Virtual Regional Consultation on Indicators for Monitoring Traditional and Complementary Medicine System Performance for the WHO South-East Asia Region

New Delhi, India, 26–28 July 2021
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Acronyms

ADR : Adverse Drug Reaction
AE : Adverse Event
UHC : Universal Health Coverage
TRM : Traditional Medicine
SEARO : South-East Asia Regional Office
DHIS2 : District Health Information Software version 2
CCRAS : Central Council for Research in Ayurvedic Science
AYUSH : Ayurveda, Yoga, Unani, Siddha and Homeopathy
ICD-11 : International Classification of Disease-11
ICD-10 : International Classification of Disease-10
DRA : Drug Regulatory Authority
PHC : Primary Health Care
MoH : Ministry of Health
MOHP : Ministry of Health and Population
AHMIS : Ayurveda’s Health Management Information system
HDC : Health Data Center
HDC TTM : Health Data Center for Thai Traditional Medicine
TT&CM : Thai Traditional and Complementary Medicine
NLEM : National list of Essential Medicine
TTM : Thai Traditional Medicine
MoPH : Ministry of Public Health
DTAM : Department of Thai Traditional and Alternative Medicine
SCORE : Survey populations and health risks (S), Count birth, deaths, and causes of death (C), Optimize health service data (O), Review progress and performance (R), and Enable data use for policy and action (E)
1. Background

In 2014, the World Health Organization (WHO) endorsed the WHO Global Traditional Medicine Strategy 2014-2023 with the goals of harnessing its potential to contribute to people’s health and wellness and of promoting the safe and effective use of traditional medicines and practices towards the achievement of universal health coverage (UHC) by regulating traditional medicine (TRM) products, practices, and practitioners. Thereafter, the WHO South-East Asia 67th Regional Committee adopted the regional resolution on traditional medicine, where all Member States agreed to adopt and implement the WHO Global TRM Strategy, and the Delhi Declaration on TRM was adopted by the Member States at the international conference held in New Delhi in February 2013.

To support the Member States in implementing them, the WHO South-East Asia Regional Office (SEARO) organized a regional workshop on TRM and identified the regional TRM action points. As per the action points, the WHO SEA Regional TRM program carried out several activities and succeeded in developing a set of standard core and reference indicators and their metadata in 2017 and tested them in four SEA Member States (Sri Lanka, Bhutan, Myanmar, and Thailand). Data was collected and analyzed using DHIS2 and a report was prepared with tables, graphs, and dashboards showing data trends and country comparisons. The development of a DHIS2 platform for TRM will further serve as the foundation for the establishment of a TRM-specific WHO South-East Asia regional TRM portal.

To further support countries’ efforts to monitor their TRM system performance, WHO SEARO updated and expanded the TRM indicator set into a monitoring framework. This framework identifies health systems inputs (governance, financing, infrastructure, health workforce, TRM products and resources, information, and research) critical for ensuring that TRM services are available, are of quality and are safe. The framework also includes metrics for measuring TRM service utilization and coverage as well as patient satisfaction with TRM services and outcomes. Additionally, WHO SEARO developed other monitoring tools to improve country indicator data reporting and access. A DHIS2-based data collection tool and database have been developed and a set of country TRM dashboards have been designed to improve data accessibility and aid decision-making.

To discuss and reach consensus on the developed framework, indicators and their metadata, data collection tools, and dashboards, this consultation was organized in July 2021 virtually given the current COVID-19 pandemic.

2. Opening session

The inaugural address of the Regional Director for WHO South-East Asia, Dr Poonam Khetrapal Singh, was delivered by Mr Manoj Jhalani, Director for the Department of Health Systems Development at SEARO. The Regional Director welcomed the participants to this virtual regional consultation on TRM system performance monitoring for South-East Asia. She highlighted the active role of TRM in the lives of individuals,
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communities, and cultures across the South-East Asia Region, and many years of efforts of the Member States in leveraging the power of TRM for achieving UHC. She emphasized that 10 of the Region’s Member States have national policies on TRM, nine have formal training and education systems for TRM practitioners. Six Member States have co-located TRM services in their health systems at some or all levels, and five Member States have a national essential drug policy on traditional medicine products and include traditional medicine products in their national essential drug list. Dr Singh also underscored the expanded use of traditional medicine globally over the past two decades, gaining significant popularity including in developed countries. A reason for this is the dramatic increase in the number of people with chronic noncommunicable diseases (NCDs) for which TRM has great potential to promote health and to prevent and manage these diseases. She reiterated that TRM can only deliver on its potentials if it was safe, equitably accessible, responsive to needs, and effective in improving health outcomes. Robust information systems for TRM are needed to generate accurate and timely information that will allow policymakers to formulate national policies and programmes that will help ensure the equitable distribution of skilled traditional medicine practitioners, the adequacy and appropriateness of financing mechanisms for affordable traditional medicine services as well as the delivery of quality and safe traditional medicine services. She highlighted also the progress in the recent years in monitoring TRM system performance by WHO SEARO such as the development of a standard set of indicators and their metadata for monitoring TRM systems, a DHIS2-based database and WHO Regional TRM portal. Dr Singh further stated that the efforts to be made during the three-day consultation will build momentum in the field of TRM monitoring and reiterated WHO’s full support in achieving health and well-being for all people at all ages (see Annex 1 for full text of the address).

Following Dr Singh’s speech, Dr Kim Sung Chol, WHO SEARO Regional Adviser for Traditional Medicine, provided an overview of the consultation and shared the objectives and expected outcomes. Dr Kim mentioned that, given the wide use of TRM in the Region, monitoring TRM system performance assumes significance. He reiterated the request from Member States to WHO to provide technical support in strengthening monitoring of TRM system performance. He added that strengthening of TRM monitoring systems will further improve TRM system performance, and the Member States need to be provided with technical guidance in the use of the monitoring framework, standard indicator and their metadata and tools. Dr Kim welcomed the Member States’ collaboration and suggested that the robust cooperation at regional and international levels be continued for information exchange on monitoring and evaluation systems on TRM system performance. The session concluded with the hope that the discussions and agreements over the three-day consultation will provide technical guidance on the framework for monitoring TRM system performance and ways forward for enhanced regional and global collaboration on TRM system performance monitoring.

