বাংলাদেশ সুপ্রীম কোর্ট
হাইকোর্ট বিভাগ
(বিশেষ মূল অধিক্ষেত্র)

রীট পিটিশন নং ৫৩৫/২০১৯

ন্যাশনাল মেডিক্যাল এসোসিয়েশন অব বাংলাদেশ ও অন্যান্য

---- দরখাস্তকারীগণ।

-বনাম-

বাংলাদেশ সরকার ও অন্যান্য

---- প্রতিপক্ষগণ।

এ্যাডভোকেট রাসনা ইমাম সংগে

এ্যাডভোকেট খন্দকার নীলিমা ইয়াসমিন

এ্যাডভোকেট মোঃ মজিবুর রহমান

---- দরখাস্তকারীগনের পক্ষে।

এ্যাডভোকেট তানজীব-উল আলম সংগে

এ্যাডভোকেট সাকিবুজ্জামান

এ্যাডভোকেট কাজী ইরশাদুল আলম

এ্যাডভোকেট ইমরান আনোয়ার

---- ৬নং প্রতিপক্ষ পক্ষে।

এ্যাডভোকেট তাপস কুমার বিশ্বাস

---- ২নং প্রতিপক্ষ পক্ষে।

এ্যাডভোকেট ওয়ায়েস আল হারুনী, ডেপুটি এটর্নী জেনারেল সংগে

এ্যাডভোকেট আশেক মোমিন, ডেপুটি এটর্নী জেনারেল

এ্যাডভোকেট ইলিন ইমন সাহা, সহকারী এটর্নী জেনারেল

এ্যাডভেকোট সায়রা ফিরোজ, সহকারী এটর্নী জেনারেল

এ্যাডভোকেট মাহফুজুর রহমান লিখন, সহকারী এটর্নী জেনারেল

---- রাষ্ট্র-প্রতিপক্ষ পক্ষে।

উপস্থিতঃ

বিচারপতি মোঃ আশরাফুল কামাল

এবং

বিচারপতি রাজিক আল জলিল

শুনানীর তারিখ ঃ ০৫.০১.২০২০ এবং রায় প্রদানের তারিখ ঃ ১৯.১১.২০২০।

বিচারপতি মোঃ আশরাফুল কামালঃ

দরখাস্তকারীগণ কর্তৃক গণপ্রজাতন্ত্রী বাংলাদেশের সংবিধানের অনুচ্ছেদ ১০২(২)(ক)(অ)(আ) এর অধীন দরখাস্ত দাখিলের প্রেক্ষিতে প্রতিপক্ষগণের উপর কারণ দর্শানোপূর্বক নিম্নোক্ত রুলটি ইস্যু করা হয়েছিলঃ-

> *"Let a Rule Nisi be issued calling upon the respondents to show cause as to why the inaction of the respondent Nos. 1, 2 and 5 in constituting a separate Regulatory Body and to prepare a separate Rules for rendering professional service and for using the prefix "Dr." before the names of the member of the petitioner's Association having MBBS (AS) degree in Alternative System of Medicine inspite of the recommendation of Bangladesh Medical and Dental Councel, Bangladesh Homeopathic Board and Bangladesh board of Unani and Ayurbadic Systems of medicine should not be declared to have been passed without lawful authority and is of no legal effect and as to why they should not be directed to constitute an independent Regulatory council and to prepare a separate Rules for rendering (medical) professional service and for using the prefix "Dr" before the names of the members of the petitioner's association having MBBS (AS) decree in Alternative System of Medicine and as to why they should not be directed not to disturb or harass the members of the petitioners Association in course of rendering professional services and for using the prefix "Dr" before their names having MBBS (AS) decree in Alternative System of Medicine and/or such other or further order or orders passed as to this Court may seem fit and proper."*

রুলটি নিষ্পত্তিতে ঘটনার সংক্ষিপ্ত বিবরণ এই যে,

১নং দরখাস্তকারী *"ন্যাশনাল মেডিকেল এসোসিয়েশন অব বাংলাদেশ"* (পূর্বের নাম ন্যাশনাল মেডিকেল সোসাইটি অব বাংলাদেশ) সমিতি নিবন্ধন আইন, ১৮৬০ এবং কোম্পানী আইন অনুযায়ী নিবন্ধিত একটি সংগঠন। ২-৯৭নং দরখাস্তকারীগণ ১নং দরখাস্তকারী সংগঠনের নিবন্ধিত সদস্য। ২-৯৭নং দরখাস্তকারীগণ বিকল্প চিকিৎসাব্যবস্থা সংশ্লিষ্ট এমবিবিএস ডিগ্রি গ্রহণ করেছেন। অত্র রীট পিটিশনের ৪নং প্যারায় দরখাস্তকারীগণ সেই বিষয়ে বিস্তারিত বর্ননা প্রদান করেছেন বিধায় নিম্নে তা অবিকল অনুলিখন হলোঃ

> *"4. That the respective members of the petitioner No. 1 Association completed 5 years M. B. B. S. Alternative*

System (A. S) Course including Allopathic, Unani, Ayurbedic, Homeopathic, Herbal and Acupuncture system of medicine and it hears an extra ordinary modernize though than that of M. B. B. S course and the said course is also a combined system of medicine and it is also free from any kind of side effect of medicine and this is why the developing countries as well as the developed countries of the world cordially accepted this system of medicine and that all of the members of the petitioners Association were admitted in M. B. B. S. Alternative System (A. S) course, under "The Global Open Research University of Indo-Allopathy and Complementary Medicines" Kolkata, West Bengal, India and the Premier University of Technology Uttara, Dhaka was established in Bangladesh as its study center and there after it was re-named as Pitchblende University of Science and Technology" and after successfully completion of the said Degree, the members of the petitioners Association obtained testimonials from the said study center and the Association of the petitioners having an Executive Committee and as many as 96 (ninety six) members and the Association is represented by their Secretary General namely Dr. M. G. Bhuiyan."

দরখাস্তকারীগণের অত্র রীট পিটিশনে বর্ণিত বর্ণনা মতে Global Open Research University of Indo Allopathy & Complementary Medicine প্রতিষ্ঠানটি Complementary Medicine-এ বিভিন্ন মেয়াদে ডিপ্লোমা ও ডিগ্রীসমূহ প্রদানের লক্ষ্যে Pitch-Blende University of Science & Technology-কে অধিভুক্ত করে। সেহেতু Pitch-Blende University একটি Tuition Provider এবং অত্র রীট দরখাস্তকারীগণ প্রকৃতপক্ষে Global Open Research University থেকেই (MBBS) in Alternative System of Medicine ডিগ্রী অর্জন করেছেন।

অল্টারনেটিভ মেডিসিন বা বিকল্প চিকিৎসা ব্যবস্থার জন্য পৃথক নিয়ন্ত্রণ সংস্থা গঠন এবং অল্টারনেটিভ বা বিকল্প চিকিৎসা ব্যবস্থায় এমবিবিএস ডিগ্রিধারী অত্র ২-৯৭নং দরখাস্তকারীগণসহ সকল

ডিগ্রীধারীদের নামের সম্মুখে (Dr.) ব্যবহার করতে পারে সে লক্ষ্যে প্রয়োজনীয় আইন প্রণয়নের নির্দেশনা চাহিয়া দরখাস্তকারীগণ সংবিধানের অনুচ্ছেদ ১০২ এর আওতায় অত্র দরখাস্তটি দাখিল করে রুলটি প্রাপ্ত হন।

দরখাস্তকারীগণ পক্ষে বিজ্ঞ এ্যাডভোকেট রাসনা ইমাম বিস্তারিত ভাবে যুক্তিতর্ক উপস্থাপন করেন। অপরদিকে, বিজ্ঞ এ্যাডভোকেট তানজীব-উল আলম ৬নং প্রতিপক্ষ পক্ষে বিস্তারিত ভাবে যুক্তিতর্ক উপস্থাপন করেন।

গুরুত্বপূর্ণ বিধায় বাংলাদেশ মেডিকেল এন্ড ডেন্টাল কাউন্সিল এর বিগত ইংরেজী ০৪.০৭.২০১৯ তারিখের পত্রটি নিম্নে অবিকল অনুলিখন হলোঃ

বাংলাদেশ মেডিকেল এন্ড ডেন্টাল কাউন্সিল
BANGLADESH MEDICAL & DENTAL COUNCIL
203, Shaheed Syed Nazrul Islam Sarani, (46, Bijoy Nagar), Dhaka- 1000

Ref. No. BM&DC/43 *Date: 04.07.2019*

To
Dr. Bardan Jung Rana
Representative to Bangladesh
World Health Organization
Country Office for Bangladesh
United House (GF to 3rd Floor)
10 Gulshan Avenue, Gulshan-1
Dhaka- 1212, Bangladesh PO. Box: 250

Subject: Query with regard to affiliation of World Health Organization with Alternative Medical Council Calcutta.

Dear Sir,

The Bangladesh Medical and Dental Council (BM&DC) is a statutory body with the responsibility of recognition of medical qualifications and establishing and maintaining high standards of medical education in Bangladesh. The BM&DC is also responsible for registration of doctors to practice in Bangladesh, in order to protect and promote the health and safety of the public by ensuring proper standards in the practice of medicine.

We have receive a number of applications from individuals for registration as medical practitioners and for reorganization of their degrees namely the M. B. B. S (A.M.) Alternative Medicine obtained from the Alternative Medical Council Calcutta (AMCC).

The certificates submitted by the individuals illustrates that the Alternative Medical Council Calcutta is affiliated with the

Open International University for Complementary Medicines Established under World Health Organization.

In the circumstances, we requested you to confirm whether the World Health Organization has any association or relationship with the Calcutta based institute namely the Alternative Medical Council Calcutta, Barasat, Kolkata-700 125, West Bengal, India.

A Copy of the certificate, issued by the Alternative Medical Council Calcutta, is provided for the purpose of this query.

Kind Regards
Sd/- Illegible
Dr. Md. Arman Hossain
Registrar (In Charge)
Bangladesh Medical @ Dental Council

গুরুত্বপূর্ণ বিধায় World Health Organization এর বিগত ইংরেজী ১৮.০৭.২০১৯ তারিখের পত্রটি নিম্নে অবিকল অনুলিখন হলোঃ

World Health Organization
Bangladesh

In reply please

refer to : BAN/HSD/B/1

Your reference : BM&DC/45 Date: 04 July 2019

Dr. Md. Arman Hossain,
Registrar (In charge)
Bangladesh Medical & Dengal Council
203, Shaheed Syed Nazrul Islam Sarani,
Bijoy Nagar
Dhaka- 1000

18 July 2019

Dear Sir,

Subject: ***Query with regard to affiliation of World Health Organization with Alternative Medical Council Calcutta***

In response to the above query, we would like to inform you that Alternative Medical Council Culcatta, Barasat, Kolkata, India is not a WHO Collaborating Centre and WHO does not provide any recognition or affiliation to this Council.

Furthermore, any individual, who locks for recognition of certificates or degrees in Unari or Ayurvedic systems of medicine in Bangladesh, should communicate with the Bangladesh Board of

Unani and Ayurvedic systems of medicine as per the Bangladesh Unani and Ayurvedic Practitioners Ordinance, 1983.

Hope this information is helpful

Thank you for your continuous cooperation.

Yours sincerely
Sd/- Illegible
Dr. Bardan Jung Rana
WHO Representative

গুরুত্বপূর্ণ বিধায় West Bengal Medical Council এর বিগত ইংরেজী ০৭.০৮.২০১৯ তারিখের Query in regard to MBBS (AM) পত্রটি নিম্নে অবিকল অনুলিখন হলোঃ

West Bengal Medical Council

IB-196, SECTOR- III, SALT LAKE CITY, KOLKATA- 700 106

No. 2077 - C/3-2019 ***Date: 7th August 2019***

Dr. Md. Arman Hossain,
Registrar (In charge)
Bangladesh Medical & Dengal Council
203, Shaheed Syed Nazrul Islam Sarani,
(86, Bijoy Nagar)
Dhaka- 1000
BANGLADESH

Sir,

Query in regard to MBBS (AM)

With reference to your letter No. BM&DC/45 dated 04.07.2019 (received at our end on 25.07.2019) please note that the qualifications, which only appear in the Schedule of Medical Council of India, New Delhi, are recognized qualifications and the West Bengal Medical Council as also all other State Medical Councils of India grant registration to those who obtains the qualification(s) as per schedule of Medical Council of India.

Alternative Medical Council(s) is/are not recognized council(s) and qualifications(s) awarded by them is/are not recognized as per Schedule of Medical Council of India.

In view of what has been stated above the qualification(s) holder(s) of Alternative Medical Council(s) is/are not at all eligible to practice modern scientific system of medicine (Allopathic).

Thanking you,

Yours faithfully,

Sd/- Illegible
06.08.2019
(Manas Chakraborti)
Registrar
West Bengal Medical Council

West Bengal Medical Council

IB-196, SECTOR- III, SALT LAKE CITY, KOLKATA- 700 106

TO WHOM IT MAY CONCERN

This is to certify that the envelope containing letter No. 2077 C/03-2019 dated 07.08.2019 addressed to Dr. Md. Arman Hossain, Registrar, (In Charge), Bangladesh Medical & Dental Council, 203, Shaheed Syed Nazrul Islam Sarani, (86, Bijoy Nagar, Dhaka- 1000, Bangladesh is an official letter issued by this office for confirmation about the genuineness of a degree of medical practitioner.

Sd/- Illegible
Debasis Ray
Assistant Registrar,
West Bengal Medical Council

গুরুত্বপূর্ণ বিধায় ইউনির্ভাসিটি অব পিস এর আইন পরামর্শক কর্তৃক বাংলাদেশ মেডিকেল এন্ড ডেন্টাল কাউন্সিল এর ডাঃ মোঃ আরমান হোসেন এর প্রতি প্রেরীত বিগত ইংরেজী ০৩.০৯.২০১৯ তারিখের পত্রটি নিম্নে অবিকল অনুলিখন হলোঃ

San Jose, 3rd of September, 2019
SJO-ICO-JJ-19-025

To
Dr. Md. Arman Hossain
Registrar
Bangladesh Medical and Dental Council

Subject: Answer to query to affiliation of University for peace with Alternative Medical Council Calcutta and Institute of Alternative Medicines.

Dear Sir,

Greetings from the University for Peace and thank you for your letter sent on July 4th, 2019, Ref. N. BM&DC/44, Regarding your question, we have consulted our legal records and we can

confirm that the University for Peace has no record of having an agreement with such institutions and therefore is <u>not associated</u> in any way with the institute Alternative Medical Council Calcutta of Barasat, Kolkata-700 125, West Bengal, India nor with the Institute of Alternative Medicines of 15 Srigopal Mullic Lane, Kolkata- 700 012, hence, the submitted certificates are not endorsed nor issued by the University for Peace and should be considered fake and illegally using the name of the University for Peace and of the United Nations.

