



In the Name of God, the Compassionate, the Merciful

Address by

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to

**THE THIRD INTERNATIONAL CONGRESS ON INFECTIOUS AND TROPICAL
DISEASES AND SIXTH GCC CONFERENCE ON INFECTION CONTROL**

Muscat, Oman, 5-8 December 2011

Dear Colleagues, Ladies and Gentlemen,

It gives me great pleasure to be here with you for the Third International Congress on Infectious and Tropical Diseases and the Sixth GCC Conference on Infection Control. I would like to thank the Government of Oman and in particular His Excellency Dr Ahmed Al Saidy, Minister of Health, and his dynamic collaborators, for organizing this important Congress, in collaboration with Sultan Qaboos University and the Gulf Cooperation Council, and for inviting the WHO Regional Office for the Eastern Mediterranean to participate.

Dear Colleagues,

As you know, emerging diseases comprise a group of diseases that has appeared in a population for the first time, or that may have existed previously but is rapidly increasing in incidence or geographic range. They also include some “older” diseases which have been effectively controlled with the help of modern technologies, such as antibiotics and vaccines, while others, such as malaria, tuberculosis and bacterial pneumonia, are now re-emerging in forms resistant to drug treatments. These diseases cause significant suffering and death toll, and impose an enormous financial burden on affected countries.

Our closely interconnected world ensures that adverse events in one country cross easily into others and can, thus, threaten global health security. The increasing movement of people between countries and continents has made it possible for emerging diseases to spread within a very short span of time, a few hours only, and thus to threaten the health and well-being of people around the globe. The international response to severe acute respiratory syndrome (SARS) was an extreme test of the mechanisms for outbreak detection and containment that had been under development in WHO since 1997. These mechanisms were themselves the response to an earlier crisis: the 1995 outbreak of Ebola haemorrhagic fever in Kikwit, Democratic Republic of the Congo. That outbreak, which escalated undetected for three months, caught the international community by surprise, and highlighted the urgent need to improve capacity in several specific ways. Outbreaks can quickly expose any shortcomings in global health security, such as in detection and reporting, response capacity, preparedness and laboratory bio-safety.

Influenza pandemics are recurring and unpredictable calamities. The overall goal of pandemic preparedness and response is to minimize serious illness and overall deaths, as well as to minimize societal disruption as a result of an influenza pandemic. Good preparedness for pandemics, outbreaks, natural and man-made disasters help delay and flatten epidemic peak, reduce peak burden on the health care system and reduce the total number of cases and human suffering. The experience of pandemic (H1N1) 2009 was a challenge and an opportunity to test our pandemic preparedness. Preparedness plans should be continuously revised and updated based on current knowledge, and validated through exercises. Now is the opportune time to develop and review additional preparedness plans for other potential emergencies. There is an African proverb that says “The best time to plant a tree is twenty years ago. The second best time is now”.

Dear Colleagues

As you know, the International Health Regulations (2005) constitute a legally binding instrument that assists States Parties in building their core capacities, especially in the areas of surveillance and response as outlined in Annex 1A of the Regulations. This strengthens national capacities in diagnosing, detection and notifying of public health events that might be of national and international concern. Accordingly, countries should notify WHO of any event that might constitute a public health emergency of international concern (PHEIC). This should be

implemented at the national level by establishing “event”-based surveillance systems, as well as by adopting an integrated approach in diagnosis, surveillance, risk communication and response. In addition, a common platform of work has been established at the WHO Regional Office for the Eastern Mediterranean to include an all-hazards approach within the context of the International Health Regulations 2005. World Health Assembly resolution WHA58.3 (2005), adopting the Regulations, provided further support to enhance national, regional and global health security.

The Regional Office has been supporting countries of the Region in assessing, building and sustaining the core capacities required for implementation of the regulations. It is currently focusing on helping countries to monitor their progress in building core capacities, using well-established tools and mechanisms. The results of the monitoring questionnaire for 2011 will be discussed with the national focal points in a meeting that will take place in Cairo in December 2011, and in which gaps and weaknesses in fulfilling the technical capacities for implementation will be identified. This will support countries in defining their position in terms of meeting the obligations and requirements to implement the Regulations by 15 June 2012. The Regional Office will continue to provide the maximum support required to countries before 15 June 2012.

Dear Colleagues

Infections acquired during health care delivery, more appropriately called health care-associated infections, are by far the most frequent adverse events in health care. Health care-associated infections occur worldwide and affect both developed and resource-limited countries. About 5%–10% of patients admitted to acute care hospitals in developed countries acquire health care-associated infections at any given time but the risk of acquiring infection is 2–20 times higher in developing countries. The Eastern Mediterranean Region has one of the highest frequencies (11.8%) of health care-associated infections in the world, confirming that this is 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 enormous. According to some estimates, preventing a case of health care-associated infection saves, on average, more than US\$ 10 000 and reduces the patient’s risk of death from 7% to 1.6%.

The continuing emergence of pathogenic microorganisms that are resistant to first-line antimicrobials is a cause of increasing concern. This emergence is associated with higher levels

of mortality and morbidity, which not only impacts on patients but also increases the burden on health care services as a result of additional diagnostic testing, prolonged hospital stay and increased intensity and duration of treatment. Antimicrobial resistance is a well-recognized problem worldwide. The development and spread of resistant bacteria is a public health issue at the local, regional and global levels. It threatens the effective treatment of infections and could reverse some of the major achievements of modern medicine. Although resistance to antibiotics is a natural phenomenon, it has been made worse by increased transmission of infections, and especially by the injudicious overuse of antibiotics.

Resistant organisms are more likely to circulate in intensive care settings, where a combination of debilitated patients and invasive technology is found. There is evidence to suggest that more prudent usage of antimicrobials, particularly in the treatment of human disease, but also in veterinary practice, animal husbandry and agriculture, could have a significant impact on the pace and extent to which resistance emerges in microorganisms pathogenic to man. WHO and the International Union against Tuberculosis and Lung Disease have shown that resistant tuberculosis is a problem in many parts of the world.

The WHO bio-safety and laboratory bio-security programme provides guidance on and promotes the use of safe and secure workplace practices, appropriate protective equipment, engineering and administrative controls in the handling of pathogenic organisms in laboratories, during transportation, in field investigations and in vaccine manufacturing facilities, to protect workers, the environment and the community from exposure, infection, and subsequent development of disease.

The aim of the programme is to assist countries to understand, adopt and implement bio-risk management strategies to minimize risk of infection through safe and secure practices in laboratory and transport environments, and to accomplish these goals in a cost-effective manner. The vision includes developing a cross-cutting coordinated WHO strategy for bio-safety and laboratory bio-security supporting vertical disease-specific programmes and activities.

Oman was the first country in the Region to implement this programme. WHO provided technical support to Oman to develop a master plan on laboratory bio-safety preparedness and response under a joint programme with the European Union and the Ministry of Health. The project aims at improving laboratory bio-safety and bio-security preparedness within the

framework of the European Union's strategy against proliferation of weapons of mass destruction. Preparations to launch similar projects in Jordan and Egypt are underway in the Region and I hope that more GCC countries will become involved in such projects.

Dear Colleagues,

Once again, I wish to express my sincere gratitude to the Government of Oman and in particular to His Excellency Dr Ahmed Al Saïdy, Minister of Health, to Sultan Qaboos University and the Gulf Cooperation Council, for organizing this important congress. I wish you all success in your deliberations and a pleasant stay in Muscat.

Thank you.