WHO CENTRE FOR HEALTH DEVELOPMEN

ANNUAL REPORT 2003

WHO KOBE CENTRE

WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTÉ

WHO CENTRE FOR HEALTH DEVELOPMENT
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ANNUAL REPORT OF THE DIRECTOR

2003

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The Director of the WHO Centre for Health Development has the honour to present a report on the Centre's activities during 2003.

INTRODUCTION

How often is it said that the provision of equitable health and welfare services for populations is a dominant concern of most countries today and, despite many efforts and attempts at reform, how often do the results remain disappointing. Governments have an obligation to provide health and welfare services to their entire population. People have the right to be informed of how they can build up their health reservoir and contribute to collective development. Sound evidence and strong leadership is required – among decision-makers, researchers, health professionals, and the people in communities. Contrary to common thinking that there are answers to many health problems but funds may be limited to implement, WKC's work with its global partnership networks points to areas where it is as much a matter of principle as it is of rules and regulations that need to be thrashed out. This takes time, and requires all stakeholders to be on board.

Developing adequate health and welfare systems that will serve all segments of society cost-effectively is deterred often because the systems operate as two distinct entities through two different ministries, despite the fact that they are both offering services to improve the quality of life of the same population groups. To address some of the fundamental issues holding back the development of health and welfare systems that befit the 21st century and support people to be more self-reliant in health, WKC's activities are based on the following.

WKC's philosophy and mission

- The philosophy of the WHO Kobe Centre is based upon the concept of leadership and a spirit of partnership for global health development.
- WKC's mission is that of international and interdisciplinary investigations of issues relating to global health and welfare systems development. WKC seeks to improve the health of individuals and society, worldwide, by bringing together the best knowledge and experience available.

PRIORITY PROGRAMMES

The major research programme areas are:

- Cities and Health, because of rapid global urbanization;
- Ageing and Health, because of the global ageing phenomenon and where Traditional Medicine is also addressed;
- Health and Welfare Systems Development, the unifying theme of all WKC activities, and where there is a special component on Women and Health.

CITIES AND HEALTH

Since the WKC's Cities and Health Programme (CHP) was launched in 1999 there has been a marked shift among WKC partner cities in the approaches taken to deal with the health and welfare problems resulting from the pressure of rapid urbanization. With WKC partner cities in different parts of the world it is also anticipated that the valuable experiences gained in recent years will serve as practical examples to other cities. Health status is influenced by a considerable number of factors originating in sectors other than health, such as education, environment, housing, employment, agriculture, industry, public works, transport and communication facilities generally. Therefore, in order to work out appropriate solutions to these multisectoral problems, CHP fosters multidisciplinary and intersectoral evidence-based approaches to improve the overall health status of people.

Building on to the solid foundation prepared between 1999 and 2002, in 2003 CHP organized and implemented activities to address the following five thematic components:

1. Partner city research plans: to strengthen communication among stakeholders in partner cities and to support needs-sensitive, evidence-based and outcome-oriented health and welfare policy, strategy and systems development;
2. WKC city partnerships: top-level city leadership involvement and empowerment;
3. City Health Information Package (CHIP): timely dissemination of validated, updated and user-friendly web-based data and information to partner cities globally;
4. WKC international forums: generation of opportunities for information sharing and transfer of technology through partner city networking; and
5. WKC Japanese city networking: support to Japanese cities and institutions in addressing priority health, welfare and quality of life issues, primarily through a policy, strategy and systems development approach.

1. Partner city research plans to strengthen communication among city stakeholders and to support needs-sensitive, evidence-based and outcome-oriented health and welfare policy, strategy and systems development

A major input has been made to support partner cities in conducting appropriate research to generate evidence-based solutions to improve health and welfare policies, strategies and systems. Being aware of the fact that, due to the gap of communication that is generally known to exist between decision-makers and research workers, decision-makers may not be well informed of the relevant research information, and researchers may not be aware of the information requirements of policy-makers. The WKC acted as a mediator to bring the two key stakeholders together through a strategic partnership model for cooperation, known as the WKC triangular partnership model. This model has been tested by the city of Mississauga, Province of Ontario, Canada, and has proven effective. Hence, the model is also named as 'Mississauga Model'. Another partner city – Bangkok, Thailand – has also confirmed that this is a useful model to address health and welfare issues in a scientific manner.

Currently other research activities are in progress in the partner cities of Dunedin (New Zealand) and Sao Paulo (Brazil). The city of Dunedin commenced a research project in collaboration with the University of Otago on environmental health (water, solid waste, housing and health), and health and welfare systems (alcohol-related harm, youth mental wellness, and inter-agency collaboration). Similarly, the municipality of Sao Paulo is undertaking a research project with the University of Sao Paulo on: drinking water quality, impact of housing on health, teenage health and mental wellness, and alcohol and drug-related harm. Research reports from both of these cities will be submitted to CHP in 2004. Colombo city (Sri Lanka) has proposed to conduct research on health and social development in low-income settlements in collaboration with University of Colombo. In addition, the cities of Hanoi (Viet Nam),

Marikina and Cebu (Philippines) are in the process of preparing research proposals in the appropriate format and WKC contractual agreements for the research finalized.

2. WKC City partnerships: top-level city leadership involvement and empowerment

One major and innovative area of remarkable achievement has been the networking among WKC partner cities. Presently 43 cities around the globe are partners in this WKC network. Being conscious of the fact that strong and enlightened leadership in cities can make a big difference in the health and welfare of citizens, WKC has systematically promoted strong alliances with partner cities, especially at the top city leadership level. In 2003, two major cities in the United Kingdom – London and Manchester – became part of the WKC global partner city network. A major criterion for such partnerships is recognition of the objectives of CHP and willingness to work along the lines of the Mississauga Model.

3. City Health Information Package (CHIP): timely dissemination of validated, updated and user-friendly web-based data and information to partner cities globally

A prototype of a web-based database – the City Health Information Package (CHIP) – has been developed in collaboration with the University of Otago, New Zealand. CHIP is continually being improved to form a comprehensive web-based database to provide relevant health-related policy and process (technology) information from partner cities around the globe in various forms: e.g. Indicator Database that contains a number of variables to assess the health status of a given city in comparison to other cities. These cover a broad range such as population, mortality, local government income, solid waste collection, electrical connections, and women-headed households. The database will be used by policy-makers, research workers, communities, the private

sector, and other stakeholders in partner cities. Such comprehensive information is expected to lead to appropriate health policies and systems that will result in improved health, welfare and quality of life.

The CHIP is being developed further to enable partner cities to log on to CHIP with usernames and passwords. This will enable them to update data from their own city and share data/information with other partner cities.

4. WKC international forums: generation of opportunities for information sharing and transfer of technology through partner city networking

Bringing partner cities together at WKC meetings, symposia, and workshops is a key feature of WKC. These provide a common platform for city policy- and decision-makers, planners and research workers to share information, exchange success and failure experiences and select the best practices available that can be adapted according to individual city conditions and requirements.