The University for Peace is an International Organization and University, established by the resolution 35/55 of the General Assembly of the United Nations on December 5th of 1980. According to the Charter of the University for Peace, article 15, "The University shall, inter alia, grant master's degrees and doctorates under terms and conditions established by the Council." As such, UPEACE is <u>only allowed to issue master's and doctoral decrees.</u>

In this regard, we really appreciate the inquire made by the Bangladesh Medical and Dental Council, as it allows us to take legal actions with the corresponding authorities.

Kind regards
Sd/- Illegible
Juan Jose Vasquez-Pacheco
Legal Advisor
University for Peace.

গুরুত্বপূর্ণ বিধায় কলকাতা হাইকোর্টের মোকদ্দমা নম্বর- C. R. M. 5503 of 2017 এর বিগত ইংরেজী ০৯.০৮.২০১৭ তারিখের রায় ও আদেশ নিম্নে অবিকল অনুলিখন হলোঃ

<u>Annexure- 19</u>

Calcutta High Court (Appellate Side)
An Application For Anticipatory... vs Unknown on 9 August, 2017
09.08.2017 C.R.M. 5503 of 2017 In the matter of:- An application for anticipatory bail under Section 438 of the Code of Criminal Procedure, 1973 presented on 14.06.2017. In the matter of: Chandan Agarwal
(ii) Dr. Suresh Kumar Agarwal.

.....petitioners Mr. Bikash Ranjan Bhattacharya, Mr. Uday Sankar Chattopadhyay, Mr. Suman Sankar Chattopadhyay, Mr. Santanu Maji, Ms. Snigdha Saha.

.....For the petitioners.

Mr. Madhusudan Sur, Ld. Addl, P.P., Mr. Debojyoti Deb... For the State.

Apprehending arrest in connection with Bidhannager Police Station FIR No. 99 of 2017 dated 25.05.2017 under Sections 419/420/465/467/468/471/472/474/475/120B/34 of the Indian Penel Code, corresponding to GR case no. 425 of 2017 pending before the learned Additional Chief Judicial Magistrate, Bidhannagar, North 24 Parganas, the petitioners being the secretary and the president of Indian Board of Alternative Medicine, having its registered office at 80, Chowringhee Road, Kolkata - 700020, have filed this application under Section 438 of the Code of Criminal Procedure for anticipatory bail.

Mr. Bhattacharya, learned senior advocate appearing on behalf of the petitioners contended that the activities of the Indian Board of Alternative Medicine were held to be legal and the institution is registered under the West Bengal Societies Registration Act, 1961 bearing registration no. S/68765/1991-92. Mr. Bhattacharya further contended that CO/CR No. 13597(W) of 1996 under Article 226 of the Constitution of India is still pending in the High Court and in fact a criminal case against the Council of Alternative System of Medicine and another was quashed by this Court in a decision reported in 1991 (2) CLJ 173 (the Council of Alternative Systems of Medicine and Anr. Vs. State of West Bengal and Ors).

Mr. Bhattacharya further contended that the allegations levelled in the first information report are not applicable to the present petitioners and the activities of the present petitioners as secretary and president of the Indian Board of Alternative Medicine are not subject to scrutiny in terms of the first information report filed by the defacto-complainant.

Mr. Bhattacharya also contended that the petitioners be admitted to bail in terms of Section 438 of the Code of Criminal Procedure.

Mr. Sur, learned Additional Public Prosecutor appearing on behalf of the State contended that in the name of pursuing the cause of alternative medicine, the petitioners are in fact issuing

fake certificates of MBBS/MD degrees against payment of huge amount by some persons, who have not even passed class-X examination. The petitioners are responsible for creating fake doctors and thereby the petitioners are not only cheating innocent persons but also endangering the entire health service of public at large. Sufficient materials have been collected against the petitioners and their custodial interrogation is required to unearth the racket involved in such issuance of fake MBBS/MD certificates.

At the outset, it may be mentioned that legality of the Board/Council is not subject matter of this application. Therefore, the submission of Mr. Bhattacharya regarding legality of the institution does not affect the legality of the prosecution against the present petitioners. Moreover, in paragraph 24 of the application, the petitioners have themselves admitted that in fact the Indian Board of Alternative Medicine never claimed itself as a council, recognized by the Medical Council of India (MCI). That clearly goes to show that the Indian Board of Alternative Medicine had or has no capacity to issue certificate of MBBS/MD degrees.

Having considered the submission of learned advocates and after going through the case diary, we find sufficient materials against the present petitioners. Having regard to the complicity of the petitioners in the case under reference, we are of considered view that the petitioners are not entitled to any order under Section 438 of the Code of Criminal Procedure in the context of their role in the alleged offences.

Prayer for anticipatory bail stands rejected. Accordingly, the CRM 5503 of 2017 is disposed of. Urgent photostat copy of this order be supplied to the parties, if applied for, upon compliance with all requisite formalities. (Debi Prosad Dey, J.) (Dipankar Datta, J.)

দরখাস্তকারীগণের এমবিবিএস ডিগ্রীর সার্টিফিকেটসমূহ, উপরিল্লিখিত পত্রসমূহ এবং কলকাতা হাইকোর্টের রায় পর্যালোচনায় এটি কাঁচের মত স্পষ্ট যে, দরখাস্তকারীগণের বিকল্প চিকিৎসার এমবিবিএস ডিগ্রী বাংলাদেশের আইন অনুযায়ী এবং বিদেশের স্বীকৃত কোন বিশ্ববিদ্যালয় হতে প্রদত্ত নয়।

যেহেতু দরখাস্তকারীগণের এমবিবিএস ডিগ্রী আইনগতভাবে স্বীকৃত কোন বিশ্ববিদ্যালয় হতে প্রাপ্ত নয় সেহেতু দরখাস্তকারীগণের রুলটি খারিজ যোগ্য।

তবে যেহেতু দরখাস্তকারীগণসহ হাজার হাজার অল্টারনেটিভ মেডিসিনের ডাক্তারগণ বাংলাদেশের আনাচে কানাচে প্রশাসন এবং কর্তৃপক্ষের সামনে আইনগত অনুমোদন ব্যতিরেকে দীর্ঘদিন যাবৎ জনসাধরণকে অল্টারনেটিভ মেডিসিনের চিকিৎসা প্রদান করে আসছে, সেহেতু বিষয়টি আলোচনার দাবী রাখে। চিকিৎসা বিষয়টি বাংলাদেশের প্রতিটি নাগরিককে স্পর্শ করে এবং এর গুরুত্বও অপরিসীম।

"সবার জন্য স্বাস্থ্য" নিশ্চিতকরণের লক্ষ্যে ১৯৭৮ সালের কাজাখিস্থানের আলমাআতা শহরে সবার জন্য প্রাথমিক স্বাস্থ্য সেবা পরিকল্পনার ঘোষণা করা হয়। আলমাআতা ঘোষণার মূল উদ্দেশ্য হলো স্বাস্থ্য সেবাকে সার্বজনীন করে একটি সুন্দর পৃথিবী গড়ে তোলা।

গুরুত্বপূর্ণ বিধায় সেপ্টেম্বর ১৯৭৮ সালে কাজাখিস্থানে গৃহীত "আলমাআতা ঘোষনার" নিম্নে অবিকল অনুলিখন হলোঃ

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12

September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following

Declaration:

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. *The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.*

III. *Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.*

IV. *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.*

V. *Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.*

VI. *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

VII. Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health

care for all, and giving priority to those most in need;

7. *relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.*

VIII. *All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.*

IX. *All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.*

X. *An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.*

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral

agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

প্রাথমিক স্বাস্থ্য সেবা ২০০০ সাল নাগাদ লক্ষ্যে পৌছানোর কথা থাকলেও তা অর্জিত হয়নি। ফলশ্রুতীতে জাতীসংঘ ২০০০ সালে মিলিনিয়াম ডেভোলপমেন্ট গোল নির্ধারণ করে ২০১৫ সাল নাগাদ লক্ষ্যমাত্রা অর্জনের সময় নির্ধারণ করা হয়। পরবর্তীতে জাতীসংঘ ২০১৬ থেকে ২০৩০ মেয়াদে এসডিজির (sustainable development goal) লক্ষ্যমাত্রা নির্ধারন করে যার মধ্যে সকলের জন্য স্বাস্থ্যের বিষয়টি বিশেষ ভাবে প্রাধান্য পায়।

গুরুত্বপর্ণ বিধায় *Global Conference on Primary Health Care From Alma-Ata towards universal health coverage and the Sustainable Development Goals* তথা *"আসটানা ঘোষণা"* নিম্নে অবিকল অনুলিখন হলোঃ

Global Conference on Primary Health Care From Alma-Ata towards universal health coverage and the Sustainable Development Goals

Astana, Kazakhstan, 25 and 26 October 2018

We, Heads of State and Government, ministers and representatives of States and Governments1, participating in the Global Conference on Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals, meeting in Astana on 25 and 26 October 2018, reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All, hereby make the following Declaration.

We envision

Governments and societies *that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;*

Primary health care and health services *that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;*

Enabling and health-conducive environments *in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;*

Partners and stakeholders *aligned in providing effective support to national health policies, strategies and plans.*

I

We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.

II

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals. We welcome the convening in 2019 of the United Nations General Assembly high-level meeting on UHC, to which this Declaration will contribute. We will each pursue our paths to achieving UHC so that all people have equitable access to the quality and effective health care they need,

ensuring that the use of these services does not expose them to financial hardship.

III

We acknowledge that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We will continue to address the growing burden of noncommunicable diseases, which lead to poor health and premature deaths due to tobacco use, the harmful use of alcohol, unhealthy lifestyles and behaviours, and insufficient physical activity and unhealthy diets. Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries' boundaries.

Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket spending on health. We can no longer underemphasize the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers. We must act on the growing costs of health care and medicines and vaccines. We cannot afford waste in health care spending due to inefficiency.

We commit to:

IV

Make bold political choices for health across all sectors

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multisectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All, leaving no one behind, while addressing and managing conflicts of interest, promoting transparency and implementing participatory governance. We will strive to avoid or mitigate conflicts that undermine health systems and roll back health gains. We must use coherent and inclusive approaches to expand PHC as a pillar of UHC in emergencies, ensuring the continuum of care and the provision of essential health services in line with humanitarian principles. We will appropriately provide and allocate human and other resources to strengthen PHC. We applaud the leadership and example of Governments who have demonstrated strong support for PHC.

V

Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health2. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that

are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks.

The success of primary health care will be driven by:

Knowledge and capacity-building. *We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. We will continue to research and share knowledge and experience, build capacity and improve the delivery of health services and care.*

Human resources for health. *We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. We assert that the international migration of health personnel should not undermine countries', particularly developing countries', ability to meet the health needs of their populations.*

Technology. *We support broadening and extending access to a range of health care services through the use of high-quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines, vaccines, diagnostics and other technologies. We will promote their accessibility and their rational and safe use and the protection of personal data. Through advances in information systems, we will be better able to collect appropriately disaggregated, high-quality data and to improve information continuity, disease surveillance, transparency, accountability and monitoring of health system performance. We*

will use a variety of technologies to improve access to health care, enrich health service delivery, improve the quality of service and patient safety, and increase the efficiency and coordination of care. Through digital and other technologies, we will enable individuals and communities to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being.

Financing. *We call on all countries to continue to invest in PHC to improve health outcomes. We will address the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems in order to improve access and achieve better health outcomes. We will work towards the financial sustainability, efficiency and resilience of national health systems, appropriately allocating resources to PHC based on national context. We will leave no one behind, including those in fragile situations and conflict-affected areas, by providing access to quality PHC services across the continuum of care.*

VI

Empower individuals and communities.

We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.

VII

Align stakeholder support to national policies, strategies and plans.

We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

- ***We will act on this Declaration in solidarity and coordination between Governments, the World Health Organization, the United Nations Children's Fund and all other stakeholders.***

- ***All people, countries and organizations are encouraged to support this movement.***

- ***Countries will periodically review the implementation of this Declaration, in cooperation with stakeholders.***

- ***Together we can and will achieve health and well-being for all, leaving no one behind.***

উপরিল্লিখিত ঘোষণা সত্ত্বেও বিশ্বব্যাপি অর্জন সামান্যই। বাংলাদেশের সাধারণ জনগণ, প্রান্তিক জনগোষ্ঠী এখনও নূন্যতম স্বাস্থ্য সেবা পায় না। এমন এক পরিস্থিতিতে বাংলাদেশে ২০১১ সালে জাতীয় স্বাস্থ্য নীতি প্রণয়ন করা হয়। উপরিল্লিখিত স্বাস্থ্যনীতি প্রণীত হওয়ার পরবর্তীতে মাননীয় প্রধানমন্ত্রী শেখ হাসিনা উপরিল্লিখিত স্বাস্থ্যনীতি সংশ্লিষ্টতায় এক বাণী প্রদান করেন। **গুরুত্বপূর্ণ বিধায় গণপ্রজাতন্ত্রী বাংলাদেশ সরকার এর মাননীয় প্রধানমন্ত্রী শেখ হাসিনা এঁর বিগত ইংরেজী ২৩.০১.২০১২ তারিখের বাণীটি নিম্নে অবিকল অনুলিখন হলোঃ**

স্বাস্থ্য মানবসম্পদ উন্নয়নের গুরুত্বপূর্ন সূচক হিসেবে সর্বজনীনভাবে স্বীকৃত। আমাদের সংবিধানের অনুচ্ছেদ ১৫(ক) এবং ১৮(১) এ চিকিৎসাসেবা এবং জনগণের পুষ্টির

স্তর উন্নয়ন ও জনস্বাস্থ্যের উন্নতিসাধনকে রাষ্ট্রের অন্যতম মৌলিক দায়িত্ব হিসেবে স্বীকৃতি দেয়া হয়েছে।

সর্বকালের সর্বশ্রেষ্ঠ বাঙ্গালি, জাতির পিতা বঙ্গবন্ধু শেখ মুজিবুর রহমানের পদাঙ্ক অনুসরণ করে বর্তমান সরকার দেশের স্বাস্থ্যসেবার উন্নয়নে নিরলসভাবে কাজ করে যাচ্ছে। বাংলাদেশের স্বাস্থ্য সূচকগুলোর উন্নয়ন কাজ বিশ্ববাসীর দৃষ্টি আকর্ষণ করেছে।

