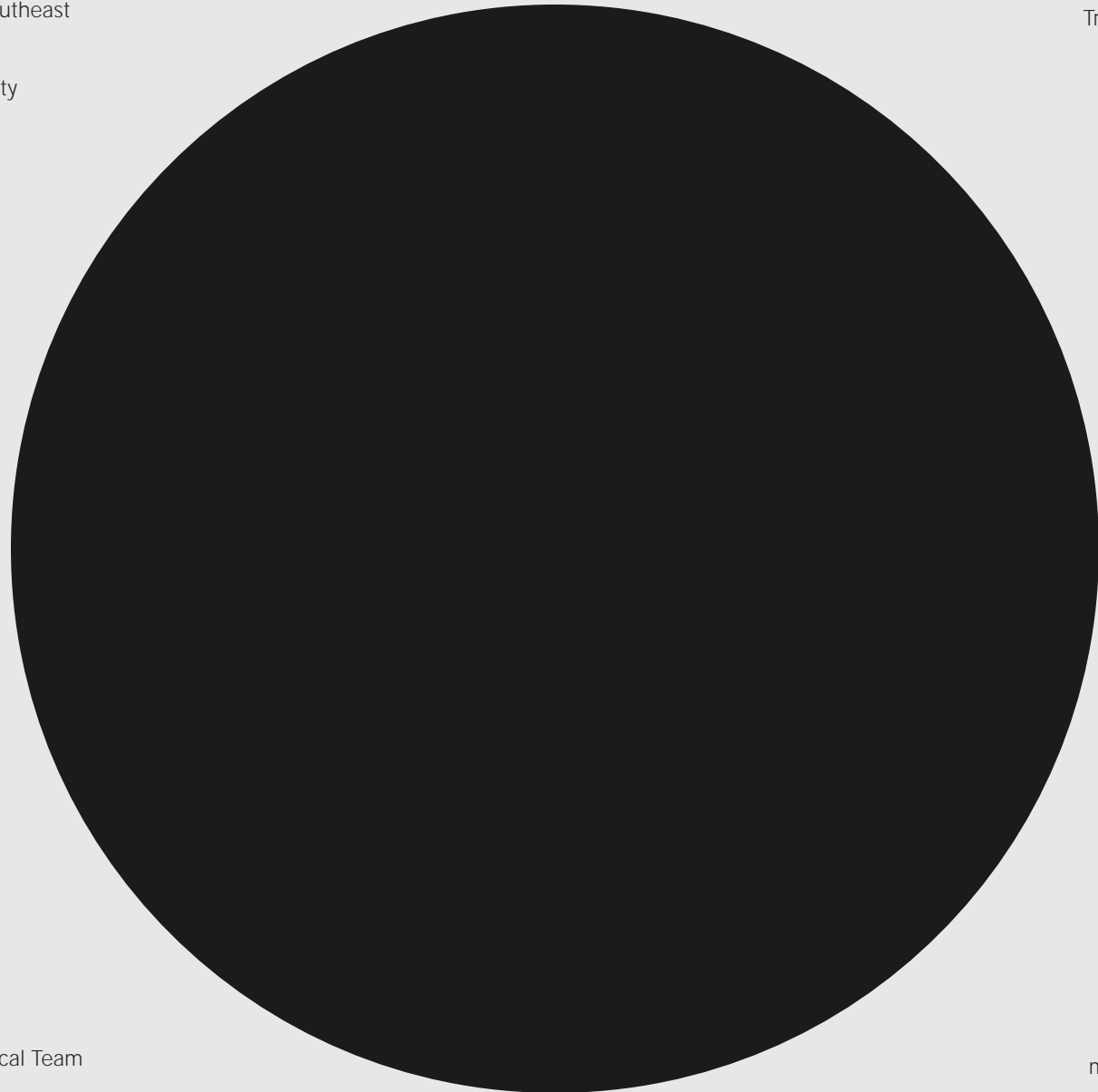
They will demonstrate that the lessons from the pandemic were learned, that action was taken, and that the course of history was shifted for a healthier, more sustainable and secure future for all.



**Dr Poonam Khetrpal Singh, Regional Director,
WHO South-East Asia Region**

Abbreviations and Acronyms

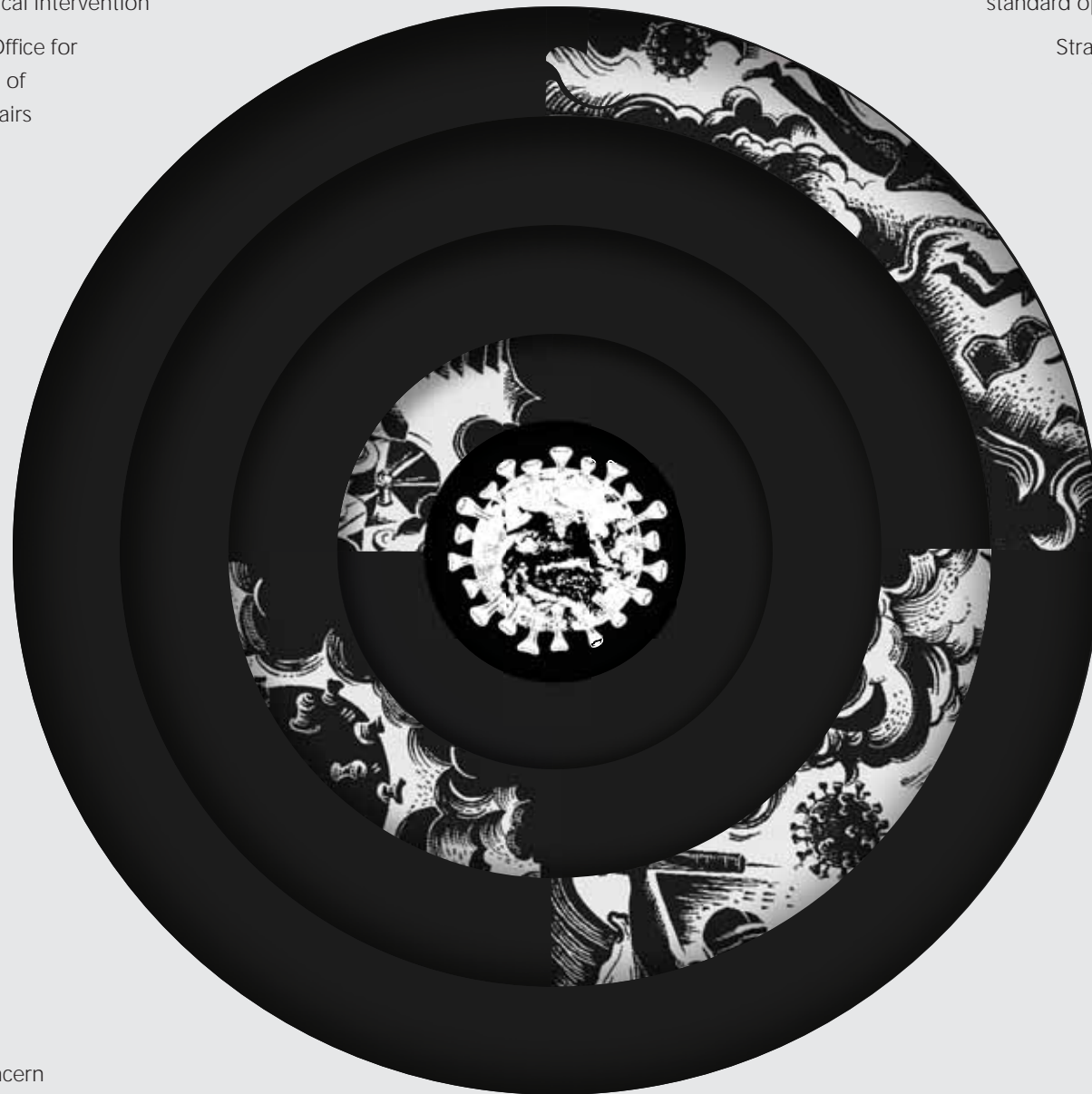
ACT	Access to COVID-19 Tools
AI	artificial intelligence
API	active pharmaceutical ingredient
ARI	acute respiratory infection
ASEAN	Association of Southeast Asian Nations
BCP	business continuity plan
CFR	case fatality rate
COVID-19	coronavirus disease
CPI	Country Health Emergency Preparedness
DPR Korea	Democratic Peoples' Republic of Korea
EHS	essential health services
EMO	emergency operations
EMT	Emergency Medical Team
EPI	Expanded Programme on Immunization
EPI-WIN	WHO's Information Network for Epidemics
EQAP	external quality assurance programme
Global Fund	the Global Fund to Fight AIDS, Tuberculosis and Malaria
GOARN	Global Outbreak Alert and Response Network



hospital-acquired infection	HAI
health-care worker	HCW
Health Emergency Operations Centre	HEOC
Health Emergency Information	HIM
Health Protection Agency	HPA
International Air Transport Association	IATA
intensive care unit	ICU
Institute of Epidemiology, Disease Control and Research	IEDCR
International Health Regulations (2005)	IHR
Integrated Management of Adolescent and Adult Illness	IMAI
incident management system	IMS
Incident Management Support Team	IMST
infection prevention and control	IPC
Immunization and Vaccine Development	IVD
medical camp kit	MCK
Middle East respiratory syndrome	MERS
Ministry of Environment and Forests (Indonesia)	MoEF

MoH Ministry of Health
NCD noncommunicable disease
NFP national focal point
NGO nongovernmental organization
NHL National Health Laboratory
NIH National Institutes of Health
NPI non-pharmaceutical intervention
OCHA United Nations Office for the Coordination of Humanitarian Affairs
OSL operational support and logistics

Strategic Advisory Group of Experts **SAGE**
 severe acute respiratory illness **SARI**
 severe acute respiratory syndrome **SARS**
 severe acute respiratory syndrome coronavirus-2 **SARS-CoV-2**
 Sustainable Development Goals **SDGs**
 South-East Asia **SEA**
 standard operating procedure **SOP**
 Strategic Preparedness and Response Plan **SPRP**
 universal health coverage **UHC**
 United Nations **UN**
 United Nations Development Programme **UNDP**
 United Nations Fund for Population Activities **UNFPA**



PEN WHO Package of Essential NCD Interventions
PHEIC Public Health Emergency of International Concern
PHSM Public Health and Social Measures
PoE point of entry
PPE personal protective equipment
R&D research and development
RCCE risk communication and community engagement
SAARC South Asian Association for Regional Cooperation

United Nations High Commissioner for Refugees **UNHCR**
 United Nations Children's Fund **UNICEF**
 United Nations Office for Project Services **UNOPS**
 United States of America **USA**
 water, sanitation and hygiene **WASH**
 World Food Programme **WFP**
 WHO Health Emergencies **WHE**
 World Health Organization **WHO**

Executive summary

From the time the cases of atypical pneumonia were first reported from Wuhan city in Hubei province, China in December 2019, the coronavirus disease (COVID-19) pandemic has wreaked havoc across much of the globe.

Countries are realizing that the virus is here to stay, at least until a safe vaccine or effective treatments become available. The unprecedented nature of the pandemic and the way in which it has upended human lives is making governments, public health experts, industry leaders and sociologists realize that the world might be radically changed once the worst of the outbreak eases. The exponential increase in the caseload of COVID-19 might surpass existing capacities of clinical and public health institutions if health systems do not contain the spread and deploy additional resources along with a redistributed workforce.

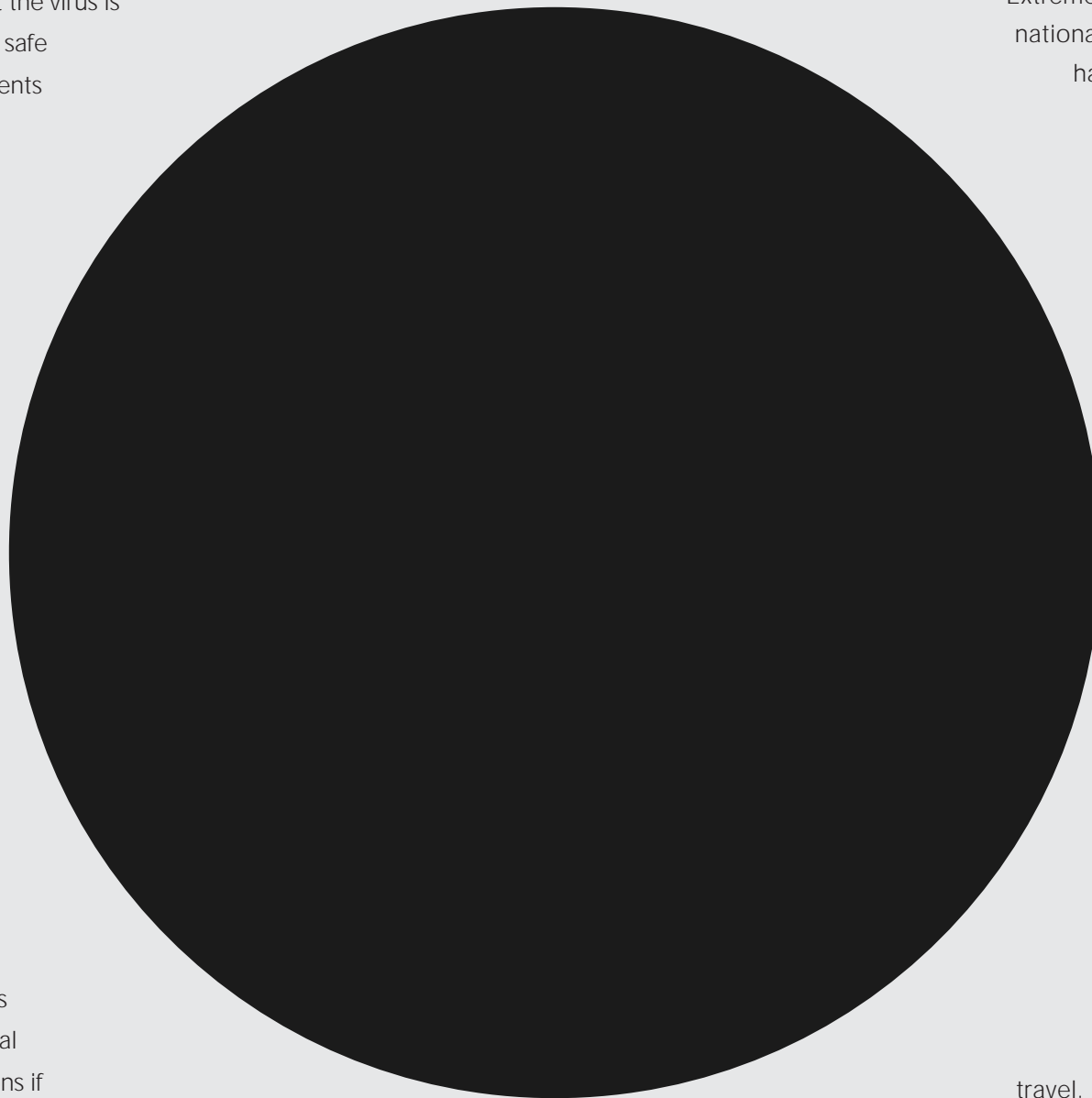
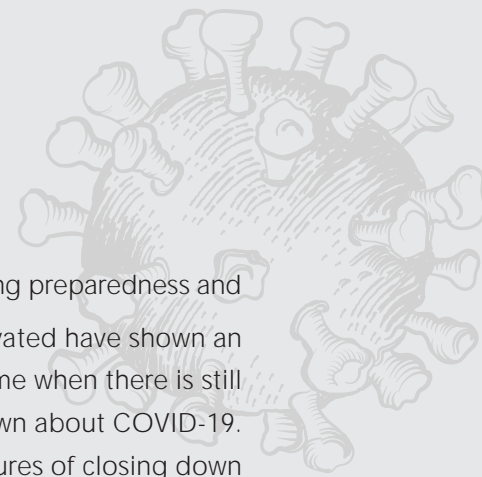
So far, the focus of the Region has been on reducing the severity of the disease by identifying, testing and isolating cases, thus minimizing the

health and socioeconomic impacts. Existing preparedness and pandemic plans that have been activated have shown an “adaptive response” at a time when there is still a lot that is unknown about COVID-19.

Extreme measures of closing down national and international borders has led to several challenges and complexities, the impact of which is being seen and felt both now and in times to come.

In the interim, countries are demonstrating remarkable innovations and notable “shifts” in their response.

Some ways in which these “shifts” are being seen is in the way people have adapted to “new normal” of physical distancing, enhancing personal hygiene, wearing masks and avoiding unnecessary travel. “Shifts” have also occurred in the way countries are assessed, surveillance strategies reshaped, protocols for infection protection and control redefined and new ways found to communicate critical information. This book draws attention to these shifts, which will be important as countries put their health systems, economies and lives back on track.



Currently, the epidemic in the WHO South-East Asia Region is largely driven by India, Bangladesh and Indonesia, where widespread community transmission is ongoing since April–May 2020. Most other countries are witnessing clusters of transmission and sporadic cases, while Thailand, Sri Lanka, Bhutan and Myanmar have been able to prevent and/or contain community spread. However, importations in other countries is once again seeing the virus spread, more so where there is a high density of the population and frequent movement. As a result, the pandemic is testing both well developed and less developed health systems alike, exposing limited surveillance and laboratory capacities, lack of trained human resources and the underlying challenges of access to health care coupled with large subnational variations.

Strategic shifts in the regional response

This book emphasizes five important “shifts” that deserve mention. These are seen in the light of the nine pillars of emergency preparedness and response, which have been taken up separately.

1. Making extra effort to strengthen coordination across different levels.

From activating teams to provide strategic, technical and operational support to Member States, to working with partners from the health domain and beyond, the WHO Regional Office put in place important coordination mechanisms at the regional and country levels. National Health Emergency Operation Centres (HEOC) were activated. In addition, the pandemic brought together United Nations Agencies and Cluster mechanisms, along with international organizations, partners and networks in the Global Outbreak Alert and Response Network (GOARN), emergency medical teams (EMTs), the Asia Pacific Risk Communication and Community Engagement Working Group and research partners. WHO worked with countries to increase surveillance and implementation of public health and social measures like maintaining social distancing, frequent handwashing, and following quarantine measures after contact or exposure. Alongside, country plans were developed, and minimum disruption ensured to essential services and business continuity and recovery operations.



2. Adapting response mechanisms with evolving knowledge about the virus.

Contingency plans were adapted and contextualized as countries stepped up “identifying, testing and treating” for the novel coronavirus. Risk assessments and country profiles helped to monitor transmission dynamics and epidemic trends.

Technical support was provided to develop strategies and standard operating procedures for contact tracing, risk assessment, modelling and surveillance. An important shift related to how lessons from past experiences of managing pandemics were being drawn upon, such as the severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS) and other known respiratory viruses. Past training and readiness checklists were revisited and re-introduced along with pre-pandemic mechanisms, showing the Region’s flexibility and openness to adapt. A major shift was seen in risk communication and community engagement. For the first time, countries installed misinformation monitoring and response systems, with hotlines, digital monitoring, fact checkers and a network of community health volunteers. Artificial

intelligence tools and chatbots were developed and partnerships established with social media companies. When countries were ready to “unlock”, they again conducted risk assessments and issued interim guidance. These initiatives had never been attempted before.

3. Accelerating the effective use of technology across all pillars of the response.

Technology bridged many barriers. WHO used these to advantage by strengthening communication, surveillance and clinical management. The Regional Office adopted and normalized remote working with bulk communication between teams and countries and switched to digital formats with health system focal points. The Regional Emergencies Director, incident management teams at country levels and regional incident management support team at regional and national levels were connected round the clock. Innovations such as an emergency “crash course” to train clinicians, doctors and nurses was developed and remotely delivered through a digital, online platform for Member States. A special information network for epidemics convened numerous technical webinars, free training and COVID-19-related courses.

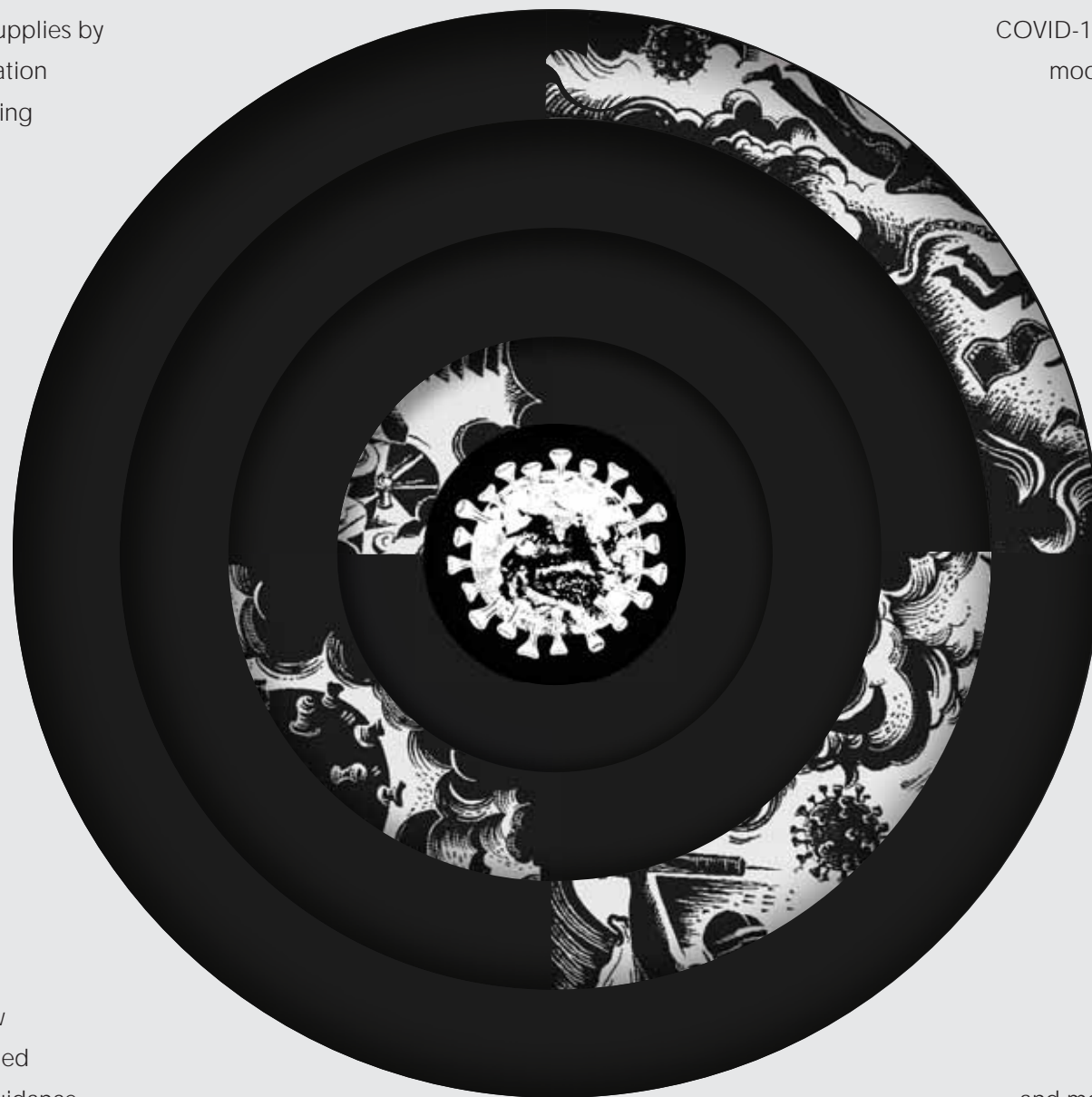
4. Not losing sight of essential health services and the non-health implications of COVID-19. WHO played a major role in leveraging networks at the global and regional levels to secure large quantities of supplies and distribute them. Due to lockdowns and restrictive measures, essential health services were disrupted. The Regional Office worked closely with ministries of health to ensure continuity of supplies by conducting rapid situation assessments, developing forecasting tools and providing technical support to the non-health sectors.