Prof. Kartar Singh Dhiman, former Director General of CCRAS (Ministry of AYUSH, Government of India), was nominated as the moderator, and Dr. Azeem Ahmed, Researcher of CCRAS (Ministry of AYUSH, Government of India), as rapporteur. Both were unanimously accepted by the consultation participants.
3. **Objectives of the meeting**

3.1 **General objectives**

The general objective of the consultation was to strengthen country systems for monitoring TRM performance in the South-East Asia Region.

3.2 **Specific objectives**

The specific objectives of the consultation were to:

1. Share country experience on monitoring TRM system performance,
2. Update the regional indicators and metadata for monitoring TRM system performance, and
3. Introduce the features and discuss the next steps for the finalization and deployment of tools for data collection, access, and visualization, namely the DHIS2-based data entry platform, WHO SEARO indicator and data portal, and TRM dashboards.

4. **Highlights of the Meeting**

4.1 **Monitoring of country traditional medicine system performance**

Each Member State provided an overview of their country’s system for monitoring TRM system performance including on the data and information flow, main indicators used, best practices, and main data challenges and feasible solutions. Countries also shared the role of TRM in delivering essential health services, responding to the COVID-19 pandemic, and augmenting the health system’s human resources needs.

India also shared their experience in implementing the National AYUSH Morbidity and Standardized Terminologies Electronic portal and contributing to the development of the ICD-11 TRM module. Thailand also provided an overview of their Health Data Center on Thai Traditional Medicine.

**Bangladesh.** TRM is one of the primary sources of healthcare in the country. Ayurveda, Unani, Herbal Medicine and Homeopathy are the TRM systems recognized by the government. There is one traditional medicine healer for every 1847 population while the ratio of medical doctor to population is 1:6579. As such, native healers are the health providers for millions of people in rural areas.

TRM system has been integrated into the health delivery system particularly at district, primary and secondary levels. TRM is also integrated into the National Health and Drug Policy. There are national formularies available for Ayurveda and Unani and drug delivery is regulated under the Drug Control Ordinance 1982. The Director General for drug administration has a separate cell that monitors the quality, safety, and efficacy of TRM formulations.
The TRM system regulation and monitoring is still at a nascent stage. A big challenge faced is the lack of opportunity of higher education and training facilities for skills upgrading. There is also limited representation of TRM practitioners or experts in national regulatory bodies. The country does not have any appropriate mechanism to regulate TRM practices and providers and monitor TRM drug safety. There is no proper financial allocation for TRM in the national budget. The paucity of financial support for TRM research is also a major concern. There is a lack in the dissemination of information to the public on the use of TRM. The functional integration of TRM in all health care levels is also lacking.

To address these challenges, the country recognizes the need to develop national policies and guidelines to promote the safe and effective use of TRM and to integrate TRM into the public health care delivery system. To improve TRM education, the country seeks to improve its education system and develop regulations on the quality, quantity, accreditation, and education structures for TRM practitioners. To improve research on TRM, the country proposes to set up research institutes and increase the allocated budget for TRM research.

Bhutan. TRM services are fully integrated into the health care delivery system at all levels. TRM practice and professionals are regulated by the Bhutan Medical and Health Council and TRM products by the Drug Regulatory Authority (DRA). The indicators used for monitoring TRM system performance include outpatient visits per capita, percentage of essential traditional medicines available at health facilities at any point of time, number of health centers providing TRM services, number of new services introduced in TRM, number of Dzongkhags with two Drungtshos, number of indigenous knowledge and practice on TRM documented and promoted, number of Sorig wellness services facilitated, TRM units providing Zheyney and spiritual care services, number of Institutional linkages built for research and innovation, number of medicinal resources preserved and promoted, TRM units reporting through DHIS2, number of researches on TRM conducted, number of TRM standards and guidelines developed, number of collaborative fora conducted among TRM and allopathic practitioners, and TRM units engaged in providing health promotional activities.

During the COVID-19 pandemic, TRM services were provided as part of essential health services. TRM human resources were engaged as frontline staff in quarantine centers and were engaged in surveillance activities, logistics management and vaccine rollout. They were not engaged in case management.

Some of the best country practices for TRM include monitoring of the workload of TRM practitioners through annual performance agreements and individual work plans, monitoring of TRM products (stocks, indent, requisition, expiry, supply, and distribution) through the Electronic Bhutan Medical Supply System, and the regulation and quality assurance of TRM products through the Bhutan DRA and Internal Quality Inspection team. Bhutan also provides free access to basic public health services including modern and traditional medicines. The National Collaboration Committee for Integration, comprised of both allopathic medical and TRM practitioners, was formed to oversee the activities and for better planning. All health-related data are monitored and recorded through their health management information system.
Democratic People’s Republic of Korea. TRM (Koryo medicine), along with modern medicine, actively contributes to the promotion of health and the prevention and management of diseases through its 230 hospitals (including central, provincial, municipal, and county hospitals) and 20 specialty hospitals. The Koryan system of medicine is integrated into the national health care system and services.

Indicators related to patient flow include number of outpatients, number of inpatients, number of hospitalizations, number of discharges, number of severe patients, number of urgent/emergency visits, number of emergency hospitalizations, number of operations performed, number of emergency surgeries performed, number of mortalities (both inpatient and outpatient). Data are summarized bi-annually and submitted to the Ministry of Public Health (MoPH). The most important indicators to monitor TRM performance include quality and safety of TRM services and products, service coverage, patient outcomes, and patient satisfaction.

The government intends to consistently integrate TRM with modern medicine and plan to increase the share of TRM in the delivery of preventive and therapeutic services. The country also ensures the quality and safety of TRM products, measures TRM contributions to UHC, measures the workload of TRM practitioners, and uses data for decision-making on policies, strategies, regulations, plans, and budget.