বাংলাদেশ আওয়ামী লীগের নির্বাচনী ইশতেহার 'দিন বদলের সনদ' এ জাতীয় স্বাস্থ্যনীতি যুগোপযোগী করা, ১৮ হাজার কমিউনিটি ক্লিনিক চালু; পুষ্টি, শিশু ও মাতৃমঙ্গল নিশ্চিত করা; জনসংখ্যা নীতি যুগোপযোগী করা; জনসংখ্যা নিয়ন্ত্রণ ও প্রজনন স্বাস্থ্যসেবা নিশ্চিত করা; মানসম্মত ঔষধ উৎপাদনে আত্মনির্ভরশীলতা অর্জন এবং রপ্তানি বৃদ্ধির লক্ষ্যে ঔষধনীতি যুগোপযোগী করার অঙ্গীকার করা হয়েছে। পাশাপাশি হোমিওপ্যাথি, ইউনানি ও আয়ুর্বেদসহ দেশজ চিকিৎসা শিক্ষা এবং ভেষজ ঔষধের মানোন্নয়নের কার্যকর ব্যবস্থা গ্রহণ; এইচআইভি/এইডস, কুষ্ঠ, যক্ষাসহ সংক্রামক ব্যাধি প্রতিরোধের ব্যবস্থা করাসহ রোগ নিরাময়ে উন্নত চিকিৎসার সুযোগ সৃষ্টি করার কথা বলা হয়েছে।

নির্বাচনী অঙ্গীকার অনুযায়ী আমরা স্বাস্থ্যখাতে ব্যাপক উন্নয়ন কর্মসূচি বাস্তবায়ন করছি। এরই ধারাবাহিকতায় প্রণয়ন করা হয়েছে জাতীয় স্বাস্থ্যনীতি।

আমি আশা করি, জাতীয় স্বাস্থ্যনীতি বাস্তাবায়নের মাধ্যমে সবার জন্য মানসম্মত স্বাস্থ্যসেবা নিশ্চিত হবে। হতদরিদ্র ও সুবিধাবঞ্চিত জনগণ আরও বেশি উপকৃত হবেন।

জাতীয় স্বাস্থ্যনীতি ২০১১ এর সার্বিক সাফল্য কামনা করছি।

জয় বাংলা, জয় বঙ্গবন্ধু
বাংলাদেশ চিরজীবী হোক।
হেখ হাসিনা

সাংবিধানিক দায়বদ্ধতা এবং আন্তর্জাতিক অঙ্গীকার সত্ত্বেও বাংলাদেশ স্বাস্থ্যখাতে তার লক্ষ্যমাত্রা অর্জন করতে সক্ষম হয় নাই। কারণ বাংলাদেশে স্বাস্থ্য বিষয়টির বাণিজ্যিকিকরণ। বাংলাদেশের বর্তমান যে স্বাস্থ্য ব্যবস্থা তা যতটা না রোগীর ব্যাথা নিরাময় কিংবা রোগ মুক্তির, তারচেয়েও বেশী ঔষধ কোম্পানী, হাসপাতাল এবং তাদের সাথে সহায়তাকারী হাতেগোনা কিছু ব্যবসায়ীদের জন্য। ফলে রাতারাতি অনেক ঔষধ কোম্পানী, হাসপাতাল, ক্লিনিক এবং তাদের সাথে সম্পৃক্ত বড় বড় ডাক্তারদের টাকার পাহাড় হলেও সাধারণ জনগণের স্বাস্থ্য সেবা পাওয়া একদম তলানীতে। এটি শুধুমাত্র ভুক্তভোগীরাই জানে।

গুরুত্বপূর্ণ বিধায় ১লা জানুয়ারী ২০১৭ সালে প্রকাশিত NEJM Catalyst এ প্রকাশিত প্রবন্ধটি ইন্টারনেট থেকে নিম্নে অবিকল অনুলিখন হলোঃ

What Is Patient-Centered Care?

Explore the definition, benefits, and examples of patient-centered care. How does patient-centered care translate to new delivery models?

This article appeared in NEJM Catalyst prior to the launch of the NEJM Catalyst Innovations in Care Delivery journal. Learn more.

In patient-centered care, an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements. Patients are partners with their health care providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.

Elements of Patient-Centered Care

Patient- and family-centered care encourages the active collaboration and shared decision-making between patients, families, and providers to design and manage a customized and comprehensive care plan.

Most definitions of patient-centered care have several common elements that affect the way health systems and facilities are designed and managed, and the way care is delivered:

- *The health care system's mission, vision, values, leadership, and quality-improvement drivers are aligned to patient-centered goals.*
- *Care is collaborative, coordinated, and accessible. The right care is provided at the right time and the right place.*
- *Care focuses on physical comfort as well as emotional well-being.*
- *Patient and family preferences, values, cultural traditions, and socioeconomic conditions are respected.*
- *Patients and their families are an expected part of the care team and play a role in decisions at the patient and system level.*
- *The presence of family members in the care setting is encouraged and facilitated.*
- *Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.*

Figure 1 .

Patient-Centered Care: Patient at heart of care continuum. Patient goals & values top priority. Family involved at every stage.

Patient-Centered Care

Benefits of Patient-Centered Care

*The primary goal and benefit of patient-centered care is to improve **individual** health outcomes, not just **population** health*

outcomes, although population outcomes may also improve. Not only do patients benefit, but providers and health care systems benefit as well, through:

- *Improved satisfaction scores among patients and their families.*
- *Enhanced reputation of providers among health care consumers.*
- *Better morale and productivity among clinicians and ancillary staff.*
- *Improved resource allocation.*
- *Reduced expenses and increased financial margins throughout the continuum of care.*

Patient-Centered Care Examples

Patient-focused care is realized in a number of ways, across a variety health care settings, from family care and specialty providers, to acute, emergency, and long-term care providers. Here are a few examples.

1. ***Patient-centered care in the doctor's office.*** *Under patient-centered care, care focuses more on the patient's problem than on his or her diagnosis. Patients have trusted, personal relationships with their doctors in patient-focused care models. Empathy, two-way communication, and eye-to-eye contact are crucial, as is the ability of the doctor to see beyond a patient's immediate symptoms or pain. This broader look at the needs of the whole patient requires providers to offer services or referral to services such as peer support programs, social workers, financial counselors, mental and emotional health providers, transportation and daily living assistance, and in some communities, language and literacy education. While human interaction takes a primary role in patient-centered care, physician practices may also employ a variety of technology-based tools to help patients take ownership of their health care outside of the doctor's office. Tools range from 24/7 online portals that let patients schedule appointments, get information about their condition and care instructions, review lab results and doctor's notes, and pay bills at their convenience, to wearable technology and apps that let patients track their "important numbers"*

such as weight, blood pressure, glucose levels, and cholesterol.

2. ***Patient-centered care in the hospital.*** *Strict visiting hours and visitor restrictions are a thing of the past in a patient-centered care model. Patients are given the authority to identify who can visit and when. Family members (as defined by the patient and not limited to blood relations) are invited to visit during rounding and shift changes so they can be part of the care team, participating in discussions and care decisions. When not in the room with the patient, they are kept informed of their loved one's progress through direct and timely updates. A patient-centered care hospital's infrastructure encourages family collaboration through a home-like environment that not only meets the needs of the patient, but also meets the needs of family members. For example, maternity wards are being redesigned with family-friendly postpartum rooms that can accommodate the mom, new baby, and family members, who are encouraged to spend up to 24 hours a day together in the room to foster family bonding.*

3. ***Personalized medicine.*** *The concept of patient-centered care extends to the treatments and therapies clinicians provide. Not only are care plans customized, but medications are often customized as well. A patient's individual genetics, metabolism, biomarkers, immune system, and other "signatures" can now be harnessed in many disease states — especially cancer — to create personalized medications and therapies, as well as companion diagnostics that help clinicians better predict the best drug for each patient.*

Cultural Shift to Patient-Centered Care

As with other forms of value-based health care, patient-centered care requires a shift in the way provider practices and health systems are designed, managed, and reimbursed. In keeping with the tenets of patient-centeredness, this shift neither happens in a vacuum, it driven by traditional hierarchies in which providers or clinicians are the lone authority. Everyone, from the parking valet and environmental services staff to c-suite members, are

engaged in the process, which impacts hiring, training, leadership style, and organizational culture.

Patient-centered care also represents a shift in the traditional roles of patients and their families from one of passive "order taker" to one of active "team member." One of the country's leading proponents of patient-centered care, Dr. James Rickert, has stated that one of the basic tenets of patient-centered care is that "patients know best how well their health providers are meeting their needs." To that end, many providers are implementing patient satisfaction surveys, patient and family advisory councils, and focus groups, and using the resulting information to continuously improve the way health care facilities and provider practices are designed, managed, and maintained from both a physical and operational perspective so they become centered more on the individual person than on a checklist of services provided.

As the popularity of patient- and family-centered health care increases, it is expected that patients will become more engaged and satisfied with the delivery of their care, and evidence of its clinical efficacy should continue to mount.

গুরুত্বপূর্ণ বিধায় Health Lead ওয়েব সাইটে বিগত ইংরেজী ০৯.১১.২০১৮ তারিখের প্রকাশিত "Patient-Centered Care: Elements, Benefits and Examples" শিরোনামের প্রবন্ধটি নিম্নে অবিকল অনুলিখন হলোঃ

Patient-Centered Care: Elements, Benefits and Examples

The Institute of Medicine defines patient-centered care as "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions." *This approach requires a true partnership between individuals and their healthcare providers, one where the individual's needs and aspirations drive both healthcare decisions and how outcomes are measured.*

Under a patient-centered model model, care teams work to know and treat the full patient *— developing individualized,*

comprehensive care plans in which mental health and social needs receive equal attention to traditional medical treatment. As the overview from NEJM Catalyst states, patient- or family-centered care plans prompt health systems to rethink their approach to healthcare delivery — bringing new attention to active collaboration and shared decision-making with patients.

Among the common elements of effective patient-centered care plans:

- *The health system's mission, vision, values, leadership, and quality-improvement drivers are aligned to patient-centered goals.*
- *Care is collaborative, coordinated, and accessible. The right care is provided at the right time and the right place.*
- *Care focuses on physical comfort as well as emotional well-being.*
- *Patient and family preferences, values, cultural traditions, and socioeconomic conditions are respected.*
- *Patients and their families are an expected part of the care team and play a role in decisions at the patient and system level.*
- *The presence of family members in the care setting is encouraged and facilitated.*
- *Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.*

While the primary goal of any patient-centered care plan is to improve individual health outcomes, healthcare providers also stand to benefit through improved patient satisfaction scores, higher staff productivity and morale, reductions in the overall cost of care, and more. This makes patient- or family-centered care an approach worth exploring in almost any healthcare delivery setting.

উপরিল্লিখিত প্রবন্ধদ্বয় পর্যালোচনায় আমরা এটি বলতে পারি যে, প্রত্যেক নাগরিকের জন্য সম্মানজনক এবং প্রত্যেকটি রোগীকে গুরুত্ব দিয়ে মূল্যায়ন করে রোগীকে কেন্দ্র করে দেশে এমন স্বাস্থ্য ব্যবস্থা তৈরী করতে হবে যার উদ্দেশ্য হবে রোগীকে সর্বোচ্চ গুরুত্ব প্রদান করা।

সুতরাং প্রচলিত বা পশ্চিমা বা ওয়েস্টার্ন চিকিৎসা পদ্ধতির সাথে সাথে বিকল্প চিকিৎসা পদ্ধতিও আমাদেরকে গ্রহণ করতে হবে। এছাড়া বর্তমানে প্রচলিত বা পশ্চিমা চিকিৎসার সাথে সম্পূরক মেডিসিন হিসেবে থেরাপির ব্যবহার করা হচ্ছে। এমনকি ইন্টিগ্রেটেটিভ মেডিসিন এখন ব্যাপক আলোচনায়।

গুরুত্বপূর্ণ বিধায় বাংলাদেশের প্রকাশিত বিকল্প ধারার চিকিৎসা পদ্ধতি সংক্রান্ত কর্ম পরিকল্পনা নিম্নে অবিকল অনুলিখন হলোঃ

Annexure- 17

4th Health, Population and Nutrition Sector Programme

(4th HPNSP)

OPERATIONAL PLAN (OP)

Alternative Medical Care (AMC)

(January 2017-June 2022)

April 2017

Directorate General of Health Services

Health Service Division

Ministry of Health and Family Welfare

Government of the People's Republic of Bangladesh

Contents

Sd/- Illegible
Dr. Monowara Sultana
Line Director
Alternative Medical Care
DGHS, Mohakhali, Dhaka.

Operation Plan (OP)

1. *Name of the Operational Plan (OP): Alternative Medical Care (AMC)*

2. *Name of the Sector Programme: 4th Health, Population and Nutrition Sector Programme (4th HPNSP).*

3. *Sponsoring Ministry: Ministry of health & Family welfare*

4. *Implementing Agency: Directorate General of Health Services (DGHS)*

5. *Implementation Period:*
   a) Date of Commencement: January, 2017
   b) Date of Completion: 30 June, 2022

6. *Objectives of the OP:*

   a. Overall objective:

   To scale up Unani, Ayurvedic & Homeopathic Medical service throughout the country along with the Allopathic treatment to ensure quality & equitable health services for all citizen of Bangladesh and develop of Unani, Ayurvedic & Homeopathic education system.

   b. Specific objectives:

   1. To develop and expand Unani, Ayurvedic & Homeopathic Medical services as an effective treatment and give those institutional shape.

   2. To monitor & Control AMC practitioners by strengthening and functioning the regulatory bodies of Homeopathic, Unani, Ayurvedic registration council.