Collaborations were entered into with business continuity plans that were already in place and were now adapted to suit changed priorities. Technical guidance and support were provided through meetings by video- and teleconference.

5. Sharing knowledge resources along with experience and skills to strengthen regional cooperation. As the pandemic evolved, the limitations and differences in the capacity of health systems within the

Region became evident. While WHO and international partners took a risk-based approach and stepped in to strengthen responses, the Region saw fine examples of camaraderie and cooperation. Member States helped each other through various solidarity measures. A special South Asian Association for Regional Cooperation (SAARC) emergency fund along with an Association of Southeast Asian Nations (ASEAN) COVID-19 Response Fund were also mooted to mobilize funding on a case-to-case basis.

Each of the strategic shifts had a cross-cutting impact on one or more of the pillars of response to the COVID-19 pandemic. These pillars included country level coordination, planning and monitoring; surveillance, rapid response teams and case investigation; laboratory strengthening; clinical case management to reduce complications and mortality, International Health Regulations (2005) and screening at points of entry through air-, sea- and ground-crossing routes; infection prevention and control; risk communication and community engagement; operational support and logistics; and maintaining essential health services and public health programmes.



Adapting to the “new normal”

As countries “unlock” and resume various functions, they also find themselves experiencing a new wave of outbreaks and hotspots.

They will have to continue building their resilience so that they are not vulnerable to epidemics and future shocks. Individuals will have to adapt their behaviours and actions and follow preventive measures so that they can deal with a resurgence of the virus.

Countries must find ways to maintain availability and access to essential health services so that they can manage and contain spurts in the outbreak. Specific vulnerabilities will need to be addressed, whether they relate to improving sanitation or providing better living conditions for migrants or ensuring uninterrupted services for those suffering from communicable and noncommunicable diseases.

Actions that have worked well and shown results will have to be expanded and taken to scale. More effective use of technology

must be backed with affordable access to lesser served populations so that a more inclusive community can be built. Familiar disease control priorities – HIV/AIDS, tuberculosis, malaria, polio – will have to be maintained so that they are not neglected; and those in need of treatment and services, especially for NCDs and mental health, will need attention. Governments must consult and engage more broadly across disciplines and sectors, both within and beyond health if they have to move together to achieve better health coverage and outcomes. WHO has provided “Access to COVID-19 Tools” (ACT) to ensure easy, unhindered, timely, affordable and equitable access to diagnostics, medicines, vaccines, medical equipment, and preventive, protective and curative health services to tackle the pandemic. This needs to be ramped up in the months to come because even countries that traditionally had no capability in these areas will seek to develop the same.

Emergency mechanisms would need to be further scaled up and a network of health facilities and hospitals for triage and surge activated to avoid overcrowding. Self-initiated isolation by people with mild disease would continue to be the most important community intervention to reduce the burden on the health system and reduce virus transmission. Testing of all suspected cases, and symptomatic contacts of probable and confirmed cases will have to remain a priority. While countries carry out their own assessments of how they have responded to their specific challenges so far, WHO will be actively supporting them with clinical management, strengthening of laboratories, restoration and maintenance of essential health

services and public health programmes, epidemiology, surveillance and analytics, logistics and supplies.

Policy formulators, implementing systems and partners must indeed shift their vision ahead so that they can contribute to shaping the life and survival of future generations. The “shift” that the COVID-19 pandemic has created has cut through all systems and routine life patterns across the world, without any discrimination. It should not be ignored or taken for granted. It has kicked off a new era full of questions that will need immediate attention, answers and remedial immediate and long-term solutions.







CHAPTER 1

A VIRUS DISRUPTS THE WORLD

The year 2020 will go down in human history as one that redefined modern humans' way of living, working, moving and navigating their immediate and surrounding environment. As the new year dawned, the world watched with trepidation, disbelief and fear, a new coronavirus – severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) – searing through the wet markets of Wuhan in Hubei province of China. The first confirmed coronavirus cases outside China were reported on 13 January 2020 in Thailand. On 21 January, the first case in the United States of America (USA) was identified in Washington state before being detected in Europe and then the rest of the world, including Asia.

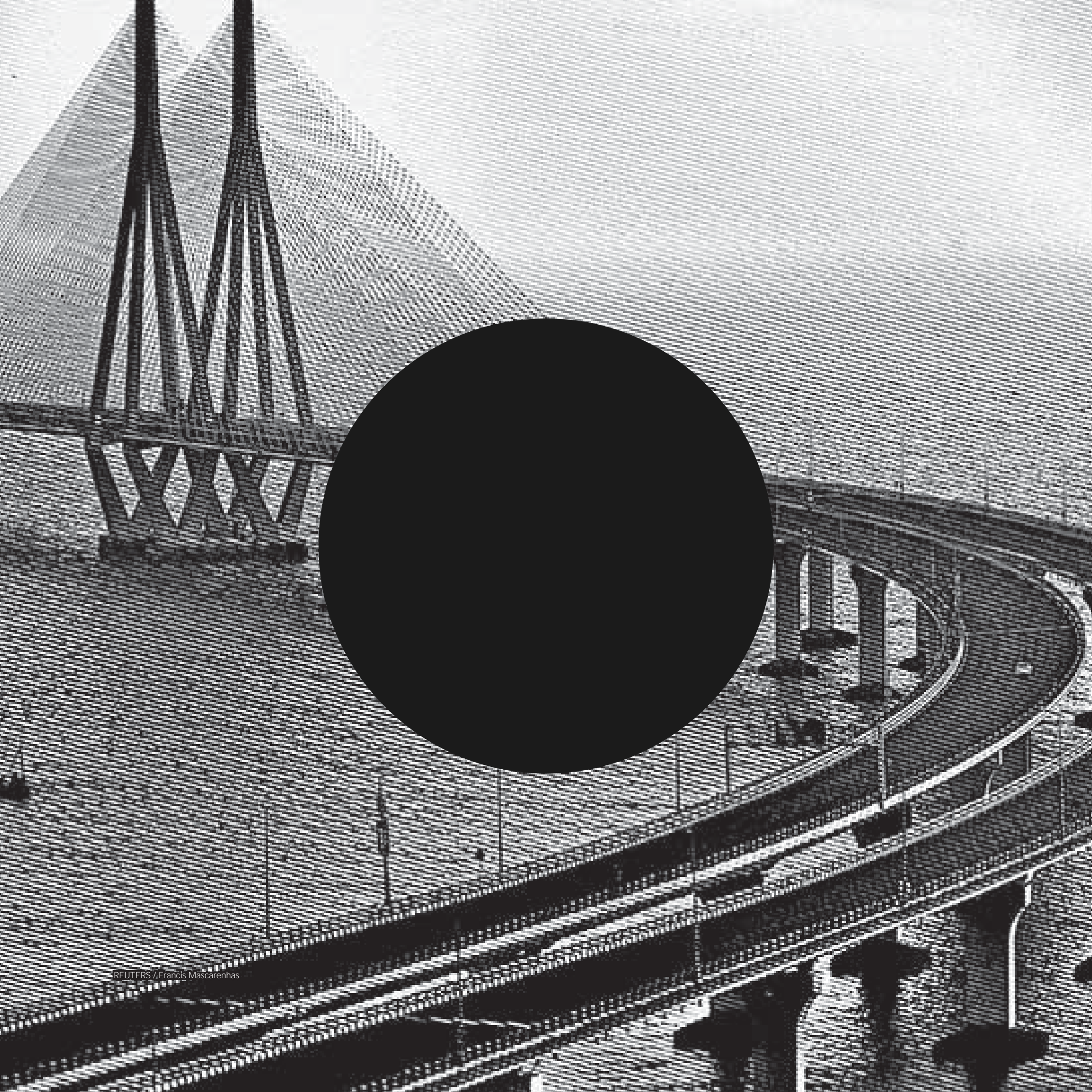
Countries that had sophisticated health-care systems, such as Italy, Spain and America, state-of-the-art medical



With the exponential growth in coronavirus disease 19 (COVID-19) cases and its rapid spread across the globe, WHO declared it as a Public Health Emergency of International Concern (PHEIC) on 30 January 2020 and as a global pandemic on 11 March 2020. The COVID-19 pandemic has been ranked as the worst in a century, not

infrastructure and some of the finest doctors and members of the scientific community, tried hard to cope as they valiantly fought an unfamiliar enemy. People across the world, including countries of the World Health Organization (WHO) South-East Asia (SEA) Region, were deluged with real-time information as well as misinformation that streamed in through the news, videos, social media and first-person accounts from hospitals and intensive care units (ICUs), cemeteries, government media briefing sessions and frontline warriors. They began to prepare for the inevitable as the virus stealthily crossed over first to Thailand on 13 January 2020 through an evacuee from China and was later reported in all countries of the Region, except from the Democratic Peoples' Republic of Korea (DPR Korea).

just because of the human casualties and the cost to the health system worldwide, but also because of the way in which it has literally "shut down" the world in a way never seen before. No pandemic is said to have had such a brutal impact on the economy as COVID-19 has, triggering a near-total shut down of social and economic activity.



Dealing with pandemics, including COVID-19

Prior to COVID-19, the world experienced these major pandemics:

1

The **bubonic plague** between the **14th and 17th centuries**, which caused an estimated **200 million deaths**

2

The **seven waves of pandemic cholera** over the past **200 years** with an estimated annual case burden of 1.3–4.0 million and **21 000 to 143 000 deaths** worldwide



5

The **2009 Influenza pandemic** (AH1N1pdm09) resulted in over **18,000 deaths**

4

The **1957–1958 pandemic (H2N2 virus)**, which recorded an estimated **1.1 million deaths** globally

3

The **1918 influenza pandemic**, which saw an estimated **50 million deaths** worldwide

Source: Centers for Disease Control and Prevention

Similar emergencies that occurred in the past include the severe acute respiratory syndrome (SARS), the Middle East respiratory syndrome (MERS), Zika and Ebola virus diseases. However, the novel coronavirus (COVID-19) is unprecedentedly unique because it continues to affect more and more people over time. Not just that, it is also going beyond the existing capacities of clinical care facilities and taking a toll on vulnerable populations with pre-existing chronic health conditions and compromised immune systems. Its highly contagious nature has made it even more complex for all stakeholders. In the absence of a vaccine or drug at this point, the concern of national governments, the health sector and the general population is certainly not misplaced.

Six months and more than 10 million confirmed cases later and a disease burden that is still rising, COVID-19 has catalysed a research revolution where scientists, doctors and researchers are working at breakneck speed to comprehend the virus and make a vaccine available, even though for every insight gained, there are just as many confounding questions that remain unanswered.

Regional emergency preparedness and operational readiness

In 2014, WHO Regional Office for South-East Asia under the leadership of the Regional Director, identified seven Regional Flagship Priorities that would define Member States' focus, and which would most

efficiently advance health and well-being across the Region. They were aligned with the Sustainable Development Goals (SDGs) for Health, and WHO's global triple billion targets: a billion more people benefiting from universal health coverage (UHC), a billion more enjoying better health and well-being, and a billion more better protected from health emergencies.

Flagship 6 specifically focuses on "scaling up capacity development in emergency risk management in countries" to support Member States in sustaining and consolidating their health emergency capacities and build greater resilience against hazards prevailing in the Region.⁽¹⁾



The International Health Regulations (IHR 2005) are a powerful tool that can strengthen country health emergency capacities to build emergency preparedness and operational readiness. As an updated and legally binding instrument, they mandate all Member States to share information on public health threats of international significance and oblige them to strengthen their capacities for public health emergencies of international concern, including pandemics. Countries self-report annually on 13 core capacities and are externally evaluated on 19 technical areas. These have enabled them to progress considerably since the last pandemic of influenza A(H1N1)pdm09. However, as COVID-19 has revealed, even in developed countries, the IHR (2005) needs much more strengthening, given the nature of concurrent pandemics, aggravated with the cross-border movement of people, goods and services.

According to the resolution of the Seventy-second session of the WHO Regional Committee for South-East Asia, all Member States signed the Delhi Declaration on Emergency Preparedness in 2019, committing to scaling up capacities in disaster risk management and emergency preparedness by identifying risks that were unique to their setting. The focus was on investing in people and systems for risk management, especially with respect to strengthening IHR core capacities, carrying out safety assessments of their health facilities and building surge capacity; developing and implementing national action plans for contingencies and testing them for operational readiness. Most importantly, the need for a firm focus on the interlinking of sectors and networks was further formally expressed so that in the event of an

emergency, each institutional partner could seamlessly join hands and mitigate the impact of that particular disaster or outbreak.

In the context of each country's risks and vulnerabilities, these commitments have since been put into action. They are a major contributor to building the resilience of the Region and its response to any given disaster that may strike. In the case of COVID-19 too, this helped Member States put forth their response strategies. Having had some lead time, national governments and local communities could finalize mechanisms and alternatives to deal with infections and any repeat waves of infection that may be seen in the coming months.



WHO SEARO / Bangladesh



Evolution of the COVID-19 pandemic in the SEA Region

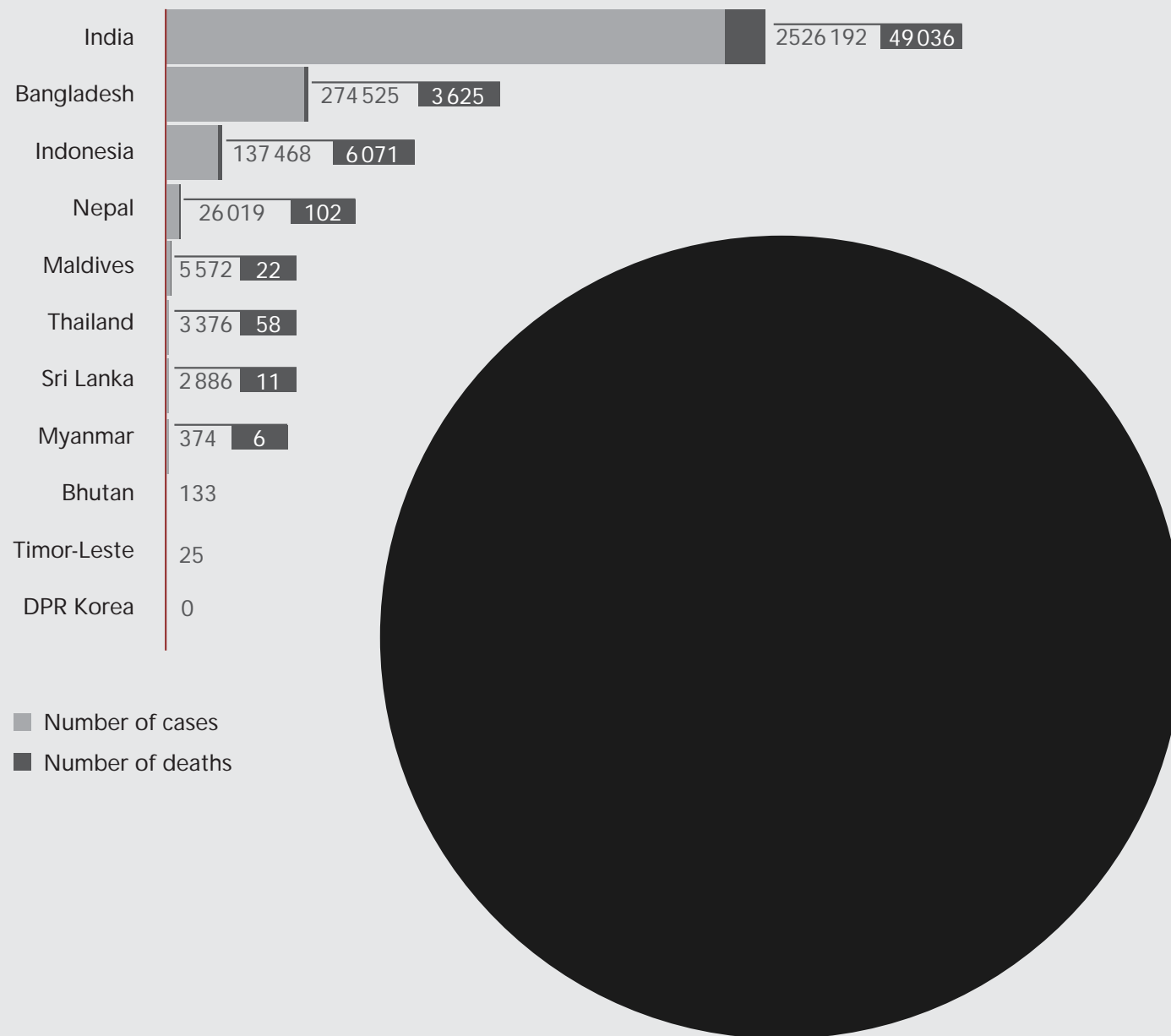


Fig. 1.1. Cases and deaths reported in Member States of the SEA Region on 15 August 2020

As of 15 August 2020, the SEA Region had reported over two million cases (2 976 570) (and 58 931 deaths) in 10 countries, with a case fatality rate (CFR) of 2.6% (Fig. 1.1). The age and gender distribution of the reported cases and risk factors for severity in the Region overlap with the overall trends seen elsewhere globally.

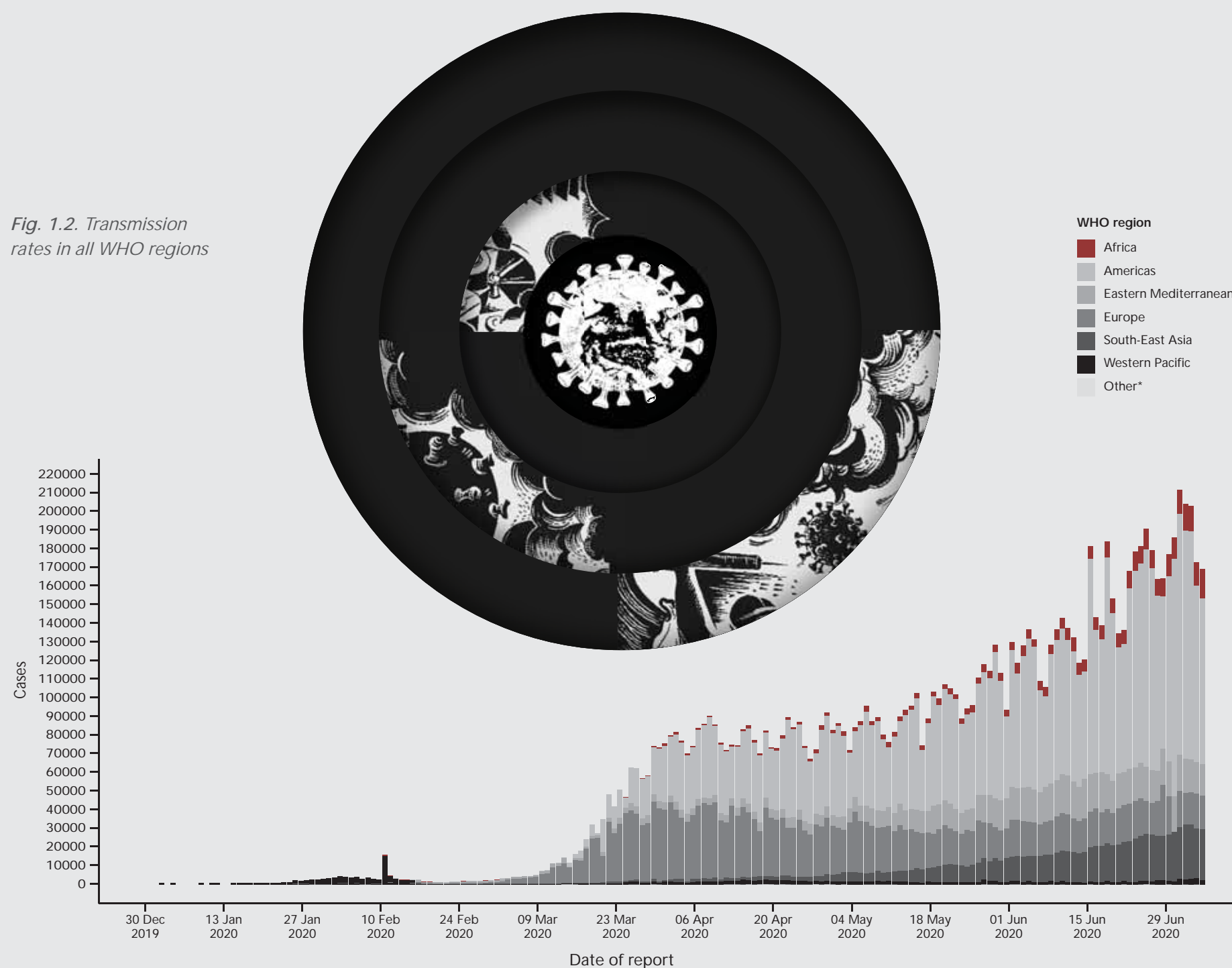
Within the Region, as of 15 August 2020, India has reported the highest number of cases (25 626 192) and stands third highest in the number of reported cases globally, followed by Bangladesh (274 525) and Indonesia (137 468). Thailand has not reported any local transmission in 82 days.

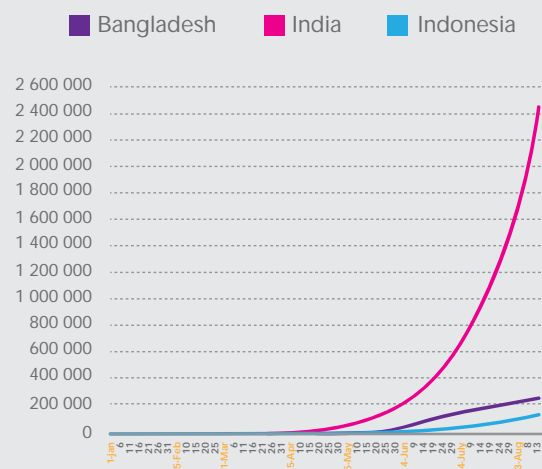
Main drivers of the pandemic

Currently, the epidemic in the Region is being largely driven by three countries – India, Bangladesh and Indonesia. These countries have been witnessing widespread community transmission since April–May 2020. Others are witnessing clusters of transmission and sporadic cases. Notably, three countries have managed to prevent or contain community spread. Thailand managed to do this

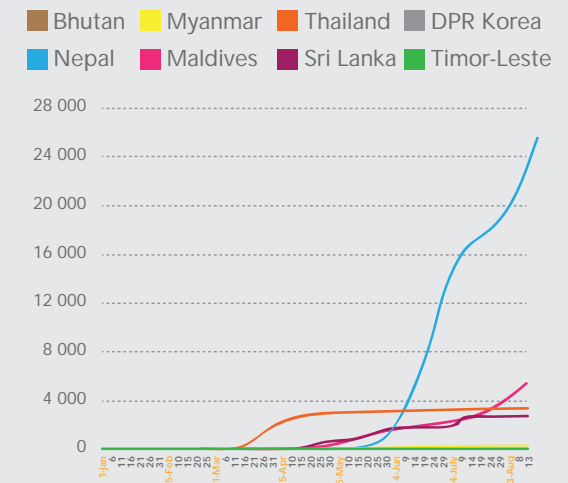
after a brief period of community spread; Sri Lanka succeeded in containing the outbreak to clusters in military camp, whereas Maldives enhanced its response to trace >99% of cases, thus preventing community spread in their densely populated capital city of Malé. Bhutan and Myanmar also managed to contain the epidemic to limited local chains of transmission or among returnees (Fig. 1.2).

