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Report on the

Thirty-third meeting of the Regional Consultative Committee

Cairo, Egypt
15–16 April 2009

World Health Organization
Regional Office for the Eastern Mediterranean

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CONTENTS

1. INTRODUCTION

The thirty-third meeting of the Regional Consultative Committee (RCC) was held in the Regional Office for the Eastern Mediterranean, Cairo, from 15 to 16 April 2009. 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 to the meeting noting the importance of the committee for advising the Regional Office on the technical issues to be presented to the Regional Committee.

The Regional Director referred to regional health developments of the past year. He noted particularly the global movement for the renewal of primary health care. The Region had witnessed a milestone meeting of Member States in Qatar which had resulted in the Qatar Declaration on Primary Health Care. The global and regional debate had highlighted the fact that the original primary health care approach as expressed in the Declaration of the Alma-Ata was well conceived and could not be improved upon. More important was the recognition of primary health care as the foundation of a good health system and the need to apply it more widely to ensure equity and accessibility to health care for all. The importance of social determinants of health and partnership had still not pervaded in the mind and practice of many health partners. The health sector in the region was in transition with forceful advocacy for health promotion and protection not yet properly positioned. Intersectoral and intrasectoral collaboration and community involvement, partnership and leadership were key issues that the Member States needed to address. The renewal of the PHC movement provided WHO in the countries with an exciting, innovative, technical, diplomatic and managerial challenge to broker a workable national vision.

Dr Gezairy drew attention to the current global financial crisis. This would definitely have an impact on extrabudgetary contributions and on WHO's work and its ability to provide countries with technical support. It was also expected to have negative impact on national health development as governments reduce spending. With regard to the emergency and humanitarian situation in the Region, on average, at any one time, 6–8 countries in the Region faced one or more types of emergeny, with some facing chronic and complex situations. The Regional Office had focused its emergency and humanitarian efforts in the past year on technical support for the people in the occupied Palestinian territory, and on reconstruction and rehabilitation in Afghanistan, Iraq, Somalia and Sudan. The events in the Gaza Strip had once again demonstrated the vulnerability of people of the Region to violence.

Dr Gezairy noted that eradication of poliomyelitis appeared to be back on track but that the situation was critical. The challenges to security in southern Afghanistan and parts of Pakistan were serious. To eradicate poliomyelitis from the remaining areas and minimize the risk of re-emergence in the post-eradication areas, resources would need to be mobilized for supplementary immunization activities. Maternal and newborn health was still a priority issue and the Regional Office continued to emphasize its importance. Successful experiences should be shared and built upon, regional networkings strengthened and efforts and resources well coordinated. Communicable diseases remained a priority in many countries of the Region, while noncommunicable diseases were rising. The main challenge was how to

strengthen health systems in order to develop the necessary integrated approach and cross-cutting activities.

The Regional Director noted that the 55th session of the Regional Committee had endorsed the report of the 32nd meeting of the Regional Consultative Committee (resolution EM/RC55/R.3) and had commended the support provided by the Committee to the Regional Director. All the recommendations provided by the Committee in its previous session had been taken into account in the presentations made to the Regional Committee and in the resolutions endorsed by the Committee.

Dr Gezairy briefly introduced the technical papers to be discussed by the Committee. Hepatitis B and C and cancer were growing threats in the Region which presented urgent challenges in terms of prevention and control. Road traffic injuries represented a growing public health concern and a major cause of death among 15–45 year olds in the Region. It was a multisectoral problem with enormous human, social and economic cost that required a multisectoral response with a clearly defined role for ministries of health. Improving hospital performance was a subject of concern to all countries, whatever their resources. Hospitals absorbed a major proportion of government expenditure on health and were a major employer of staff within health systems. Optimal use of hospitals and of technology and effective management were key issues for cost-effectiveness. The Region currently lacked a culture of costing and cost analysis and of professional management. Improving hospital performance was high on the reform agenda of many countries, but had to be addressed within the context of improving health system performance as a whole.