Since 1999, CHP has organized the following ten meetings:

- WKC Consultative Meeting on Health Planning and Delivery at City Level (Kobe, Japan) in 2003
- WKC International Symposium: Achievements with WKC Partner Cities (Kobe, Japan) in 2002
- Cities and Health Advisory Task Force Meeting (Shanghai, People's Republic of China) in 2002
- Cities and Health: Summit on TB Control (Osaka, Japan) in 2002
- International Meeting on Cities and Health (Mississauga, Canada) in 2001
- Second Global Meeting on Cities and Health (Awaji Island, Hyogo Prefecture, Japan) in 2001

- Consultative Meeting on Private Sector Involvement (Dunedin, New Zealand) in 2001
- Global Meeting on Cities and Health (Kobe, Japan) in 2000
- Global Symposium on Violence and Health (Kobe, Japan) in 1999
- International Meeting on Cities and Health (Kobe, Japan) in 1999

5. WKC Japanese city networking: support to Japanese cities and institutions to address priority health and welfare issues and systems development

In 2003, the CHP conducted three meetings with representatives of several cities in Japan. The first meeting was held with representatives from Takarazuka City, Itami City, Kawanishi City, and Inagawa Town, all of which are in Hyogo Prefecture. In these meetings two priority areas were highlighted for investigation: reduction of smoking prevalence and diabetes prevention. Investigations are now underway in these cities with the assistance of Kobe University School of Medicine. In May 2003, a meeting was held with Kobe City representatives who identified lifestyle-related diseases as well as declining birth rate as major concerns, and the participants acknowledged the importance of evidence-based and cost-effective approaches for solving these issues. Moreover, in June, the CHP team met with the Osaka City health officials to discuss future collaboration. Osaka representatives recognized the significance, not only of a firm system to facilitate the link between research and policy making, but also of the participation of the community as a whole and the people, individually and collectively.

Disaster Reduction Alliance (DRA)

With the Kobe Disaster Reduction and Human Renovation Institution's initiative and coordination, the Disaster Reduction Alliance (DRA) has been established. WKC, with its mandate for health and welfare systems development, is a partner in this Alliance. The purpose

is to link the relevant institutions and organizations in the Kobe area, Japan, for information dissemination and collaborative activities aimed at reducing the impact of possible future disasters. In 2003, one symposium, some meetings and workshops were coordinated within the Alliance, with more active participation of CHP foreseen in the next biennium, 2004–2005. In particular, CHP, with its emphasis on urban settings, may support some cities in Japan to conduct health impact assessment of possible future disasters, such as earthquakes and typhoons, in order to propose strategies to minimize negative health effects.

AGEING AND HEALTH

During 2003 – the second half of the implementation period of the WKC biennial Work plan 2002–2003, and within the unifying theme of WKC's overall mission to improve global health and welfare systems development, Ageing and Health Programme (AHP) continued its intensive efforts with a special focus on integrated health and social care needs of older people and their families. At the same time, AHP also continued expanding its efforts to explore and bring together the best knowledge available to support WHO's policy directions for healthy and active ageing.

1. Development of community health care for ageing societies

In recent years, the quest for adequate and cost-effective care for the growing number of older persons has received increased attention from national and local governments, international organizations, NGOs, the scientific and service communities and the general public. Major issues concerned are better integrated and more comprehensive approaches to the health and special needs of older persons, their families and communities. This situation involves and requires multisectoral and interdisciplinary cooperation.

There are challenges but also opportunities to respond to global population ageing and changing individual and societal needs, and to promote 'a society for all ages' in the 21st century. One objective among the priority directions of the Madrid International Plan of Action on Ageing 2002, adopted by the Second United Nations World Assembly on Ageing, is to develop a continuum of integrated health and social care to meet the needs of older persons and societies at the community level.

In response to changing needs of the increasing number of older persons and their families, and inspired by progress and development of the primary health care approach (PHC), AHP has been working to address fundamental health and welfare systems and services

development issues. Together with other WHO and UN offices, national governments of Member States, WKC partner cities and institutions, and other concerned parties, WKC has systematically promoted a to-date under utilized potential and scope of care for older persons in ageing societies, namely Community Health Care (CHC) to offer added value, comprehensive and integrated services and an intersectoral approach to the improvement of overall PHC, particularly for older persons and their families at community level.

- **The International Glossary of Terms on Community Health Care for Ageing Societies**

Box 1: The formulation process of the International Glossary of Terms on Community Health Care for Ageing Societies

With respect to and valuing cultural and socio-economic diversities with and across nations, one of the fundamental drawbacks to CHC development and research is the lack of standard terminology and definitions. The result is a lack of a common platform for dialogue among a variety of important stakeholders preventing comprehensive exchange of ideas and the sharing of experiences on practice, research, education orientation, appropriate policy formulation and resource allocation.

AHP therefore initiated a research project to develop an International Glossary of Terms on Community Health Care for Ageing Societies. In collaboration with WKC partner institutions and expert networks, the

project started with a wide search and formulation of a draft based upon existing terms and definitions (Box 1). A global expert consultation via internet-based methodology was then conducted. This was followed by an in-depth review and discussion at an Expert Meeting in Kobe, Japan, November 2003. The Glossary will be finalized according to the comments and suggestions put forward at that time.

Further expected outcomes are the production of a number of glossaries and dictionaries related to Community Health Care for authorities and experts in various constituencies. Though there is, at present, no internationally accepted common set of definitions for many of the terms used to describe health and social care and services, including Primary Health Care and Community Health Care of older persons, the outcome of this research project will be a practical tool to meet an urgent need to correct this deficiency and facilitate international and inter-municipal exchange of information with the optimal aim of influencing and assisting policy formulation for improved holistic services and care of older persons.

- **Technical Report on Development of Community Health Services in Shanghai, People's Republic of China**

The Ageing and Health Programme is supporting case studies of 'good practice models' by identifying, collecting, collating and analyzing information through a case study approach. Three or four case models are being identified among WKC partner cities, and a series of technical reports based upon these experiences is being prepared. AHP is coordinating and providing technical support to the project by assigning international experts to assist in technical report preparation. The information and experiences obtained will offer solid evidence to facilitate a global review and expansion of the Primary Health Care approach with considerably enhanced Community Health Care as an option and adding value for ageing and older populations.

Box 2: Guiding principles for community health care and services in Shanghai;
- **Government's leadership;**
- **Intersectoral cooperation and coordination;**
- **Community involvement and responsibility;**
- **Health sector (community health service centre) implementation; and**
- **Human resource capacity-building a priority.**

The first case study model is in collaboration with officials from Shanghai Municipal Health Bureau and researchers from Fudan University, Shanghai (Box 2). A technical report will be prepared on community health services development to meet health and socio-economic challenges of the fast growing older population in the city. In Shanghai, since 1995, community health services have been provided to the residents in geographically based administrative catchment areas usually ranging from 50 000 to 100 000 residents. The community takes responsibility for helping the people in the community to meet their minimum health care needs. Approximately 95 community health service centres are covering about 8 million urban Shanghai residents who can conveniently receive minimum medical and health care within 15 minutes' walking distance.

Several features of community health services in Shanghai are in line with WKC's initiative to stimulate a community health care framework, through applying community and health resources as well as related technology. The framework considers the health needs from the perspectives of the older persons and their families, women, children, and the disabled, and provides them with efficient, affordable, convenient and comprehensive basic health services on a continuing basis.

2. Improvement of oral/dental health conditions in ageing societies

• Bridging the gap between oral/dental health and general health

Oral health is an important contributing factor for improved general

health and quality of life. Its importance is universal, with the need to take a life-course perspective in ageing societies. Through scientific and technological advancement, both medical and dental sciences have developed adequate practices and services within their discipline. However, despite progress and achievements, it is observed that communication and information sharing between medicine and dentistry for policy, research and practices have become less frequent due to the segmentation of professional areas behind the development of science and the lack of international comparative data. Therefore, it is urgent and necessary to raise awareness of the importance of both fields taking a holistic approach for the betterment of health.

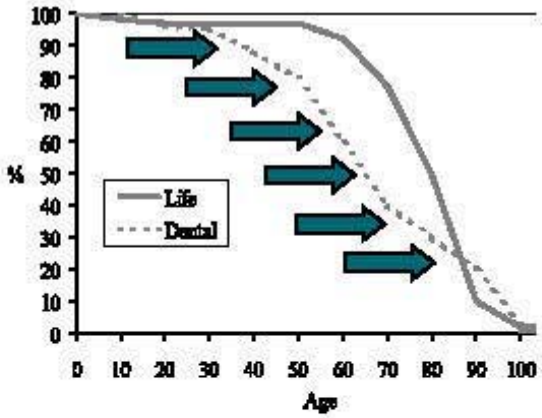
To contribute to health and welfare systems development through evidence-based good practices in oral/dental health and general health, Ageing and Health Programme aims to facilitate and coordinate research activities and collect information on the relationship between oral/dental health and general health conditions at community level. In addition to providing an opportunity for exchange of views and experience sharing between dental and medical professionals, it is also equally important to facilitate opportunities for dialogue between policy-makers and researchers. Basic work has therefore been carried out to prepare a technical report on global review of the relationship between oral/dental health and general health and various other related activities in 2004.