Fig. 1.2. Transmission rates in all WHO regions





COVID-19 Cases in Member States of South-East Asia Region as of 15 August 2020



Factors contributing to the spread of the virus

Once introduced, the spread of the virus was facilitated in most countries through the high density of their populations as well as frequent population movement, especially within large individual countries such as India, Indonesia and Thailand. While the current pandemic has been unprecedented in terms of scale and speed and is continuing to test both well-developed and less developed health systems alike, there have been other important systemic factors, such as limited surveillance capacity, more so for respiratory pathogens, limited laboratory capacity, lack of trained human resources and the underlying challenges of access to health care combined with large subnational variations. In addition, the Region is known to be vulnerable in terms of public health and socioeconomic indicators that have a direct linkage to ensuring compliance with and political buy-in for public health measures.

The first case in the Region was reported in Thailand on

13 January 2020 through importation from China. In other countries of the Region, there was an importation of cases, initially from China and then mainly from Europe and the Middle East. Importations occurred both through visiting tourists as well as returning nationals. The major risk factors that facilitated this importation were extensive travel and tourism links between Member States of the SEA Region and China and Europe, large migrant populations, both within and outside the Region, especially those who moved back to the Region, including through porous borders in some situations.

While the current pandemic has been unprecedented in terms of scale and speed and is continuing to test both well-developed and less developed health systems alike, there have been other important systemic factors, such as limited surveillance capacity, more so for respiratory pathogens, limited laboratory capacity, lack of trained human resources and the underlying challenges of access to health care combined with large subnational variations. In addition, the Region is known to be vulnerable in terms of public health and socioeconomic indicators that have a direct linkage to ensuring compliance with and political buy-in for public health measures.



In addition to the above risk factors and vulnerabilities, the initial response of many Member States in the Region has been characterized by other critical gaps. Overall, surge capacity has been limited and testing strategies have not been responsive enough to cope with the demands of the fast-emerging epidemiological situation. This has at times led to over-testing and testing of less relevant group/s from the perspective of outbreak control. Combined with these have been gaps in information management and transmission of

information for timely and evidence-based decision-making. All these have made monitoring the progress of the outbreak a challenge for both Member States and WHO. Compounding the problem further has been the difficulty in ensuring and estimating the effective reproductive number, burden of disease, growth rates, doubling times and rate of test positivity. These are common indicators that have been difficult to estimate and monitor in the absence of or limited surveillance information.

Addressing on-ground challenges

With technical support from WHO, national governments have been able to rapidly establish surveillance and contact tracing systems that are needed for early detection and isolation of cases and tracing and quarantining of contacts. The necessary guidance and regional context

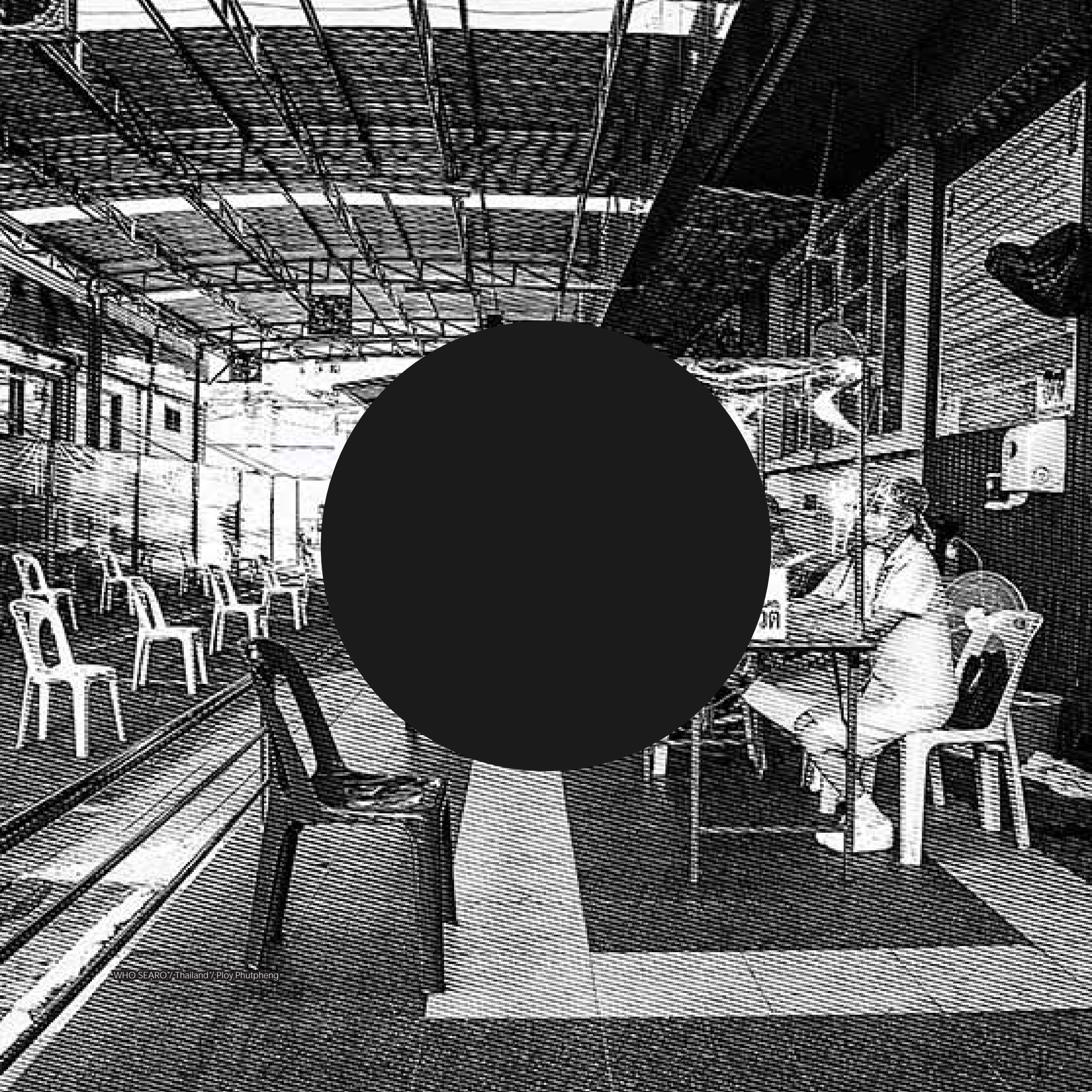
were duly provided by the **Regional Surveillance Strategy** that included surveillance at points of entry (PoEs), **event-based surveillance** and enhancement of routine **surveillance systems**, among others. Given the critical importance of contact tracing, support was provided by



WHO SEARO / Maldives

the roll-out of the Go.Data contact tracing software whenever requested by Member States, with the aim of improving the efficiency and quality of the contact tracing function. Eventually, diverse approaches were taken to contact tracing, ranging from the use of existing technology-based solutions such as Go.Data to the use of Excel spreadsheets and even paper-based data management. Similarly, laboratory capacity for detection of COVID-19 infection was also

established and gradually scaled up. However, this was often constrained due to a shortage of reverse transcriptase-polymerase chain reaction (RT-PCR) test kits, which led to the introduction of different rapid tests and point-of-care tests by individual countries. As part of the Regional Surveillance Strategy, a regional reporting platform was developed and offered to country offices to enable better monitoring of the pandemic's progression.



Enforcing public health and social distancing measures

In addition to strengthening surveillance, most countries enforced public health and physical distancing measures or “lockdowns” of varying coverage and degree to slow down the spread of the virus and prepare health systems for possible community transmission. Even as countries grappled with the crisis and the decisions of their national governments, lives began to change dramatically.

Whether driven by fear and anxiety or by social pressure and legal directives, the lockdowns brought with them major shifts in how people had led their lives this far. As the months rolled on and the official lockdowns, quarantines and restrictions on physical movement began to get lifted in part or whole, countries, governments, health systems, companies and communities realized that this pandemic, however grave and debilitating, was fundamentally different from other, more traditional health and business continuity threats.



In low- and middle-income countries, the lockdown most impacted people without secure housing, water and sanitation, and reliable employment. Their “locking themselves out of the virus” meant facing devastating economic and health consequences. It was clearly a Catch-22 situation, where if they went about conducting business as usual, they faced the risk of getting infected and if they stayed at home as was being directed, they risked losing their livelihoods and sources of sustenance. At the national level, countries were grappling for securing their medical and other essential supplies. With the closure of national and international borders, the movement of goods and services was bound to be affected. The absence and shortage of critical human resources would impact every conceivable sector of the economy.



CHAPTER 2

SHIFTS IN THE COVID-19 RESPONSE
WITH EVOLVING NEEDS



As of August 2020, it would be six months since the first case of COVID-19 was detected in the SEA Region. As WHO's Member States begin to emerge from different stages of lockdown, many are experiencing challenges and constraints across sectors.

While some are managing to return to normalcy, others are seeking clarity on how to resume community lives and get their economies back on track. Countries soon realized that the exponential increase in the caseload of COVID-19 might surpass the existing capacities of the clinical and public health institutions and programmes if they did not find ways to contain the spread of the virus and equip their health systems with additional resources and a redistributed workforce.

While new vaccines and treatment protocols are still in different stages of development and testing, the Regional Office has adapted standard global protocols to suit regional and country-specific scenarios. Existing preparedness and pandemic plans were activated in the initial days of the pandemic, even as a spontaneous and "adaptive response" deftly cut across all strategic interventions that were being implemented. These measures were related to testing, managing essential supplies, undertaking solidarity measures

by countries to reach out and help one another, sharing technical expertise and leveraging technology and online resources. All this was being done while educating and urging communities and high-risk groups to adhere to the globally recommended Public Health and Social Measures (PHSM) guidelines.



Just the way this pandemic was unprecedented in its rapid spread, the regional response too was acknowledged as being one of its kind. Why this response was unusual was because countries were still "inadequately informed" about the novel pathogen and had to mobilize their resources, actions and decisions based on their shifting understanding of the pandemic. This was largely due to the absence of any precedence on how to deal with it. In the initial stages, countries decided to close their borders, exercising the sovereign right of protecting their populations, halt airline services, shut down schools and offices, and announce curfews in attempts to curb transmission, even though it disrupted global trade and emergency supply chain systems.

The extreme measures of closing down national and international borders led to a situation where manufacturers of essential emergency items struggled to supply these even as countries in acute need of these items were ready to pay but could not access them. The extent to which these measures dampened the impact of the pandemic, flattened its curve and improved survival and delayed cases is something that is being evaluated. However, in the interim, countries have demonstrated noteworthy innovations, taken decisions that are out of the box and stepped up routine strategies that were developed and used for earlier outbreaks and emergencies. These were enhanced not just at the political level but also at the health, community, household, media, corporate and nongovernmental organization (NGO) levels. Inevitably, routine strategies have been adapted by countries to their COVID-19 response, in addition to new measures that they have implemented with good results.



This section examines how the Region has controlled (and continues to do so) several dimensions of the pandemic by bringing a timely and strategic “shift” in each of the nine pillars of pandemic response.

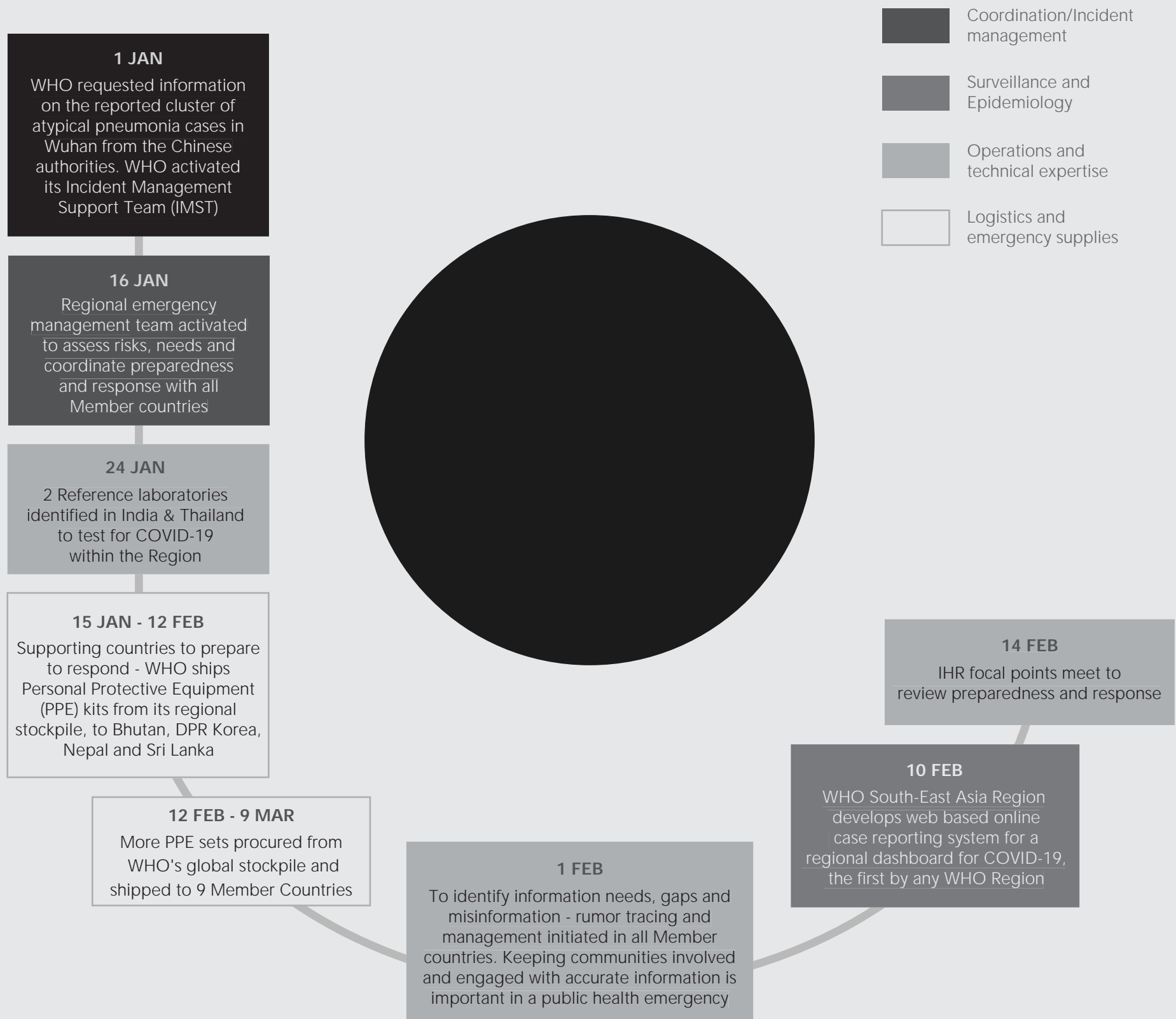
These pillars are based on identified gaps and risks in self-assessment by Member States and key priorities identified by WHO to meet strategic objectives.

Documenting these adaptive “shifts” will pave the way for refining them further and institutionalizing them, so that they become part of the overall pandemic preparedness and response strategy as we move forward.

A chronology of key response activities is summarized in a timeline that has been developed as per actions and decisions taken post-December 2019 up till August 2020 (Fig. 2.1). Against this backdrop, five important “shifts” have been highlighted followed by key actions taken by the Region along the nine pillars of response. The section also looks at areas that go beyond the pillars, in an attempt to provide a comprehensive overview of how Member States are responding to COVID-19.



Fig. 2.1 Chronology of key response activities and Support to Member States



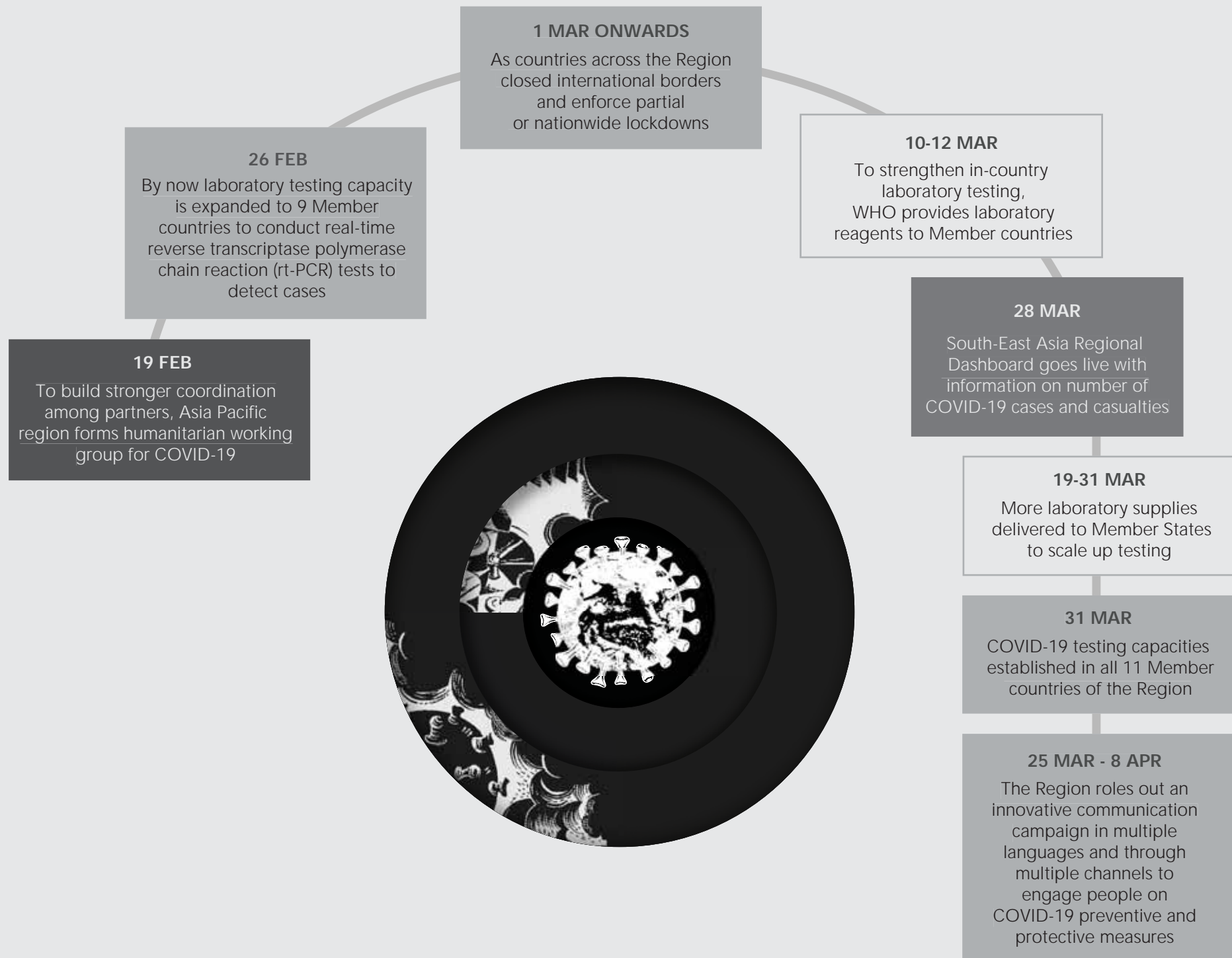
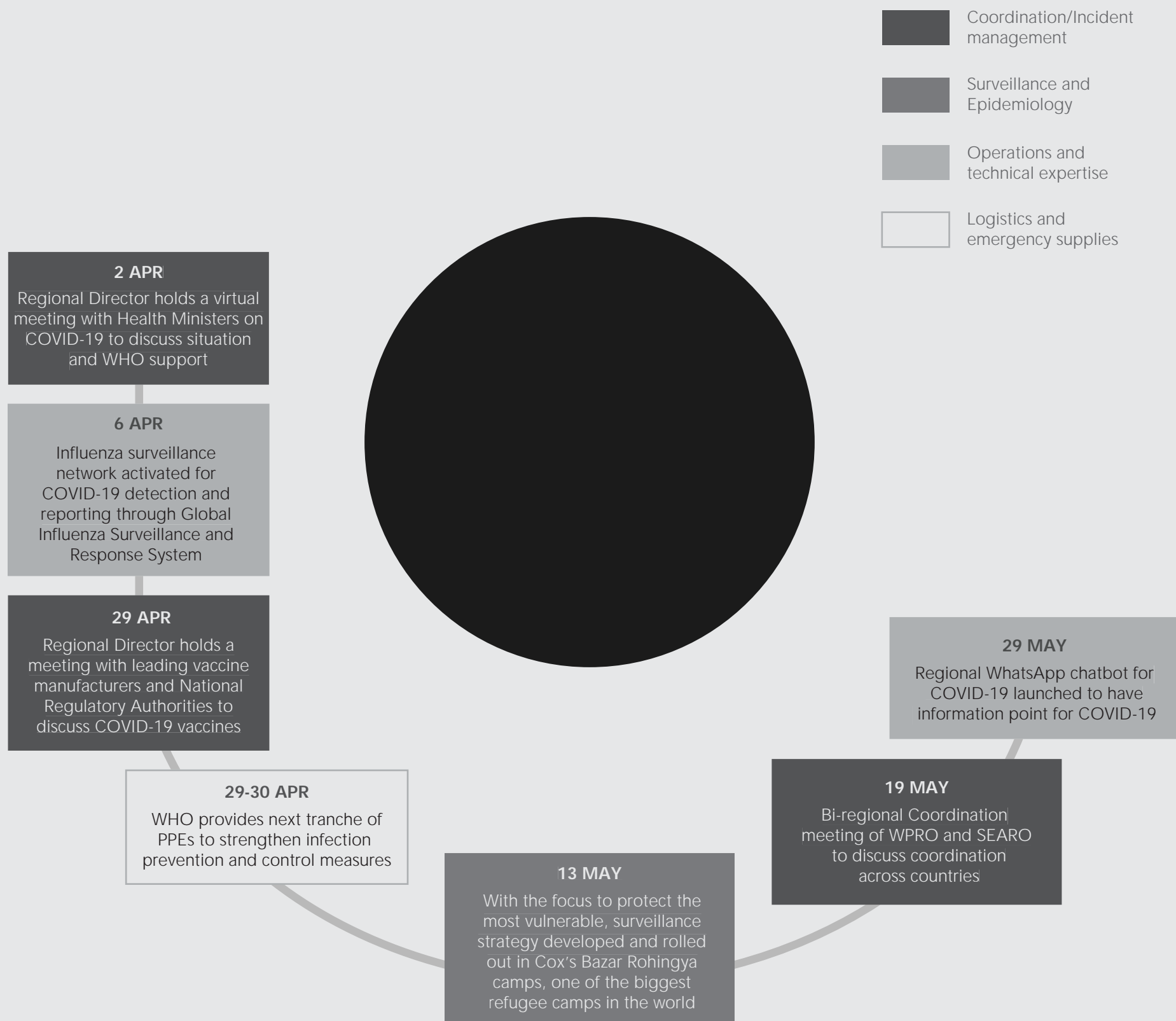
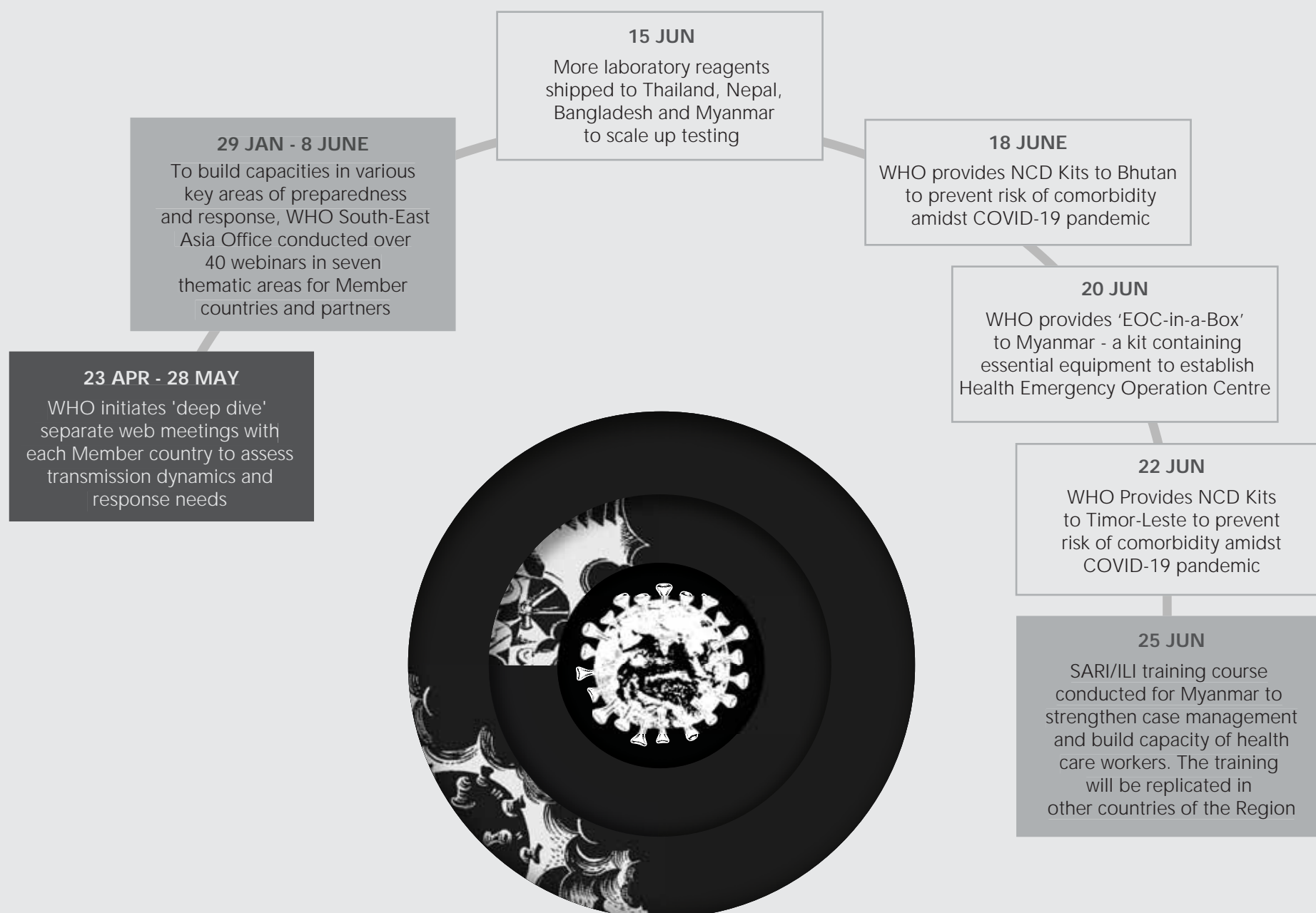