3. *To establish a central research council and a national herbal garden for academic and research purpose.*
4. *To develop a strict regulation to control the quality of AMC drugs in the country.*
5. *To establish a Central research Council and a National Herbal garden for academic and reserch purpose.*
6. *To upgrade the existing Unani, Ayurvedic & Homeopathic Medical College & Hospital.*
7. *To develop capacity of AMC service providers by conducting workshop; Orientation & Training.*
8. *To developed a carrier path (a national strategic plan) for the development of Unani/ Ayurvedic/ Homeopathic system of medicine.*
9. *To explore people's perceptions about Unani, Ayurvedic & Homeopathic medicine by providing quality services and thus reduces the unsound practices by the name of the AMC.*

7. Estimated Costs

7.1 PIP and OP Cost

				(Taka in Lac)
	Total	GOD	PA (UPA)	Source of PA
Estimated Total Cost of the PIP	115,48,636.00	96.63,913.00	18,84,723 00 (11,67,607.00)	Credits from IDA & JICA and Grants from DPs (DFID, GAC USAID, SIDA, EKN, WHO, UNICEF GHAIM ect.,)
Estimated Non-Development Cost of the PIP	72,00,000.00	72,00,000.00	0 0	
Estimated Development Cost of the PIP	43,48,636.03	24,63,913.00	18,84,723 00 (11,67,607.00)	
Estimated Cost of the OP	44,055.00	39,855.00	4,200.00	Pool Funds
OP cost as of PIP development cost	1.013%	1.618%	0.22%	

7.2 Estimate Cost of OP (Accounting to Financing Pattern):

Source	Financing Pattern	Y-1	Y-2	Y-3	Y-4	Y-5	Y-6	Total	Source of PA
GOB	GOB Taka (Foreign Exchange)	2,079.00	7613.25	8418.50	8336.75	8056.50	5351.00	39855.00	
	CD-VAT	-	-	-	-	-	-	-	
	GOB Others ... IDCF	-	-	-	-	-	-	-	
	Total GOB	2,079.00	7613.25	8418.50	8336.75	8056.50	5351.00	39855.00	
PA	RPA (Through IDCF)	0.00	1,140.00	1040.00	840.00	1040.00	140.00	4200.00	**Pool Funds**
	RPA (others)	-	-	-	-	-	-	-	
	DPA	-	-	-	-	-	-	-	
	Total PA	0.00	1,140.00	1040.00	840.00	1040.00	140.00	4200.00	
	Total (GOB + PA)							44055.00	

8. OP Management Structure and Operational Plan Components (Attached Management set up at Annexure- I)

8.1 Line Director: Director, Homeo & Traditional Medicine, DGHS.

8.2 Major Components of OP and their Programme Managers/DPM:

Name of Components	*Promgramme Manager*	*Deputy Programme Manager*
1. Strengthen AMC service in public hospitals in a phased manner by providing adequate Human resource, Medicine and equipments through the LD-AMC, DGHS to the MCHs, DHs, & UHCs. And supply of herbs and materials for herbal garden.	*PM (Deputy Director, Homeo & Traditional Medicine (DGHS)*	*DPM (Unani) Homeo & Traditional Medicine, DGHS*
2. Up gradation of Unani, Ayurvedic, Homeopathic education system by preparing Unani, Ayurvedic and Homeopathic pharmacopeia and standard treatment guideline and develop of existing Unani, Ayurvedic and Homeopathic Medical college and hospitals and review & upgrade of Curriculum of BUMS/BAMS/BHMS, introduce scholarship/fellowship for PG course.		*DPM (Hemeo) Homeo & Traditional Medicine. DGHS*
		DPM (Syurved) Homeo & Traditional Medicine. DGHS
3. Functioning of production & research of GUAMCH (Dhaka), GHMCH & GUAMCH (Sylhet), by Supply of equipment for Research quality Control of medicine, established of herbal garden in collaboration with concern Ministry & survey of AMC service.		
4. Capacity and Awareness build up by providing training workshop, BCC activities and		
5. National strategy & Action Plan in phases by forming different Committee for different activities, seminars & tacking to steps for established For AMC Registration Council.		

8.3 Proposed manpower in the development budget:

i. The list of the existing manpower (carried over from HPNSDP):

SL. No.	*Name of the Post*	*No. of the post*	*Pay scale 2015*	*Grade*	*Consolidated pay person/ Month*	*Total Month*	*Total Pay (taka in lakh)*	*Remarks*
	A. Officer							
1.	*Asst. Director (Unani-I/Ayur-I)*	*2*	*43000 – 69850*	*5th*	*66000*	*66 month*	*90.00*	
2.	*Asst. Prof (Ayur-I, Unani-2, Homeo-I)*	*4*	*35500 - 67010*	*6th*	*56525*	*66 month*	*150.00*	
3.	*R. P (U/A-1, H-I)*	*2*	*23000 - 54470*	*8th*	*37150*	*66 month*	*50.00*	
4.	*RMO-I (Unani)*	*1*	*23000 - 54470*	*8th*	*37150*	*66 month*	*25.00*	
5.	*Register (U/A-1, H-I)*	*2*	*23000 - 54470*	*8th*	*37150*	*66 month*	*50.00*	
6.	*Medical Officer (U-I/A-I/H-I)DGHS*	*3*	*22000 - 53060*	*9th*	*35600*	*66 month*	*71.00*	
7.	*Lecture (U-15/A-10/H-10)*	*35*	*22000 - 53060*	*9th*	*35600*	*66 month*	*823.00*	
8.	*Anesthesiologist (H)*	*1*	*22000 - 53060*	*9th*	*35600*	*66 month*	*24.00*	

9.	*Radiologist (U/A)*	*1*	*22000 - 53060*	*9th*	*35600*	*66 month*	*24.00*	
10.	*IMO (U-6, A-6, H-6)*	*18*	*22000 - 53060*	*9th*	*35600*	*66 month*	*423.00*	
11.	*Production/Research : QC officer (U-I/A-I/H-I)*	*3*	*22000 - 53060*	*9th*	*35600*	*66 month*	*71.00*	
12.	*Medical Officer (U-95/A-90/H-90)*	*275 (43**)*	*22000 - 53060*	*9th*	*35600*	*66 month*	*7569.00*	
	B. Staff							
13.	*Computer operator*	*1*	*10200 – 24680*	*14th*	*18300*	*66 month*	*13.00*	
14.	*Office Assistant*	*1*	*9300 - 22490*	*16th*	*17045*	*66 month*	*12.00*	
15.	*Support Personal (Compounder)*	*277 (63**)*	*9300 - 22490*	*16th*	*17045*	*66 month*	*3117.00*	
16.	*Herbal Assistant /Medical Assistant*	*5*	*9300 - 22490*	*16th*	*17045*	*66 month*	*57.00*	
17.	*Herbal Assistant (Gardener)*	*469**	*9300 - 22490*	*16th*	*17045*	*66 month*	*7375.00*	
18.	*Account Assistant*	*1*	*9300 - 22490*	*16th*	*17045*	*66 month*	*12.00*	
19.	*MLSS*	*2*	*8250 - 20010*	*20th*	*15550*	*66 month*	*21.00*	
	Total	*1103*					***19977.00***	

- *This post transferred in the 4th Sector Programme as RP (Ayur) and Register (Ayur) because existing Manpower appointed from Ayurvedic department.*
- *This Manpower come from UNPSP.*

ii. Newly created man power in the development budget (2017-2021):

SL. No.	*Name of the Post*	*No. of the post*	*Pay scale 2015*	*Grade*	*Consolidated pay person/ Month*	*Total Month*	*Total Pay (taka in lakh)*	*Remarks*
	A. Officer							*Additional reponsibility/to be deputed/attached*
1.	*Line Director*	*1*		*¾*				
2.	*Program Manager*	*1*		*4/5*				
3.	*Deputy Program Manager (U-I/H-1/A-1)*	*3*		*5-7*				
4.	*Accounts Officer*	*1*		*10*				*to be deputed/attached*
5.	*Accountant*	*1*		*14*				
6.	*Ast. Director (Hom-I)*	*1*	*43000 – 69850*	*5th*	*66000*	*66 month*	*44.00*	
7.	*Asst. Prof (Unani-I, Ayur-I, Homeo-I)*	*3*	*35500 – 67010*	*6th*	*56525*	*66 month*	*112.00*	
8.	*R. P. (U-I)*	*1*	*23000 – 54470*	*8th*	*37150*	*66 month*	*25.00*	
9.	*Register (U-I)*	*1*	*23000 – 54470*	*8th*	*37150*	*66 month*	*25.00*	
10.	*Lecturer (U-7, A-2, H-2)*	*11*	*22000 - 53060*	*9th*	*35600*	*66 month*	*260.00*	
11.	*Asst. Register (U-I/A-I)/H-I)*	*3*	*22000 - 53060*	*9th*	*35600*	*66 month*	*71.00*	
12.	*Medical Officer (U-19/A-20/H-20)*	*59*	*22000 - 53060*	*9th*	*35600*	*66 month*	*1390.00*	
13.	*Production/Research /QC Officer (U) GUAMCH, Sylhet*	*1*	*22000 - 53060*	*9th*	*35600*	*66 month*	*24.00*	
14.	*Drug Superintendent (U-1/A-1/H-1), DGDA*	*3*	*22000 - 53060*	*9th*	*35600*	*66 month*	*71.00*	
15.	*Pharmacist*	*3*	*16000 – 38640*	*10th*	*27100*	*66 month*	*54.00*	
16.	*Inspector (U-3, A-3, H-3) DGDA*	*9*	*16000 – 38640*	*11th*	*21700*	*66 month*	*129.00*	
	B. Staff							
17.	*Production Assistant*	*4*	*9300 - 22490*	*16th*	*17045*	*66 month*		*To be outsourced*
18.	*Herbal Assistant (Gardener)*	*3*	*9300 - 22490*	*16th*	*17045*	*66 month*		
19.	*Driver*	*6*	*9300 - 22490*	*16th*	*17045*	*66 month*		
20.	***Sub Total***	***115***					*2205.00*	
21.	*Festival Allowance of Total Manpower (4713)*						*2240.00*	
22.	*Bangla New year Allowance (4714)*						*284.00*	
23.	*Outsourcing Manpower Labour Fee & allowances (4851)*						*294.00*	
24.	***Total***	*1218*					***25000.00***	

** Recruitment procedure:*

Officers of different categories will be selected by a 5 (five) member committee approved by the Ministry of Health & Family Walfare. Priority shall be given during selection to those who will possess excellent academic background & experiences. Application will be invited from the intending candidates in National Dailies for filling the created development posts of DGHS, Selected Medical College Hospital, Govt. Unani & Ayurvedic Medical College & Hospital, (Dhaka & Sylhet) Govt. Homepathic Medical College & Hospital, District Hospital & Upajila Health Complexes, Written test followed by viva voce will be undertaken for selection & the details to be worked out by the selection committee.

The others manpower (Supporting Staff) will be selected on the basis of Written a by the selection committee.

Selection Committee for Officer

a. Additional Secretary (MOH&FW)	*Chairperson*
b. Director Admin. DGHS	*Member*
c. Principal Govt. Unani, Ayurvedic Degree College/ Principal Govt. Homoeopathic Degree College	*Member*
d. Representative from MOH&FW (project Implementation) (Not below than DS)	*Member*
e. Line Director, Alternative medical care, DGHS	*Member Secretary*

Selection Committee for staff

a Line Director, Alternative medical care, DGHS	*Chairperson*
b. Deputy Director Hospital, DGHS	*Member*
c. Representative from MOH&FW	*Member*
d. Representative, Director AMC (Not below the rank of Medical officer AMC)	*Member*
e Deputy Director/P.M, Alternative medical care, DGHS	*Member Secretary*

9. Description:

a) Background information, current situation and its relevance to National Policies. Sectoral Policy, SDG, vision 2021, Seventh Five Year Plan, MTHF.etc.

Alternative Medicine (AM)/ Traditional Medicine is as ancient as human civilization, dating back to 5000 B.C. in China. 4500 B.C. in India 1000 B.C in Egypt. Babylon. Traditional Medicine includes mainly Unani, Ayurvedic medicine in this

region. In Bangladesh AMC means Homoeopathy and Traditional Medicine (Unanı, Ayurvedic.). Homoeopathy is low-priced, less side-effected available treatment system which is popular in rural areas in case of PHC sector as well as in case of chronic metastatic conditions. These medicine may be herbal, animal & mineral origin, Both the Systems of medicine (Unani and Ayurvedic) can be called as Traditional Medicine, which are used in this country for years together & is handed down generation to generation. TM Provide health care mostly in the rural community. Our country is very rich in medicinal flora & these Systems are closed at our culture, diet & regimen. Introducing Traditional Medicine as an Alternative Medicine will help the Nation in Five dimensions;

1. *Saving foreign exchange.*
2. *Use general labor for intensive Cottage industries.*
3. *Make self reliant in medicine.*
4. *It will save the environmental balance by Plantation of more medicinal Plants.*
5. *It also makes vital roles in GDP by producing Alternative Medicine (Unani, Ayurvedic & Homoeopathy) in Traditional method to use different medicinal Plants or herbs which are available in our country.*

The rural people of Bangladesh accept the Alternative medicine over allopathic medicine due to.

1. *It is cheap, simple & generally without serious side effects,*
2. *It involves Indigenous technology & labor.*
3. *It is locally available & culturally acceptable.*

It is an effective extension of home remedies quit prevalent in rural areas. Alternative medicine (AM) playing a significant role in health care delivery not only in developing countries but al the developed countries including USA, UK, Canada and others. The Alternative medicine in Si Lanka meets the basic health needs of 70% of population up to 80% of the people in Africa are

reported to seek traditional medicine for their medical care, in China it is said to be 40%. The percentage of traditional medicine utilized in Australia is reported to the 48%, 70% in Canada, 42% in the USA, 38% in Belgium and 75% in France

Alter the Drug Control Act of 1982, Bangladesh Government has taken different stops for the development of alternate medical care and present Public friendly Government also has taken different steps for this purpose such as manpower recruitment and strengthen of educational institutes Government Unani and Ayurvedic Medical College & Hospital with Production & Research Unit was established in 1990 and Government Homoeopathic Medical College & Hospital established separately in the same year. Bachelor of Unani Medicine & Surgery (BUMS), Bachelor of Ayurvedic Medicine & Surgery (BAMS), Bachelor of Homeopathic Medicine & Surgery (BHMS) degrees are given in the three disciplines after five years of study. After graduation a one year internship is compulsory in the 100 bed hospital established for the AMC In addition a private Homeopathic Medical College, 17 Unani diploma institutes, 9 Ayurvedic diploma institutes and 53 homeopathic diploma institutes in Bangladesh. These diplomas are given after four years of study and 6 months of internship: The Board of Unani & Ayurvedic Systems of Medicine and Homeopathic board controls offering of the diploma certificates & Practice Registration Bachelor degrees in any of these three disciplines are given by the University of Dhaka and registrations for graduate doctors are given by the Homeo & Traditional Medicine wings of DGIIS. Near about 3,50,000 different categories Unani, Ayurvedic & Homoeopathic doctors are practicing in our country and about 700 industries are producing Unani, Ayurvedic & Homoeopathic drugs.

Already 338, Unani, 314 Ayurvedic & 1424 Homoeopathic registered graduate doctors are practicing in the country.

In the 40th World Health Assembly held in May 1987, a resolution urging the member states to utilize the traditional practitioners of their country optimally was adopted unanimously. In the proposed National Health Policy of 2010 of Bangladesh, which was approved in the Cabinet, particular emphasis has been given to encourage systematic improvement in the practice of

indigenous systems of medicine and to engage additional man power, giving particular attention to the scientific evaluation of indigenous medicines, currently 255 medical officers or equivalent have been recruited to strengthen the services under AMC and signed of Memorandum of Understanding (MOU) between The Peoples Republic of Bangladesh and The Peoples Republic of India to develop education sector and Alternative medicine.

