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Development of Traditional Medicine in the South-East Asia Region

*Report of a Regional Consultative Meeting
Pyongyang, DPR Korea, 22-24 June 2005*



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1. INTRODUCTION

1.1 Background

The fifty-sixth session of WHO Regional Committee of South-East Asia, held in September 2003, adopted a resolution (SEA/RC56/R6) which requested the Regional Director:

- (1) to share evidence-based information and country experiences on traditional systems of medicine in the Region as well as experiences of other regions;
- (2) to assist Member States in developing/strengthening national policies, strategies and plans of action on traditional systems of medicine;
- (3) to establish a "Regional Task Force" on traditional medicine for regularly reviewing the regional situation and facilitating the development of national and regional strategies and policies on traditional systems of medicine, and
- (4) to facilitate and advocate, in collaboration with development partners and WHO headquarters, for the establishment of a "Global Alliance on Traditional Medicine".

Accordingly, a Regional Working Group (RWG) on Traditional Medicine met in August 2004 in the WHO Regional Office for South-East Asia India and reviewed developments in traditional medicine (TM) in the South-East Asia Region (SEAR). Based on the recommendations of the Regional Committee and RWG, the Regional Director decided to organize a regional consultative meeting on TM, with larger participation.

At the invitation of the Ministry of Public Health, DPR Korea, a Regional Consultation on Development of Traditional Medicine in the SEA Region was convened in Pyongyang, DPR Korea, from 22-24 June 2005 with the following objectives and expected outcomes:

1.2 Objectives

General objective

To strengthen the development of traditional medicine as part of the national health system in countries of the WHO South-East Asia Region.

Specific objectives

- (1) To review the development of traditional medicine in countries of the WHO South-East Asia Region and to identify priority issues and challenges in strengthening traditional medicine as part of the national health system.
- (2) To formulate an agenda and a work plan for an intercountry programme of work for collaboration with the WHO Regional Office for South-East Asia and,
- (3) To prepare a framework for writing monographs and relevant documents on the use of traditional medicine in primary health care.

Expected outcomes

- (1) Country priority issues identified to strengthen the development of traditional medicine as part of the national health system in countries of the WHO South-East Asia Region.
- (2) Priority issues identified for intercountry collaboration in developing traditional medicine as part of the national health system where WHO assistance is needed. An outline of a work plan established for intercountry collaboration and,
- (3) A generic outline of monographs to be used by countries in writing monographs on "Use of Traditional Medicine in Primary Health Care".

2. OPENING SESSION

The opening session consisted of a welcome address by Dr Pak Jong Min, Director, Department of External Affairs, Ministry of Public Health, DPR Korea, followed by an address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, which was delivered by Dr Eigil Sorensen, WHO Representative to DPR Korea. The inaugural address was delivered by Professor Dr Choe Chang Sik, Vice-Minister, Ministry of Public Health, DPR Korea.

Welcome Address by the Director, Department of External Affairs, Ministry of Public Health, DPR Korea

Dr Pak Jong Min, in his welcome address, said that the Regional Consultation on Development of Traditional Medicine in the WHO South-East Asia Region

was held amidst great expectations and interest of the health workers in the Region since this provided an opportunity to realize the goal of improved health and longevity. He extended a warm welcome to the participants, especially professionals of traditional medicine from various countries and specialists of traditional medicine in DPR Korea. Dr Pak said that the consultation would discuss measures undertaken by various countries for this development of traditional medicine, which played an important role in the implementation of the "WHO Strategy on Traditional Medicine" and in the attainment of the goal of "Health for All". The fact that diseases that could not be cured by modern medicine were successfully treated by the traditional medicine fully proved the vitality of the latter. He also elaborated on the use of TM in developing and developed countries. He hoped that the meeting would contribute to the noble cause for health protection and promotion of the people.

Address by the Regional Director, WHO South-East Asia Region

Dr Eigil Sorensen, WHO Representative to DPR Korea read out the address by Dr Samlee Plianbangchang. In his address, the Regional Director thanked His Excellency, Dr Kim Su Hak, Minister of Public Health and his staff for hosting this important meeting, and welcomed the participants. Dr Samlee said that the 21st Meeting of Ministers of Health of the South-East Asia Region, held in 2003, had recognized the key role of TM in the provision of health care and agreed that traditional systems of medicine should be included as part of the national health care systems. They also emphasized that to ensure undisputed health benefit to the patient, safety must be the overriding consideration in using traditional remedies. The WHO Regional Committee for South-East Asia at its fifty-seventh session in 2004, recognized that traditional systems of medicine played a vital role in health care in the Region. With a view to promoting its wider use, Member States were urged to collaborate in the exchange of information as a first step, and in the development of human resources. Accordingly, WHO convened a meeting of the Working Group on Traditional Medicine in 2004, which recommended, among others, the development of evidence-based information on quality, efficacy and safety of TM. The Group also urged Member States to collaborate in research, evaluation and development of TM. Based on the recommendations of the Regional Committee, the Meeting of Health Ministers and the Working Group on TM, WHO decided to convene a regional consultative meeting to ensure health benefits and patient's safety in the use of TM in PHC.



The Regional Director also touched upon sociocultural acceptance in the use of TM which could facilitate its assimilation as an integral part of a comprehensive national health care system. Development of human resources with basic skills that could contribute to improved health conditions, based on ethically sound professional practice, was highlighted. The proper use of traditional remedies was emphasized in the context of conservation, protection of biodiversity, prevention from destruction of natural habitats of medicinal plants and their sustainable use. WHO's readiness to provide the required support to ensure more effective use of traditional systems of medicine in the South-East Asia Region was reiterated (for full text of the address see Annex 1).

Inaugural Address by Vice-Minister of Public Health, DPR Korea

Professor Dr Choe Chang Sik, in his inaugural address, said that it was a pleasure to host the WHO Regional Consultation on Development of Traditional Medicine in Pyongyang with the active participation of experts in traditional medicine. He expressed his appreciation to the WHO Regional Director and his staff for their active support in the consultation. The consultation was convened following WHO's recommendation for the development of traditional medicine on a global scale, in order to share experiences gained in the development, utilization of and research in traditional medicine in different countries of the Region. This would contribute considerably to the implementation of the "Declaration on Health Promotion in the South-East Asia Region in the 21st Century".

Professor Choe said that the South-East Asia Region enjoyed favourable reputation globally for a promising future because of significant efforts made by Member States in the development of traditional medicine. In this regard, DPR Korea was pursuing a policy of promoting traditional medicine in combination with the modern systems of medicine and updating it in accordance with contemporary needs. The Academy of Koryo Medicine was involved in research to make traditional medicine scientific. The faculty of the Academy of Koryo Medicine and the Pyongyang Medical University were training traditional practitioners and pharmacists, while provincial Koryo medicine specialized hospitals and Koryo medicine departments of the hospitals and clinics in the city, county and ri (peripheral) levels provided medical services in Koryo medicine. His country paid particular attention to the interests of the masses, which was considered most valuable, and spared nothing for their life and health. All services in traditional medicine were given

free of charge together with those of modern medicine. DPR Korea would continue to expand and foster collaboration in the development of traditional medicine with other countries. Professor Choe hoped that the consultation would acquire rich experience in health promotion of the people, lift traditional medicine to a higher level, in line with its current requirements (for full text of the address, see Annex 2).

3. PLENARY SESSIONS

3.1 Introduction of Participants and Nomination of Office Bearers

Dr Kin Shein introduced the participants of the consultation. Dr Eigil Sorensen, WHO Representative to DPR Korea nominated Professor Choe Thae Sop as Chairperson, Dr Vichai Chokevivat as Co-chairperson and Dr M. Hayatie Amal and Dr Pramote Stienrut as Rapporteurs.

3.2 Technical Presentations

Global and regional perspectives on development of traditional medicine

Dr Xiaorui Zhang, Team Coordinator, Traditional Medicine, WHO headquarters, in her paper on *Global and Regional Perspectives on Development of Traditional Medicine*, said that traditional medicine was increasingly being used by both high- and low-income countries for different purposes. For example, 60-80% of the population in some countries still depended on traditional medicine for their primary health care needs including some Member States in the SEA Region. About 70% of the population in Canada and 80% in Germany also used traditional medicine as complementary and alternative treatment.

At present, certain forms of traditional, complementary and alternative medicines played an increasingly important role in health care and health sector reform globally. Hence, safety, efficacy and quality as well as economic aspects of complementary and alternative medicines, and protection of knowledge of traditional medicine had become important concerns for both health authorities and the public. In order to meet these challenges and concerns and to promote the use of indigenous and complementary/alternative medicines, WHO had developed the *Traditional Medicine Strategy for 2002-2005* which was adopted by the Fifty-Sixth World Health Assembly in 2003 through a resolution. The resolution urged Member States, where

appropriate, to formulate and implement national policies and regulations on traditional medicine and its integration into national health care systems, depending on national circumstances. It also requested WHO to provide technical support for the development of a methodology to monitor or ensure quality, efficacy and safety of products, preparation of guidelines, and promotion of exchange of information.

