The Pandemic Influenza Preparedness (PIP) Framework is an innovative public health instrument that brings together WHO, Member States, industry and other stakeholders to implement a global approach to pandemic influenza preparedness and response. The Framework includes a benefit-sharing mechanism called the Partnership Contribution (PC). PC is collected as an annual cash contribution from influenza vaccine, diagnostics and pharmaceutical manufacturers that use the WHO Global Influenza Surveillance and Response System (GISRS). Funds are allocated for pandemic preparedness capacity-building, response activities during a pandemic, and the implementation of the framework.

In the WHO South-East Asia Region, Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Myanmar, Nepal and Timor-Leste directly receive funds from the PIP PC to strengthen laboratory and surveillance and influenza pandemic preparedness planning capacities. This report focuses on how beneficiaries of PIP PC in the SEA Region, including the Regional Office, implemented activities to strengthen capacities in 2020. It includes recommendations of the virtual regional meeting on annual progress review of implementation of PIP-PC funds in priority countries in the SEA Region held in December 2020 that called for implementation of PIP activities in 2021 after adjusting for challenges and bottlenecks encountered in 2020. The report further outlines how beneficiaries plan to conduct PIP PC activities in 2021 and beyond.
Implementation of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution Funds in the WHO South-East Asia Region

Annual Report 2020
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# Abbreviations and acronyms

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<tr>
<td>AG</td>
<td>Advisory Group</td>
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<td>EQAP</td>
<td>External Quality Assurance Programme</td>
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<td>GISRS</td>
<td>Global Influenza Surveillance and Response System</td>
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<td>HLIP</td>
<td>High-Level Implementation Plan</td>
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<td>IEDCR</td>
<td>Institute of Epidemiology, Disease Control and Research</td>
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<td>IHR</td>
<td>International Health Regulations</td>
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<td>ILI</td>
<td>influenza-like illness</td>
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<td>IPPP</td>
<td>Influenza Pandemic Preparedness Plan</td>
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<td>IVPP</td>
<td>influenza viruses with pandemic potential</td>
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<tr>
<td>L&amp;S</td>
<td>Laboratory &amp; Surveillance</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MoHP</td>
<td>Federal Ministry of Health and Population</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>NAPHS</td>
<td>National Action Plan for Public Health Security</td>
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<td>NIC</td>
<td>National Influenza Centre</td>
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<td>NPHL</td>
<td>National Public Health Laboratory</td>
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<td>PC</td>
<td>Partnership Contribution</td>
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<td>PHSM</td>
<td>public health and social measures</td>
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<td>PIP</td>
<td>Pandemic Influenza Preparedness</td>
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<td>RCCM</td>
<td>risk communication and community mobilization</td>
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<td>REG</td>
<td>Regulatory Capacity-Building</td>
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<td>RT-PCR</td>
<td>reverse transcriptase polymerase chain reaction</td>
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<tr>
<td>SARI</td>
<td>severe acute respiratory infection</td>
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<tr>
<td>SEA</td>
<td>South-East Asia</td>
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<td>SARS-CoV-2</td>
<td>severe acute respiratory syndrome coronavirus 2</td>
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Introduction

The WHO South-East Asia (SEA) Region consists of a group of 11 Member States. The SEA Region is home to almost one fourth of the world’s population. The health system and socioeconomic diversity of the Region is exhibited by its rapidly changing economic, social and environmental landscape, coupled with advancing and transitional economies. The Region has experienced constant health security-related risks, including emerging infectious diseases with high-threat pathogens, natural calamities and disasters, and lack of access to safe food and drinking water. The nature and extent of these multiple health security threats are becoming more and more intricate day by day, such as climate change and antimicrobial resistance, among others. The above background has been further complicated by the serious threats posed by the ongoing COVID-19 pandemic to the existing status of health security and stability in the WHO SEA Region.

The current COVID-19 pandemic has once again demonstrated how important advance planning and preparedness are to mitigate the adverse impacts of health security threats. In this context, the Region has made considerable progress in strengthening health emergency preparedness through implementation of the International Health Regulations (IHR), 2005. These plans and preparedness have paid dividends in the response to the ongoing COVID-19 pandemic. Investments in infrastructure, human resources and capacities under national influenza pandemic preparedness planning have contributed massively to build the foundation for fighting the current COVID-19 pandemic in the SEA Region. However, there are still many gaps that need attention and actions to strengthen the response to public health emergencies.

In 2020, the whole world was involved in responding to the current pandemic. So far, the world has witnessed 106.3 million incidences of the disease and more than 2.3 million deaths. Already 224 countries, areas or territories have reported cases of COVID-19. The SEA Region has also been affected severely by the pandemic, with 13.1 million cases and 0.2 million deaths. The burden of the pandemic in the Region is substantial and accounts for 12.3% of total global cases and almost 8.7% of global deaths (data as of 10 February 2021). The capacities developed under influenza preparedness efforts, namely, influenza sentinel surveillance systems, laboratory network, human resources, enhanced knowledge and capacities of experts are proving to be useful, appropriate and supplementary to the response to the COVID-19 pandemic. The contribution to COVID-19 preparedness and response was as follows:

♦ Systems: Global Influenza Surveillance and Response System (GISRS), sentinel surveillance systems for influenza-like illness (ILI) and severe acute respiratory infections (SARI), national and WHO’s influenza data-sharing platforms, and national and external quality assurance platforms for influenza diagnostics;

♦ Capacities: regulatory capacities, risk communication and community mobilization (RCCM), data management and analytics, pandemic planning, laboratory diagnosis and clinical management;
Knowledge: knowledge-enhancing activities carried out in all aspects pertaining to the strategic pillar of national influenza pandemic preparedness plans.

Advanced preparedness for responding to influenza pandemics becomes a high priority based on the general consideration that it is one of the major risks to global health security. In 2018, the world observed the centenary of the 1918–1919 influenza pandemic that claimed over 50 million lives.

Lessons learnt from the current pandemic stress the importance and value of scaling up and strengthening efforts at pandemic influenza preparedness to respond to influenza pandemics and pandemics due to other emerging and re-emerging respiratory pathogens in future. It is substantiated by factors such as exposure of glaring weaknesses in countries’ response mechanisms and health systems by the COVID-19 pandemic. COVID-19 response actions predominantly support immediate pandemic response needs. However, some of those will strengthen systems for future pandemic preparedness. Coupling activities of national influenza pandemic preparedness for response with response to COVID-19 pandemic potentiate the effectiveness of the latter. While the current pandemic is benefitting from previous investments in national influenza pandemic preparedness, the opportunities in the COVID-19 response yielded many collateral benefits to national influenza programmes for strengthening pandemic influenza preparedness in the future. Thus, the Pandemic Influenza Preparedness (PIP) Framework will be a bi-directional tool designed to prepare for responding to influenza pandemics, which will provide benefits for the current COVID-19 response. Similarly, it also benefits from the lessons learnt in the process of responding to COVID-19 at the national, regional and global levels.

