



An advocacy toolkit

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Printed in Belgium by Edition & Imprimerie, Brussels.

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Preface

World Health Day is the annual flagship event of the World Health Organization. Since 1950, it has been held each year on 07 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.

World Health Day 2006 – A message from the Director-General

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.

LEE Jong-wook
Director-General
World Health Organization

Introduction and key messages

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.

FIGURE 1: HEALTH WORKERS INCREASE THE SURVIVAL OF MOTHERS AND CHILDREN



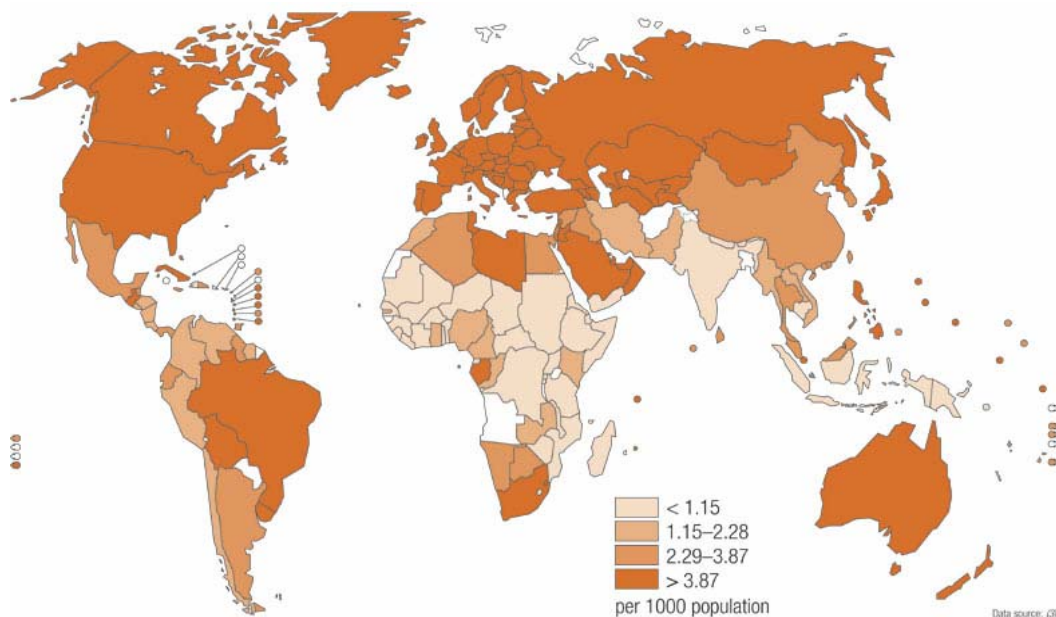
Source: WHO (2006). *The World Health Report 2006 – Working Together for Health*. Geneva, World Health Organization (*in press*)

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.

Health systems around the world are now facing a triple crisis of personnel shortages, low

morale and fading trust. 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 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. Figure 2 shows that the lowest concentration of health workers is in sub-Saharan Africa, where the greatest shortages are also found (FIGURE 2).

FIGURE 2: DISTRIBUTION OF THE GLOBAL HEALTH WORKFORCE



Source: WHO (2006). *The World Health Report 2006 – Working Together for Health*. Geneva, World Health Organization (in press)

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 2006, 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.

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, DR Congo¹

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 skills-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. 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.
- **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, 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.
- **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.

¹ World Health Organization, "Heroes for health", African Regional Office, 2006

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 (**BOX 1**), as well as the changing nature of labour markets and the new skills mixes required (**BOX 2**). In all these areas, rational and innovative new approaches will be needed. 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;
- diversifying the roles of health workers; and
- creating new health worker categories, along with new education programmes.

BOX 1: 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.

BOX 2: BUILDING AN APPROPRIATE SKILL-MIX IN HEALTH PROVIDERS IN SAMOA

Samoa is an independent island nation in the South Pacific comprising a land area of 1800 square kilometres with a population of over 180 000. In Samoan society, the level of women's participation in the paid labour force is relatively high, and their access to education and achievement in the formal educational system is virtually equal to men. Strong democratic traditions and social systems based on village communities and extended family ties and churches greatly influence public opinion and policy-making.

