

Report on the  
**Thirty-fourth meeting of the Regional  
Consultative Committee**

Cairo, Egypt  
20–21 April 2010

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## 1. INTRODUCTION

The thirty-fourth meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 20 to 21 April 2010. Members of the RCC and the WHO Secretariat attended the meeting. The programme and list of participants are included in Annexes 1 and 2, respectively. Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, welcomed the members of the Regional Consultative Committee.

The Regional Director referred to the evidence for climate change and the many changes already being witnessed in the Region. He noted that climate change had a wide range of implications for human health, including death and disease through natural disasters, such as heat waves, floods and droughts, increase in vector-borne diseases such as malaria and dengue, as well as other major killers such as malnutrition and diarrhoea.

He informed the Committee of the good progress made in poliomyelitis eradication in the Region despite the challenges and commitment of countries to reach the target. The situation continued to improve in the two endemic countries (Afghanistan and Pakistan), despite the challenges in the security-compromised areas, in part due to the strategy of using the bivalent vaccine in these countries. He noted the recent reporting of a serious epidemic in Tajikistan and indicated that the Regional Office was taking action to review and secure the situation in the border areas. In Pakistan emphasis was being placed on improvement in the high-risk areas in Pakistan and it was anticipated that the basic development needs approach would be helpful in improving advocacy with the community in this regard. Noting the impact of the financial crisis and global economic recession on donor capacity and on WHO's resources, he noted that while the polio programme was not currently threatened, it was becoming more difficult to attract new funds.

The Regional Director updated the RCC on the implementation of the WHO Global Management System (GSM), which had been rolled out for the Regional Office in January 2010. Staff members were now learning to work with it and the indications were that the rollout had been successful and as smooth as could be expected. The impact for operations had yet to be felt but it was expected to increase transparency and efficiency in WHO work in the Region.

Turning to the agenda of the meeting, the Regional Director introduced the technical papers that were proposed for discussion and subsequent presentation to the Regional Committee. Referring to the challenges of health care financing and moving towards universal health care coverage, he noted the wide variation in health expenditure and health care utilization between and within different countries of the world. The share of out-of-pocket health expenditure remained unacceptably high. Equity studies carried out in some middle-income countries of the Region showed that up to 5% of households in some countries face financial catastrophe following ill health and that half of them are pushed into poverty. The Regional Director also noted the growth of urbanization in the Region and the need to ensure equitable access to health care for the urban poor. Universal health care coverage

would pave the way for reducing out-of-pocket expenditure and reducing financial barriers in accessing health care.

The Regional Director noted that maternal, child and adolescent mental health was a neglected issue in the Region. The estimated prevalence of maternal mental disorders and child and adolescent mental disorders in the Region was significantly higher than the estimates for developed countries. Cost effective interventions are available to prevent and manage the common mental disorders in mothers and children. A comprehensive and integrated approach to reducing the burden of mental ill health for these vulnerable sections of society is essential.

Inadequate dietary intake continued to cause major problems in the Region, including protein energy malnutrition, high prevalence of low birth weight and micronutrient deficiencies. At the other end of the spectrum, the burden of overweight, obesity and diet-related chronic diseases was also increasing. The Regional Office had worked with partners to develop a regional nutrition strategy, the overall goal of which was to improve the nutritional status of people throughout the life cycle.

While overall adult HIV prevalence had remained low at an average estimated 0.2 %, evidence had accumulated that the epidemic was gaining hold in sub-groups of the population at increased risk. In the majority of countries there were still major gaps in knowledge of local dynamics of the HIV epidemic. The regional strategy for health sector response to HIV 2011–2015 would advocate for urgent action to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support and ultimately to attain the relevant targets of the Millennium Development Goals.

Infection prevention and control in health care facilities was an emerging agenda item for public health. The Eastern Mediterranean Region had one of the highest frequencies of health care-associated infections in the world confirming that this was a growing challenge to quality of health care in the Region and a threat to patient safety. A considerable proportion of this burden could be prevented with low cost interventions. However, compliance with standard infection control practices remained very low, particularly in low-income and middle-income countries. More public health action was needed for universal application of evidence-based precautions, compliance, behavioural change, risk management and standardized surveillance methods.