Fig. 2.1 Chronology of key response activities and Support to Member States





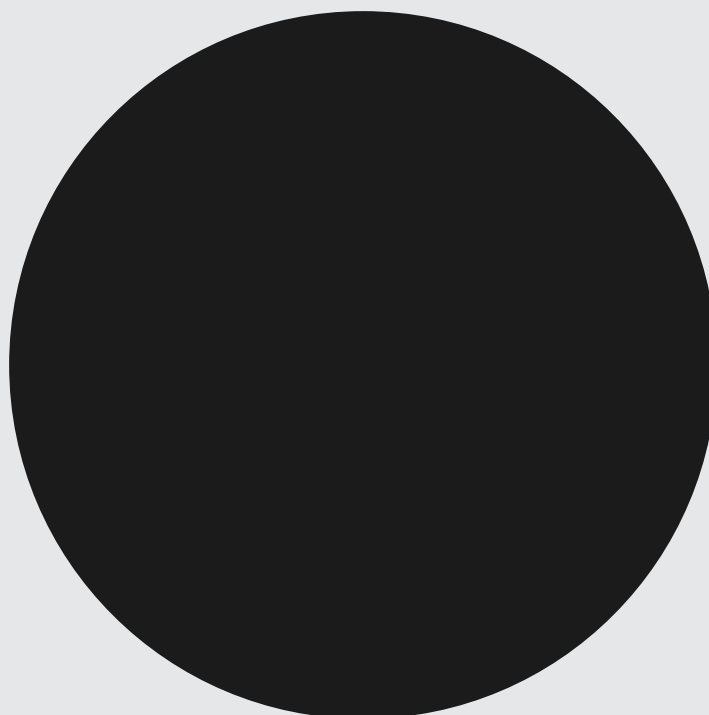
* Only few major activities enlisted

A. Shifts in the regional response

SHIFT 1:

Making an extra effort to strengthen coordination across different levels

The Regional Office activated its teams to provide strategic, technical and operational support to Member States, keeping in mind their unique attributes and risk factors. It collaborated extensively with partners from the health domain and beyond. Important coordination mechanisms were put in place within the Regional Office, between the Regional Office and WHO country offices in the SEA Region, between WHO and the ministries of health and between the United Nations (UN) agencies themselves. At the level of Member States, national Health Emergency Operation Centres (HEOCs) were activated early in the pandemic to provide a strategic coordination mechanism to monitor implementation of response operations such as the incident management support teams (IMSTs) interlinking subnational HEOCs. Unlike in usual emergencies when the incident management system (IMS) is confined to one or two countries, this time all affected countries in the Region



activated their incident management teams. The IMST and Regional Office assigned two staff as country focal points for each country to provide effective and efficient support.

Sensing the urgency to step up the response, additional coordination mechanisms were created to deal with the scale of fast transmission to new countries and regions. The UN Agencies and Cluster mechanisms, international organizations, partners and networks in the Global Outbreak Alert and Response Network (GOARN), emergency medical teams (EMTs), the Asia Pacific Risk Communication and Community Engagement Working Group and national and international NGOs, regional networks and research partners involved in the development of diagnostics, vaccines and therapeutics were all pulled in to work closely with WHO under the Global Partnerships Forum.¹

¹The Forum brings together up to 150 participants, including representatives of Member States, intergovernmental organizations and relevant non-State actors (academic institutions, civil society organizations, philanthropic foundations and private sector entities), upon invitation. Participants are encouraged to nominate senior decision- and policy-makers in the areas of international development, international cooperation and/or health.

At the country level, national response efforts were supported to increase surveillance and implementation of PHSMs. Most countries in the Region developed strong general command and coordination mechanisms at the national level with a public health emergency response plan to address the outbreak of respiratory illness, emergency operations centre and IMS, multidisciplinary emergency response committees, partners for supporting the response, political engagement as well as public health laws pertaining to infectious diseases (e.g. quarantine). Almost all countries committed to mobilizing government funds if the need arose and their COVID-19 situation worsened.(2)

Existing public health emergency preparedness and response plans were applied, and national emergency response committees briefed. WHO worked closely with decision-makers and political leaders at every stage of the evolving pandemic, gauging the needs of public health, the general population and vulnerable groups, speeding up development of country plans for distribution of health and non-health supplies that could address medical concerns, as also essential services and business continuity and recovery operations.



SHIFT 2: Adapting response mechanisms to evolving knowledge about the virus

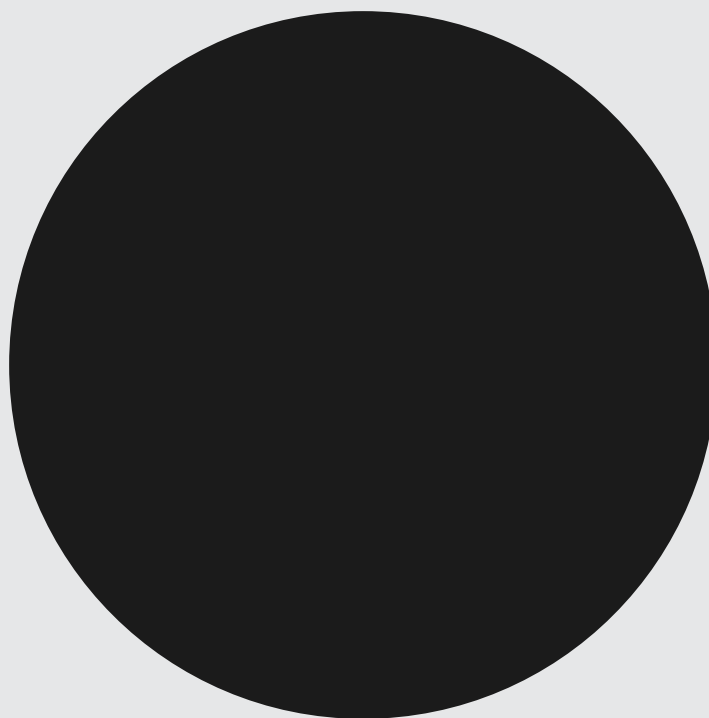
Right from the outset, the regional response to the pandemic had regional limitations and specificities. It became incumbent upon WHO at the regional and country levels to ensure timely and contextual adaptation. This applied to strategies, standards, guidance, standard operating procedures (SOPs) and advice such as systematic and regular risk assessments aimed at finalizing evidence-based and effective actions. Contingency plans were constantly adapted and contextualized as countries undertook strategies for “identifying, testing and treating” COVID-19. These risk assessments (country profiles) were useful in not only guiding response but also monitoring transmission dynamics and epidemic trends.

To operationalize these adaptations, direct technical support to countries was stepped up so that they could develop strategies and SOPs for contact tracing, risk assessment, modelling and surveillance. Existing surveillance systems (such as for SARS) were enhanced and teams operationalized for contact tracing and monitoring. A Regional Surveillance Strategy, complementing the WHO global surveillance guidance, was provided to Member States to monitor emerging trends.

By 10 January 2020, WHO published advice and technical guidance on important issues to enable all countries to prepare better for managing an increasing number of cases.

The Region was quick to draw from its past experience of managing pandemics and adapting these lessons to the ground situation as and when new information about the virus became available. In the first few weeks of 2020, not enough accurate knowledge was forthcoming so guidance at the time drew from past experience with SARS and MERS and other known modes of transmission of respiratory viruses. It guided the infection and prevention control (IPC) measures that were followed to protect health workers. Advice on droplets or aerosol-generating procedures and contact precautions when caring for patients were recommended as panic was rising and a (mis)information explosion was seen. Many countries revisited past training and readiness checklists to adapt these to the COVID-19 context.

The simulation exercises that were held previously as part of readiness training were conducted again across the Region with the aim of strengthening the response.⁽³⁾



স্বাস্থ্য পরামর্শাবলি

স্বাস্থ্য পরামর্শাবলি

- হাত ধোয়া
- মাস্ক পরিধান
- স্বাস্থ্য পরামর্শাবলি



স্বাস্থ্য পরামর্শাবলি

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Many existing pre-pandemic mechanisms and for which preparedness and training had already been done came in handy, demonstrating the Region's readiness to handle a calamity of a large magnitude. As the situation evolved, the Region showed flexibility and openness in its response. Supported by the WHO Health Emergencies and Health Systems departments and the Empowered Group's activities, they were guided on activating and building existing strengths and mechanisms that prevailed as part of their laboratory networks. They further developed surveillance of respiratory pathogens under the influenza pandemic preparedness plans and regional readiness training.

At this point, there was another important shift in the COVID-19 response. This was around how countries managed their risk communication strategies. The global pandemic saw news travel across borders with lightning speed and not always in an authentic manner. Even countries with limited capacity for risk communication realized that they had to step up and look at this aspect seriously. In the absence of a vaccine, non-pharmaceutical interventions (NPIs) were recommended and these needed to be communicated and practiced. Countries reallocated staff as risk communication focal points and deputed risk communication and community engagement staff to work closely with rapid response teams to make sure that people self-reported to the concerned authorities during contact tracing activities.



A major shift that was seen in risk communication and community engagement related to the management of infodemics. For the first time, all countries put in place strong misinformation monitoring and response systems, with hotlines, digital monitoring, fact checkers and a network of community health volunteers. Artificial intelligence tools and chatbots were developed. The Regional Office as well as many Member States partnered with established social media companies to highlight facts about COVID-19 and shared them with users in record time. Risk communicators scrutinized and undertook rumour management, devising ways of separating myths from facts. They had to simultaneously keep themselves abreast with the government response mechanism and translate relevant information with different target groups.

Keeping in mind the unique needs of the COVID-19 response, national communication and community engagement strategies were developed and aligned with global and regional guidance on risk communication and community engagement (RCCE). Focal teams coordinated and implemented strategies with government and nongovernment networks, partners, civil society and community representatives. They identified and established ongoing networks of trusted community influencers and developed mechanisms for rapid clearance and timely communication of key messages. The Regional Office developed a Regional Risk Communication Strategy for this "new normal" to meet the needs of Member States.

When countries were ready to open up after lockdowns, their decisions were again based on risk assessment and interim guidance that was provided as per the individual country's context, epidemiology and health system performance indicators.

Overall, WHO followed a “whole-of-society” approach with a “It’s on us to win the fight against #Covid-19” campaign.



IT'S
CORONA
VIRUS
TO WIN THE FIGHT AGAINST #COVID19



WHO SEARO / Bhutan

*BHUTAN
REPURPOSES
EXISTING
MEDICAL
CAMP KITS AS
TEMPORARY
FLU CLINICS IN
RECORD TIME*

Shortage of hospital beds and crowding of hospitals was anticipated as cases of COVID-19 began to rise. Learning from past experience, medical camp kits (MCKs) that were developed and used during the 2015 Nepal earthquake were quickly repurposed as temporary flu clinics in Bhutan. They helped to provide timely services to COVID-19-affected patients. The kits were already there as part of the emergency and preparedness measures and pre-positioning exercises undertaken for Member States by WHO. The solar-powered kits contain water and sanitation facilities and can be assembled within 24 hours, thanks to the training provided by WHO. The flu clinics were set up at a distance from the health-care centres to ensure physical distancing between routine patients attending the health centres and those with flu or COVID-19 symptoms. They provided inpatient and outpatient services with provision for male and female wards, staff and consultation rooms.



WHO SEARO / Bangladesh



INTERIM GUIDANCE ON MASS GATHERINGS IN THE CONTEXT OF COVID-19

With the announcement of lockdowns and strict penalties on violations, it was evident that large gatherings would not be without risk. However, lack of clarity and absence of uniform guidelines from a credible authority made it difficult to implement this public health measure. An interim guideline was announced on an emergency basis. Routine planning for mass gatherings included conducting of risk assessments to determine overall risk of disease spread. A risk assessment and mitigation checklist was provided to countries and organizers and staff of mass gatherings. The checklist included an operational tool offering guidance for holding meetings during the outbreak and was accompanied by the WHO COVID-19 Generic Risk Assessment Excel file that was to be read in conjunction with WHO's key planning recommendations for Mass Gatherings in the context of COVID-19 (interim guidance). By 10 July 2020, the WHO Mass Gathering COVID-19 Risk Assessment Tool was finalized for generic events, sports events and religious events. While WHO provided advice and technical guidance to host countries on public health risks, it could not uphold, postpone or cancel mass gatherings hosted by Member States.

SHIFT 3: Accelerating effective use of technology across all pillars of the response

The COVID-19 pandemic has transformed the global health community's acceptance and use of digital health technologies. The Regional Office was quick to adopt and normalize remote working early in the pandemic. Meetings went from "onsite" to "online" as cancelled and postponed meetings got a new lease of life. The bulk of the communication between teams and countries switched to digital formats. Efficient and time-saving systems emerged organically as entire teams and groups interfaced through audio and video telephone/mobile calls. These communication calls were made globally between emergency focal points from MoHs, the Regional Emergencies Director, incident management teams at country level, incident management regional support team at the regional level, several technology groups and others in the Region and within the countries themselves. An interconnectedness was seen, which was reassuring,



since barriers of distance and time had collapsed and merged simultaneously.

The South-East Asia Regional Knowledge Network of IHR national focal points (NFPs) and domain experts established in 2019 provided an online platform for free flow of information, knowledge and ideas, while hosting all virtual meetings, webinars and one-on-one interactions among those involved in the COVID-19 response from WHO as well as the NFPs. Technology bridged many a challenging barrier across functions and pillars of response. WHO used it to advantage by strengthening communication, surveillance, clinical and case management, and training. Teams across the Region overcame any technological reservations they had and showed a dramatic shift by taking to webinars to transfer technical knowledge, provide updates and share experiences.



Most technology platforms served to build confidence with safe and speedy links to the Regional Office, headquarters and the rest of the world. Another significant advantage was seen when nursing staff and health-care workers on the frontlines needed to be apprised of ground realities and important protocols. The imposed restrictions on movements catalysed the uptake of digital tools since there was not much time to print training materials, depute experts and travel to different locations. Online training proved to be an effective and reliable way of rapidly equipping health-care staff with knowledge, guidelines and SoPs.

The COVID-19 emergency prompted rapid preparation of materials that focused on critical aspects related to IPC, severe acute respiratory illness (SARI) and other severe illnesses. Keeping in mind the travel restrictions, an emergency “crash course” to train clinicians, doctors and nurses was developed by the Regional

Office–Integrated Management of Adolescent and Adult Illness (IMAI) Alliance and remotely delivered through a digital, online platform. The course was for health-care personnel and those on the frontlines.

Myanmar and Bangladesh have completed the training and other countries have enrolled for it. Technology was also used to strengthen surveillance through innovative, state-of-the-art, user-friendly tools like the Go.Data tool that was customized by countries for contact tracing, data entry and maintenance as well as for generating data and making projections. WHO’s Information Network for Epidemics (EPI-WIN) has convened over 44 technical webinars on various aspects of COVID-19 response ranging from contact tracing, laboratory testing strategy, field surveillance, Go.DATA implementation, clinical case management, infection, prevention and control, screening, quarantining and isolation at points-of entry, risk communication and community engagement to overall country-level preparedness and response planning.



SHIFT 4: Not losing sight of essential health services and the non-health implications of COVID-19

Seeing how Member States were severely constrained on account of medical supplies, protective gear and hospital beds, the Region was quick to assess its own capacities and find alternate solutions.

WHO played a major role in leveraging networks at the global and regional levels to secure large quantities of supplies and distribute them by systematizing what was rapidly turning into a fragmented, duplicative and competitive market scenario.

Due to the lockdowns and other restrictive measures, there was unprecedented disruption in the nature, scale and duration of essential health services (EHS). The entire health system (workforce and infrastructure) was reorganized to support the response to the pandemic, as it spread rapidly to different areas and clusters. In many places, immunization services were discontinued, and primary health care services suspended. Many disease control programmes suffered, with people postponing their hospital visits and cancelling surgeries for their noncommunicable diseases and other life-threatening conditions. Bearing in mind this situation and its implications on public health, the Regional Office collaborated with WHO country offices and ministries of health to activate business continuity plans (BCPs) that were already in place in all Member States. These were adapted to the changed



priorities and needs so that Member States could keep pace (if not be ahead) with the fast-evolving pandemic.

The Regional Office provided technical guidance and support to its country offices and ministries of health through one-on-one meetings by video- and teleconference. It worked closely with ministries of health to ensure continuity of EHS by conducting rapid situation assessments, developing forecasting tools and providing technical support to non-health sectors, demonstrating a high level of coordination and support to its Member States. Technical experts from departments within the Regional Office were involved in IMST to transmit appropriate and timely technical guidance to Member States. Governments responded differently, with each country facing trade-offs between the immediate need to manage the pandemic and the socioeconomic costs of doing so. The regional response strategy for COVID-19 was developed keeping in mind the manner in which the pandemic was spreading, with the majority of countries seeing imported and sporadic cases or even clusters of cases and others rapidly progressing to widespread community transmission.

SRI LANKA CLEARS IMMUNIZATION BACKLOG AND RESUMES ESSENTIAL HEALTH SERVICES

In March, immunization services in Sri Lanka were abruptly suspended following a nationwide lockdown. However, by end-April, a detailed assessment of the COVID-19 situation by the Epidemiology Unit of the Ministry of Health (MoH) set the ground for restarting the immunization programme. Guidelines were issued and virtual meetings held with regional epidemiologists and community physicians in provinces and districts, orienting them on safety protocols such as physical distancing, hand hygiene and wearing of masks to prevent COVID-19 transmission. Specialized training for health workers were held to guide them on how vaccines could be administered in accordance with COVID-19-related precautions. The Ministry urged the community to bring their children to the immunization clinics. Extensive communication campaigns through print and electronic media announced the resumption of immunization services. Women and children followed a rigorous appointment-only schedule put together by health workers and, by mid-May, the immunization backlog was cleared. Similarly, other essential services were operationalized. People who were staying away from health centres due to their fear of COVID-19 were brought back through active messaging by influencers and the mass media. The country showed how control measures could be balanced with efforts to safeguard livelihoods and ensure the well-being of its people.(4)

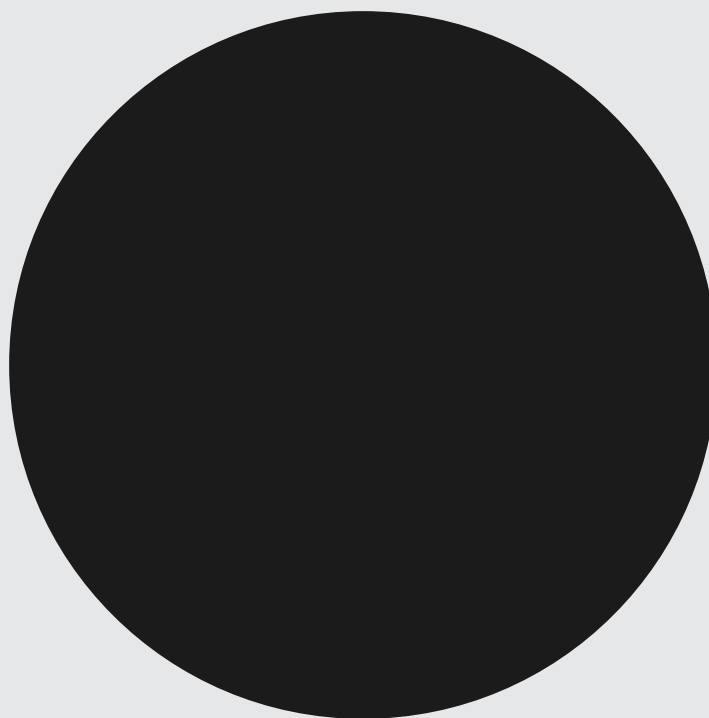




SHIFT 5: Sharing resources, knowledge, experience and skills to strengthen regional cooperation

As the pandemic evolved, the limitations and differences in the capacity of health systems within the Region became evident. While WHO and international partners took a risk-based approach and stepped in to strengthen the response, the Region witnessed some fine examples of regional camaraderie and cooperation. Nearly all countries rose to the occasion and gave a helping hand to their neighbours, keeping aside any difference they may have had. The COVID-19 pandemic had a unifying force that transcended barriers of international diplomacy and cultural orientations.