The government, community leaders, health leaders and other stakeholders have long recognized a persistent shortage of doctors in rural areas, where much of the population lives. As a result, nurses and other front-line primary health care workers were often providing care

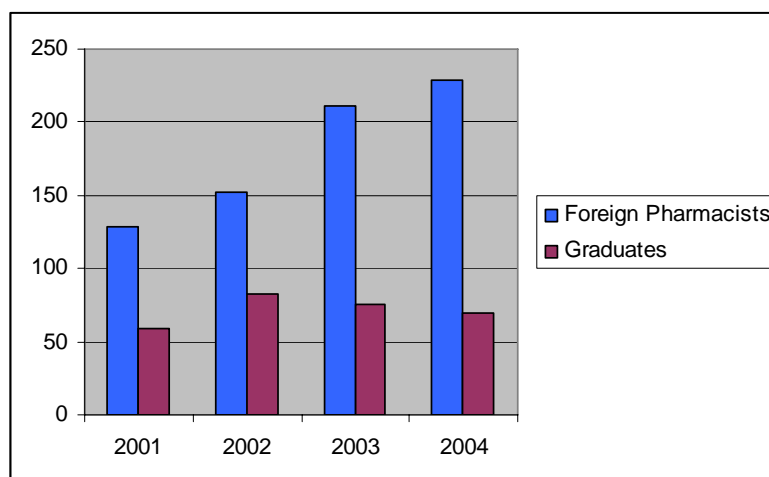
beyond the scope of their training. Traditional chiefs (*matai*) and community leaders strongly voiced the need for trained nursing personnel in villages.

In 1987, the Ministry of Health officially endorsed strategies to upgrade the skills-mix of selected senior nurses. With the support of consulting physicians located in central hospitals, nurses could now provide the full range of curative and preventive health services in communities. In 1990, a five-year nursing strategic plan was developed. This was based on a primary health care model and included key activities to develop and sustain appropriate nursing and midwifery skills to meet the projected health needs.

The overall goal of the nursing strategic plan was the provision of high quality health services to rural areas in a cost-effective manner. The approach is now considered to be an effective and efficient way to deliver health services to vulnerable and under-served rural groups.

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 3**) was tackled by the opening of a new pharmacy school.

FIGURE 3: PHARMACISTS ENTERING THE WORKFORCE PER YEAR IN IRELAND



Source: International Pharmaceutical Federation (FIP) (2005). *Global Pharmacy Workforce and Migration Study* www.fip.org/hr

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 (**BOX 3**), new training approaches and supervisory techniques, and the use of modern information technologies.

BOX 3: COMMUNITY HEALTH WORKERS IN THE ISLAMIC REPUBLIC OF IRAN

The selection and training of community health workers (*Behvarz*) in the Islamic Republic of Iran started in the early 1970s. Initially these were pilot projects designed to introduce new frontline health workers. Literate young people with intermediate qualifications were selected and introduced by their communities to be trained by the district health authorities for two years, and stationed in the “health houses” established in their own villages. Each worker was to be responsible for the provision of primary health care services to a defined population of around 1500 people.

In the mid-1980s, the district primary health care network was successfully expanded throughout the country with *Behvarzes* acting as first-line contacts between the community and the health system. Today more than 25 000 *Behvarzes* provide the bulk of primary health care services in rural areas all over the country.

By delegating tasks to community workers within a comprehensive and well-managed health care system, the Iranian solution has produced impressive results. Programme evaluation has clearly demonstrated the effectiveness of the initiative in reducing mortality and morbidity, improving health care indicators in rural areas, and improving overall health coverage.

2. Supporting and protecting the health worker community

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

Fijian doctor¹

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 4**). 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. In the worst cases, political instability and conflict have further damaged an already insufficient health infrastructure and have seriously overburdened health workers.

BOX 4: 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 US\$ 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).

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.