### *Discussion*

Responding to the update on the poliomyelitis situation and the potential challenge to sustained funding, the Committee noted the need to maintain emphasis on national capacity-building. The Regional Director confirmed that the regional polio eradication programme supported health system strengthening and would continue to do so.

The Committee noted that the GSM was an experience that should be shared with ministries of health, particularly in relation to transparency and cost-effectiveness, and if

possible the technology should be shared in order to minimize the gap in technology and effectiveness between the Regional Office and Member States.

The Committee suggested that, after 34 years, the time had come to review the functions, process and value of its work. Such a review might consider effectiveness, method of work, whether the Committee provided the best mechanism for advising the Regional Director, what improvements could be made and whether its role should be extended to Member States that might wish to. It also suggested that Member States should be more closely involved in the development of technical papers to the Regional Committee.

### **Recommendations to the Regional Office**

1. Document the experience with development and implementation of the GSM and share this with Member States.
2. Conduct a review of the work of the Regional Consultative Committee.
3. Provide an update at the next meeting of the Regional Consultative Committee on the poliomyelitis situation in the Region.
4. Develop a mechanism to collect, document and share best practice across all health areas of relevance to the Region.

### **2. FOLLOW-UP ON THE RECOMMENDATIONS OF THE THIRTY-THIRD MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE**

The report of the thirty-third meeting of the Regional Consultative Committee had been presented to the 56th Regional Committee for consideration. The Regional Committee had endorsed the report and commended the support provided by the Regional Consultative Committee in preparation of the technical papers presented to the Regional Committee and requested the Regional Director to implement the recommendations of the report.

The Regional Committee had endorsed the regional strategy for the prevention and control of cancer 2009-2013 and requested Member States to adopt and adapt the strategy, raise awareness of other sectors, implement all the related initiatives, integrate cancer control interventions into primary health care and contribute to establishing a regional fund for cancer prevention and control. It had requested the Regional Director to strengthen and expand partnerships with other stakeholders, support development and implementation of national plans and facilitate information collection and sharing, promote research and raise funds.

The Regional Committee had urged Member States to develop national strategies to reach the regional targets in reducing the prevalence of hepatitis B and C, develop and implement national strategies for prevention and control of blood-borne pathogens, expand vaccination programmes, promote infection control, ensure transfusion safety, establish education and communication programmes, scale up harm reduction services, and improve

epidemiological surveillance systems. It had requested the Regional Director to continue providing support for development of national strategies and plans of action, facilitate transfers of technology, support surveillance activities and support securing medicines at affordable prices.

The Regional Committee had urged Member States to assess and improve hospital management and quality of services, establish referral systems, promote a culture of cost analysis and cost containment, develop regulatory instruments, conduct reviews on hospital autonomy, develop cost-effective alternative approaches to hospital admissions, and evaluate the surge capacity of hospitals to cope with internal and external disasters. It had requested the Regional Director to provide technical support and guidance to improve hospital performance and development of strategic plans for strengthening hospital service management.

### *Discussion*

The Committee highlighted the problem of lack of standardization between countries in regard to testing for hepatitis. The result of this was a particular problem for migrant workers who may have tested negative prior to taking up jobs outside their country and were subsequently found to be positive for hepatitis. It was noted that hepatitis would be discussed by the World Health Assembly.

In response to the Committee's enquiry regarding follow-up on resolutions of the Regional Committee, the Regional Director clarified the role of the Regional Office in follow-up and implementation, and in reporting back to the Regional Committee, and the role of Member States in adopting and adapting regional strategies and guidelines. The Regional Consultative Committee was not involved in follow-up.

### **3. STRATEGIC DIRECTIONS TO IMPROVE HEALTH CARE FINANCING IN THE EASTERN MEDITERRANEAN REGION: MOVING TOWARDS UNIVERSAL COVERAGE**

Every year, hundreds of million of people seek health care. In doing so, millions of them become exposed to financial catastrophe and/or are eventually pushed into poverty because of having to pay for health care at the point of use. In addition, many households find themselves obliged to borrow money, use their savings and sell possessions to obtain needed health care. Some households even forgo needed care and live with the consequences of ill health because of financial barriers.