Dr Zhang said that after three years of implementing the WHO Traditional Medicine Strategy, progress in countries could be seen in the results of the WHO global survey on national policy and regulation of traditional and complementary/alternative medicine (TM/CAM). Currently, 45 Member States had a national policy on TM/CAM, 51 Member States were in the process of formulating a policy, 92 Member States regulated herbal medicines, and 42 Member States had a plan to establish regulations. Eight of the 11 countries in the WHO South-East Asia Region had a national policy on traditional medicine and seven countries had a national law on traditional medicine. Ten countries had established a national office for traditional medicine in the Ministry of Health. Nine countries had established national expert committees and seven countries had established national research institutes of traditional medicine or herbal medicines. Seven countries had set up regulations for herbal medicine products and nine countries registered herbal medicines. The survey results showed that progress in the field of traditional medicine was more advanced in the SEA Region as compared those in other WHO regions.

Dr Zhang said that traditional medicines differed widely from Western medicine in approaches and methodologies. How to conduct research on traditional therapies and herbal medicines and how to evaluate them would present a new challenge to all concerned. WHO had developed a series of guidelines and documents with the aim of meeting these challenges and difficulties.

In order to facilitate sharing of countries' experiences in regard to national policies and regulations, a global database on national TM/CAM policy and regulation of herbal medicines had been established. Dr Zhang also informed the meeting of major documents published between 2001 and 2004 relating to the legal status of TM, WHO Traditional Medicine Strategy, monographs on medicinal plants, acupuncture, agricultural and collection practices of medicinal plants, safety monitoring of herbal medicines, developing consumer information on clinical trials on treatment using a combination of traditional Chinese medicine and Western medicine in SARS.

***Regional strategic framework for development of traditional medicine:
Regional advisory group on traditional medicine***

Dr K. Weerasuriya, Regional Adviser, Essential Drugs and Medicines Policy Unit, WHO Regional Office for South-East Asia, said that TM had existed in the countries of the Region from ancient times and there were many different systems with some commonalities. Similarly, there were differences and similarities in the role of traditional medicine in health care systems too. However, modern requirements for the use of TM (regulation, quality of products, safety) were becoming similar.

The diversity in the Region was demonstrated by different dominant systems (Bangladesh – Unani, Bhutan – Sowa rigpa, DPR Korea – Koryo system, India, Nepal and Sri Lanka – Ayurveda), to name a few. In some countries, there were councils to regulate the practice of the profession and official pharmacopoeias, whereas others were in the process of initiating these activities. With such a diversity, how could regional cooperation be implemented? The principles could broadly be as follows: where similarities existed, technical cooperation was possible but this might not be possible for the Region as a whole and sub-grouping might be necessary. Where content was different but underlying principles were the same, there was a potential for cooperation, and exchange of experiences and technical know-how is possible among virtually all countries.

What were factors that should be considered in activities in traditional medicine? While keeping the essentials of TM, modern demands required regulation of training, the profession, products and promotion. A national traditional medicine policy would provide a framework for these activities. It was very important that ownership of TM knowledge remained within individual countries. Finally, all stakeholders (profession, consumers, health care administrators, producers) should be consulted in activities relating to TM.

Dr Weerasuriya further said that implementation of regional traditional medicine activities could be under a Regional Advisory Group. Such a group would coordinate activities through the more economical method of communications (email, fax, bulletin boards) keeping meetings to a minimum. The group could advise the countries on development and implementation of practices. Priorities could be identified: Harmonization, where possible (curriculum, pharmacopoeias), research and development (newer drugs, clinical trials), safety and efficacy. It could exchange experiences on policy, safety, efficacy, quality, knowledge management (intellectual property,

databases, sharing knowledge) and on centres of excellence. It could also develop a work plan for regional activities. Where necessary, sub-groups could be formed for specific areas co-opting those with experience in the areas.

3.3 Theme1: Traditional Medicine and National Health System

DPR Korea

Professor Choe Thae Sop said that traditional medicine was playing a pivotal role in the national health system in DPR Korea. Traditional medicine and Koryo medicine were unique national systems of medicine. It was a valuable medical legacy accumulated by ancestors through a long historical evolution in battling against diseases.

There was no privately-owned hospital or clinic in DPR Korea. All treatment facilities were under the health system of the government. The Academy of Koryo Medicine in Pyongyang served as an integrated centre for Koryo medicine, and all central-level hospitals down to the provincial, city/county hospitals had a Koryo medicine department. The cost of Koryo medical services was provided and paid for by the government based on the national budget allocated to the Ministry of Public Health, as well as modern medicine services. Therefore, the entire population, wherever they were, had access to good quality Koryo medical services.

Treatment coverage by traditional medicine at different levels of health facilities was approximately 30-40% at the central level, 40-60% at the city/county level, and 70% in the ri (peripheral) level. Particularly at the PHC level, coverage with traditional medicine accounted for more than 70%.

The government encouraged the use of Koryo medicine and recognition by the population of its effectiveness contributed to the increased proportion of treatment by Koryo medicine in health facilities at different levels. Currently, MoPH was focusing on the development of high quality and effective Koryo medicines and treatment methods. Importance was attached to introducing and disseminating them on time to health institutions.

However, difficulties lay ahead since resources of natural herbs were decreasing with increasing use of traditional medicines. Some of the preparations of Koryo medicine tended to be of lower quality than what was required by internationally high standards. Further promotion of the Koryo medicine was being undertaken as a national policy.

The great leader, General Kim Jong Il taught that “Koryo medicine therapy had to be introduced extensively. Rational combination and development of Koryo medicine and modern medicine was one of the important policies that DPR Korea was upholding”. MoPH with pragmatic teachings of the great leader General Kim Jong Il as a guideline in the field of Koryo medicine, had formulated strategies to promote Koryo medicine and coordinated and supervised its correct execution within the scope of the national health system.

Articles 15, 29, and 36 of the Law of Public Health of DPR Korea legally stipulated that Koryo medicine be developed as part of the national health system. The government’s policy requirement for the promotion of Koryo medicine was to decisively improve its quality. Diagnosis was made according to modern medicine and treatment administered through a combination of traditional medicine and modern medicine.

Another policy requirement was to update Koryo medicine in line with modern scientific medicine. The government required exploring the beneficial practices of long-inherited Koryo medicine to be used effectively in disease treatment, at the same time, improving its treatment method to attain a higher degree of development when measured according to modern scientific principles.

Another policy requirement was to train many Koryo medicine specialists who were also well versed in modern medicine. Today, all faculties of Koryo medicine in the 6-year curriculum of Medical universities were cultivating many young Koryo medicine doctors, and clinical medicine faculties were training new doctors with good knowledge of Koryo medicine capable of providing services. DPR Korea encouraged technical exchange and collaboration with other countries in the field of Koryo medicine.

Professor Choe further informed the meeting that the Academy of Koryo Medicine had been a WHO Collaborating Center for traditional medicine for more than 10 years. The Academy actively participated in technical collaboration, exchange of technical information, and comparative research of Koryo medicine and modern medicine, achieving considerable success in several areas. It was the desire of the Academy to be redesignated as the WHO Collaborating Centre on Traditional Medicine as soon as possible.

Thailand

Dr Vichai Chokevivat, Director-General, Department for Development of Thai Traditional and Alternative Medicine, in presenting a paper on the Use of

Traditional Medicine in the Thai Health Care System, said that “Thai traditional medicine” (TTM) originated during the Sukhothai period (1238-1377 AD) and progressively developed as a means of national health care until the early 20th century when modern medicine replaced TTM as the mainstream health service system. The revival of TTM began around 1978 after the Alma-Ata Declaration. As WHO urged its Member States to include medicinal plants in their primary health care (PHC) programme, Thailand’s Ministry of Public Health (MoPH) responded to WHO’s call by including a policy on promoting the use of medicinal plants in PHC since the Fourth Health Development Plan (1977-1981). The government policy on promotion of the use medicinal plants and Thai traditional medicine in the country’s health care system had continued until today, as stated in the 5th to 9th or the present National Economic and Social Development Plans (2002–2006).

In 1993, the “Institute of Thai Traditional Medicine” (ITTM) was established under the Department of Medical Services to play an active role on the revival of TTM and its integration into the health service system. Subsequently, the “Department for Development of Thai Traditional and Alternative Medicine” (DTAM) was established in October 2002 as a new department under MoPH, comprising of the Institute of Thai Traditional Medicine, Division of Alternative Medicine, and the Office of the Secretary.

According to Section 2.3.3 of the policies of the new government, TTM has become a part of the national health policy as the government would “*develop, transfer, and protect the wisdom of Thai traditional medicine, indigenous medicine, alternative medicine and medicinal plants*”. DTAM, in collaboration with other related organizations, were therefore responsible for implementation of this policy by strengthening the body of knowledge of TTM/IM/CAM through research and development; transferring the knowledge of TTM/IM (indigenous medicine)/CAM that had been selected and well studied by the public and health care personnel through training, demonstration, exhibition, printed matters and various other channels of media, and developing herbal products and TTM/IM/CAM services to meet international standards.