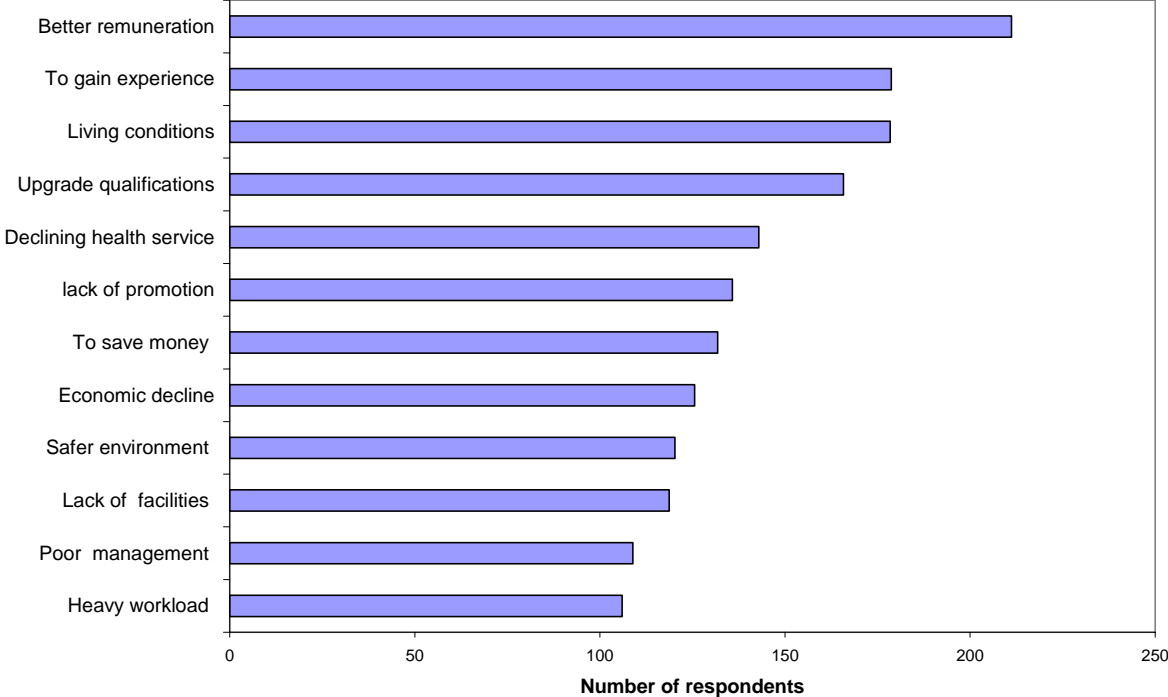
Primary health care nurse, South Africa²

¹ 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. World Health Organization. Western Pacific Region. Manila, The Philippines, 2004

² Joint Learning Initiative (2004). *Human resources for health: overcoming the crisis*. Cambridge, Massachusetts, USA.

Poor management is now leading to unprecedented levels of frustration among health workers. These workers are now leaving their jobs to either change careers or to emigrate. (FIGURE 4).

FIGURE 4. SELECTED REASONS FOR MIGRATION IN FOUR SUB-SAHARAN AFRICAN COUNTRIES (CAMEROON, SOUTH-AFRICA, UGANDA AND ZIMBABWE)



Source: Awases M, Nyoni J, Gbary A and Chatora R.(2004) *Migration of health professionals in six countries: a synthesis report*. World Health Organization, WHO Regional Office for Africa, Division of Health Systems and Services Development, Geneva, Switzerland.

What can countries do to support and protect health workers?

Supporting and protecting health workers requires competitive salaries and other benefits (**BOX 5**), good working conditions (including flexible working hours) and a workplace safe from the risks of infection, injury and violence.

BOX 5: THE ZAMBIAN HEALTH WORKER RETENTION SCHEME¹

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 3000 USD subsidy;
- A monthly hardship allowance depending upon the remoteness of the district (250-300 USD 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 (7500-9500 USD);
- End-of-contract incentive (2000-2600 USD);
- 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.

¹Dr. Simon Miti, MoH, Zambia Presentation to the Consultation on human resources for health, Oslo, February 2005.

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 6**).