India. India has a pluralistic system of medicine with the traditional and complementary systems inclusive of Ayurveda, Unani, Sowa-Rigpa, Siddha, Homoeopathy, and Yoga, and Naturopathy. These are regulated by the Indian Medicine Central Council Act 1973. Monitoring TRM system performance includes indicators on TRM integration into the health system, financial protection for access and use of TRM services and products, quality and safety of the TRM services and products, TRM service coverage, and patient outcomes and satisfaction. These were based on the 2017 WHO core and reference indicators for monitoring traditional and complementary medicine in South-East. Data is available from the AYUSH in India, an annual publication by the Ministry of Ayush.

Total Health expenditure in India was 306.99185 million USD in 2018-19. There are 40,266 hospitals and clinics that offer TRM services. India has a national body to oversee TRM-related research and the TRM regulated practitioner density is 0.302. All TRM manufacturers are GMP-certified and all states have state licensing authorities to regulate this. A pharmacovigilance system exists to monitor the quality and safety of TRM products.

Education and training in TRM are regulated by the National Commission for Indian System of Medicine Act and the National Commission for Homeopathy Act. TRM is reflected in the national health sector plan and adequate funding is allocated in the national budget for TRM. Functional integration of TRM and modern medicine is present, and services are made available through 10,872 hospitals and clinics at primary, secondary, and tertiary tiers. India has 581,157 licensed TRM practitioners. The budgetary allocation for TRM research by the Government of India is 167.837112 million USD and it is conducted through 92 research institutes/centers. There are 31,975 peer-reviewed TRM scientific publications available in the AYUSH research portal. Two guidelines are available for agricultural and collection practices while 2,253 monographs are published for herbal raw materials. There are 1,863 products with pharmacopoeia or monograph. TRM services are included in the essential health services and include National Health Mission and working towards UHC for TRM.
Ayush services are utilized to the full extent in the prevention, treatment, and post COVID-19 care along with standard care across the country, enabling delivery of essential health services during the COVID-19 outbreak.

The best practices in TRM in India include monitoring of TRM practitioner stock level and workload of TRM practitioners, monitoring of TRM products availability, consumption and demand, ensuring the quality and safety of TRM products, ensuring and expanding TRM financial protection, measuring TRM contributions to UHC, TRM integration into health care delivery system, and using TRM data for decision making including policy, strategy, regulation, plan, and budget.

Some of the challenges faced by the TRM program include access to remote areas (this is being addressed through telemedicine and customized programs through the involvement of local communities), low awareness in marginalized sections and remote tribal pockets (being addressed by using specialized outreach activities such as the National Programme for Prevention and Control of Cancer, Diabetes, CVD, and Stroke), and mainstreaming health policy of AYUSH (being addressed through National Health Mission, and National Ayush Mission).

**Indonesia.** The legal basis for TRM services in Indonesia is Government Regulation No. 103 of 2014. It regulates the implementation of TRM services, human resources, and other aspects related to the development of empirical traditional health services, traditional complementary health services, and integration of traditional health services in health centers and hospitals.

In Indonesia, primary health care (PHC) units collect TRM data from communities/families, PHC networks, and Health Service Facility networks. Data from PHC units and hospitals are submitted to the district health offices, then to the provincial health offices, and then submitted to the Ministry of Health (MoH). Data from the Health Care and Social Security Agency and cross sectors are also submitted to the MoH.

TRM contributes to the delivery of essential health services by encouraging promotive and preventive efforts. During the COVID-19 pandemic, TRM was used to help increase the body's resistance to the disease.

The quality and safety of TRM services and products are monitored under the Director General of Pharmaceutical and Medical Devices Development and National Agency of Drug and Food Control. Indicators for monitoring financial protection, TRM service coverage, and patient outcomes and satisfaction are currently not available in the country.

Monitoring of TRM services is performed by the MoH through the provincial and district health offices, which aims to (a) ensure that the policies being implemented are in accordance with the goals and objectives, (b) find faults as early as possible thereby reducing greater risk, (c) take action to modify the policy if the monitoring results require it, and (d) use monitoring results as input for developing or implementing policies.

Challenges in TRM are the unavailability of data in electronic format, limited resources, limited data accessibility, and limited collaboration with research institutions and other sectors to conduct TRM surveys. Feasible solutions are to transform TRM data into electronic
format, conduct trainings to increase human resource capacity in data processing, create an integrated health information system, and improve the quality of researchers.

**Maldives.** TRM has a long history in the country but the TRM practice is at a very rudimentary level with no proper mechanisms in place for practice and research. There is currently no official mechanism for the regular monitoring of the TRM system performance. The country recognizes the importance of having indicators and data to measure TRM integration into the health system, financial protection, quality and safety of the TRM services and products, TRM service coverage, and patient outcomes and satisfaction.

TRM practitioners have not been officially involved in the COVID-19 response in any capacity. However, some TRM practitioners prepared syrups and capsules that were allegedly useful to combat the symptoms of COVID-19.

The TRM program is challenged by the lack of formally educated TRM practitioners, education and training for TRM providers, mechanism to monitor the safety of TRM practice, research data, and mechanisms to monitor the safety of TRM products including herbal medicines. Feasible solutions to these challenges include providing opportunities for formal trainings in TRM, establishing a mechanism for continuing professional development, establishing best practice guidelines and regular monitoring to ensure these guidelines are adhered to, ensuring that all TRM providers are registered, establishing a regular monitoring mechanism, establishing a proper research facility, and ensuring the safety of TRM products including herbal medicines through research and monitoring.

**Nepal.** The country has two parallel systems of medicine: the Allopathic Medical System and Ayurvedic Medical System. Nepal has one central Ayurveda hospital, one regional Ayurveda hospital, 75 district and zonal level Ayurveda health centers, and 305 local level Ayurveda Aushadhalaya (health centers or dispensaries). The country has national policies and directives that include TRM (Nepal Health Policy 2019, Nepal Health Sector Strategy, Ayurveda Health Policy 1995, and Public Health Act 2019). Ayurveda and alternative medicine is part of the basic health services, which is free for all Nepalese citizens.