The Pandemic Influenza Preparedness Framework

The Pandemic Influenza Preparedness (PIP) Framework came into effect on 24 May 2011 when it was unanimously adopted by the Sixty-fourth World Health Assembly (2011). The objective of this unique programme is to help countries better prepare for the next influenza pandemic and increase their access to vaccines and other pandemic products during a pandemic. The PIP Framework is an innovative public health instrument that brings together WHO, Member States, industry and other stakeholders to implement a global approach to pandemic influenza preparedness and response. Its goals are to improve and strengthen the sharing of influenza viruses with human pandemic potential, and to increase the access of developing countries to vaccines and other pandemic response supplies.
The Framework includes a benefit-sharing mechanism called the Partnership Contribution (PC). The PC is collected as an annual cash contribution from influenza vaccine, diagnostics, and pharmaceutical manufacturers that use GISRS. Funds are allocated for: (a) pandemic preparedness capacity-building; (b) response activities during the time of an influenza pandemic; and (c) PIP Secretariat for the management and implementation of the Framework.

The implementation of the PIP-PC has been guided by two strategic implementation plans – the PIP-PC High-Level Implementation Plan I (2014–2017) (HLIP I), and the PIP-PC High-Level Implementation Plan II (2018–2023) (HLIP II). These plans guide the use of PIP-PC funds towards capacity-building to improve global pandemic preparedness over their dedicated time period. Their development and implementation have relied on engaging a broad range of stakeholders, including the PIP AG, GISRS, industry and civil society organizations.

For capacity-building, activities are implemented according to six outputs in the HLIP II (2018–2023) – Laboratory and Surveillance (L&S), Burden of Disease (BOD), Regulatory Capacity-Building (REG), RCCM, Planning for Deployment (DEP) and Influenza Pandemic Preparedness Planning (IPPP). WHO’s country-level and regional support to Member States is provided through the biennial workplans corresponding to WHO’s country cooperation strategies (CCS) with a step-wise approach to improving capacities over the six-year implementation period.

In the WHO SEA Region, seven Member States directly receive funds from the PIP-PC to strengthen L&S and IPPP capacities: Bangladesh, the Democratic People’s Republic of Korea, India, Indonesia, Myanmar, Nepal and Timor-Leste. This PC is one part of the collective global investment in health security. The report describes how Member States directly receiving PIP-PC funds implemented PIP activities in synergy with the COVID-19 response amid challenges encountered and based on lessons learned during the COVID-19 pandemic, contributing to improve overall, regional and national pandemic preparedness.
Implementation of PIP-PC-supported workplans at the country and regional levels
Bangladesh

All countries in the SEA Region are susceptible to respiratory infections of epidemic or pandemic potential. Bangladesh is no exception. The risk is aggravated by the health implications of the ongoing humanitarian emergency at Cox’s Bazaar. In the war against all these infectious hazards, Bangladesh established a surveillance system. The infrastructure of surveillance and investments over the years helped them to quickly adapt to the pandemic response. Bangladesh’s trained health workforce, including that of the ILI and SARI surveillance network, contributed immensely to COVID-19 pandemic response ever since the first case of COVID-19 was reported in the country.

Public and private institutes in the country collaborate to strengthen routine ILI/SARI and SARS-CoV-2 surveillance in the context of the pandemic

Bangladesh was exemplary in bringing together public and private sector health institutes to strengthen surveillance and response to the COVID-19 pandemic while maintaining ILI and SARI surveillance despite some operational disruptions. The country’s main strength was the ability to use the laboratories that were prepared for responding to a pandemic influenza in the country since the 2009 Influenza A(H1N1) pandemic, use of the country laboratory network and the expansion of the network helped characterization of Severe Acute Respiratory Syndrome coronavirus 2 (SARS CoV 2 ) virus transmission in the country. At the time of compilation of this report, the number of laboratories capable of diagnosing COVID-19 by polymerase chain reaction (PCR) had been expanded from one to 120 laboratories.
Bringing together public and private institutes to strengthen routine ILI/SARI and SARS-CoV-2 surveillance in Bangladesh

The Institute of Epidemiology, Disease Control and Research (IEDCR), the National Influenza Centre (NIC) was the only laboratory with influenza and COVID-19 testing capacity in Bangladesh at the beginning of the COVID-19 pandemic. All the ILI and SARI sentinel surveillance sites were overwhelmed by COVID-19 patients. This situation imposed a huge burden on IEDCR for testing samples for SARS-CoV-2. This impacted not only testing for influenza for influenza surveillance but also for SARS-CoV-2 monitoring. At one point of time, in mid-2020, ILI and SARI sample transportation from surveillance sites was limited due to general holidays and implementation of the lockdown.
Against this background, the Government of Bangladesh decided to use the existing influenza laboratory network as the foundation for both influenza surveillance and SARS-CoV-2 monitoring. Accordingly, they developed 100 sentinel sites as COVID-19 testing sites throughout the country. The Director General of Health Services took the initiative and requested help from the private sector to establish laboratories that could perform reverse transcriptase (RT)-PCR testing other than the laboratory at IEDCR. The NIC used the ILI/SARI platform to integrate monitoring of SARS-CoV-2. Meanwhile, the testing capacity in these designated laboratories was strengthened with more trained human resources with the help of IEDCR. The number of RT-PCR machines was increased at these laboratories. Increasing the number of trained human resources at these laboratories re-established influenza diagnostic activities for ILI/SARI surveillance. As most of the ILI/SARI cases enrolled for surveillance were suspected of having COVID-19 infection as well, a decision was taken to test all ILI/SARI samples for influenza and COVID-19, bringing it in line with WHO’s interim guidance on *Maintaining surveillance of influenza and monitoring SARS-CoV-2*. After Bangladesh strengthened its laboratory network and increased the number of RT-PCR testing laboratories to 120 all over the country, their influenza testing also increased almost by 50%. The number of samples processed was low during the period before this change in the pandemic as compared to previous years. However, after re-establishment of sample testing through this network of laboratories, the number of samples processed has increased. Another noteworthy observation is the increased reporting of acute respiratory infection cases from health facilities throughout the country. As far as laboratory testing was considered, a total of 5073 samples was collected through the influenza surveillance platform in Bangladesh and 4353 (86%) were tested. Among these, from January to October 2020, 346 (8%) were influenza positive. Of the samples tested for SARS-CoV-2 among enrolled SARI and ILI cases from sentinel surveillance sites, 67 (1.5%) were found to be positive for COVID-19.