BOX 6: PROVIDING CARE FOR HEALTH WORKERS¹

The Ministry of Health in Uganda has been distributing free antiretroviral (ARV) 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 ARVs 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 ARVs, 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%.

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 7**).

BOX 7: SUPPLEMENTARY PAY AND ALLOWANCES VALUED BY HEALTH WORKERS²

- 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).

¹ 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/>)

² WHO (2006) - World health report 2006 - Working together for health (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 Africa¹

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

A Ghanaian doctor¹

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 Tanzania². 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.

¹ Ijumba P (2002). "Voices" of primary health care facility workers. In: Ijumba P, ed. *South African health review*. Durban, Health Systems Trust:181–200.

² McKinsey et al. (2004). *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.

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 life-long 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. 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.

But it is not just the formal workforce that can be better managed for improved performance. For example, in 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. Promoting cooperation between professional and informal health workers can also yield surprising and often inspiring results thanks to the trust enjoyed by the latter within their own communities (**BOX 8**).

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 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.

BOX 8: INNOVATING FOR GREATER IMPACT

- **Delivering health¹** – 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 success²** – 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 hope³** – 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.

¹ Bhattacharyya K et al. (2001). *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.

² Kluger J (2005). Vitamin Sherpa: Ram Shrestha. *Time*, 31 October 2005

(<http://www.time.com/time/magazine/printout/0,8816,1124312,00.html> accessed 5 December 2005).

³ WHO (2004). *Scaling up HIV/AIDS care: service delivery and human resources perspectives*. Geneva, World Health Organization.

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, Zimbabwe¹

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 and regions with the highest relative need (**TABLE 1**).

TABLE 1: IMBALANCES IN HEALTH²

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

The global shortage of health workers is currently estimated at 4.25 million. The WHO *World Health Report 2006*² 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 6**). 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 workers 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.

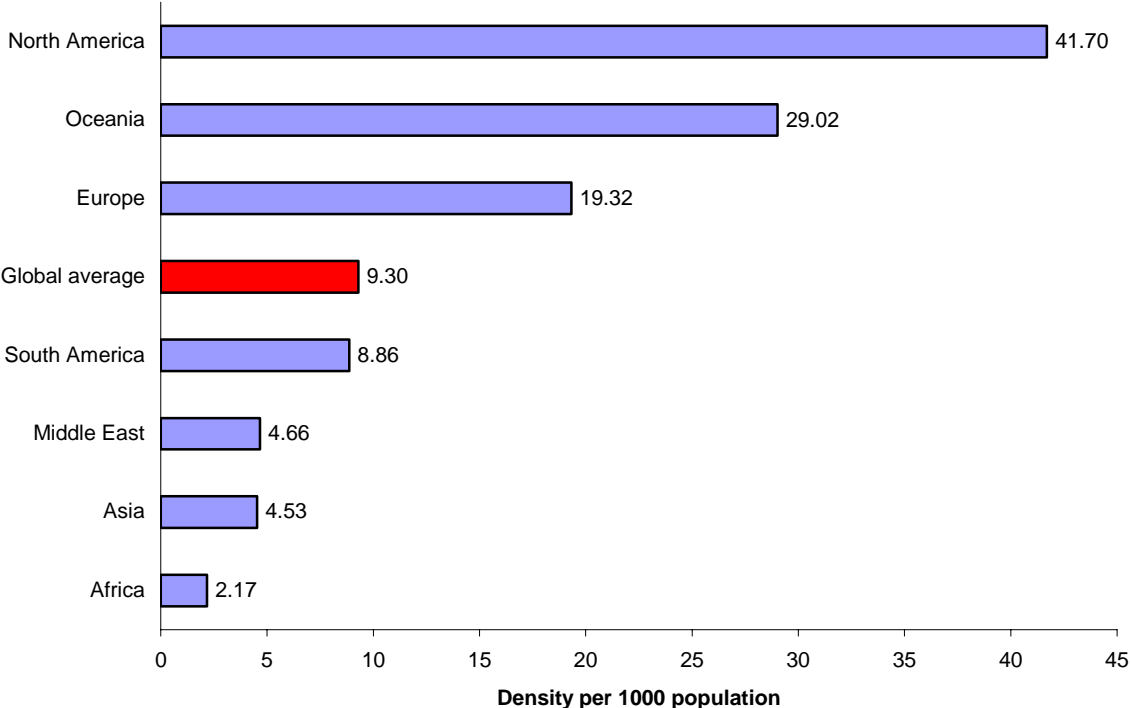
Demographic trends are also making health imbalances and inequities worse. As the populations of the developed world and its health workforce get older, ever more people are needed to provide care. This “pulls” health workers from developing countries. At the same time, as working conditions in developing 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 OECD countries, while for every 100 nurses and midwives working