- **Measuring dental health – dental expectancy (DE)**

Extending average life expectancy of teeth is important to match extended average life expectancy and better health and quality of life. However, it is difficult and challenging to lead policy, research and practice in a favourable direction for two major reasons: one is the lack of a standard measurement of dental expectancy, which will have comparable value to the common general health outcome (theoretical model – Figure 1); and the second is the lack of global information on

oral/dental health conditions. The availability of such information would allow those who are interested to develop such a measurement tool and further test its validity and reliability for multinational comparison.

Figure 1: Challenge to fit dental survival to human survival (Theoretical Model)



Ageing and Health Programme, in working with Member States, WKC partner institutions and other WHO offices, attempts to facilitate collaborative efforts to develop a useful dental measurement – dental expectancy (DE) – information collection on dental health conditions, and building an Information Database which ultimately contributes to health and welfare systems development for ageing societies, with special interest in the older and ageing population groups.

3. Dietary practices and healthy longevity in ageing societies

Nutrition and proper dietary practices are important contributing factors for health development from both individual and societal aspects and a life course perspective. Scientific studies showing their contribution to counter health risks, in association with non-communicable diseases and premature mortality, have been well documented. However, their potential as an investment for increasing health capacities from the health development point of view is still given inadequate attention. Under WKC's unifying

theme of health and welfare systems development, AHP is therefore complementing the work of other WHO offices to promote and advocate proper dietary practices for active and healthy ageing and longevity.

- **Global Symposium on Food, Dietary Practices and Health**
  29 November 2003, Kobe, Japan

Over the past decade, rapid changes in dietary practice and lifestyles have been observed in parallel with rapid growth of global industrialization and urbanization. These socioeconomic changes have had a significant impact on nutritional and health status of populations, particularly in developing countries and those countries with transitional economies. Improper nutritional intake and dietary practices are leading risk factors for non-communicable diseases and premature death.

An estimated 16.6 million, or one-third of total annual global deaths, result from various forms of cardiovascular diseases many of which are preventable. These trends can also be observed even in countries like Japan, where it is widely recognized that Japanese people have the longest life expectancy in the world. With the introduction of some alternative dietary practices, traditional Japanese diets are increasingly being neglected in many Japanese households, particularly among the younger generation. With such trends, it is important to share scientific evidence-based information along with examples of models of good practice in order to influence the maintenance of healthy nutrition and proper dietary practices to improve health status in different age groups. WKC therefore organized a Global Symposium at the end of November 2003, with the following purposes:

1. To provide, from a health investment point of view, updated scientific information on nutrition, dietary practices and health for promoting health and prevention of lifestyle-related diseases;
2. To explore and share good practice models for healthy nutrition and proper dietary practices in different age groups.

• **Promotion of fruit and vegetable (F&V) consumption**

In collaboration with WHO headquarters and regional offices, WKC Ageing and Health Programme is designated to take the lead in organizing an International Conference on Fruits and Vegetables for Health, which is planned to be held in Kobe in 2004. This Conference is in preparation for the fruit and vegetable initiative, a global collaborative project and a formally shared responsibility between WHO and other UN agencies.

From the health and welfare systems development point of view, AHP will take the opportunity to expand this F&V initiative into a research theme on proper dietary practices and healthy longevity, taking into consideration cultural and societal values.

It is planned to take a different approach from the traditional one with regard to risk factors and nutritional intake and dietary practices. The proposed research theme on proper dietary practices and healthy longevity will focus on a health investment perspective, and will explore their protective and potential aspects to build up self-reliant health capacities or 'health reservoirs', capable of tackling aspects of risk factors about which, today, there is little or no information.

It is expected that this research area will become another example of WKC's unique role as a global research arm of WHO that adds value and is complementary to the work of other WHO offices, as well as provide evidence and support WHO's global policy framework on active and healthy ageing.

TRADITIONAL MEDICINE

Within the framework of the Ageing and Health Programme, activities of the Traditional Medicine Programme (TRM) are based on the premise that Traditional or Complementary and Alternative Medicine (TRM/CAM) has an important role to play in a number of areas in the 21st century. These include: (1) a more complete and comprehensive health and welfare systems development; (2) promotion of health and protection of life; (3) promoting personal and national self-reliance and minimizing dependence on costly and unaffordable external interventions; (4) caring for people in a holistic manner, particularly with respect to the rapidly increasing group of elderly population; (5) protection of biodiversity and the environment through conservation of medicinal plants; and (6) trade-related aspects of the intellectual property rights (TRIPS).

To support evidence-based Health and Welfare Systems development, the TRM Programme in 2003 has been collaborating with all WHO Offices to initiate activities in response to a need to better understand the current global, regional and national situations on the status of utilization of various therapies and procedures in TRM/CAM. Reliable information about their use is needed to identify areas for operational research and further development of the field, carrying out clinical and scientific investigations on efficacy, safety and quality of these remedies, educating and training health care personnel, and in formulating national legislation and regulation, and contribute significantly to national health policy revision or formulation.

The TRM Programme is responding to the needs of Member States by complementing the work of WHO at the global, regional and country levels. To further collaborate and assist WHO member countries, WHO promulgated the WHO Traditional Medicine Strategy 2002–2005 at the 55th World Health Assembly in May 2002. The areas that have been identified and reaffirmed to be important as global TRM/CAM issues and challenges are: (1) developing and implementing national policies and

programmes; (2) safety, efficacy and quality of traditional remedies; (3) increase in availability and affordability or accessibility to TRM/CAM; and (4) rational use – proper use of TRM/CAM by providers and consumers.

The WKC's contributions are in the global situation analysis of TRM/CAM practices and utilization and in the development of an InfoBase in four areas of cost, namely cost effectiveness, cost benefit, cost comparison, and cost utility in the use of TRM/CAM (see 2 below).

1. Development of the Global Atlas of TRM/CAM

Since its resurgence more than a decade ago, global interest in TRM/CAM continues for several reasons: (1) in recent years, self-empowerment in caring for one's own health has increased; (2) availability and affordability of the traditional remedies especially in remote rural areas have become an important factor since modern health care services are still not available in these areas; (3) possibility of preparing remedies at home by simple traditional methods such as decoction; (4) inherent belief in the traditional remedies because of their long tradition of use; (5) desirability of people to use materials derived from nature; (6) dissatisfaction in some instances with conventional medicines due to untoward experiences with their adverse effects; (7) rapid advances in modern medicine resulting in the use of sophisticated technology and equipment that are costly and out of the reach of those who do not have proper health insurance coverage; and (8) there are those who prefer TRM/CAM therapy to conventional methods of treatment particularly in using some of the herbal remedies, manual therapies and acupuncture.

Commissioned by WKC, the Karolinska Institute of Sweden carried out a comprehensive review of the literature. This lends support to the need for a systematic investigation of the TRM/CAM situation

worldwide in order to have an overview of the present status of practices and utilization in WHO Member States. An overview of the global situation, in the form of an atlas, was therefore considered useful for national policy and decision-making authorities to consider inclusion of effective and useful TRM/CAM practices in the national health care system. Information using twenty-six standardized indicators has been collected and stored in WKC's InfoBase for analysis (Table 1).

• InfoBase on background, structural and process indicators

It was decided at an International Consultative Meeting held in Kobe in September 2001, that collection of information to reveal the global situation on practices and utilization of TRM/CAM would be carried out using the twenty-six indicators. Information collected is entered into an InfoBase developed by WKC Information Technology Group which is updated with additional information received from time to time from countries, regional offices and WHO/HQ.