**Figure 3:** Sample collection through the influenza surveillance platform in Bangladesh

![Photo](WHO Country Office, Bangladesh)

**Data- and virus-sharing with the GISRS**

In consultation with the WHO Country Office and with technical assistance from the WHO Regional Office for South-East Asia, the influenza team at the NIC has registered in the FluMart system and successfully uploaded influenza data to the global data-sharing platform of the GISRS. Additionally, the country through NIC has sent 74 samples for isolating viruses to WHO collaborating centres in September 2020.
PIP-PC funds are one of the largest sources of external funding for the Democratic People’s Republic of Korea’s Ministry of Public Health (MoPH). It has been extremely useful for the MoPH to implement PIP work and some key achievements were highlighted in the mid-term analysis of the HLIP on implementing PIP-PC funds in WHO’s SEA Region. The country already has an extensive, well-spread out, population-based influenza surveillance system, with 46 facilities reporting ILI data, and 66 reporting SARI data to the Central Hygienic and Anti Epidemic Institute (HAEI) laboratory that acts as the NIC.

**Implementation of PIP PC-supported activities**

The Democratic People’s Republic of Korea (DPR Korea), owing to non-reporting of COVID-19 cases, was able to utilize 92% of PIP-PC funds allocated to the country. With the help of the WHO Country Office for DPR Korea and the Regional Office, the country finalized the reporting format of laboratory results, which included, in addition to influenza results, other viral diseases for the first time. Among the major achievements, the MoPH finalized the updated version of the national influenza pandemic preparedness
Implementation plan for 2021 based on the challenges and lessons learnt through the COVID-19 pandemic

The implementation plan for 2021 included a focus on increasing collaboration with the MoPH to overcome challenges, including capacity-building, planning well in advance for activities that can be implemented in 2021, planning and organizing more virtual meetings, training sessions and workshops, and planning and forecasting for logistics in advance in order to avoid delay in the shipment of goods.

### Surveillance and reporting

#### Conducting surveillance during the COVID-19 emergency and regularly reporting to FLU-MART and GISRS

Due to existing problems and travel restrictions due to COVID-19, DPR Korea encountered a countless number of challenges. These included supplies and logistics challenges due to delayed shipment of goods to the country. United Nations sanctions too challenged the procurement of equipment and other auxiliary supplies resulting in delays in upgrading laboratories. These difficulties posed some challenges to sustaining ILI/SARI surveillance and monitoring COVID-19 in the country.

In spite of these challenges, the MoPH has taken measures to strengthen surveillance, which are as follows:

Laboratory capacity has been strengthened with parallel increases in human resources and PCR machines.

Enrolled cases of SARI and ILI from sentinel surveillance sites have been tested for both COVID-19 and influenza.

Information, education and communication activities were carried out extensively to create awareness among people. Posters were distributed depicting influenza symptoms, diagnosis and treatment.

At the same time, measures to reduce transmission of respiratory infections were initiated with the dual purpose of responding to seasonal influenza and COVID-19 in DPR Korea from the beginning of 2021. All these efforts helped the country to continue with and sustain influenza surveillance in the country and initiate COVID-19 monitoring by leveraging the extensive influenza surveillance network and pandemic influenza preparedness activities outlined in the National Influenza Pandemic Preparedness Plan. The numbers of testing increased and were kept at a reasonably high level during the pandemic. Public health and social measures (PHSM) implemented with a view to reducing transmission of COVID-19 have contributed effectively to contain influenza transmission as well. During this period, as compared to historical figures, there was no increase in the reported cases of acute respiratory infection (ARI) while cases of COVID-19 were not reported from sentinel surveillance sites.
As a result of enhanced and integrated surveillance, DPR Korea was able to consistently and regularly on a monthly basis report epidemiological and laboratory surveillance data to the Regional Office and via the Regional Office share with FLUMART of the GISRS for global policy-making.

**Figure 4:** COVID-19 monitoring by leveraging the extensive influenza surveillance network in DPR Korea

Photo: WHO Country Office for DPRK
India is a recipient of PIP-PC funds in the WHO SEA Region to support pandemic preparedness planning. The national pandemic influenza preparedness and response plan was updated in the context of all-hazards preparedness in the IHR (2005) and global health security in the HLIP-II. However, the COVID-19 pandemic impacted the updating of the national pandemic influenza preparedness plan that was started in 2019. Though the activity was not supported by PIP-PC funds, routine influenza surveillance activities reported by NIC to the global data-sharing platform was severely impacted by the ongoing COVID-19 pandemic during 2020.

**Surveillance system was fine-tuned to monitor co-circulation of SARS-CoV-2 with other seasonal pathogens of epidemic potential, including influenza**

Co-circulation of SARS-CoV-2 and other respiratory viruses of epidemic potential has been described in a number of studies. The most prominent among these are the respiratory syncytial virus (RSV), enteroviruses and influenza virus. Theoretically, during established periods of transmission (seasonality), seasonal influenza viruses may co-circulate with SARS-CoV-2.

The Ministry of Health and Family Welfare (MoHFW) of India developed clear guidelines to detect co-circulation of multiple pathogens of national interest. These pathogens with the potential for co-circulation were determined to be dengue, malaria, seasonal influenza, leptospirosis and chikungunya. These guidelines emphasized the possibility of co-circulation of both COVID-19 and seasonal influenza among cases of ILI/SARI. Hence, the MoHFW recommended that all ILI/SARI cases in areas reporting COVID-19 cases must be evaluated and tested for both SARS-CoV-2 and seasonal influenza viruses to determine if both viruses were circulating in the population under consideration.
This recommendation of the MoHFW and the lessons learnt from its implementation would contribute to the effort of updating the national IPPP in India in the long run as it would enable monitoring of other respiratory borne pathogens with epidemic potential in addition to influenza. Among other activities that were conducted, planning and implementation of seasonal influenza vaccination for mass gathering events such as Haj (2021) and upgrading the real-time information system to capture influenza, SARS-CoV-2 and other seasonal pathogens were noteworthy.

In spite of the challenges faced by India due to the COVID-19 pandemic, the WHO Country Office for India is continuing regular discussions with Ministry officials to identify ways to finalize the national IPPP, updating of which was started in 2019.
Based on the experience of handling influenza A/H5N1 in the country, Indonesia considers influenza A/H5N1 as a priority infectious hazard with epidemic and pandemic potential. Therefore, efforts were made to strengthen and streamline pandemic influenza preparedness as an important component of the national health security agenda.