In addition, under Section 2.3.1 of the government policy concerning improvement of the quality of the “Universal Coverage” (UC) programme of the national health security system, it was the responsibility of MoPH and DTAM to increase public access to TTM/IM/CAM at public health service facilities by increasing the number of all levels of health service facilities that provided TTM/IM/CAM services; and adding more TTM/IM/CAM services into the UC programme.

Currently, the types of TTM service covered by the UC Programme were treatment and diagnosis with Thai traditional medicine and applied Thai traditional medicine. Another service was treatment and rehabilitation with traditional herbal medicines or traditional recipes comprising medicinal plant materials; therapeutic massage for treatment and rehabilitation; herbal steam bath and herbal hot compress for therapeutic purpose.

Currently, TTM services were provided in the health system through various channels, i.e. *TTM clinics* operated by licensed TTM practitioners; *community or provincial/general hospitals* that set up their own TTM section to provide TTM services. There were over 100 such hospitals in the country. These hospitals could be divided into four levels based on their services:

Level 1 – Those that sell herbal medicines.

Level 2 – Those that sell herbal medicines and provide TTM services, e.g. Thai traditional massage, hot herbal compress, and herbal steam bath.

Level 3 – Those that provide level 2 services and serve as a training centre on TTM, e.g. training courses on Thai massage, Thai traditional stretch exercise.

Level 4 – Those that provide level 3 services and produce herbal medicines.

TTM Health Promotion Centres had been set up by ITTM in cooperation with community or provincial/general hospitals as models of TTM service centres in every province with a total of 150 centres (2 centres/province) established so far.

Drug stores could sell registered Thai traditional medicines and traditional household remedies and general stores could sell only traditional household remedies. However, even though the production value of traditional medicines had gradually increased over the years, production and imported values of traditional medicines accounted for about 2% of those of modern medicines.

According to ITTM survey in 2003, the numbers of health service facilities that provided any level of TTM services were as follows:

Regional / General hospitals	80/96 (83.3%)
Community hospitals	492/726 (67.8%)
Health centres	2169/9683 (22.4%)

Dr Vichai concluded that as in other countries of the Region, Thailand had a national policy to integrate traditional medicine into the mainstream health care system. The integration process required strengthening of the body of knowledge of TTM, human resource development, development of quality herbal medicinal products, and commitment and financial support from the government. All of these could be achieved by good administration, information system on TTM, research and development, certified educational system and training curricula, and good collaboration among concerned institutions and organizations at both national and international levels.

Sri Lanka

Ms Soma Jayatunge, Director, National Institute of Traditional Medicine, Sri Lanka gave a general introduction about her country followed by health status of Sri Lankans in general, evolution of health care systems, three basic components of primary health care namely, promotion, prevention and curative aspects, primary health care in both sectors – modern and traditional, by comparing their institutional capacities, human resources and number of patients treated. She also discussed the role of traditional medicine in primary health care.

Ms Jayatunge's presentation paid attention to the activities undertaken by the Sri Lankan Ministry of Indigenous Medicine in the past, activities that were being undertaken at present and future plans to be implemented through its subordinate institutions. It identified sector-specific strengths, weaknesses, opportunities and threats in order to prepare future plans more comprehensively and implementing them successfully. Emphasis was placed on priority issues to be addressed urgently by the government and the Ministry of Indigenous Medicine, particularly with regard to the use of traditional medicine in PHC in terms of availability, affordability and accessibility.

Finally, Ms Jayatunge presented suggestions and recommendations for enhancement of the use of traditional medicine in primary health care in order to achieve the ultimate goal of 'building up a healthy and prosperous nation for contributing to the development of the country through the indigenous medical system.

Nepal

Dr Bishnu Prasad Pandit, Director-General, Department of Health Services in his presentation on *The Network of Traditional Medicine Services in Nepal*,

said that his country had a rich source of valuable medicinal plants. From ancient times, TM had been practised as a major component of health care by the people. The government had established more than 290 institutions for delivery of traditional health care services.

For integration of TM in the national health service, there was a unit of Ayurveda and Alternative Medicine in the Ministry of Health and Population (MoHP) along with a unit of Ayurveda in each of five regional directorates for supervision and monitoring. National health camps were conducted jointly. Information for public awareness was also being jointly broadcast by the media with the National Health Education and Information Centre. MoHP had also decided to involve traditional medicine human resources in national programmes such as immunization, family planning, etc. Traditional practitioners were also trained for active participation in burning health problems.

Dr Pandit emphasized that bilateral exchange of knowledge and techniques between practitioners of modern medicine and tradition medicine should be enhanced. Traditional healers and practitioners should be properly trained and registered to preserve and modernize their experiences. Effectiveness of traditional medicine practices should be proven by clinical trial, laboratory studies and research. The huge potential for research on traditional medicine of Nepal should be utilized, mobilized and developed.

3.4 Theme 2: Public and Private Sectors in TRM Development

Bangladesh

Dr Hakim Aatur Rahman, Principal, Unani and Ayurvedic Degree College, Dhaka, in his presentation, said that traditional systems of medicine, namely, Unani and Ayurvedic medicines had been used in medical practice for thousands of years and had played a significant role in maintaining human health. The Government of Bangladesh had taken different steps to develop these systems of medicine along with modern medical care in primary and secondary health care institutions. At the same time, government is also patronizing the development of traditional medical care in the private sector.

After the Drug Control Act (1982), the Government of Bangladesh had given more emphasis to expand traditional medicine throughout the country. The Government Unani and Ayurvedic Degree College with a 100 bed hospital attached, established in 1990, was providing BUMS (Bachelor of

Unani Medicine and Surgery) and BAMS (Bachelor of Ayurvedic Medicine and Surgery) certificates after successful completion of a five years' course with one year of internship. Another public institution namely, Sylhet Tibbia Habibia College, with a fifty bed hospital, had been offering a diploma course in Unani Medicine and Surgery (DUMS) since 1948. Diploma/certificate was given by the Bangladesh Unani and Ayurvedic Board. In the private sector, there were 11 Unani diploma colleges and 7 Ayurvedic diploma colleges with attached hospital in different places. The course curriculum of these colleges were the same as in government diploma colleges.

In order to strengthen the system of traditional medicine, the government had appointed 30 Unani and Ayurvedic Medical Officers in secondary-level hospitals under the Health and Population Sector Programme (HPSP) in 1999. They were providing health care with the existing health facilities so that services could be rational and cost-effective. The government had also taken steps to appoint traditional graduate physicians in the remaining districts and all the Upazilla health complexes. Establishment of 467 herbal gardens in district hospitals and Upazilla health complex premises was a positive step to influence the people through Behaviour Change Communication Programme to use traditional medicine in both public and private sectors. The Directorate of Homeopathy and Traditional Medicine had prepared uniform treatment guidelines for rational and cost-effective use of traditional medicine with the support from WHO in 2003, which would be useful for 182 BUMS doctors, 153 BAMS doctors and about 1200 Diploma doctors practising TM.

Indonesia

Drs Ketut Ritiasa informed that traditional systems of medicine had been used by Indonesian society since ancient times and empirically passed on from generation to generation, to eliminate or reduce symptomatic disorders and had made a significant contribution to maintaining and promoting health. The use of traditional medicines was still prominent and played an important role during the economic crisis as an alternative to conventional medicines in the 1990s.

Considering the prominent use of traditional medicines in the country, the government gave importance to regulate these products especially to ensure their safety, efficacy and quality. For this specific purpose, the National Agency for Drug and Food Control (NADFC) was responsible for controlling

the products. In line with the WHO Traditional Medicine Strategy, NADFC had strengthened the product control system to ensure safety, efficacy and quality of herbal medicines and developed a master plan for the development of Herbal Medicines.

The regulation of traditional medicines followed a WHO framework on key components of drug regulation with some adjustments to suit the country's needs, thus providing a control mechanism to protect the community from the risk of non-compliant TM products. Within this regulatory framework, essential regulatory elements, among others, were standardization of extracts and raw materials of medicinal plants, pre-market evaluation of finished products, sampling for products in the market and laboratory testing for its quality and safety as well as inspection of good manufacturing practices. Moreover, NADFC conducted post-marketing surveillance to protect the community from undesired effect of herbal medicines.

One strategic approach that could be used as an effective mechanism to integrate traditional medicines into the health care system was to include the development of Indonesian traditional medicines into the framework.

The national policy on Indonesian Herbal Medicines Development covered a strategic plan that included classification of Indonesian herbal medicines into three schemes, namely *Jamu*, standardized herbal medicines and Phytopharmaca with specific criteria and logo for each scheme for integration into the formal health system. NADFC had also developed a master plan for Indonesian herbal medicines to speed up implementation of the national policy and strategy.

Finally, Drs Ketut said that if safety, quality and efficacy of traditional medicines could be assured, they could be accepted as part of the primary health care and conventional health care systems.

3.5 Theme 3: Production of Traditional Medicine

Myanmar

Dr Thein Swe said that Myanmar traditional medicine was widely practised since a long time ago. In 1976, the Institute of Traditional Medicine was established and it produced systematically trained traditional medicine practitioners. In 2001, the University of Traditional Medicine was opened in order to upgrade the standards of traditional medicine practitioners.