Out-of-pocket payment is the main culprit for households who suffer from financial catastrophe and its consequences. The share of out-of-pocket payments in many countries of the Region remains relatively high. As a result many households are exposed to the risk of financial catastrophe and impoverishment every year. Despite efforts made by Member States, WHO and other development partners, the progress in social health protection, in low- and middle-income countries, has been relatively slow. The development of prepayment schemes

and the move towards universal health care coverage provide a direct route to alleviate the burden associated with the demand for health care.

The paper aims to assess the major challenges facing health care financing globally and in the Region, and to suggest strategic directions to improve coverage by social health protection and implement Regional Committee and Health Assembly resolutions aimed at moving towards universal coverage based on primary health care. It provides practical steps to expedite the move towards universal health care coverage, recognizing the diversity among Member States and building on existing initiatives and policy reforms.

### *Discussion*

The Committee noted the importance and timeliness of the subject, and praised the structure of the paper. It emphasized the need to document and share best practices, with examples both from the Region and from the rest of the world. It also highlighted the need to clarify data sources, and to take into consideration the presence of multiple budget lines for health and which differ from one country to another. In focusing on primary health care, emphasis must be placed on renewed and comprehensive primary health care models that are responsive to the needs of populations and acceptable to them. There is also need for more investment in interventions to strengthen health care capacity among families and communities.

The theme of effective health care financing and universal coverage concerns fundamentals of the social welfare state. Multiple approaches are needed that are well-integrated and include the roles and responsibilities of both the public and private sectors. In this regard, advocacy is vital for raising awareness, and must be targeted not only towards the health sector but also to the highest level of governance and to the finance sector. Within the advocacy component, public acceptance of health care delivery needs to be addressed. For example, experience has shown that a rise in health care service provision tends to be accompanied by a rise in health care demand. As well, advocacy is an important tool for addressing the high cost of up-to-date medical services. In this regard, more attention should also be given to the issue of cost-sharing, and to research on cost-effectiveness. The Committee suggested that new models for primary health care should be explored, such as self-care, collective care and community care.

The Committee drew attention to ambiguity in the classification of countries by income level, noting that economists and health authorities classified them differently. Additional challenges in the Region that should be mentioned include: the need to address social determinants of health and basic minimum needs; poverty; unhealthy lifestyles and deteriorating environments; shortage of human resources for health; weak research; problems related to medical education; managerial weaknesses in the health sector; and governance issues.



**Recommendations to the Regional Office**

1. Document regional and international experiences in moving towards universal coverage, including success stories and best practices.
2. Clarify the functions of ministries of health in different countries with regard to social health insurance.
3. Encourage Member States to move away from line-item budgeting for ministries of health, to allow them more flexibility in allocating resources according to priorities.
4. Promote social health protection as a component of a broader strategy for social protection.
5. Develop practical guidelines for countries in moving towards universal coverage.
6. Target recommendations not only to the Ministry of Health but also to other health stakeholders.
7. Take into consideration changes in public health situation, public expectations and demand for health care services, and encourage development of innovative models of primary health care delivery.
8. Identify the roles of individuals and communities in moving towards universal coverage, and advocate for community-oriented services.

**4. MATERNAL, CHILD AND ADOLESCENT MENTAL HEALTH:  
CHALLENGES AND STRATEGIC APPROACHES**

The mental health of all sections of the society is important in its own right and the Regional Office is in the process of developing a regional mental health strategy. However, the need to take the lead in this particular area stems from the fact that the Region is undergoing rapid social, political, economic change. Seven countries are experiencing complex emergency situations affecting about 40% of the population of the Region. High population growth rates have resulted in an estimated 60% of the population below 19 years of age. As a result of these factors, mothers and children and adolescents share a disproportionate burden of neuropsychiatric disorders (26% and 27%, respectively).

Maternal mental disorders are associated not only with adverse reproductive health outcomes but are also one of the modifiable risk factors for adverse child and adolescent development outcomes. There are cost effective interventions available to prevent and manage the common neuropsychiatric disorders. The strategic directions and actions suggested in the paper provide a foundation for development of national strategies and action plans for development of a comprehensive and integrated approach to reducing the burden of mental ill health for these vulnerable sections of the society. The priority areas for action

include integration of mental health services in the existing health and social services, intersectoral action to prevent mental disorders and promote well-being, and promotion of research evaluation and monitoring.