Table 1: Indicators for Collection of Information on TRM/CAM (WHO Global Atlas on TRM/CAM: Perspectives on Policy and Practice)

Background indicators	
BG 1	Total population
BG 2	Average annual growth of the population
BG 3	Life expectancy
BG 4	GDP per capita
BG 5	Infant mortality rate
BG 6	Maternal mortality rate
BG 7	Top ten causes of morbidity
BG 8	Top ten causes of mortality
BG 9	Total number of prescribers (including prescribing doctors, nurses, etc.)
BG 10	Total number of TRM/CAM providers within and outside the conventional health system
BG 11	Total health expenditure for the conventional health care sector (total, primary, secondary, tertiary)

Structural Indicators	
ST 1	Is there an official national TRM/CAM policy?
ST 2	Is there TRM/CAM legislation?
ST 3	Is there a ministry, institution or national expert committee whose mandate includes TRM/CAM control, education, information and/or research?
ST 4	Is there a national voluntary self-regulatory body for TRM/CAM or Association?
ST 5	Are there any financing systems that contribute to the provision of certain TRM/CAM therapies in the public sector?
ST 6	Is there a TRM/CAM user survey conducted in the country in the past twenty years?
ST 7	Is there a TRM educational school in the formal education system?
ST 8	Survey quality assessment indicator
Process Indicators	
PR 1	Estimated prevalence of national TRM/CAM use.
PR 2	Estimated prevalence of the five most popular individual therapies used.
PR 3	Estimated prevalence of national herbal medicine use.
PR 4	Medical determinants for TRM/CAM use.
PR 5	Patient satisfaction and perceived outcome of TRM/CAM treatment.
PR 6	Sociodemographic characteristics of consumers associated with the use of TRM/CAM.
PR 7	Total out-of-pocket payments and total national expenditure estimates for TRM/CAM utilization.

· Development of website for exchange of information

WKC has undertaken secondary collection of information on utilization of traditional medicine in the six regions of WHO in close collaboration with regional expert groups commissioned by WKC, the respective WHO Regional Offices, the WHO Representative Offices in the countries of the Regions and the national traditional medicine departments and institutions. The site contains the following sections: (1) Homepage; (2) Meeting information for the International Meeting on Global Atlas of TRM, Kobe, 17–19 June 2003; (3) Country and regional data; (4) TRM atlas maps; (5) Process indicators; (6) Data requirements;

and (7) Questions for the participants who were invited to attend the International Meeting. By accessing the website and looking at the maps and datasets relevant to their Regions, participants could collect additional data from their own sources of information for the Global Atlas.

The collected data obtained by using the indicators in information collection from the countries were reviewed at the International Meeting in June 2003. A total of 48 international participants from 33 countries in six Regions of WHO attended the meeting. Additionally, twenty-eight observers from Japan, three international observers, two from Bangladesh and one from Russian Federation also attended.

Participants of the International Meeting on Global Atlas of TRM

The purpose of the meeting was as follows:

1. To review and finalize the contents and format of the draft Global Atlas on Traditional/Complementary and Alternative Medicine;
2. To further collect qualitative and quantitative information to make the draft Global Atlas as complete as possible; and
3. To strengthen the partnership networks of WKC for future collaboration in TRM/CAM.

The meeting reviewed a number of maps covering areas such as

global profiles on TRM/CAM legislation and policy (Figure 2) and status of public financing. Additionally, the following regional maps were also presented:

- Status of TRM/CAM legislation and policy in the WHO regions of Africa (AFR), the Americas (AMR), Eastern Mediterranean (EMR), South-East Asia (SEAR) and Western Pacific (WPR)
- Status of TRM/CAM education and professional regulation in AMR, EMR, SEAR and WPR

Figure 2: Global Profile: Status of TRM/CAM legislation and policy

The general conclusions and recommendations of the meeting fell into the following areas:

- Method of scoring data such as cumulative scoring may be used without distortion or squandering of date;
- Wider use of available databases including those of WHO;
- WHO's technical and financial support for surveys in the countries;
- WHO assistance in the cultivation of traditional medicinal plants; and
- Obtaining information on how TRM/CAM is practiced in reality rather than relying on information from official sources.

2. InfoBase on cost aspects of TRM/CAM

The cost parameters would be important for national authorities in determining the utility of TRM/CAM in national health care services. To be able to provide concrete information for decision-making, on behalf of WKC the Peninsula Medical School of the Universities of Exeter and Plymouth in the United Kingdom has reviewed available information in the electronic databases from their inception up to July 2003. They are: AMED (Allied and Complementary Medicine Database, the Health Care Information Service of the British Library), CINAHL, The Cochrane Library, EMBASE, MEDLINE (via PubMed) and NHS Economic Evaluation Database. The available information should assist decision makers in national health care services regarding the applicability and feasibility of TRM/CAM in their respective countries. Adjustment of cost information would need to be carried out to be relevant to the national situation.

Among the four cost parameters of cost effectiveness, cost benefit, cost comparison and cost utility, cost effectiveness is receiving a great deal of interest from various institutions and organizations.

There is an explicit need to develop an information base on cost information in relation to the use of TRM/CAM. There have been a number of studies undertaken with respect to the four aspects of costs. Such information needs to be collected, evaluated and systematically put in an InfoBase for further sharing among relevant parties.

The initial InfoBase was developed by WKC during the 2002–2003 biennium in collaboration with the Peninsula Medical School, United Kingdom and the University of Tokyo, Japan. This work will be continued in order to render WKC's Cost InfoBase more complete and up-to-date, and increase its utility for all those interested in cost issues pertaining to TRM/CAM.

HEALTH AND WELFARE SYSTEMS DEVELOPMENT

The Health and Welfare Systems Development Programme (HWP) focuses on issues impinging on overall health and welfare systems development (HWSD) globally, the principal and unifying theme of all WKC activities; HWP thus has a unique role to play in this regard.

The challenge to health and welfare systems in the 21st century in all parts of the world is to address the increasing difficulties and obstacles in providing equitable access to health and welfare services. Many countries have instituted health sector reforms to ameliorate the situation, but whilst these may have led to certain improvements, large segments of the population, in both urban and rural areas, persistently lack access to basic health and welfare services. Therefore, the dominant concern for most nations today, both in the developed and developing countries, is to form appropriate strategies for the establishment of sound health and welfare systems that can address the needs of all segments of society. In doing so, special attention must be paid to women and overall gender related issues, the ageing population and marginalized groups.

The issue has become one of the most complex challenges of our time against the backdrop of immense social transformation, such as rapid demographic changes due to the exponential increase in the ageing population and massive migration from the rural to urban areas. Moreover, due to advances in informatics and health technologies, public demand for better access to health and welfare services continues to increase.

To address these issues, WKC, in its commitment to health development on a global scale, embarked on a mission to provide information and directions for development of equitable health and welfare systems and services in countries. As an initial step, WKC promoted an international forum for debate and exchange of views on the issue, by organizing three global symposia on HWSD in the 21st century, in 2000, 2001 and 2002, to sensitize national authorities on the need to

develop integrated health and welfare systems by encouraging integration of health and welfare ministries/divisions at all governmental levels within their respective countries. In 2003, HWP commenced initial activities to take the recommendations from these symposia to the next level, by endorsing operational research on HWSD in order to generate evidence-based information for sound policy and decision-making processes in countries.

HWP is confident that these research activities will lead to re-evaluation of the status quo in the Member States in order to identify shortcomings in the current systems. Additionally, the re-examination of the systems may also contribute towards identifying successful examples of systems or services rendered, which could subsequently be considered for adoption or adaptation in countries requiring substantial changes within their health and welfare systems.

