WORLD HEALTH DAY 2006

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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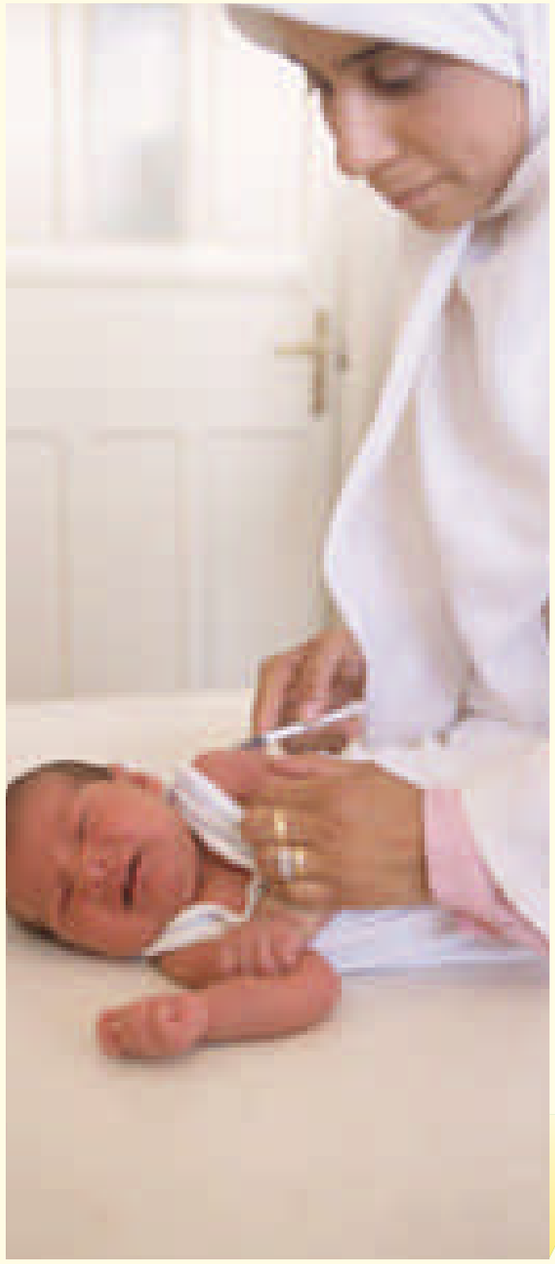
Contents



WORKING TOGETHER for Health

Preface

World Health Day is the annual flagship event of the World Health Organization. Since 1950, it has been held each year on 7 April to raise awareness of specific global health issues. This year's theme – Working together for health – highlights the challenging and often inspiring work carried out by health care workers. On World Health Day 2006, WHO will release its world health report 2006, which is on the same theme. With the support of the Government of Zambia and other key partners, WHO will also announce a new global alliance for human resources for health in Lusaka. This alliance will work to harmonize international efforts in this vitally important area. These and other events will bring together top policy-makers, human rights leaders and health experts in this area. A concerted campaign of action will then be undertaken to promote fair and safe working conditions for health workers, and to strengthen the effectiveness of the health workforce.

As part of these activities, this World Health Day 2006 toolkit outlines the crucial importance of health workers and identifies the key issues and priorities for action that countries and their partners in all sectors can take. The toolkit will be continuously updated using the feedback of its users. All updates and other information will be made available on the World Health Day 2006 web site – www.who.int/world-health-day/2006.

WORKING TOGETHER for Health

A message from Dr LEE Jong-wook Director-General World Health Organization

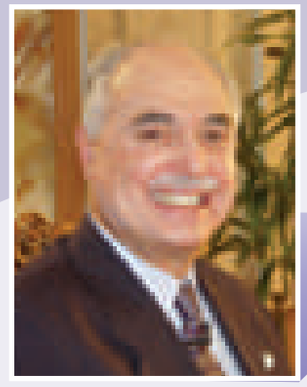
World Health Day 2006 gives us all an opportunity to celebrate the remarkable contribution to human health and development made by health workers. If progress can be made in the priority areas of action outlined in this toolkit and if public trust in health systems can be strengthened, or rekindled where it has been lost, then the potential gains to be made in human health and well-being are incalculable.

All over the world, national health systems are finding it difficult to train, sustain and retain their health workers. In developed countries, as populations age and chronic conditions increase, there is an ever-growing demand for health workers. That need is increasingly being met by recruitment of trained workers from developing countries; a trend which exacerbates the resource shortfall there.

Without a strong health workforce, advances in healthcare cannot reach and benefit the people who need them. Effective ways of preventing and treating disease require assessment, delivery and monitoring by health workers. The capacity to respond to the threat of pandemic human influenza, global efforts to reach the Millennium Development Goals, and all our efforts to address priority diseases are threatened by health workforce shortages. These shortages are not limited to health practitioners, but extend to educators and trainers, managers and support staff. Poor distribution of resources, wasted and unused skills, and migration of health workers are making a bad situation worse.

Solutions do exist and new ones are being actively sought. Innovative and effective ways to educate and train the health workforce, private-public partnerships, adequate financing and management policies, and successful country experiences all help us to learn from each other.

I invite you to join with WHO to raise awareness of this chronic problem and to build support to ensure that health workers will be working where they are needed, when they are needed, with the right skills to provide the highest attainable level of health for people everywhere.



A message from Dr Hussein A. Gezairy, Regional Director, WHO Eastern Mediterranean Region

This year, World Health Day celebrates all the members of the health workforce who have always been and will keep on "Working Together for Health" to save lives and promote health of humankind. the health workforce includes both trained health professionals, such as doctors, nurses, midwives, pharmacists, dentists, laboratory and other technical assistants, as well as non-health professionals working in health systems, such as managers, economists, accountants, information technologists and other administrative support workers. It also includes those individuals who have gained some health care knowledge and skills and volunteer to support health in families and communities.

The increasing demand for health, cost cutting, and underinvestment have resulted in overburdened, underpaid and unsupported health workers. There is a need for a closer look into the problems facing planning, education, training and management of health workers There is a growing health workforce crisis in many parts of the world. Across the developing world, health workers are facing economic hardship, deteriorating health infrastructures and social unrest. In the industrialized world, with increase in life span and chronic diseases, there is a need for more doctors and health workers. This compounds the problem for developing countries, as more and more health workers are attracted to migrate from the developing to the industrialized countries. In the Eastern Mediterranean Region, disparity in supply and demand, geographic maldistribution between urban and rural settings and imbalance in the number of different categories of professionals, represent another dimension of the crisis. Furthermore, even in the countries where ratio of health workers to population is high, the number of expatriate workers exceeds that of the nationals. This situation deprives these countries of a sustainable national capacity, an issue that should be addressed seriously in the long term.

Health systems around the world are now facing a triple crisis of workforce shortages, low morale and fading trust. WHO estimates the current global health workforce to be around 60 million women and men. It is estimated that there is a global shortage of millions of health workers. In the Eastern Mediterranean Region, there are currently more than 2 million health workers, and the immediate need exceeds an additional 2 million workers.

The development of human resources for health has consistently been a vital area for WHO's collaborative work with Member States of the Eastern Mediterranean Region since its founding more than half a century ago. The Regional Office supported countries to develop capacities to produce health workers in priority areas through community orientation of education and strengthening of national planning and management.

An important issue that relates to the investment in human resources for health is allocation of additional funds by governments to the health sector as an investment in overall development. In this regard, WHO headquarters in collaboration with its six regional offices has produced a global report entitled *Tough Choices: Investing in Health for Development—Lessons from Developing Countries.*

There can be no doubt, the changing roles and functions of health professionals in response to the changing health systems and population health needs demand continuous review, and reform of the process of human resources development.

"Health workforce in crisis", the theme of this year's World Health Day, marks the beginning of a decade that will be devoted to human resources development as a priority, by WHO and Member States, and the strategies and action that can be taken to address the various issues. I would like to call on all countries to invest more in this field and to make effective use of global, regional and intercountry cooperation and support in order to achieve the dramatic improvements needed in balance and efficiency of the health workforce.

Why focus on the health workforce?

Health workers save lives (Figure 1). Without them, advances in health care cannot reach those most in need. Preventing and treating diseases require assessment, delivery and monitoring by health workers. Despite this, national health systems worldwide are finding it increasingly difficult to train, support and retain their health workers. These problems are directly threatening global efforts to achieve the Millennium Development Goals (MDGs) and to deal with dire health threats such as pandemic human influenza, epidemics of chronic disease, and disasters. In addition, shortages of health educators and trainers, support staff and managers, and the wasting of available resources are making a critical situation even worse.

There can be no doubt that there is a growing health workforce crisis in many parts of the world. The global population is rising, but the number of health workers is stagnating or even falling. This is especially true in places with the most serious health problems. Across the developing world, health workers are facing economic hardship, deteriorating health infrastructures and social unrest. The HIV/AIDS pandemic has decimated health workers and patients alike. This has dramatically intensified the need to prevent HIV infection among the health workforce, and to provide antiretroviral treatment to those already infected. In developed countries, a rise in chronic health problems among ageing populations has led to an ever-growing demand for health workers. This demand is increasingly being met by the active recruitment of trained workers from developing countries. This makes shortages of skilled human resources even worse in the poorest countries.