¹ 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.

² WHO (2006). *The World Health Report 2006 – Working Together for Health*. Geneva, World Health Organization.

in Africa, there are about 4 working in these OECD countries¹. Driven by these “pull-and-push” forces, migration brings mixed consequences – positive for some but detrimental to health for many.

FIGURE 6: INEQUITIES IN THE DISTRIBUTION OF HEALTH WORKERS WORLDWIDE



Source: WHO (2006) World health report 2006 - Working together for health (in press)

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.

¹ WHO (2006) World health report 2006 - Working together for health (in press)

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 (**BOX 9**).

BOX 9: ADDRESSING THE HUMAN RESOURCES FOR HEALTH CRISIS - THE EMERGENCY PROGRAMME OF MALAWI¹

Recent policy reports and donor-funded research attributed the public health system crisis in Malawi to the near collapse of its human resources capacity. To address this, an Emergency Human Resources Programme has been put in place that includes:

- improving incentives for recruitment and retention of Malawian staff through salary increases;
- external stopgap recruitment of physicians and nurse-educators; and
- a significant expansion of domestic training capacity.

A 52% gross salary top-up is being awarded to 5400 doctors, nurses and other key staff. The total programme, costing an estimated US\$ 278 million, is supported by the United Kingdom's Department for International Development, along with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Government of Malawi and other donors.

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.

¹ Palmer, D. Human resources for health case study: Malawi's emergency human resources programme. DFID-Malawi, December 2004.

- **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 Organization¹

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, NGOs, 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 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, Canada²

- **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.

¹ Statement at the High level forum on the health MDGs (2005). *Working together to tackle the crisis in human resources for health*. Paris, 14–15 November 2005.

² Canadian International Development Agency. News release, November 7, 2005. Canada invests \$12 million for health in Africa

We have a difficult job to do and shouldn't have to worry about what to eat tomorrow. It impedes our professionalism.

Oxana Zavtoni, National Midwives' Association, Moldova¹

Based on these principles, specific targets may be set for the coming decade (**TABLE 2**)

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

TABLE 2: TEN-YEAR ACTION PLAN FOR STRENGTHENING THE HEALTH WORKFORCE

	2006	2010	2015
	Immediate	Mid-point	Decade
Country leadership	<ul style="list-style-type: none"> ▪Strategies and plans for countries available ▪Investment in education increased ▪Best-practices in management shared 	<ul style="list-style-type: none"> ▪Implementation and evaluation of plans on-stream ▪Workforce capacity improved in numbers and types ▪Country knowledge base expanded 	<ul style="list-style-type: none"> ▪New cycle of planning and implementation started ▪Improved health outcomes ▪National capacity strengthened
Global solidarity	<ul style="list-style-type: none"> ▪High political priority among global stakeholders stimulated ▪Harmonized donor practices ▪Shared best practices 	<ul style="list-style-type: none"> ▪High political priority enhanced ▪Increased/sustained resource flows/ managed migration ▪Global knowledge base expanded 	<ul style="list-style-type: none"> ▪High political priority sustained ▪Country support sustained ▪Powerful knowledge base in use

Source: World health report 2006 - Working together for health

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, NGOs, 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;

¹ World Health Organization, Making Pregnancy Safer, European Regional Office, Copenhagen, 2005

- **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.