For this purpose, HWP adopted a three pronged approach in 2003, which includes the following: (a) promoting international leadership and global partnerships in HWSD; (b) collection, analysis, sharing and dissemination of information on innovative practices; and (c) operational research in HWSD in selected countries through collaborative partnerships among experts in the field.

1. Promoting international leadership and global partnerships

In the three global symposia organized thus far, policy makers, academics, and public health administrators from different parts of the world have presented their findings on various aspects of HWSD. These symposia proved to be unique forums for sharing experiences, debating policy issues and making important recommendations for the future. Through these forums, it became evident that, in many countries, health and welfare systems operate as two distinct entities through two different government ministries despite the fact that they offer services that affect

the health and quality of life of the same target population. To minimize duplication, inefficiencies and to provide synergy for health and welfare services, each symposium reached a consensus on the following important issues:

The First Global Symposium in November 2000 recommended that health and welfare systems should be integrated in order to increase efficiencies in the provision of services and develop better financing mechanisms to ensure health insurance coverage for the poor and marginalized groups. It also recommended to incorporate and heighten attention to gender perspectives in HWSD.

The Second Symposium in October 2001 further emphasized the need for an integrated approach to health and welfare systems development through changes in perspectives, policy-making, programme development and provision of services. Other recommendations included that HWSD should promote: (a) decentralization of services to transform the systems to become even more responsive to the needs of the society; (b) partnership development; (c) active role of universities in HWSD; and (d) development of mechanisms to direct financial resources to meet health and welfare needs of the poorest quintile of societies.

The focus of the Third Symposium in November 2002 was on the role and impact of the private sector on HWSD. There was general agreement that the private sector has a great potential to contribute significantly towards the overall goals of HWSD, although societies should also be aware that the private sector may cause negative impacts on the services available for the poor and marginalized groups. The participants recommended that in-depth research be promoted on the following key areas: (a) the impact of public-private partnerships (PPP) on HWSD; (b) case studies on country experiences of innovative approaches to HWSD; and (c) integration of health and welfare systems.

Initial steps for the establishment of networks and partnerships for this purpose commenced in 2003 and will continue in 2004–2005.

2. Collection, analyses and dissemination of information

In addition to sharing of information through the Global Symposia, HWP is actively engaged in collection and dissemination of information from countries on innovative experiences. The important publications produced by HWP in this area in 2003 include the following: (a) a technical report entitled, the Solidarity Triangle and Community Health: A Pilot Evaluative Study of Costa Rica's Participatory Development Strategy; (b) the Proceedings of Third Global Symposium on Health and Welfare Systems Development in the 21st Century; and (c) the second HWP country report entitled Country Studies on Health and Welfare Systems: Experiences from Indonesia, Islamic Republic of Iran and Sri Lanka.

All three publications have been widely circulated. The first country report was on the experiences of community participatory development in Costa Rica. The second country report consists of information derived from HWP supported research studies on health and welfare systems in Indonesia, Islamic Republic of Iran and Sri Lanka. In the presentation from Indonesia, the researcher describes the profile, the mechanism and management of integrated health and welfare activities at the village level with active participation of the community. The health system in the Islamic Republic of Iran is documented as a unique case of structural integration between the health care delivery system and medical education where the universities of medical sciences deliver most of the health care. Social security and welfare is provided by the government through different sector ministries and by social service organizations. The report from Sri Lanka provides insight into the evolution of health and welfare, which illustrates policies and programmes from the immediate post-independent period to the present.

It demonstrates how government's policy to provide free education at all levels contributed to better education of women, which in turn led to better health of the children and the family as a whole.

It is anticipated that these publications would be extremely useful to policy-makers and public health administrators seeking to develop equitable health and welfare services in their respective countries.

3. Operational research on HWSD

The third major thrust of activities of HWP is to promote operational research in different aspects of HWSD in Member countries. In preparation for undertaking operational research, HWP is working towards the development of the following: (a) indicators and tools for documenting the status of health and welfare systems; and (b) a comprehensive research protocol to assess the role and impact of public-private partnerships (PPP) in health and welfare systems development. Although a number of health indicators are available to assess health systems, there is a serious lack of indicators and tools to assess the performance of the welfare system. HWP has therefore commissioned the Institute for International Health, University of Sydney, to develop these indicators and tools. HWP is also developing a research protocol to assess the role and impact of PPP in HWSD with Stanford University, United States of America. These protocols will be reviewed, modified if necessary, and endorsed by experts in consultative meetings that will be held in 2004. Following the finalization of protocols, the proposed research projects on HWSD are scheduled to commence in the same year.

4. Case studies

- **Role and impact of PPP in HWSD**

HWP aims to conduct such case studies in 5 to 10 countries. The

research will focus on the following key areas: (a) the present scenario of PPP, the strengths and weaknesses; (b) the present status of financing of health and welfare services by the private sector; (c) the involvement of private sector within the public sector; and (d) the role of government in promoting and monitoring PPP through legislation and regulatory strategies.

The end products are expected to contribute to a global database on PPP in HWSD and be published as a technical report for wide circulation.

- **To document HWSD in selected countries and develop an InfoBase**

HWP has been working to promote research in HWSD in five to ten countries with a particular focus on welfare systems. Even though welfare services exist in different forms and at different levels in many countries, the welfare system has not been well documented or analysed. To plan for improvement of welfare systems, it is important to study their present status, the organizational structure, the strengths and weaknesses, lessons learnt, and successful examples.

Research scientists in selected countries will be commissioned by WKC to undertake the studies in collaboration with national health and welfare authorities utilizing the indicators and tools developed by the Programme. This method of uniting research scientists and national public health authorities will also add to WKC's efforts to help bridge the gap between researchers and policy/decision-makers.

In the context of rapidly changing societies, health and welfare systems development or reorganization of current systems must, therefore, be planned with great foresight. This requires a common shared vision, intersectoral coordination, integration of health and welfare systems, mobilization of financial and human resources, and good governance mechanisms at all levels. Additionally, gender-specific

perspectives and the special needs of marginalized groups of people must be at the top of the agenda. WKC is working steadfastly on the premise that the provision of health and welfare services is a human rights issue and is committed to assist countries in their efforts to develop health and welfare systems that are equitable, accessible and affordable. HWP seeks to achieve these through sharing of available information, promotion of operational research in HWSD to generate information for evidence-based decision-making and promotion of international partnerships and global leadership.

WOMEN AND HEALTH

The activities in 2003 were planned to build on the consensus expressed in the Awaji Statement (2000)[1], and action proposed in the Canberra Communiqué (2001)[2], and incorporated in the Kobe Plan of Action for Women and Health (POA) issued at the Third International Meeting on Women and Health convened in 2002. An agenda for priority action-oriented research was proposed (Box 2).

Four International Task Forces were organized on a voluntary basis to implement the POA. The fifty members from 18 countries have contributed to the work of Women and Health Programme (WHP) by providing their comments/views and perspectives and through on line consultation. Activities were in four main areas: research, meetings/symposia, partnership networking and information dissemination.

1. Research

The research was undertaken using four priority areas of the POA as a framework.

- Comparative analysis of gender equity/equality indicators
- Use of gender analysis
- Women's leadership in health
- Enhancing research transfer in specific gender equity and health issues

WHP commissioned three research institutes to produce reports in the first three of the above priority areas. The fourth area, "research transfer" was followed up through the International Symposium on Gender-Sensitive Medicine, held in Chiba Prefecture, Japan, 1 March 2003.

[1] First International Meeting on Women and Health, Awaji Island, Hyogo Prefecture, Japan, April 2000

[2] Second International Meeting on Women and Health, Canberra, Australia, April 2001

• **Comparative analysis of gender equity/equality indicators**

La Trobe University Public Health Consortium, Australia, conducted the research for Task Force 1. The report produced is divided into of four parts (1) a summary report, (2) a health information framework, (3) an audit of selected indicators used by international agencies, and (4) an annotated bibliography. The La Trobe Consortium identified and mapped 1095 indicators against a Health Information Framework (HIF) (Box 3) and evaluated the indicators according to criteria for technical quality and gender sensitivity. The research aims at building a common set of "leading health indicators" that could be used by international agencies and Member States for identifying and raising awareness of issues, and improving the evidence base for policy development and decision making.