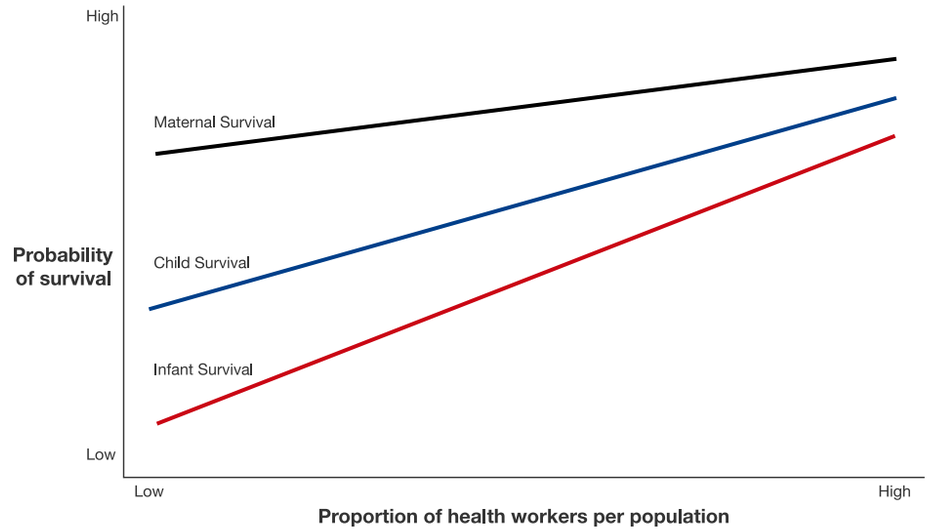


Figure 1. Health workers increase the survival of mothers and children

Source: *The world health report 2006 – Working together for health. Geneva,* World Health Organization, 2006 (in press).

Health systems around the world are now facing a triple crisis of personnel shortages, low morale and fading trust (Box 1). WHO estimates the current global health workforce to be around 59 million women and men. There are 39.5 million health service providers and over 19.5 million management and support workers. It is estimated that there is a global shortage of more than 4 million doctors, midwives, nurses, pharmacists, dentists and support workers. Decades of cost cutting and under-investment in health have also resulted in truly terrible working conditions for many in the health workforce. The morale and performance of overburdened, underpaid and unsupported health workers have sharply declined. As a result, many health workers feel they can no longer continue under these conditions. This has led to loss of health workers, deterioration of health services and erosion of public trust in the health system. The lowest concentration of health workers is in sub-Saharan Africa, where the greatest shortages are also found (Figure 2).

Solutions to these problems do exist, and new ones are being actively sought. Innovative and effective ways to educate, support and manage the health workforce, and encourage private–public partnerships are already reaping benefits. In recent years, WHO and its partners have moved health workforce issues up the political agenda. To give further momentum to efforts in this area, *World Health Day 200*6, The World health report 2006, and this toolkit have all been aligned around the key theme of Working together for health. The hope is that this will encourage all stakeholders – policy makers, international donors, politicians, health professionals, academia, civil society, faith-based organizations, media – to unite and work together to strengthen the health workforce.

What follows is an outline of four priority areas for action. These have been organized around a "working lifespan" approach, which focuses on strategies at the various stages of the working life, from entry into the workforce, through to current work, and exit. The four priorities for action encompass educating and training health workers; supporting and protecting them; enhancing their effectiveness; and tackling health imbalances and inequities. Each priority area described below is illustrated by pictures, graphs, country examples and stories – reflecting the voices and experiences of health workers themselves.

Box 1. Obstacles to human resources development in most countries

1. There is absence of a comprehensive national health development plan or strategy for health sector development that incorporates all aspects of human resources development.
2. The prerequisites for health staff development are not in place.
3. The education programmes of academic institutions are not directly linked to population health needs.
4. Admission policies are unrealistic.
5. Effective national systems of continuing professional development linked to job careers are lacking.
6. Salaries are not linked to performance and impact.
7. Primary health care and non-curative activities are overlooked.
8. There is ineffective coordination and utilization of capacities within ministries of health, universities and other care providers.

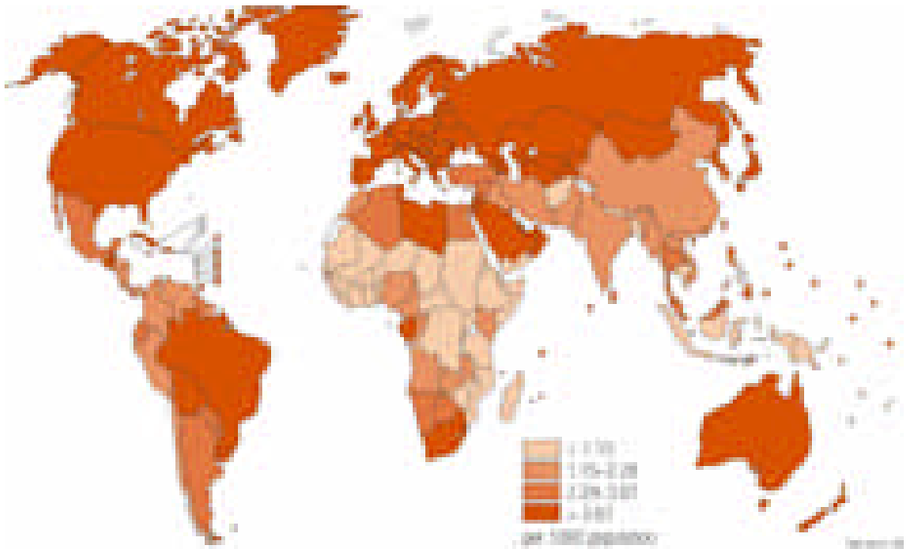


Figure 2. Distribution of health care providers

This map is an approximation of actual country borders.
Source: *The world health report 2006 – Working together for health. Geneva*, World Health Organization, 2006 (in press).

Key messages for World Health Day 2006

1. Educated and well-trained health workers save lives – They are vital for providing access to disease prevention, treatment and care for all, including those living in extreme poverty.
see section 1 Educating and training health workers

2. Support and protect health workers – Safe and supportive working conditions must be ensured, and salaries, resources and management structures improved.
see section 2 Supporting and protecting health workers

3. Enhance the effectiveness of the health workforce through new strategies – Enormous opportunities to achieve efficiency gains exist in many settings, and strategies must focus on the existing workforce because of the time lag in recruiting or training new health workers.
see section 3 Enhancing the effectiveness of the health workforce

4. Tackle imbalances and inequities – There are now widening imbalances and inequities in the availability and migration of health workers that seriously undermine the provision of fair and universal health care.
see section 4 Tackling imbalances and inequities

5. Governments must take the lead – To make progress in all the above areas, governments must provide leadership in planning, formulating and implementing the required policies.
see Taking action together at the national and global level

6. Promote partnership and cooperation – Alliances of stakeholders within countries backed by global and regional reinforcement are needed to properly address the technical and political challenges of health workforce development.
see Taking action together at the national and global level

7. Build trust among all stakeholders – Trust between governments, employers, health professionals and the communities they serve must be nurtured and maintained.
see Taking action together at the national and global level

Priorities for action

1. Educating and training health workers

I would like to pursue postgraduate studies. If I'm able to achieve my ambition of postgraduate education, I would not emigrate – I would return here to serve the local people.

Mr Bernard Tshilenge Muswamba, Laboratory technician, Democratic Republic of Congo[1]

Rapid advances in medicine, technology and case-management approaches are changing the mixture of skills required to respond to current and emerging health needs. Matching the skill mix of health workers with the needs of diverse populations is a key requirement of successful health education and training. The first requirement for an effective health workforce is to have sufficient numbers of skilled workers equipped with the necessary technical and other competencies. They must also be accessible and able to reach diverse clients and populations. Achieving this first step will need:

- **Comprehensive planning** to guide the training of a sufficient pool of health workers with the appropriate mix of skills. Such planning needs to focus on optimizing public and private investments in education and training, and on managing labour markets. Recruitment and placement policies should aim to ensure the acceptability and accessibility of health workers, especially in terms of gender, language and ethnic compatibility.

- **Public sector investments in education** and training to ensure a broad range of graduate skills and an emphasis on prevention (Box 2). This is especially true where market-driven "curative" services are not providing the full range of skills required. The key to successful financing in this area will be to harness the growing private sector in health training while continuing to allocate sufficient public funds to ensure comprehensive skills training and fair coverage (Figure 3).

- **Building strong and responsive institutions** to produce health graduates of the right type and number. The world's 1600 medical schools, 375 schools of public health, 880 schools of pharmacy and 6000 nursing schools are not training sufficient numbers of the right type of workers to meet patient needs. Faced with accelerating erosion of the workforce, these institutions are only providing a slow "drip" of graduates into a leaking bucket. The training of health workers requires capable and motivated teachers, using innovative teaching approaches to reach students from different sociocultural backgrounds. In the Eastern Mediterranean Region, the number of medical schools rose from 18 in 1950 to around 250 in 2005.