### *Discussion*

The Committee noted the importance of emphasizing the need to update existing national strategies for maternal, child and adolescent mental health and formulate new strategies where none exist. Member States need to be provided support and guidance regarding the process/steps to formulate/update these national strategies. Enhanced political commitment and visibility and addressing stigmatization should be two of key components in formulating/updating these strategies, supported by detailed plans of action.

The Committee identified the integration of mental health services into primary health care as a priority area for action. The challenges for the integration of a mental health component in these services include the need to build the capacities of both health personnel and health systems; nurse, midwives and doctors need to be provided with training and education. Counselling services, in particular, need to be developed, especially for children, many of whom are being traumatized by their exposure to conflict which is affecting several countries of the Region. There have been successful experiences in some countries, such as the Islamic Republic of Iran and Pakistan, which managed to integrate mental health component in the community and lady health workers programmes, respectively. The best models and practices from countries should be emulated and a plan of action created. Another area identified for priority action was to instigate a process of cultural change to reduce the levels of stigma and discrimination faced by those experiencing mental health problems and disorders, through involvement of the civil society, education sector and media in promoting mental health literacy. The mental health component needs to be an integral part of school curricula and should also be part of the school health surveys which are conducted every five years and which could provide useful data if mental health was addressed. Mental health policy should emphasize the need to protect vulnerable groups and focus on the requirements for these services. The role of the police and prison staff in the treatment of the mentally challenged is also an issue for consideration in this area.

There is a vital need for research, especially on effective intervention strategies and the adaptation of the management strategies shown to be effective in other regions, to reflect the sociocultural ethos of the Region. A research forum could be established to identify case management strategies. Greater effort needs to be invested in the development of community-based interventions for management of cases and mother, child and adolescent mental disorders. It is essential to ensure cultural validation of the diagnostic tools and instruments used in conducting research and evaluation studies. Concern was expressed at the assertion that there was a connection between maternal depression, and suicide and the perinatal period, and it was suggested that a greater number of suicides were taking place as a result of the economic hardship being faced by many in the Region, but there is clear evidence that the consequences of maternal depression can lead to suicide.

Although eight countries have updated mental health legislation in the last few years there is a need for strengthened legislation in the Region. Egypt, Pakistan and Kuwait have all strengthened their mental health legislation and would serve as good models for countries, such as Oman, which is currently in the process of strengthening its legislation. It has been identified that there are an estimated 5 million people with epilepsy in the Region; epilepsy is classified as a neurological disorder in the International Classification of Diseases (ICD 10). Although some concern was raised about its inclusion among the common neuropsychiatric disorders affecting children and adolescents, there is robust evidence for regarding epilepsy as being on the interface of neurology and psychiatry. These dimensions need to be taken into account when devising management plans.

Intersectorality must be more explicitly defined identifying the roles of individual sectors like education, social welfare, finance and law at policy formulation as well as at the operational level. At an operational level it means that mental health issues are addressed as part of all the health programmes being implemented.

#### **Recommendations to the Regional Office**

1. Further emphasize the importance of mental health as part of the primary health care package and primary health care facility profiles, especially for mothers, children and adolescents as the most vulnerable population groups.
2. Emphasize the development of human resources in mental health care, especially for mothers, children and adolescents, as a priority at all levels of health care to enable the provision of quality services, and the integration of a mental health component into the education curricula of all health professions.
3. Promote research and evaluation to fill the information gap through developing a regional research agenda and use of culturally valid instruments/tools.
4. Emphasize the need to strengthen the concept of intersectorality and intrasectoral coordination, especially at the level of policy formulation.
5. Develop a regional mental health strategy to provide an overarching framework that should include the strategic directions suggested for maternal, child and adolescent mental health.
6. Develop partnerships with the media, civil society organizations and the education sector in promoting mental health literacy and advocating against stigma and discrimination.

#### **5. REGIONAL STRATEGY ON NUTRITION 2010-2015**

The burden of disease associated with inadequate nutrition continues to grow in countries of the Region. Countries of the Eastern Mediterranean Region, like many

developing countries, are undergoing unprecedented nutritional and demographic transition, with a broad shift in disease burden. Malnutrition presents significant challenges to human health, especially in developing countries. More than one third of child deaths worldwide are attributed to under-nutrition. It is estimated that about 195 million children under 5 years of age globally are stunted, resulting from insufficient food intake, a vitamin- and mineral-poor diet, and disease. The overall proportion of underweight in children under 5 years of age increased in the Region from 14% in 1990 to 17% in 2004, due to complex emergency situations and internal conflicts in Afghanistan, Iraq, Pakistan, Palestine, Somalia, Sudan and Yemen, by the financial and food crises. About 45% of the population in the Region suffers from anaemia, and noncommunicable diseases are estimated to account for over 50% of all deaths, and for more than 60% of the disease burden.