There are 75 district-level and 523 local-level TRM service provider centers that deliver essential health services. Six TRM system isolation centers and 598 district-level and 523 local-level TRM service provider centers responded to the COVID-19 pandemic by providing immune-booster Ayurveda medicine, yoga, and psychosocial counseling. An open-level clinical trial for the management of COVID-19 was conducted by the Nepal Health Research Council.

Some of the program’s best practices include: (a) the use of TRM data by the Department of Ayurveda and Alternative Medicine under the Ministry of Health and Population (MOHP) for decision-making including on policy, strategy, regulation, plan, and budget, and (b) existence of a national adverse event reporting system for T&CM products under the Department of Drug Administration under the MOHP to ensure the quality and safety of TRM products.

DHIS2-based Ayurveda management information system (AMIS) is in the development phase. Data flows from the local level health section to the provincial level health
directorates, then to the federal level – first at the Department of Ayurveda and Alternative Medicine and then to MOHP.

Since the AMIS was only recently developed, not all of the WHO SEARO TRM core and reference indicators have been incorporated. It only provides limited data for service indicators and makes evidence-based decision-making difficult. The country needs to upgrade the AMIS software to incorporate other indicators for TRM monitoring and in accordance with country health service needs, as well as build human resource capacity for data entry and analysis. The country also needs to establish a safety monitoring and regulatory mechanism for TRM products.

Sri Lanka. The TRM systems are under the Ministry of Indigenous Medicine Promotion, Rural and Ayurveda Hospital Development and Community Medicine. The TRM medical systems being implemented are allopathic, Ayurveda, Siddha, homeopathy, Unani, and traditional medical systems. In addition, Korean and Chinese acupuncture are also being practiced. The indigenous medical systems in Sri Lanka were established through the Ayurveda Act, No. 31 of 1961. The Department of Ayurveda is the administrative center to carry out the objects of the Act. Nine provincial departments of Ayurveda are responsible for indigenous medicine under the Provincial Council system established in 1988.

The government structures to deliver TRM services are Ayurveda National Hospital, Bandaranaike Memorial Ayurveda Research Institute, National Institute of Traditional Medicine, Sri Lanka Ayurveda Drugs Cooperation, teaching hospitals, research hospitals, provincial hospitals, base hospitals, district hospitals, rural hospitals, central dispensaries, drug production centers, and herbal gardens.

There are four government university institutions for Ayurveda, Sidda, and Unani. Knowledge and skills in traditional medical systems are also given through university education. In 2018, the Post Graduate Institute of Indigenous Medicine for masters, which is under the Central Council of Indian Medicine guideline of India, was established.

In the COVID-19 pandemic response, TRM practitioners provided health education on traditional primary health care prevention measures, promoted traditional preventive medicine among the communities and front-line health workers, distributed traditional medicine to improve body immune system against the disease, managed hospitalized COVID-19 patients, and used Ayurveda remedies in Ayurveda hospitals for minor complaints.

The main challenges faced by the TRM system in the country are integrating TRM into the healthcare delivery system, monitoring TRM system performance (TRM indicators need to be incorporated into the national health information systems and the completeness of TRM indicator reporting needs to be improved), using TRM data for decision-making, measuring TRM contributions to UHC, ensuring and expanding TRM financial protection, ensuring the quality and safety of the TRM products (there is need to establish a national adverse event reporting system for TRM products), monitoring the stock level and workload of TRM practitioners, and monitoring TRM products stock levels, consumption and demand.

The feasible solutions to these TRM system challenges include the development of an integrated decision-making and monitoring system, building a knowledge base for the active
management of indigenous medicine through appropriate national policies, regulating indigenous medicine products, practices, and practitioners, and promoting UHC by integrating indigenous medicine services into the health care service delivery.

**Thailand.** The Health Data Center for Thai Traditional Medicine (HDC TTM) Service is the country’s information system to monitor and evaluate the provision of TRM services in all levels of health service facilities under the MoPH. It records data on health services in all health service facilities. The HDC database provides comparative reports on TRM service between or within regions, provinces, districts, and sub-districts. The data generated are also classified by health facility level, outpatient and inpatient visits, and patients’ health security system. The HDC TTM has five key categories: 1) diagnosis data with TT&CM diagnosis ranking, 2) prescription data that show the top 20 herbal medicines prescribed, the value of herbal medicines, and usage of herbal medicines by age and gender, and usage of herbal medicines in the national list of essential medicines (NLEM), 3) medical treatments by TT&CM modality, 4) health promotion by TT&CM, and 5) the coverage of TT&CM services.

The TT&CM service plan follows a “six building blocks plus” framework. The building blocks are service delivery, workforce, information systems, access to essential medicines, financing, governance, and community engagement. TT&CM services are covered by three health security systems: Universal Health Coverage Scheme, Civil Servant Medical Benefit Scheme, and Social Security Scheme. A total of 86 herbal medicine products are included in the NLEM.

Some key indicators used for monitoring of TRM system performance, specifically TRM service coverage, include the percentage of patients in outpatient and inpatient department visits receiving TT&CM services, the value of herbal medicines prescribed in the outpatient department, number of health facilities providing TT&CM services, per capita budget for TT&CM services, number of herbal medicines in NLEM, and the ratio of TRM doctors per population.

During the COVID-19 pandemic, Thai traditional medical doctors played a prominent role in health promotion and COVID-19 prevention and management. They worked as frontline health workers and were part of multidisciplinary teams battling the pandemic. Potential TTM or folk medicine formulas from classical textbooks were selected to relieve some COVID-19 symptoms. Research (including clinical trial) were conducted to evaluate the efficacy and safety of Fa Thalai Chon to prevent COVID-19 disease progression and shorten viral shedding period. Fa Thalai Chon capsules and TTM formulas for mild COVID-19 patients were distributed to hospitals, field hospitals, and prisons.