- **Strengthening professional regulation** through accreditation (licensing, certification and registration) and wise investment of public funds. Governments must ensure the competency and quality of professional bodies, backed up by regulatory enforcement, if widespread trust in health services is to be achieved. In countries of the Region, establishment of national systems of accreditation has reached different stages (Table 1). The WHO Regional Office for the Eastern Mediterranean is supporting national authorities to follow steps towards establishing these systems. (Box 3).

[1] *Heroes for health.* WHO Regional Office for Africa, 2006 (www.who.int/features/2006/heroes/africa/en/index.html)

Box 2. Questions to be answered to orient medical schools towards national health needs

1. Have national health needs and health system requirements well been taken into account?
2. Have prospective roles of health professionals been analysed?
3. Does the medical school properly respond to priority medical workforce needs?
4. What determines admission to a medical school?
5. Are primary health care and preventive aspects given sufficient emphasis in education, research and service delivery?
6. Is the medical school actively participating in community health programmes?
7. Are curricular contents adapted to prepare the needed medical doctors?
8. Are appropriate effective methods and techniques used to steer and evaluate medical education?
9. To what extent is the medical school taking interest in the future of its graduates?
10. Are graduates encouraged to work in general practice and community health?
11. Are sustainable partnerships developed with key stakeholders in the health system?
12. Is the medical school submitting itself to evaluation and accreditation procedures?
13. Are efforts in leadership and academic staff development appropriate?

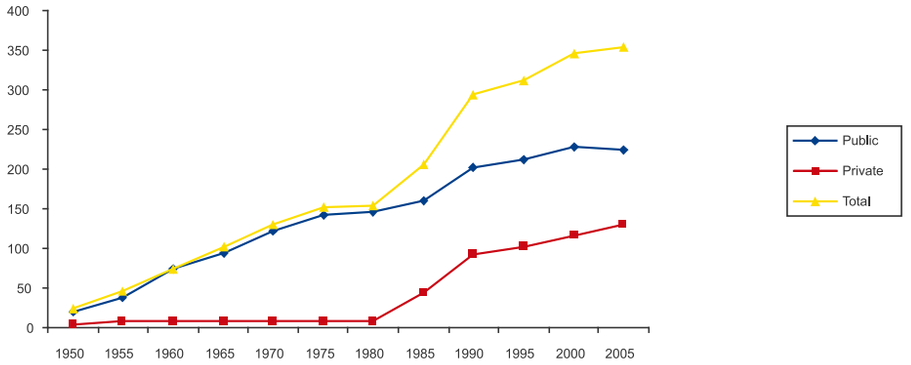


Figure 3. Growth trend in public and private colleges of health professions education in the Eastern Mediterranean Region, 1950-2005

Box 3. Priority actions for planning national accreditation systems

1. Nominate a national task force.
2. Ensure legislation and political commitment.
3. Design organizational structure.
4. Engage professionals, etc.
5. Define role of WHO Regional Office in supporting actions.
6. Draft terms of reference for accrediting body.
7. Raise awareness.
8. Define and obtain financial resources.
9. Set national standards based on regional and global sets.
10. Plan workshops and seminars.
11. Agree on timelines and implementation.

Table 1. Status of implementation of accreditation in the Eastern Mediterranean Region

Country	Accreditation introduced	Accrediting body *	National standards	Self studies	Unified exams	COME	External accreditation
Afghanistan	Plan 2006	Plan 2007	2006	–	Planned	No	Plan 2006
Bahrain	Yes	GCC	GCC set	Yes	Planned	Yes	Yes
Djibouti	No	No	No	No	No	No	No
Egypt	Yes	Plan 2006	Yes	Yes	–	Yes	Plan 2006
Iran, Islamic Republic of	Yes	GSpBrds	Revise	Yes	–	Yes	Plan 2006
Iraq	Yes	MOHSR	Revise	Yes	Yes	Yes	–
Jordan	Yes	MOHE	Yes	Yes	–	Yes	Plan 2006
Kuwait	Yes	GCC	GCC set	Yes	Planned	No	Yes
Lebanon	Yes	External	External	External	No	No	External
Libyan Arab Jamahiriya	Plan 2006	Plan 2007	Plan 2007	–	–	No	–
Morocco	Yes	–	Plan 2006	2006	–	No	–
Oman	Yes	GCC	GCC set	Yes	Planned	No	Yes
Pakistan	Yes	PMDC	Revise	Yes	Yes	Yes	Yes
Palestine	No	No	No	No	No	No	No
Qatar	Yes	GCC	GCC set	Yes	Planned	No	Yes
Saudi Arabia	Yes	GCC	GCC set	Yes	Planned	Yes	Yes
Somalia	Plan 2006	2006	Plan 2007	2006	Planned	Yes	Plan 2006
Sudan	Yes	SMC	Yes	Yes	Yes	Yes	Plan 2006
Syrian Arab Republic	Plan 2006	–	2006	–	Planned	No	–
Tunisia	Yes	Plan 2007	Plan 2006	2006	–	Yes	–
United Arab Emirates	Yes	GCC	GCC set	Yes	Planned	Yes	Yes
Yemen	Yes	YMC	Yes	Yes	Yes	Yes	Plan 2006

–	not addressed
COME	community-oriented medical education
GCC	Gulf Cooperation Council (Committee of Deans of Medicine)
PMDC	Pakistan Medical and Dental Council
SMC	Sudan Medical Council
YMC	Yemen Medical Council
MOHE	Ministry of Higher Education
MOHESR	Ministry of Higher Education and Scientific Research
GSpBrds	Graduate specialties boards

What can countries do to educate and train health workers?

All countries, poor or rich, should develop updated comprehensive national plans to identify health workforce shortages and bottlenecks, and develop a consensus for joint action. Plans should respond to health needs and personnel requirements, as well as the changing nature of labour markets and the new skill mixes required. In all these areas, rational and innovative new approaches will be needed (Box 4). Approaches that have already yielded good results in many countries include:

- adapting education and training curricula to fit national health priorities;
- improving coordination and planning between the health, education and finance sectors;
- continued training and support for health professionals (Figure 4);
- diversifying the roles of health workers; and
- creating new health worker categories, along with new education programmes.

The global shortage of health workers stems from a shortage of health education and training capacity and the frequent lack of specialized training facilities. Opening new training institutions has therefore become a priority in many settings. In Ireland, a growing dependence on foreign pharmacists (Figure 5) was tackled by the opening of a new pharmacy school.

However, training health workers does not always require expensive investments. Successful innovations have frequently been demonstrated in pilot and other small-scale studies that can be brought to national scale. In the case of health workforce development, success has been demonstrated in many settings. Examples include delegating tasks to community workers, new training approaches and supervisory techniques, and the use of modern information technologies (Boxes 5 and 6).

Box 4. The public health movement in south-east Asia – regional initiatives and new schools

Although almost one third of the world's population lives in south-east Asia, the region has less than 5% of the world's public health schools. Efforts to rapidly increase public health training for health professionals are urgently needed. In response, national, regional and international stakeholders are now aligning the resources and political will required to develop new and innovative approaches. In 2004, the South-East Asia Public Health Initiative to strengthen public health planning was launched in order to:

- position public health high on regional and national agendas;
- strengthen public health education;
- enhance technical cooperation in the development of national public health training institutions;
- establish a public health education institutions' network; and
- help countries to define an appropriate package of essential public health functions.

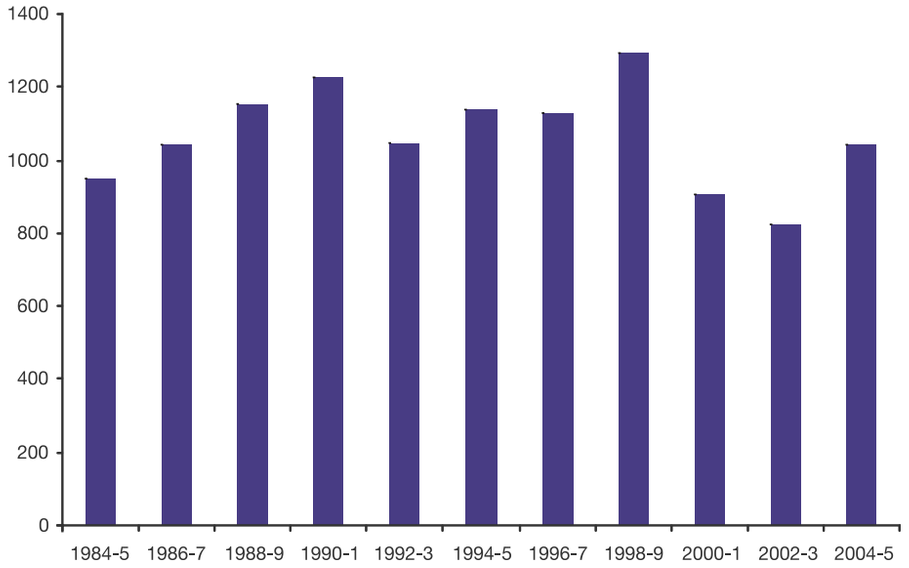


Figure 4. Fellowships awarded to countries of the Region, 1984–2004

Source: EMR Fellowships database, 2005.