The report highlights the need for a smaller list that could be tracked over time and could be more readily maintained in countries with limited resources. A draft core set of gender-sensitive leading health indicators were discussed at an Expert Group Meeting from 3 to 5 November 2003 in Kobe, and pilot testing is in progress.

• **Use of gender analysis**

The University of Melbourne, Australia - The Key Centre for Women's Health in Society conducted this research for Task Force 2. The report gives a historical outline of the development of gender analysis and several excellent case studies on policy development and programme implementation. The report provides a useful analysis of the relationship between gender, poverty and health; addresses the social understanding of health and covers critical gender-related issues (e.g. reproductive health, gender-based inequity). Also provided is a good description of the different approaches taken to introduce a gender perspective into policy development and programme implementation at national, regional and community levels. Different tools used to evaluate the efficacy of

these programmes are assessed. The focus of the research and case studies on policy development was on international aid agencies. The case studies on programmes were drawn from developing countries.

- **Women's leadership in health**

The University of Canberra – National Centre for Social and Economic Modelling (NATSEM), Australia, conducted the research for Task Force 3. The report provides a summary of the literature on key characteristics of leaders, differences between male and female leaders, and an analytical framework for assessing the impact of women's leadership. The report also identifies hindrances and benefits in the different spheres of a woman's life. Several case studies from developed and developing countries are used to illustrate the framework. The case studies are at local/village, state/provincial and national levels. The report draws some important conclusions on key trends, catalyzing effects, and incentives.

- **Enhancing research transfer in specific gender equity and health issues**

On 1 March 2003, the International Symposium on Gender-Sensitive Medicine was organized in collaboration with Chiba Prefecture, Japan, paying attention to gender-sensitive practice in women's clinics. Presentations covered diverse ways of implementing a gender-sensitive approach and reiterated the concern about insufficient attention given to gender-specific aspects of health determinants. The Symposium participants defined the notion of a gender-sensitive approach and concluded that gender-sensitive medicine is part of an ensemble of practices that comprise a gender-sensitive approach to health and health care. The conclusions endorsed at the end of the Symposium, included fifteen strategies to address and redress gender inequities in health outcomes. The proceedings of the International Symposium are available in English and Japanese.

• **Booklet on the Progress of the POA**

WHP produced a Booklet to summarize progress in implementing the POA. Designed mainly for policy makers and advisers, the booklet was used as background document at WKC's Fourth International Meeting on Women and Health, Dar es Salaam, United Republic of Tanzania, 5–8 October 2003.

2. Meetings/symposia in 2003

• **International Symposium on Gender-sensitive Medicine**
Chiba Prefecture, Japan, 1 March 2003

In line with priority 4, the objectives of the Symposium were to: (1) exchange research outcomes on gender-sensitive medicine (GSM), which identify a range of issues related to women, gender and health; (2) identify strategies to address the issues raised; and (3) draw conclusions and articulate action-oriented strategies based on presentations and discussions.

More than 100 participants attended this one-day International Symposium composed of four sessions. Seven papers were presented and discussions on the different topics were of a highly interactive nature. Some fifty questions were raised during the plenary discussions.

The Symposium reaffirmed that women's health is a human right, and gender-sensitive medicine is part of an ensemble of practices that comprise a gender-sensitive approach to health and health care. A gender-sensitive approach involves recognizing and understanding the ways in which the combination of factors that shape men's and women's lives – such as biological sex and wide-ranging social practices – produced inequities in their health outcomes. Strategies to address and redress gender inequities in health outcomes need to be informed by a gender-sensitive approach.

The impact of the Symposium was immediate with participants agreeing to 15 strategies and establishment of a network of gender-sensitive medicine experts and policy-makers for ongoing research transfer.

- **Fourth International Meeting on Women and Health**
  Dar es Salaam, United Republic of Tanzania, 5–8 October 2003

The meeting was a follow-up to the three previous international meetings held in 2000, 2001 and 2002 in Awaji Island, Japan, Canberra, Australia, and Kobe, Japan, respectively. The focus of the meeting was on "gender perspectives for better health and welfare systems development". One of its main objectives was to report on the progress made in implementing the POA and to advance the Plan. Issues related to the health of women in Africa were also given special attention. Participants endorsed a set of conclusions from the Meeting, including strategies to expand the POA proposed for implementation in the next biennium, 2004–2005.

The meeting was highly supportive of the POA and its associated activities as outlined in the progress report. The meeting recognized the high quality of the work since April 2002 and expressed confidence that this would continue. Since the meeting was held in Africa, participants also acknowledged and proposed strategies on issues of importance to the health of women in Africa.

- **Expert Group Meeting on Gender-Sensitive Leading Health Indicators, Kobe, Japan, 3–5 November 2003**

This meeting was organized as a next step to follow up the first priority area of the POA. The report produced by the La Trobe Consortium was reviewed and discussed. The Meeting brought together the work being done in several agencies and countries, and explored

commonalities and issues to be resolved. Participants proposed strategies to gather support and made a proposal for piloting this draft core set of gender-sensitive leading health indicators and the related monitoring system in interested countries and international agencies.

3. Partnership network

WHP has built a strong partnership network through its meeting/symposia and research collaboration, composed of internationally recognized researchers, policy-makers and advisers, experts in the field of health, women, gender and welfare. The network was also strengthened by the establishment of five online consultation groups, one for each Task Force and one for the group of experts on leading health indicators.

4. WHP homepage development

As part of the development of its homepage as a tool for information dissemination, WHP has set up a Headlines system, designed to keep WHP's partners informed of the ongoing activities of the Programme.

Information dissemination was also conducted through a workshop on gender-sensitivity organized by Japan International Cooperation Agency (JICA) and interviews with representatives of the media. At the same time, WKC started an internship programme and WHP welcomed one intern to develop a project on the evaluation of holistic care in women's clinics in Japan.

Box 2: Kobe Plan of Action for Women and Health

Preamble

Building on consensus expressed in the Awaji Statement and action proposed in the Canberra Communique, the WHO Kobe Centre's Third International Meeting on Women and Health was convened to consider enabling strategies for women to gain equal access to resources, security and empowerment and to devise an agenda for action-oriented research.

Meeting participants recognized that women's good health is critical for the development of healthy societies and economies. In order to achieve better health outcomes and better management of scarce resources, governments, non-governmental organizations, the private sector and the international community need to mobilize their resources and work in partnership for women's health, and to ensure that the distribution and use of resources are appropriate and effective.

Underscoring WKC's role in collecting, reviewing, evaluating and disseminating information on models of good practice and in facilitating partnerships, and recognizing the need for further stocktaking and evaluation of the evidence base for action and skills development, Meeting participants recommended the agenda given below for implementation in 2002–2003 and in the medium to long term beyond.