The regional nutrition strategy was developed through a consultative process by the WHO Regional Advisory Committee on Nutrition, which includes representatives from Member States, FAO, UNICEF, WFP, UNRWA, ICCIDD and MENANA and IUNS. The objective of the strategy is to assist countries to establish and implement action plans for nutrition according to their national situation. The overall goal of the nutrition strategy is to improve the nutritional status of people throughout the life cycle by encouraging countries in the Region to reposition nutrition as central to their development agenda. The strategy aims to reduce malnutrition, including under-nutrition and micronutrient deficiencies, and to enhance prevention and control of obesity and noncommunicable disease.

#### *Discussion*

The Committee expressed concern at the continuing existence of micronutrient deficiencies in the Region. It emphasized the need to address the multisectorality of this problem, why current national strategies in some countries are not working, and the need for WHO to work with other ministries and sectors in this regard. Private sector awareness with regard to its social responsibilities in nutrition and food fortification needed to be strengthened, including its promotion of food trends of low nutritional value.

The Committee emphasized the need for national food-based dietary guidelines. It drew attention to the role of food safety in supporting population nutrition, and the effect of unsafe foods on depleting nutritional status. It highlighted the role of nutrition in supporting healthy child development. It also noted the link between nutrition and national health development. In this regard, it considered that WHO should address the nutrition 'literacy' of parliamentarians and governments in order to ensure political support for a broad intersectoral approach to the problem, for better legislation and for better regulation of the food sector, and for effective evidence-based social welfare support. At the same time, ministries of health needed to show coordination at an intrasectoral level within the health sector. Nutrition did not receive the attention it deserved and should be linked across all health programmes. The regional strategy should target the underlying causes of malnutrition, including poverty and deficiencies in social welfare systems, and place nutrition in the broad social, cultural and environmental context. Malnutrition could not be tackled without reference to underlying causes, in particular social, cultural and environmental determinants. In this regard,

innovative and alternate approaches, such as 'sprinkles', and building on the best practices in both this and other regions, needed to be explored.

Advocacy for and promotion of healthy nutritious foods, through media, schools and food outlets and with the food industry, should be an important component of the strategy. This would raise public expectations and demand for nutritious food. At the same time, the strategy should support awareness-raising of the public in regard to nutrition and diet.

The Committee noted the importance of identifying which version of the child growth standards was the source of the data presented since this would have an impact on analysis of the situation. It also suggested that the double burden of disease relating to over-nutrition and under-nutrition in the Region should be highlighted in the introduction to the paper. The Committee noted that the recommendations proposed in the paper were many and recommended that the strategy should indicate priority actions in relation to the different situations and capacities of the countries of the Region.

#### **Recommendations to the Regional Office**

1. **Emphasize the need to increase nutrition awareness of the public, as an efficient means to increase the knowledge of people about healthy and balanced diets.**
2. **Advise all countries to adopt the new child growth monitoring standards and advise them on how standardization of the methods of comparison between the old and new standards.**
3. **Emphasize the need to place more focus on the link between over-nutrition and noncommunicable diseases, according to the nutrition profile of the countries.**
4. **Highlight the linkage between food safety and nutrition status.**
5. **Emphasize the role of nutrition in the national development process and its link with social determinants of health, as defined by the WHO Commission on Social Determinants of Health, and with basic development needs, as well as with the achievement of the Millennium Development Goals.**
6. **Emphasize the need to introduce the regional food-based dietary guidelines to Member States as an efficient means to ensure diet diversification among the people, and encourage development of national guidelines.**
7. **Highlight models of best practice, efficient programmes and mass intervention to address micronutrient deficiencies in the Region.**