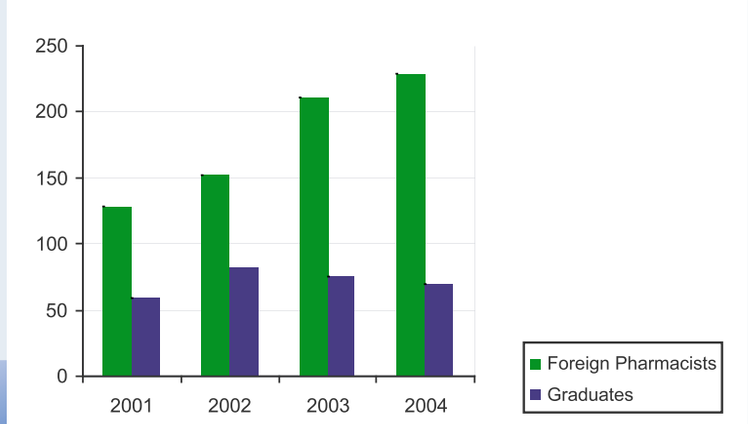


Figure 5. Pharmacists entering the workforce per year in Ireland

Source: International Pharmaceutical Federation. *Global Pharmacy Workforce and Migration Study*, 2005. www.fib.org/hr

Box 5. Lady Health Workers (Pakistan)

The National Programme for Family Planning and Primary Health Care aims to deliver basic health services at doorstep of the underprivileged segments of society through training and deployment of Lady Health Workers (LHWs). The selected LHWs are middle level educated, preferably married and residing in the catchment areas in which they serve. On the average, each LHW is responsible for a population of around 1000–1500 persons. The programme is currently being implemented in almost all districts of the country. At present, 70 000 LHWs are providing primary health care services to nearly 70% of the population of the country.

The LHWs are trained to provide preventive, promotive and simple curative care. Accordingly, LHWs promote nutrition education including exclusive breastfeeding, child weaning and complementary feeding practices and use of iodized salt. They promote education on personal hygiene and environmental health. They perform vaccinations with direct positive impact on polio eradication, provide prescribed treatment to tuberculosis patients and manage common health problems such as diarrhoea, acute respiratory infections, fever and simple skin and eye infections. They also provide antenatal and post-natal care to mothers, deliver reproductive health care services and advise families on referral in the case of obstetric or child-related emergencies. LHWs also keep records of births, deaths and service delivery of their catchment areas.

Box 6. Female community health volunteers (health communicators) in the Islamic Republic of Iran and women health volunteers in Pakistan

The role of female health communicators in the Islamic Republic of Iran is building bridges between households of their neighbourhood and the respective health centre in urban areas. They are selected from among the educated women of the urban neighbourhoods and participate in health promotion/ prevention activities on a voluntary basis. Activities include dissemination of health messages to families, supporting family health activities, following up health services utilization (vaccination, family planning) and promoting environmental health activities. Women health volunteers in Pakistan are being trained by Lady Health Worker supervisors and Lady Health Visitors working in the nearest health facilities on growth monitoring skills, nutrition promotion, reproductive health and other priority health issues. In this initiative, four literate volunteer women are selected for each village and are made partners and resource persons for nutrition, reproductive health promotion and education.

Community health management in the Eastern Mediterranean Region

Community health management is a practical training methodology that provides health authorities with an effective means of strengthening the management capabilities of health professionals and managers.

Experience has shown that whenever health care personnel are closely involved in the decision-making process as in community health management, health services improve and a stronger relationship between providers and users and the community as a whole is developed. In the community health management approach, training is organized on the basis of teams composed of staff working in the same health unit and serving a defined community.

The community health management approach is a practical response to the new realities affecting health systems in which learning-by-doing, teambuilding, information collection and analysis, thorough planning, and monitoring and evaluation are considered essential components in the management of health services. If harnessed well, community health management can act as a powerful vehicle for health systems development at all levels (Box 7).

Box 7. Features of community health management

- Builds managerial capacity throughout the health system through a practical approach
- Changes the attitude of staff
- Establishes confident relations and partnerships with the community
- Ensures optimal use of available resources
- Enhances interactive communication between service delivery staff, their supervisors, and first referral level
- Helps staff to develop an integrated approach to the delivery of health services
- Creates awareness among staff of the importance of information
- Solves organizational and operational problems
- Promotes quality of care
- Fosters teamwork and self-learning

2. Supporting and protecting the health worker community

People need to be compensated for their hard work and after-hours duty.

Fijian doctor [2]

In many countries, strict limits have been put on the number of health staff and their salaries. At the same time, government spending on professional education and development has often been severely reduced. As a result, the morale of health workers has plummeted, and wages in many places have fallen well below acceptable levels (Box 8). Health workers often struggle to provide for their families, and practise privately to supplement their meagre income. Increasingly, health workers are coming under pressure to "vote with their feet" and change jobs or emigrate (Box 9). In the worst cases, political instability and conflict have further damaged an already insufficient health infrastructure and have seriously overburdened health workers.

Shortages of basic supplies, sanitation, electricity and water are putting health workers and patients at serious risk of injury and infection. Increasing violence in the health workplace in many parts of the world compounds these problems. Much of this violence is directed against women who comprise a growing proportion of the health workforce. On top of all these, particularly in sub-Saharan Africa, HIV/AIDS further depletes the already limited numbers of health workers.

Our personal safety is not guaranteed. Patients are harassing us and shouting at us. They have guns and you are not expected to retaliate, to say anything to them, because it is said they are right.

Primary health care nurse, South Africa [3]

Poor management is now leading to unprecedented levels of frustration among health workers. These workers are now leaving their jobs to either change careers of to emigrate (Figure 6).

Box 8. 60 cents a day

Dr Eugène Serdouma is head of the maternity ward at the Bangui Community Hospital in the Central African Republic. He earns USD 20 a month (60 cents per day). He is owed 48 months of salary and has run up huge debts. This is true of many of the civil servants in the country. He says his greatest wish is this list of essential life-saving materials:

- Caesarean-section kits (5000 per annum);
- Delivery kits (7000 per annum);
- Delivery room lamps (2);
- Operating tables (2);
- Resuscitation devices (6); and
- Sterilizers (2).

[2] Naidu LK. Contemporary professional emigration from Fiji [MA thesis]. Suva, University of South Pacific, 1997. Cited in *The migration of skilled personnel in the Pacific Region*. A summary report. Manila, WHO Regional Office for the Western Pacific, 2004

[3] *Human resources for health: overcoming the crisis*. Cambridge, Massachusetts, Joint Learning Initiative, 2004.

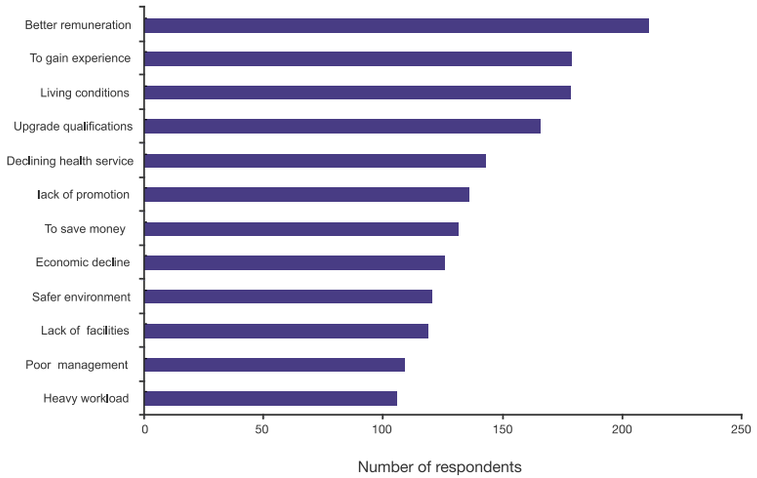


Figure 6. Selected reasons for migration in four sub-Saharan African countries (Cameroon, South Africa, Uganda and Zimbabwe)

Source: Awases M, Nyoni J, Gbary A, Chatora R. *Migration of health professionals in six countries: a synthesis report.* WHO Regional Office for Africa, 2004.

Box 9. Motives and perceptions for joining the nursing profession in the Eastern Mediterranean Region

A study was undertaken to identify why female students in Qatar decide to become nurses and how the students perceived the community attitude towards nursing.[4] A self-administered anonymous questionnaire was distributed to all (57) female students of the four academic classes of the Nursing Unit, University of Qatar for the academic year 1999–2000. The two most common reasons for joining the nursing profession were an interest in medical services and the humanitarian nature of nursing. There were 33 (57.89%) students who considered there was a negative community attitude towards nursing mainly due to the presence of male patients and colleagues and the working hours. A mass media campaign and government support were two strategies suggested to change this.

The most common motive, given by more than half the students, was an interest in working in medicine. The second most common motive was the humanitarian or service nature of the nursing profession, which was mentioned by about two-fifths of the students (38.60%). Other motives included the scores obtained in the final years of secondary school, national needs or community service, economic reasons and others.