The Department of Traditional Medicine was established in 1989 under the Ministry of Health. There was one major section in the department, which was responsible for the development of herbal gardens and cultivation of medicinal plants. Various species of medicinal plants such as *Orthosiphon aristatus* (Bl) Miq., *Plumbago rosea* L., *Piper longum* L., *Piper nigrum* L. are cultivated in the department which owned seven herbal gardens with the objective of conserving rare species, demonstration for practical training of students and supply of raw materials for drug production. Some of the private pharmaceutical companies had their own herbal plantations while some ministries had their own herbal gardens.

There were some limitations to cultivation of medicinal plants, such as improper soil, which needed to be treated before planting, shortage of skilled workers in herbal gardens, and requirement of technical know-how. Multi-sectors involvement, technical support by international organizations and collaboration of Member countries would improve the cultivation of good quality, safe and easily available medicinal plants.

Bhutan

Mr Dorji Wangchuk, Director, Institute of Traditional Medicinal Services, Bhutan said that traditional medicine system in his country had come a long way since its inception in 1967 due to a strong political commitment from the government. It was one of the most sustainable methods for the health care delivery system as all traditional medicines were manufactured within the country. Human resources were also being developed. However, there was a need to build adequate infrastructures for all three units of the Institute of Traditional Medicine Services in order to fulfil its mission of development of human resources for traditional medical services, production of traditional medicines and provision of quality traditional medical services. The major challenges for traditional medicine services were mobilization adequate resources for infrastructure development.

For sustainable production of traditional medicine, availability of raw materials at all times would be very critical and cultivation of medicinal plants by farmers like any other cash crops for income generation would go a long way in meeting the requirements of the Pharmaceutical and Research Unit (PRU). Natural habitats for medicinal plants needed to be protected from over-harvesting and destruction by domestic animals. Production capacity at PRU needed to be enhanced to meet the growing demand for traditional medicines.

Mr Wangchuk said that with farsighted vision of its leaders, the country had managed to keep its environment intact. If dividend from its rich natural resources and heritage were to be reaped, it was necessary to make cautious developmental strides. Research in traditional medicine and a natural resource base presented a great potential. However, building leadership in research and drug development was a resource and knowledge intensive activity and top priority must be accorded to capacity building.

3.6 Theme 4: Capacity Building in Traditional Medicine: Education and Research

Traditional medicine education in India

Mrs Uma Pillai, Secretary, Department of AYUSH, Government of India, gave a general introduction to development of traditional medicine in India followed by a brief description of individual TMs practised in the country. Thereafter, system-wise infrastructure was presented. There were a total of 20 811 dispensaries of traditional systems of medicine in India of which 13 925 were for Ayurveda only. India had 40 manufacturing units in government and cooperative sector whereas 9000 private manufacturing units were in operation. A total of 694 492 practitioners were registered of which 432 650 belonged to Ayurveda. A brief description about the Central Council of Indian Medicine, its aims and objectives and area of jurisdiction was given. Rules guiding the opening of new colleges for traditional medicine in India were also detailed.

Data regarding colleges of traditional systems of medicine in India were presented in detail. There were 221 Ayurveda colleges, 7 Siddha, 40 Unani, 10 Yoga and Naturopathy and 180 Homeopathy colleges. These colleges collectively had a total of 24 930 student admission capacity.

All traditional systems of medicine (TSM) are being taught at the university level of five and half years. The degree course was divided into 3 semesters of one-and-a-half years each with a one-year supervised clinical training. These graduates were awarded the degree of Bachelor of Ayurveda System of Medicine (BAMS), BUMS, BHMS and BSMS for Unani, Homeopathy and Siddha systems of medicine respectively.

Postgraduate facility in traditional system of medicine was available at more than 100 colleges. Of this, 65 colleges belonged to Ayurveda. In these institutions, a three-year postgraduate course in 22 specialties was being

conducted. On completion of the course, students of different traditional systems of medicine were awarded the degree of M.D. Ayurveda/Siddha/Unani/Homeopathy as the case may be.

Nearly 40 universities in India were awarding the Ph.D. research degrees in various specialities of Ayurveda. Till date, nearly 1300 Ph.D. degrees have been awarded in Ayurveda. The Government of India has nine national institutes, which work as centres of excellence for traditional systems of medicine. These institutes are fully financed and governed by the Government of India.

Along with teaching, separate institutes for research in TM had been established. There were separate central institutes for research in different traditional systems of medicines practised in India; viz. Central Council for Research in Auyrveda and Siddha (CCRAS), Central Council for Research in Unani (CCRU), Central Council for Research in Homeopathy (CCRH), etc. These Institutes were also fully equipped with research facilities and managed by the Government of India.

Separate courses for pharmacy education in Indian systems of medicine and homeopathy have been started. The two year diploma course - D. Pharm. (Ayurveda), four-year degree course – B. Pharm. (Ayurveda) and two years Masters degree course – M. Pharm. (Ayurveda) had been started at Gujarat Ayurved University in Jamnagar and some other institutes were in process of establishing such courses. For Siddha and Unani too, diploma courses in Pharmacy had been started. A separate two-year graduate degree course, M.Sc. in TM pharmaceuticals, had been started at the National Institute of Pharmaceutical Education and Research, Mohali.

The Government of India had several schemes for the development of Indian systems of medicine, institutions and personnel. Various components such as development of undergraduate colleges, assistance to postgraduate medical education of TSM, reorientation training programme for Indian systems of medicine and homeopathy, personnel, renovation and strengthening of TSM hospitals were presented. Various amounts available as grants-in-aid for the development of undergraduate colleges such as capital works, equipment and library books, were depicted. Government of India had provision of funds to colleges for establishment of computer laboratory and other facilities for upgradation.

The Gujarat Ayurved University, Jamnagar, is conducting exclusive courses for foreigners, viz. BAMS, diploma in Ayurveda, introductory course in Ayurveda and self health care in Ayurveda. Banaras Hindu University was also conducting two months' introductory course and one year certificate course in Ayurveda for foreign nationals.

New initiatives of the Government of India regarding development of model institutes, establishment of Indian Medicine and Homeopathy Pharmacy Council and Amendment to Central Council of Indian Medicine Act to cope with the present demand in the country was also presented. Two new national institutes, viz. National Institute of Unani Medicine at Bangalore and National Institute of Siddha at Chennai had become operational since 2004.

Documentation of traditional medicine knowledge: Digital library of India

Mr V.K. Gupta, Director, National Institute of Science Communication and Information Resources, Ministry of Science and Technology, said that Traditional Knowledge Digital Library (TKDL) was the maiden initiative of India to prevent misappropriation of traditional medicine knowledge. The project was initiated after the well-known cases of turmeric and neem biopiracy at United States Patent and Trademark Office (USPTO) and European Patent Office (EPO) to safeguard Indian Traditional Medicine.

TKDL is a tool for protection and is a valuable database for active research programme. It acts as a bridge between TK as prior art and patent examiners, since data in local languages are made available in patent application format in five international languages, i.e. English, French, German, Japanese and Spanish. The basic tool for retrieval of the desired data is Traditional Knowledge Resource Classification (TKRC), which is made in a format similar to the International Patent Classification (IPC) for easy understanding by the patent examiners at international patent offices throughout the world.

TKDL database having secured access will be available at its website, which will be provided access 24 hours, 7 days a week. The usage of database has been made easy by providing simple search, advanced search and boolean search. Currently, 60 000 medicinal formulations (36 000 Ayurveda and 24 000 Unani) are available for access and search for prior art, i.e. 9 million A4 size pages are ready for access at the website and another 22 million pages will be available for access by December 2005 and the balance

is likely to be available by December 2006. This extensive database can act as a tool for active research programme and become a base for the "Golden triangle project" which includes modern science, modern medicine and TK for evolving new molecules of therapeutic value.

Mr Gupta informed the meeting that decisions are being taken for giving access to international patent offices under non-disclosure agreement with user conditionality. Access for collaborative research shall be provided on the basis of bilateral agreements based on the principles of established Bonn guidelines and Access and Benefit Sharing concept. Moreover, regional initiatives are in pipeline for creating database of traditional medicines at the South Asian Association for Regional Cooperation (SAARC) forum.

3.7 Theme 5: Traditional Medicine and Health for All

Traditional medicine: A novel approach for available, accessible and affordable health care

Professor Bhushan K. Patwardhan, Director, Interdisciplinary School of Health Sciences, University of Pune, said that TM was attracting increasing attention within the context of health care provisions and health sector reform. The majority of the population in most developing countries continued to use traditional medicine for their common health needs. The prime issues of concern for attention were: (1) endorsement of TM. (2) validation of efficacy, regulation for safety, standardization of materials and harmonization of practices. (3) training of professionals. (4) construction of delivery infrastructure. (5) protection of intellectual property. (6) enforcement of equitable distribution of TM. (7) guarantee of sustainability of supply of resources. (8) supervision of price structure; and (9) Intellectual Property Rights inequities and backpressure from pharmaceutical industries (lack of innovations and productive outcomes).