## **6. REGIONAL STRATEGY FOR HEALTH SECTOR RESPONSE TO HIV/AIDS 2011–2015**

HIV prevalence in the general population has remained low in most countries of the Region except for Djibouti, the southern part of Sudan and parts of Somalia. However, there is evidence that the epidemic is gaining foot in sub-groups of the population at increased risk associated with injecting drug use or risky sexual behaviours. In the majority of countries there are still major gaps in knowledge of the local dynamics of the HIV epidemic. Efforts to prevent further spread of the epidemic and to expand access to life-saving antiretroviral therapy (ART) have increased substantially, resulting in a 70% increase in the number of people receiving ART between 2007 and 2009. However, regional ART coverage remains below 10%, the lowest globally. Only three countries have achieved appreciable coverage of people in need of prevention services. Low coverage of programs reaching those at increased risk are the main reason for the continued transmission of HIV.

The purpose of the regional strategy for health sector response to HIV 2011–2015 is to advocate for urgent action of Member States to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support and ultimately to attaining the Millennium Development Goals. The strategy takes into consideration commitments made by Member States to the achievement of universal access and builds on the two previous strategies 2002–2005 and 2006–2010. It accommodates the need for re-orientation based on better knowledge of HIV epidemiology in the Region, on lessons learnt from national HIV/AIDS programmes' successes and failures, as well as the need to strengthen commitment and to address persisting challenges more efficiently.

The regional strategy promotes expansion of coverage and improvement of quality of known effective health sector interventions. It puts increased emphasis on strengthening existing health systems to enable integration of HIV programmes and services, targeting interventions to those population groups where most transmission is likely to take place and improving the information on local dynamics of the HIV epidemic to enable strategic decision-making. It promotes specific approaches to enhance access to prevention, care and treatment.

### *Discussion*

The Committee noted that the paper on the regional strategy for the health sector response to HIV/AIDS would benefit from mapping HIV epidemic status and incidence and evaluating previous surveillance studies. The regional strategy proposes that countries incorporate proposed priority interventions. To enhance the added value to countries' national strategies the regional strategy should include a collection of best practices, such as the success of the surveillance system in Pakistan and Morocco in determining trends in HIV prevalence among high-risk groups, such as injecting drug users, sex workers and men having sex with men, the latter group of which is notoriously difficult to reach. The conducting of workshops to promote and disseminate these best practices would be most useful in the Region. Pakistan has also had very successful experiences in the use of civil society to

implement HIV prevention and control programmes. There is a need for their greater involvement in the Region, whose increased role would also represent a way forward in addressing the reluctance of some governments to deal with the issue of HIV.

The rudimentary nature of reporting in the Region is a challenge for accurate and timely data collection which is evidenced from the disparity in the numbers being reported from countries which are disproportionate to population sizes. Improved surveillance will be key to better and more accurate estimates of the number of people living with HIV, HIV incidence (new infections) and treatment needs. There is a need to improve weak surveillance systems in many countries of the Region as improved surveillance would not only lead to more accurate estimates of the number of people living with HIV but would help to better target prevention and treatment interventions. The regional strategy should focus on closing the gap between the estimated need and actual regional ART coverage; despite the fact that 146 000 people living with HIV are estimated to need ART in the Region, only 10% of these are receiving ART. Performance-based monitoring and evaluation is needed to show the progress of countries in achieving the targets of the strategy. Testing for pregnant women is offered for free as a component of antenatal care packages and in countries such as Oman this testing is being well accepted.

Awareness-raising campaigns are needed in schools to educate younger populations whose education on the issue has been neglected over recent years, and would also assist in decreasing prejudice and stigmatization in the Region suffered by those with HIV.

#### **Recommendations to the Regional Office**

1. Highlight achievements with regard to the regional strategy for the health sector response to HIV/AIDS 2006–2010.
2. Emphasize the importance of countries strengthening their monitoring systems and include indicators that show the progress of countries in achieving the targets of the strategy.
3. Emphasize the urgent need to improve surveillance.
4. Highlight gaps in treatment coverage and emphasize priority interventions to increase access to treatment.
5. Elaborate on the integration of HIV testing of pregnant women in antenatal care for prevention of mother-to-child transmission through provision of antiretroviral therapy or prophylaxis to HIV-infected women.
6. Include examples of best practice from countries.