Most of the students (57.89%) felt that there was a negative community attitude towards the nursing profession. The most frequent given reason for this attitude was "dealing with male patients" (57.57%). The second most common reason was the night shifts involved in nursing work (51.51%). Long working hours (39.39%) and "working with male colleagues" (36.36%) were also mentioned.

In terms of the community's negative attitude towards nursing, the most commonly stated manifestation was husbands' refusal to allow their wives to work as nurses (51.51%), followed by the reluctance of young men to marry nurses (48.48%) and family resistance to allowing their daughters to work as nurses (36.36%).

Half the students said that they would insist on continuing working as nurses even if their husbands (or future husbands) wanted them to leave the profession.

What can countries do to educate and train health workers?

Supporting and protecting health workers require competitive salaries and other benefits (Box 10), good working conditions (including flexible working hours) and a workplace safe from the risks of infection, injury and violence.

In the era of HIV/AIDS, illness among individual health workers, their colleagues and family members seriously threatens the viability of health care systems. All health workers should therefore be protected against HIV infection. This includes providing protective gloves, safe disposal of sharp materials, and procedures to prevent needlestick injuries. HIV-positive health workers should be accorded the highest priority for antiretroviral treatment (Box 11).

In addition to the risks associated with infection and workplace accidents, health workers face the added threat of violence. A shift towards a "zero-tolerance" approach to violence against health workers and its systematic reporting is one of the most important issues in protecting health workers, and one that needs to be addressed now.

Successfully mobilizing support from both the public and private sectors will also be a key part of retaining health workers. Building up the capacity for ongoing training, encouraging career advancement, and providing managerial support are all urgent priorities. Not all strategies for supporting and protecting health workers require large-scale financial investment or infrastructure (Box 12).

[4] Okasha MS, Ziady HH. Joining the nursing profession in Qatar: motives and perceptions. *Eastern Mediterranean Health Journal*, 2001, 7(6): 1025–33.

Box 10. The Zambian health worker retention scheme [5]

The following list of employment conditions for health workers was approved as an official pilot within the Public Service Reform Programme (PSRP) by the Cabinet Office and the cooperating partners of the Harmonization in Practice (HIP) initiative.

- A 3-year contract with district authorities, incorporating:
  - basic professional conditions in place – including operating theatre, X-ray department and laboratory facilities
  - a housing plan entitling a maximum one-off payment of a USD 3000 subsidy;
- A monthly hardship allowance depending upon the remoteness of the district (USD 250–300 per month);
- Education for a maximum of 4 children paid on a full-cost recovery basis;
- Access to a loan up to 90% of the value of the 3-year contract, towards the purchase of a vehicle or house mortgage (USD 7500–9500);
- End-of-contract incentive (USD 2000–2600);
- Priority treatment in selection for postgraduate training; and
- Benefit from the scheme to be dependent upon satisfactory performance assessment.

The immediate result of implementing these terms was that 66 highly enthusiastic doctors (mainly from tertiary hospitals) were contracted to work in rural areas. The main challenges appeared to be the need to give more attention to the preparation and administration of the scheme and its terms, and to managing its performance.

The expansion of the retention scheme was guided by the following principles:

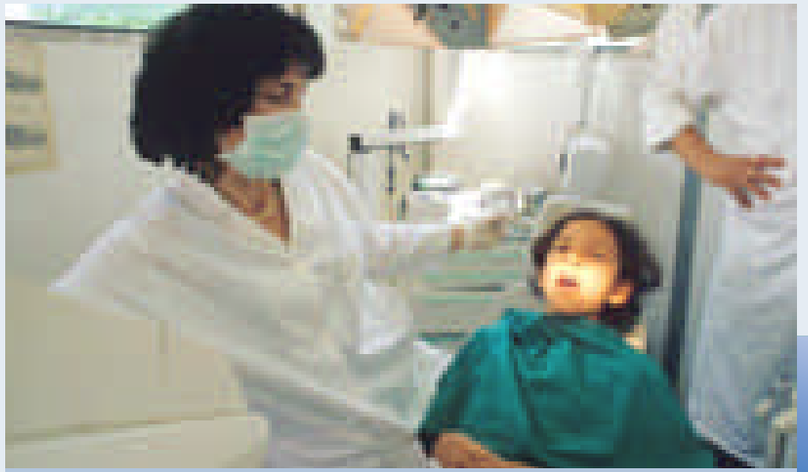
- it should be targeted to areas where shortages are most critical;
- destabilization of the workforce to be minimized by maintaining the balance of health worker and facility types;
- expansion to be incremental following monitoring and adjustment;
- should build upon district-level initiatives (to support decentralization);
- should use simple and unambiguous systems; and
- other strategies to complement the retention approach should be used.

Box 11. Providing care for health workers [6]

The Ministry of Health in Uganda has been distributing free antiretroviral treatment for HIV infection countrywide to those unable to afford it since June 2004. Uganda's Joint Clinical Research Centre is the largest provider of antiretroviral drugs in sub-Saharan Africa and provides care and support services to its personnel. In 2005, Omwony Ojwok, Uganda's Minister for Economic Monitoring, announced that around 10 000 Ugandan government workers living with HIV/AIDS would also receive free antiretroviral drugs, made available by the Ministry of Health. The prevalence of HIV infection in Uganda has fallen from over 20% in the 1980s to around 6%.

Box 12. Supplementary pay and allowances valued by health workers [7]

- Contract signing bonuses;
- Reimbursement of job-related expenses (such as uniforms or petrol);
- Education, accommodation, transport or childcare subsidies;
- Health insurance;
- Access to loans (including subsidized mortgages);
- Training course per diems;
- Remote area allowances;
- Out-of-hours allowances (such as for overtime and night shifts); and
- Specific performance incentives (for example, for high immunization rates).



[5] Dr Simon Miti, Ministry of Health, Zambia. Presentation to the consultation on human resources for health, Oslo, February 2005.

[6] Kinoti S, Tawfik L. *Impact of HIV/AIDS on human resources for health*. Geneva, World Health Organization, 2005 (background paper for *The world health report 2006*; available at: http://www.who.int/hrh/documents/en/).

[7] *The world health report 2006 – Working together for health*. Geneva, World Health Organization, 2006 (in press).

3. Enhancing the effectiveness of the health workforce

On the ground today teams of health workers are deploying their collective ingenuity to address critical health challenges. We must harvest this know-how more systematically, critically evaluate it and share lessons more broadly.

Dr Tim Evans, WHO

As health care changes, so do the demands placed on health workers. In particular, the HIV/AIDS pandemic and increased levels of chronic disease have placed great strain on health systems. At the same time, advances in technology have allowed the focus of care to shift towards community-based and home-based models. The opportunity to manage patients as outpatients minimizes over-reliance on hospitals.

Health care delivery is now increasingly the domain of family members, community health workers with minimal training, and patients themselves. In order to respond to the challenges of the changing health environment, health workers must be helped to become more effective, and health systems management must become more supportive. At present, those providing care at the grassroots level can feel isolated, unsupported and let down by the formal health care system.

We will just work…and no one will see that these people are meeting their objectives because we are not being evaluated. Since I came here, no one came to me and asked me how good are these objectives, which one did you meet?

Primary health care worker, South Africa [8]

The system is not incentive-based; it does not recognize performance.

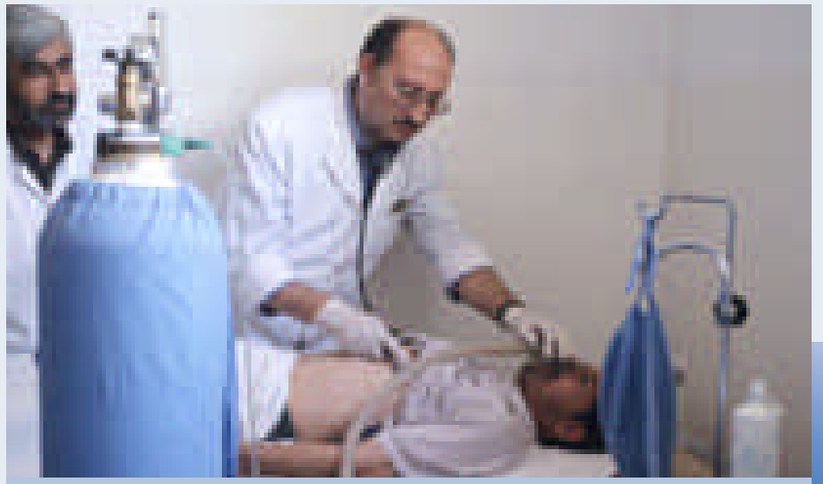
A Ghanaian doctor [8]

Treating health workers with respect and dignity goes a long way in increasing workforce motivation and effectiveness. The enormous potential benefits that well-implemented management strategies can bring have recently been quantified by a study conducted in the United Republic of Tanzania.[9] It was found that there was a 78% difference in the productivity levels of the best and worst performing health facilities. The study went on to estimate that total productivity gains of 60%–75% could be achieved simply by improving the support, management and deployment of well-motivated health staff.

What can countries do to enhance health workforce effectiveness?

