
**Report of the first meeting of the Technical Advisory Committee to the
Regional Director Cairo, Egypt
15–17 April 2013**

Introduction

1. In October 2012, the Fifty-ninth Session of the WHO Regional Committee for the Eastern Mediterranean issued resolution EM/RC59/R.6 endorsing the establishment of a Technical Advisory Committee to the Regional Director that would provide independent advice and assistance on matters pertaining to regional health priorities and programme development. The Committee was to be composed of a maximum of 12 external experts appointed by the Regional Director and serving in their personal capacity.
2. The Committee convened for the first time on 15–17 April 2013 at the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt. The objective of the meeting, in line with the terms of reference of the Committee, was for the Committee to:
 - act as an advisory body to the Regional Director in matters relating to the implementation and evaluation of WHO strategies and plans in the Eastern Mediterranean Region;
 - provide advice on measures to strengthen the capacity of the Regional Office and country offices in support of Member States;
 - provide advice to the Regional Director on policies and strategies for the development of technical cooperation among and between countries of the Region;
 - assist the Regional Director in mobilizing funds and securing extrabudgetary resources for strengthening the WHO collaborative programme in the Region;
 - suggest innovative means to engage key stakeholders from the health and non-health sectors in order to promote the concept of “health in all policies”;
 - provide advice on any other topics referred by the Regional Director.
3. Nine members of the Committee attended the meeting, along with relevant staff of the WHO Regional Office for the Eastern Mediterranean. The meeting was chaired on a rotating basis by Dr Faisal Al-Mosawi (Day 1), Professor Zulfiqar Bhutta (Day 2) and Professor Rowaida Al-Maaitah (Day 3).
4. During the meeting, the members were requested to discuss a number of working papers that had been provided to them in advance of the meeting and identify what additional challenges existed and provide advice on how WHO could best respond. Section 2 of the report documents the feedback of participants, by agenda item. Section 3 summarizes the closing session including procedural matters related to the future meetings, and Section 4 outlines strategic and operational recommendations for WHO based on the discussions of the Committee. The agenda, programme and list of participants are attached in Annexes 1–3, respectively. The terms of reference and rules and procedures for the Technical Advisory Committee are attached as Annex 4.

Summary of discussions

WHO regional priorities

5. The Committee agreed with the strategic directions laid out for shaping the future of health in the Region. There was recognition of the consultative process undertaken to arrive at this agenda. The strategy outlined was comprehensive and well adjusted to the epidemiological situation in the Region. That said, the Committee suggested further emphasis in the following areas.
6. A higher priority needs to be given to emergency preparedness and response, especially response. The Syrian crisis will remain an issue for some time, and insecurity is likely to persist in the Region for the years to come. The values that will shape the future in the Region are solidarity and security, and these need to be emphasized.
7. More work is needed to determine how WHO can address health equity most effectively. At minimum, WHO can monitor equity and help ensure indicators for health equity are included in national health information systems. Great disparities exist between and within countries and these should be analysed and public health strategies designed to address them.
8. Nutrition is important and is not given sufficient emphasis except in regard to maternal and child health. More attention needs to be given to addressing the double burden of undernutrition and overnutrition and the nutritional risk factors of noncommunicable disease. Reference to injury prevention should also be strengthened.
9. The role of the private sector in provision of services is varied but increasing rapidly and in an ad hoc unregulated manner. Private sector legislation is important.
10. Systems know-how is weak in the Region and should be developed in most domains. In health systems in particular, the developments are moving faster than the underlying knowledge of these and there is a research challenge in this domain.
11. The Committee agreed with the need for strong public health leadership in the Region, noting that public health capacities have diminished in the Region lately. Focus on education of health professionals has also been neglected.
12. The Committee supported the recent initiatives of the Regional Office on health diplomacy. Greater attention needs to be given to delineating the role of the Region in international and global health initiatives, analysing the regional specificities and shaping implementation to suit the particular regional circumstances.
13. Attention should also be paid to the role of community engagement, especially engagement of women and youth.
14. In terms of accountability, WHO needs to do more in also making countries accountable for their part in joint action, and country adherence to internationally agreed commitments should be regularly monitored.
15. The recent upgrade of technical skills in the Regional Office was acknowledged, but the need for improved WHO performance at country level was now imperative.

The health system strengthening agenda: from policy and strategy setting to concrete action

16. The Committee acknowledged the high quality of the work that had been undertaken by the Regional Office in analysis of health systems gaps and challenges in the Region. There was endorsement of the approach described in the paper presented to the 59th Regional Committee (EM/RC59/Tech.Disc.1) and also an understanding that the commitments in the accompanying resolution (EM/RC59/R.3) constitute an immense agenda for both the WHO secretariat as well as Member States of the Region. The seven priorities for health system strengthening were thought appropriate. The complexity of the issue was recognized and suggestions and advice were provided using the same logic as in the paper.