**Efforts to strengthen and streamline pandemic influenza preparedness**

While multiple resources were channelled to strengthen national pandemic influenza preparedness, the PIP-PC funds were used to support the following activities in 2020:

- conducting PCR training for the laboratory network in the country and support the proficiency testing programme for influenza;
- conducting refresher ILI/SARI sentinel surveillance training;
- adapting the ILI/SARI sentinel surveillance network in the GISRS for monitoring SARS-CoV-2 and expanding the national ILI/SARI sentinel surveillance network to include eight additional hospitals for SARI sentinel surveillance and five additional ones for ILI sentinel surveillance sites;
- adapting the contingency plan for influenza pandemic preparedness and response to respond to the COVID-19 pandemic;
♦ supporting the COVID-19 intra-action review (IAR) and field assessment on pandemic preparedness and response in Indonesia (15 provinces) with a view to using the lessons learnt and findings for planning to effectively respond to influenza pandemics in future;

♦ mobilizing technical assistance to train rapid response teams (RRTs) on outbreak/pandemic preparedness, joint risk assessment, detection of outbreaks, specimen handling and planning for laboratory testing from 34 provinces;

♦ supporting the “Joint Risk Assessment Training” for three batches in collaboration with WHO, Food and Agriculture Organization (FAO), World Organization for Animal Health (OIE);

♦ continuing to share influenza isolates with the WHO Collaborating Centre at the Victoria Infectious Disease Reference Laboratory, Melbourne, Australia.

The country also participated in the external quality assessment programme (EQAP) for COVID-19 and achieved 100% correct results.

**Indonesia uses ILI and SARI sentinel surveillance of the Global Influenza Surveillance and Response System (GISRS) platform to monitor COVID-19 trends**

Indonesia, as part of the GISRS, has 26 ILI sentinel surveillance sites and six SARI sentinel surveillance sites to monitor influenza trends in Indonesia. Indonesia decided to leverage the national ILI/SARI surveillance network to monitor COVID-19 trends as the pandemic evolved in the country.

Taking into consideration the surge of COVID-19 cases, staff availability, commitment of the staff, and appropriate infrastructure for the purpose, the Ministry of Health (MoH) Indonesia designated eight additional hospital-based SARI sentinel surveillance sites and five primary health centre ILI sentinel surveillance sites for monitoring SARS-CoV-2 and influenza. This brought the number of sentinel surveillance sites to a total of 14 for SARI and 31 for ILI.

With this new turn of events, WHO supported MoH Indonesia to conduct refresher training sessions for SARI and ILI sentinel surveillance and test samples collected from national ILI/SARI surveillance for both influenza and SARS-CoV-2 monitoring. WHO also supported sample shipments from the sentinel surveillance sites to the reference laboratory for influenza and SARS-CoV-2. Using virtual methods, WHO and MoH jointly trained 119 healthcare workers engaged in disease surveillance from the new expanded sentinel surveillance sites.

WHO presented the global updates on COVID-19 and influenza, and discussed the WHO interim guidance on using the GISRS platform for monitoring COVID-19 and influenza surveillance during these training sessions. The MoH presented an overview of ILI and SARI sentinel surveillance in Indonesia, the standard operating procedures for sample collection and shipment, recording and reporting, and shared experiences of and lessons learnt at selected existing ILI and SARI sentinel surveillance sites in terms of integrated surveillance of both disease entities. The MoH provided additional support for reagents, viral transport media (VTMs), supplies and specimen shipment for continuity of integrated surveillance through the national ILI/SARI surveillance network using national, PIP and other resources.
Indonesia continued with refresher training sessions and support for specimen shipment. Sentinel surveillance can continue with ILI/ SARI sample collection and shipment to the NIC. ILI and SARI sentinel surveillance sites can share epidemiological data and specimens for generating virological data with the NIC. These samples will be tested for COVID-19 and influenza. Given the fact that Indonesia gradually picked up sample testing for influenza and COVID-19 cases leveraging the ILI/SARI sentinel surveillance, the country will be able to monitor the trends in COVID-19 together with routine influenza trend monitoring, effectively guiding the COVID-19 pandemic response and influenza surveillance activity.

Given below is the algorithm adopted from WHO’s interim guidance on leveraging GISRS for monitoring SARS-CoV-2 and influenza to test samples for both influenza and SARS-CoV-2.

**Figure 5:** PIP PC funds were used to enhance the capacity for pandemic preparedness and response.
Implementation of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution Funds in the WHO South-East Asia Region

Figure 6: The algorithm adopted from WHO’s interim guidance for testing samples for both influenza and SARS-CoV-2 in Indonesia.

It has to be also noted that Indonesia participated in the EQAP organized by WHO for the detection of influenza viruses by RT-PCR, and testing of antiviral susceptibility; Indonesia achieved the highest possible scores.
Myanmar over the years has developed a system capable of detecting and monitoring seasonal influenza viruses through an influenza sentinel surveillance network. This is inclusive of building capacities for laboratory diagnosis of influenza with a specific focus on strengthening the capacity to promptly confirm influenza outbreaks. The country has paid special attention to strengthening intersectoral preparedness and core capacities to respond to seasonal influenza outbreaks and pandemics with a focus on using these capacities to respond to respiratory pathogens of epidemic and pandemic potential.

**A regional role model in overall implementation of PIP-PC activities**

The country has proved to be a regional role model for overall implementation of PIP-PC activities, despite multiple challenges encountered, including those due to the COVID-19 pandemic. Since the beginning of the pandemic, the government took the policy decision of leveraging ILI/SARI sentinel surveillance for the twin purposes of influenza surveillance and COVID-19 monitoring. However, this was operationally challenging due to laboratories being overwhelmed with samples related to COVID-19 during its surge, missing the chance to test ILI/SARI samples for influenza at the NIC resulting from decentralizing COVID-19 testing at the state/regional level and overburdening of staff at laboratories. The country participated and scored 100% in the EQAP for influenza laboratory diagnosis.
Using opportunities offered through PIP-PC funds for preparedness and response to the COVID-19 pandemic

Capacity-building programmes conducted prior to the reporting of COVID-19 cases in Myanmar with a view to strengthening biosafety and biosecurity (March 2020) ensured that Myanmar was better prepared than before in terms of responding to COVID-19 from the biosafety and biosecurity aspects. Myanmar’s quick expansion from no local PCR testing capacity for diagnosing SARS-CoV-2 to testing 15 000–20 000 samples per day at 40 testing facilities for COVID-19 was possible due to long-term national influenza pandemic preparedness activities in which a significant role was played by investments using PIP-PC funds. The country also fixed a dedicated day for influenza testing per week to ensure continuity of influenza surveillance at the country level.