Strategies to enhance the effectiveness of the health workforce must initially focus on existing staff because of the time lag in training new health workers. In the short-term, one challenge will be improving health worker performance and impact by matching skills to health needs while maintaining professional standards and codes of conduct. In the longer term, sustained improvements are only likely if they are accompanied by improved working conditions, salaries and management as well as workplace policies that support lifelong learning.

A team approach to patient care should be encouraged. Innovative approaches to turn individual health workers into members of health teams, backed by effective and supportive supervision, should be implemented (Box 13 and 14). Recognizing the contribution of all health workers and finding efficient ways for them to contribute will be vital if significant gains are to be made.



Box 13. Integration and coordination education, services and research to improve effectiveness and efficiency of health workforce: models from the Region

In the Islamic Republic of Iran, the Ministry of Health and Medical Education was created in 1985 by integrating the health professions education institutions and the previous Ministry of Health. The main objectives were to improve and orient the capacity of education towards the community needs; expand the coverage and improve the quality of health care services through optimum utilization of staff in the two sectors; and provide more physical and human resources for quality services, training and research. In 1993, the programme was expanded towards the establishment of "provincial universities of medical sciences and health services". This was done with the aim of promoting decentralization; providing more autonomy at provincial level; supporting newly established schools and training centres; improving management; and expanding research activities to peripheral levels. The integration has been successful in increasing the number of graduates from different health professions degree programmes, whereby improving the quantity of health workforce, and expanding the training institutions to the periphery and remote areas where most of graduates stayed in serving their local communities. It has also allowed the Ministry to make use of hidden capacities in terms of physical and human resources within the health system, and has resulted in revision of the curriculum in health professions education towards community needs and guiding research activities towards health system and operational research.

At present, different levels of integration are practised in Tunisia, where education is governed by both ministries of health and higher education, and in Bahrain and Saudi Arabia, where colleges of medicine and other health professions are established within the Ministry of Health.

[8] Ijumba P "Voices" of primary health care facility workers. In: Ijumba P, ed. *South African health review*. Durban, Health Systems Trust, 2002:181–200.

[9] McKinsey et al. *Acting now to overcome Tanzania's greatest health challenge: addressing the gap in human resources for health*. Report of a field visit, United Republic of Tanzania, 2004.

Box 14. Supporting Yemen in establishing a BSc degree programme in health management

The Department of Health Management with a BSc programme was established in the Faculty of Administrative Sciences at Aden University. The purpose of establishing this department is to provide an opportunity for specialization in the area of health management which is lacking, not just in Yemen, but also in the Region. It is a unique and distinguishing experience in its type and as being a partnership between the three parties – the Ministry of Public Health and Population, Aden University and WHO. The establishment of this department required great efforts and dedication to accomplish several crucial tasks that are managed by a local consultant.

The second step in the establishment of new and innovative management training is by completing the development of the competency-based, community-oriented and skills developing curriculum for health management. This updated curriculum will be a model that can be replicated in existing and future management schools in the Region.

The Curriculum is based upon a problem-based learning approach. It should serve as the mode of teaching which would be appropriate for health managers in Yemen. This methodology not only encourages students to acquire the skills of self-learning but also teaches them the art of practising management in various settings at community level as well as other health care levels. By adopting this methodology, future managers will be able to strengthen the health care delivery system of the country.

But it is not just the formal workforce that can be better managed for improved performance. For example, in the Islamic Republic of Iran, Pakistan and Thailand, village health volunteers perform primary health care and disseminate health information in their communities. In return they receive non-financial incentives, such as social recognition and continuous training. Such innovative and cost-effective ideas can enable informal health workers worldwide to carry out basic yet life-saving functions such as drug distribution, health surveillance and outreach programmes. (Box 15, 16 and 17).

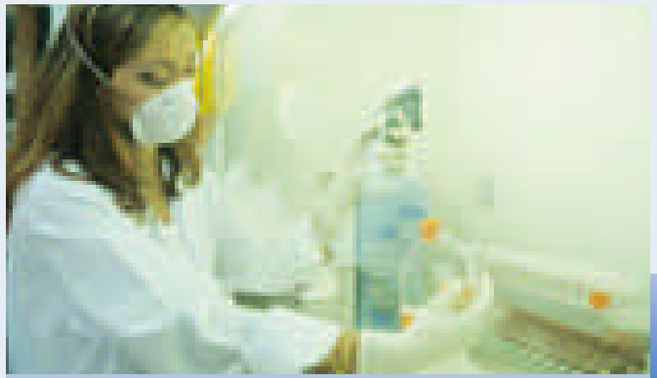
If implementing these and other approaches is to be successful, it will be vital to gain trust. Without trust, health systems cannot be fully effective. Fighting corruption in all its guises must therefore be a priority if trust in state health systems is to be regained. A lack of transparency and accountability, limited

Box 15. Innovating for greater impact

- **Delivering health**[10] – Drugs may be important, but for their impact to be really broad, health workers must be there in person to bridge the gap between technology and the patient. In Egypt, infant mortality decreased by 15% when oral rehydration solution was made available in pharmacies. But when community health workers were able to bring the solution to people's homes, infant mortality decreased by 40%.
- **Cooperation brings success**[11] – In Nepal, health expert Ram Shrestha realized that he could distribute life-saving vitamin A pills to a wider community by going to the grandmothers. They have the time to distribute the pills and the authority to see that children take them. Today there are 49 000 grandmothers distributing vitamin A to 3.5 million Nepalese children every year. The same programme is now getting vitamin A to pregnant women as well, to prevent eye disease.
- **Using personal experience to bring hope**[12] – Helen is the administrative clerk at an HIV/AIDS clinic in rural Uganda. As a person living with HIV/AIDS who started antiretroviral therapy (ART) nine months ago, she has gained considerable knowledge about treatment. As an expert patient, she can answer many questions from other patients visiting the clinic. As an activist of the national organization of women living with HIV/AIDS, she is involved in organizing nutritional support to patients on treatment. She is also a member of the local AIDS drama group and is involved in group education within the community. Helen is in an excellent position to link service providers, patients and community members.

Box 16. Steps to be taken in establishing an effective national system of continuing professional development

Step 1	Develop the concept of continuing professional education and increase awareness of its importance.
Step 2	Develop a national policy for staff professional development and have it approved by concerned authorities.
Step 3	Create the administrative structure for managing the programme.
Step 4	Set clear objectives and criteria for the programme.
Step 5	Provide adequate financial support and other resources.
Step 6	Initiate steps to enact supporting regulations and legislation.
Step7	Establish a partnership with all the organizations currently involved in continuing professional development.
Step 8	Conduct an inventory of all currently ongoing continuing professional development activities, their history and sponsoring organizations.
Step 9	Select priorities for action on an annual basis.
Step 10	Provide for a continuing evaluation process of the programme as a whole and of individual activities within the programme.



Box 17. Formulating a national policy and plan for continuing professional development

- It should be comprehensive covering all professional health workers.
- It should be mandatory to all professional health workers and provided on a continuous and regular basis.
- It should identify all the organizations and institutions who are willing to participate in the program and their designated roles.
- It should identify and recognize all legitimate development activities and subject them to continuous evaluation. Each activity should be assigned a quantitative value (score) depending on its value, duration and contents.
- The programme should be assigned a definite budget from the regular health budget rather than being dependent on ad-hoc support or outside support from donor organizations.
- It should identify one single agency that will be in charge of managing the programme.
- It should indicate the intent to develop regulations and to enact legislation that will make continuing professional development mandatory and that it will be linked to important professional issues such as career development, professional advancement and licensing to practice.

[10] Bhattacharyya K et al. *Community health worker incentives and disincentives: how they affect motivation, retention and sustainability*. Arlington, Virginia, USA, Basic Support for Institutionalizing Child Survival project (BASICS II), United States Agency for International Development, 2001.

[11] Kluger J. Vitamin Sherpa: Ram Shrestha. *Time*, 31 October 2005(http://www.time.com/time/magazine/printout/0,8816,1124312,00.html (accessed 5 December 2005).

[12] *Scaling up HIV/AIDS care: service delivery and human resources perspectives*. Geneva, World Health Organization, 2004.

enforcement of rules, and lax fiscal controls has led to serious abuses. Corruption may also take the form of "ghost workers" who are only ever seen on the payroll. Such widely known abuses at all levels of the health system have led to a damaging loss of public trust over the past decade. These abuses must be addressed if trust is to return and the full beneficial impact of the health workforce is to be harnessed.

In conclusion, increasing consultation with communities and patients on their health service needs and introducing policies that strengthen the effectiveness of health workers within communities must become prime objectives of local and national health planning. If the considerable challenges that exist can be overcome, there is an enormous opportunity to enhance the effectiveness of health workers and health systems worldwide.

The Management Effectiveness Programme in the Eastern Mediterranean Region

The Management Effectiveness Programme (MEP) is a regional programme that provides national health authorities with an approach and practical framework for building individual competencies and organizational capacity in management throughout the health system.

Strengthening management is a critical component of any strategy to improve health systems. Improving the organization and management of health services demands new competencies that are based on both knowledge and skills. The MEP approach focuses on the health care facility, referred to as the "site", as the most effective learning environment for developing these competencies. The programme can be applied to further sites such as health 'areas' where it seeks to improve the health for an entire a residential area or community in addition to being an effective means to strengthen district level management systems.