As a sign of solidarity, DPR Korea sent aid and medical supplies to China while Indonesia donated epidemic prevention and control supplies and Maldives donated one million cans of tuna to China. US, Japan and China donated test kits to Myanmar. Thailand allowed several international cruise ships to dock after they were denied entry in other countries. It shared its reference laboratories where nasal swabs from suspected patients were sent for testing to its



National Institutes of Health (NIH) by countries from the Region. India provided timely evacuation and quarantine support to foreign nationals in Bangladesh, Maldives and Myanmar. Several countries sent clinical samples to Pune's National Institute of Virology for testing high-risk pathogens till such time that their own laboratories were not ready. India also assisted the Government of the People's Republic of China by providing a consignment of 15 tonnes of medical supplies. Testing samples were sent to Bhutan and technical assistance provided in the form of protocols for screening passengers. The Indian government restricted the export of 26 active pharmaceutical ingredients (APIs) to produce life-saving medicines, including paracetamol, but in light of COVID-19, relaxed the restriction of essential drugs and other necessary drug materials. The setting up of a special South Asian Association for Regional Cooperation (SAARC) emergency fund, which was mooted recently, will provide funding support on a case-to-case basis.



WHO SEARO



EXPERIENCE-SHARING MEETING HELD ONLINE WITH 150 PARTNERS WITH FOLLOW UP 3 MONTHS LATER

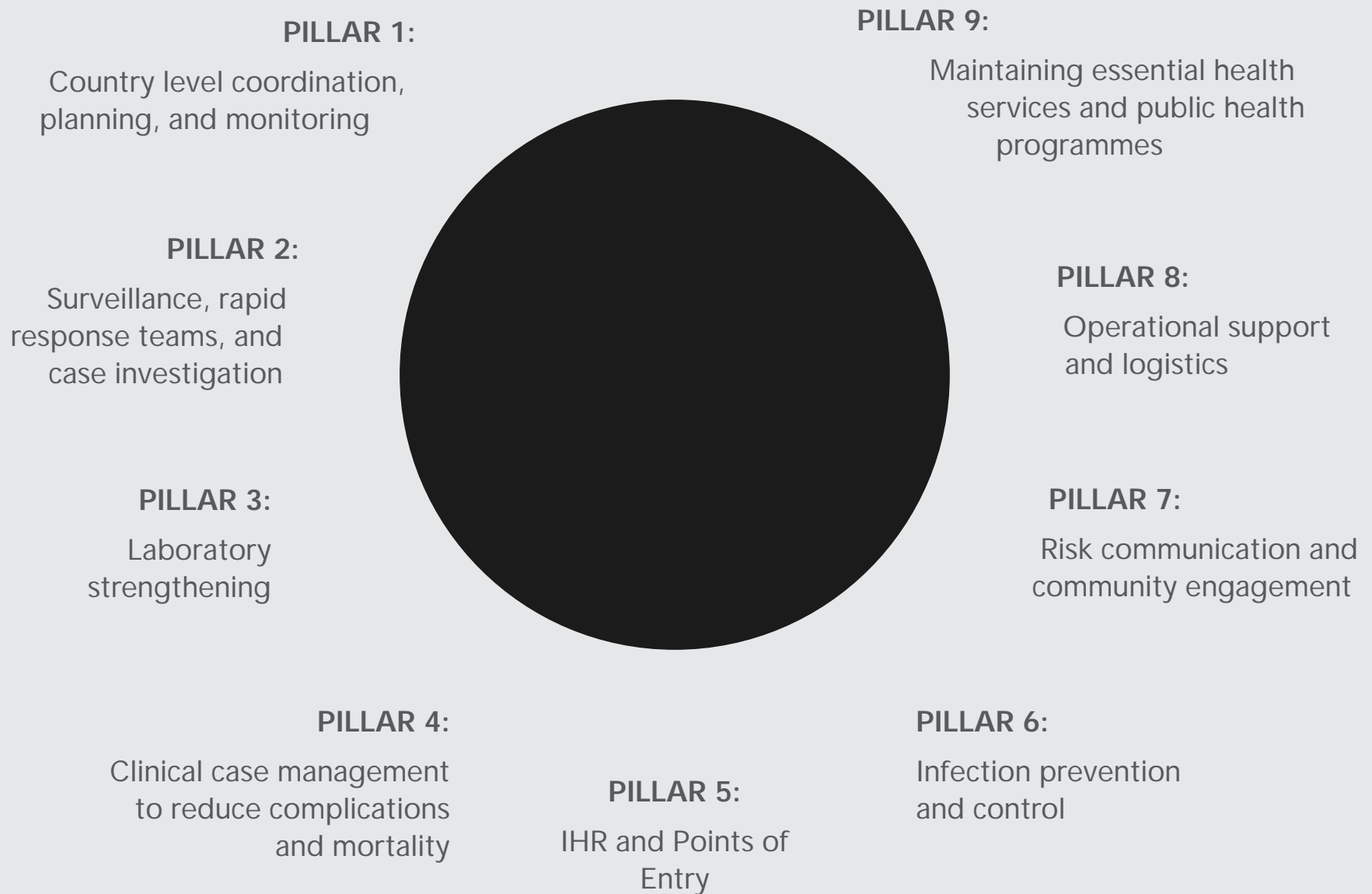
A first-of-its-kind online "Partners' meeting" was held with over 150 institutional, health and government partners from 11 Member countries. WHO facilitated the two-day "experience-sharing" workshop on 12-13 March 2020 to discuss ways of strengthening collective commitment and alignment of State and non-State actors to maintain essential health services. This was done at a time when health systems were overwhelmed due to multiple direct and indirect consequences of the pandemic. Partners shared experiences and suggested how to collaborate better for reviving essential health services.

The success of the meeting encouraged the group to reconvene four months later on 29 July 2020. Once again, the Regional Office hosted the Partners' meeting, focusing on where they were, given the increase in the number of cases and the "unlock" period in each of the countries.

B. Pillars of the regional response customized to COVID-19

The strategic shifts seen in the Region are having a cross-cutting impact on one or more of the pillars of response to the COVID-19 pandemic. They are playing a part in curtailing the ability of the virus to spread through communities. Some of the interventions and decisions are strengthening defensive measures that would help to limit the short-term

impacts of the virus, while others are providing insights on transitioning into the future, with a “new normal” establishing itself. The focus of the Region has so far been on reducing the severity of the disease by identifying, testing and isolating cases, thus minimizing the health and socioeconomic impact.



PILLAR 1: Country level coordination, planning and monitoring

1. The Regional Strategic Preparedness and Response Plan (SPRP) was developed in February 2020, in line with the global SPRP.
2. National response efforts were supported to increase surveillance and implementation of PHSM through the UN Country Team, Health Cluster, EMTs and GOARN partner networks.
3. Coordination capacities were enhanced of regional- and country-level supplies with centralized information to monitor demand and prioritize distribution.
4. Special task forces and empowered groups were set up in the Regional Office in response to the pandemic.
5. An ad hoc Working Group was set up with designated staff from the WHO Country Office for Thailand, which liaised with IMST to strengthen coordination of the response among partners in the Asia-Pacific Region.
6. NPIs implemented during lockdowns and coordination between departments and ministries were improved with technical support from WHO and others.
7. Health Emergency Information & Risk Assessment (HIM), Country Health Emergency Preparedness & International Health Regulations (CPI) and Emergency Operations (EMO) shared experiences with the WHO country offices.

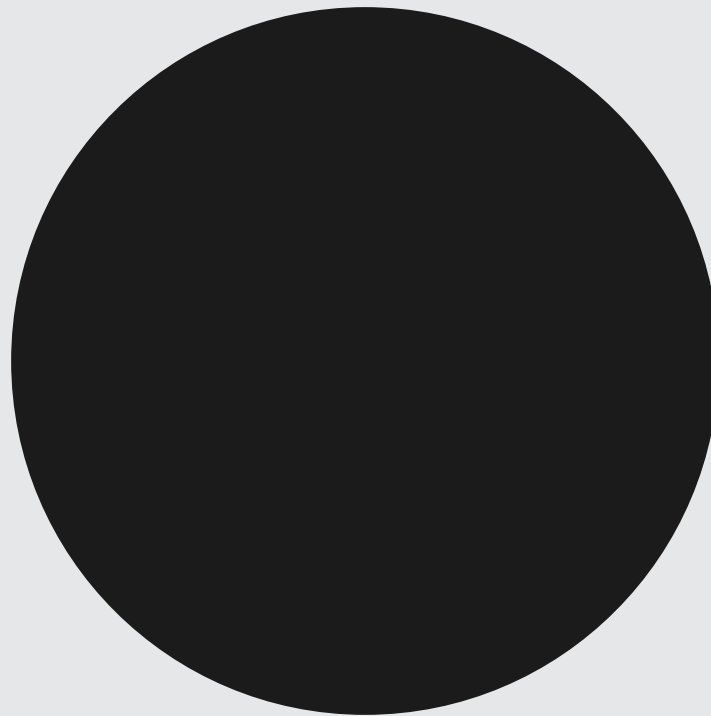


Coordination is critical for efficient delivery of interventions, especially in a rapidly evolving situation that is as unprecedented as the present pandemic. Ever since the IHR (2005) was promulgated, WHO has been working steadily with Member States to build capacities with an emphasis on coordination of the response. This is being efficiently tested in the current pandemic. The Region braced itself for the spread of infection and emergence of new hotspots, while being aware that this would complicate their public health strategies and deepen economic impact. To avoid this, more aggressive and whole-of-society efforts were put in place to prevent the spread of infection and reduce mortality.

The IMST played a major role in maintaining regular communication between incident managers at different levels. They ensured operational coordination with national governments and partners with influence across sectors and services of public life. The mechanisms and procedures for submitting procurement proposing requests were established through the setting-up a global COVID-19 supply portal for distribution and procurement.

PILLAR 2: Surveillance, rapid response teams and case investigation

1. The Regional Surveillance Strategy complemented the WHO global surveillance guidance to help facilitate risk assessments, and monitor transmission dynamics and epidemic trends at country and regional levels.
2. The Go.Data software tool was introduced to support efficient contact tracing and outbreak investigation.
3. Training and capacity-building for contact tracing was facilitated through free online courses available on OpenWHO and Johns Hopkins Bloomberg School of Public Health (JHSPH).
4. Country profiles were developed to provide a dynamic understanding of the evolution of pandemic in individual Member States as well as to inform overall risk assessment. These included innovative monitoring indicators (test positivity rates and Twitter feed trends) and Twitter scores to monitor the progress of the outbreak.
5. International/WHO protocols were adopted for special studies to investigate additional epidemiological, virological and clinical characteristics, including severity and transmissibility.
6. Technical support was strengthened with country-level and regional-level webinars, involving country offices, MoHs and other departments at the Regional Office.



Given the efficient human-to-human transmission and potential for rapid spread of COVID-19, surveillance for early detection, isolation and contact tracing were identified as the most effective tools for interrupting and slowing the spread of the pandemic. At the same time, the Regional Office was aware of the inherent weaknesses of the surveillance systems, including laboratory capacity. Years of effort at strengthening surveillance, especially through pandemic influenza preparedness, thus came in handy in adapting to the rapidly evolving situation. Surveillance was duly strengthened at the national and subnational levels to ensure effective case detection and contact tracing.



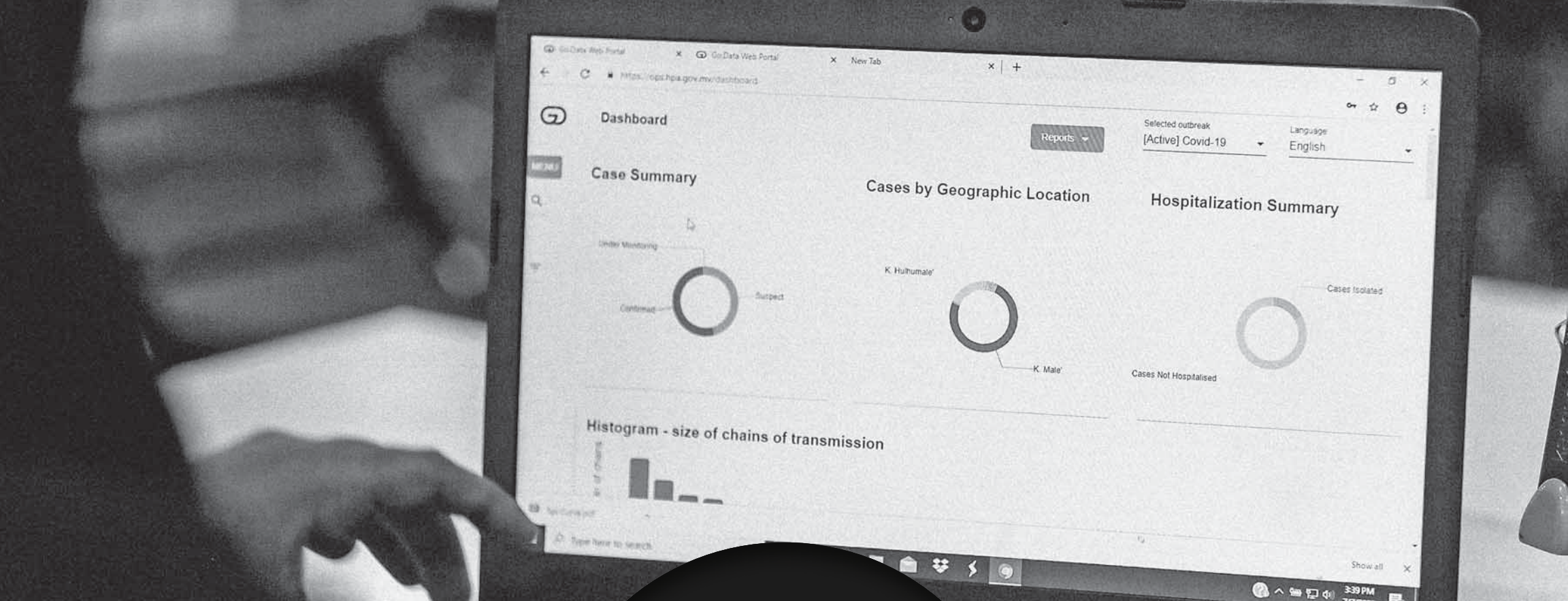
On 20 January 2020, the Regional Office recognized “detecting, isolating and contact tracing” as the main strategic objectives for responding to the pandemic. Support was provided to Member States in establishing active case-finding at PoEs through entry screening and self-reporting of passengers from affected areas. On 1 February 2020, the Regional Office provided potential transmission scenarios and guidance to develop national SOPs for early detection and contact tracing using Go.Data. By 10 February 2020, an online case report form was developed and made available to countries in addition to an internal SEA regional dashboard on 14 February 2020.

On 25 March, a Regional Surveillance Strategy was released that has since formed the basis of surveillance efforts in the Region.

The Strategy complements the global surveillance guidance while being conscious of the regional context, such as limited surveillance and laboratory capacity, and provides efficient solutions accordingly.

The Regional Office continued to monitor transmission dynamics, analysing data and providing necessary technical oversight to course-correct operations. Event-based surveillance was enhanced through communication and instructions to all health professionals for detection of cases according to the national case definition. Disease trends were monitored and epidemiological information provided to guide response measures. Country-risk profiles were developed for all the 11 Member States based on rapid risk assessments to guide, feed-in and inform COVID-19-specific country emergency preparedness and response plans.(5)





WHO SEARO / Maldives



*MALDIVES USES THE
GO.DATA TOOL
TO CONDUCT
EFFECTIVE
CONTACT TRACING
AND SUPPORT
OUTBREAK
INVESTIGATION AND
MANAGEMENT*

Go.Data is a software tool developed by WHO to support efficient contact tracing, outbreak investigation and data management during field data collection during public health emergencies. The tool includes functionality for case investigation, contact follow up, and visualization of chains of transmission, including secure data exchange. It is designed for flexibility in the field to adapt to a wide range of outbreak scenarios. It was successfully used by WHO in the African Region during the Ebola outbreak to speed up detection and slow down transmission. It also helped epidemiologists control disease outbreak in the Rohingya camps in Bangladesh. In case of COVID-19, it was used by countries in online and offline settings. Its user-friendly interface with visual dashboards for the chain of transmission as well as ample data transfer security ensures its acceptability. Accordingly, it was customized for use in Maldives with features such as atolls and islands added to the database. It was the core tool used by national Emergencies Operations Centres for contact tracing, data entry and data management. The staff was trained via a mobile phone app to manage large amounts of data, conduct case investigations, contact follow up and visualize chains of transmission, helping the country to make quick and informed decisions to contain the outbreak. (6)



WHO SEARO / Bangladesh

DISEASE SURVEILLANCE AT THE HEART OF BANGLADESH'S EVIDENCE-BASED RESPONSE

WHO's early warning and response disease surveillance system in Cox's Bazar provided crucial information on diseases of outbreak potential to ensure timely response and containment measures. WHO trained over 300 volunteers on contact tracing using the Go.Data software to allow efficient and effective contact tracing of those who had been in contact with confirmed positive cases. As of 28 June, as many as 2456 cases of infection were confirmed in Cox's Bazar District and 50 refugees tested positive. Testing was needed to initiate a timely response. To scale up diagnostic confirmation of positive cases in Cox's Bazar, WHO provided the necessary equipment, supplies, personnel and technical guidance to the field laboratory of Bangladesh's Institute of Epidemiology, Disease Control and Research (IEDCR). The laboratory now tests over

1000 samples of COVID-19 daily from the camps as well as host population of Cox's Bazar and neighbouring districts. WHO also trained over 1000 health personnel as well as those from other sectors of the government and humanitarian agencies in Cox's Bazar on IPC and on-site supervision. With technical support from WHO, partners set up isolation and treatment centres with over 1000 extra beds for patients with SARI. Another 250 health personnel were trained on clinical case management to ensure that treatment protocols were in line with the recommended guidelines and were meeting minimum standards. Given the low literacy level of the local population, the WHO Country Office developed radio programmes and undertook community awareness using megaphones and through household visits by volunteers. (7)



REUTERS / Adnan Abidi

Dharavi in Mumbai is Asia's largest slum. Spread over 613 hectares, it is one of the most densely populated areas in the world, with over 3.6 lakh people per sq.km, making it impossible to practise social distancing. In April 2020, Dharavi was a COVID-19 hotspot. The first case was recorded on 1 April 2020 and by 30 April, there were 491 positive cases. In May, there were 1216 cases with 56 deaths. In June, Dharavi reported zero deaths. The case doubling time improved to 43 days in May and 78 days in June. Dharavi contained the virus even as it surged elsewhere in the city and country. Efficient contact tracing, isolation and quarantine measures were followed by the state government, health department, volunteers and over 2450 health workers. Most private clinics had shut down in Mumbai but private doctors in Dharavi kept their clinics open. By the second week of April, officials and private doctors had screened 47 500 people. Of those who reported symptoms, 20% were found positive and were immediately quarantined. Wearing full-body protective kits, officials and doctors went door to door testing people



*INDIA'S LARGEST
SLUM "TESTS,
TRACES,
CONTAINS AND
REPEATS" TO
REDUCE COVID-
RELATED DEATHS*

in their houses, educating them that it was not a crime to test positive for COVID-19. This helped to reduce panic and fear and if tested positive, officials sealed off the patient's house and surrounding area. Volunteer "COVID warriors" ensured that containment zones got supplies of essential groceries and medicines. Public toilets were sanitized, and water tankers positioned so that people could wash their hands frequently. "Test, trace, contain and repeat" were key to Dharavi's success where a focused approach along with intense community engagement helped to contain a situation that could have spiralled out of control. (8)

PILLAR 3: Laboratory strengthening

1. Laboratory staff was trained in testing protocols, coordinating quality assurance, ensuring availability of laboratory kits and ramping up capacity of government hospitals with dedicated COVID-19 wards.
2. The Pandemic Influenza Preparedness Framework Partnership Contribution to allocate funds/ generate additional funds/mobilize funds from national contributions to strengthen existing laboratories in Member States was brought into focus.
3. Regional webinars were organized to share laboratory expertise and support online training within national influenza centres and public health laboratories on biosafety, specimen collection and transport and data management, and remotely train laboratory staff.
4. This pillar ensured that all 11 Member States had the capacity for real-time reverse transcriptase polymerase chain reaction (RT-PCR)-based laboratory testing for COVID-19 patients.
5. National laboratory systems were ramped up using WHO's Laboratory Assessment Tool and quality assurance prioritized through the global external quality assurance programme (EQAP) and external referral testing and optimal biosafety and biosecurity practices.



Early detection of COVID-19 cases and their isolation to limit spread depends heavily on timely access to quality laboratory testing. However, with an overwhelming number of patients and a potentially large number of asymptomatic cases seen in the Region, clinical laboratories faced massive challenges, especially in testing. Given their already limited capacity, laboratories across countries found it difficult to manage with limited health-care resources at their command.

Anticipating a rise in cases, WHO along with the

health ministries of the respective countries

focused on training laboratory staff in testing protocols, coordinating quality

assurance, ensuring availability of

enough laboratory kits and ramping up the capacity of government

hospitals with dedicated COVID-19

wards. A few months into the

pandemic, every country in the

Region had established diagnostic

capacity for COVID-19, besides

ensuring a robust laboratory

response to the pandemic. Their

success was enabled in large part by a

decade of preparedness activities in the

Region to build laboratory capacities for

pandemic influenza. Three of the

26 global laboratories for reference testing are

now located in India and Thailand. Since 24 February

2020, WHO has been providing molecular testing kits for

COVID-19 directly to countries, increasing their capacity to detect cases

or clusters. To further scale up testing and support epidemiological and

surveillance activities, rapid kits and serological tests are being developed

and standardized. Most of these activities are coordinated by WHO along

with reference laboratories in the Region.⁽⁹⁾





WHO SEARO / Thailand / Ploy Phutpheng

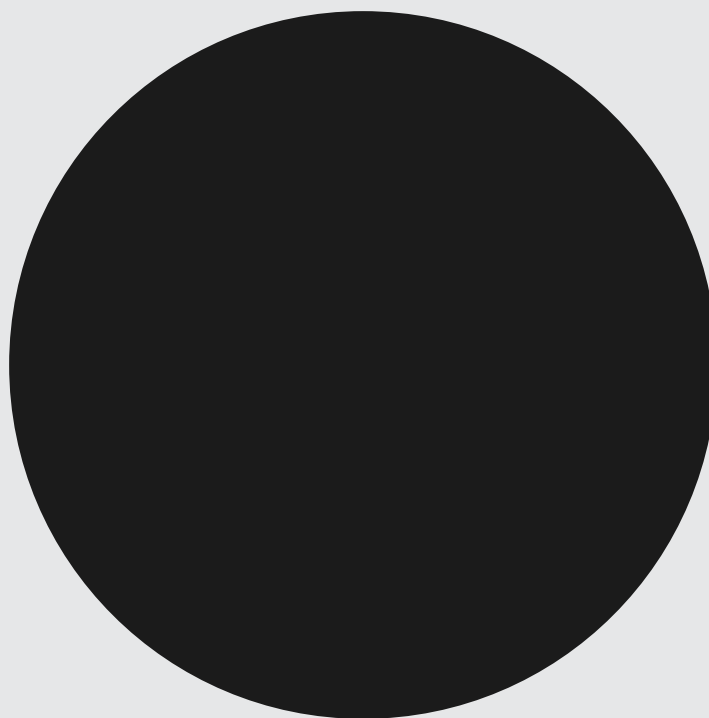
COVID-19 PCR TESTING RAMPED UP IN THE REGION

WHO played a major role in expanding testing capacities for COVID-19 at subnational levels. Capacity-building for performing PCR is an important aspect of the quality assurance of laboratories. By 2019, all 11 Member States had built the capacity to accurately and reliably detect influenza viruses through real-time PCR, as recognized by the 2019 WHO EQAP. The Regional Office supported the leveraging of national influenza surveillance systems with involvement of national influenza centres in COVID-19 surveillance. Member States in the Region have come a long way in the months following the initial set of cases. By 31 January 2020, when a PHEIC was declared, only four Member States had real-time RT-PCR-based laboratory testing capacity for COVID-19 patients. By 26 February 2020, the number grew to nine and by 31 March 2020, all 11 Member States had the capacity, with the addition of DPR Korea and Timor-Leste. This achievement was instrumental in providing a basis for COVID-19 PCR testing in the Region, following which guidelines for specimen collection, packaging and transportation for SARS-CoV-2 were developed and disseminated.