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

Campaign logo and slogan

The World Health Day logo and slogan can be downloaded from the World Health Day 2006 web site – www.who.int/world-health-day/2006 – and can also be obtained from the World Health Day 2006 Coordinator at WHO headquarters (see **Annex C**). 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 in print from February 2006. A form for ordering the World Health Day 2006 package has been provided in **Annex B** of this toolkit and may be used to obtain the relevant materials from WHO regional offices – for these and other contact details, please refer to **Annex C**.

Web site

The event web site – www.who.int/world-health-day/2006 – will be regularly updated up to and beyond 07 April 2006. The site contains 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 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 **Annex B** 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 provided in **Annex B** to allow feedback on activities hosted for World Health Day 2006. We ask you to kindly complete this form and to send it back to us via your regional office or directly. Alternatively, you can complete this form online at www.who.int/world-health-day/2006. All feedback received will be consolidated in a compendium of events planned for World Health Day 2006, which will be accessible on the event web site.

Annex B: Key sources for preparing World Health Day 2006 materials and activities

Key documents on the health workforce

Dreesch N et al. (2005). An approach to estimating human resource requirements to achieve the Millennium Development Goals. *Health Policy Planning*, 20(5):267–276.

High level forum on the health MDGs (2005). *Working together to tackle the crisis in human resources for health*. Paris, 14–15 November 2005 (<http://www.hlfhealthmdgs.org/Documents/CrisisHRforHealth.pdf> accessed 12 December 2005).

Joint Learning Initiative (2004). *Human resources for health: overcoming the crisis*. Cambridge, Massachusetts, USA.

Travis P et al. (2004). Overcoming health-systems constraints to achieve the Millennium Development Goals. *Lancet*, 364:900–906.

WHO (2004). *World report on knowledge for better health: strengthening health systems*. Geneva, World Health Organization.

WHO (2005). *Health and the Millennium Development Goals*. Geneva, World Health Organization.

Key documents on health workforce categories

ILO (1990). *International Standard Classification of Occupations: ISCO-88*. Geneva, International Labour Office. (www.ilo.org/public/english/bureau/stat/class/isco.htm accessed 10 November 2005).

International Standard Industrial Classification of all Economic Activities, ST/ESA/STAT/SER.M/4/Rev.3.1, E.03.XVII.4. Section: N – Health and social work, Division: 85 – Health and social work, Group: 851 – Human health activities.

UN Statistics Division (1989). *International Standard Industrial Classification of All Economic Activities, Third Revision: ISIC Rev.3*. New York, United Nations Statistics Division.

UNESCO (1997). *International Standard Classification of Education: ISCED 1997*. Paris: United Nations Educational, Scientific and Cultural Organization.

Useful web sites

World Health Day 2006: www.who.int/world-health-day/2006

WHO headquarters: www.who.int

Department of Human Resources for Health: www.who.int/hrh

WHO regional offices

African Region: www.afro.who.int

Region of the Americas: www.paho.org

South-East Asia Region: www.who.sea.org

European Region: www.who.dk

Eastern Mediterranean Region: www.emro.who.int

Western Pacific Region: www.wpro.who.int

Form to order additional World Health Day 2006 packages

Please send the following additional World Health Day 2006 materials

Indicate the required quantity:

____ Complete package

____ Toolkit only

____ Posters only

____ Stickers only

in Arabic Chinese English French Russian Spanish

For the following purpose (please indicate how the package will be used):

To:

Organization name:

Contact name: _____

Address: _____

Telephone: _____ Fax: _____

E-mail address: _____

Description of the organization:

Delivery is by surface mail. Please allow 6–8 weeks for delivery.

Submit this form to the WHO regional office in your area.

Do not fill in below – for internal use only

Date rcvd	Approval 1	Approval 2	Date sent to distribution	For use by distribution

Form to request a listing on the World Health Day 2006 web site

Please list our event organized for World Health Day 2006 on the WHO web site:

Organization name: _____

Title of event: _____

Location: _____ Date of event: _____

Web site link for further details of the event: _____

The following information will not be printed on the web site but may be needed to determine whether or not the event is in compliance with WHO policy. In case of any doubt, the event will not be mentioned on the WHO web site.