The MEP approach has seen strong success in the Region so far, with Egypt and the Islamic Republic of Iran having explored the potential of the programme in depth. Examples of successes include projects to improve utilization of family planning services, waiting conditions in outpatient clinics, cost effectiveness of laboratory testing, coverage of thyroid screening in neonates and use of standard operating procedures. These successes are a reflection of the widespread applicability of the programme and its efficacy in strengthening the underlying management processes operating within health care.

4. Tackling imbalances and inequities

The migration of health workers needs to be addressed as a matter of urgency because it has reached critical levels. There has to be a political will to address the grievances of health workers without confrontation

Abel Chikanda, Zimbabwe [13]

Access to health care remains very uneven and very unfair. In many places, this is contributing to the dwindling level of public trust in health systems. Health workers are disproportionately lacking in countries (Figure 7) and regions with the highest relative need (Table 2).

The global shortage of health workers is currently estimated at 4.25 million. The world health report 2006 has shown that in general, countries with fewer than 2.3 doctors, nurses and midwives per 1000 people fail to achieve an 80% coverage rate for measles immunization, or the presence of skilled birth attendants during childbirth. This has a demonstrable impact on people's lives and deaths. Fifty-seven countries fall below this minimum threshold, mainly in sub-Saharan Africa and Asia (Figure 8). For these countries to reach the required threshold, an additional 2.36 million health service providers would be required. Add to this the other types of worker needed to support health care providers and the total shortfall is estimated at 4.25 million.

This global workforce shortage is made even worse by imbalances within countries. There is a general lack of adequate staffing in rural areas compared to cities. However, systematic monitoring of imbalances within many countries is lacking, due to inadequate health information systems. Setting policies without information and with no means of measuring progress is not a recipe for success.

Demographic trends are also making health imbalances and inequities worse. As the populations of the developed world and its health workforce get older, ever more people are needed to provide care. This "pulls" health workers from developing countries. At the same time, as working conditions in developing

Table 2. Imbalances in health [14]

The Americas	Sub-Saharan Africa
14% of the world's population	11% of the world's population
10% of the global burden of disease	24% of the global burden of disease
37% of the world's health workers	3% of the world's health workers
>50% of global health expenditure	<1% of global health expenditure

[13] Chikanda A. *Skilled health professionals' migration and its impact on health delivery in Zimbabwe*. Centre on Migration, Policy and Society Working Paper No.4. University of Oxford, 2004.
[14] *The World health report 2006 – Working together for health*. Geneva, World Health Organization, 2006 (In press).

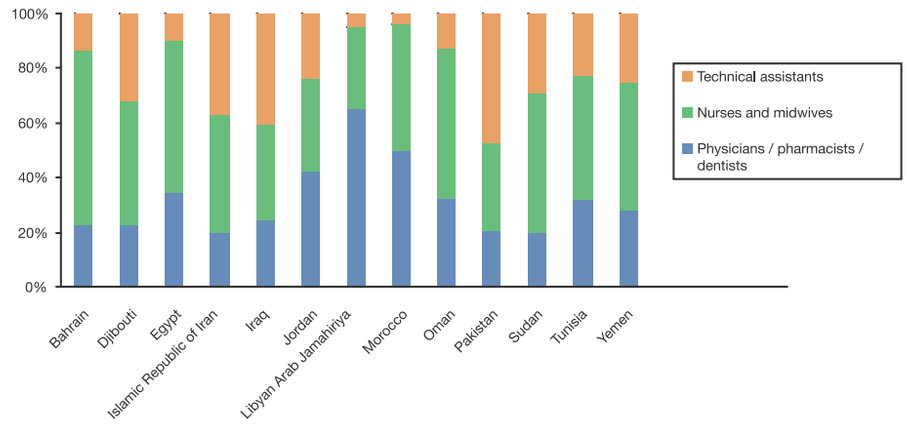


Figure 7. Relative proportion of human resources for health categories in countries of the Region

Source: WHO/EMRO human resources for health database, 2005.

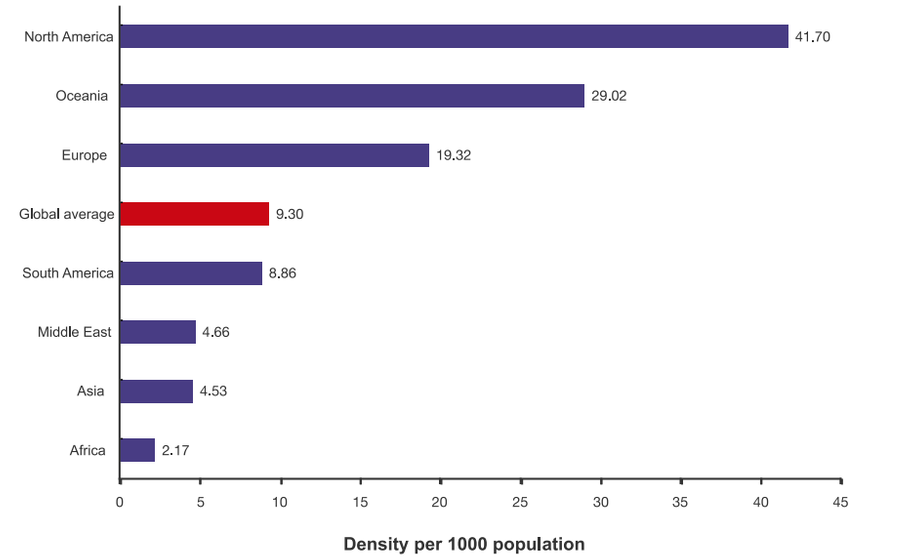


Figure 8. Inequities in the distribution of health workers worldwide

Source: WHO, 2006.

countries become intolerable, health workers there feel "pushed" to move away. For example, for every 100 African doctors working at home, there are 23 working in 8 countries of the Organisation for Economic Co-operation and Development (OECD), while for every 100 nurses and midwives working in Africa, there are about 4 working in these OECD countries. Driven by these "pull-and-push" forces, migration brings mixed consequences – positive for some but detrimental to health for many.

The accumulated effects of migration, premature death, illness, and career changes can lead to significant losses of health workers. In some regions, the losses may be large enough to undermine the ability to provide effective health services. When a country has a fragile health system, the loss of its workforce can bring the whole system close to collapse and the consequences can be measured in lives lost. While freedom of movement is a basic human right that must not be constrained, managing the causes and consequences of migration must be tackled responsibly by national governments and the international community.

What can countries do to tackle imbalances and inequities?

Strategies must be developed to manage internal and international migration, and make health work a safer and more attractive occupation. Where appropriate, the statutory age of retirement should be re-considered and made more responsive to an era of ageing workforces. Whatever approaches are adopted there should be a focus on protecting health in the poorest countries while ensuring individual freedom of movement.

Countries must work both individually and together to find solutions. Governments should invest in their health systems, particularly the workforce, in order to attract and retain sufficient health personnel to meet the health needs of their populations. In order to manage international migration and minimize inequities, action will be required in source countries, receiving countries and internationally.

Source country strategies

Source countries can employ a wide range of strategies for managing migration, including:

- **Adjusting training to needs**. Training that is focused on local conditions can help to retain health workers. Success here will depend upon a wide range of on-the-job incentives and support, and the involvement of key institutions such as universities and professional associations.
- **Improving local conditions**. Improving the employment conditions of workers helps to remove the "push" factors that induce workers to migrate.
- **Making it easy for health workers to return home after working abroad**. Surveys show that many migrant workers eventually want to come back home, either to work or to retire. Mechanisms to make proper use of their skills and knowledge should be sought.

Receiving country strategies

Receiving countries should demonstrate concern for the rights and welfare of migrant health workers by:

- **Adopting responsible recruitment policies**. Receiving countries have a responsibility to recognize that significant investments were made in source countries in training health care professionals, and their absence may have immediate and adverse effects. Discussions and negotiations with ministries of health, workforce planning units and training institutions will help to avoid claims of "poaching" and other disreputable recruitment behaviour.

- **Providing support to human resources in source countries**. Many receiving countries are also providers of overseas development assistance for health. Support could be more directly targeted at expanding the health workforce, thus stemming the impact of outgoing migration.

- **Ensuring the fair treatment of migrant workers**. Migrant workers should be recruited on terms and conditions equal to those of locally recruited staff.

International strategies

From an international perspective, the need to balance the rights of migrant health workers while ensuring an adequate health workforce in source countries has led to the development of ethical international recruitment policies, codes of practice and various guidelines. Although not legally binding, these do set important norms for behaviour among the key actors involved in the international recruitment of health workers.

Taking action together nationally and globally

We have to work together to ensure access to a motivated, skilled, and supported health worker by every person in every village everywhere.

Dr LEE Jong-wook, Director-General, World Health Organization [15]

A strong and motivated health workforce is the foundation for success in achieving the health goals of countries and of the broader international community. Without this, priority disease control and other health initiatives cannot succeed. All countries, rich and poor, must confront problems such as chronic shortages, imbalances in available skills and widespread inequities. Some of these problems require urgent intervention now; others may take longer to implement.