The TTM system faces some data challenges. There are missing or incomplete data due to having different reporting systems. Data from the private sector are also lacking. Data recorded under the ICD-10 TTM coding system is quite broad as such TTM doctors are unable to record actual diagnosis nor properly use the information on TTM diagnosis for the future development of TT&CM. To address these data challenges, there is a need to improve and develop the system to be more efficient in compiling the data from different systems. The ICD-10 coding system also needs to be made more specific for the recording of diagnosed diseases and systems according to ICD-10 TTM. More clinical practice guidelines
in TTM for specific diseases should also be developed. Lastly, coordination with the private sector to obtain more TT&CM services data needs to be improved.

**Timor-Leste.** The practice of TRM in the country is quite limited: acupuncture (available in one unit at the national hospital), herbal medicines, traditional Chinese medicines (run by Chinese clinics in the capital), and individual traditional therapeutic massage. Local TRM practitioners include traditional healers, herbalists, and traditional birth attendants (home-based practitioners). The country had an existing national plan to integrate TRM into the national strategic plan. There is no state budget allocated for TRM. The country relies on traditional Chinese medicine donations through bilateral aid. There is no health insurance coverage for TRM but polyclinic treatment for acupuncture at hospitals is free. There is no specific regulatory framework for herbal medicines, complementary medicines, and other similar products.

Data are not available for indicators to monitor TRM system performance including indicators on TRM integration into the health system, financial protection, service coverage, and patient outcomes and satisfaction. Data related to TRM research activities are also not available.

The main challenges faced by the TRM system include the lack of mechanisms and capacities to regulate TRM practices, products, and practitioners, difficulty in integrating TRM with allopathic medicine and into the health service delivery system, including herbal medicines into the NLEM, and lack of TRM research data due to lack of financial support. Possible solutions to overcome these challenges include information sharing, improving the technical capacity of regulatory authority on TRM, strengthening bilateral and regional cooperation on TRM, development of research database, capacity building to integrate TRM into the health service delivery system, and technical assistance to develop guidelines on TRM therapies.

**The National AYUSH Morbidity and Standardized Terminologies Electronic (NAMASTE) portal and the development of ICD-11 for TRM.** The NAMASTE portal is a comprehensive resource for standardized terminologies and national morbidity codes for Ayurveda, Siddha, and Unani systems of medicine. It is also an ICD-10 and ICD-11 resource for TRM. India was instrumental in WHO’s work on terminology standardization and continues to contribute towards the development of the TRM module for ICD-11.

The NAMASTE portal facilitates the implementation of a double coding system (AYUSH and ICD) and provides more real-time statistics. ICD-10 is fully used while ICD-11 is partially used in India’s TRM medical systems.

The NAMASTE portal provides public access to view published statistics and dashboards while authorized users are provided the rights to input data. Monthly, consolidated and time-trend outpatient and inpatient morbidity statistics are available on the portal for each of the TRM medical systems. Data are also disaggregated by age and sex. About 80 hospitals upload or submit their data into the portal. There is also a process for checking and finalizing the data prior to publication for public access, as well as for checking the completeness and timeliness of reporting by the different health facilities. The portal
currently holds 5-6% of the national TRM morbidity data and this is expected to expand as more health facilities intend to report their data through the portal.

**Health Data Center for Thai Traditional Medicine.** The Thai Traditional and Complementary Medicine (TT&CM) system is recognized by the MoPH. More than 10,000 health facilities provide at least one type of TTM service, and there is an increasing number of herbal medicines in the NLEM.

The Department of Thai Traditional and Alternative Medicine (DTAM) is the national authority on TTM. From 2013 to 2021, the Technical and Planning Division of DTAM has cooperated with the Provincial Health Office of Chanthaburi Province, National Health Security Office, and Information and Communication Technologies Center of the Office of the Permanent Secretary to develop the HDC TTM Service application to obtain data from the provincial level using the existing 52-standard folder system for the monitoring and evaluation of TTM services and system. Service record data are collected through different reporting systems at health service facilities and undergo quality inspection before these are uploaded at the regional/provincial health office level. These are then summarized into ad-hoc reports for planning and formulating national strategies.

The HDC TTM Service (1) serves as the reporting system for TT&CM services from all healthcare facilities at the provincial, district and sub-district levels, (2) provides evidence for TT&CM services given to the beneficiaries and is used to allocate funding to service units, (3) facilitates decision-making including the setting of key performance indicators on TT&CM services for the next fiscal year, selection of traditional or herbal medicine items to promote the use in the health care system, and understanding of the main causes for patients to seek TT&CM services and how the service plan can be adjusted accordingly, and (4) provides information on the traditional medicine items prescribed, which is useful for the production planning of herbal medicines by hospitals and manufacturers and cultivation planning of herbal raw materials.

The challenges in the reporting system are mainly on data quality and human resources. Data entry errors can occur if the responsible hospital personnel do not properly understand the indicator metadata or data dictionary. There have been data errors on incorrect herbal medicine values, package prices, or 24-digit herbal medicine codes. In response, DTAM plans to conduct regular training for existing and new health staff on data management for the HDC TTM, update the standard operating procedures for data management, and work with the primary care teams, primary care clusters, and palliative care teams to develop a reporting system for monitoring and evaluation.

### 4.2 WHO Health Information Initiatives

This session provided the participants an overview of some of the WHO initiatives in the area of health information system strengthening. There has been a real gap in the measurement and accountability of traditional medicine. Traditional medicine is a key part of health service delivery and by improving its measurement and accountability there is an opportunity to link this effort into the broader UHC agenda in countries.
WHO has developed a package of tools, resources, and essential interventions called SCORE to help countries improve data availability and quality, and enhance data synthesis, analysis, access, and use. SCORE has five components, namely (S) Survey populations and health risks, (C) Count births, deaths, and causes of death, (O) Optimize health service data, (R) Review progress and performance, and (E) Enable data use for policy and action. The latest SCORE assessment for South-East Asia showed that improvements can be made for each of the SCORE components. SCORE tools and other resources can be accessed at https://www.who.int/data/data-collection-tools/score.