PILLAR 4: Clinical case management to reduce complications and mortality

1. The Regional Office provided technical support for designating referral facilities earmarked for the care of COVID-19 patients.
2. It supported procurement of equipment and medical supplies for managing SARI patients.
3. The Regional Office developed a regional tool to survey and assess facility-based oxygen supply along with estimated needs and forecasting.
4. An emergency “crash course” and simplified algorithms for clinical management were designed and rolled out for clinicians, doctors and nurses along with a District Clinician Manual and Quick Check Wall Chart.
5. The Regional Office contributed to developing the clinical database platform to improve the quality of public health clinical operations.
6. Guidelines and training were adapted for non-ICU settings to improve clinical outcomes; the Regional Office in partnership with IMAI trained health-care functionaries.
7. A user-friendly version of simplified algorithms of WHO’s guidance was developed to better align national clinical management guidelines with WHO’s interim guidance on clinical management.
8. Webinars were held with experts from CDC, Canada, China, Japan, India, the United Kingdom (UK) and Northern Ireland.



In addition, online experience-sharing sessions were conducted with Sri Lanka, Indonesia and India.

A rapid increase in cases, especially those requiring critical care, are expected as the pandemic evolves into community spread. This will put pressure on health-care systems, more so those that have limited capacities. The quality of health care in such situations will probably get compromised and thus adversely affect clinical outcomes.

Hospitals will experience immense pressure to access protocols and guidelines on all aspects of patient care when dealing with the novel pathogen. No doubt vulnerabilities are higher in countries within the Region since they are already constrained and stretched in terms of their health systems and capacities.

Accordingly, WHO’s main focus will have to be to continue to slow and stop transmission. It must work with partners and governments to provide optimized care for all patients and minimize the impact of the epidemic on health systems, social services and economic activity, especially in vulnerable parts of the world. The focus has been to reduce the complications and mortality due to COVID-19. Member States have been duly supported to ensure hospital readiness and surge capacity with the availability of equipment and medical supplies for managing SARI patients as per national guidelines, in alignment with WHO guidelines. Member States were supported to designate referral facilities for the care of patients with COVID-19. Existing public/private health facilities and referral systems and care/capacities for surge were mapped and their findings shared with a view to improving the quality of services, including supplies for case management and infection control.



REUTERS / Danish Siddiqui



DEVELOPING AN OXYGEN AND RESPIRATORY SUPPORT SURVEY TOOL

In critical cases, what has been seen worldwide is the need for oxygen and respiratory support. Often patients end up dying, not having had timely access to these lifesaving interventions. In the absence of WHO-recommended antivirals for COVID-19, oxygen therapy remains a critical element. In this regard, the WHO Health Emergencies (WHE) team developed a regional tool to survey and assess facility-based oxygen supply along with estimated needs and forecasting. With the potential to be seen as an innovation and a first-ever to be developed tool anywhere in the world, the “oxygen and respiratory support survey tool” developed by WHO in partnership with GOARN and the University of Liverpool will help hospitals to handle the overwhelming demand at the peak of a pandemic when they are likely to run out of oxygen. The tool is part of the Pandemic Influenza Preparedness Planning process.

PILLAR 5: IHR (2005) and Points of Entry

1. A public health emergency contingency plan was activated through country offices to gather updated travel restrictions and shared on a weekly basis; additional measures under Article 43 of IHR (2005) were shared with IHR NFPs.
2. The Regional Office provided clear guidance on setting up health assessment areas, isolation facilities and transport of suspected patients from PoEs to designated health facilities.
3. Regular updates and interim guidelines were shared on WHO's website on a weekly basis on repatriation and quarantine of travellers with travel restrictions.
4. A public health corridor and Aviation Restart Task Force was developed to brainstorm on restarting the international air transport sector.
5. The established South-East Asia Regional Knowledge Network of IHR NFP+ was utilized as an online platform for facilitating communication, experiences and exchange of ideas, as well as discussions and virtual meetings between WHO offices and NFPs.
6. A webinar was organized on safely resuming air travel to inform Member States on the latest information and developments regarding safety measures for resuming travel and sharing experiences.



The IHR (2005) provides a global framework of regulations to prepare and respond to PHEICs. While the IHR (2005) has been generally successful in ensuring a coordinated response on global issues such as avian/zoonotic influenza, Ebola, SARS and MERS, the framework has been put to the test during COVID-19. The challenges in the initial few months related to getting access to information on the origin of the novel strain of coronavirus, clinical and epidemiological profile of COVID-19 patients, information on the case fatality rate and death burden. The concerned articles of the IHR (2005), for example, Articles 43, 44 and 56, were not optimally and effectively implemented, thus leading to a surge in cases and spread of COVID-19 across regions and countries. (10)

As countries grappled with understanding the risk factors related to COVID-19, they tightened their PoEs to halt the virus from crossing borders. There were many unanswered questions relating to cruise ships, stranding of international passengers and how international legal issues would be resolved, among others. Measures imposed by Member States led to restriction of movement of supplies and much-needed technical support. The urgency to facilitate communication between countries, given the growing international pressure and rise in the number of cases, necessitated swift actions. When some Member States of the Region resumed domestic travel, others prepared for a resumption in their international flights later in 2020.



WHO SEARO / Thailand / Ploy Phutpheng



*MULTISECTORAL
TASK FORCE
DEVICES
PLAN FOR
RESUMPTION OF
PASSENGER
AIR TRAVEL
AT POINTS
OF ENTRY*

Following government restrictions, aircraft were grounded and passengers unable to travel. WHO, along with partners, developed a public health corridor and an Aviation Restart Task Force to ensure a safe, secure and sustainable restart and recovery of the global aviation sector that would best be supported by an internationally harmonized approach. The Council Aviation Recovery Taskforce (CART) provided practical aligned guidance to governments and industry operators so that they could restart the international air transport sector and recover from the impacts of COVID-19 on a coordinated global scale. The guidelines are being continuously reviewed and updated as per the latest medical and operational advice and are intended to harmonize, not replace, COVID-19 roadmaps currently established by states, regions and industry groups. These have been developed through broad-based consultations with countries and regional organizations and with important advice from WHO and key aviation industry groups, including the International Air Transport Association (IATA), Airport Council International (ACI) World, the Civil Air Navigation Services Organisation (CANSO) and the International Coordinating Council of Aerospace Industries Associations (ICCAIA).



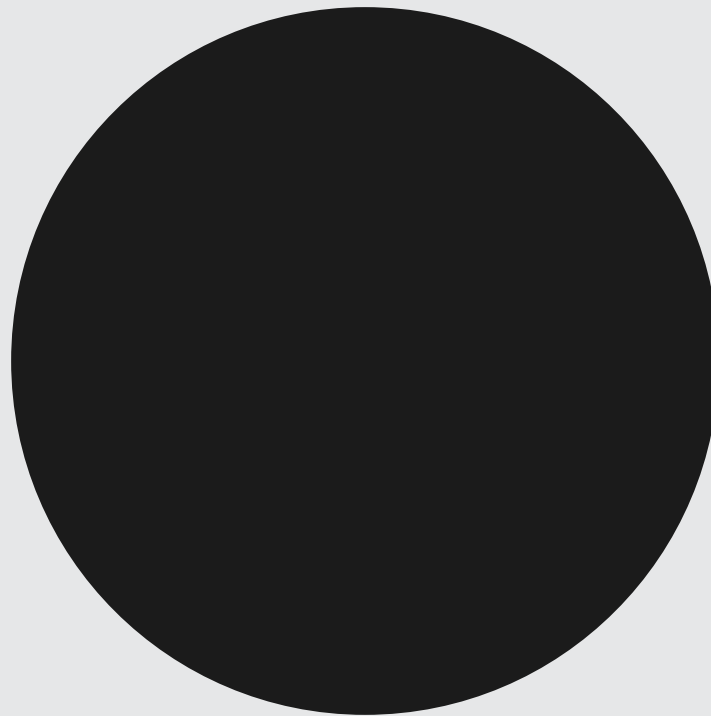


PILLAR 6: Infection prevention and control

1. Country-specific updates were provided on latest IPC guidance aligned with WHO IPC guidance on SARS-CoV-2 and refresher training rolled out.
2. Training materials/opportunities were provided along with translation of OpenWHO courses on IPC into the local languages.
3. Regular online training on IPC compliance at the first PoC was undertaken on triage, early recognition, standard precautions, isolation capacity and referral procedures.
4. Protocols were widely shared for IPC in community management of cases, home quarantine, isolation and treatment of milder cases.
5. Ongoing efforts were made on triage systems for cases with acute respiratory infection (ARI), precautions for airborne droplet transmission and clinical waste management.
6. Capacity was scaled up for follow up of exposed health-care workers as well as patients not infected with SARS-CoV-2.
7. Webinars were conducted on IPC to disseminate knowledge and best practices and IPC experts deployed for on-site technical support and local adaptation of standard IPC practices.

In the absence of specific medical interventions for COVID-19, IPC forms the backbone of the response to the pandemic. Ensuring sound IPC in health-care facilities and as part of non-pharmaceutical interventions (NPIs) is critical to contain the spread of the virus and ensure integrity of the response through the safety of health-care workers. Protection of health-care workers, patients and their attendants from hospital-acquired infection (HAI) is thus a crucial and cross-cutting issue.

Recommended protocols have to be followed (hand hygiene resources, personnel protective equipment [PPE], environmental cleaning and waste management). Country-specific technical advice sessions were provided to Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste. The areas supported were rational use of PPE, its local manufacturing and quality certification, hospital surge planning, isolation facility management and disinfectants.



At all levels of the health-care system, risk assessments were undertaken, including availability of triage and appropriately ventilated isolation rooms. Attention was paid to ensure compliance with basic IPC principles at the first point of care for patients (usually primary care). This entailed dealing effectively with triage, early recognition, standard precautions, isolation capacity and referral procedures. Simultaneously, along with health-care facilities, there was a plan for IPC in the community management of cases since infections were spiking and many countries were in the throes of widespread community transmission.

Home quarantine, isolation and treatment in milder cases was being recommended and protocols for IPC in these cases had to be widely disseminated. Under the guidance of WHO's technical teams, Member States were trained to identify IPC surge capacity and directed to install protocols to assess and manage health-care workers (HCWs) with exposure to the risk of acquiring SARS-CoV-2. Appropriately, referral pathways were defined in collaboration with case management capacities.



WHO SEARO / Bangladesh



*DPR KOREA'S MOST
STRINGENT IPC MEASURES
THROUGH ACTIVATION OF
NATIONAL EMERGENCY
ANTI-EPIDEMIC SYSTEMS*



Since mid-January 2020, the DPR Korea Government has activated its anti-epidemic system, which amounts to a national emergency. It was the first country in the Region that not only quarantined all suspected cases and incoming travellers for one month (despite the 14-day quarantine period followed by other countries as per global recommendations) but imposed stricter IPC measures that included disinfection of even COVID-19-specific cargo supplies along with quarantine of crews of ships.



WHO SEARO / Indonesia

*INDONESIA'S
INTERIM POLICY
MEASURE
ENSURES THAT
HOSPITALS
PRACTISE
SAFE WASTE
MANAGEMENT*

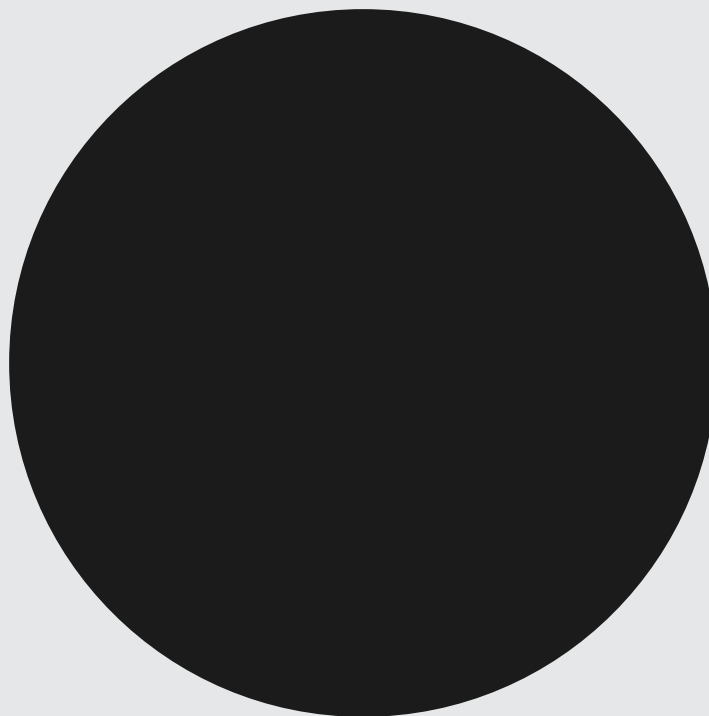
As part of its COVID-19 response, the Government of Indonesia worked with other ministries, agencies and the private sector to ensure safe and efficient disposal of medical waste. The Ministry of Environment and Forests (MoEF) took an emergency decision. Across the country, out of 2889 hospitals, only 82 had a license to operate incinerators on their premises while other hospitals were resorting to contracting private health-care waste management providers, 92% of whom were located on Java island. The long distance from the hospital to the final medical waste disposal site increased the risk of illegal dumping, cross-contamination and disease transmission due to a greater chance of accidents and human errors during the extended transport time. To avoid this, the MoEF released a circular in February 2020 allowing hospitals to operate unlicensed incinerators during the finalization stage of the permit attainment process.



They finalized plans for constructing a province-based health-care waste management facility by placing incinerators in five locations (Aceh, East Nusa Tenggara, West Nusa Tenggara, South Kalimantan and West Sumatra) to be extended to other provinces by 2024. Since June, WHO has been supporting the MoH to host webinars on medical waste management, sharing current policies and national protocols on water, sanitation and hygiene (WASH) and medical waste management in health-care facilities as well as safe use of incinerators and autoclaves in the context of COVID-19. More than 10 000 participants from all 34 provinces participated in the series. The MoEF also recommended that health-care facilities, under the supervision of the province and district health offices, coordinate with polluting industries (cement, etc.) to manage the disposal of health-care waste. A WHO handbook on Safe management of waste from healthcare activities, second edition provided comprehensive guidance on safe, efficient and sustainable methods for handling and disposing of medical waste in both normal and emergency situations. A range of information, education and communication (IEC) materials on waste management were developed in collaboration with the United Nations Development Programme.(11)

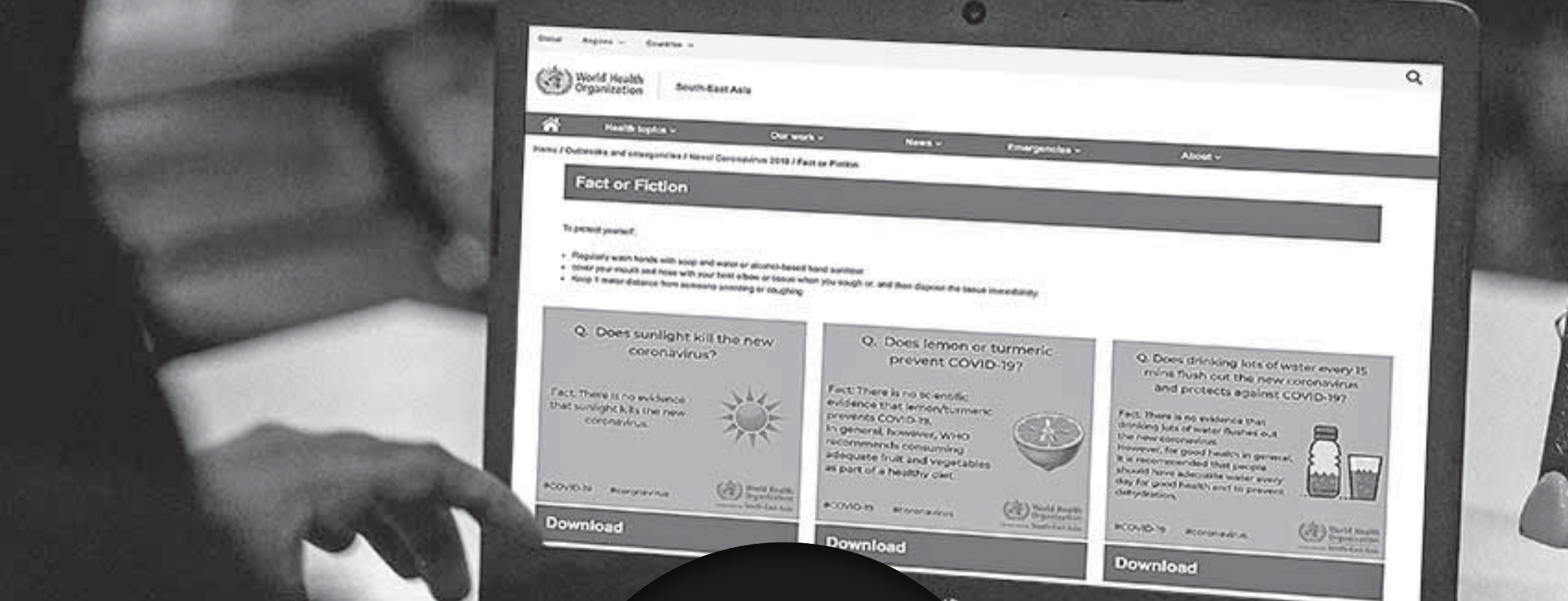
PILLAR 7: Risk communication and community engagement

1. A new area of “infodemiology” emerged, using artificial intelligence tools to scan a million conversations a week in 10 languages to identify and address misinformation.
2. Partnerships with Facebook, WhatsApp (chatbot) and Twitter were finalized to highlight credible facts from WHO and independent fact-checkers enlisted to sift fact from fiction/misinformation.
3. An anti-stigma campaign launched with messages on protection of health-care workers, and for the public, media and community leaders.
4. Coordination was strengthened across the Asia Pacific through an Interagency Asia-Pacific Risk Communication and Community Engagement Working Group
5. Regular webinars on risk communication and community engagement helped countries to address their needs, covering uncertainty management, behavioural insights, monitoring and evaluation of community engagement.
6. Active engagement was sought with faith leaders, teachers, women’s networks, alternative health-care providers, pharmacies and village community organizations.
7. Media sensitization was conducted via online learning on the principles of risk communication and their role in an outbreak.



This century has not seen a pandemic of this nature. In a digitally connected age, massive implosion of information through the mass media and social media meant instant access to information. In the case of COVID-19, this was a double-edged sword. In the initial months, little was known and the information that that emerged was not entirely validated. A wave of misinformation from across the world aggravated people’s fears and anxieties and also contributed to increasing cases of stigma and discrimination. Widespread rumours and sometimes dangerous misinformation were circulated about prevention and cures, diluting the impact of information related to wearing masks, maintaining social distancing, washing hands and staying home.

An all-out effort was made to address rumours and misinformation, by pointing out myths, highlighting facts on social media, and working with communities to address local beliefs. Many countries developed measures to discourage the spread of deliberate misinformation with penalties, fines, legal consequences and even imprisonment. A structured approach was followed to deal with “infodemiology” via a systematic and timely risk communication plan. WHO established a system of digital listening to public concerns and misinformation using an artificial intelligence (AI) tool, and shared timely and accurate information so that different audiences could be reached with accurate and verified information and updates. In countries, systems were established to listen, detect and proactively and rapidly respond to misinformation through multiple, multiway channels. These included hotlines, talk-shows, mid-media, social media and face-to-face engagement with the community. More than 300 visuals (.gif and video formats) were developed and disseminated in 11 languages. Regional and national risk communication and community engagement strategies were developed in addition to mechanisms for listening and two-way communication tailored to community needs.



WHO SEARO / Maldives



INFODEMIOLOGY AND A SYSTEMATIC APPROACH TO MISINFORMATION MANAGEMENT

The pandemic saw an overload of information – true and false – spreading as rapidly as the virus itself. WHO launched a new field of infodemiology to study this phenomenon. In the absence of a vaccine or cure, information became acknowledged as a powerful tool. The Regional Office focused on misinformation management (false information that prevented communities from getting much-needed factual information). Managing rumours was important because if left unaddressed, it could fuel mass hysteria, violence and actions detrimental to the well-being of individuals, communities, health-care personnel and governments. A strong plan for monitoring rumours was planned with digital and social media. AI-based tool was developed to scan over a million conversations in 10 languages. Out of this large body of rumours, those that got identified as fake news/misinformation were analysed and addressed appropriately. As of July 2020, over 300 instances of rumours were detected and addressed through a “Fact or Fiction” web section on the WHO website. Partnerships with Facebook, WhatsApp (chatbot) and Twitter highlighted WHO pages that contained credible information. Partnerships were also established with independent fact-checkers.

PILLAR 8: Operational support and logistics

1. The UN COVID-19 Supply Chain Task Force was set up and the global COVID-19 supply portal coordinated by WHO and World Food Programme (WFP) to scale up procurement and delivery of PPE, testing and diagnostic supplies, and biomedical equipment.
2. Guidance was provided to countries on having in place business continuity plans (BCPs) so that they could open up with minimum disruption to the social and economic sectors.
3. Technical support was provided to non-health sectors from the initial stages of the pandemic, demonstrating that coordination between the Regional Office and Member States was comprehensive and well-rounded, despite the health and non-health vulnerabilities of the Region.
4. The Immunization and Vaccine Development (IVD) Programme conducted a rapid situation assessment on the effects of COVID-19 on the Expanded Programme on Immunization (EPI) in Member States.
5. Forecasting tools were developed by the Health Systems Divisions to assess and analyse workplace dynamics and logistics requirements in different phases of the COVID-19 response.

The rapid emergence and spread of the virus and corresponding travel and trade restrictions disrupted the established mechanisms for operational support and logistics (OSL) and put the supply chain under

tremendous pressure, threatening to compromise the response. While all countries indicated that they had procurement mechanisms, sufficient storage capacity, a stock management system as well as a transport and distribution system in place, there were differences in the capacity of Member States in the Region, which made it essential to maintain the integrity and performance of OSL. Accordingly, in the Region, countries were assigned focal points for logistics and procurement who were able to link with response-related pillars at the national level. In the acute phase of the pandemic, WHO estimated that each month, there would be a need to ship a minimum of 100 million medical masks and gloves, up to 25 million N95 respirators, gowns and face-shields; and up to 2.5 million diagnostic tests.⁽¹²⁾

Governments responded differently, with each country facing trade-offs between the immediate need to manage the pandemic and the socioeconomic costs of doing so. The Regional Response Strategy for COVID-19 was developed keeping in mind the way the pandemic was evolving, with some Member States seeing imported and sporadic cases or even clusters of cases while others rapidly progressed to widespread community transmission.