17. In terms of the move towards universal health coverage, the importance of explicit linkage between universal health coverage and primary health care was emphasized. Universal health coverage will not be attained if the issue of health inequity is not addressed by a “whole of government approach”. It was noted that there is a need for a good strategy paper on health equity.

18. Good examples of effective and efficient primary health care exist in countries inside and outside the Region and these experiences need to be documented and shared. With limited fiscal capacity in most countries, attainment of universal health coverage will centre on developing affordable primary health care offering basic packages of services.

19. When developing national health policies and priorities, the approach must be inclusive and should involve the private sector, nongovernmental organizations and other sectors.

20. There was a strong plea for WHO to develop indicators to measure health system performance and provide benchmarks against which countries can measure changes over time and evaluate impact of policy interventions. Such benchmarking was thought to be an important vehicle for action at national level.

21. Lack of reliable and updated health information for policy development and decision-making is a major challenge in most countries and helping countries to overcome this challenge should be a regional priority.

22. With regard to leadership and governance, the Committee emphasized the importance of strengthening public health leadership. There is need to draw on relevant experience and lessons learned in the Region, for example in the areas of polio eradication and outbreak response. Models can also be drawn from successful country experiences at subnational level. Clarity is needed on the roles of WHO at different levels and of other partners. There is a need to enhance accountability and transparency in health care spending.

23. With regard to achieving a balanced and well managed workforce it was recognized that, despite great achievements made by some countries, there are still major deficiencies in all 23 countries of the Region. Workforce production is not meeting the skill needs of the 21st century. There is need for revision of curricula for many categories of health workers as well as institution of innovative problem-oriented programmes for continuous education. There has not been sufficient recognition of the changing of roles and responsibilities of individual categories of health workers over time. The role of community health workers in universal health coverage was underscored and good examples in the Region should be promoted. Most countries lack an overall plan for health workforce development and greater clarity is needed on segregation of tasks. Those countries of the Region currently engaged in mass training programmes should be supported by WHO and lessons learnt from these initiatives should be shared. New innovative approaches must be introduced to retain staff and combat “brain drain”.

24. With regard to the private sector, WHO should map the best examples of regulatory practice. There is a need for more detailed study of all elements of the private sector. For example education in this sector is unregulated, as is uptake and utilization of technologies and medicines. WHO has an important role to play to support Member States that are embarking on legislation of the private sector.

25. With regard to access to essential technologies, vaccines, diagnostics and medical devices there are several actions needed. WHO must assist the 10 “countdown” countries in procurement of vaccines and life-saving commodities. In countries where lack of access is not the prime problem there is ample room for improvement in appropriate utilization. Health technology assessment is one of the most effective cost containment measures in health systems. The Region is not well placed with regard to health technology assessment institutions but WHO could immediately facilitate contact to outside institutions and commission advice to Member States. In the long term, capacity for routine and more sustained health technology assessment should be built in the Region. There is a need for more emphasis on working with stakeholders in the informal sector. In terms of pooled procurement, life-saving commodities are a separate category from essential medicines.

26. With regard to improving access to quality health care services, countries should recognize this as a human right. Countries should accordingly revise their models of health systems delivery and focus on attaining high coverage and easy access to primary health care facilities offering a basic package of services. It is also important that the most rural areas and disadvantaged populations are reached.

Health information systems: the way forward in supporting Member States and addressing the gap in civil registration and vital statistics

27. Reinforcing national health information systems including civil registration and vital statistics is a prerequisite for health systems strengthening and was singled out in a resolution of the fifty-ninth Regional Committee (EM/RC59/R.3). The resolution urges Member States to strengthen health information systems by “improving reporting of births, deaths and cause of death, by improved monitoring of exposure to risk factors and social determinants of health, morbidity, mortality and performance of the health system.” The Committee discussed how WHO could best support this initiative.

28. The Committee acknowledged that the monitoring and evaluation framework is a structured and comprehensive way to appraise health information. To bridge the difficulty of connecting data with its use, what is urgently needed is consensus on a core set of indicators that are assembled in line with the needs of health policy-makers. In developing such a contracted manageable core set of indicators, WHO will look closely at all available internationally agreed indicators. This work will be taken forward at a meeting planned for early May 2013.

