Policy Analysis

COVID-19 response in South-East Asia: promoting healthcare quality through political engagement

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Abstract
Coronavirus disease-2019 (COVID-19), a disease caused by coronavirus severe acute respiratory syndrome coronavirus 2, led to a pandemic that affected every region of the world. The World Health Organization South-East Asia Region (SEARO) is composed of 11 countries: Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste. Each of these countries faced different challenges in tackling COVID-19 depending upon their resources and health system. However, in general it was evidenced that no country was prepared to handle such a pandemic. Two strategies were adopted globally: closing the international borders and restricting movement within countries. These measures were adopted throughout the SEARO.

Key words: COVID-19, healthcare quality, accreditation

Key Messages
• Need for Smart, Resilient & Ever ready healthcare systems.
• Priority focus on primary care.
• Urgent need for building skilled healthcare workforce.
• Leveraging the technology- digital healthcare.

Introduction
Coronavirus disease-2019 (COVID-19) disease was first identified in Wuhan, China, in late December 2019. Then, on January 13, 2020, Thailand became the first country in the world to confirm a case of the new virus outside of China. By the end of the month, Nepal, Sri Lanka, and India also had confirmed cases. For example, the first case of COVID-19 reported in India were medical students returning from Wuhan University when they tested positive in Kerala. The Indian health ministry began surveillance measures for COVID-19. Following a meeting of the International Health Regulations Emergency Committee on January 30, 2020, the World Health Organization (WHO) Director-General Dr Tedros Adhanom Ghebreyesus declared the outbreak a public health emergency of international concern.

The WHO declared COVID-19 as a pandemic on March 11, 2020. The proceeding months were unprecedented in terms of the viral spread, as scientists, governments, and communities responded to the new disease with utmost care and sincerity. A year later, the development of multiple COVID-19 vaccines shifted a rapidly spreading pandemic into one with an opportunity to respond with a public health intervention. Leading scientists report that the vaccine implemented with evidence-based public health strategies and social measures can significantly reduce the spread of the highly infectious virus.

Analysis
The South-East Asia Region (SEARO), [1] home to one-fourth of the global population, has unique challenges due to political climate and economic conditions. Despite the populous countries, such as India, Indonesia, and Bangladesh, and the smaller countries such as Timor-Leste having different public health priorities, COVID-19 resulted in a universally high level of political engagement in the regional response to the pandemic. Led by the political leaders, the countries implemented a comprehensive all-encompassing (government, private, and civil society) public health response to detect, test, treat, and isolate infected patients to prevent the spread and to save lives [7]. Efforts to promote COVID-19 mitigation behaviours such as maintaining social distancing, wearing masks, and promoting hand hygiene, as prescribed by the Centers for Disease Control and Prevention and subsequently adopted by WHO and national governments, were a high priority.

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The countries in the region worked hard during difficult conditions to establish a testing infrastructure—a key strategy to contain the virus spread. To ensure testing adequacy, national governments adopted culturally and contextually optimized processes and procedures. In this regard, India rapidly identified and approved additional testing laboratories in the government sector. By accessing the existing ISO 15189 accreditation standards to approve private laboratories, India was able to scale-up testing capacity while maintaining quality through regulatory standards [8]. As the most populous country, India provided a realistic example for how to expand testing infrastructure through involving public and private sectors. However, other countries in the region remain dependent on public facilities, which limit their ability to fully respond to the pandemic and prepare for future disease outbreaks.