Strengthening the TRM performance monitoring system should not focus so much on data production and developing dashboards. Greater investments need to be made in progressing further along the health data value chain. That is taking stock of how the data collected are being analyzed and disseminated, finding opportunities for feedback, and providing opportunities for local decision-making and policy support.

4.3 Overview of TRM Monitoring Tools

An overview of the different proposed tools for monitoring TRM system performance was provided. This includes the TRM monitoring framework, indicator set, indicator metadata, data collection tool, and country dashboards. The WHO SEARO Health Information Platform was also introduced as the portal that will allow public access to the TRM indicator data and dashboards.

**TRM Monitoring Framework, Indicators, and Metadata.** The TRM monitoring system is proposed to be updated by adopting an expanded framework that is more aligned to the latest WHO and other international monitoring frameworks including the WHO 2018 global reference list of 100 core health indicators, the draft WHO monitoring framework and indicators for primary health care measurement for improvement, and the framework for measuring primary health care performance by the Primary Health Care Performance Initiative. The proposed monitoring framework for TRM sets out the indicator and data requirements to measure and monitor TRM system inputs and processes, and programmatic results (outputs, outcomes, and impact). It identifies health systems inputs (governance, financing, infrastructure, health workforce, TRM products and resources, information, and research) critical to ensuring that TRM services are available, of quality, and safe. The framework also includes metrics for measuring TRM service utilization and coverage, and patient satisfaction with TRM services and outcomes (refer to Annex 2 for the proposed indicator framework). Each of these indicators is accompanied by a metadata to facilitate standardized data measurement and interpretation. Indicator data will come from institution- and population-based data sources.

**TRM Data Collection Tool.** The TRM data entry tool has been developed using the DHIS2 open-source information system. The indicator list and elements in the tool are based on the proposed updated TRM indicators and metadata.

The design of the form has been kept simple to facilitate data entry. Where applicable, values for select indicators (e.g., indicators for percentages and density) are automatically calculated to reduce manual calculations and calculation errors. The tool also has embedded
data validation check features, e.g., entry cell color change when invalid entries are made. The tool will be further revised to align with the final TRM indicator list and metadata.

TRM Dashboards. Country dashboards have been designed to facilitate access and use of the TRM indicator data. Six dashboards have been designed with the following themes: (1) governance and financing, (2) availability and use of TRM products and services, (3) TRM human resources, (4) TRM research, (5) TRM product manufacturing and safety monitoring, and (6) TRM Service delivery and patient satisfaction (refer to Annex 3 for the dashboard designs). These themes based on the TRM monitoring framework domains and indicators and designed to bring together related indicators to convey focused messages that would hopefully lead to meaningful policy or programmatic actions. The actual dashboards will be developed once agreements on the contents and designs are reached and when the WHO TRM team has collated validated indicator data from the Member States.

TRM Portal. The TRM indicator data and dashboards will be made accessible through WHO SEARO’s Health Information Platform (https://hip.searo.who.int/dhis/dhis-web-commons/security/login.action). The portal allows users to view TRM indicator data for the different Member States in the region and for different time points. Data can be viewed in tabular or graphical formats and can also be rendered through maps. The portal will also be used to provide links to the future TRM dashboards.

5. Discussions on the TRM Monitoring Tools

The Member States recognized the importance and need to expand the efforts to monitor the performance of country TRM systems. WHO's initiative to develop tools to support countries’ monitoring efforts was very much appreciated. Suggestions were provided to finalize the proposed monitoring tools.

5.1 TRM Monitoring Framework, Indicators, and Metadata

The Member States expressed that the majority of the proposed indicators are relevant for monitoring TRM performance and should be uniformly collected across the countries. They recognized that most of the Member States have their mechanisms for monitoring different indicators, and these systems may be further strengthened based on the proposed TRM monitoring framework with technical support from WHO. It was also recognized that data from surveys may only be made available every 3 to 5 years. Obtaining data from the private sector remains to be a challenge in the countries.

The following were the agreed suggestions by the Member States on the proposed indicator framework domains, indicators, and indicator metadata:

- on health financing indicators: to refine the indicators on sources of health financing to align with WHO health financing indicators,
- on TRM human resource: to reword “TRM regulated practitioners” to “registered formally trained TRM practitioners” and to add an indicator to measure the registered informal traditional healers,
on service utilization: to add an indicator on inpatient department utilization for TRM services,

on outpatient and inpatient service utilization: to capture data in absolute and mean number to facilitate comparison across time and countries, and

on service coverage: to delete the indicator “Percentage of population that use TRM for self-care”.

The Member States also suggested to:

- standardize the categories for capturing diseases or medical conditions,
- remove the data disaggregation for location (urban and rural),
- develop indicators to measure TRM contributions to UHC, and
- develop a standard set of questions for indicators to be measured through surveys (i.e., percentage of the population who report problems in accessing TRM services care when they have a healthcare need, percentage of patients who report having a regular TRM provider, percentage of patients who report being involved in decisions about their TRM care and treatment, percentage of the population that use TRM services, percentage of the population with demand for TRM services satisfied, and percentage of patients satisfied with TRM services and outcomes).

5.2 TRM Data Collection Tool

The following recommendations were provided by the Member States:

- to add the contact email of WHO TRM responsible person in the general information section to allow the Member States to email WHO for queries on the use of the tool or provide feedback.
- to ensure that the “Source” and “Remarks” data entry cells have adequate text length to allow entry of lengthy text.
- to provide pop-up messages in the tool to guide users in the proper entry of indicator data and lessen data entry errors.
- to allow the Member States to try out the data collection tool and provide final feedback before its finalization.
- to allow the TRM DHIS2 system to generate a spreadsheet (e.g., in excel format) based on the final TRM DHIS2 data collection tool to serve as an alternative data collection tool for the Member States. The spreadsheet should be in a non-editable format and allow data to be exported into the TRM DHIS2 database.
- to develop a short video or practical user manual on the proper use of the tool.
5.3 **TRM Dashboards**

It was clarified that while all available indicator data can be accessed through the portal, only select indicators and their data will be visualized through dashboards.