## **7. INFECTION PREVENTION AND CONTROL IN HEALTH CARE FACILITIES: AN EMERGING AGENDA FOR PUBLIC HEALTH**

Infections acquired during health care delivery—health care-associated infections—are by far the most frequent adverse events that threaten the safety of patients around the world. Health care-associated infections occur worldwide and affect both developed and resource-poor countries. About 5%–10% of patients in hospitals in developed countries acquire such infections at any given time but the risk is 2–20 times higher in developing countries. The Eastern Mediterranean Region of WHO has one of the highest frequencies (11.8%) of health-care associated infections in the world confirming that this is emerging as a growing challenge to quality of health care in the Region. The economic cost of health-care associated infections, as well as the opportunity cost to health services, is staggering. According to some estimates, preventing one case saves on an average more than US\$ 10 000 and reduces the patient's risk of death from 7% to 1.6%.

The pandemic (H1N1) 2009 virus infection, the growing emergence of antimicrobial resistant microorganisms and the evolving public health threats from known and unknown disease pathogens like the SARS and viral haemorrhagic fevers have underscored the need for standard infection control practices in health care facilities for the management of highly pathogenic infectious diseases. In this time of changing epidemiology of infectious diseases, the risk of amplifying transmission in health care settings remains greater than ever before without a culture of sustained safe health care practices in the health systems.

The recent launch of World Alliance for Patient Safety, led by WHO, has resulted in a global movement, commitment and action to control health-care associated infection. Despite being a threat to patient safety, a considerable proportion of the burden of disease attributable to health-care associated infections can be prevented with low cost interventions. The implementation of evidence-based infection control measures needs more clinical governance at a very high level. More public health action is needed for universal application of evidence-based precautions, compliance of precautions, behavioural change, risk management, standardize surveillance methods, sterility assurance and to generate more reliable estimates of the burden of health-care associated infections through clinical audit. All these interventions need to be embedded and sustained in a comprehensive patient safety climate.

### *Discussion*

The Committee noted that infection control is an important issue on the public health agenda, with awareness, training, management and regulatory dimensions. Education and awareness are important both for health care workers and for the public, especially patients. The experience with pandemic H1N1 has highlighted vaccination of health care workers as an important infection control policy issue. As well, antimicrobial-resistant organisms such as methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant enterococci and ESBL-producing *Klebsiella pneumoniae* are particular challenges for control of infection in health care facilities that need to be addressed.



An independent regulatory body is needed to oversee infection control, which should be linked to health facility accreditation. Such a body could be located within ministries of health or other institutes. The Committee highlighted the strong link between the issues of infection control, medical error and patient safety. More exploration is needed of underlying causes of hospital acquired infection, for example environment-related and health system-related causes. National-level studies on medical errors are needed in all countries.

#### **Recommendations to the Regional Office**

1. Emphasize the establishment an independent national regulatory authority or body to oversee patient safety in health care settings, including: health-care associated infections; medical errors; accreditation of facilities; mandatory training of the health workforce; and national level assessment, including cost analysis, of the patient safety situation.

#### **8. SUBJECTS FOR DISCUSSION DURING THE THIRTY-FIFTH MEETING OF THE REGIONAL CONSULTATIVE COMMITTEE (2011)**

The Committee noted that presentation of four papers only was preferred to enable effective discussion. It suggested the following topics for consideration.

Social determinants of health

Health services and health care in crisis and post-crisis situations

Urbanization and health with special reference to equitable health care delivery

Patient safety

Health and environment

Primary health care

## Annex 1

## PROGRAMME

**Wednesday, 20 April 2010**

08:30–09:00	Opening remarks	<i>Dr Hussein A. Gezairy Regional Director</i>
09:00–09:15	Follow up on the recommendations of the 33rd meeting	<i>Dr Naeema AlGasseer Assistant Regional Director</i>
09:15–10:00	Strategic directions to improve health care financing in the Eastern Mediterranean Region	<i>Dr Hossein Salehi Regional Adviser, Health Economics, Legislation and Ethics</i>
10:30–11:15	Mental, child and adolescent mental health: challenges and strategic approaches	<i>Dr Khaled Saeed Regional Adviser, Mental Health and Substance Abuse</i>
11:15–12:00	Regional Strategy on Nutrition, 2010–2015	<i>Dr Ayoub AlJawaldeh Regional Adviser, Nutrition</i>
12:00–12:45	Regional Strategy for health sector response to HIV/AIDS 2011–2015	<i>Dr Gabriele Riedner Regional Adviser, AIDS and Sexually Transmitted Diseases</i>
12:45–13:30	Infection Prevention and control in Health Care Facilities: An emerging agenda for Public Health	<i>Dr Mamunur Malik Technical Officer, Emerging Diseases</i>