Name of person in charge: _____ Telephone: _____

Fax: _____

E-mail: _____

Description of event:

Please list our organization on the WHO web site as a source of information on:

WHO may choose to list organizations and establish a link entirely at its own discretion. Should there be any doubt as to the legitimacy or reliability of the organization or site, it will not be included.

Name of organization: _____

Name of President/Chairperson/CEO: _____

Address of organization: _____

Telephone: _____ Fax: _____

Web site (URL) _____

Description of the organization:

Contact person: _____ Phone number: _____

E-mail address: _____

Do not fill in below – for internal use only

Date rcvd	Approval	Action taken by	Date

Form to provide feedback on activities hosted for World Health Day 2006

Please complete this form to report to WHO on the outcome of activities planned for World Health Day 2006

Organization name: _____

Contact name: _____

Address: _____

Town _____ Postal code _____ Country _____

Telephone: _____ Fax: _____

E-mail address: _____ Web site: _____

Short description of the event: *Please include the subject addressed, type of activity, specific audience for which it was organized, and the attendance rate.*

The activity received the following press coverage in our area:

You may attach press clippings for our reference.

This activity/event led to the following concrete actions in our community/region:

We plan a follow-up activity: No Yes

If yes, please describe the type of activity and expected outcome.

Submit this form to: **Coordinator**
World Health Day 2006
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Fax: +41 22 791 47 47
E-mail: whd2006@who.int

Annex C: WHO contact information

National and local organizations should contact the relevant WHO country office using the information provided at www.who.int/country/en. In countries where WHO is not present, groups should contact the relevant WHO regional office from the following list.

WHO Regional Office for Africa

Ms Magda Awases, Regional Adviser, Human Resources for National Health Systems Development (HRD), Division of Health Systems and Services Development; WHO Regional Office for Africa; B.P. 6; Brazzaville, Republic of Congo

Telephone: +47 241 39273
Fax: +47 241 39511
E-mail: awasesm@afro.who.int

WHO Regional Office for the Americas

Dr Charles Godue, Coordinator, Human Resources Development Program, WHO Regional Office for the Americas; 525, 23rd Street N.W., Washington, D.C. 20037, USA

Telephone: +1 202 974 3000
Fax: +1 202 974 3612
E-mail: goduecha@paho.org

WHO Regional Office for the Eastern Mediterranean

Dr Ghanim Alsheikh, RA/HRD, WHO Eastern Mediterranean Regional Office; WHO Post Office, Abdul Razzak Al Sanhoury Street, Nasr City, Cairo 11371, Egypt

Telephone: +20 2 670 2535
Fax: +20 2 670 2492 or 670 2494
E-mail: alsheikhg@emro.who.int

WHO headquarters

Xu Baert, World Health Day 2006 Coordinator, World Health Organization, Avenue Appia 20, CH-1211 Geneva 27, Switzerland

Telephone: +41 22 791 34 36
Fax: +41 22 791 47 47
E-mail: baertx@who.int

WHO Regional Office for Europe

Dr Galina Perfilieva, Regional Adviser, Health Sector Human Resources; Division of Country Support; WHO Regional Office for Europe; 8, Scherfigsvej; DK-2100 Copenhagen, Denmark

Telephone: +45 39 17 15 44
Fax: +45 39 17 1899
E-mail: GPE@euro.who.int

WHO Regional Office for South-East Asia

Dr P.T. Jayawickramarajah, Coordinator, SHS, WHO Regional Office for South-East Asia; World Health House; Indraprastha Estate; Mahatma Gandhi Road; New Delhi 110002, India

Telephone: +91 11 337 0804 or 337 9351
Fax: + 91 11 337 0197
E-mail: jayawickramarajahp@whosea.org

WHO Regional Office for the Western Pacific

Dr Ezekiel Nukuro, Regional Adviser for Human Resources, WHO Regional Office for the Western Pacific; PO Box 2932 (United Nations Avenue), 1099 Manila, Philippines

Telephone: +63 2 528 8001
Fax: +63 2 521 1036
E-mail: nukuroe@wpro.who.int