AMC makes a vital roles in SDG's better health for prosperous society' to provide equitable access to high quality Unani. Ayurvedic and Homeopathic medical services for all citizen of Bangladesh. For this we should strengthening AMC council to regulate practitioners through a registration system.

1. *Raise awareness about AMC and treatments especially for NCDs.*
2. *Promote effective treatments based on Unani, Ayurvedic and Homeopathic Medical services within communities and wider health systems.*
3. *To build up capacity of AMC services providers by conducting orientation, workshop & training and collaboration with local health facilities.*

b) Related Strategies as the PIP:

The use of Traditional Medicine is increasing throughout the world. In this subcontinent Traditional Medicine is being utilized from very ancient time. The demand of Traditional Medicine in our country is increasing day by day. If the Alternative Medical Care facilities is expanded throughout the country people will get the service easily with least cost. Expansion of Alternative Medical Care services will help the people of all classes to get health facilities with least costs, burden on conventional treatment can be reduced and also unscientific and quackery treatment can also be reduced.

1. *Creation of central herbal garden will be used for academic and research purpose for both students and researchers, collection of raw materials and also preservation of some medicinal plants to avoid distinction.*

2. *To use medicinal plants in PIC (Primary Health Care).*

3. *Office equipments, furniture's and other accessories will help to lead better treatment data collection for patients, data collection from herbal garden, Record keeping, communication with headquarter, global perspective and other for smooth running of the college and Hospitals, District Hospitals and Upazilla Health Complexes.*

10. Priority Activities of the OP

Components wise Activities.

Components-1: Strengthen AMC services in public hospitals in a phased manner

The National strategy and action plan of AMC proposed that 3 AMC doctors (1 from each stream Unani, Ayurvedic and Homoeopathic) may be provided to Medical College Hospitals whereas only 2 AMC Doctors (One from Unani or Ayurvedic and the other form Homoeopathy) may be provided to district hospitals and upazilla hospitals. This was strongly opposed in the dissemination workshops, on the ground that Unani and Ayurvedic are very different from each other. It was suggested that, as such, at least I Medical Officer from each of the three streams should be made available from each to these three levels.

Activities:

1. *Continuation of AMC services by providing adequate Human resources, Medicine and equipments through the LD-AMC, DGHS to the MCHS, DHs & UHCS.*

2. *To provide preventive and curative services to the service recipients at Govt. Health facilities.*

3. *To integrate AMC services with the national health care delivery systems.*

4 *Service facilities increase from primary to tertiary level.*

To implement the above activities procurement of necessary Unani/Ayurvedic/Homoeopathic medicines, equipments

of MSR & furniture will be needed. Fund also be allocated for pay & allowance, orientation, workshop & training purposes.

Component-2: Upgradation of Unani/Ayurvedic/Homoeopathic education system.

GUAMCH, GHMCH and Govt. Tibbia College, Sylhet do have attached hospital but these could be better utilized particularly in term of providing maternal and child health care services. There is no institution available in the country to impart Post graduate education and research. BSMMU mandate includes establishment of a faculty for AMC (Unani, Ayurvedic and Homoeopathy).

However, this has not yet been implemented. For this the "National Strategy and Action Plan of autonomous institution under 11SMMU. It also proposed that Unani, Ayurvedic and Homoeopathic hospital many start 24X7 MCH care and should also start handling minor pregnancy complications overtime. This should be a re requisite for considering PG education in these two institutions.

Activities:

1. *Prepared Unani, Ayurvedic and Homoeopathic Pharmacopoeia and formularies.*
2. *Review & upgrade of Curriculum of BUMS/BAMS/BHMS.*
3. *Introduce Scholarship/Fellowship for PG courses, MD, PhD.*

Comprent-3: Functioning of production & research unit of GUAMCH, GHMCH & Govt. Tibbia(Unani) College.

Currently there is no academic research in AMC (Unani, Ayurvedic and Homoeopathy) in the country as there is no academic institution providing PG education and research. To encourage collaborative research for a) Testing efficacy of AMC in handling public health issue and b) developing integrated protocols for major communicable and non-communicable diseases particularly for life style diseases like diabetes, HTN.

For this the "National Strategy And Action Plan of AMC" proposed that established a) national ethics committee for AMC

research, b) to establish "Bangladesh AMC research challenge fund". c) sponsor for PG courses, d) setup a "Center for Coordination Applied Research in Alternative Medical Care" in the BCSIR. For this now we suggest to develop production and research unit in GUAMCH and GHMCH and set up a production & research unit in Govt Tibbia (Unani) College.

Activities:

1. *Formation of Ethics committee for research.*
2. *Supply of Equipment for research, quality control and production of medicine.*
3. *To build up of skilled manpower.*
4. *Purchase of raw materials (herbs and medicinal plants).*
5. *Research and survey for determining the situation of Unani, Ayurvedic and Homocopathy NCD and CDC services.*
6. *Establish herbal garden in collaboration with concern ministry/ divisions.*

Compotent-4: Awareness buildup.

Homoeopathy and Traditional Medicine, which are used in this country for years together & is handed down generation to generation. Those provide health care mostly in the rural community. Our country is very rich in medicinal flora & these Systems are closed at our culture, diet & regimen. The rural people of Bangladesh accept the Alternative medicine along with allopathic medicine due to.

* *It is cheap, simple & generally without serious side effects.*
* *It involves Indigenous technology & labor.*
* *It is locally available & culturally acceptable.*

It is an effective extension of home remedies quit prevalent in rural areas. Alternative medicine (AM) playing a significant role in health care delivery not only in developing countries but also in the developed countries including USA, UK, Canada and others. In Bangladesh AMC means Homoeopathy and Traditional Medicine (Unani, Ayurvedic.). Homeopathy is low-priced, less side-effected available treatment system which is popular in rural

areas in case of PHC sector as well as in case of chronic metastatic conditions. But lack of awareness about AMC (Unani Ayurvedic and Homoeopathy) huge amount of malpractice occurred by quack level in throughout the country by the name of about AMC (Unani, Ayurvedic and Homoeopathy).

Activities:

1. *To make a new herbal garden in different MCH and UHC.*
2. *To setup Billboard in different health centers for awareness and advertisement in electronic and press media.*
3. *To prepare leaflet, festoon and impart training to the service provider for creating awareness among the mass people on AMC services.*
4. *Research and survey for development of Unani, Ayurvedic and Homoeopathic system of medicine.*

Compotent-5: National Strategy and Action Plan implementation in phases.

National strategy of AMC has recommended various actions- on service deliveries, educations and training, Regulation of education & practice, quality control of drugs, cultivation & conservation of medicinal plants, research & Programme Management. These recommendations will be implemented in phases.

Activities:

1. *Formation of different committee for different activities.*
2. *Support for holding regular meeting.*
3. *Organize workshop/seminars.*
4. *TA support for implementation of different activities under AMC action plan.*

11. Relevant result Frame Work Indicators (RFW) and OP level indicators:

Relevant RFW Indicators:

11.1 Relevant RFW Indicators

Not Applicable

11.2 OP level Indicators (output/Process):

	Indicators	*Unit of Measurement*	*Base Line (With Year and Data Source)*	*Projected Target*	
				Middle of Programme	*End of Programme*
(1)		*(2)*	*(3)*	*(4)*	*(5)*
1.	*Facilities Introduced AMC*	*Number (Admin record)*	*59 DH, 5 MCH & 145 UHC's (also 3 DGHS, 27*	*63 DH, 15 MCH & 180 UHC*	*63 DH, 26MCH & 200 UHC*

			Unani & Ayurvedic Colleges & Hospital, 21 Homeopathic College & Hospital. 11 Tibbia Colleges (APIR 2016)		
2.	*No. Of AMC Pharmacopoeia & Formularies/Prepared Unani, Ayurvedic & Homeopathic Pharmacopoeia & Formularies*	*No (Record)*	*05 (Office Record, DGHS)*	*10*	*15*
3.	*No. Of medicinal Herbal Garden/Prepared Herbal Garden (Plantation of medical Plants)*	*No (Record)*	*472 (Office Record, DGHS)*	*490*	*500*

11.3 Source and methodology of data collection to measure/preparation of annual progress report:

OPD data will be collected from the selected medical College Hospital's, District Hospital's & upazila health complexes & Indoor Patient Department (IPD) data will be collected from GUAMCH & GHMCH, Dhaka. Through DHIS2 Under the supervision of LD, AMC, Data will be accumulated & finalized for report writing.

গুরুত্বপূর্ণ বিধায় বিগত ইংরেজী ১২ই নভেম্বর ২০১৯ তারিখে Hindawi (Evidence-Based Complementary and Alternative Medicine, Volume 2019, Article ID 3706143, 14 pages https://doi.org/10.1155/2019/3706143)-তে প্রকাশিত গবেষণা প্রবন্ধটি নিম্নে অবিকল অনুলিখন হলোঃ

Research Article

Contributing to Global Health: Development of a Consensus-Based Whole Systems Research Strategy for Anthroposophic Medicine

Published 12 November 2019

1. Background

Traditional and complementary medicine (T&CM) is broadly and increasingly used around the world [1].) ewide use is

related to cultural aspects and health belief models and to the needs of patients for "whole person care."T&CM has a strong focus in health maintenance and disease prevention but is also frequently applied for chronic non-communicable diseases (NCDs). Former WHO general director Margret Chan regarded T&CM as an often-underestimated part of health services, particularly with regard to addressing the challenges of chronic NCDs [1–3]that reach epidemic proportions worldwide, accounting for two-thirds of all deaths. Chronic NCDs have a huge economic impact and lead to high morbidity and disability[4, 5]. Risk factors are mainly lifestyle-related [6] and are associated with the increasing globalization. To address this enormous health challenge, a wider perspective may be sensible: an integration of successful health-supporting strategies and treatments from conventional medicine and T&CM, embedded in transcultural understanding and collaboration.)is could increase the number of effective approaches, implement them in culturally related health strategies, and target them to the personal values, needs, and resources of the highly heterogeneous populations of patients. As an example, India is mitigating the disease burden of NCDs by launching a National Health program that includes AYUSH systems [7].

The basis for such integrated endeavors is transparency of efficacy, effectiveness, safety, ethics, economics, and understandability of the healthcare strategies, which are the goals of evidence-based healthcare (EBHC): decision-making should be based on evidence, clinical expertise, and patients' values [8–10]. In pursuit of this goal, the development of new health technologies is driven by systematic research. Medicine, however, consists of many interventions, procedures, and treatment systems that have existed since long before the principles of EBHC were introduced. This applies not only to surgical, pharmacological, and no pharmacological interventions and general care principles, but also to T&CM (traditional Chinese medicine and Ayurveda, for instance, have existed for thousands of years); self-help approaches (like teas, baths, and wraps);healthy and disease-preventive lifestyles; and integrative medicine (IM) overall.

IM is an umbrella concept, still being developed for the modern and evidence-informed integration of traditional, natural, mind-body, and complementary treatments with conventional

medicine. IM systems share the following characteristics: emphasis on salutogenesis, the "natural healing power" of the organism; a holistic understanding of the human being, incorporating physical, mental, emotional, spiritual, and social issues; a focus on lifestyle modifications; extensive use of non pharmacological interventions; strong emphasis on the therapeutic relationship between practitioner and patient; shared clinical decision-making sup-ported by evidence; and the use of both conventional and complementary treatments [11, 12]. T&CM or IM systems comprise whole healthcare systems that have a distinct, unique perspective on nature, the human organism, and disease and derive their therapies accordingly [13]. Some T&CM interventions have received wide attention in medicine, e.g., Artemisia annua (Nobel Prize 2015 [14]),mind-body medicine techniques like meditation [15], yoga[16, 17], acupuncture [18], and many modern medicines derived from natural products that were first used in a traditional medicine context [1–3].

T&CM methods are broadly investigated, further developed, tested, and verified using scientific methods[2, 3, 18–20] that are supported by research networks (e.g., WHO, CAMbrella, NCCIH, SIO, ISCMR, ACIMH)[1, 21–28].)e Cochrane library lists more than 460Cochrane reviews and more than 26,000 randomized con-trolled trials (RCTs) on T&CM [29]. These often mimic conventional mono-drug research investigating specific efficacy with explanatory placebo-controlled RCTs. However, given the specific challenges of investigating complex therapies as well as patient-centered care, there is currently a shift toward pragmatic research targeting comparative effectiveness of interventions as they are practiced in real-life situations. Furthermore, the importance of patients' subjective experiences is increasingly recognized as accountable and as necessary measures in health intervention evaluations. Also patient's healthy resources and values are seen as essential to promote a healthy lifestyle, reduce risk factors, and support compliance. These considerations lead to an increased use of qualitative research to explore patients' views and needs. They also lead to the construction of questionnaires that assess dimensions of health care that are of real concern for patients. A mixed-methods approach is pursued to gather information from multiple sources[1, 9, 21–28, 30–35].

Anthroposophic Medicine (AM) is one of the whole healthcare systems of IM [36]. It is based on a holistic, system-oriented understanding of man and nature, including disease and treatment. Its organismic concept consists of four levels (physical organization, life processes, soul, and spirit) and three constitutional systems (nerve-sense, metabolic-limb, rhythmic). AM is embedded in country wide care systems, secondary and tertiary care hospitals, primary health centers, and private medical practices [36]. It applies medicines derived from plants, minerals, and animals; nursing procedures like rhythmical embrocations, baths, and wraps; arts therapies like music, painting, and sculpture; movement (eurythmy) therapy; physiotherapies such as rhythmical massage; lifestyle recommendations associated to AM philosophy concerning nutrition, agriculture, education; and meditation and mindfulness, psycho-spiritual counseling, and psychosocial support. AM care is provided by certified medical doctors, nurses, therapists, midwives, psychotherapists, and nutritionists [36–38]. AM education is provided by specific schools, universities, and other academic institutions [36].

AM has been widely investigated [36, 39, 40]; however, additional research activities are needed: owing to the goals of EBHC; for research-driven innovation and development in AM therapies and strategies; and to assess whether certain AM approaches can contribute to the management of significant healthcare problems, particularly chronic NCDs. These approaches include specific treatments such as certain nursing applications (to treat, for instance, insomnia, anxiety, chronic pain, osteoarthritis) [41, 42]; herbal extracts(e.g., for skin diseases, cancer, maternity care, and atopic diseases) [43, 44]; and eurythmy therapy (e.g., for chronic pain, mental conditions, high risk of falling among the elderly) [45]. They also include multimodal concepts (e.g., for fatigue and other quality-of-life issues in chronic NCDs and chronic infections) [46, 47]; models of patient-centered care (e.g., for pediatric diabetic care or depressive disorder)[48–50]; community care (e.g., for chronic pain with associated multimorbidity) [51]; strategies for dealing with fever (http://warmuptofever.org/en/) [52]; prevention strategies (for atopic diseases and allergies) [53, 54]; and support of self-efficacy [55] and perspectives on both the patient's and the care provider's needs [56, 57].