Discussion

In response to the opening remarks of the Regional Director, the Committee highlighted a number of issues for further consideration. The global financial crisis in particular was highlighted. It was noted that the economic stimulus packages being implemented in various countries provided opportunity for WHO to highlight the impact of the crisis on health and to advocate for some of the funds being invested in economic stimulus to be placed in the health sector. This was also an opportunity to emphasize the economic role of the health sector as a producer of wealth rather than the stereotypical view of it as a consumer and a service industry. It was also timely, following the culmination of events that led to the food and financial crises, to highlight the need for social safety nets for the poor and vulnerable. Health is a vehicle for social development and ministers of health should be encouraged to advocate on behalf of the health sector from this political perspective. Health reform should include re-evaluation by governments of the role of the ministry of health, not only as a provider of essential health care but as an advocate for coordination, collaboration and cooperation between and within sectors where health issues are at stake. Innovative ways of addressing the impact of such crises should be discussed in regional forums. With regard to the impact of the financial crisis on WHO and its ability to support its Member States, it was suggested that the time has come to review the financial regulations so that contributions made late in the biennium can be implemented appropriately.

With regard to the war in the Gaza Strip, the need to maintain concentration of attention on the health situation there as well as to document the cost of the war on health and on the health system and present it to the UN was highlighted. Concerning the renewed vision for primary health care, new models and strategies, that are appropriate for the communities in the Region, need to be developed. This is currently a stagnant area. There are several good models within the Region and that these should be showcased as such. At the same time there should be stronger advocacy on behalf of primary health care as the foundation of any good health system, with a clear role for the community as the major stakeholder. Integration with primary health care and equitable access to health care should be included in all regional meetings and forums as a major point of discussion otherwise momentum would be lost. The Committee agreed that the lack of a culture of costing and cost analysis in the Region hindered health sector development in general, not just improvement of hospitals. There is also no methodology for innovation in the health sector in the Region and this hinders countries' ability to anticipate and address issues specific to their context. Inclusion of road traffic injuries on the agenda was commended while it was noted that injuries in general and childhood injuries in particular are a major area of neglect in the Region with very little data available on the magnitude of the problem. Finally, focus on maternal and neonatal health in the Region should be sustained.

The Committee suggested that the preparation for the annual meeting of the Committee might be broadened to include academia and partners in order to provide a wider range of experience and views. It also suggested there is need to strengthen regional health networks.

Recommendations to the Regional Office

1. Advocate strongly with Member States not to disinvest in the health sector at this time of global economic crisis, but rather to invest in the health sector as a vehicle for social and economic development, and in particular to invest in primary health care as a cost-effective strategy for long-term health development.
2. Evaluate and showcase good models of primary health care in the Region, and include integration with primary health care as an element in all regional meetings and forums.
3. Request the WHO governing bodies to review the financial regulations, particularly in relation to use of late contributions.
4. Develop a paper for presentation to the UN on the impact of acute and chronic conflict in the Region on the health of populations, health development and health systems, with particular focus on the recent war in the Gaza Strip.

2. GROWING THREATS OF HEPATITIS B AND C IN THE EASTERN MEDITERRANEAN REGION

The global and regional threat of viral hepatitis B and C is substantial. The global burden of disease due to cirrhosis of the liver and hepatocellular carcinoma represents around 2% of all deaths and is expected to increase over the next 2 decades. WHO estimates that around 4.3 million persons are newly infected with hepatitis B virus (HBV) and 800 000 with hepatitis C virus (HCV) in the Region each year. In addition, 17 million persons have chronic

HCV infection. Studies indicate that more than 75% of cirrhosis and hepatocellular carcinoma in the Region is attributable to HBV or HCV infection. The cost of treating patients with chronic HBV or HCV infection outweighs the cost of implementing prevention programmes. Based on current treatment guidelines for chronic hepatitis C, the lifetime cost of treating 50% of eligible patients in Region is estimated at more than US$ 125 billion and is expected to increase over time as additional persons become infected.

Strategies and tools for prevention and control of transmission of such blood-borne pathogens are available and have been proved to be effective wherever they are well implemented. Unfortunately, implementation of these strategies is far from optimum in several countries of the Region. Adopting a comprehensive strategy and scaling up implementation of the currently available highly effective prevention and control measures is urgently needed to prevent transmission of these blood-borne pathogens. It is also highly recommended that countries adopt a regional target of reducing the prevalence of chronic hepatitis B virus infection to < 1% among children below 5 years of age by 2015.