The Strategy aimed to limit the introduction of cases into countries, their rapid detection and containment of subsequent spread; interrupt transmission of the virus from one person to another in countries already seeing community transmission; prevent further exportation of cases so that international spread could be contained; prevent further transmission from exported cases; and prepare countries to mitigate the impact should community transmission occur.



WHO SEARO / Timor-Leste



TRANSFORMING TIMOR-LESTE'S ABILITY TO DEAL WITH COVID-19

In barely 4–6 weeks of the outbreak, WHO had successfully facilitated the transformation of a country with no testing capacity, no identified isolation and quarantine facilities and limited surveillance. Even before the first confirmed case was recorded in the island nation, WHO along with the MoH had put in place in-country testing, functional COVID-19 facilities, a rapidly trained health workforce in infection control and case management, increase in PPE stocks, enhanced capacity for an expanded testing strategy and active surveillance capabilities.

Availability of essential medical supplies and testing kits provided the National Health Laboratory (NHL) with primers and probes to carry out 1000 COVID-19 tests. The Country Office, along with the Regional Office and headquarters, closely coordinated with the MoH to prepare

the National Action Plan for COVID-19 preparedness and response. In addition, they met laboratory needs and built capacities of health professionals through training for staff at PoEs, emergency responders and rapid response teams.

The IMS was activated and a web-based surveillance portal set up with a team trained in active surveillance and contact tracing. Rapid independent reviews of national preparedness and quality standards were conducted at isolation and quarantine facilities to shape scientific advice on the use of COVID-19 PHSM, including developing a monitoring and evaluation framework for response to the pandemic. Since time was of the essence, effort was made to refine and adapt from existing guidelines and SOPs.

A costed action plan was developed jointly by the MoH and WHO to estimate and address funding gaps for the response.



WHO SEARO / Maldives



WORLD HEALTH ORGANIZATION
CORONAVIRUS



WHO SEARO / Myanmar

*COVID-19 SUPPLY
CHAIN TASK FORCE
DRIVES THE AGENDA
FOR MAKING SUPPLIES
AVAILABLE TO ALL*

In early April, the United Nations launched the UN COVID-19 Supply Chain Task Force coordinated by WHO and WFP to massively scale up procurement and delivery of PPE, testing and diagnostics supplies, and biomedical equipment such as ventilators and oxygen concentrators. The Task Force leveraged the capabilities and expertise of each partner into a mega-consortium to identify procurement needs and better negotiate with suppliers. Members include the United Nations Children's Fund (UNICEF), the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the United Nations Office for Project Services (UNOPS), United Nations Development Programme (UNDP), United Nations Fund for Population Activities (UNFPA), United Nations High Commissioner for Refugees (UNHCR), NGOs, Red Cross and Federation and other WHO health cluster partners. The goal was to make supplies available to everyone, wherever they were needed, at all times.



WHO SEARO / Myanmar



*THE REGIONAL
OFFICE ALONG
WITH PARTNERS
PROVIDED TIMELY
LOGISTICAL SUPPORT
TO MEMBER STATES*

The Regional Office distributed over 300 000 laboratory testing kits to 11 Member States, along with 484 500 E-gene tests and 98 200 rdrp gene tests. It also coordinated with Member States, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and WHO headquarters to facilitate testing through automated PCR, namely GeneXpert. The PPE shipped to all 11 Member States included 482 000 surgical masks, 47 265 N95 masks, 511 500 examination gloves, 36 800 gowns, 9950 goggles and 15 336 face shields. WFP provided logistics support by establishing air routes, chartering flights and setting up global distribution hubs. They used eight 747 aircraft and eight medium-sized cargo aircraft to move supplies, spreading the overall supply chain to hubs in eight countries.

PILLAR 9: Maintaining essential health services and public health programmes

1. Information and guidance were provided through advisories on the WHO website and through bulletins.
2. The WHO NCD/WIN Working Group on COVID-19 and NCDs was established.
3. The WHO SEA Region's Suicide Prevention Strategy urged organizations to join hands and work closely with NGOs, community-based organizations (CBOs), academic and professional institutions and resident welfare associations (RWAs) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
4. Maintenance of EHS and public health programmes was prioritized for discussion during the health ministers' regional virtual meeting on 6 August 2020.
5. Webinars were organized and attention drawn to domestic violence, in line with WHO's recommendations for safeguarding mental health.



The change in priorities and shift in focus to cope with the unexpectedly emerging situation disrupted the continuity of treatment availability of non-COVID health conditions and either suspended or delayed public health programmes in Member States of the SEA Region. Closing down of all PoEs in most of the countries compromised the logistics supply chain system for essential medicines and equipment. The lockdowns led to restricted access to overall health services, aggravating morbidity and disability load in the Region. In many places, immunization services were discontinued, and primary health care services suspended. Many disease control programmes suffered as people postponed hospital visits and surgeries scheduled earlier for noncommunicable and other life-threatening diseases. The situation continues to be grim as the season for diseases approaches and there are collateral damages due to the additional morbidity and mortality expected due to these disruptions. Reverses to public health will be difficult to overcome, even as several disease programmes see a setback eroding the good work they achieved over the past few years.

The disruption in continuation of essential health services has been on both sides; limited and overstretched service providers as well as a beneficiary population that was hesitant, anxious and unwilling to reach health facilities due to fear of the unknown, misinformation and stigmatization of those infected with SARS-CoV-2.

The negative effects on EHS was across a range of services, with some being more affected than the others. Access of pregnant women to antenatal check-ups, delivery and postnatal care, and of children to diarrhoea and pneumonia treatment, and routine immunization services were also affected. There was a decline in uptake of treatment services for chronic conditions such as HIV/AIDS and TB.

Continuing to meet peoples' routine health needs and priorities is the responsibility of Member States, even if there are changed priorities amid the ongoing pandemic of COVID-19. In order to prevent avoidable morbidity, mortality, disabilities, mental disorders and psychological stress, health systems should be able to manage the caseload of COVID-19 as well as maintain continuity of essential health services and implement public health programmes. It may require innovations, resource management and building up of surge capacity but health systems and service delivery must go on



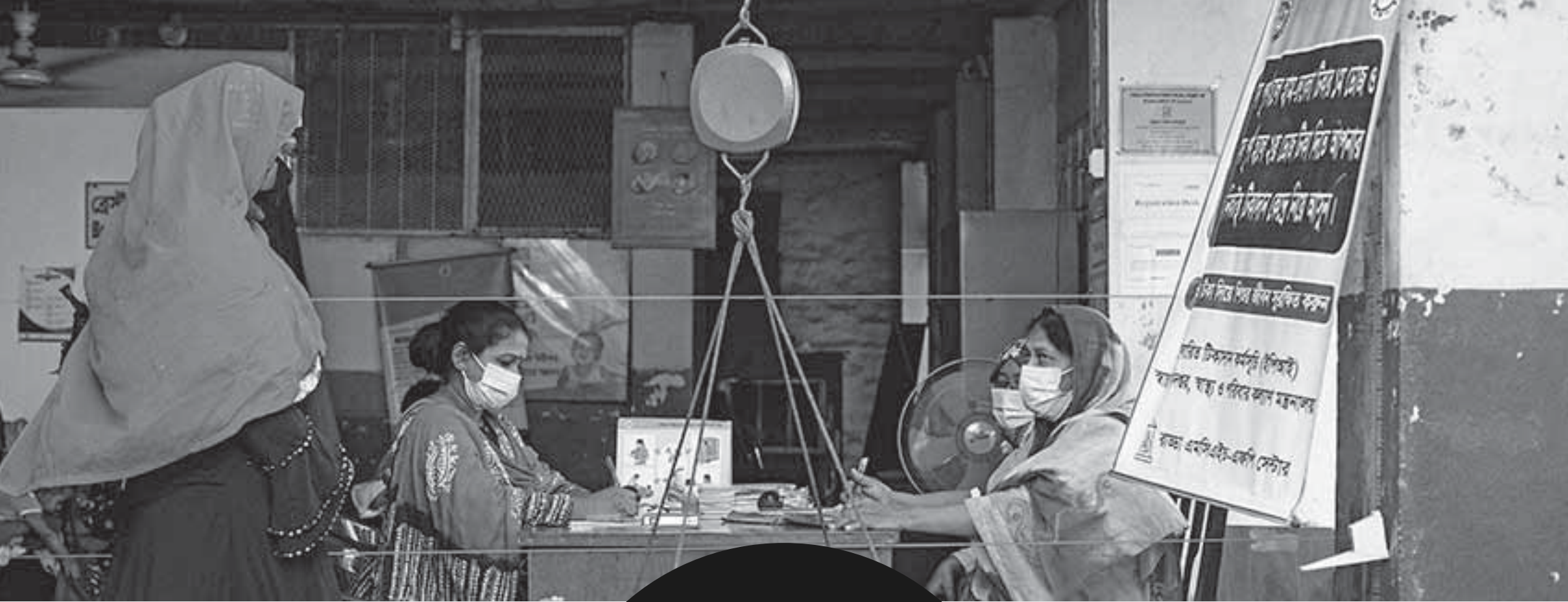
building resilience within the system as well as in the catchment populations they serve.

WHO has been working with Member States from the beginning to provide the required technical assistance to support the continuation of EHS delivery. In March 2020, WHO added “Maintaining essential health services” as the critical ninth pillar of the global SPRP for COVID-19, in addition to issuing operational guidance on maintaining EHS during outbreaks. This guidance was further revised in June based on changes in transmission dynamics.

With the COVID-19 pandemic impacting people in multiple ways, WHO called upon Member States to pay greater attention to mental health and suicide prevention. The Region's Suicide Prevention Strategy guides countries through a multisectoral public health approach to identify early signs of mental health issues and suicidal behaviours. A comprehensive assessment of the prevalence, severity and nature of COVID-19-related mental health challenges, as well as factors contributing to risk and resilience across the general public and especially in at-risk populations, will enable governments to plan for the inevitable wave of mental health problems and dedicate the necessary resources for targeted interventions.







WHO SEARO / Bangladesh

BANGLADESH ATTENDS TO A VULNERABLE POPULATION WITH ESSENTIAL SERVICES, INCLUDING MENTAL HEALTH

The camps in Cox's Bazar comprise over 850 000 refugees living in extremely crowded conditions. This put immense pressure on essential services such as water, electricity and health care. During the monsoon and cyclone season, there was a significant drop in utilization of services. The high risk of an increase in other diseases and conditions further stretched the capacity of the existing health system. Further, as the risk of water- and vector-borne diseases remained high in the camps, WHO continued to monitor risks and support partners in prevention and management activities. The efforts of WHO, the MoH and other agencies was to ensure that the most vulnerable populations had access to and could utilize critical health-care services. The immunization strategy in the camp was revised to ensure that vaccination continued in order to prevent another potential communicable disease outbreak. Technical assistance was increased in the areas of mental health and psychosocial support, sexual and reproductive health and gender-based violence to minimize the adverse impacts of COVID-19 to the extent possible for those in lockdown, isolation or quarantine. (13)



WHO SEARO / Timor-Leste



*WHO PROVIDED
NCD KITS TO
PREVENT THE RISK
OF COMORBIDITY
AMID THE PANDEMIC*

WHO provided special NCD kits to Timor-Leste to prevent the additional risk of comorbidity and mortality from NCDs (cancer, cardiovascular diseases, diabetes and hypertension) and strengthen essential health services amid the ongoing pandemic. The kit contains a pre-packed set of essential medicines and medical devices to meet the priority NCD health needs of at least 30 000 people for three months in emergencies when medical facilities and regular supplies are disrupted. Each kit contains five submodules, comprising oral medicines, essential diagnostic equipment, renewables and additional products that require a cold chain, such as insulin. Selection of medicines in the kits is aligned with the WHO Package of Essential NCD Interventions (PEN) for primary care – an effective and low-cost tool for early identification and management of NCDs and their risk factors in primary health care settings. In several parts of Timor-Leste, WFP facilitated transportation of NCD kits from Kuala Lumpur to Dili, Timor-Leste, using its humanitarian flight service.

The ongoing COVID-19 pandemic is a wake-up call and precious window of opportunity for all Member States, operational partners and WHO offices to appreciate and consolidate ongoing efforts at emergency risk management, and increasing investment in resources, skills and innovations to build health systems that would be resilient in any disaster or health emergency. The principles of “right to life” and “right to health” must be considered while prioritizing and

allocating resources at any level. Uncertainties around the further progression or possible waning of the ongoing pandemic and its “when” and “how” provide an opportunity for Member States and implementing partners to protect, facilitate and maintain the continuity of EHS and public health programmes, along with focused and persistent efforts in curbing the pandemic and further strengthening UHC.



C. GOING BEYOND THE PILLARS OF RESPONSE

Accelerating priority research and innovation

1. A research and development (R&D) blueprint has been activated to accelerate diagnostics, vaccines and therapeutics.
2. WHO and partners planned the Solidarity Trial, an international clinical trial that aims to generate robust data from around the world to find effective treatments for COVID-19.
3. Solidarity II is working towards developing a standardized serology assay for collaborators who wish to use a global standard assay and methodologies for laboratories that will develop their own serological assays.
4. So far, 24 proposals have been received under the Unity studies in the SEA Region, of which five are undergoing national and local ethics committee reviews.



While the Region is grappling with the COVID-19 crisis and economic uncertainty is reigning in most parts of the world, the commitment of researchers and the scientific community to ending the pandemic has assumed greater importance.

It has forced a re-examination of the global health architecture to promote an approach to sustainability with the potential to increase investment in emergency preparedness. Indeed, COVID-19 has placed greater value on data, research and epidemiological surveillance and the need for countries to be better prepared with their pandemic response.

R&D is an important part of the COVID-19 global narrative and WHO is bringing the world's leading scientists and global health professionals together to contain the spread of the coronavirus pandemic and help to care for those affected. As part of WHO's response, an R&D blueprint has been activated to accelerate diagnostics, vaccines and therapeutics for the novel coronavirus. The blueprint provides the global framework, platform, partnerships and networks for activating research during public health emergencies. It aims to improve coordination between scientists and global health professionals to accelerate research and development and develop new norms and standards to learn from and improve upon the global response. In the context of COVID-19, WHO has provided a global platform on serology for public health research, besides conducting the Solidarity trials and Unity studies.



On 18 March 2020, WHO and partners initiated the Solidarity Trial, an international clinical trial that aims to generate robust data from around the world to find the most effective treatments for COVID-19. This is a global collaboration of public health agencies and academic institutions led by WHO to understand the serology for public health in the context of COVID-19. It is still in the planning stage and is yet to be implemented at the participating countries' level. It will provide a collaborative workspace and global research database for sharing scientific protocols, training materials, scientific publications, survey findings and other information for collaborators. It facilitates sharing of well-characterized panels of sera to enable standardization of serological assays worldwide, and access to high-quality antigen specifically for assays to conduct serological surveys. The number of potential vaccines to be added to the trial will soon be confirmed through a Vaccines Prioritization Expert Group.

Solidarity II is also working towards developing a standardized serological assay for collaborators who wish to use a global standard assay and methodologies for laboratories around the world to develop their own serological assays. It facilitates sharing of laboratory protocols for serological assays for the purposes of serology surveys and study protocols, such as the Unity

studies. It provides support for analysis of individual serological surveys and is working towards a meta-analysis of findings across surveys from collaborators to provide a global understanding of the seroprevalence and seroincidence of SARS-CoV-2 infection, and the potential impact of different control measures. Finally, Solidarity II provides a global research database and collaborative workspace for sharing scientific protocols, training materials, scientific publications, survey findings, and other information for Solidarity II collaborators.

To strengthen the research agenda, WHO launched a global initiative to enable countries, in any resource setting, to rapidly gather robust data on key epidemiological parameters.

WHO, in collaboration with technical partners, developed generic investigation protocols under the brand of "WHO Unity Studies". These protocols use a combination of molecular and serological testing. So far, potentially 24 proposals have been received from the Region, of which those from five Member States have been confirmed.

Two studies from Sri Lanka are ongoing, 11 from India and one each from Indonesia, Thailand and Bangladesh are undergoing national/local ethical committee reviews.

At least three more studies are under preparation from Bangladesh.





Not leaving those with noncommunicable diseases and mental health behind

Unparalleled public health measures such as border closures implemented by countries have severely affected, among other things, the global supply chain for essential medicines and diagnostics. This has put countries with no local production capacity at higher risk. A recent WHO survey conducted in 155 countries revealed significant disruptions of essential NCD services in almost every country, further increasing the risk for those with pre-existing NCDs to fall severely ill or die from COVID-19.

People with underlying health conditions, such as cardiovascular diseases, diabetes and cancer, are at higher risk of getting infected with COVID-19 and have a greater chance of suffering from complications, including loss of life. In other words, risk factors for NCDs can make people more vulnerable to becoming severely ill with COVID-19. For example, smokers may have reduced lung capacity, which would greatly increase the risk of serious illness. Informing populations about these health risks posed by COVID-19 is critical. The WHO NCD/WIN Working Group on COVID-19 and NCDs looked at building resilient health systems and health services and infrastructure to treat people living with NCDs and prevent and control their risk factors during the COVID-19 pandemic. The focus was on countries most vulnerable to the impact of COVID-19, against the



backdrop of commitments made by Heads of State and Government in the 2018 United Nations General Assembly (UNGA) Political Declaration on NCDs.

The lockdowns led to restricted access to overall health services, aggravating the morbidity and disability load in the Region. In many places, immunization services were discontinued, and primary health care services suspended. Many disease control programmes suffered as people postponed hospital visits for NCDs and other life-threatening diseases and surgeries that were scheduled.

With the COVID-19 pandemic impacting people in multiple ways, WHO called upon Member States in the Region to pay greater attention to psychosocial support and mental health and suicide prevention services. The Region's Suicide Prevention Strategy guides countries through a multisectoral public health approach to identify early signs of mental health issues and suicidal behaviours. A comprehensive assessment of the prevalence, severity and nature of COVID-19-related mental health challenges, as well as factors contributing to risk and resilience across the general public and especially in at-risk populations, will enable governments to plan for the inevitable wave of mental health problems and dedicate the necessary resources for targeted interventions.⁽¹⁴⁾



CHAPTER 3

BUSINESS UNUSUAL,
A SHIFT FROM THE NORMAL



The COVID-19 pandemic has created an unimaginable level of disruption in almost all spheres of human endeavour. It has seen a range of emotions that have vacillated from the extremes of panic and fear to disbelief and a sense of bravado. Keeping all things aside, there is now growing acceptance of the emergence of a new normal that confronts the entire cross-section of the human population. Routine ways of working and office life, governance, the way civil society organizations functioned and businesses were run, as also international, intergovernmental organizations and communities administered their affairs – everything is undergoing a change and humankind is preparing to make the necessary shift that will operate at all levels of their existence.

The short-term implications of this global challenge are evident everywhere, but the long-term consequences of how it will reshape civil societies, health and development institutions, occupations, and priorities are still being evaluated to enable countries prepare themselves for changes that loom large over the horizon. While countries will be carrying out their own assessments of how they have responded to their specific challenges so far, WHO is actively supporting them with clinical management, strengthening of laboratories, restoration and maintenance of



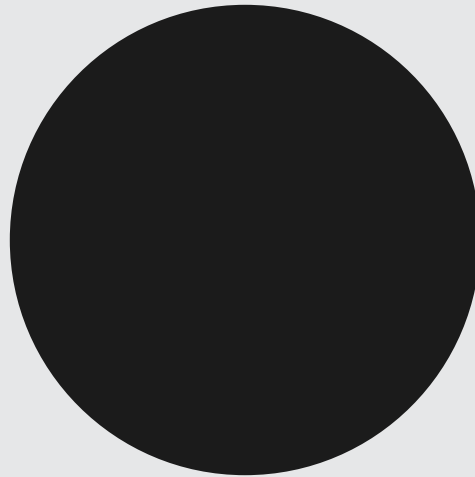
essential health services and public health programmes, epidemiology, surveillance and analytics, logistics and supplies.

In the period January–August 2020, national governments were steadfast in their fight against the novel infectious disease, supporting health workers, delivering social services and protecting livelihoods, despite the challenges of access, safety, supply chain logistics and financial stress. Some countries are seeing a steady stabilization or decline in new cases while others are reporting an increase in new cases and resurgence, both during and after the adjustment of certain public health measures. Countries have changed their testing strategies and are capturing more cases in their surveillance systems. Although studies of mathematical modelling, clinical trials and drug testing have received approvals and funding, there is still a huge gap that we are staring at, in terms of the unknowns. There remain many epidemiological and health response challenges. As social scientists, policy-makers and epidemiologists plan, design and implement mitigation measures to control the spread of COVID-19 and undertake efforts to “flatten the curve”, measures like travel restrictions and bans, lockdowns and impact on the public health infrastructure have so far shown limited evidence of effectiveness.

Taking steps towards settling into a “new normal”

As countries across the world and those of the WHO SEA Region start opening up their economies by gradually relaxing public health and other restrictions on movement, they remain in agreement that the pandemic has infiltrated the physical, mental, social, economic and geographical landscapes they all inhabit. Citizens are being made aware, advised and expected to conform to new national laws and policies on physical distancing, wearing masks in places with potential for gatherings and undertaking only essential travel or movement. Their day-to-day routine needs to be adapted to what works and what can keep them safe. Transitioning into this “new normal” must therefore be guided by public health principles, together with economic and societal considerations.

The pandemic has been acknowledged as an unparalleled humanitarian disaster after the lethal pandemic of influenza in 1918. Despite a comparatively lower case fatality rate, the immediate and urgent measures required to support policy measures and action, public health



experts say that there is no reason for panic. Decades of work and experience with previous pandemics and lessons learnt from COVID-19 itself are paving the way for recovery that will in due course cement a “new normal”. Meanwhile, the transition is being guided by public health principles, with economic and societal considerations. People, institutions, governments, corporates and public health organizations are making a shift in their coping mechanisms to battle the impact of the pandemic.

Amid rising cases of COVID-19 and as countries in the Region ease lockdowns in a graded manner, WHO has called for careful assessment of the local epidemiology to guide future actions to combat the virus. Member States are being urged to monitor this continuously, and gradually adjust their responses as they wind back public health and social measures. They are being asked to continue taking evidence-informed actions and conduct careful risk assessments, identify hotspots and clusters, and build the capacity of systems and responders to find, isolate

and care for cases and quarantine contacts. It also made national governments and intergovernmental organizations rethink their approaches in mitigating health risk by reducing human encroachment into habitats of animals and wildlife, adapting to climate change and re-emphasizing the importance of a sanitary and healthy environment for health security.

Countries are realizing that the virus is here to stay, at least until a safe vaccine or effective treatments become available. Work is under way with eminent scientists and research and pharmacology institutions to fast-track its development. A Working Group on COVID-19 vaccines and vaccination was set up as part of the Strategic Advisory Group of Experts (SAGE) on Immunization to provide guidance to ensure equitable access to vaccination. WHO is supporting this work so that the world can respond as one to defeat COVID-19.

In May 2020, the WHO Regional Office for South-East Asia held a virtual technical briefing meeting with senior health officials of 11 Member



States for the forthcoming virtual Seventy-third World Health Assembly session. Member States were asked to continue with a whole-of-government and whole-of-society approach. Decision-makers were advised on planning the transition gradually and carefully because the concern is that as more and more countries relax restrictions and lower controls, there could be a clear threat that infection may surge. The concern is that if those surges are not properly managed, subsequent waves of infection are likely. They were told to make real-time monitoring of the epidemic crucial, with adherence to proven measures that include the following:

- identify, isolate and test all suspect cases;
- quarantine and monitor the health of all contacts;
- provide prompt care to those who need it;
- prepare to reimpose some restrictions if necessary.