29. Rapid assessments of civil registration and vital statistics in the Region have been completed and show that only a minority of countries have satisfactory systems in place. However, strengthening civil registration systems was described as a long process. To escalate the improvements, attention was drawn to fully exploring new avenues in civil registration and vital statistics data collection. Joint work with the relevant government sectors is key. Improving cause-specific mortality takes time and interim measures need to be adopted to start the incremental process of improvement, for example using verbal autopsy in resource-poor settings.

30. Although some work has been done in information and communication technology, it is an area of weakness in WHO and more investment needs to go into understanding the full scale of opportunities this technology offers. Data concurrence between countries and agencies continues to be

an issue. This problem is not unique to the Region and needs to be taken up at WHO central and regional levels to further enhance the country consultation process.

Strengthening technical expertise within WHO

31. The paper prepared highlighted some of the challenges and gaps that influence the quality of WHO's technical products, both those of normative character and those related to implementation in countries. Committee members acknowledged the need to strengthen technical capacity. One suggestion was to encourage countries to participate in expert selection. The general observation, however, was that this is not a crisis situation for the Region.

32. The Committee emphasized the importance of flexibility with regard to human resources selection and retention and advised that WHO should have at its disposal an array of contractual modalities to cater for the different types of assignments. WHO needs to look at innovative ways to secure the necessary expertise, such as linking up with national resources and institutions and aiming for a greater outreach in search of suitable candidates including the use of headhunters.

33. Short-term, time limited (2–3 year) assignments to WHO for mid-career health professionals in the Region could be a mutually beneficial practice, and would help build public health experience in the countries. For high-priority areas, individuals could be identified within WHO to allow teams to assemble at short notice to respond to country needs for urgent technical guidance in a limited number of technical domains.

34. Some WHO publications are no longer of the requisite quality and compare negatively to previous series such as the highly lauded "technical series". While guideline review procedures exist in WHO, these have not always been followed, rendering it difficult for countries to appraise the robustness of the individual publications and their recommendations. The Committee agreed the quality and relevance of WHO information products is critical to the issue of technical excellence and noted the need to discuss the issue in more detail in the future.

35. A long debate ensued on WHO collaborating centres. While underscoring the importance of these institutions played in furthering WHO's technical work, the Committee highlighted the need for clarity around the roles and expected contributions of collaborating centres. There needs to be tougher evaluation prior to redesignation and better articulation of the contribution to WHO's work. However collaboration requires input from both sides and collaborating centres also need to be nourished by WHO. It was suggested to look at all the regional collaborating centres and appraise to what extent their contribution is still relevant to the current agenda of the Region.

The unfinished agenda of communicable diseases: challenges in the global eradication of polio

36. The Committee pointed out that control of communicable diseases is an important component of security. International forums including the World Health Assembly and meeting of the Group of 8 should all be approached to explore how the political engagement of countries can be elevated. At present there are major gaps in the Region in a number of areas. Building strong technical capacity for communicable disease control at the country and regional level is a priority.

37. Inadequate capacities for surveillance and laboratory diagnosis were emphasized. Viral hepatitis is a major health threat in many countries: prevention and control efforts need to be scaled up and should include an audit of injection safety and blood transfusion services. Hand hygiene is poor and merits more emphasis for communicable disease control and as a patient safety and quality assurance issue.

38. Building strong technical capacity at country and regional level for communicable disease control should be a priority. Investment is needed to train personnel for deployment of rapid response teams in the event of a public health emergency. This would most effectively be achieved by creating a network of experts and institutions for the Region. Guidance from WHO on emerging infections is important for country response.

39. Health education is an important element for changing risky behaviour that contributes to disease transmission. Partnership with community and religious leaders, women and civil society is crucial for raising awareness. There is still appreciable stigmatization of HIV/AIDS patients in the Region and social networks are powerful agents in changing perceptions. In engaging with the population, the rights and responsibilities of the individual in infection control should also be stressed.

40. Strong health systems are key for communicable disease control. It is important that the establishment of epidemiological surveillance systems is linked to health system capacity-building efforts in order to generate reliable representative data for monitoring and evaluation of the impact of disease control programmes.

41. With regard to polio eradication, the Committee agreed with steps taken so far to build regional ownership of the programme. It drew attention to persisting gaps in communication and cohesion in delivery between polio and other related programmes such as EPI and maternal and child health. There is a need for the EPI to be closely linked with the polio programme and coordination with maternal and child health should be strengthened. The recent experience of the consultation with Islamic scholars was highlighted as a good example of the kind of community outreach needed to achieve public health goals in general and support the eradication of polio in particular.

International Health Regulations

42. All Member States of the Region, apart from one, fell short of meeting the initial deadline to have core capacities for IHR in place by June 2012 and requested a 2-year extension. This stark reality illustrates the need for much improved advocacy and capacity-building across all the IHR components.