**Thursday, 21 April 2010**

10:00–11:00	Conclusion and recommendations	
11:00–11:30	Subjects for discussion during the 35th meeting of the RCC (2011) Closing	<i>Dr Naeema AlGasseer Assistant Regional Director</i>

**Annex 2****LIST OF PARTICIPANTS****Members of the Regional Consultative Committee**

Professor Mamdouh Gabr	Secretary-General, Egyptian Red Crescent Society, Cairo, EGYPT
Dr Alireza Marandi*	President of the Iranian Academy of Medical Sciences, Member of Parliament and Professor of Pediatrics and Neonatology, Chairman of the Board of Trustees, Society of Breast Feeding, Teheran, ISLAMIC REPUBLIC OF IRAN
Dr Abdul Rahman Al Awadi	President, Islamic Organization for Medical Sciences, KUWAIT
H. E. Dr M. Jawad Khalife*	Minister of Public Health, Ministry of Public Health, Beirut, LEBANON
H.E. Dr A. Bin Abdul Aziz Al-Rabeeah*	Minister for Health, Ministry of Health, Riyadh, Saudi Arabia
H.E. Mr Ejaz Rahim	Former Federal Minister for Health, Government of Pakistan, Islamabad, PAKISTAN
Dr Omar Suleiman	President, Development Action Now (DAN), Director Development Technology and Services International (DTASI), Khartoum, SUDAN
H.E. Dr Mohamed C. Biadillah*	Former Minister of Health, Rabat, MOROCCO
H.E. Dr Saad Kharabsheh*	Former Minister of Health, Amman, JORDAN
Dr Zulfiqar Bhutta*	Professor of Paediatrics, Department of Paediatrics, The Aga Khan University, Karachi, PAKISTAN
Professor Koussay Dellagi*	Director of the Centre for Research and Scientific Intelligence on Emerging Infectious Diseases in the Indian Ocean (CRVOI), Tunis, TUNISIA
Dr Ali Bin Jaffer Suleiman	Advisor, Health Affairs Supervising the Directorate General of Health Affairs, Ministry of Health, Muscat, OMAN
Professor Peter Hansen*	Former Commissioner General, UNRWA, Diplomatic-in-Residence, Fordham University, New York

\* Did not attend

**WHO Secretariat**

<b>Dr Hussein A. Gezairy</b>	<b>Regional Director</b>
<b>Dr A. Assa'edi</b>	<b>Deputy Regional Director</b>
<b>Dr N. Al Gasseer</b>	<b>Assistant Regional Director</b>
<b>Dr M. H. Wahdan</b>	<b>Special Adviser (Polio) to Regional Director</b>
<b>Dr B. Sabri</b>	<b>Director, Health Systems and Services Development</b>
<b>Dr R. Thomas</b>	<b>Director, General Management</b>
<b>Dr H. Madi</b>	<b>Director, Health Protection and Promotion</b>
<b>Dr J. Mahjour</b>	<b>Director, Communicable Diseases Control</b>
<b>Dr S. Bassiri</b>	<b>Co-ordinator, Programme Planning, Monitoring and Evaluation</b>
<b>Dr H. Salehi</b>	<b>Regional Adviser, Health Economics, Legislation and Ethics</b>
<b>Dr K. Saeed</b>	<b>Regional Adviser, Mental Health and Substance Abuse</b>
<b>Dr A. Al Jawaldeh</b>	<b>Regional Adviser, Nutrition</b>
<b>Dr G. Reidner</b>	<b>Regional Adviser, AIDS and Sexually Transmitted Diseases</b>
<b>Dr M. Malik</b>	<b>Technical Officer, Emerging Diseases</b>
<b>Ms J. Nicholson</b>	<b>Programme Manager, Editorial, Graphics and Publishing Support</b>
<b>Ms Nermine Salah</b>	<b>Senior Secretary, Programme Planning, Monitoring and Evaluation</b>
<b>Ms Doaa Gad</b>	<b>Secretary, Programme Planning, Monitoring and Evaluation</b>