### Focusing on strengthening biosafety and biosecurity capacity for safe handling of infectious hazards during packaging and transportation

The subnational laboratories send infectious biological samples to the National Health Laboratory for laboratory confirmation of the incriminated pathogen. In addition, the National Health Laboratory sends selected infectious samples to WHO collaborating centres for using advanced diagnostic methods, sharing influenza isolates and clinical materials for antiviral susceptibility testing and use in the composition of annual northern and southern hemisphere seasonal influenza vaccines. Moreover, Myanmar has been conducting ILI/SARI sentinel surveillance at eight hospitals across the country since 2018. These sentinel sites were also sending regularly samples to the NIC for typing and subtyping.

In Myanmar, clinical/biological samples are transported by air and highway transport. Therefore, knowledge and implementation of safe handling, packaging and transportation of samples and infection prevention and control measures in laboratories are crucial for laboratory personnel, transport staff and the general public.

Another limitation is that hospital and public health laboratories across the country have limited laboratory capacities for safe handling of infectious biological samples during storage and transportation.

Taking all these into consideration, the WHO Country Office for Myanmar supported the Ministry of Health and Sports, Myanmar to conduct a biosafety and biosecurity training focusing on safe handling of highly infectious biological samples during their packaging and transportation. The training was conducted in March 2020 in two batches. It consisted of interactive presentations, demonstrations of safe practices through videos, group work, and a pre- and post-training evaluation. Seventy-six laboratory professionals from the National Health Laboratory, subnational public health laboratories and hospital laboratories participated in the training. The participants were from 17 states and regions across the country. The training package focused on infectious risks associated with laboratory procedures; donning and doffing of personal protective equipment; infection prevention and control practices in the laboratory; biosafety cabinets and procedures for clean-up of biohazardous spills; waste management and waste disposal; and guidance on sample packaging and transportation of potentially highly infectious biological samples for diagnostic screening, including those for influenza and COVID-19.
This training helped the health professional and health staff at facilities across the country to have the following benefits:

- All 76 participants were well trained in biosafety and biosecurity procedures in routine laboratory practices.

- Although the training targeted safe handling and transportation of influenza biological specimens, it also helped laboratory and public health professionals engaged in the COVID-19 pandemic response.

- Using suggestions and recommendations from this training programme, the pocket manual on biosafety in handling infectious materials was developed with support from the Regional Office and WHO collaborating centres. These handbooks were distributed to all laboratories in 17 states and regions across the country to strengthen implementation of laboratory biosafety and biosecurity measures.
Over the years, Nepal has been attempting to explore how best to operationalize the “One Health” approach for pandemic preparedness and response. In 2020, Nepal used the COVID-19 pandemic as an opportunity to strengthen the country’s health system for responding to current and future pandemics.

**Nepal enhances laboratory capacity for diagnosing SARS-CoV-2 and influenza viruses**

The rapid expansion of molecular diagnostic capacity has strengthened SARS-CoV-2 surveillance in Nepal. Nepal has invested in this capacity to strengthen integrated surveillance of influenza and SARS-CoV-2 at provincial levels with the objective of consolidating those investments for sustaining influenza sentinel surveillance and extending surveillance for other respiratory pathogens.

In this regard, when WHO declared COVID-19 as a public health emergency of international concern, Nepal began expanding its laboratory diagnostic capacity for SARS-CoV-2. In less than ten months, the country built a network of 74 laboratories capable of laboratory confirmation of SARS-CoV-2 using the PCR method. Training, proficiency testing and on-site reviews have ensured continuous quality improvement of PCR diagnosis in laboratories in the national network. This network is now being leveraged to conduct influenza surveillance in a more nationally representative manner.

This new laboratory network was facilitated by the Federal Ministry of
Health and Population (MoHP) with active participation and contribution of the provincial and local governments together with the private sector. Its strong performance is attributed to the skill development conducted through a combination of standard in-person and virtual online training by the National Public Health Laboratory (NPHL) and WHO Country Office for Nepal. The second important component established was the comprehensive national quality assurance programme.

Nepal is one of the first Member States in WHO’s SEA Region to integrate monitoring of SARS-CoV-2 and surveillance of influenza by leveraging the influenza sentinel surveillance system in the country. Nepal has also implemented a pilot project on respiratory syncytial virus (RSV) surveillance. Meanwhile, the Nepal government has identified better-performing COVID-19 laboratories as a part of the expanded national laboratory network that would provide diagnostic services for surveillance of influenza and SARS-CoV-2. Thus, with laboratories capable of molecular diagnosis in all provinces, Nepal has strengthened the country’s preparedness for responding to influenza and other respiratory infectious diseases with epidemic or pandemic potential.

**Sustaining Influenza surveillance while supporting the public health response to the COVID-19 crisis in Nepal**

Nepal was affected by the COVID-19 pandemic in mid-March 2020. The pandemic response resulted in national lockdowns and travel/transport restrictions till July 2020. These measures significantly affected influenza surveillance in general, sample collection and transportation of samples to the NIC at the NPHL particularly.

However, when the national lockdown was lifted, samples collected and stored at the sentinel surveillance sites were transported to the NPHL and tested. This enabled retrospective reporting of influenza data for the period of April to July 2020. Samples that were PCR negative for SARS-CoV-2 received from hospitalized SARI cases were tested at the NIC for influenza to supplement disrupted influenza surveillance. It helped in updating influenza data in the global Influenza data-sharing platforms. While these steps helped to restore influenza sentinel surveillance, the NIC established a quality assurance programme targeting all laboratories testing for SARS-CoV-2 in the country.
Timor-Leste is converting its relative insufficiencies to build a strong foundation for pandemic response based on the experience of the COVID-19 pandemic. The country demonstrated how strong links between pandemic influenza preparedness, and related IHR core capacity-building contributed effectively to respond to the needs of the current COVID-19 pandemic. The joint external evaluation (JEE) of IHR core capacity in 2018 in Timor-Leste laid the foundation for their developing the National Action Plan for Public Health Security (NAPHS) encompassing all hazards. The IPPP was taken as the contingency plan for responding to any biological hazard in general and respiratory infections of epidemic and pandemic potential specifically. Thus, the revised pandemic influenza plan as a model contingency plan contributed to the broad all-hazards approach to prepare for and respond to health emergencies. MoH Timor-Leste shared its experience in this regard with the audience in the 13th bi-regional meeting of the NICs and influenza surveillance in the South-East Asia and Western Pacific Regions held at Ulaanbaatar, Mongolia. The approach of the NAPHS is thereby a measure that enables and strengthens health security and health system resilience in Timor-Leste.