WHO SEARO / Thailand / Ploy Phuiheng

Opportunities for building resilience

The pandemic crisis has reinforced the need for global cooperation on priorities, including addressing health workforce shortages and ensuring equitable access to new diagnostics, medicines and vaccines. If retained, positive innovations developed during the pandemic – in service delivery models, information technology, product development, financing, governance, and ways of working will need to be highlighted and replicated so that countries in the Region can learn and benefit from these innovations.

As emphasized by the World Health Assembly, COVID-19 is a global crisis requiring sustained international solidarity and action. WHO is striving to bring governments and partners together to have a joint vision for resilient health systems and take priority actions based on the lessons learnt so far. A renewed and urgent focus is needed for increased investments in risk-informed systems and plans, risk communication and community engagement, risk prevention, disease surveillance, laboratories and diagnosis, health information systems, and building of public trust in the health system. Since these are unlikely to be provided by markets, they will need public financing and collective action. Unless this aspect is



addressed, communities will be more vulnerable to epidemics and other shocks in the months and years to come.

Public adaptation to preventive behaviours in

their lives: in the absence of drugs or effective vaccines, it is essential that the public follows preventive measures like wearing a mask, washing hands regularly with soap and water, keeping a safe distance from others, avoiding closed spaces and other people to break the chain of transmission and limit the spread of the virus. However, after so many months, people are experiencing fatigue, which may lead to some laxity in observing restrictions. Therein lies the risk of resurgence and sporadic spurts of infection.

Change in the behaviour of people in the context of COVID-19 is therefore critical. This has to extend to all aspects of their lives, including personal hygiene, keeping the surrounding environment clean and sanitary, minimizing purposeless movements at public places and avoiding mass gatherings. Digital technology is being used optimally for communication and businesses with government support.



Some of the actions taken in the “unlockdown” phase

Bangladesh

In the wake of COVID-19, Bangladesh was quick to draft a law legalizing the operation of offices digitally once the intense phase of the pandemic lessens. The Cabinet Division released the draft “Digital Governance Act 2020” that will soon become a law, stipulating offices to operate digitally amid the pandemic. This will allow government offices to collect and disburse money digitally. Documents, including agreements, will have the option of being presented digitally, opening the door to using audio-visual technology for conferences, meetings, court hearings, recording of and questioning witness statements.(15)

Indonesia

The Indonesian Investment Coordinating Board (BKPM) shared an agreement with the Ministry of Manpower and Ministry of Law and Human Rights to provide support to companies bringing further investment into Indonesia.(16)

India

The Indian government has finalized an action plan to reskill unemployed migrant and informal sector workers. The move will not only help rehabilitate those who lost their jobs because of the coronavirus crisis, but also make workforce readily available once economic activity restarts. The Ministry of Skill Development and Entrepreneurship will provide new opportunities for re-skilling in the wake of dramatic structural changes in the economy.



Thailand

Thailand plans to set up a special rehabilitation centre to revitalize the economy by introducing relief measures for small businesses, balancing what its government says are “disease issues and the mouth and stomach of the people”.

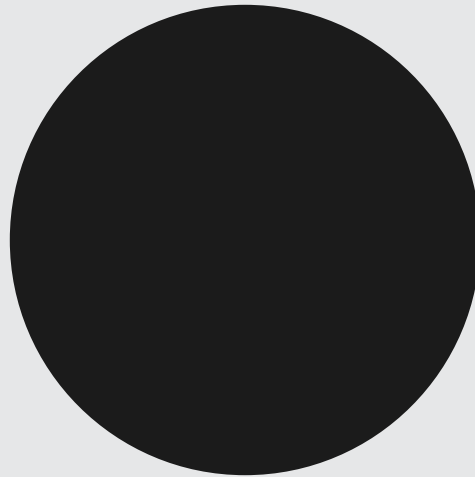
The government plans to extend debt moratoria for small- and medium-sized enterprises (SMEs) in consultation with the Prime Minister, economic agencies and the private sector.(17)

Maldives

Maldives reopened its borders to tourism in July following the Tourism Ministry's issuance of a 28-page guideline for restarting tourism. The guideline outlines

minimum standards to be followed by stakeholders, including central government agencies, local governments, resorts, hotels, guest houses, tourist vessels and supporting businesses. The guidelines, based on research, international best practice, case studies and industry consultation, contain a host of recommendations and envisage a phased reopening of tourist facilities with new standards for self-isolation of guests and staff. Resorts are mandated to have medical officers who have undergone Health Protection Agency (HPA)-certified training and provide a health and safety plan to the Ministry of Tourism before being allowed to reopen. They have also been urged to rehire retrenched workers so that there is minimal disruption to their lives.(18)

Maintaining the availability and accessibility of essential health services: health systems are facing the dual challenge of responding to the increasing burden of infectious disease outbreaks, including the ongoing pandemic, while ensuring the continuity of essential services. It is an accepted fact that any disruption of routine health services will directly impact the most vulnerable groups and may further aggravate the distribution, morbidity and mortality patterns of the global disease burden. Children, the disabled, the elderly and women are likely to be affected severely in addition to labourers, daily wage earners, migrants, those with preexisting health conditions, among others. Lockdown measures have already stretched their survival and coping mechanisms and they are beginning to run out of patience. The policy and State measures for infection control, namely lockdown and ban on population movement, can contain the spread of the disease but the emerging needs of food, nutrition, health, hygiene, access to clean drinking water and sanitation, as well as mental health must be met.



More familiar disease control priorities — HIV/AIDS, TB, malaria, polio – which have been part of the global health efforts to date – may suffer a decline in attention as priorities shift to infectious disease threats. Experts fear that treatment of NCDs may either suffer neglect or prove to be inadequate in a humanitarian context if the response is poorly planned and these diseases are not considered a priority. Mental health services are crucial in this pandemic to cater to the needs of those with several pre-existing conditions, those who are traumatized, survivors of domestic abuse and sexual violence, or keyed up and anxious due to the failure of the basic fundamental response to the pandemic. For some groups of particularly vulnerable people, the restrictive measures will have a significant and negative effect. Also, diarrhoea and ARIs are common causes of morbidity and mortality. Patients with disabilities as well as NCDs require prolonged treatment and health care. They may not get the attention they need as resources in hospitals and health centres get strained, fatigued and oversaturated with the unrelenting nature of the pandemic. Further, a post-Covid-19 surge of chronic disease flare-ups is likely and will have to be managed.

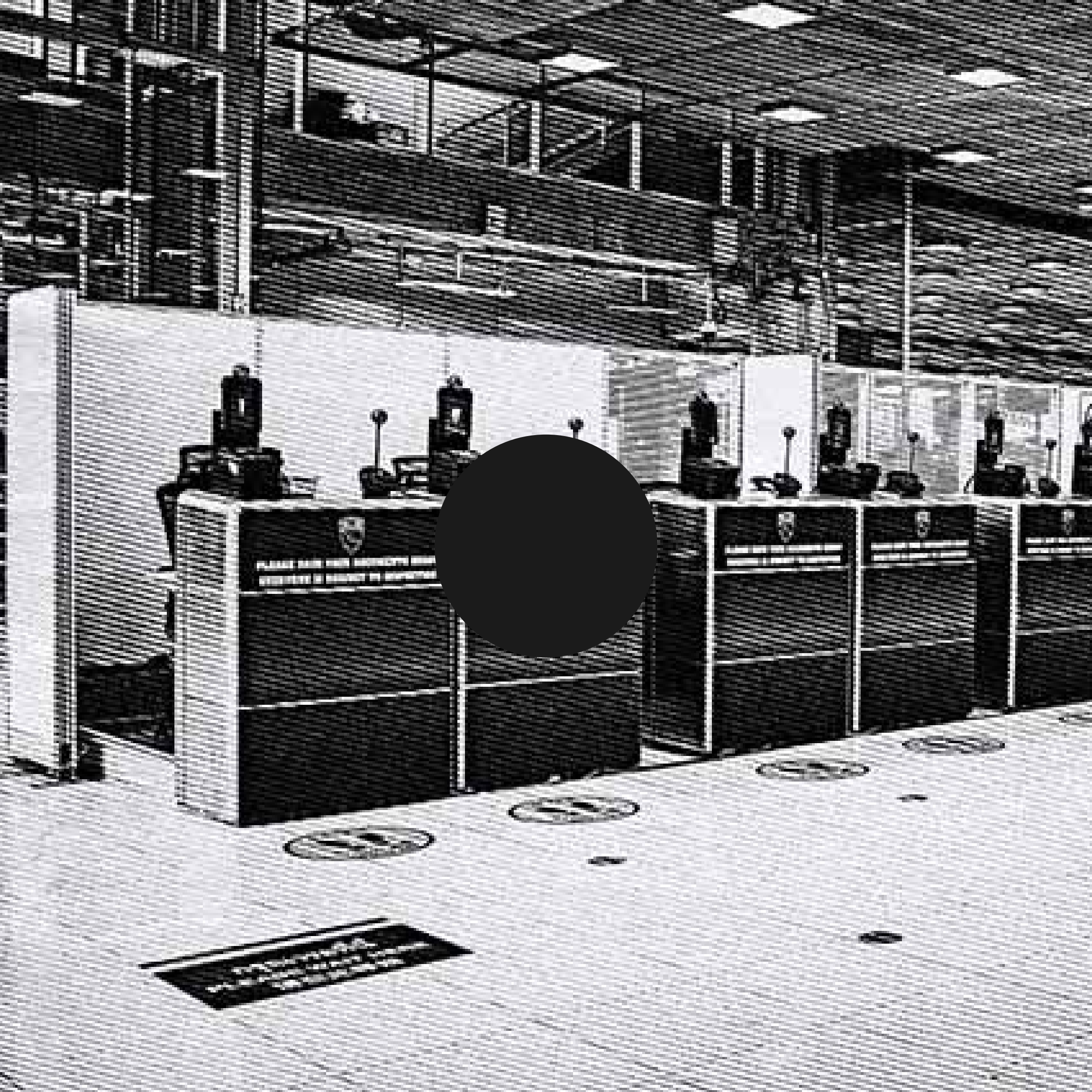
Learning to manage contradictions: the one thing local governments are finding hard to address are the contradictions. How to make people, especially those at risk, like migrants, maintain social distance when they live in cramped shared accommodation? How to observe hand-washing and hygiene in areas where there is a shortage of water and people are practising open defecation? Issues of downsizing staff leading to unemployment, serious economic losses to the aviation, food, hotel and tourism industries and the small-scale sector, due to the imposition of ill-planned, and strictest-ever movement restrictions and public health measures have challenged the politico-administrative and socioeconomic systems of affected Member States in the Region.

The closure of schools and educational institutions, although laudable as an effective IPC measure, has heralded the opportunity for distance and online learning. However, this will highlight inequities in access to digital learning platforms. Compounding this further will be issues related to the consequences of school closure, including isolation, lack of adequate food and nutrition if mid-day meals are provided in schools, parents' inability to provide learning at home, gaps in child care and eventual drop-outs. However, though these challenges are real, they



are at the same time invoking innovative thinking and solutions for transforming the usual and superficial approaches to addressing public problems.

Leveraging technology in new ways: COVID-19 could be what makes us finally deliver on the promises of remote learning and support, with impacts that will serve health workers – particularly in rural areas. Once deployed, the use of these technologies will only expand as we revert to solving the challenges and problems that preoccupied us prior to COVID-19 – too few health personnel, inadequate budgets and weak health systems. More advanced technologies, including artificial intelligence (AI), will need to be studied to provide insights into complex questions of how individual behaviours impact transmission and what kind of policies are effective for specific groups. With telehealth and remote monitoring solutions, a shift to virtual health care will be embraced at a time when non-essential visits to the medical facility will be avoided. From preventive health services to mental health therapy, primary care and follow-up appointments, a maturity of the remote monitoring market seems inevitable.





Returning to community-based models and multilevel partnerships:

as governments come to terms with their national responses, global health, financial and human rights institutions are realizing their need for resources and political space to build a response that is truly global. Institutions, donor agencies and national governments are reconnecting to the fact that any public health crisis will be mastered only with communities at the centre. As even well-resourced health systems struggle to cope, governments will turn to communities to support the social, economic and health impacts.

Governments and intergovernmental organizations like WHO will be central to this effort, as they track risks and preparedness. They will work closely with local communities as part of a solution to the pandemic. For populations to be better protected, governments will need to create space for communities to participate actively in shaping more equitable health systems.

Strong civil society voices demanding health systems that protect everyone will have to be heard and respected.

Faced by COVID-19, a shared responsibility will help strengthen health systems, especially primary health care, both to respond to emergencies effectively and to reach the whole population, leaving no one behind.

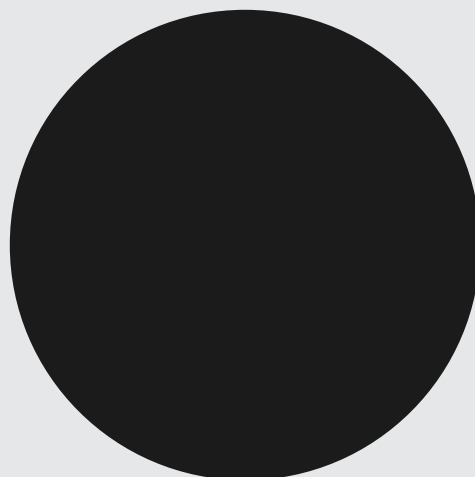
Multisectoral collaboration will be important. Governments must consult and engage more broadly across disciplines and sectors, both within and

beyond health if they have to move together to achieve better health coverage and outcomes.

Not getting submerged under the information overload:

COVID-19 has seen a large-scale spread of the “misinfodemic” that has increasingly impeded access to trustworthy and reliable information. It has led to citizens endangering themselves by ignoring scientific advice, fomenting distrust in policy-makers and governments, and diverting the media’s efforts towards reactive disproving of falsehoods instead of proactive reporting of new information. Indeed, the pandemic has served as a highly fertile ground for misinformation and rumours, whether accidental and unintended or deliberate and malicious. Accuracy, credibility and resonance will be vital for authenticity and effectiveness.

Impressing upon early warning systems that encourage trust and transparency: lack of transparency in sharing of information on the origin, genetic sequencing and routes of transmission in earlier phases of the pandemic were not practices as per the IHR (2005). It affected the relations between Member States and proved to be a reputational threat to WHO. Wherever there was an early warning of COVID-19, governments reacted rapidly by ramping up testing and engaging the entire



population in contact tracing and containment, thereby potentially reducing the economic and social costs of the pandemic. But early warning also requires governments to tell the world about emerging or re-emerging pathogens or unknown pathogens as soon as these are discovered, which can be a sensitive matter going forward.

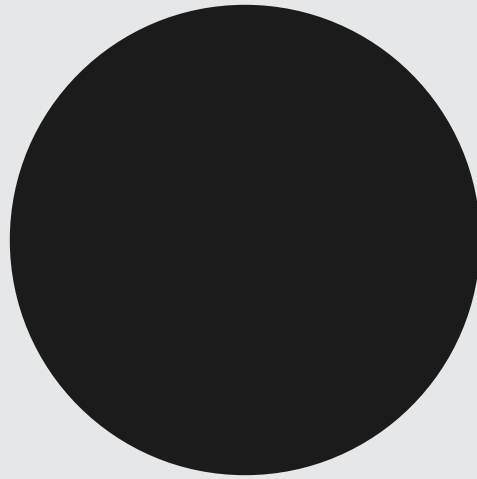
Towards greater self-sufficiency: it is clear that the outcry in almost every country about the lack of equipment and supplies to test for and protect against COVID-19 will lead countries to re-examine their supply chains for critical health- and livelihood-related products. This will lead to a surge of nationalism with respect to the need to produce pharmaceuticals, medical supplies and equipment domestically. WHO has provided “Access to COVID-19 Tools” (ACT) to ensure easy, unhindered, timely, affordable and equitable access to diagnostics, medicines, vaccines, medical equipment, and preventive, protective and curative health services to face the COVID-19 pandemic. This needs to be ramped up in the months to come because even countries that traditionally had no capability in these areas will seek to develop the same. Better use of data, evidence and technology will have to be brought into play to improve our ability to react to crises.

Another important area where this pandemic will force us to articulate



what matters most is the way in which we prioritize investments. Funding of the health sector had never been as much as during the COVID-19 pandemic when the existence of populations, systems and governance mechanisms were all threatened and economies destabilized. The same prioritization and allocation of resources is now expected from Member States in building resilience in communities as well as systems under the “new normal”. The “shift” across all levels of human existence must mature and refine itself based on the “crisis learning” that it has seen so far.

Investing in research: there is an increasing realization that the economic costs of a pandemic can be huge, far surpassing investments in research and prevention, leading to billions more dollars of investment in research, vaccines, therapeutics and non-medical methods of prevention. This will mean that trillions of dollars in economic losses, loss of life and livelihoods for millions of poor people all over the world will be averted. As the health infrastructure finally becomes responsive to the dynamics of the situation, there is a need to assess, monitor and learn from these measures. Some key areas that will call for immediate attention and research include collecting baseline information on the socioeconomic impacts of the pandemic and control measures, how the existing hospital mitigation measures are faring, and what the crucial foreseeable gaps are in health infrastructure.





CHAPTER 4

SHIFTING OUR SIGHTS AHEAD

The COVID-19 pandemic has had substantial health, social and economic impacts in all countries, small or large in size, developing or developed. It is a sharp reminder that everyone, everywhere should have access to quality and affordable health services. The world will be living with COVID-19 and its consequences for some time to come.

The SEA Region, with one fourth of the global population and a disproportionately high disease burden, continues to be vulnerable due to high population density, mega-urban slums, migrant groups and socioeconomic drivers impacting compliance with physical and social distancing. In addition, there is a global shortage of indigenously manufactured essential medicines, COVID-19-specific diagnostics, equipment and other essential commodities. In the coming period, all efforts should be made to control and suppress the spread of COVID-19, strengthen and maintain health services, and provide support for staying safe, healthy and well.

Even as Member States of the Region have various transmission scenarios and see a rise in cases, they will need to carry on with core public health measures – to rapidly detect, test, isolate, provide care and trace contacts. Simple public health measures such as practising hand hygiene, covering one's mouth and nose while coughing and

sneezing, and practising social distancing cannot be emphasized enough; these have the potential to substantially reduce transmission. However, if community transmission sets in, countries would need to gear their responses to slow down transmission, as well as end outbreaks at community levels.

Emergency mechanisms would need to be further scaled up and a network of health facilities and hospitals activated for triage to avoid overcrowding. Self-initiated isolation by people with mild disease would continue to be the most important community intervention to reduce the burden on health systems and reduce transmission of the virus. Testing would be needed of all suspected cases and symptomatic contacts of probable and confirmed cases.

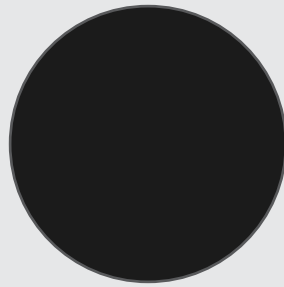
WHO's careful assessment of local epidemiology will guide future actions to combat the virus. The initial focus was on taking evidence-informed action and conducting careful risk assessments while winding back public health and social measures as countries reviewed their local epidemiology with respect to COVID-19, identified their hotspots and clusters, repurposed and strengthened the capacity of their systems and responders to find, isolate and care for cases and quarantine contacts.



The aforementioned strategy has to now be intensified. In the absence of a vaccine, cities that thought the worst had passed may be hit afresh. States that had lucky escapes may find themselves less lucky. The future is uncertain, and most countries must reconcile with the fact that neither will there be a swift return to normalcy nor a unified national experience. They must find ways to respond to COVID-19 and live with it, with minimum consequences.

Embracing this fundamental reframing – widely described as the “new normal” – means confronting uncertainty head-on and building it into the country’s national plans. Evidence indicates that we are in for a long haul and perhaps a series of such long hauls in future with such types of novel and unknown threats.

The triple burden of an increasing frequency of natural hazards, emerging and re-emerging disease outbreaks including zoonoses, and chronic health conditions is getting heavier and further complicating the survival of human populations. It has kicked off a new arena full of questions that will need immediate attention, answers and remedial immediate and long-term solutions. Although systems may be ill-prepared for unknown or novel threats, why have they not been able to identify, prevent and/or mitigate even seasonal hazards, risks and threats? If there is to be a “shift” in emergency preparedness, operational readiness and response following the COVID-19 pandemic, then the policy changes that have



to be introduced and exercised must be collectively approached. How should a future resilient community along with human settlements (city or village) and health systems look like amid upcoming drastic and unexpected changes in the surrounding ecological environment?

This question merits answers in the coming months by experts from different domains.

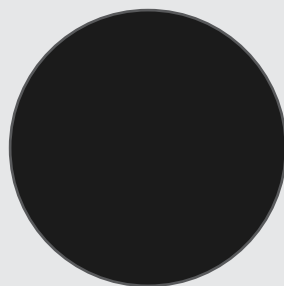
Policy formulators, implementing systems and partners must indeed shift their vision and look ahead so that they can contribute to shaping the life and survival of future generations. The “shifts” that the COVID-19 pandemic has brought about in all systems and routine life patterns across the world, without any discrimination, should not be ignored or taken for granted. The economic loss that it has caused to the world seems much bigger than the investments made so far in risk reduction, emergency preparedness and operational readiness.

National governments will have to think over these critical issues again before revisiting and deciding the type of investments they need to make in terms of human resources, innovative technologies, coordination mechanisms, governance, systems, funding and ways of living. What type of society and habitation would be most appropriate in the coming times? Will communities be able to thrive through any such “shift” in the future, which has a lethal and sector wide drastic impact? Perhaps the vision of what comes next lies in the answers to these questions.



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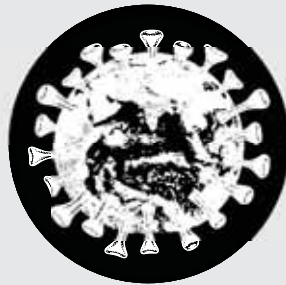


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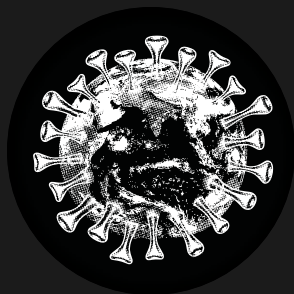
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History
will remember the year 2020
as the year when a minuscule new virus has
done the once unthinkable – it brought the world to
a halt. In eight months, more than 20 million people have
suffered from the new COVID-19 disease, and more than 750 000
people have died. It also brought out the best of the human spirit, as
countries fought back against this unknown, unexpected threat. This book
captures the WHO South-East Asia Region's response to the COVID-19 pandemic
during the first eight months of 2020, and how this pandemic has transformed,
perhaps permanently, how we live and work. It tracks the spread of the new
coronavirus across the Region, the unique challenges, and the innovative responses.
It describes the WHO's support to its 11 Member States of the Region, as responders
had to act quickly in an uncertain, complex and ever changing situation of a scale that
had not been experienced in living memory.

COVID-19 has fundamentally changed the way we live and work. This has led
to several "shifts" in behaviour, response and actions of governments,
countries, communities and the WHO Regional Office for South-
East Asia. This book brings out these "shifts" both in terms
of the current response and the new world order
that is being created.