Participants agreed to form voluntary task groups to immediately advance the 2002–2003 agenda items relating to the comparative evaluation of health indicators for gender equity/equality, gender-based analysis, developing women's leadership and enhancing research transfer. The task groups agreed that the following principles would govern their approach:

- *Collaborative and participatory, with concern for issues at grassroot level*
- *Respecting experiential and other forms of evidence*
- *Valuing experiences from different countries and contexts, and learning from cultural diversity*
- *Inclusive of men as an approach to addressing gender-specific concerns*
- *Inclusive of all stakeholders, including decision-makers, to ensure translation into action*
- *Incorporating gender-sensitivity training*
- *Establishing appropriate communication strategies to accompany activities*

IMMEDIATE PRIORITIES FOR 2002–2003:
(not in priority order)

1. *Comparing the health indicators used by international agencies and evaluating them for gender equity/equality*
2. *Identifying good practice in the use of gender-based analysis*
3. *Describing, analysing and developing women's leadership in health*
4. *Enhancing research transfer in specific gender equity and health issues*

Kobe, Japan, 10 April 2002

Box 3: Overview of the Health Information Framework

1. HEALTH STATUS

Well-being	Illness, injury, and health-related status	Human function	Life expectancy and deaths

Key Equity Issues

2. DETERMINANTS OF HEALTH

Environmental factors	Socioeconomic factors	Social and community factors
Household factors	*Health-related mediators: Health behaviour & psychosocial factors*	Biomedical factors

Key Equity Issues

3. HEALTH SYSYTEM PERFORMANCE

Accessibility	Effectiveness	Cost
Availability	*Service/programme effectiveness*	*Technical efficiency*
Affordability	*Safety*	*Allocative efficiency*
Service access	*Appropriateness*	*Sustainability*
Acceptability/ Responsiveness	*Continuity/Continuous*	
	Competence/Capability	

Key Equity Issues

4. COMMUNITY AND HEALTH AND WELFARE SYSTEM CHARACTERISTICS

Economic resouces	Human settlement	Governance	Health and welfare systems

Key Equity Issues

INFORMATION SUPPORT AND SERVICE

INFORMATION CENTRE

1. Research Information

During the year 2003 the Information Centre (IC) installed a new library system. The aim is to facilitate access to the latest research information as well as to streamline the management of items collected in IC. The selected system, MetaLib/S.F.X. provided a much-needed central platform to access online databases, electronic journals, and Internet searches. The new system will also eventually incorporate all IC's document and monograph collection, and, when completed, all the research information available at IC will be centralized in electronic format.

IC has also started to make its information resources available to the general public on a selective basis. In addition to answering e-mail, fax and phone enquiries which continued as before, IC opened up access to its information resources to external researchers who were welcome to visit WKC by appointment to utilize information resources when necessary. This was part of the process to develop a more collaborative relationship with researchers in the Kansai area of Japan and further encourage dissemination of reliable information to the general public.

Subscription to online journals and electronic databases were continued from 2002. Subscription for CDs and regular journals also continued, though the new materials were mostly in electronic format as shift to online resources continued.

2. Cooperation with other libraries

The library work remained a core part of IC, but with advancing technology, the need to cooperate and collaborate with other libraries increased and became one of the key goals for the IC in 2003.

In addition to close links with WHO/HQ Library, the Global Library Network programme was continued to build links with libraries on an international level. Approximately eighty libraries joined this programme to receive WKC publications on a regular basis. Currently the aim of the programme is more on information dissemination, but future plans include more active information exchange between institutions and libraries for increased access to research information using the Internet and other suitable available medium.

PUBLIC INFORMATION

1. Information dissemination

Throughout the year 2003 the Public Information Group (PUB) has produced materials for the media and the general public to disseminate information on WKC activities – press releases, activity reports, WKC News Reports, Annual Report and video products both in English and Japanese. Particular efforts have also been made to further publicize the technical reports and meeting proceedings of WKC's programmes to sensitize the general public to WKC's technical information and strategies to support self-reliant health behaviour among individuals and in communities.

All the information products of the Public Information Group are available through WKC web site and a large number of accesses to the site have been recorded.

2. Media relations

Answering enquiries from the media regarding WKC events and technical research issues by e-mail, fax and telephone, is an important aspect of the PUB's work. Previously enquiries came largely from local and national newspapers or television channels in Japan, but in 2003

many more enquiries were also received from the international media, indicating the increasing awareness of WKC's activities globally. Various national and international newspapers, television and radio channels, newswires and journals have covered WKC's international meetings, such as those of the Traditional Medicine and Women and Health programmes. PUB will continue to deliver attractive information worldwide to strengthen its relations with the media.

In collaboration with WKC programmes, efforts will be continued to find innovative ways to disseminate relevant and reliable technical information in an appropriate and timely manner. Another plan is to collaborate closely with institutions such as the Hyogo International Association to contribute to disseminating useful health awareness information among the local people.

INFORMATION TECHNOLOGY

With recent advancements in information technology (IT), including the Internet, and in order to fulfil WKC's objectives as a research arm of a global organization, it is imperative to have a state of the art IT infrastructure and support system. WKC is now equipped with modern computer and office equipment facilities to provide staff members and researchers with an optimal working environment. The primary functions/objectives of the Information Technology group of the WKC could briefly be described as follows:

1. To provide a smooth and efficient working office environment, with adequate and timely user support to WKC staff members to carry out the day-to-day activities with adequate stability and security of the data;
2. To plan, implement and support the IT related requirements of the individual programme's research related activities;
3. To publish and disseminate the WKC research outcomes and publications through the World Wide Web;

4. To systematize the WKC official information related activities;
5. To maintain and coordinate the IT and office equipment inventories.

In order to achieve the above objectives, the resources are made available both internally and through partnership with external organizations.

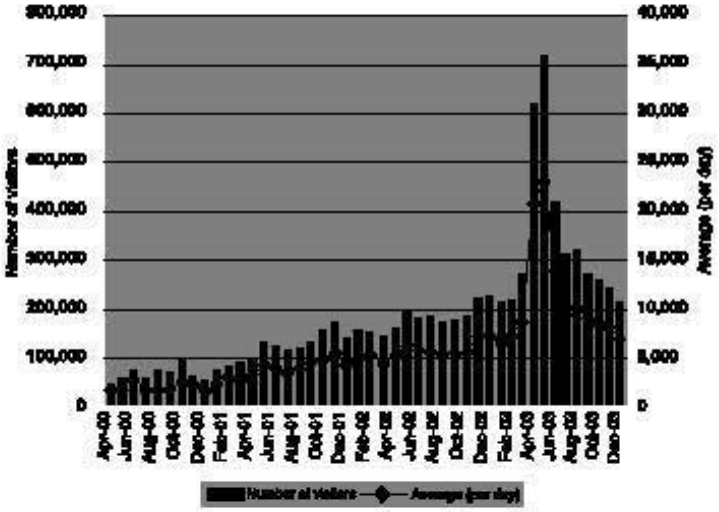
With respect to the Cities and Health Programme (CHP), the Cities and Heath Information Package (CHIP) developed at the University of Otago, New Zealand, acquisition of the required resources is in progress to host the CHIP from WKC premises.

As for the Women and Health Programme (WHP), to facilitate information sharing and discussion among WHP Task Force members, IT has created and maintains an online programme.

With respect to the Traditional Medicine Programme (TRM), IT studied, designed and implemented a suitable database for the collected indicators information and their related mappings. In addition, IT supported the development and hosting of a secure website to share maps and meeting information among the meeting participants.

The research output and the publications of the WKC are hosted in the World Wide Web for the public without any interruptions. As indicated in the figure 3, the number of people accessing the homepage of WKC has increased more than three-fold in the past two years.

Figure 3: Access to WKC Homepage



In accordance with the overall objectives of the WKC, to be of assistance to the local community and to promote awareness among the public, IT supported the planning and opening up, as of July 2003, of the WKC Computer Room to the public and for use by WKC interns.

In addition, international meetings and symposiums of all WKC programmes were fully supported on-site by IT to ensure their smooth running and successful completion.

EXECUTIVE MANAGEMENT

The Director's Office continued to provide policy direction and technical leadership in carrying out WKC's mission and mandate. To keep abreast with the development of activities, the Director initiated a monthly review of each programme, with the participation of all programme team members. The reviews provided added value and an opportunity for staff interaction and to clarify issues necessary for the smooth implementation of activities.

In line with one of the objectives of the Director's Development Fund which is to provide support in certain emergency situations, WKC responded to the growing concern about the sudden and serious worldwide situation of Severe Acute Respiratory Syndrome (SARS). The establishment in WKC of a SARS Information Support Desk (including a 24-hour automatic answering telephone system) during the crisis period enabled the provision of updated and reliable information to the public, particularly to Japanese nationals and local agencies, in the Japanese and English languages.