43. The Committee suggested that the IHR issue should be brought to the attention of high level regional forums such as the Organization of Islamic Cooperation. One practical way forward would be to produce a political paper explaining the intimate linkage of IHR to security which could be used in such high level political settings.

44. A special weakness in countries was pointed out, namely the often peripheral position of the national IHR focal points, rendering it difficult for these individuals to influence even the Ministry of Health and impossible for them to engage other sectors. Given the cross-cutting nature of the IHR, actors outside the health sector must be mobilized and here WHO must exercise its convening power. Heads of WHO country offices could also be trained to be more active in promoting “all of government” engagement in the implementation of IHR.

45. To make progress, WHO collaborating centres, intergovernmental organizations and technical institutions in the Region and outside must be fully engaged to increase the access to capacities. Special reference was made to the need to vastly upgrade laboratory capacity to become IHR compliant. There is a need for a small number of regional reference laboratories equipped for specific events, for example virus identification in the face of pandemics. The private sector must also be engaged for structured national IHR implementation.

46. There was a suggestion to try to seek financial support from high income countries to help low income countries of the Region.

47. Given the multisectoral response needed, WHO has also revisited its own organization in this area and moved to a less vertical programmatic structure.

Noncommunicable diseases: how are we going to make a difference in our Region?

48. The Committee found the road map to be clear and comprehensive. The Committee agreed with the approach of the Regional Office that what is lacking for many countries is the know-how and an inventory of practical tools, standards and guidance on how to translate the framework into concrete actions.

49. All possible efforts are needed to ensure multisectorality in the implementation of the noncommunicable disease “best buys” at national level. WHO needs to reach out directly to all national partners and not limit its action to its natural collaborators in the Ministry of Health. Considering the vital role of nongovernmental organizations and civil society in implementation of the noncommunicable disease agenda, WHO needs to engage more actively with them and build their capacity.

50. In relation to mass awareness it was noted that an estimated 60% of the regional population is under the age of 30. This is an opportunity for WHO and its partners to move forward and strongly engage youth in raising health awareness on risk factors and behavioural changes. Noncommunicable disease awareness, prevention and control needs to be integrated into the work of different youth organizations and youth groups and should permeate youth settings. The use of social media could be an important tool in this regard. It was underscored that both formal and new “street wise” innovative approaches should go hand in hand. The importance of targeting women as agents of behavioural change was also highlighted, given their central role in family matters and nutrition. It was suggested that identification of role models from the entertainment and the arts circle could be another avenue to create greater public awareness on noncommunicable disease.

51. If focus was needed and only a limited part of the noncommunicable disease health promotion agenda could be addressed at any given time, tobacco was put forward as the priority area, despite the massive current opposition from the tobacco lobby. Proven interventions such as taxation exist, best examples are available in the Region, an internationally agreed public health treaty is widely subscribed to (the WHO Framework Convention on Tobacco Control) and standardized surveillance and reporting mechanisms exist.

52. Although political instability is negatively impacting the ability of some governments to implement far reaching new legislation, it should not prohibit the refining of existing legislation in support of the noncommunicable disease agenda to implement proven interventions and “best buys”. WHO and countries need to assess the gaps in existing legislation and work to bridge these in a multisectoral fashion in acknowledgment of the fact that some of the most effective interventions lie outside the competence of ministries of health.

53. Considering the significant role of primary health care in prevention, early detection and treatment of noncommunicable diseases, WHO needs to focus on strengthening the role of primary health care for noncommunicable disease prevention and control. Documenting successful regional experiences in this regard is important.

54. In light of the limited community-based interventions in the Region, WHO could consider promoting noncommunicable disease prevention demonstration projects. However an element of restraint should be exercised before embarking on this with careful analysis of data and synthesis of lessons learned being undertaken. The proposed noncommunicable disease centre of excellence in Qatar may offer an opportunity to initiate this work. The overall aim would be to move from limited pilot projects to more full scale community-based intervention programmes of proven benefit. This is

just one example of the much-needed focus on scaling up operational research on noncommunicable diseases. WHO should continue to engage with partners in discussing and shaping the noncommunicable disease research agenda based on priority needs and country realities. WHO and regional academic institutions and established networks (e.g. network of Arab Scholars) must work in an integrated manner to provide the necessary evidence.

55. Even where data exist they may not be available in the public domain (e.g. STEPS data for Egypt). WHO could have a role in facilitating wider access to available data to support the translation of knowledge into practical policies.

56. Access to essential medicines and technologies is key. The Committee drew attention to global experience in reducing the prices of HIV medication. The Region should consider making similar efforts in the area of noncommunicable disease medicines and simple diagnostic technologies, especially for cancer.