For the dashboard on the availability and use of TRM products and services, the Member States recommended to:

- expand the main reasons for seeking TRM to the top 10,
- standardize the naming of the diseases,
- include data inpatient department service utilization, and
- if country data are available, to also include data on T&CM service utilization in the public and private sector, and hospital stay and/or treatment costs.

For the dashboard on TRM human resources, it was recommended to add the category “Ph.D.” in the graph on the number of TRM graduates. For the dashboard on TRM research, it was recommended to:

- add details of other sources of TRM research funding, and
- add categories (e.g., research articles in high impact factor journals, book publications, monographs, and workshop or seminar proceedings) for the indicator on scientific publications.

6. **Agreed Next Steps**

The following actions by WHO SEARO and the Members States were agreed to be taken to finalize the TRM monitoring tools.

6.1 **For WHO SEARO**

- To revise the TRM monitoring framework and indicator set based on the agreed indicators to add, delete or reword.
- To adjust the indicator metadata to accommodate requests to standardize or delete some disaggregation categories.
- To refine the TRM DHIS2 data entry tool based on the updated indicator list and metadata and suggestions to its formatting and features.
- To develop a user video or manual on the proper use of the TRM DHIS2 data entry tool.
- To work with the Member States on the development of indicators to measure TRM contributions to UHC.
- To develop a set of questions for collecting data for survey-based TRM indicators.
To collaborate with the Member States on efforts to summarize research and clinical practice results on the efficacy and outcomes for health conditions where TRM has higher efficacy than modern medicine or where TRM has comparable efficacy but with fewer side effects or costs.

6.2 For the Member States

- To provide final feedback to WHO SEARO for the finalization of the TRM monitoring tools.
- To provide WHO SEARO with updated and validated data for the agreed TRM indicators.
- To collaborate with WHO SEARO for the further strengthening of country systems for measuring and monitoring TRM systems performance.
- To promote the use of the TRM monitoring tools and indicator data for decision-making to improve the availability, accessibility, and quality of TRM services and products.
Annex 1

Agenda

(1) Opening session including objectives and expected outcome
(2) History and role of Pharmacovigilance (PV) and WHO Programme
(3) Status of regulation for Traditional Medicines (TRM) & their Pharmacovigilance (PV) System in the WHO SEA region
(4) Tools for reporting AE/ADR with the use of TRM Products.
(5) Introduction & Classification of Adverse Drug Reaction
(6) Introduction of various methods used in Pharmacovigilance
(7) Data Entry & Management of T&CM products by using WHO-Uppsala Monitoring Centre (UMC) Tools
(8) Causality Assessment of TRM products as compared to Allopathic products.
(9) Recording & coding the identity of herbal medicines.
(10) Challenges in monitoring the safety of TRM products
(11) Risk communication
(12) Educational material to support training by future trainers
(13) To highlight the most challenging aspects of training on TRM pharmacovigilance and to propose and test solutions to these challenges
(14) Closing with post-training assessment including recommendation for finalizing the training programme/module for the future local training.
Annex 1

Opening remarks by Dr Poonam Khetrapal Singh, Regional Director of WHO SEARO

Distinguished participants, ladies and gentlemen,

A very good morning.

It is my privilege to speak at this regional consultation, which I am certain will help strengthen monitoring traditional medicine system performance in this very important area.

Traditional medicine plays an active role in the lives of individuals, communities, and cultures across the South-East Asia Region, as across the world. It is an area of knowledge and practice that is embedded in many people’s day-to-day lives. More importantly, traditional medicine encourages people to engage with the health systems that would otherwise be unfamiliar or culturally foreign. And so we must welcome this initiative as together we strive to achieve universal health coverage.

Distinguished participants, for many years the Member States in the Region have sought to leverage the power of traditional medicine for achieving UHC. Ten of the Region’s Member States have national policies on traditional medicine. Nine have formal training and education systems for traditional medicine practitioners. Six have co-located traditional medicine services in their health systems at some or all levels. Five countries have a national essential drug policy on traditional medicine products and include traditional medicine products in their national essential drug list.

Over the past two decades, the use of traditional medicine has expanded globally, gaining significant popularity including in developed countries. One reason for this is the dramatic increase in the number of people with chronic NCDs such as cardiovascular disease, metabolic disorders, cancer, and mental disorders. Traditional medicine has great potential to promote health and to prevent and manage NCDs.

We must nevertheless be clear that traditional medicine can only deliver on its potentials if it is safe, equitably accessible, responsive to needs, and effective in improving health outcomes. To enable this, robust information systems for traditional medicine are needed to generate accurate and timely information that will allow policymakers to formulate national policies and programmes that will help ensure the equitable distribution of skilled traditional medicine practitioners, the adequacy and appropriateness of financing mechanisms for affordable traditional medicine services as well as the delivery of quality and safe TRM services. Monitoring and evaluation systems also need to be in place to be able to demonstrate its contributions in expanding primary health care services, achieving UHC, and improving the health of communities.
In recent years, we have seen great improvements in monitoring traditional medicine system performance, which WHO has been pleased to support. Particularly in 2015, WHO SEARO identified strengthening TRM system performance monitoring as a regional priority area of the traditional medicine program. In 2017, a standard set of indicator and their metadata was developed as the framework for monitoring TRM system performance. And in 2018, WHO SEARO developed a DHIS2-based TRM database and initiated the WHO Regional portal for sharing traditional medicine data and information among the Member States.

Future efforts to further strengthen TRM system performance monitoring will build on this momentum and take advantage of advances in digital and information technologies to harness the power of traditional medicine to achieve universal health coverage. Member States have clear roadmaps toward establishing and strengthening traditional medicine system performance monitoring according to the country’s legislation and circumstances. WHO has been a strong partner in helping Member States meet the global strategic objectives for TRM, which are to build a strong knowledge base; strengthen quality assurance, safety, and effectiveness; and promote universal health coverage.