Using the influenza surveillance and laboratory platform for the COVID-19 response

During mid-2020, with the consensus of all partners, the country decided to focus on integration and strengthening of influenza surveillance and COVID-19 monitoring using the influenza surveillance network. The existing influenza surveillance and laboratory infrastructure provided the ideal platform to leverage it for responding to the current pandemic. This policy direction enabled Timor-
Leste to consolidate and even nationally expand its influenza surveillance network coupled with COVID-19 monitoring with the expectation that the legacy would leave a system to continue a laboratory-assisted influenza surveillance system and quickly adapt it to respond to epidemics and pandemics due to respiratory pathogens of epidemic and pandemic potential.

### From no system for surveillance to a robust one across the country

At the beginning of the current COVID-19 pandemic, Timor-Leste was constrained by its limited surveillance and diagnostic capacity for detection, early warning, alert and response to influenza and other epidemics and pandemics. However, the country utilized the opportunities that arose as a result of the COVID-19 pandemic to leverage the influenza surveillance network for COVID-19 monitoring, starting from an influenza sentinel surveillance system that was almost rudimentary. In this direction, the country expanded SARI and ILI sentinel surveillance to all five referral hospitals, national hospitals (originally three), all community health centres (CHCs, 69 in total). Additionally, the focus was also upon three municipalities bordering Indonesia and the capital Dili. In the process, the country increased the total number of surveillance sites (both sentinel and non-sentinel) from eight to 77 across the country.

Meanwhile, using PIP-PC funds, COVID-19 response funds and other contributions from partners, the country enhanced its laboratory capacity in general with more focus on adequately trained human resources, supplies and logistics, especially PCR machines.

All these efforts helped the country increase the number of SARI and ILI samples collected, processed and tested in line with the recommendation of WHO’s interim guidance on leveraging GISRS for integrated monitoring of SARS-CoV-2 virus and influenza. All collected samples were tested for both influenza and COVID-19. The low influenza positivity rate has suggested low transmission of influenza. This has been corroborated by the very low number of reported cases with acute respiratory infections from health-care facilities across the country.

**Figure 10:** Timor Leste used the opportunities that arose as a result of the pandemic to enhance the laboratory capacity

Photo: WHO Country Office for Timor Leste
On 13 January 2020, Thailand reported that a Wuhan resident who had travelled to Bangkok on 8 January had tested positive for SARS-CoV-2. This was the first COVID-19 case detected outside China and in the WHO SEA Region. With the genomic sequencing information from China, Thailand managed to diagnose the first case with PCR testing in the country. Since then, all Member States in the Region successfully managed to establish PCR testing capacity for COVID-19 and ensured a robust laboratory response to the pandemic. Their overwhelming success in a short period to diagnose SARS-CoV-2 was made possible largely by infrastructure development and capacity-strengthening as result of a decade of preparedness activities in the SEA Region under the national influenza pandemic preparedness plans. In this regard, support for strengthening the National influenza laboratory and surveillance systems in the biennium workplan supported by PIP-PC funds also played a significant role. All Member States quickly set up diagnostic capacity for detecting SARS-CoV-2 by leveraging the existing influenza platform and the influenza surveillance system to monitor SARS-CoV-2 in parallel with revitalization of influenza surveillance performance indicators prior to the COVID-19 pandemic.
A number of MS in SEA Region leveraged their Influenza surveillance platforms to rapidly develop and strengthen the diagnostic capacity for COVID-19. While engaged in diagnosis of SARS-CoV-2 virus on priority basis, all NICs and public health laboratories in MS where NICs are not available demonstrated the quality of diagnosis by scoring 100% in the Global External Quality Assurance Programme (EQAP) for detection of influenza viruses through PCR in 2019. The success demonstrated in the Influenza EQAP boosted confidence of the countries to rapidly establish and expand high quality testing for SARS-CoV2 using real time PCR.

Currently, all MS in the SEA Region have Covid-19 specific real-time PCR diagnostic capacity. Among these MS, so far, six have participated and achieved 100% in the WHO organized EQAP for COVID-19 PCR testing. At the time of compiling this report, the other MS are in the process of receiving panels or reporting results of the EQAP.

Meanwhile, WHO SEARO with a view to rapidly sharing new knowledge pertinent to laboratory diagnosis of SARS-CoV-2 virus, initiated a regional Webinar series. The SEA Regional informal laboratory network for preparedness and response to public health emergencies established in September 2019 has been playing a pivotal role as a vehicle for effective information sharing and conducting on line training since the beginning of the COVID-19 pandemic.

The first Webinar on “Laboratory biosafety” was organized in January 2020 targeting NICs and public health laboratories involved in influenza surveillance in the region. With establishment of SARS-CoV2 virus transmission in SEAR MS, these laboratories were in the forefront of diagnosis of COVID-19. Since then, there have been several regional webinars organized mainly on topics related to laboratory aspects pertaining to COVID-19 diagnosis synergistically with influenza diagnosis.

**Figure 12:** Regional countries leveraged their Influenza surveillance platforms to rapidly introduce diagnostic capacity for COVID-19
In alignment with the output of “National influenza laboratory and surveillance systems contribute to GISRS for timely risk assessment and response measures” in the PIP PC results hierarchy in the HLIP-II, during 2019, at least 5 Countries in the WHO’s SEA Region underwent laboratory assessments using the WHO’s laboratory assessment tool (LAT) for NICs. LAT for NICs is a comprehensive tool to capture key components of laboratory systems on the basis of laboratory quality management. These assessments helped MS to be aware of strengths and weaknesses in their laboratories and work towards addressing them. Laboratory assessments and measures aimed at addressing gaps enabled these MS to quickly handle increasing demands for COVID-19 laboratory response.

PIP-PC funds were utilized for improving laboratory capacity for diagnosing COVID in complementarity with Influenza diagnosis. These investments laid a strong foundation to establish an effective laboratory response mechanism to multiple respiratory pathogens of epidemic and pandemic potential in SEA region.

**Pandemic Influenza Preparedness Planning**

Member States in WHO’s SEA Region are reaping the benefits of long-term investments in national influenza pandemic preparedness planning while shaping their response to the COVID-19 pandemic.