57. WHO could also help in developing measures and standards for insurance reimbursements.

The Dubai Declaration on Saving the Lives of Mothers and Children: how to rise to the challenge?

58. The Committee recognized the Dubai Declaration as major step in focusing attention on the critical issues relevant to action for saving lives of mothers and children. It was seen as a timely and needed initiative given the high burden of maternal and child mortality in some countries of the Region. It was recognized to be an initiative where overall success would depend on WHO working with many partners within and outside the UN family. The launch at a time with only two years remaining until 2015 was meant to spotlight the issue as an unfinished agenda and help ensure the sustainability of this issue in the post-2015 agenda.

59. At this point in time there are two main challenges, namely developing tangible scale-up plans for the 10 high burden countries and, most importantly, ensuring the overall financing from a wide variety of both national and international sources.

60. Appropriate mechanisms to raise funds will need to be identified and some Committee members are envisaged to play a role in resource mobilization. The financial situation can be improved by movements in government fund allocation, avoiding duplication of activities, improving efficiency of national health systems and closer coordination with donors. However, these initiatives are unlikely to be sufficient and large-scale infusion of additional resources will be needed, in particular for Group 3 countries. WHO will continue to be a constructive partner in the overall regional initiative of saving the lives of mothers and children as articulated in the Dubai Declaration.

61. Members of the Committee stressed the need to build on Dubai Declaration to address social determinants of health approaches for reducing maternal and child mortality in the Region. The current climate of change in some areas of the Region has exacerbated vulnerabilities, health risks and inequity in access to services, especially for women and adolescents. It is important that, while the focus is on MDGs 4 and 5, these other areas are not forgotten. Ministries of social development, women's organizations and civil society at large are needed to help move the broader agenda and are particularly effective in reaching the poorest and most marginalized segments.

62. A number of events will take place this year that may offer opportunities critical to maternal and child health, such as the launch of the global action plan for prevention and control of pneumonia and diarrhoea, global action plan on nutrition (June 2013) and global action plan on newborn health (November 2013).

63. With regard to nutrition, WHO is focusing its limited resources on providing normative guidance while other UN agencies take a leading role in providing support in the area of nutrition at country level. Micronutrient deficiencies remain an important issue and more efforts are needed to address it and population interventions such as food fortification are needed.

64. It was noted that there is need for accurate data on access to life-saving commodities throughout the Region.

The need for a regional public health leadership programme

65. The Committee was unanimous in noting that a regional public health leadership programme under WHO auspices is wanted and needed. There was a feeling that the public health capacity of the Region has deteriorated and is no longer capable of dealing adequately with the current challenges.

66. The Region has previous experience from the leadership development programme offered in the 1990s. The challenge is now to develop a programme in public health fit for the realities of the Region in the 21st century.

67. The Committee engaged in a very spirited discussion of the issue and made a large number of varied, sometimes mutually exclusive, suggestions regarding the aim, selection of candidates, content, conduct, training methodologies, location, financing, partnering, use of foreign experts, certification, evaluation and expected impact of such a programme. These suggestions and ideas were noted and will be analysed and carefully considered when developing the next and more concrete version of the paper which will be presented at a future meeting of the Committee.

68. Despite the wide array of suggestions, a consensus emerged that while the programme is to have a clear regional focus it should build on experiences elsewhere. It should: not be a conventional programme; supplement existing public health training institutions and opportunities; be prestigious; and above all be of high quality.

Antimicrobial resistance

69. The Committee agreed that this was an important issue to address. It highlighted the scarcity of data and emphasized that more reliable and representative data should be secured on magnitude and health risks associated with antimicrobial resistance in the Region. This could include epidemiological modelling to better understand the adverse impact and economic consequences.

70. Advocacy and awareness-raising are needed to strengthen the regulation and rational use of antibiotics, including a fight against the availability of counterfeit poor quality antibiotics. In this respect the private sector would seem to be a particular reservoir of inappropriate antibiotic utilization. Antimicrobial resistance can be linked to the issue of patient safety, infection prevention and control as well as quality of health care and accreditation of health facilities.

71. Laboratory facilities for typing, isolating and mapping resistance patterns are lacking.

72. At regional level there is a need to map country regulations with regard to antimicrobials. A regional initiative such as a task force could be established for that purpose. As well, a regional meeting involving representatives from the Ministries of Health and Agriculture would be useful to discuss the problem and agree a set of coordinated actions.

Political and social changes and implications on public health: how can WHO be better positioned to address the challenge?