During the year WKC provided opportunities in the form of internships for undergraduate and postgraduate students to gain deeper insight into the work of WKC and different United Nations offices. The students were given access and guidance on approaches to information sharing and dissemination through WKC's facilities and global networks. In addition, a computer room was made available to external researchers interested in accessing the electronic library resources of WKC. A MetaLib/S.F.X library network system was also acquired and installed in WKC. It is understood that WKC is only the third institution in Japan to have this facility.

A two-day WKC Retreat for Programme Evaluation was held at the Fruit and Flower Park, Kobe City, Hyogo Prefecture, in August 2003, for all WKC staff and consultants. This year the Retreat provided a forum for: (i) focus on enhancement of awareness of health issues related to

office work and individual responsibility for improving health through daily exercise, attention to diet etc; and (ii) discussion on WKC's achievements and to identify strategies to improve WKC's quality of work.

Collaborative visits, presentations and lectures in different countries, continued to be a major activity, to strengthen partnerships and linkages between WKC institutions and organizations within and outside Japan.

EIGHTH MEETING OF THE WKC ADVISORY COMMITTEE

The Eighth Meeting of the Advisory Committee of the WHO Centre for Health Development was held on 12 and 13 November 2003 at the WKC International Conference Room, Kobe, Japan.

In his address at the Opening Session, Dr Yuji Kawaguchi, Director WKC, extended a welcome to all participants, especially the new Members of the Advisory Committee (AC). He also welcomed Mr Toshizo Ido, Governor of Hyogo Prefecture and Dr Yusuke Fukuda representing the Ministry of Health, Labour and Welfare, Government of Japan, and reiterated his appreciation for the continued strong support to the Centre by Japanese authorities.

A welcome was also extended to Mr Denis Aitken, representing the WHO Director-General, as well as other colleagues from WHO headquarters.

The meeting was then addressed by Mr Toshizo Ido, Dr Yusuke Fukuda and Mr Denis Aitken, all of whom recognized the importance of the challenging issues for the 21st century being tackled by WKC.

The Meeting unanimously elected Dr Abdul Rahman Al-Awadi as Chairperson and Professor Jerzy Szczerban as Rappporteur.

In introducing the Director's Report on 2003 activities, Dr Kawaguchi expressed his appreciation for the inspiration and support WKC received locally, nationally and internationally and emphasized that WKC's global networks and forums were the backbone of WKC's work and the best assurance for lasting results. WKC was urging new thinking to mould appropriate health and welfare systems that befit the 21st century, without which investments in fighting disease and ill-health could not give the hoped for returns.

Following the Director's presentation, supplementary information

was provided by WKC officers working in the individual/interrelated programme areas – Cities and Health, Ageing and Health, including Traditional Medicine, Health and Welfare Systems Development, including Women and Health, plus activities of the Information Centre and regarding Information Technology. Extensive discussions by AC Members and WHO colleagues followed and suggestions for consideration in the different areas were made. The Director's report on 2003 activities and the proposed Plan of Work 2004–2005 were endorsed.

The Advisory Committee Members commended the work of WKC and acknowledged the wide range of achievements. They also recognized that health and welfare systems development was a vast, complex and crucial area and the work of WKC was making a laudable contribution globally in that regard.

SUMMARY

The WKC programmes are at different stages of development in their research activities – all for different reasons – and the work along the paths to attain WKC objectives have revealed different obstacles that needed to be overcome. These include general paucity of disaggregated data at city level; lack of standard definitions and terminology in addressing community health care for the elderly; the breadth and complexity in assembling sound information in the field of traditional medicine/alternative and complementary medicine. In the prime area of Health and Welfare Systems Development, there is a lack of indicators and tools for documenting HWSD, notably the "welfare" component as well as a core set of leading health indicators to make comparative analyses across peer countries and regions of women's health and gender equity/equality and a valid list that could be tracked over time and be more readily maintained in countries with limited resources. During the year considerable efforts were made by the Programmes to gradually overcome these obstacles.

WKC's work is now setting its mark in all regions of the world, with some additional involvement in the WHO regions of Africa and Europe. As examples, it is gratifying that, with respect to Europe, two major cities in the United Kingdom – London and Manchester – have joined the global WKC partner city network. In Africa, the Fourth International Meeting on Women and Health was opened by the Vice-President of the United Republic of Tanzania, hosted throughout by the Minister of Health, and closed by the country's Prime Minister. Such examples of leadership and interest in the efforts to drastically uplift the health of women are highly appreciated. The Meeting participants also made a one-day field visit to the island of Zanzibar where they were graciously received by the President of Zanzibar who also gave his strong support to the issues being addressed at the WKC Meeting. Participants also had the privilege to visit some local maternity facilities, as well as discover local women's handicrafts.

It is highly satisfying to once again report that the mission and objectives of WKC's work are increasingly well understood within WHO offices and other United Nations offices, as demonstrated by the increased involvement in WKC's activities as added value to the much needed groundwork required to get improved development of health and welfare systems on a firmer setting in all parts of the world.

ANNEX I

WKC ADVISORY COMMITTEE MEMBERS, 2003

Honorable Anna Abdallah, Minister, Ministry of Health, Dar es Salaam, United Republic of Tanzania

Dr Abdul Rahman Al-Awadi, President, Islamic Organization for Medical Sciences, Sulaibekhat, Kuwait

Professor Shigeaki Baba, Chairman, International Institute for Diabetes Education and Study (IIDES), Kobe, Japan

Her Worship Hazel McCallion, Mayor, City of Mississauga, Ontario, Canada

Dr Hideo Shinozaki, Director-General, National Institute of Public Health, Saitama, Japan

Mr Niletthi Nimal Siripala de Silva, Member of Parliament, Parliament of Sri Lanka, Colombo, Sri Lanka

Professor Jerzy Szczerban, Chairman, Science Advisory Council, Ministry of Health, Warsaw, Poland

Her Worship Sukhi Turner, Mayor, City of Dunedin, Dunedin, New Zealand

ANNEX II

WKC PUBLICATIONS: 1996–2003

2003

Technical Report on the Impact of Women's Leadership in Health and Welfare Systems Development. 2003.

Technical Report on Comparative Evaluation of Indicators for Gender Equity and Health. 2003.

Technical Report on Gender Sensitivity and Gender-based Analysis in Women's Health Development. 2003.

Town Meeting: Who is responsible for your life? – Preventive risk management for people's health. Report of an International Symposium, Kobe, Japan, 16 November 2002. (English and Japanese)

Gender-Sensitive Medicine. Proceedings of an International Symposium, Chiba, Japan, 1 March 2003. (English and Japanese)

Progress Report on the Kobe Plan of Action for Women and Health. Technical Report , 2003.

Country Studies on Health and Welfare Systems: Experiences in Indonesia, Islamic Republic of Iran and Sri Lanka. Health and Welfare Systems Country Report Series 2, 2003.

2002

Cities and Health: Achievements with WKC Partner Cities. Proceedings of a WKC International Symposium, Kobe, Japan, 29 November 2002.

Cities and Health Advisory Task Force Meeting: Organization and Management of Health Services in Large Cities. Proceedings of a WHO Task Force Meeting, Shanghai, People's Republic of China, 23–24 May 2002.

2002

Health and Welfare Systems Development in the 21st Century. Proceedings of Third Global Symposium, Kobe Japan, 6–8 November 2002.

Prevention and Control of HIV/AIDS: Ethical Aspects. Report of WHO Kobe Centre International Symposium, Kobe, Japan, 29 November 2001.

International Symposium on Healthy Life from Good Dietary Practices. Proceedings of an International Meeting, Kobe, Japan, 6 April 2002. (English and Japanese)

Economic, Social and Health Issues in Tobacco Control. Report of a WHO International Meeting. Kobe, Japan, 3–4 December 2001

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