The investigation of a whole healthcare system like AM[13] entails a number of specific challenges:

(i) The patient-centered vs disease-centered approach, which is a hallmark of AM with its strong focus on individual resources of the patients and their psychological, biographical, and spiritual needs, and on shared decision-making and support of self-efficacy. This approach shifts the focus from study methods that assess effectiveness of therapies for average patients sharing a particular diagnosis; rather, it addresses the question of whether the therapy is effective for this individual patient with (potentially)several diagnoses (in theory, highly individualized patient-centered care can be tested as a black box in pragmatic comparative trials, but these trials, in addition to their exceeding complexity, lose explanatory power, transparency, and transferability of the results) [58].

(ii) The multimodal approach, applying several interventions (including conventional and other T&CM methods) in the same patient, depending on the condition.)is addresses the complexity of chronic NCDs in particular and the frequent concomitant diseases.

(iii) The large diversity of treatments: about 1000 medicinal products and medicinally used natural substances [59], as well as therapeutic approaches like nursing approaches, arts or movement therapies, and counseling. This by far exceeds the single-component efficacy testing with one or two clinical trials each.

(iv) The limited number of patients "fitting into" the trials while accepting a standardized care allocated randomly and who are not already recruited by competing trials [60–62]. Also, the limited acceptance of randomization by AM care providers [62]restricts the conductibility of large trials.

(v) The high costs of trials (confirmatory drug trials costing 11–53 million US$, on average [63]) and sparse funding possibilities (commercial interest

restricted to a few remedies, rare public funding, most research being supported by foundations, philanthropic engagement or personal commitment of researchers). This necessitates an efficient use of resources.

(vi) *AM care is often perceived as a therapeutic process, a "healing journey" shared by patient and practitioners stemming from a spiritual "commitment"[64] and not to be disturbed by a clinical trial design. Specifically, as these "joined healing journeys" may reveal perspectives for addressing unmet needs of severely ill patients [65, 66], evaluation designs should preserve or even uncover preferences, individualization and intercultural experience, and potential effects related to practitioner-patient communication and rapport.*

Given this complex situation and the challenges it presents, a strategic framework is sensible to test efficacy, effectiveness, and the cost-benefit ratio; to ensure safety and ethical principles as well as real-life application; to provide transparency and explore patients' needs, views, experiences, and the public's interest; and to contribute potential solutions for health challenges such as chronic NCDs. To develop this research strategy, a consensus process was chosen in order to incorporate different views, expertise, and resources.

2. Development of a Consensus-Based Research Strategy: Methodology

In developing the research strategy, we pursued a three-phase consensus process adapted to the Guidance for Developers of Health Research Reporting Guidelines[67, 68]:)is consisted of (1) premeeting literature reviews, firstly on recommendations for investigating whole healthcare systems, and secondly on which objectives, to what extent, have been investigated on AM up to now; this was followed by interviews with key stakeholders to supplement or revise items of the research strategy, to include rationale and supporting references, and to tailor the strategy to AM research; (2) face-to-face consensus meetings for further

developing and tailoring the strategy; and (3) post meeting feedback followed by finalization.

2.1. Phase I. Key items of the strategy were developed from first literature review. They were presented to, discussed with ,and supplemented by 162 key stakeholders in the field who fulfilled at least one of the following criteria: members of AM research council; representatives of AM at academic institutions, AM physicians, or members of patients associations; researchers in the field with different expertise; AM nursing and nursing scientists; arts therapists; representatives of AM supporting foundations; pharmacists (including AM-related pharma executives and research or medical directors); AM contact persons for regulatory agencies; and medical educators (including lecturers with university academic appointments). Stakeholders included healthcare practitioners employed in a conventional non-AM medical setting, and medical directors of units/departments within a conventional setting where AM is being newly implemented. Countries represented were Germany, Italy, Switzerland, Great Britain, Hungary, Sweden, Slovenia, Spain, South Korea, Netherlands, Israel, Russia, USA, Brazil, Chile, Peru, Argentina, and India.

2.2. Phase 2. The face-to-face consensus meeting at the International Research Council in Dornach, Switzerland(September 2017), included 25 participants. The meeting began with a review and discussion of the recommendations elicited during the literature review and interviews of Phase1. These recommendations were clarified, further justified, modified, or new details were added. Additionally, the strategy was presented and discussed at two conferences in Filderstadt, Germany (May 2017), and Dornach, Switzerland(March 2018), including 45 and 107 international experts on AM research and practice, respectively.

2.3. Phase 3.The draft strategy was refined and sent for review to the AM Research Strategy Group (n=48). The finalized strategy incorporated the feedback from this group.

3. Results: An Integrative Research Strategy

Just as AM covers many fields in healthcare, nearly all medical specialties, in different settings (outpatient, inpatient;

primary, secondary, tertiary care; private practice or within the public health insurance system; acute and chronic conditions; medical prevention; health education and pedagogy) with the help of a wide variety of healthcare providers and training specialties, the field of active research is widespread.

Therefore, an integrative evaluation strategy is seen as sensible and has already been implicitly pursued. A reasonable amount of methodologically rigorous confirmatory RCTs on exemplary therapies and indications should be conducted. However, the majority of interventions should be assessed in system evaluations and smaller studies. Research on biomedical, physiological, pharmacological, psychological, anthropological, and nosological issues provides insight into treatment and care processes and also into patients' perspectives, goals, and achievements.)e different sources of information around this strategy address individual interventions and also the complexity, different core aspects, and challenges of the whole healthcare system and the patientcentered approach. Loss of important information using only one design is minimized, as the specific focus and strength of each design complement those of others.)us, by merging different designs and results, a comprehensive "evidence house" will be possible, with different parts serving as pieces of a puzzle to complete a whole picture.

The strategy could be a framework for

(i) Researchers investigating AM and T&CM, assessing or discussing AM, collaborating internationally

(ii) Care providers participating in, supporting, informing, or presenting research

(iii) The medical community in general, professional organizations, medical directors for information, transparency, dialogue, and decision-making

(iv) Authorities, regulating AM

(v) Health policy and prevention policies implementing research results

(vi) Private and public funders, pharmaceutical companies funding research

(vii) Patients and their relatives and representatives, advocacy groups

(viii) Students and educational organizations (e.g., universities) with interest in T&CM

(ix) The public, civil organizations, via public relations and journalism

The methodological aspects of the strategy are outlined in the following section, supplemented by examples of previous and current AM research. The details are exemplary and will have to be adapted based on resources, research results, research methods, quality standards and administrative requirements, healthcare issues and health policy, funding policies, and the resources and interests of researchers.

The strategy refers to the research on (I) efficacy/effectiveness; (II) safety; (III) economics; (IV) evidence synthesis; (V) methodological issues; (VI) biomedical, physiological, pharmacological, pharmaceutical, psychological, anthropological, and nosological issues as well as innovation and development; (VII) patient perspective and involvement, public needs, and ethics; (VIII) educational matters and professionalism; and (IX) disease prevention, health promotion, and public health.

3.1. Efficacy/Effectiveness

3.1.1. Evaluation of the Multidisciplinary Health System as a Whole, or of Complex Multimodal Therapy Concepts. A system evaluation, rather than assessing a specific remedy or treatment modality, approaches the entire complex, multidisciplinary, and multimodal treatment procedure. It is a "black box" approach to the whole treatment system or to specific multimodal therapy concepts and does not primarily differentiate the effects of the singular interventional elements. System evaluation studies assess several interventions that are simultaneously applied (for instance [46]) and/or individually tailored (for instance [62, 69, 70]). These studies can investigate established multimodal AM treatment concepts for relevant conditions (like rheumatoid arthritis [71] or cancer-related fatigue [46]) applied across all patients, and individually adapted to meet the patients' strengths and limitations. Outcomes can be disease-specific or more general PROMs (e.g., health-related quality of life) or patient-generated (e.g., MYMOP [72]). Such studies can also investigate the whole system of AM, for instance in patients with one or more chronic conditions (e.g., [69, 70, 73]), but also with acute diseases (e.g.,

[62]), diagnosed, treated, and counseled within the AM understanding of man and nature. Hereby, the healthcare providers' diagnostic and therapeutic abilities are also a major part of the "black box." Depending on the conditions included, possible outcomes can be more generic, like a disease score or survival (e.g., in cancer), or patient-generated, or health-related quality of life, but also diseasespecific outcomes in subgroups with a specific condition (as in the Anthroposophic Medicine Outcome Study, AMOS [69, 70]). These studies can also investigate certain care models, particularly for chronic diseases (e.g., depression [50] or community care models [51]), or specific patientcentered care models (like patient-centered diabetic care [48, 49]).)e evaluation methods acknowledge the multilevel nature of many diseases and the individual presentation of diseases in most patients and the necessity for a multimodal and individualized therapeutic approach [1, 9, 21–28, 30–34, 74]. For such evaluations, different study designs can be chosen depending on the patient groups, interventions, controls, and contexts: comparative effectiveness studies, observational research (potentially using a bias suppression analysis or systematic outcome comparison as used in AMOS [75, 76]), experimental designs, pragmatic trials [69, 70], preference-based trials, quasi experimental designs (using for instance interrupted time-series, instrumental variable analysis, regression discontinuity analyses, as reviewed in [77, 78]), or health services research [79]. In several of these designs, also matched-pair comparisons, synthetic controls and other regression techniques can be applied.

These evaluations require a good deal of methodological competence, knowledge, experience, and collaboration. Detailed a priori planning in this field is limited as it depends on the individual researcher and on opportunities to conduct such studies and available funding. A prespecified plan for the analysis and public protocol registration is strongly encouraged, whenever possible, using common databases such as ClinicalTrials.gov.

3.1.2. Exemplary Interventions in Certain Indications: Confirmative Randomized Clinical Trials. A variety of specific AM interventions are well established and widely regarded as beneficial in certain health conditions. They may also support, independently from the AM treatment context, the effective treatment of major healthcare conditions (e.g., allergies, skin

diseases, reducing non indicated antibiotic prescriptions and resistance, chronic pain, mental diseases, risk of falling in elderly, and other chronic NCDs).)e efficacy, safety, and efficiency of exemplary interventions should be investigated in a reasonable and feasible number of sufficiently powered confirmatory RCTs, with the potential goal of the interventions being implemented in treatment guidelines.

To be worthwhile for an investigation in confirmative RCTs, interventions need to meet certain conditions: they have to have a rationale for the improvement of a relevant health condition. This should be supported by good empirical data from clinical, physiological, or exploratory studies, in order to design the trial, define outcomes, follow-up periods, control intervention, and calculate the sample size. This also refers to issues of application form, dosage, and duration. They should be applied in a health condition with a need for further interventions, e.g., when standard interventions have limited efficacy, are not well accepted by patients, or are better accepted with a cointervention (e.g., mistletoe extracts in cancer or cancer-related symptoms [80, 81], NCT02948309, NCT02106572); dermatology [44]; eurythmy therapy in cases of high risk of falling (DRKS00016609); and nursing procedures in pain, obstipation, nausea, sleep disturbance, anxiety, and others [82, 83]). Confirmative RCTs are often large, conducted in multicenter settings, as a collaborative effort of experts in different fields (including patient representatives) and guided by various guidelines, standards, and national requirements. These trials are very expensive and require appropriate funding and clinical infrastructure, both of which are in relatively short supply in AM.

3.1.3. The Wide Range of Remaining Interventions and Patient-Centered Care Strategies: Well-Conducted Small Trials and Observational Studies, High-Quality Case Reports and Series, Subgroup Analyses from Whole-System Studies, and Health Service Research.)e large quantity of AM interventions and their use within a patient-centered approach (about 1000 medicines, but also nursing procedures, arts therapies, eurythmy therapy, massages, embrocation, packs, teas, dietary advice, lifestyle counseling, therapeutic talks regarding emotional, biographical, social, and spiritual issues, and educational methods) exceed the current capacity to assess these interventions in large confirmative

trials. Therefore, the majority of interventions should be (and have been) investigated or transparently presented, partly in smaller formats but still with high methodological quality: for instance, observational studies and small clinical trials; case series and case reports; subanalyses from large studies [70, 84]; matched-pair comparisons (AM vs not AM-treated patients); health service research (e.g., clinical registries); or research syntheses from other similar interventions (e.g., non-AM Arnica preparation). Many methodological elements described above for the evaluation of health systems can also be applied.

Altogether, many of these methods, supported by quality standards and guidelines, are less demanding, complex, and costly and can be conducted as smaller research projects. Every effort has to be done to enhance quality and transparency and reduce the risk of bias. Still, these designs will often not provide causal evidence and are frequently subject to bias.)ese studies will often make use of "real-life data," with the primary focus sometimes switching to the point of care, providing insights into therapeutic procedures like patient-centered care [48] or addressing specific, unique conditions. [42, 85] Some of these methods will be influenced by future specific or general developments [86-88].

3.2. Safety. With regard to safety, a variety of objectives and methods can provide information and have been used for investigations in AM: a key source for safety data are adverse events and tolerability assessed within clinical trials and studies. Another, much wider source for safety information is pharmacovigilance studies and health service research [59, 89]. Many side effects of interventions, also rare ones, are captured with case reports and reports from authorities [39]. Vulnerable populations, like pregnant women, children, or elderly, need particular attention and research—in clinical trials, observational or pharmacovigilance studies, or specific registries. Specific safety issues (e.g., pharmacological interaction of AM-drugs with conventional drugs or with other AM or T&CM drugs [90–92]) may need a focused investigation using different methodologies.

Besides these classic assessments of untoward effects of interventions, also other safety issues are related to the whole field of T&CM as well as AM and can be investigated with different methodologies: for instance the impact of AM on patients' adherence to conventional medicine treatments (e.g., compliance

with scheduled chemotherapy protocol [93]) and associated treatment effectiveness or the impact of AM on decreasing unjustified overuse of conventional drugs (non indicated antibiotics prescriptions, analgesics overuse, etc. [51, 62, 94, 95]), to reduce drug-associated adverse effects, morbidity, and health costs [59, 71, 96–98]. A further safety issue necessitating also exploratory research relates to patients who adopt "alternative" health belief models that they (wrongly) associate with AM, expressed by negation of evidence-based conventional treatments or prevention recommendations (e.g., certain vaccinations, antibiotics, chemotherapy, steroids).

For the various methods, standards and guidelines exist or have to be adapted. A large body of evidence is available [36, 39, 59] and cooperation with national drug agencies established.