73. The situation of the past two years in the Region, characterized by widespread social and political unrest affecting several countries politically, socially and economically, is having an impact on health. The major short term health consequences are injuries and deaths, population displacement and damage to the health system.

74. Interlinked problems include unemployment, particularly among youth, status of women with high rates of illiteracy and low political and economic participation, dismantling an already weak welfare system that is not protecting the population from the harms arising from stagnant economies and economic liberalization, and rapid rises in food prices.

75. Social and health indicators in the Region reflect poor investment in the public sector. Government expenditure on health and on social protection benefits (e.g. for sickness, unemployment, old age, maternity, family, invalidity, etc.) is low, while out-of-pocket expenditure is high and includes significant catastrophic health expenditure.

76. A weak welfare system (including the health system) does not compensate for the disproportionate economic burden (e.g. obliging people to pay for basic services) and cannot play a role in redistributing wealth or contribute to fighting poverty and inequity.

77. The unrest in the Region is also based on dissatisfaction with the lack of basic needs including health and education. WHO can assist countries to improve health access and quality of health care.

78. The populations of affected countries are looking for tangible proof that their governments are addressing the values of solidarity, fairness and transparency. This is important for society to regain trust in the government.

79. The Committee noted that the current situation is an opportunity to highlight the need to improve social protection (in which funds collected through a fair taxation system, with people paying proportionally to their wealth, are utilized to deliver effective public services, equal for everybody, which can ensure universal health, education and social protection coverage) and to increase investment in the public health sector. WHO needs to be innovative in bringing the health agenda to the forefront. It should continue to promote universal health coverage, investment in primary health care and family practice and interventions for the prevention and control of noncommunicable diseases.

80. Extra attention is needed for the areas of adolescent and reproductive health in order to protect the gains of recent years and prevent a reversal of progress.

81. Youth are a critical force in the prevailing social context, and the opportunity they offer for peer education in the health sector should not be missed. WHO needs to reach out to them through innovative mechanisms and seek their partnership on issues related to health. Women and religious leaders are other important stakeholders who can play key roles in promulgating health awareness.

82. The Committee noted that the opportunity to contribute to social and health reform in countries of the Region may be attractive to experts from the Region who are currently working in the international arena. WHO may be able to play a facilitative role in encouraging skilled expatriates working abroad to return to the Region.

83. More lines of communication need to be opened with the non-profit area (nongovernmental organizations, civil society) through forums of discussion and other networking initiatives. Links with the media also need to be strengthened.

Current status of WHO's image, use and performance in the Region: how/what can we do to improve?

84. This session focused on how the Regional Office and its country offices could be brought to better support Member States.

85. The Committee suggested that WHO needs to raise its visibility in the Region. At present the Organization is not widely known outside of ministries of health and the public health community in the Region, and its knowledge and information do not reliably reach other sectors or the public. Developing a targeted communication strategy and strengthening relationships with the media are two ways to raise WHO's visibility in the public eye. Opportunities to showcase WHO's work, such as in noncommunicable disease prevention and control and health information systems, could be one way to raise WHO's visibility across other sectors.

86. WHO's public image is based on its communications. In addition to improving the communications of WHO, the Committee noted the need for WHO to adhere to its core values and in partnerships show leadership and exercise its convening power.

Closing session

87. The Regional Director thanked the members of the Committee for their presence and important input and praised the discussions as stimulating, candid and challenging.

88. Members of the Committee discussed the timing of the next meeting, noting that the rules of procedure specify that the Committee "meet at least once (and maximum twice) per year." In light of the Committee's recent establishment, it was proposed that a follow-up meeting might be held in the last quarter of the year, after the forthcoming session of the Regional Committee for the Eastern Mediterranean in October 2013.

Recommendations

1. Emphasize the importance of solidarity, security and transparency in the current sociopolitical context of the Region when engaging with policy-makers in the health and social sectors.
2. Promote the importance of addressing equity in health and focus in particular on monitoring and highlighting disparity in health outcomes between and especially within countries with the aim of improving health outcomes among the most marginalized and disadvantaged populations.
3. Emphasize primary health care-based approaches to health systems strengthening and in doing so gather more knowledge to arrive at a best practice model for primary health care.
4. Improve regional capacity in public health in general and give priority to the development of a regional public health leadership programme.
5. Exercise WHO's convening power in order to promote and catalyse multisectoral action in the public health domains where outcome is dependent upon input from actors outside the health sector.
6. Enhance outreach and partnership with youth, women, religious institutions and other stakeholders in raising health awareness, recognizing the importance of culturally sensitive approaches and making use of modern technology and social media.