WHO continues to support the Member States through this consultation meeting by facilitating sharing of countries’ best practices on monitoring traditional medicine system performance, by updating the traditional medicine system performance monitoring framework, and deploying tools for a more standardized collection and wider access and exchange of traditional medicine data and information for the WHO South-East Asia Region.

Even if this consultation meeting is being organized virtually, our time together is indeed invaluable, and I urge all of you to take full advantage of the coming three days to ensure that traditional medicine delivers on its promise of advancing health and well-being as part of a comprehensive approach to universal health coverage.

I wish the regional consultation every success and I reiterate WHO’s full support in our collective effort of optimizing the potential contributions of traditional medicine for achieving health and well-being for all people in all life stages.

Thank you.
Annex 3

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Dili

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Ms. Ruchita Rajbhandary  
HIS Technical Officer

Dr. Kim Sungchol  
TRM Regional Advisor

Ms. Chitra Salil  
TRM unit
# Annex 4

## Proposed Indicator Framework for Monitoring Traditional Medicine System Performance in South-East Asia

<table>
<thead>
<tr>
<th>Indicator Area</th>
<th>Sub-indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>TCMF monitoring and reporting systems effectiveness (e.g., your definition)</td>
</tr>
<tr>
<td></td>
<td>Availability of TCM products (e.g., number and types)</td>
</tr>
<tr>
<td></td>
<td>Quality of TCM services (e.g., patient satisfaction)</td>
</tr>
<tr>
<td></td>
<td>Financial sustainability of TCM services (e.g., cost-effectiveness)</td>
</tr>
<tr>
<td></td>
<td>Health workforce (e.g., number and qualifications of practitioners)</td>
</tr>
<tr>
<td></td>
<td>Research and development (e.g., publication rates)</td>
</tr>
<tr>
<td></td>
<td>Integration with health systems (e.g., complementary with other services)</td>
</tr>
<tr>
<td></td>
<td>Capacity building (e.g., training programs)</td>
</tr>
</tbody>
</table>

### Notes

- **TCMF:** Traditional Chinese Medical Framework
- **TCM:** Traditional Chinese Medicine
- **TCM products:** Traditional Chinese Medicine products
- **TCM services:** Traditional Chinese Medicine services
Annex 5

Proposed Designs for Country Traditional Medicine Dashboards using Mock Data

Dashboard 1 on TRM Governance and Financing
Dashboard 2 on the Availability and Use of TRM Products and Services

Country X

Availability of T&CM Products and Services

Number of T&CM products included in the national essential medicines list (2016)
123
Number of health facilities offering T&CM (2020)
79
Density of health facilities offering T&CM per 10,000 population (2020)
1.04

A total of 123 T&CM products are accessible through the national essential medicines list. In 2018, there is about 1 health facility offering T&CM services for every 10,000 population.

Utilization of T&CM Services

Per capita number of outpatient department visits for T&CM services

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4</td>
<td>1.6</td>
<td>1.2</td>
<td>1.4</td>
<td></td>
</tr>
</tbody>
</table>

T&CM outpatient department visits as a percentage of all outpatient visits

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>75%</td>
<td>25%</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

Hospital discharge rate for T&CM services per 100,000 population

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>387</td>
<td>476</td>
<td>377</td>
<td>243</td>
<td></td>
</tr>
</tbody>
</table>

From 2017 to 2020, the outpatient visits for T&CM services ranged from 1.2 to 1.6 visits per person. This accounted for 20-25% of all outpatient visits in the country. The hospital discharge rate for T&CM services was 476 per 100,000 population in 2018 and dipped to 243 per 100,000 population post-pandemic.
Virtual Regional Consultation on Indicators for Monitoring Traditional and Complementary Medicine System Performance for the WHO South-East Asia Region

Dashboard 3 on TRM Human Resources

Country X

Density of T&CM Human Resource

- Registered formally trained T&CM practitioners per 10,000 population
  - 2017: 1.9
  - 2018: 2.3
  - 2019: 2.3
  - 2020: 2.5

- Registered informal traditional healers per 10,000 population
  - 2017: 4.2
  - 2018: 4.0
  - 2019: 3.8
  - 2020: 3.5

Ratio of Registered Formally Trained T&CM Practitioners to Allopathic Medical Doctors

- Allopathic medical doctors
- Registered formally trained T&CM practitioners

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>60%</td>
<td>80%</td>
<td>66%</td>
<td>64%</td>
</tr>
</tbody>
</table>

Number of T&CM Bachelor Graduates

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Mechanisms for Ensuring the Quality of T&CM Education and Training

- Existence of a national mechanism to ensure quality of T&CM education and training (2020)
- Existence of a continuing professional development programme for T&CM practitioners (2020)

The number of registered formally trained T&CM practitioners gradually increased across the years. In 2020, there were 2.5 registered formally trained T&CM practitioners per 10,000 population.

While the number of informal traditional healers has declined, their numbers are still higher than the formally trained T&CM practitioners.

T&CM practitioners account for almost 40% of health care doctors in the country.

Dashboard 4 on TRM Research

Country X

Integration into National Research Policies and Bodies

- Existence of a national body to oversee T&CM-related researches (2020)
- Incorporation of T&CM in the national health research strategy (2020)
- Integration of T&CM in a national research council or national health council (2020)

Research Funding

<table>
<thead>
<tr>
<th>Year</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total government budget allocated for T&amp;CM research in USD</td>
<td>71,428</td>
<td>71,428</td>
<td>45,000</td>
</tr>
</tbody>
</table>

T&CM Research Institutions, Results and Publications

- Number of research institutions or centres that conduct research on T&CM, including network universities (2020): 1
- Number of T&CM research results in the national research registry (2020): 18
- Number of peer-reviewed T&CM scientific publications in local and international journals (2020): 15


Dashboard 5 on TRM Product Manufacturing and Safety Monitoring

Dashboard 6 on TRM Service Delivery and Patient Satisfaction
Virtual Regional Consultation on
Indicators for Monitoring Traditional and
Complementary Medicine System
Performance for the
WHO South-East Asia Region

New Delhi, India, 26–28 July 2021