The pandemic also results in a large volume of patients entering an already resource-constrained and capacity-limited health system. As such, the influx of new patients caused intense pressure, with some health systems collapsing while others remaining on the verge of collapsing. Strong political will, commendable leadership, and commitment to serving the people resulted in the health systems continuing to function despite the overwhelming volumes of infected people. State governments coordinated with the central government to implement a national strategy to organize a coordinated response to the pandemic. While many clinical departments were closed to provide space for critical care for COVID-19–positive patients and laboratories were working around the clock to test people for COVID-19, the open exchange of clinical protocols across the region facilitated the safe return of the other services. Throughout the pandemic, India was not only sustaining itself but also supporting other countries in the region. India has provided medical aid/humanitarian assistance in the form of medicines, personal protective equipment (PPE) kits, test kits, and medical equipment. India has extended developmental assistance in the form of ‘Made in India’ vaccines to its neighbouring countries. As on March 17, 2021, Bangladesh, Myanmar, Nepal, Bhutan, Maldives, Mauritius, Seychelles, Sri Lanka, and Afghanistan have received nearly 179 lakh doses (nearly 18 million) of vaccines, out of which more than a third (62 lakh doses or 6.2 million doses) have been provided on a grant basis and the rest have been provided through facilitated contracts or the WHO/Covax facility [3–6].

In India, similar to the laboratories, hospitals designated as COVID treatment facilities were in the public and private sectors. The Indian Council of Medical Research, an agency within the Ministry of Health and Family Welfare, was designated to manage the COVID-19 agenda (i.e. formulation, dissemination, and implementation of strategies, policies, and guidelines) to ensure standardization and quality [2]. Maintaining medical device quality, including PPE, test kits, reagents, and other materials. Distributing adequate PPE was paramount to limit virus transmission from patients to healthcare worker. The lack of PPE in developed as well as underdeveloped countries highlighted for the world the importance of maintaining safe occupational standards during a global pandemic. A timely response to this reality was the WHO dedication of World Patient Safety Day, September 17, 2020, to the safety of healthcare workers around the world.

There have not yet been sufficient comparisons of ‘quality of care’ for patients with and without COVID, during the peak of the pandemic and different periods of the lockdowns. Also, comparisons among health systems, hospitals, and temporary facilities have not been reported. In this regard, hospitals previously accredited, nationally and internationally, in their respective countries were probably more capable of maintaining higher quality, including good infection prevention control (IPC), as they were required to have written policies, procedures, and practices as well as regularly completed practice disaster responses. Those without existing policies, procedures, and practices, however, were probably more likely to have developed them while simultaneously handling cases, reorganizing services, and implementing training to respond to the pandemic. From deliberations and experience sharing at national and regional levels, one thing that emerges is that hospitals which were part of health care quality and patient safety initiatives demonstrated an excellent response to pandemic compared to those not part of such systems. This can be attributed to the level of preparedness to deal with disasters, availability of adequate resources, and commitment to provide safe care.

Following a government-issued advisory in India, many hospitals activated Hospital Infection Control Committees to implement IPC activities and to organize regular IPC trainings for healthcare workers. However, the IPC measure fortification may have benefitted other wards and positively impacted services outside the pandemic. This pandemic provided multiple opportunities for reflection and rapid implementation of new ways to improve our health systems including alternate approaches for learning and skill building in healthcare quality. Importantly, the resulting work will benefit the entire system following the pandemic.

Health service researchers were an essential element to limit the impact of the pandemic, from identifying the best testing methodologies for virus identification, to implementing enhanced IPC to limit the viral spread and to improving communication strategies with the public to reduce the population impact. Notably, the ‘bench science’ researchers were actively working to develop vaccines to ‘cure’ the pandemic. This demonstrates the necessity for traditional researchers and applied researchers working together to solve many problems during an active pandemic.

Conclusion

Finally, it is clear that there was a high level of political involvement to address the pandemic in the region. Top leadership of these countries swung into action and sought support from each other. India led many initiatives including providing PPE and vaccines.

The pandemic has also spurred innovations in health care including increased use of telehealth and advances in home health care for acute but manageable conditions. Home health care was an essential strategy to clinically manage millions of low acuity and asymptomatic cases outside the overcrowded hospitals [8–12]. Furthermore, there is increased focus on the importance of accreditation as a strategy to prepare hospitals for pandemic conditions. Importantly, robust regulatory and accreditation systems should not be developed only as a response to a crisis, but these strategies should continue throughout the health sector to strengthen healthcare
facilities over time, in order to have resilient systems capable of providing patients with access to quality health services.

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Conflict of interest
None declared.

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