Discussion

The Committee noted that the paper captured almost all patterns relating to the magnitude of the problem. It noted the need to emphasize the importance of awareness-raising and health education with regard to transmission and prevention of these diseases, especially for health professionals, many of whom lack knowledge in this area, and of including health education in health professions education. Disposal of health care waste and promotion of use of autodisable syringes are major challenges for the Region. Awareness of the problem also needs to be raised among the public, parliamentarians and parliamentary health committees so that the necessary legislation and regulations can be put in place.

The Committee advocated greater cooperation between countries in tackling this and other health system issues. A major cause of hepatitis B and C was the health system itself and all health systems had lessons to learn in this regard, not only those that were under-resourced. For example, quality assurance in the dental care system is not well applied in some countries.

It was noted that the suggested strategies and steps that countries could take to address the problem should be linked to the epidemiological situation and availability of resources so that countries would know exactly what should be done as priority. The proposed resolution should be accompanied by a practical package of information for countries including implementation guidelines, cost implications and model experiences. This would enable Member States to develop a plan appropriate to their situation, in collaboration with WHO, to implement the plan more quickly and to evaluate impact and challenges more effectively. Sharing of country profiles with regard to the situation would also benefit countries.

The birth dose of hepatitis vaccine for vulnerable neonates in relation to subsequent doses should be clarified. It was also suggested that the birth dose provided an entry point and opportunity for more comprehensive care for neonates in high risk groups.

The Committee expressed concern at the sustainability of current vaccine provision and emphasized the need to institutionalize hepatitis B vaccination. In addition, there is very little information available in the Region with regard to the risk factors for hepatitis C transmission. Advocacy for local and relevant research in this regard is important.

Recommendations to the Regional Office

1. Emphasize the need to raise awareness of decision-makers and educate the public and health care workers with regard to transmission and prevention of hepatitis, and to include health education programmes within health professions education curricula.
2. Consider the need to ensure long-term sustainability of HepB vaccine provision through legislation and institutionalization.
3. Highlight among the major causes the health system itself in some countries and the need for health system development and implementation of proven prevention strategies including patient safety, greater attention to dental care services, systematic immunization of medical students and health workers and quality assurance in health care.
4. Make it clear which strategies should be applied as priority within groups of countries, based on epidemiological situation and resource capacity
5. Highlight the gap in information relating to epidemiological patterns as well as the high-risk factors in several countries of the Region, and use this opportunity to: advocate for conducting studies/surveillance in order to understand the situation, using a unified protocol to enable comparison of data between countries; and assess the impact of prevention strategies.
6. Highlight the role of the Ministry of Health in raising parliamentary awareness of the problem and the need for national legislation and regulation enabling implementation of the recommended strategies including hepatitis B immunization, adoption of patient safety strategies and financial allocation for prevention and control.
7. Scale up the use of a birth dose of HepB vaccine in countries with high and intermediate rates of perinatal transmission.
8. Make available to the countries a package of information on how to implement the recommended strategies relating to the proposed resolution, and share country profiles summarizing the HepB situation across the Region.

3. STRATEGY FOR CANCER PREVENTION AND CONTROL IN THE EASTERN MEDITERRANEAN REGION

Cancer is an increasing problem in the Eastern Mediterranean Region. It ranks as the fourth leading cause of death in the Region and is one of the leading causes of death in the world. It is estimated that cancer kills 272 000 people each year in the Region. Furthermore, the largest increase in cancer incidence among the WHO regions in the next 15 years is likely to be the Eastern Mediterranean Region, in which a projection model predicts an increase that could reach 180%.

At present half of the cancers in the Region occur before the age of 55 years. The mortality/incidence ratio is 70%, which is high (40% in the United States of America, 55% in Europe), indicating significantly lower survival rates from diagnosed cancer. The main risk factors are associated with tobacco use and changes in diet and lifestyle. It is estimated that 40% of cancers worldwide could be prevented by risk factor modification. Thus prevention offers the greatest public health potential and the most cost-effective long-term strategy for cancer control. Resources for cancer control in the Region as a whole are not only inadequate but are directed almost exclusively to treatment.

The regional strategy for cancer control was developed in response to the increasing burden of cancer in the Region and the need for coordinated action in this regard. It is hoped that adoption of the strategy will generate sufficient political support at country level for cancer control programmes; stimulate Member States to develop a comprehensive action plan to address the cancer problem; and lead to development of policies and regulations for cancer prevention.