Ever-increasing discovery costs and increased failures at the end of discovery pipeline made medicines unaffordable to the developing countries. This made new approaches, such as reverse pharmacology and systems biology more attractive, which provided opportunities for innovation based on experiential wisdom and holistic viewpoint of TM.

Current policies on Intellectual Property Rights at international level were positive detriments to making health care available and affordable to developing countries and therefore the *sue generis* systems became more

important to protect the interests of traditional knowledge from possible exploitation. Social and ecological obligations, education, human resource development and integration also remained the key issues. Professor Patwardhan gave important recommendations useful for development of TM in developing countries.

Traditional medicine and “Health for One”

Professor Qian Jia, Institute of Scientific and Technical Information, People’s Republic of China, used the phrase “Health for One” instead of “Health for All”. “One” is used to mean “whole” or “Everyone”. Prof. Jia said that Traditional Chinese Medicine (TCM), was based on the philosophic idea of “correlation between man and nature”, “balance of Yin and Yang”, characterized by “integrated concept” and “syndrome identification and treatment determination”. TCM adjusted and activated the self-recuperating ability to rectify its variation from normality of human body to meet the goal of prevention and treatment of diseases mainly by means of traditional Chinese medicinal herbs, acupuncture and moxibustion, etc.

The idea that “human should be in harmony with nature including bacteria, viruses, etc., but not to exterminate microbe on a large scale, held and promoted by TCM gave rise to a delicate physiological equilibrium kept between man and microbe”. This was just the development trend of medical science of the future.

Professor Jia said that for thousands of years, TCM had made an indelible contribution to the reproduction and prosperity of China and under countless attacks of pestilence had never decimated her people in millions such as a tragedy that once occurred in Europe. TCM was also characterized by “simple, convenient, cheap and effective method of treatment” and was especially good at preventing and treating chronic diseases, complicated multi-system diseases and newer types of viral diseases. Therefore, only when the sanitation and health care system was established could the health of 1.3 billion people in China and the problem of shortage of doctors and medicines for 900 million rural population and large number of poverty-stricken urban population be solved.

Prof. Jia recommended five promotion projects, namely: TCM policy and statute guarantee, TCM qualified personnel cultivation, TCM scientific research, development of TCM in rural areas and TCM administrative system reform be carried out in real earnest to develop TCM in a sustainable way.

Preparation of monographs and relevant documentations on the use of traditional medicine in primary health care

Dr Kin Shein, Short-term Professional, Essential Drugs and Medicines Policy Unit, SEARO said that in improving equitable access to health services, all systems of medicine that had been shown to be effective and not deleterious to the health and well-being of the people should play their respective roles. This must be in a manner that was commensurate with their salutary benefits and in a safe and cost-effective manner.

Traditional medicines were culturally and socially accepted by people. They were available, accessible and affordable to the underserved, indigent and marginalized groups of population for health care, particularly in rural areas. Hence, use of traditional medicine in primary health care could contribute to facilitate progress towards "Health for All" in the 21st century.

Dr Kin Shein then presented the Proposed Format of Monographs on the Use of Traditional Medicine in Primary Health Care for review and discussion. The revised format of monographs after discussion contained the following sections:

- (1) **Description of common medical problem** (Disease, symptom, disorder, health condition)

Describe the common medical problem.

Advise on when to seek medical assistance.

- (2) **Traditional medicine treatment**

*(Recommended treatment **by national health authorities**, different countries may recommend different medicinal preparations)*

- (3) **Actual name of preparation and its English equivalent**

- (4) **List of ingredient(s) in preparation**

- (5) **Dosage forms: powder, liquid, traditional tablet, etc.**

- (6) **Medicinal uses.** Medicinal uses described in the monographs may include any one of the following categories.

Use supported by long traditional use and/or clinical data

This category includes medical indications, which are well established in some countries and which have been validated by clinical works documented in the world's scientific literature. Clinical trials may be controlled, randomized, double-blind studies,

open trials, cohort studies, or well-documented observations on therapeutic applications.

Uses described in national formulary/pharmacopoeias and well-established documents

This category includes medicinal uses, which have been well established in many countries and are included in official pharmacopoeias or government monographs. Uses having pharmacologically plausible basis are to be included, as well as information resulting from clinical studies although they clearly need to be repeated because of conflicting results.

- (7) Dosage
- (8) Mode of administration
- (9) **Precautions:** *General, Pregnancy: teratogenic effects if known, nursing mothers, paediatric use and other precautions.*
- (10) **Traditional method of preparation:** *Collection season, processing after harvest, steps for preparation and condition for storage.*
- (11) **References**

Dr Kin Shein then presented a list of common medical problems for selection. The list was revised and it contained the following conditions:

- | | |
|-------------------------------|--------------------------|
| – Acidity (gastric) | – Joint pain |
| – Conjunctivitis (prevention) | – Leukorrhoea |
| – Constipation | – Lice |
| – Cough | – Malaise |
| – Cold | – Parasitic infestations |
| – Dermatitis (fungal) | – Painful menstruation |
| – Diarrhoea | – Piles |
| – Dysentery | – Scabies |
| – Earache | – Sexual dysfunction |
| – Eye discharge | – Sprain |
| – Eczema | – Toothache |
| – Fever | – Urinary disorder |
| – Headache | – Vomiting |
| – Indigestion | – Wound |
| – Jaundice | |

The selected experts from Member States are to write monographs on well-accepted traditional methods of treatment for the above conditions to serve as generic models for countries to develop their own monographs for the use of TM in PHC.

4. FIELD TRIP

On the second day of the meeting, participants had the opportunity to learn more about integration of traditional medicines and modern medicine in DPR Korea at primary, secondary and tertiary levels of health care.

The government owns all health care facilities in DPR Korea. Health care is provided free of charge for both traditional and modern medicines. This system of integration is national policy in DPR Korea as stipulated in the Public Health Law to increase accessibility to health care services.

Diseases are diagnosed with the help of modern technology such as ultrasound, electrocardiogram, electromyogram, echocardiogram, etc., while treatment could be either traditional or modern depending on the disease and the method decided by the doctor.

Treatment coverage by traditional medicine depended on the level of the health facility. At ri (peripheral) level, coverage with traditional medicine is about 70% and about 30% for modern medicine. At the top referral hospital, approximately 30% of the treatment provided was according to traditional medicine and 70%, modern medicine.

Every health facility generally has its own production unit of herbal medicine including extraction and storage units. Herbal medicine is usually prescribed by traditional doctors and traditional drugs (pills, tablets, granules, capsule form) are prescribed by both modern as well as traditional doctors.

4.1 Visit to Wonhwa Ri Hospital, Pyongwon County, South Pyongan Province (Primary Health Care facility)

Wonhwa Ri Hospital is a rural health facility which functions as a basic, front-line health care service. It is located about 40 km from the capital city of Pyongyang and was built in 1974. This peripheral hospital with 10 beds provides services to the farmer and covers approximately 3400 population (about 700 families) in the surrounding area. There are seven medical personnel in this hospital: four doctors, one pharmacist, one dentist, one

dental prosthetist and one midwife. The hospital provides outpatient and inpatient care as well as home visits to follow up on patients.

Services provided to the community are limited to less severe illnesses such as common cold, mild respiratory diseases, gastrointestinal disorders, chronic diseases; normal delivery, prenatal, antenatal and postnatal care. Since this facility does not treat serious cases, they are referred to a higher level of health care facility; either to the district, city or central hospital.

The type of traditional medicine provided by this hospital is acupuncture, moxibustion, cupping and herbal medicines. Around 120 herbal medicinal plants are used by this facility and these plants are cultivated in the hospital area.

4.2 Visit to Taedonggang District Hospital

The visit took place in the afternoon of 23 June 2005. The hospital was founded in 1955 and provides medical service to a population of approximately 270 000. There are about 300 staff employed by the hospital out of which 120 are doctors and 60 are nurses. The hospital has 300 beds. About 200–300 outpatients visit the outpatient department each day.

Services provided by the hospital consists of traditional as well as modern medicine and therapies. The traditional methods of treatment consists of acupuncture, moxibustion, cupping, massage and herbal drugs with more than 100 preparations in the drug list. In contrast, the list of modern medicines are only about 15 in number. The doctors make the diagnosis and may use instruments and equipment of modern medicine such as X-ray, electrocardiogram, etc. Endoscopy was also used for investigation.

4.3 Visit to Pyongyang Maternity Hospital, Traditional Medicine Department

This modern medical service centre with approximately 1500 beds is a comprehensive and one of the top referral hospitals for maternal and child care. It was built in 1982 and was dedicated by President Kim Jong Il for mothers and children. Out of 1500 beds, 650 are allotted for obstetric patients, 350 for gynecology, 500 for infant care and 57 for general medical conditions.