The Region has supported national influenza pandemic preparedness plans for the risk posed by avian influenza (A/H5N1) outbreaks. This gained further momentum following the pandemic caused by influenza A/H1N1 pdm09 in 2009. Since 2018, under the HLIP-II, the PIP PC funds have supported six Member States in the Region to update and test their national influenza pandemic preparedness plans. As the Region grapples with the fast-evolving COVID-19 pandemic, its past investments and efforts are paying dividends as five out of six Member States reported that their national influenza pandemic preparedness plans and preparedness activities implemented over the years provided the foundation to build the national pandemic response (see Box).
Today, when the whole Region is affected by the COVID-19 pandemic, Member States value the importance of national influenza pandemic preparedness planning that evolved from the need to respond to avian influenza outbreaks in 2006 and was strengthened during the influenza A (H1N1) pandemic in 2009. In recent times, the global emphasis was focused on developing and operationalization of the NAPHS. The NAPHSs were promoted to adopt the all-hazards approach in strengthening country core capacities. In spite of the introduction of NAPHS, the Region remained committed to continue with national influenza pandemic preparedness plans as the contingency plan for biological hazards under the NAPHS. The stand-alone national influenza pandemic preparedness plans as a contingency plan under the NAPHS have demonstrated their value during the COVID-19 pandemic and, in turn, the COVID-19 pandemic has acted as a live simulation exercise for updating the existing national influenza pandemic preparedness plans based on the lessons learnt.

**Implementation of the PIP-PC workplan**

Providing Secretariat support for the management of the PIP-PC workplan is a responsibility of the Infectious Hazard Management unit of the WHO Health Emergencies (WHE) unit of the Regional Office. Monitoring and review of implementation of the PIP-PC workplan by seven PIP-PC-eligible countries is a function of the Infectious Hazard Management (IHM) unit.

To exercise this function, IHM organized a virtual annual meeting to review progress on implementation of PIP-PC funds-supported workplans in priority countries in Region on 16 and 17 December 2020.

**The virtual meeting on progress review of implementation of workplans supported by PIP-PC funds in priority countries in the Region**

WHE conducted a virtual meeting on progress review of implementation of workplans supported by PIP-PC funds in priority countries of the Region on 16 and 17 December 2020.

The general objective of the meeting was to review the progress of activities in 2020 and plan for activities in 2021 in the context of COVID-19.

The specific objectives of the meeting were:

- to seek updates from the PIP Secretariat/headquarters on administrative and financial requirements for 2021 and recommendations of the PIP advisory group;
- to review the country and regional progress of activities in 2020, highlight lessons learnt and, based on lessons learnt, plan for implementation by the Regional Office and Member States in 2021;
- to discuss with the PIP Secretariat areas for reprogramming the approved country PIP budgets based on anticipated country-specific bottlenecks due to the COVID-19 pandemic in 2021; and
- to achieve consensus on workplans for implementation in 2021 based on feasible activities, and develop key recommendations for workplan implementation in 2021.
Participants at the meeting concluded the following:

♦ PIP-eligible countries in the Region acknowledge the importance of PIP-PC funds for supplementation and acceleration of national pandemic influenza preparedness and response in the Region.

♦ However, 2020 was challenging for implementation of PIP-PC workplans due to the COVID-19 pandemic. It affected overall implementation in countries as compared to pre-COVID-19 years.

♦ Despite these challenges, countries in the Region attempted to use PIP-PC funds in the best possible and innovative ways to strengthen pandemic influenza preparedness and response in complementarity with the COVID-19 response.

♦ In 2021, based on the lessons learnt and bottlenecks identified, PIP-eligible countries in the Region look forward to optimal implementation of planned activities, having adopted to the “new normal” and utilizing the strategic direction of continuing the delivery of essential health services in the context of COVID-19.

♦ PIP-PC-eligible countries in the Region view 2021 as an opportunity to update (a) influenza pandemic preparedness and response contingency plans in countries with NAPH5 or (b) national influenza pandemic preparedness and response stand-alone plans in other countries, considering the response to COVID-19 as a live exercise for testing their influenza preparedness and response plans.

♦ Considering the importance of risk communication for managing infodemics in the current COVID-19 pandemic, PIP-eligible countries highlighted the importance of strengthening national RCCM activities for influenza epidemics and pandemics and sought support for such activities from the Regional Office under PIP-PC funds.
The meeting recommendations to PIP-PC-eligible countries and the WHO secretariat were as follows:

**PI-PC-eligible countries**

- to plan implementation of the PIP workplan for 2021 in an optimal way after reviewing and adjusting for challenges and bottlenecks encountered in 2020;
- to work with WHO country offices to identify activities to be reprogrammed in 2021 to ensure feasible implementation in complementarity with COVID-19 support with the guidance of the PIP Secretariat;
- to plan for national RCCM activities and seek support from the Regional Office for implementation through the WHO country offices;
- to consider updating (a) the influenza pandemic preparedness and response component in the NAPHS or (b) the stand-alone National Influenza Pandemic Preparedness and Response Plan based on lessons learnt from the COVID-19 pandemic;
- to review implementation of the PIP workplan on a quarterly basis with the WHO country office and the Regional Office;
- to plan for activities to be included in the PIP-PC workplan (2022–2023) based on country needs and guided by the recommendations of the PIP advisory group.

**WHO**

- to work with PIP-PC-eligible countries in the Region to facilitate programme changes where necessary for optimal implementation of the workplan to achieve HLIP-II outcomes (responsibility – WHO country office, Regional Office, headquarters);
- to conduct quarterly reviews with PIP-PC-eligible countries to assess implementation and reprogramming of activities where necessary (responsibility – WHO country office, Regional Office);
- to provide regionally developed materials for use and also support national efforts on RCCM (responsibility – WHO country office, Regional Office);
- to provide technical support (where needed) to PIP-PC-eligible countries in the Region for updating (a) the influenza pandemic preparedness and response component in the NAPHS or (b) the stand-alone National Influenza Pandemic Preparedness and Response Plan based on lessons learnt from the COVID-19 pandemic (responsibility – WHO country office, Regional Office);
- to provide technical guidance from the PIP Secretariat and work with countries to plan for the PIP-PC workplan (2022–2023) (responsibility – WHO country office, Regional Office, headquarters);
- to work with countries to document contributions of the PIP-PC funds to surveillance, national pandemic influenza preparedness and response and other outputs of the PIP workplans (responsibility – WHO country office, Regional Office, headquarters).
The way forward