Discussion

The Committee emphasized the importance of cancer prevention, noting that it was a neglected issue in the Region. The media should be utilized to raise public awareness and fill the gaps in knowledge about the risk factors for cancer, especially tobacco use. An extensive prevention campaign could be launched across the Region, including country visits by WHO technical staff to advocate for cancer prevention. A monthly bulletin on causes of death could also be issued to raise awareness and increase government commitment on cancer prevention and control.

Cancer and related disorders show the inequities in health systems at their starkest, and approaches to cancer prevention and care must address these inequities. Guidance is needed from WHO on how to integrate cancer prevention, treatment and care into primary health care, including how to link specialized treatment hospitals within the health system. Breast cancer screening should be promoted within primary health care and incorporated into medical education, and breast self-examination should be taught in schools. More research is also needed, especially on herbal medicines and traditional approaches.

In coordination with cancer centres, WHO should promote and emphasize the importance of palliative care, which is not well understood within ministries of health. Community nursing and home care can have key roles in this regard. The accessibility and affordability of palliative care medicines must also be ensured.

Concern was expressed over current regional cancer data, which are a mix of registry data and estimates. Sound efforts are needed at systematic review of population-based estimates on the burden of cancer. Cancer registries need to be established or strengthened to provide reliable data on cancer incidence.

Recommendations to the Regional Office

1. Strengthen advocacy for cancer prevention, and emphasize integration of prevention and management into primary health care.
2. Promote the role of civil society in cancer prevention and care and foster the collaboration of civil society organizations with health systems in the Region.
3. Emphasize the need to improve the quality of palliative care and strengthen palliative care, including the role of community nursing and home care.
4. Highlight the need to strengthen public health education about cancer prevention and early detection, including education on breast self-examination, tobacco use and diet, physical activity and health, through school health programmes and medical education curricula and through making use of community settings, such as workplaces, with particular emphasis on breast cancer.
5. Emphasize the need for population-based cancer prevalence surveys to produce systematic and reliable data and for the establishment/strengthening of cancer registries.
6. Explore new methods for screening for cervical cancer which may be appropriate and relevant to the Region.

4. ROAD TRAFFIC INJURIES: A GROWING PUBLIC HEALTH CONCERN

Globally, every year 1.2 million people are killed and 20 million – 50 million receive moderate to severe injuries as a result of road traffic crashes. In the Eastern Mediterranean Region every year more than 132 00 people die from road traffic injuries. Most of those who die are young males at their most productive age. If the current trend continues, mortality and morbidity due to road traffic injuries will rise many fold, especially in the low-income and middle-income countries, putting tremendous strain on scarce resources. Road traffic injuries are a major socioeconomic issue. Of those affected, 90% are from the low socioeconomic groups (pedestrians, public transport users, motorcyclist and cyclists), who have limited power to influence policies and seek effective post-crash medical care. Road traffic injuries, directly and indirectly, cost the equivalent of 1%–1.5% of GNP in the low-income and middle-income countries.

Although the major brunt of road traffic injuries (in the form of human casualties) is borne by the health sector, traditionally the role of health sector in primary prevention has been very limited. There are many challenges at regional level which contribute to (or compound) this situation. These include limited data on the causality of road traffic injuries, weak political support, limited capacity at the national level and ill-defined leadership for the issue of road safety. Recognizing this, WHO and the United Nations identified the issue as a major public health concern and mandated WHO to coordinate global road safety efforts. As a result, WHO published the World Report on Road Traffic Injury Prevention in 2004, together with the World Bank, identifying key risk factors and effective evidence-based interventions. Thereafter, many countries in the Region have applied various measures for road traffic injury prevention, but the progress is uneven and inconsistent.

Since road safety is a widely multisectoral and multidisciplinary issue, highly motorized countries have employed a system approach by looking at the system issues (law enforcement, road designs, vehicle safety) rather than only investing in behaviour change. Ministries of health have been active in playing a stewardship role in advocating for a multisectoral and multidisciplinary approaches. Although solutions from the high-income countries applied elsewhere may not be completely applicable to the situation in the Region, the basic elements of road traffic injury prevention are the same and can be applied effectively in most of the low- and middle-income countries. By employing a public health approach to road traffic injuries, and tackling road safety in a similar fashion to the approach for prevention of any disease, a marked reduction in mortality and morbidity can be achieved. It is recommended that a national level multisectoral committee (or a lead agency) is identified with a pronounced role assigned for the Ministry of Health. Building national capacity, gathering data on causality and effectiveness of interventions, allocating human and financial resources and establishing an effective pre-hospital and hospital-based trauma care system are the major elements for any country to prevent the occurrence of road traffic injuries and also prevent secondary deaths.