The hospital is furnished with modern medical equipment for treatment, experimentation, drug manufacturing and provides training for medical

workers as well as research. It provides a wide range of maternal and child health care services including delivery, infertility, menstrual disorder, dystonia, chronic inflammatory disease, problems associated with pregnancy and other general health problems in the areas of cardiology, neurology, ophthalmology, dentistry, ear, nose and throat and physiotherapy. The hospital introduces a unique concept of TV communication to substitute direct visit to post-delivery mothers with the aim of avoiding cross-infection.

The hospital also has a separate Department of Traditional Medicine and as in other facilities; most of the traditional methods used are cupping, acupuncture (including electro-acupuncture) and moxibustion. Around 60 traditional drugs are used for treating obstetric and gynaecological diseases. The Koryo Medical Gynecology Department is considered to be a small-scale unit as compared to the overall service of the hospital (about 30% for traditional care as compared to about 70% for modern care).

As in many other health facilities, this hospital also manufactures traditional medicines and has a separate pharmacy for herbal medicine. The production unit for herbal medicine had extraction, sterilization and storage units for both raw materials and finished products. The hospital staff assured that traditional products are routinely subjected to quality control.

4.4 Visit to Academy of Koryo Medical Science

The visit to the Academy of Koryo Medical Science was made in the afternoon of 23 June 2005. The Academy was established in 1962. It covers an area of approximately 20 000 square metres.

It consists of Acupuncture and Moxibustion Research Institute, Basic Medical Science Research Institute, Classical Encyclopaedia Research Institute, and an Information Centre. Medical care service is provided to the people through the application of various Koryo therapeutics based on modern scientific research on acupuncture treatment, moxa therapy, cupping treatment, finger-pressure treatment, dermal treatment, ophthalmic treatment and physiotherapy.

The major tasks of the Academy are modernization of Koryo medicine on a scientific basis and to improve the quality of Koryo medical science to achieve high quality. It has an in-patient capacity of 500 beds. It also has outpatient facility. The Academy trains students to the level of Bachelor, Master and doctorate degrees.

5. GROUP WORK

5.1 Report of Group 1: Priority Issues to Strengthen Development of TM as Part of the National Health System in the Countries of the Region

Group 1 consisted of 14 members, namely: Dr Hakim Ataur Rahman (Bangladesh), Dr Kim Son Mu and Prof. Choe Thae Sop (DPR Korea), Mrs Uma Pillai and Prof. Bhushan K. Patwardhan (India, Chairperson), Drs Ketut Ritiasa (Indonesia), Dr Ahmed Razee (Maldives), Dr Sein Win (Myanmar, Rapporteur), Dr T.R. Adhikari (Nepal), Ms Soma Jayatunge (Sri Lanka), Dr Pramote Stienrut (Thailand), and Dr Krisantha Weerasuriya (WHO) as facilitator.

After comprehensive discussions on the present and immediate future needs of Member countries, the following priority issues or activities were identified.

Policy

Recognition of TM

- Separate department of TM.
- More budget allocation.
- Integrate TM into mainstream health care at all levels.

Protection and preservation of TKDL relating to health

- Creation of digital library for preservation and protection of TM in each country.
- TKDL is an appropriate model, which requires modifications for individual country needs.
- WHO to develop a model framework for initiating country-specific TKDL project.

Safety, efficacy and quality

Evidence base for TM

- An expert working group should be established for evaluating suitable approaches based on long-term, practical usage. This would enhance acceptability of TM at global level.
- An evaluation protocol for clinical efficacy of TM needs to be developed

Guidelines on safety, efficacy and quality

- Development of national pharmacopoeia to ensure quality of TM product.

Access

Recognition of role of TM providers in health care

- Establishment of TM council/academy for registration and regulation of profession

Protection of medicinal plants

- To establish an institutional mechanism such as a national medicinal plant board for proper cultivation and collection of medicinal plants

Rational use

Proper use by providers

- Systematic institutional training on TM to create competent practitioners
- Such training should be a prerequisite for practitioners
- Country cooperation in postgraduate education and research
- Sharing of best practices and experiences in TM for the benefit of larger population
- TM education should be included in modern medicine (medical and para-medical personnel) education
- TM education should be encouraged at appropriate level in school education

5.2 Report of Group 2: Intercountry Priority Activities for Regional Cooperation in Developing TM as Part of the National Health System

Group 2 consisted of 14 members, namely: Dr M. Hayatie Amal (Indonesia), Dr M.S. Baghel (India, Rapporteur), Dr Vichai Chokevivat (Thailand), Ms Ramani Gunawardena (Sri Lanka), Dr Hakim Aatur Rahman (Bangladesh), Dr Ri Hun Jae (DPR Korea), Prof. Qian Jia and Mr Hailiang Zhong (China), Dr Bishnu P. Pandit (Nepal), Dr Md. Abdul M. Sarker (Bangladesh), Dr Thein Swe

(Myanmar, Chairperson), Dr Dorji Wangchuk (Bhutan) and Dr Xiaorui Zhang and Dr Kin Shein (WHO) as facilitators.

After comprehensive discussions on the present and immediate future needs of Member States for intercountry or multicountry collaboration, the priority issues or activities as described in the following table were identified:

Table. Intercountry (IC) or multicountry (MC) activities for Collaboration in the SEA Region

Area of work	S. No.	Description of IC/MC activity	Participating countries in IC/MC
1. Development of TM as part of national health system	1	IC/MC meeting for sharing experiences among countries in the development of TM as part of national health system.	All Member States
2. Increase access to TM of good quality, safety and efficacy for PHC	1	Finalization of guidelines and outlines of monographs for use of TM at PHC level as well as other levels of health care.	All Member States
	2	Exchange of information on good agricultural and field collection practices (GACP).	All Member States
	3	Training workshop on good manufacturing practices (GMP) and good agricultural and field collection practices (GACP).	All Member States
	4	Workshop to develop database on raw materials.	All Member States
	5	Exchange information on registered TM as multicountry activity.	All Member States
3. Promote safety, efficacy and/or quality of TM by expanding the corresponding knowledge base on TM and supporting regulation and quality assurance standards	1	Workshop on development of training guidelines for regulation and quality assurance of traditional remedies.	All Member States
	2	Workshop on strengthening research capability in the area of safety, efficacy and quality of TM.	All Member States

Area of work	S. No.	Description of IC/MC activity	Participating countries in IC/MC
4. Promote therapeutically sound use of appropriate TM by providers and consumers	1	Exchange of information on consumer education system / method on TM.	All Member States
	2	Exchange of information on provider information system.	All Member States
	3	Exchange of information on the control of advertisement / promotion.	All Member States
5. Develop or strengthen and implement national TM policies and programmes based on national priorities	1	IC or MC meeting on national TM policies, guidelines, programmes.	All Member States
6. Develop/ strengthen human resources	1	Regional fellowship and study tour programmes among the Member States.	All Member States
	2	Regional multi-country training programme.	All Member States

6. CONCLUSIONS AND RECOMMENDATIONS

The following were the conclusions and recommendations of the meeting:

6.1 Conclusions

Countries of the South-East Asia Region have a rich heritage of traditional medicine. In keeping with the recommendations of the Meeting of Health Ministers, 2003, inclusion of TM in the national health system is important for strengthening TM in the countries of the Region. This would also facilitate progress towards "Health for All" in the 21st century.

Increased utilization of traditional medicines in the countries of the Region had led to a shortage of some medicinal plants because of over-harvesting or inappropriate collection.

The development of TM depended on the country's history and culture. However, there was lack of databases and information especially relating to

regulation requirements for traditional medicines as well as product information and quality of manufacturers and their good manufacturing practices.

There was also a lack of regional databases on the regulatory situation of traditional medicines, registered traditional medicinal products, registered manufacturers of TM, and information on endangered medicinal plants.

There was a scarcity of resources for development and implementation of national programmes of TM, including research.

6.2 Recommendations

To countries

- (1) Appropriate policies should be formulated and implemented to integrate TM in national health systems. Developing mechanisms such as a Department of TM would facilitate this process.
- (2) Financial resources for implementation of national TM programmes should be increased.
- (3) Traditional medicine knowledge should be preserved and protected through various measures and mechanisms. These could include digital libraries, formularies, monographs, pharmacopoeias and national inventories of medicinal plants.
- (4) Steps should be taken to upgrade the knowledge of TM practitioners. Training programmes for undergraduate students of modern medicine (MM) as well as seminars and lectures on TM for MM doctors and other health care workers should be organized. Encouraging licensed practice of TM would help to ensure adequate standard of practice.
- (5) Sharing of best practices and experiences in training, research and regulation of TM should be carried out.
- (6) Mechanisms should be set up to control inappropriate publicity and advertisement of TM and also to develop and undertake consumer information and education campaigns.
- (7) Appropriate institutional mechanisms such as a national medicinal plant board should be established to encourage proper cultivation and collection of medicinal plants in a sustainable manner including protection of endangered species.

- (8) An evidence base for TM should be developed. This could be done through expert working groups evaluating the already available evidence on safety and efficacy, and developing appropriate protocols for clinical study of efficacy and safety of TM.