Aligning global strategies

The world has been fighting the COVID-19 pandemic since the start of 2020. The pandemic has impacted the implementation of PIP-PC-supported activities across all WHO regions, including the WHO SEA Region. Strong systems such as the influenza sentinel surveillance systems, enhanced knowledge, skills and capacities of experts in Member States of the Region were utilized for a rapid response to the COVID-19 pandemic. These have elaborated the extent to which PIP-PC-supported investments have contributed to lay the foundation for preparedness for an effective Member State response to large-scale epidemics and pandemics such as COVID-19. On the other hand, COVID-19 investments have started to provide collateral benefits to influenza programmes in strengthening pandemic influenza preparedness, keeping future influenza pandemics in mind. Implementation of PIP-PC workplans have been impacted by the COVID-19 pandemic. Nevertheless, it was possible to execute the intended objectives of implementation of the HLIP, thanks to the flexibility of funds for investing in defined complementary activities and the efforts of Member States in integrating PIP activities with those for COVID-19. Meanwhile, The PIP Advisory Group (AG) meeting scheduled in March 2020 was cancelled due to the COVID-19 pandemic. Instead, the AG was convened from 12 to 16 October 2020 in their first-ever virtual meeting. Seventeen of the 18 Members of the AG participated in the deliberations. Before the meeting, three technical consultations were held to brief members on specific topics. Based on the experience of the current COVID-19 pandemic, the independent AG issued recommendations and they will be the basis on which workplans already approved for 2021 would be implemented. Despite the varied scale of the pandemic in different areas of the Region, Member States will continue to champion the importance of pandemic influenza preparedness. In particular, special attention would be focused on accelerating efforts to reach the minimum number of specimens collected and tested as per WHO recommendations and sharing whatever available isolates of seasonal influenza viruses or clinically positive specimens with WHO collaborating centres. Sharing influenza viruses with pandemic potential (IVPP) also remains a high priority activity for pandemic influenza preparedness.

With support from PIP:PC funds, recipient countries will continue with influenza sentinel surveillance and, where feasible, will integrate the monitoring of SARS-CoV-2, thereby leveraging the sentinel system. Timely data will be reported (both on influenza and COVID-19) to the FluNet/FluMart.

Another area of focus for 2021 will be reducing the burden on overwhelmed laboratories in Member States. One way of reducing the burden is supporting the use of multiplex PCR testing that include both influenza viruses and SARS-CoV-2. The Regional Office will continue to engage with the Global Influenza Programme for support in the areas of supplies and technical expertise to roll out multiplex PCR diagnostics for surveillance in the Region. Routine support for testing materials and consumables will continue as planned in the biennium PIP workplans of recipient countries supplemented with support for COVID-19.
The mid-term review of the HLIP II would be expected to take place between February and May 2021. Based on the findings and recommendations of the mid-term review, the Regional Office will carry out necessary mid-term adjustments to the programme of implementing the HLIP II in the Region.

**2021 and beyond**

Contemplating on 2021 and beyond, the Region intends to focus on the following four broad areas.

♦ Assess implementation in 2020 and plan for 2021: A review meeting of recipient Member States titled “A virtual annual meeting on progress review of implementation of pandemic influenza preparedness (PIP) partnership contribution (PC) funds in priority countries in SEAR” was conducted on 16–17 December 2020. The objectives of the meeting were to review the progress of implementation of the PIP-PC workplan in the various countries in 2020 and plan for effective implementation in complementarity with the COVID-19 pandemic response in 2021. Discussions involved successes, achievements and challenges in 2020, rescheduling of activities scheduled originally for 2020 but were not completed, and discussed plans for utilizing PIP-PC funds in 2021 complementarily for both COVID-19 and pandemic influenza preparedness on the basis of experience and lessons learnt in 2020.

♦ Critically reviewing progress towards achieving the HLIP II indicators based on the mid-term review and focusing on activities where gains would be maximum and those that require reprogramming; these include effective implementation of the 2020–2021 workplan, and focusing on the implementation of activities planned for 2021 while trying to incorporate activities that were not implemented in 2020 in the operation plans for 2021, where feasible and realistic.

♦ Start planning for the PIP-PC workplans for 2022–2023, taking into consideration review results such as intra-action reviews (IARs), lessons learnt from the current pandemic and other recommendations of the PIP AG.
Conclusion

Based on the experience of implementing the PIP-PC workplan and deliberations of PIP-PC-recipient Member States during the virtual meeting on progress review of implementation of pandemic influenza preparedness (PIP) partnership contribution (PC) funds in priority countries in the Region, it must be concluded that PIP-PC funds have been extremely useful for supplementing and accelerating national pandemic influenza preparedness and response in the Region.

However, 2020 was challenging to the implementation of PIP-PC workplans due to the COVID-19 pandemic. It affected overall implementation in countries as compared to pre-COVID-19 years.

Despite these challenges, PIP-PC-recipient countries in the Region attempted to use PIP-PC funds in the best possible and innovative ways to strengthen pandemic influenza preparedness and response in tandem with the COVID-19 response.

In 2021, based on the lessons learnt and bottlenecks identified, PIP-eligible countries in the Region require optimal implementation of planned activities, having adapted to the “new normal” and utilizing the strategic direction of continuing delivery of essential health services in the context of COVID-19.

It is important to update (a) influenza pandemic preparedness and response contingency plans in countries with NAPHSs or (b) national influenza pandemic preparedness and response stand-alone plans in other countries utilizing the experience of responding to COVID-19 as a live exercise to test influenza preparedness and response plans.

Considering the importance of risk communication for managing infodemics in the current COVID-19 pandemic, strengthening national RCCM activities for influenza epidemics and pandemics is viewed as an area for continued investments in 2021 and beyond under PIP-PC funds.
The Pandemic Influenza Preparedness (PIP) Framework is an innovative public health instrument that brings together WHO, Member States, industry and other stakeholders to implement a global approach to pandemic influenza preparedness and response. The Framework includes a benefit-sharing mechanism called the Partnership Contribution (PC). PC is collected as an annual cash contribution from influenza vaccine, diagnostics and pharmaceutical manufacturers that use the WHO Global Influenza Surveillance and Response System (GISRS). Funds are allocated for pandemic preparedness capacity-building, response activities during a pandemic, and the implementation of the framework. In the WHO South-East Asia Region, Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal and Timor-Leste directly receive funds from the PIP PC to strengthen laboratory and surveillance and influenza pandemic preparedness planning capacities. This report focuses on how beneficiaries of PIP PC in the SEA Region, including the Regional Office, implemented activities to strengthen capacities in 2020. It includes recommendations of the virtual regional meeting on annual progress review of implementation of PIP-PC funds in priority countries in the SEA Region held in December 2020 that called for implementation of PIP activities in 2021 after adjusting for challenges and bottlenecks encountered in 2020. The report further outlines how beneficiaries plan to conduct PIP PC activities in 2021 and beyond.