Discussion

Road traffic crashes and their resulting injuries are an "orphan" issue whose causative factors lie across many sectors and for which there is no responsible coordination body or programme at national level. Within the health sector, priority must be given to improving medical management of road traffic injuries. Important actions to be taken include strengthening emergency departments to deal effectively with traffic casualties and classifying the departments according to capacity to manage casualties, and improving the quality of pre-hospital treatment. In particular, ambulances are the first line of response for road traffic injuries and must be well equipped and staffed. Training and knowledge on basic emergency skills, especially transport of trauma patients, should be provided not only for health workers but also for the general public, such as through mass awareness campaigns.

The Committee drew attention to several issues related to the data on road traffic injuries. Different countries define traffic-related mortality differently; a single definition needs be identified and applied in countries for reporting purposes. The burden of traffic-related morbidity in the Region is considerable, and more attention is needed on data on morbidity due to road traffic crashes. Current figures for road traffic accidents in countries of the Region reflect different levels of transparency as well as different approaches to data collection. The current focus on road traffic injuries can be used as an entry point to address other forms of injuries, e.g. poisoning and falls, which have been shown to result in considerable mortality in some countries based on national studies. More data are needed on injuries of all types, and WHO support to countries should include developing registries for all types of injury.

The Committee noted that the issue of road traffic injuries, along with other existing and emerging economic, social and environmental determinants of health, called for careful re-consideration of the role of ministries of health. Rather than leading efforts to address such

issues, the most effective role for health ministries might be in producing data, creating awareness and monitoring results.

Recommendations to the Regional Office

1. Advocate for governments to adopt public policies for prevention o f road traffic crashes and promotion of interministerial action to reduce morbidity and mortality relating to road traffic injuries.
2. Advocate for ministries of health to take the lead role in creation of partnership and advocating for prevention of road traffic injuries by bringing the issue to the attention of government at cabinet level, highlighting the social, financial and health burden, and advocating for a joint intersectoral response and conduct of intensive advocacy for road safety campaigns targeted at policy-makers, the public and schoolchildren.
3. Emphasize the need for public health education about how to deal with victims of road traffic crashes.
4. Emphasize the need to strengthen ambulance services and accident and emergency departments through quality assurance and accreditation of accident and emergency departments according to capacity to deal with emergencies and road traffic injuries.
5. Promote the use of a uniform definition for 'mortality due to road traffic injuries' according to WHO guidelines and advocate for the establishment of a regional database on burden of morbidity and mortality due to road traffic injuries.
6. Advocate for improved driver education through adoption of proven strategies for prevention of road traffic injuries, including severe penalties for driving under the influence of alcohol or other substances, use of protective headgear for motorcyclists, driving standards, vehicle safety, speed reduction, banning of trailers and road safety education in schools.
7. Emphasize the full burden of road traffic injuries (death, disability, social and economic cost) and not only mortality.

5. IMPROVING HOSPITAL PERFORMANCE IN THE EASTERN MEDITERRANEAN REGION

In 2002 WHO and the International Hospital Federation undertook the largest and most comprehensive global study to date on hospital performance covering 20 countries from the six WHO regions. From the Eastern Mediterranean Region Egypt, Lebanon, Morocco and Syrian Arab Republic took part. The results were published in 2007. The study identified the major challenges affecting hospital performance as: limited coordination between hospitals and the national health system, chronic under funding and increasing dependency on user fees in low-middle income and low-income countries, constraints in organization of service delivery (e.g. dysfunctional referral systems) and weaknesses in hospital management, especially, financial and human resources management in most middle and lower income countries. In order to address issues relating to the need to improve hospital performance and based on perceived needs of countries in the field of hospitals, WHO has produced several focused publications, policy papers and tools for use in strengthening hospital leadership and management and assessing and improving quality. WHO supports countries through several

means including building support networks, establishing collaborating centres and launching interactive websites.