To WHO

- (1) Technical support should be provided to increase access to TM of good quality, safety and efficacy for national health systems including PHC and self-medication. Regional monographs on the use of TM for PHC should be prepared as reference for developing national monographs.
- (2) Information exchange should be supported through study tours. Establishment of regional and global databases should be supported.
- (3) A series of regional and inter-regional training workshops should be organized on good agricultural and collection practices (GACP), good manufacturing practices (GMP), pharmacovigilance, and clinical trials.
- (4) A model framework of a traditional knowledge digital library suitable for adaptation to individual countries should be developed.

Annex 1

ADDRESS BY THE REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

I have great pleasure in conveying greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, who would have liked to attend this important meeting. However, due to urgent commitments elsewhere, I am honoured to deliver his inaugural address. I quote:

“With great pleasure, I welcome you all to this Regional Consultation. I would like to take this opportunity of thanking His Excellency, Dr Kim Su Hak, Minister of Public Health, and his Ministry for hosting this important meeting.

As we are all aware, Member States of WHO’s South-East Asia Region have a rich heritage of traditional medicine. Recognizing the key role of this system of medicine in the provision of health care today, the Health Ministers of our Region discussed the subject at their 21st Meeting in 2003. The Ministers agreed that traditional system of medicine should be included as part of the national health care systems. They also emphasized that to ensure undisputed health benefit to the patient, the patient’s safety must be the overriding consideration while using the traditional remedies.

The WHO Regional Committee for South-East Asia, at its fifty-seventh session in 2004, recognized that traditional system of medicine had played a vital role in contributing to health care in the Region. With the view to promoting a wider use of traditional medicine, the Regional Committee urged Member States to collaborate among themselves in information exchange as a first step, and in the development of human resources.

Subsequently, a meeting of the Working Group on Traditional Medicine was convened by the Regional Office last year. To enhance the effectiveness of traditional medicine, the group recommended, among others, the development of evidence-based information on their quality, efficacy and safety. The group also called for collaboration by Member States in research, evaluation and development in this important area. As a follow-up of the above recommendations, I decided to convene this consultation, with the general objective to reiterate WHO’s policy to promote the use of traditional medicines in primary health care, with the assurance of their health benefits and patient’s safety. I am very happy to see the keen interest and the broad participation of the concerned nationals from several countries in our Region.

WHO estimates that about one-third of the world's population does not have access to essential medicines. In the poorest parts of Africa and Asia, this figure is over 50%. Therefore, in order to improve access to basic health care services, especially for the poor, underserved, and indigent sections of the population, traditional medicines should find a proper place in the national health care systems. This approach will promote the required complementarity between traditional and the modern systems of medicine.

To use traditional medicines effectively, various therapeutic claims need to be carefully assessed, keeping in mind socio-cultural foundation of the system in individual countries. The methodologies used in such an assessment therefore need to be specially designed and properly applied. When integrating traditional system of medicine in the national health care systems, it is important to train traditional practitioners, so that they can successfully adapt and become a part of the environment of overall health care delivery. At the same time, health care personnel practising modern medicine should also be appropriately exposed to traditional medical practice, in order to appreciate its important role in the national health care system. It is necessary to emphasize in this connection, a need for complementary systems of medicine, whereby collective efforts towards good health and well-being of all people can be ensured.

The use of traditional medicines in primary health care is an appropriate step to ensure the realization of health for all in the most cost-efficient and cost-effective manner. The role that WHO can play in such a process would be to assist Member States in various key areas, such as:

- Identification of common illnesses or diseases that can be treated at the primary health care level with the use of traditional remedies;
- Careful assessment of health benefits and patients' safety of such remedies.
- Preparation of a list of appropriate, safe and effective traditional remedies for use in the treatment of common ailments.
- Setting up of an appropriate training programmes on traditional systems of medicine.
- Promotion and support in the establishment of an appropriate national mechanism for policy and regulatory guidance and coordination in the development and use of traditional systems of medicine.

We have to ensure that traditional systems of medicine are socially recognized and culturally acceptable among population groups, in order to facilitate their assimilation as an integral part of a comprehensive national health care setting. There is a need for collecting and updating information on human resources in the field of traditional systems of medicine available in individual countries. In addition, conditions, ailments and diseases that were successfully treated by using traditional remedies should be duly recorded. These in turn should be reviewed and assessed to facilitate the preparation of important sources of information, such as a formulary or pharmacopoeia.

Human resource development is certainly a highly important aspect in the area of traditional system of medicine. A vital consideration in this regard is to develop human resources with basic skills that can contribute to improving health conditions based on an ethically sound professional practice. At the same time, harmful practices must be identified and curtailed.

This can be achieved, among others, through education of the community, and through appropriate regulation. Proper use of traditional remedies is becoming more important with the increasing use all over the world of medicinal plants. Therefore, in promoting therapeutically sound use of appropriate traditional remedies WHO is assisting Member States in the development and protection of their herbal plants. In this regard, WHO, in collaboration with the World Conservation Union and World Wildlife Fund for Nature, has provided guidelines on conservation and sustainable use of medicinal plants. Furthermore, biodiversity should be preserved; extinction of endangered species, and destruction of natural habitats and sources of herbal medicines must be prevented.

I have attempted to suggest a number of ways to facilitate further development of traditional medicine for more effective use in our Region. What Member States may do in this connection is to give due attention to these issues and pursue them within the framework of their overall national health development.

Whatever attempts are being made towards the effectiveness of traditional systems of medicine, we must always be aware that this system is an integral part of socio-cultural heritage, handed down for generations. Traditional systems of medicine are a part of people's lives; it is really a specific domain for individual countries and social or ethnic groups. The transfer of knowledge and practice in traditional medicine is therefore a real challenge indeed. At the same time, we have to keep in mind that traditional

systems of medicine that we are dealing with today are mostly confined within the area of herbal remedies. The whole gamut of traditional systems of medicine is much more complex, particularly its social and cultural dimensions. The value of traditional systems of medicine in many cases is still beyond proof by any scientific means today.

We may not always be able to treat traditional system of medicine in the same way as we do in the modern system of medicine, which is developed on the basis of scientific findings and discovery. Therefore, efficient and effective use of traditional systems of medicine along with modern system of medicine is really challenging.

In conclusion, I wish you every success in your deliberations and a very productive meeting.

I look forward to your conclusions and recommendations for our further actions.

WHO is ready to provide the required support to ensure more effective use of traditional system of medicine in our countries.

Finally, ladies and gentlemen, let me wish you all a very pleasant stay in Pyongyang." Unquote.

I will, of course, inform the Regional Director on the outcome of this meeting including its conclusions and recommendations.

Before concluding, I too would like to welcome you all to this meeting and to wish you fruitful deliberations.

Thank you.

Annex 2

INAUGURAL ADDRESS BY THE VICE MINISTER, MINISTRY OF PUBLIC HEALTH, DPR KOREA

(This translated version was provided by the Ministry of Public Health,
DPR Korea)

Dear delegates, ladies and gentlemen,

I would like to start my speech by expressing once again our hearty welcome to all of you who came to our country to participate in this consultation.

I consider it a great pleasure to host the WHO Regional Consultation on Development of Traditional Medicine in Pyongyang, capital of the Democratic People's Republic of Korea, under the great expectation and attention of global traditional medicine experts. We would like to express our appreciation to Dr Samlee Plianbangchang, Regional Director, the WHO Regional Office and the staff of WHO office in DPR Korea for their active support in hosting this consultation.

This consultation, convened following the recommendation of WHO for encouragement and development of the traditional medicine on the global scope, will share the precious achievements and experiences gained in the development, utilization and research in traditional medicine in the different countries of the Region. This would contribute considerably to the implementation of the "Declaration on health promotion in the South-East Asia Region in the 21st Century".

I want to be sure that this consultation will serve as an important opportunity in introducing you to each other, successes and experiences achieved in adapting to the modern setting on scientific basis, legacies of traditional medicine practices evolved through long histories of each country. This will also facilitate the development of each country's medical science.

The South-East Asia Region is enjoying favourable reputation globally for its effectiveness and promising future in the field of traditional medicine because of significant efforts directed by the regional countries for the development of their traditional medicines.

DPR Korea is pursuing its government's unchangeable policy of promoting traditional medicine in a well-balanced combination with modern medicine, and updating it in accordance with contemporary needs.

In DPR Korea, the Academy of Koryo Medicine is involved in research activities to make traditional medicine scientific. The Faculty of Koryo Medicine in the medical universities of the country including Pyongyang Medical University are training traditional practitioners and pharmacists, while provincial Koryo medicine specialized hospitals and Koryo medicine departments of the hospitals and clinics in the city/county and ri (peripheral) levels are providing medical services in Koryo medicine.

Our country is giving great importance to the interests of popular masses and considers human being as most valuable and spares nothing for their life and health. All traditional medicine and modern medicine services are free of charge.

We are now strengthening, and continuing to expand and foster collaboration and exchange of information in the development of traditional medicine with other countries.

I hope this Consultation will acquire precious experiences for health promotion of the people, upgrading traditional medicine to a higher level, which is in line with the current requirements and having many successful outcomes.

Thank you.