3.3. Economics. The economic implications of therapeutic strategies should be evaluated [96–98]. Direct, indirect, and intangible costs have to be considered, as well as different perspectives (e.g., societal, patient, and health insurance), depending on the setting. Different evaluation techniques are available (e.g., cost-effectiveness analysis, cost-utility analysis, and cost-benefit analysis), cost-effectiveness analysis being the most common. RCTs should consider collecting cost data (e.g., inpatient care, outpatient care, etc.) and standardized quality-of-life metrics to allow an estimate of quality-adjusted life-years (QALYs). Real-life data (registries) can be used as well in context with good quality records. The extent of the evaluations should be such to capture all relevant differences regarding outcomes between the intervention and comparators; therefore, lifetime horizons using decision-analytic models are preferred [99–101]. Adopting Good Research Practices from ISPOR is highly recommended (http://www.ispor.org). Reporting of economic evaluations of AM should follow the standard Consolidated Health Economic Evaluation Reporting Standards (CHEERS) [102].

3.4. Evidence Synthesis, Systematic Reviews, and HTA Reports. The results of efficacy and effectiveness research and of safety and economic evaluations have to be systematically collected, reviewed, and assessed in their methodological quality and analyzed across individual studies. This applies to both single interventions on certain conditions and complex, multimodal or individualized therapeutic systems. The goal would be that the

strengths of and specific information gleaned from the different designs and studies complement each other so that the compiled data and results form a reasonable, informative, and transparent evidence house (which should then also include points 3.5.–3.7.). Modeling studies can be helpful in estimating the public health benefit and costs of AM based on data from primary or secondary sources to inform decisions on healthcare policy [103].

For clinical trials and observational studies, the methodology of systematic reviews and meta-analyses has been developed, and widely used methods as proposed by Cochrane and GRADE are available (http://www.cochrane. org). For other assessment designs, complex, integrative intervention models, case reports, etc., meta-methods like mixed-methods reviews, critical appraisal, and evidencemapping remain to be fully considered or further developed. On a broader perspective, HTA reports can be useful [39, 40, 104].

3.5. Methodologic Issues. For many research designs, methods and standards have been developed, and guidelines are available to ensure quality and to define the applicability and generalizability of the results. For other designs, such as analyses and subanalyses, these methods have to be further developed. This concept relates specifically, for instance, to "whole system" and "complex intervention" research; bias reduction and systematic outcome comparison in large observational studies [75, 76]; case reports [105, 106] and their use (e.g., applicability, strengths, weaknesses, generalizability, causality, [107–109]) and their systematic assessment; health service research, care models, and issues related to clinical judgment and expertise [110], clinical decision analysis, individualizing and patterning of clinical responses [107, 108, 111], and "process-oriented research" [112].

The development of methods is carried out in close cooperation and consensus procedures with competent epidemiologists, statisticians, economists, methodologists, clinical researchers, and healthcare experts in related fields. An ongoing dialogue with decision makers, health professional organizations, and journal editors helps to incorporate their views and interests.

3.6. Biomedical, Physiological, Pharmacological, Pharmaceutical, Psychological, Anthropological, and Nosological Issues, as well as Innovation and Development. Research should

unravel the working principles of the interventions, contribute to the transparency of the AM concepts of the human organism and of health and disease, relate these to other medical and scientific concepts, and further develop medical and healthcare strategies. This relates to AM remedies, to understand their molecular, epigenetic, cellular, biochemical, physiological, pathophysiological, immunological, neurological, psycho-neuro-immunological mechanisms involved, the social context, etc. [43, 113, 114]. The same accounts to nonpharmacological interventions, lifestyle changes, or counseling: do they have effects on physiological rhythms, epigenetics, the psychosocial level, or on individual mental-cognitive developmental processes? A key issue is specifics of dosage and application and other pharmacological questions as well as issues of pharmaceutical quality. As AM has a distinct and hierarchical concept of the human organism that extends into nosological and diagnostic categories, these diagnostic (practice) methods, for instance, the constitution types of AM, have to be further elaborated and validated. This also includes the development and validation of questionnaires in different fields [115, 116]. Altogether, the anthroposophic-anthropologic concept of the human being, nature, health, and disease (salutogenesis) and therapy is a large field for epistemological, conceptual, and experimental research. This includes the concepts of human beings as social individuals (bio-psycho-socialspiritual approach), of organisms as complex adaptive systems, and of emergent behavior [117–119]. Also, AM nursing models and concepts, widely established in practice, can be further investigated. Last not least, these fields connect to innovations and further development of interventions within AM health care [82, 83, 114).

3.7. Patient Perspective and Involvement, Public Need, and Ethics. The view from the goal—investigating patients' perspectives using AM healthcare systems or specific AM interventions, and involving patients in research—provides important information and is a key area in the research field today: patient and public needs, interests, and perspectives on AM are assessed by qualitative and questionnaire-based methods and systematic metaethnographic approaches [120–122]. For clinical research, patient-relevant and experience measurements are developed (PROMS and PREMS) [123]. First-person perspective

studies, including biographic introspection, can give important insight in understanding the subjective dimension of disease. Patients are increasingly involved in the development of study designs and priority-setting (see http://www.invo.org.uk), also in AM (e.g., ENTAIER trial, DRKS00016609), which is another field of further development. Patient involvement and research also focuses on the development, evaluation, and implementation of patient empowerment, patient information, and decision-making material, as well as self-care programs using AM [49, 124, 125]. Another large field refers to the elements of ethics in AM healthcare professions and in applications of AM interventions in and outside AM and to contributions to the general ethics discussion. This includes general topics of medical ethics but also the important issue of informed consent, particularly with regard to missing evidence or to lacks in safety data, and the issue on how to deal with interventions or recommendations, which lack robust evaluation.

3.8. Educational Matters and Professionalism. Educational research provides important insights into the clinical trainings of healthcare professionals, the quality and issues of medical training, and the AM education, including medical students' possible contributions to patient-centered care [126, 127]. Furthermore, integration of AM (or parts of it) into established healthcare systems could be outlined and investigated, and the impact of AM courses on medical students' perspectives in pregraduate and postgraduate settings could be evaluated [128, 129]; furthermore, the impact of integrative medicine training on a mixed AM and non-AM group of practitioners, preferably in a multidisciplinary context, could be evaluated [130], as well as the influence of stress on burnout symptoms and empathy of care providers and their spiritual needs [57, 131]. Criteria for professionalism specific to AM or T&CM physicians [132] could be further adapted for all health professions.

3.9. Disease Prevention, Health Promotion, and Public Health. AM healthcare aims to understand and support the whole human being. Therefore, in addition to treating illnesses and symptoms, healthy development is supported during the entire lifetime (i.e., before, during, and after birth; during childhood, adolescence, adulthood, and end-of-life) and also during the development of emotional, cognitive, and spiritual competencies. A

positive health concept is the goal [133]. Interdisciplinary work is pivotal and also includes consideration of pedagogy and agriculture and environmental aspects. Research in these areas will depend on research collaboration and networking on a large scale, including collaboration with, for instance, epidemiologists, healthcare insurers, and public health institutions. [53, 54, 134].

4. Discussion

This research strategy covers the large spectrum of a whole healthcare system. It encompasses an array of experimental and explanatory to observational and pragmatic designs, from preventive to palliative care, from intervention to the patient's perspective, from inpatient to outpatient care. The fields of basic and conceptual research and innovation also are a part to this strategy but are only roughly outlined. The strategy is based on the following: existing methodological discussion of investigating whole medical and healthcare systems including complex interventions [1, 9, 21–28, 30–34]; what is regarded as important by key stakeholders; and what research is actually currently pursued or planned. Future developments may further evolve and refine this strategy.

This strategy can provide a broad view of the different aspects of the whole medical and healthcare system of AM and can also support the development of specific interventions or healthcare concepts that may be relevant for healthcare in general. It also provides insight about patients' perspectives and needs and with regard to issues of education and professionalism. It offers a framework for different stakeholders in medicine, science, and the general public, and it may improve intercultural transparency. The pluralistic and integrative nature of the presented strategy portends that the whole body of results will present a more adequate perspective of the complex field of AM than the isolated parts would have.

The scope of the strategy does not specify the fields actually being the focus of research. We presume that managing and treating chronic NCDs and focusing on disease prevention will be of primary interest. Still, the actual focus depends on the individual researchers and clinicians; their institutions' interests, capabilities, and infrastructures; the related collaboration and networks; the potential benefit expected with the specific

intervention under investigation; and also on public interest and the priority-setting of funders.

Four leading obstacles impede the promotion of AM research with high-quality methodology.

4.1. External Factors. Successful high-quality research will be impeded by budget limitations. However, even large studies are increasingly funded, and therefore an increasing rate of high-quality and clinically significant research will foster trust in AM research. Inclination of the scientific community to embrace explanatory rather than pragmatic trials and RCTs rather than observational and real-life studies will impede the successful conduction, funding, and publication of whole healthcare systems studies. However, there is an increasing interest in a broader spectrum of designs due to the complexity and individualization of medicine [9, 30–34, 86–88], and therefore, high quality of these studies as well as research on methodologic issue will be essential.

4.2. Internal Factors. These relate to a limited number of trained AM researchers and healthcare settings as well as to potential reluctance of some AM clinicians and healthcare providers to conduct, support, and participate in clinical research due to workload, skepticism about research, standardized care, and randomized treatment allocation that conflicts with the individualized, patient-centered approach they would like to employ. Close collaboration, consideration of clinicians' and healthcare providers' needs and constraints, and communication about the benefits and risks of research (e.g., presenting research projects and results at AM practitioners' conferences and integrating AM clinicians, healthcare providers, and patients in research planning and study design) may help to overcome these limitations. Still, a variety of research studies, specifically experimental, highly standardized designs like RCTs on a specific treatment in a certain disease, will have to be conducted outside the AM setting (e.g., NCT02948309 and NCT02106572).

4.3. Methodologic Factors. While for RCTs a variety of guidelines, standards, and requirements are well defined, other study types may have less rigor and less demanding quality criteria and guidelines. Therefore, quality and scrutiny parameters in planning, design, data quality, analysis, presentation, careful inferences, and general standards of good clinical research have to be strictly followed [135–137]. Commitment by researchers and

review by ethical committees, funders, and journals still might not ensure high quality. Therefore, the development of further specific methodological-quality guidelines for researchers and funders and later assessments, as well as specific training, additional internal and external peer review, discussion within the broader network already in the planning phase, and continuous methodological dialogue and awards for high-quality projects, may support and improve this approach long-term. Furthermore, the assessments of such an area of integrative research studies, for instance with HTA reports, may become elaborate. This may necessitate further methodological developments to improve pragmatic and efficient meta-assessments.

The strength of this consensus-based strategy is the consideration of different dimensions of a healthcare system, the inclusion of a large variety of stakeholders like care providers, MDs from in and outpatient care with different specialties, directors of institutions or hospitals, pharmacists, patient representatives, funding bodies, and researchers with diverse expertise and intercultural aspects. Thus, the input is based on specific scientific knowledge as well as long practical experience with patient care, research projects, and extensive collaboration.

Still, this consensus strategy also has some limitations. It is a current view and does not foresee future developments, researchers, and stakeholders, which may modify some items of the strategy. It also does not foresee the availability of resources and funding. Therefore, the strategy is a matter of estimation and intention. Although the consensus process includes many, it does not include all relevant stakeholders outside AM, like public funders, journal editors, researchers conducting future systematic reviews and HTA reports on AM or investigating other whole healthcare systems, and authorities. However, the included stakeholders have multiple collaborations with these "external" stakeholders.

In conclusion, this strategy provides a wide spectrum of research that will assess many facets of a whole healthcare system pursuing patient-centered care. This may contribute to solutions for global health challenges, particularly with regard to chronic NCDs and health promotion. The culture of collaboration with other IM and non-IM methodologists and researchers is of great importance and value. Researchers investigating other integrative

modalities such as traditional Chinese and Ayurvedic medicine as well as researchers investigating patient-centered care and patienttailored treatment (e,g. Family medicine, palliative medicine, narrative-based medicine, and psycho-social-ethno literature, spiritual care research) are confronted with some or all of the challenges described in this article. Interdisciplinary and international collaboration effect more expertise and infrastructure for high-quality research projects. Furthermore, collaboration with other stakeholders in the healthcare system, at academic institutions, at professional and patient organizations, with associations and committees involved in guideline development and healthcare planning, research, and funding, will assist with purposeful, efficient, and high-quality research development.

5. Conclusion

T&CM, used worldwide and integrated into EBHC, can play an important part in health services, supporting health, and addressing chronic NCDs. Its focus is on patient-centered care, and it is linked to the cultural background and needs and values of patients. Transparency and information are provided by a strong and differentiated evidence base regarding benefit and implementation of T&CM approaches, assessing efficacy, effectiveness, safety, costs, modes of action, patient and public perspective, ethical issues, educational matters, professionalism, and healthcare procedures and concepts. A broad research strategy, as outlined for Anthroposophic Medicine, supports research and healthcare, transcultural understanding, and collaboration among different stakeholders of healthcare.

গুরুত্বপূর্ণ বিধায় WHO GLOBAL REPORT ON TRADITIONAL AND COMPLEMENTARY MEDICINE 2019 এর Foreword এবং EXECUTIVE SUMMARY নিম্নে অবিকল অনুলিখন হলোঃ

WHO GLOBAL REPORT ON TRADITIONAL AND COMPLEMENTARY MEDICINE 2019

FOREWORD

Traditional and complementary medicine (T&CM) is an important and often underestimated health resource with many applications, especially in the prevention and management of lifestyle-related chronic diseases, and in meeting the health needs of ageing populations. Many countries are seeking to expand coverage of essential health services at a time when consumer expectations for care are rising, costs are soaring, and most budgets are either stagnant or being reduced. Given the unique health challenges of the 21st century, interest in T&CM is undergoing a revival.

Monitoring health trends is a core function of the World Health Organization (WHO) and is key to supporting countries in generating evidence-based policies and strategic plans. This report reviews global progress in T&CM over the past two decades and is based on contributions from 179 WHO Member States. It clearly shows that more and more countries are recognizing the role of T&CM in their national health systems. For instance, by 2018, 98 Member States had developed national policies on T&CM, 109 had launched national laws or regulations on T&CM, and 124 had implemented regulations on herbal medicines.

Countries aiming to integrate the best of T&CM and conventional medicine would do well to look not only at the many differences between the two systems, but also at areas where both converge to help tackle the unique health challenges of the 21st century. In an ideal world, traditional medicine would be an option offered by a well-functioning, people-centred health system that balances curative services with preventive care.

WHO is halfway through implementing the WHO Traditional Medicine Strategy 2014–2023. Our current focus is to develop norms, standards and technical documents based on reliable information and data, to support Member States in providing safe, qualified and effective T&CM services and their appropriate integration into health systems for achieving universal health coverage and the Sustainable Development Goals. I am very pleased to introduce the WHO global report on traditional and complementary medicine 2019. I believe that this report provides valuable information for policy-makers, health professionals and

the public for capitalizing on the potential contribution of T&CM to health and well-being.