Discussion

There is a need for greater management training of hospital managers as weak management has been highlighted as one of the causes of low hospital performance in the Region. Members discussed the importance of providing a clearer definition of what is meant by 'hospital' in the context of understanding public-based health systems. They discussed hospital autonomy and its possible synonymity with privatization and deregulation as countries with limited resources are unable to provide funds for autonomous hospitals leading to the provision of increasingly privatized services inaccessible to poorer segments of the population. National and subnational regulatory frameworks with social protection for the poor must be in place before hospitals are allowed to adopt an autonomous status. A common framework for both public and private hospitals is greater accountability to the community. Maternal and newborn health could be used as an entry point for the community.

There is great diversity in the size of hospitals and a possible recommendation is for WHO to determine the appropriate number of hospital beds per population and size of hospitals. Health centres could be created providing services for trauma, toxicology, birthing and training.

The current global economic crisis is affecting the health sector in a more substantive way than people may be aware of and it is estimated that it has forced a reduction in health spending of between 30%–40%. Costing exercises need to be conducted, particularly intra-departmental costing. It is necessary to address hospital-related services in crisis and to investigate cost–effectiveness and innovations to reduce the costs of care, such as conducting day-care procedures, promoting home health care, moving disciplines out of the tertiary setting into outreach services and also increasing people's awareness of potential risks of hospital care, such as lack of infection control practices.

Recommendations to the Regional Office

1. Promote a culture of costing and cost analysis in hospitals in order to improve financial management, programme budgeting, accountability and cost containment.
2. Support countries in developing cost-effective alternative approaches to hospital admissions through development of day care, day surgery and home health care.
3. Support countries in better assessing and improving their hospital performance through use of tools and frameworks, including the WHO performance assessment tool for quality improvement in hospitals (PATH).
4. Support countries in instituting appropriate reforms that address gaps in hospital performance, including governance, training of hospital managers and incentives for human resources.
5. Conduct in depth review of the regional experience of hospital autonomy as part of health system decentralization and raise awarenesss of the advantages and

disadvantages of autonomy, emphasizing the role of the ministry of health in regulation, evaluation and ensuring equitable access.

6. Provide guidance on the role of government in developing necessary regulatory instruments aimed at setting norms and standards for hospital geographic and functional distribution including master plans for hospital development, at protecting equity in access and at promoting patient safety in hospitals.
7. Make use of available data, including data generated by the global Patient Safety Alliance for improving quality of hospital services and enhancing patient safety.

6. SUBJECTS FOR DISCUSSION DURING THE THIRTY-FOURTH MEETING OF THE RCC (2010)

- Impact of economic crisis on health
- Partnerships
- Review of EMRO performance and strengthening of image
- Future health challenges and impact of the economic crisis
- Diet, physical activity and health, with special reference to diabetes
- Maintaining the momentum of primary health care
- Health effects of peaceful use of atomic energy
- Involving the community in health care
- Health implications of genetically modified food
- Food security and nutrition
- Early childhood development
- Role of ministry of health
- Impact of conflict on health and health systems

Annex 1

PROGRAMME

Wednesday, 15 April 2009

08:30–09:15	Opening remarks and follow up on the recommendations of the 32nd meeting	*Dr Hussein A. Gezairy* *Regional Director*
09:15–10:00	The growing threats of hepatitis B and C in the Eastern Mediterranean Region	*Dr Ezzeddine Mohsni* *Regional Adviser, Vaccine Preventable Diseases and Immunization*
10:30–11:15	Strategy for cancer prevention and control in the Eastern Mediterranean Region	*Dr Ibtihal Fadhil* *Regional Adviser, Noncommunicable Diseases*
11:15–12:00	Road traffic injuries – a growing public health concern	*Dr S. Jaffar Hussain* *Regional Adviser, Healthy Lifestyle Promotion*
12:00–13:00	Improving hospital performance in the Eastern Mediterranean Region	*Dr Amr Mahgoub* *Regional Adviser, Health Management Support*

Thursday, 16 April 2009

10:00–11:00	Conclusion and recommendations	
11:00–11:30	Subjects for discussion during the 34th meeting of the RCC (2009) Closing	*Dr Abdulla Assa'edi* *Assistant Regional Director*

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	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
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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 (D'TASI), 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
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Professor Koussay Dellagi*	Director of the Centre for Research and Scientific Intelligence on Emerging Infectious Diseases in the Indian Ocean (CRVOI)
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

* Unable to attend

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