Annex 3

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Annex 4 PROGRAMME

22 June 2005 (Wednesday)

- 08:30 – 08:55 hrs **Registration**
- 09:00 – 09:45 hrs **Opening Session**
Welcome Address
by Dr Pak Jong Min, Director, Department for External Affairs, Ministry of Public Health, DPR Korea
Opening Address of Dr Samlee Plianbangchang
Regional Director, WHO Regional Office for South-East Asia
Inaugural Address
by Professor Dr Choe Chang Sik, Vice Minister, Ministry of Public Health, DPR Korea
- 10:15 – 11:15 hrs **Business Session**
Plenary Session 1: Introduction of participants and nomination of office bearers
Plenary Session 2: Technical presentations
Global and regional perspectives on development of traditional medicine *by Dr Xiaorui Zhang*
Regional Strategic Framework for the Development of TM: Regional Advisory Group on TM in SEAR *by Dr Krisantha Weerasuriya*
- 11:15 – 12:30 hrs **Theme 1: Integration of traditional medicine in the national health system**
Development of traditional medicine as part of the national health system in DPR Korea
*by Dr Ri Hun Jae, Dr Kim Son Mu and Prof. Dr Choe Thae Sop**
The use of traditional medicine in the Thai health care system
by Dr Vichai Chokevivat, Dr Anchalee Chuthaputti and Dr Pvana Khumtrakul*
The use of traditional medicine in primary health care in Sri Lanka
by Ms H.M.S. Jayatunge and Ms R.P.W. Gunawardhana*
The network of traditional medicine services in Nepal
by Dr Bishnu P. Pandit and Dr Thakur R. Adhikari*

- 13:30 – 14:10 hrs **Theme 2: Public and private sectors in TM development**
Case management facilities in Bangladesh: Public and private roles in traditional medicine *by Dr Hakim Atur Rahman* and Dr Md. Abdul Mannan Sarker*
Traditional medicine and regulation in Indonesia *by Dr M. Hayatie Amal, Dr Niniek Soedijani and Drs Ketut Ritiasa**
- 14:10 – 14:50 hrs **Theme 3: Production of traditional medicine**
Herbal gardens and cultivation of medicinal plants in Myanmar *by Dr Thein Swe* and Dr Sein Win*
Sustainable manufacturing of TM in Bhutan *by Mr Dorji Wangchuk*
- 14:50 – 15:30 hrs **Theme 4: Capacity building in traditional medicine: Education and research**
Traditional medicine education in India *by Mrs Uma Pillai* and Dr M.S. Baghel*
Documentation of Traditional Medicine Knowledge: Digital Library of India *by Mr V.K. Gupta*
- 15:50 – 17:00 hrs **Group Work Sessions**
Introduction to Group Work *by Dr Kin Shein*
Group 1: Identification of country priority activities to strengthen development of TM as a part of the national health system in countries of SEAR (Including Drafting of Overall Conclusions and Recommendations)
Group 2: Identification of inter-country priority activities for regional cooperation in developing TM as a part of the national health system where SEARO assistance is needed and preparing an outline of inter-country work plan (Including Drafting of Overall Conclusions and Recommendations)

23 June 2005 (Thursday)

08:00 hrs onwards Field Trip on Koryo Medicine

24 June 2005 (Friday)

- 09:00 – 10:00 hrs **Theme 5: Traditional medicine and Health for All**
Traditional medicine: A novel approach for available, accessible and affordable health care *by Professor Bhushan K. Patwardhan*
Traditional Medicine and "Health for One" *by Professor Qian Jia*
Presentation and discussion on proposal for preparation of monographs on the use of traditional medicine in primary health care *by Dr Kin Shein*

- 10:00 – 10:30 hrs **Group work sessions (Continued)**
Including drafting of overall Conclusions and Recommendations
- 10:50 – 12:30 hrs **Group work sessions (Continued)**
Including drafting of overall Conclusions and Recommendations
- 13:30 – 14:30 hrs **Plenary session 3: Presentation of group work**
Including drafts of overall Conclusions and Recommendations
- 14:30 – 15:10 hrs **Final review of Conclusions and Recommendations**
- 15:30 – 16:00 hrs **Closing Session**
Congratulatory speech *by Professor Dr Choe Chang Sik, Vice Minister, Ministry of Public Health, DPR Korea*
Remarks on behalf of the Participants *by Dr M.S. Baghel*
Closing address *by Dr Eigil Sorensen, WHO Representative, DPR Korea*
Final remarks and closing of the meeting *by Prof. Dr Choe Thae Sop, Chairperson, DPR Korea*

* Presenter

Annex 5

CONGRATULATORY AND CLOSING ADDRESS BY PROFESSOR DR CHOE CHANG SIK, VICE MINISTER, MINISTRY OF PUBLIC HEALTH, DPR KOREA

(This translated version was provided by the Ministry of Public Health,
DPR Korea)

The WHO Regional Consultation on Development of Traditional Medicine, which took place in Pyongyang, DPR Korea with close attention of the people and health workers of the Region, is closing today. I would like to thank all of you for your contributions in achieving great success for this consultation.

This consultation was a significant opportunity, which will bring innovative improvement in the development of traditional medicine in the South-East Asia Region, while strengthening the ties of cooperation between Member States in the promotion of health in the Region through traditional medicine.

We came to find the basic key to achieve WHO strategic goals in the development of traditional medicine.

I sincerely appreciate the staff of WHO/SEARO and the delegates of the regional countries for all their efforts for the success of this consultation, and congratulate you all at the same time.

Many precious experiences have been gained by the countries of the Region in the development of traditional medicine. They have been exchanged and approaches for further development of traditional medicine in line with the WHO strategic objectives in the Region have been discussed in detail in this consultation.

All participants unanimously acknowledged that traditional medicine, as a national legacy, is an excellent therapy suiting the physical features of the people. It is one of effective methods to improve the health status of the population with limited funds. At the same time, they agreed that abundant resources of traditional medicine could be easily utilized free from side-effect, but still be an effective and practical traditional therapy, which could be incorporated broadly in national health activities and medical services, contributing to health protection and promotion of the people.

The meeting also discussed the difficulties and challenges encountered in the development of traditional medicine; confirmed priority issues to be focused in eliminating difficulties in developing TM.

I once again thank all of you for good discussions and contributions to this meeting to make it a success.

Let me end my speech with sincere wishes for further success in your activities for the implementation of the issues discussed this consultation.

Thank you.

Annex 6

LIST OF DOCUMENTS AND TECHNICAL PAPERS

Name of document	Document no.
Provisional Agenda	Document no. 1
Provisional Programme	Document no. 2
Objectives and expected outcomes	Document no. 3
List of Participants	Document no. 4
Background Papers	
(a) Review of traditional medicine in the South-East Asia Region – Report of the Regional Working Group Meeting, New Delhi, India, 16-17 August 2004	Document no. 5
(b) List of reference and reading materials	
Country and Technical Papers	
Global and regional perspectives on development of traditional medicine <i>Dr Xiaorui Zhang</i>	Document no. 6
Regional strategic framework for the development of TM: Regional Advisory Group on TM in SEAR <i>Dr Krisantha Weerasuriya</i>	Document no. 7
Development of traditional medicine as part of the national health system in DPR Korea <i>Dr Ri Hun Jae, Dr Kim Son Mu and Prof. Dr Choe Thae Sop</i>	Document no. 8
Use of traditional medicine in the Thai health care system <i>Dr Vichai Chokevivat, Dr Anchalee Chuthaputti and Dr Pavana Khumtrakul</i>	Document no. 9
Use of the traditional medicine in primary health care in Sri Lanka <i>Ms H.M.S. Jayatunge and Ms R.P.W. Gunawardhna</i>	Document no. 10

Network of traditional medicine services in Nepal <i>Dr Bishnu P. Pandit and Dr Thakur R. Adhikari</i>	Document no. 11
Case management facilities in Bangladesh: Public and private roles in traditional medicine <i>Dr Md. Abdul Mannan Sarkar and Dr Hakim Ataur Rahman</i>	Document no. 12
Traditional medicine and regulations in Indonesia <i>Dr M. Hayatie Amal, Dr Niniek Soedijani and Drs Ketut Ritiasa</i>	Document no. 13
Sustainable manufacturing of traditional medicine in Bhutan <i>Mr Dorji Wangchuk</i>	Document no. 14
Research and evaluation of traditional medicine <i>Professor Ranjit R Chaudhury</i>	Document no. 15
Documentation of traditional medicine knowledge: Digital library of India <i>Mr V.K. Gupta</i>	Document no. 16
Traditional medicine: A novel approach for available, accessible and affordable health care <i>Professor Bhushan Patwardhan</i>	Document no. 17
Traditional medicine and "Health for One" <i>Professor Qian Jia</i>	Document no. 18
Proposal for preparation of monographs on the use of traditional medicine in primary health care <i>Dr Kin Shein</i>	Document no. 19
Herbal gardens and cultivation of medicinal plants in Myanmar <i>Dr Thein Swe and Dr Sein Win</i>	Document no. 20
Traditional medicine education in India <i>Mrs Uma Pillai and Dr M.S. Baghel</i>	Document no. 21