Our responses must be commensurate with these challenges. Business as usual is not an option. Bold actions are now an imperative. In sections 1–4 of this toolkit, the first four key messages of World Health Day 2006 (see page 7) have each been expanded upon. The three remaining key messages taken together are the fundamental principles upon which action must now be based:

- **Governments must take the lead** in developing and implementing policies and programmes tailored to local realities. Governments, nongovernmental organizations, national and international agencies must play important roles as providers, advocates and watchdogs. Transparency and accountability will be needed in important areas such as professional regulation and ensuring the highest ethical standards.
- **Promote partnership and cooperation at all levels** without cooperation, the technical and political dimensions of workforce development will never be properly addressed. Scarce expertise and other resources must be pooled and shared. Alliances of stakeholders within countries backed by global and regional reinforcement, including international professional associations, are the most effective way forward.

Working together, what can we and our partners do to support the mobilization and retention of 100 000 additional trained and equipped front-line health care workers in Africa?

Honourable Aileen Carroll, Minister of International Cooperation, Canada [16]

- **Build trust among all stakeholders** – between governments, employers, health professionals and the communities they serve. Without trust, health systems deteriorate and collapse. The public wants competent, responsive and reliable health workers. Health workers in return will seek respect and remuneration commensurate with their skills and with the contribution they make to the development of society.

Based on these principles, specific targets may be set for the coming decade (Table 3):

- Every country, poor or rich, should have a strategic national workforce plan – several countries in the next year and all countries within five years.

Table 3. Ten-year action plan for strengthening the health workforce

	2006	2010	2015
	Immediate	**Mid-point**	**Decade**
Country leadership	• Strategies and plans for countries available • Investment in education increased • Best practices in management shared	• Implementation and evaluation of plans on-steam • Workforce capacity improved in numbers and types • Country knowledge base expanded	• New cycle of planning and implementation started • Improved health outcomes • National capacity strengthened
Global solidarity	• High political priority among global stakeholders stimulated • Harmonized donor practices • Shared best practices	• High polical priority enhanced • Increased/sustained resource flows/ managed migration • Global knowledge base expanded	• High political priority sustained • Country support sustained • Powerful knowledge base in use

Source: *The world health report 2006 – Working together for health. Geneva*, World Health Organization, 2006 (in press).

- Investments in preparing the workforce through strengthening education and training should be dramatically increased.
- Local and national innovations should be scaled-up through the systematic extension and application of workforce strategies, including better management of knowledge.

What individuals and organizations can do

Each of the priority areas for action described in this toolkit provides potential "entry points" for a very broad range of individuals and their organizations. These include national and international agencies, academia, journalists and other media representatives, nongovernmental organizations, professional associations and trade unions. Examples of the specific activities now required within each of the priority areas of this toolkit include:

- **Advocating for the right to health** – to provide momentum for change and for increased accountability and transparency in health decision-making;
- **Raising awareness** – of the scope of the health worker crisis and possible solutions;
- **Policy advocacy** – for example, in relation to the training, supporting and retaining of health workers;
- **Research and intelligence gathering** – for example, to better understand current health worker numbers and their distribution, and to inform effective interventions;
- **Network building** – to engage different sectors and agencies in planning and implementing policies; and
- **Action monitoring** – to encourage interventions and measure their impact.

[15] Working together to tackle the crisis in human resources for health. Statement at the high level forum on the health MDGs, Paris, 14–15 November 2005.

[16] Canadian International Development Agency. Canada invests $12 million for health in Africa. News release, 7 November 2005.

Getting the World Health Day 2006 messages out

What kind of information do you need to gather and how should you use it?

Here are some suggestions of ways to present the World Health Day 2006 messages:

- Highlight the situation regarding health workers in your region or country.
- Emphasize the local, national or regional situation regarding health workers.
- Publicize and promote the good work done by you or your organization to improve the situation.
- Indicate the gaps (areas that are still not covered or the problems that remain) and what more can be done to raise awareness and stimulate action.
- Highlight health worker success stories.

Packaging the message

Once you are armed with information and supporting research on a particular message, you will need to transform your material into something to which everyone can relate. Sound bites (short, catchy statements) are the best method. Remember that your treatment of the message needs to be oriented to the target audience.

Creating events

Parades, competitions, street events, or quizzes with a health worker theme all create media attention and get the messages out to large numbers of people in an interesting, entertaining and stimulating way. Such events are a good means of reaching an audience which might not be attracted by more traditional events, e.g. seminars or meetings.

You might consider involving celebrities as spokespersons. Remember that it takes time and preparation to get celebrities involved.

- Choose individuals who are well known and respected within the country or community, and who can attract positive attention to World Health Day 2006.
- Invite personalities in music, film, sports or politics.
- Find out if a well-known person lives in or is from your area – such a person may be more likely to give “local support” to your event.
- Celebrities will often be unaware of the importance and impact of the context of World Health Day 2006 messages. So make sure they are briefed in advance. Specify clearly to their agent or manager, or to them, how you want them to contribute and the message you hope to put across. In creating an event, especially if a celebrity is involved, you will have created an opportunity for a news item. If your event is reported by the media, you will reach a much wider audience.

The media are potentially the most effective tools for communicating a message. But to work with the media you must understand how the media work. Timing is everything, and again sound bites are best. News reporters find information that is new, surprising, compelling or has impact on the public, most newsworthy. Make sure that the story:

- will interest the intended audience; for example, find a personal story and link it to a news event – this is much more interesting than isolated statistics;
- only includes facts and figures that are absolutely accurate – make sure that every name, date and piece of information has been double-checked with a reliable source.

Organizing a news conference

Perhaps the single most effective means of getting media coverage for your World Health Day 2006 event is to hold a news conference. The following checklist will help you to organize a successful news conference:

- invitation list – printed press, radio, television and others;
- time and date: check any possible conflicts with competing events;
- media advisory;
- photo opportunity;
- call back to invited press members to confirm their attendance;
- media kit – include speeches, main announcement release, biographies, background, fact sheet, photographs and so on;
- anticipate possible questions from the media and prepare answers;
- focus all presentations and answers on a small number of key messages;
- on-site arrangements – room rental, name signs on podium for speakers, audiovisual equipment, and so on; and
- refreshments (snacks and drinks) if desired.

Do not neglect national or international news agencies. In addition to newspapers and magazines, you should contact the national news agency, also known as a wire service. If the news agency puts out a dispatch on health workers for World Health Day 2006, the story will go out to every newspaper, magazine, radio station and television network in your country. If you contact the international news agencies or media in addition to your national media outlets, you will have potentially worldwide coverage.

Important international media
Associated Press (AP)
Reuters
Agence France-Presse (AFP)
International Herald Tribune
Le Monde
El Pais
The Economist
Financial Times (FT)
Cable News Network (CNN)
BBC

Annex 1.

What can WHO provide to organizers of World Health Day 2006 events?

Campaign logo and slogan

The regional World Health Day logo can be downloaded from the World Health Day 2006 web site - www.emro.who.int/whd2006 - and can also be obtained from the World Health Day 2006 Coordinator at the WHO Regional Office for the Eastern Mediterranean. The slogan for World Health Day 2006 is *Working together for health*. We encourage you to make use of both the logo and slogan when preparing your materials and events

Organizers are reminded that both the design and slogan are WHO copyright property and should be used together solely to identify events and materials relating to World Health Day 2006. The design may not be reproduced for the purpose of self-promotion or to obtain any commercial or personal financial gain, nor may it be used in any manner that implies WHO endorsement of the activities or products of a commercial enterprise.

Materials

The WHO World Health Day 2006 package of materials includes this advocacy and media toolkit, a poster and stickers with the World Health Day design and slogan. Additional items are currently being considered for inclusion in the package, which is expected to be available from March 2006.

WORKING TOGETHER for Health

WORLD HEALTH DAY 2006

العمل معاً من أجل الصحة

يوم الصحة العالمي 2006

Web site

The event web sites at WHO headquarters – www.who.int/world-health-day/2006 – and the Regional Office for the Eastern Mediterranean – www.emro.who.int/whd2006 – will be regularly updated up to and beyond 7 April 2006. The sites contain information and materials relating to World Health Day 2006 as well as electronic versions of printed materials such as this toolkit. In the lead up to World Health Day 2006, WHO is following the experiences of six teams of health workers in different countries. The resulting photo feature (entitled Heroes for Health) can be viewed on the headquarters web site. The web site will also feature various country events being organized by partners around the world in celebration of World Health Day 2006. If your organization wishes to share information about planned events, please complete the relevant form provided in the folder to request a listing on the World Health Day 2006 web site. Kindly note that WHO reserves the right to decide whether or not to list organizations on its web site.

Evaluation of World Health Day 2006

To assist us in our efforts to document and assess the many activities that will occur as part of the celebrations for World Health Day 2006, a form has been developed to allow feedback on activities hosted for World Health Day 2006. You can complete this form online at www.who.int/world-health-day/2006.

WORLD HEALTH DAY 2006

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

www.emro.who.int/whd2006