7. Develop and obtain consensus on the key components of health information systems and a core set of health indicators, arranged in a way that is conducive to evidence-based policy-making and facilitates measurement of changes over time and evaluation of the impact of policy interventions.
8. Strengthen overall health workforce management. Emphasis should be placed on the production of a workforce with the appropriate skill mix, development of relevant continuous education programmes and identification of innovative solutions for health worker retention.
9. Strengthen regional and national laboratory capacity to support surveillance and monitoring of priority communicable diseases as well as the detection of emerging diseases.
10. Analyse the overall contribution of the private sector in health care provision in the Region focusing on quality of services and regulation of practice, and develop strategies and tools for relevant legislation across various public health domains.
11. Emphasize the concept of quality assurance in health care through implementation of practical models of quality improvement, for example in the areas of injection practice and hand hygiene.

Annex 1

Agenda

1. WHO regional priorities (Document *EM/RDTAC1/1*)
2. The health system strengthening agenda: from policy and strategy setting into concrete action (Document *EM/RDTAC1/2*)
3. Health information systems: the way forward in supporting Member States and addressing the gap in civil registration and vital statistics (Document *EM/RDTAC1/3*)
4. Strengthening the technical expertise within WHO (Document *EM/RDTAC 1/4*)
5. The unfinished agenda of communicable diseases: challenges in the global eradication of polio (Documents *EM/RDTAC1/5*, *EM/RDTAC1/6*)
6. International Health Regulations (Document *EM/RDTAC1/7*)
7. Noncommunicable diseases: how are we going to make a difference in our Region? (Document *EM/RDTAC1/8*)
8. The Dubai Declaration on Saving the Lives of Mothers and Children: How to rise to the challenge? (Document *EM/RDTAC1/9*)
9. The need for a regional public health leadership programme (Document *EM/RDTAC1/10*)
10. Antimicrobial resistance (Document *EM/RCTAC1/11*)
11. Challenges in the Region:
 - Political and social changes and implications on public health: how can WHO be better positioned to address the challenge?
 - Current status of WHO's image, use and performance in the Region: how/what can we do to improve?
12. Conclusions, follow up actions, dates and venue of the next meeting

Annex 2

Programme

Monday, 15 April 2013

08.30–09.15	Opening session Process, objectives, expected outcomes Introduction of participants Election of the Chair, terms of reference, adoption of the agenda, methodology of work
09.15–10.15	Short presentation, followed by discussion on the WHO regional priorities
10.30–12.30	The unfinished agenda of communicable diseases: challenges in the global eradication of polio
12.30–13.30	Antimicrobial resistance
14.30–16.00	The health system strengthening agenda: from policy and strategy setting into concrete action
16.00–17.00	Health information systems: the way forward in supporting Member States and addressing the gap in civil registration and vital statistics

Tuesday, 16 April 2013

09.00–10.00	International Health Regulations
10.00–12.30	Noncommunicable diseases: how are we going to make a difference in our Region?
12.30–13.30	The Dubai Declaration on Saving the Lives of Mothers and Children: how to rise to the challenge?
14.30–15.30	The Dubai Declaration: what are the next steps?
15.30–17.30	The need for a regional public health leadership programme

Wednesday, 17 April 2013

09.00–10.00	Strengthening the technical expertise within WHO
10.00–12.00	Challenges in the Region: Political and social changes and implications on public health: how can WHO be better positioned to address the challenge? Current status on WHO's image, use and performance in the Region: how/what can we do to improve?
12.30–13.30	Conclusions, follow up actions, dates and venue of the next meeting

Annex 3

List of participants

Members of the Technical Advisory Committee

Professor Ahmed Abaddi
Secretary General
Rabita Mohammadia des ouléma of Morocco
Rabat
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Professor David L. Heymann (*via videoconference*)
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WHO Secretariat

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean
Dr Samir Ben Yahmed, Director of Programme Management, WHO/EMRO
Relevant staff according to agenda item

**Unable to attend*

Annex 4

Terms of reference and rules and procedures of the Technical Advisory Committee to the WHO Regional Director for the Eastern Mediterranean

1. Title

Technical Advisory Committee to the Director, World Health Organization (WHO) Regional Office for the Eastern Mediterranean.

2. Establishment

The WHO Regional Committee for the Eastern Mediterranean at its fifty-ninth session (October 2012) adopted resolution EM/RC59/R.6, para 1(c) endorsing *the establishment of a Technical Advisory Committee to the WHO Regional Director for the Eastern Mediterranean*.¹

3. Purpose

The overall purpose of the Technical Advisory Committee (TAC) is to provide independent advice, and assistance to the Regional Director on matters related to regional health priorities and programme development.

4. Terms of reference

More specifically the TAC will:

- a. act as an advisory body to the Regional Director in matters relating to the implementation and evaluation of WHO strategies and plans in the Eastern Mediterranean Region²;
- b. advise on measures to strengthen the technical capacity of the Regional and Country Offices in support of Member States;
- c. advise the Regional Director on policies and strategies for the development of technical cooperation among and between countries of the Region;
- d. assist the Regional Director in mobilizing funds and securing extrabudgetary resources for strengthening the WHO collaborative programme in the Region;
- e. suggest innovative means to engage key stakeholders from the health and non-health sectors in order to promote the concept of “health in all policies”;
- f. provide advice on any other topics referred to the Committee by the Regional Director.

5. Membership

The TAC will be composed entirely of external experts serving in their personal capacity.

A maximum of 12 members shall be appointed by the Regional Director. In the selection of the members, consideration will be given to obtaining an adequate technical distribution of expertise, geographical representation and gender balance.

6. Terms of office

Members of the TAC, including the Chairman, shall be appointed to serve for a fixed term of three years³. Extension of the term of office will be applied only in extraordinary circumstances.

The term of office may be terminated at any time by the Regional Director if WHO's interest so requires or as otherwise specified in the letters of appointment.

¹ Concomitantly the Regional Consultative Committee established through EM/RC30A/R1 (1983) will be disestablished.

² For the period 2012–2016 the strategic direction is articulated in the WHO publication *Shaping the future of health in the WHO Eastern Mediterranean Region: reinforcing the role of WHO* (Document WHO-EM/RDO/002)

³ In order to obtain continuity in the functioning of the TAC the terms of office of the first cohort will be as follows. Half the members will serve 3 years – half will serve 2 years. Unless amicable agreement is reached on who will serve 3, respectively 2 years, there will be the drawing of lots.

7. Conflict of interest

Members must respect the impartiality and independence required by WHO. In performing their work the Committee members may not seek or accept instructions from any Government or from any authority external to the Organization. Members must be free of real, potential or perceived conflict of interest. To this end, proposed members/members will be required to complete a DoI form and their appointment will be subject to evaluation according to WHO's global standard practices.

8. Confidentiality

Members of the TAC should commit to maintaining confidentiality around Committee deliberations and documentation that they have access to as part of their functions. Members of the TAC must not pass on, quote from, or make reference to confidential discussions, deliberations and documents until such a time that these are made public. Information and documentation to which members may gain access in performing TAC related activities will be considered confidential and proprietary to WHO.

9. Media

Should Committee members receive invitations to speak to the media/other organizations/institutions and/or other third parties in their capacity as a member of the TAC the Regional Director should be contacted for advice on appropriate course of action. Such actions should at all times be conducted in accordance with WHO Rules and Regulations.

10. Rules of procedure

The general method of work is described below to the extent it is formalized prior to the first meeting. It is expected that the TAC members and its chair will influence the detailed working modalities.

- a. The TAC shall meet face to face at least once (and maximum twice) per year. Inter-sessional communication including through teleconferences and videoconferences is also foreseen.
- b. The Regional Director will appoint the Chair and Vice-chair.
- c. If a member misses two consecutive meetings, WHO may consider to end his/her appointment as a member of the TAC.
- d. To have a quorum to hold a meeting and /or make recommendations half the Committee members should be present
- e. Decisions will normally be taken by consensus, while dissenting opinions can be noted in the minutes
- f. Sessions will be of a private character and only members of the Committee and relevant secretariat will attend.
- g. Meetings will be held at appropriate regular intervals⁴.
- h. The default location for meetings will be Cairo but other venues may be considered.
- i. The working language will be English with translation of documents and interpretation into Arabic and French as needed.
- j. Secretariat will be provided through the office of the Regional Director.
- k. Draft agendas will be drawn up by the secretariat for comments by the Committee members.
- l. TAC members will not deal with routine correspondence and enquiries from staff, public or other stakeholders.

⁴ The timing of regular sessions will be further defined once the Committee is established.

- m. TAC members will not receive a fee but will be compensated for travel and per-diem according to the prevailing WHO rules and regulations.

11. Reporting

Minutes will be taken from all interactions/deliberations of the Committee both from face to face and virtual meetings. Such minutes are private. Recommendations from the Committee and their background may be published⁵. Reporting to the Regional Committee may be considered, as appropriate.

12. Costs

The cost of the TAC will be fully budgeted within the budget for the Regional Director's Office. The expenditure will be disclosed as part of the statutory reporting on Programme Budget implementation.

⁵ Publication of reports could be on the Regional Office internet site – the TAC may also consider to have their own 'space' on both the regional intranet and internet – to be decided.