Sd/- Illegible
Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

EXECUTIVE SUMMARY

WHO's 13th General Programme of Work (GPW13) came into effect this year for 2019–2023. As a strategic priority, GPW13 sets an overarching goal of reaching 3 billion more people, to move towards Sustainable Development Goal 3 (SDG 3) – ensuring healthy lives and promoting well-being for all at all ages – by achieving universal health coverage (UHC), addressing health emergencies and promoting healthier populations. Traditional and complementary medicine (T&CM) can make a significant contribution to the goal of UHC by being included in the provision of essential health services.

Improving equitable access to safe, quality and effective T&CM services can potentially meet communities' needs and build sustainable and culturally sensitive primary health care. The Declaration of Astana, adopted at the Global Conference on Primary Health Care in October 2018, made clear that the success of primary health care will be driven by applying scientific as well as traditional knowledge, and extending access to a range of health care services, which include traditional medicines.

In 2005, WHO published a report on national policies on traditional medicine and regulation of herbal medicines, based on the first global survey on T&CM. To identify global trends and the current situation in the area of T&CM, WHO conducted a second global survey during 2010–2012 (second survey), and a further survey during 2016–2018 (update survey). This made it possible to compare the information and data in the two most recent surveys with those in the first global survey, and thus identify global trends.

Globally, the landscape for T&CM has been improving consistently. In line with the WHO Traditional Medicine Strategy 2002–2005 and the WHO Traditional Medicine Strategy 2014–2023, and relevant World Health Assembly resolutions, Member States took steps between 2005 and 2018 to promote the safety, quality and effectiveness of T&CM. They also took steps for the

appropriate integration of T&CM into health systems (particularly health services) by developing national policies, regulatory frameworks and strategic plans for T&CM products, practices and practitioners.

Based on current information, ***88% Member States have acknowledged their use of T&CM which corresponds to 170 Member States.*** *These are the countries that have, for example, formally developed policies, laws, regulations, programmes and offices for T&CM, and the actual number of countries using T&CM is likely to be even higher.*

This report represents a unique milestone.

- *It is the most comprehensive report on T&CM, with 179 of the 194 Member States officially contributing information; thus, it addresses the challenge of lack of credible data and information in this field.*
- *It captures the three phases of progress made by Member States; that is, before and after the first WHO Traditional Medicine Strategy (1999–2005), from the first global survey to the second global survey (2005–2012) and from the second survey to the most recent update survey (2012–2018).*
- *It covers not only policy and regulation, but also products, practices and practitioners of T&CM.*
- *It is the most current and up-to-date report, based on information from most Member States across the six WHO regions.*

BioMed Central-এ প্রকাশিত (Cite this article as: Heusser et al.: The subjectively perceived quality of postgraduate medical training in integrative medicine within the public healthcare systems of Germany and Switzerland: the example of anthroposophic hospitals. BMC Complementary and Alternative Medicine 2014 14:191) গবেষণা প্রবন্ধটি নিম্নে অবিকল অনুলিখন হলোঃ-

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RESEARCH ARTICLE

The subjectively perceived quality of postgraduate medical training in integrative medicine within the public healthcare systems of Germany and Switzerland: the example of anthroposophic hospitals

Peter Heusser, Sabine Eberhard, Bettina Berger, Johannes Weinzirl and Pascale Orlow

Background

As the use and acceptance of complementary and alternative medicine (CAM) is growing amongst the public and health professionals [1,2], its status within the public healthcare system is also becoming more official. ***In 2002 58% of the Swiss population demanded more CAM for the future of medicine [3], and in 2009 67% accepted an amendment to the national constitution declaring CAM to be a matter of official policy [4].*** *This was tied to demands for an improved official status of CAM disciplines practiced by physicians, i.e. in research, medical education, health insurance, drug legislation and certification of health professionals [5]. There have been frequent studies of the reasons for the use of CAM. They include a need for additional or less toxic therapeutic options especially in chronic and incurable diseases, improved quality of life, a better doctor-patient relationship with more time for patients and more holistic care [6-8]. Indeed, a comparative Swiss national survey in 2006 showed that patients of medical practices providing CAM document longer-lasting and more severe health problems, but also higher overall patient satisfaction with treatments than patients of conventional (CON) practices [9]. This was especially true for practices offering anthroposophic medicine (AM)[10]. The public wish for more CAM includes stationarycare: the majority would prefer CAM to*

CON hospitals given equal success rates [11] and opt for public financial support of CON hospitals offering CAM [12]. This shows that what is at stake is a meaningful integration of CAM into CON within the public healthcare system, including stationary forms of care.

If this is to happen, however, integrative medicine (IM) needs to become an integral element of undergraduate and postgraduate medical education, in addition to the need to create an appropriate evidence base for the safety and effectiveness of CAM methods as such. Also, in the spirit of evidence-based medical education, the evaluation of quality and effectiveness of IM education will be necessary. A majority of those responsible for representing medical schools in Germany, Switzerland and Austria as well as their medical students favor the integration of CAM into the medical system, but only a limited number of courses on CAM have been introduced and evaluated in undergraduate medical education [13-15]. A promising development is the creation and controlled evaluation of a clinical education ward for IM at Witten/Herdecke University, Germany, where final year undergraduate medical students learn to take active care of patients under supervision in an IM setting, integrating anthroposophic medicine (AM) into CON, with a positive impact on the quality of care [16].

In the field of postgraduate medical training (PGMT) an increasing need is articulated to include some forms of IM[17], but so far little has been done to evaluate PGMT in IM except for an internet-based on-line IM training pro-gram implemented in family residency programs in the United States [18]. In Germany and Switzerland some CON hospitals offer forms of CAM [19,20] and some of these take part in PGMT. Indeed, PGMT in an onward form can be expected to be the richest and most effective form of training in IM, because it usually provides more systematic, interdisciplinary and scientific learning formats in theory and practice, combined with responsible patient work for more challenging patients, under direct supervision of a more diversified array of experienced trainers in comparison to medical practices. Additionally, AM hospitals usually have a more complete set of specific pharmacological and non-pharmacological AM treatments than medical practices can offer [21].

AM hospitals in Germany and Switzerland have long-standing and substantial experience in PGMT in IM and can serve as models for such training. AM is an integrative form of CON which has developed since the1920s [22]. It is based on a holistic concept that takes account of physical, living, emotional, cognitive, spiritual and social aspects in theory and practice [23]. It is practiced by conventionally trained physicians with an additional training in AM. In Germany and Switzerland AM hospitals are well integrated in the public health-care systems and are accredited for the official PGMT of physicians in both countries [24-26]. PGMT in AM hospitals includes CON and AM aspects in a completely integrative way, i.e. conceptually as well as practically. However, so far an evaluation of IM training in AM hospitals is lacking.

For this reason and in view of public interest in IM we conducted a comprehensive cross-sectional evaluation of the subjectively perceived quality of CON and AM aspects of PGMT among trainees and trainers in all AM hospitals in Switzerland and Germany. In this paper we report on the results relating to the basic dimensions of PGMT, the working situation and the specific IM learning culture and teaching structure. The analyses are differentiated for Germany and Switzerland and for department sizes and clinical disciplines but not for single departments or hospitals. In addition, in order to provide a differentiated basis for possible improvements to PGMT in AM hospitals, we performed detailed quantitative and qualitative analyses of specific problems in IM training in PGMT as well as problem-solving options from the viewpoints of trainers and trainees. For reasons of space these results have to be published in two additional separate papers.

ভেষজ বা উদ্ভিদের মাধ্যমে যে চিকিৎসা পদ্ধতি তার নাম আয়ুর্বেদ। এ চিকিৎসা পদ্ধতি প্রায় ৫০০০ বছরের পুরোনো। সনাতন ধর্মাবলম্বীদের আদি ধর্মগ্রন্থ বেদ-এর একটি ভাগ আয়ুর্বেদ। বাংলাদেশ, ভারত, পাকিস্তান এবং শ্রীলংকায় এ চিকিৎসা পদ্ধতি সবচেয়ে জনপ্রিয়। পার্শ্বপ্রতিক্রিয়া কম থাকায় উন্নত বিশ্বের বিভিন্ন দেশ আকৃষ্ট হচ্ছে এ পদ্ধতির দিকে।

*চীনের একটি প্রাচীন চিকিৎসা পদ্ধতি আকুপাংচার। এই পদ্ধতিতে শরীরের বিভিন্ন জায়গায় সুঁচ ফুটিয়ে রোগের চিকিৎসা দেয়া হয়। যেকোন জটিল রোগ এই পদ্ধতিতে সারিয়ে তোলা সম্ভব বলে দাবি আকুপাংচার চিকিৎসকদের। শাকুর বনাম সিতু (**Shakur Vs***

Situ) [2000] 4 All ER 181 EBD মোকদ্দমার বিচারক BERNARD LIVESEY Q.C এর মতে Traditional Chinese Herbar Medicine (TCHM) এর ৪০০০ (চার হাজার) বৎসরেরও বেশী মৌখিক এবং ২০০০ (দুই হাজার) বৎসরের বেশী লিখিত ঐতিহ্য আছে।

বিকল্প চিকিৎসার পদ্ধতির মধ্যে সবচেয়ে জনপ্রিয় হোমিওপ্যাথি। ১৭৯৬ সালে এর উদ্ভাবন করেন স্যামুয়েল হানেমান। রোগীকে অল্প ওষুধ দিয়ে সুস্থ করে তোলাই হোমিওপ্যাথির মূলমন্ত্র।

বিকল্প ধারার চিকিৎসা ব্যবস্থার(**Alternative/ Complementary Medicine)** শুধুমাত্র হোমিওপ্যাথি, ইউনানী ও আয়ুর্বেদ-এর মধ্যেই সীমাবদ্ধ নয়, বরং কয়েক হাজার বছর ধরে বিভিন্ন দেশে প্রচলিত নানা চিকিৎসা ব্যবস্থা (যা শুধুমাত্র ঔষধ নির্ভর নয়) এর মধ্যে অন্তর্ভুক্ত, যেমন-

Acupressure	Unani	Mud Therapy
Acupuncture	Mantra Therapy	Biochemic Medicine
Auricular Therapy	Visualisation Therapy	Fasting Therapy
Alexander Technique	Siddha	Faith Healing
Art Therapy	Silva Method	Psychotherapy
Aromatherapy	Naturopathy	Organic Therapy
Homeopathy	Osteopathy	Magnetotherapy
Hypnotherapy	Oriental Medicine & Diagnosis	Iridology
Hydrotherapy	Indo Allopathy	Tibetan Medicine
Chinese Medicine	Shiatsu	Spiritual Healing
Cupping	Yoga Therapy	Music Therapy
Diet Therapy	Zen Therapy	Macrobiotics
Electrotherapy	Meditation	Gem Therapy
ElectroHomeopathy	Physiotherapy	Chromotherapy
Herbalism	Breath Therapy	Colonic Hygiene & Therapy
Chiropady-Heliotherapy		Tantra Therapy
Megavitamin Therapy	Taichi – Aikido & Martial Arts	Therapeutic Touch

পৃথিবীর মোট জনসংখ্যার প্রায় দুই তৃতীয়াংশ জনগোষ্ঠী বিকল্প ধারার চিকিৎসা ব্যবস্থার উপর নির্ভরশীল। এর কারণ (১) সহজলভ্যতা (২) স্বল্পখরচ (৩) অ্যালোপ্যাথিক চিকিৎসার তুলনায় পার্শ্ব প্রতিক্রিয়া কম (৪) প্রচলিত চিকিৎসক এর অপ্রতুলতা ইত্যাদি।

বর্তমানে বিকল্প ধারার বিভিন্ন ধরনের চিকিৎসা পদ্ধতিকে আইন ও বিধিমালা প্রণয়নের মাধ্যমে বিশ্বব্যাপী স্বীকৃতি দেওয়া হচ্ছে। **WHO** এর ১৯৪ টি সদস্য রাষ্ট্রের মধ্যে ১৭৯ টি সদস্য রাষ্ট্র বিকল্প ধারা চিকিৎসা পদ্ধতির আইন ও নিয়ন্ত্রণ অবকাঠামো প্রণয়ন করেছে। পৃথিবীর অনেক দেশ ইতিমধ্যেই বিকল্প ধারার চিকিৎসা পদ্ধতিকে মূল ধারার

চিকিৎসায় অন্তর্ভুক্ত করেছে। বর্তমানে পৃথিবীর বিশাল জনগোষ্ঠীর স্বাস্থ্য সেবার চাহিদা মেটাতে দীর্ঘদিন ধরে বিকল্প ধারার চিকিৎসা ব্যবস্থাকে জাতীয় স্বাস্থ্য সেবা খাতের আওতায় আনার লক্ষ্যে **WHO** সদস্য রাষ্ট্রগুলোকে উৎসাহিত করার লক্ষ্যে সর্বাত্মক সাহায্য ও সহযোগীতা প্রদান করে আসছে।

একবিংশ শতাব্দীর কঠিন চ্যালেঞ্জের মধ্যে স্বাস্থ্য খাত অন্যতম, সে কারণে বিকল্প ধারার চিকিৎসা ব্যবস্থার উপর মানুষের আগ্রহ উর্ধ্বমুখী। **WHO** এর মহাপরিচালক **(Dr. Tedros Adhanom Ghebreyesus)** এর তথ্যমতে, বর্তমান একবিংশ শতাব্দীর স্বাস্থ্যসমস্যার চ্যালেঞ্জ মোকাবেলার জন্য **Alternative/Complementary Medicine (**বিকল্প ধারার চিকিৎসা) ব্যবস্থার প্রতি মানুষের আগ্রহ পুনর্জীবিত হচ্ছে। **‘WHO Global Report-Traditional and Complementary Medicine 2019’** এ পরিস্কার ভাবে এটি উঠে এসেছে যে, গত দুই দশক ধরে **Traditional and Complementary Medicine** বিশ্বব্যাপী অগ্রগতি সাধন করেছে। ১৯৪টি সদস্য রাষ্ট্রের মধ্যে ১৭৯টি দেশ এই অগ্রগতির অংশীদার। **WHO** এর ২০১৯ সালের রিপোর্টের তথ্য অনুযায়ী, বর্তমানে বহু দেশ **Traditional and Complementary Medicine**-কে তাদের জাতীয় স্বাস্থ্য ব্যবস্থার মধ্যে অন্তর্ভুক্ত করেছে। উদাহরণস্বরূপ ২০১৮ সালে ৯৮টি সদস্য রাষ্ট্র **Traditional and Complementary Medicine** এর উপর জাতীয় পর্যায়ে নীতিমালা তৈরী করেছে, ১০৯টি দেশ **Traditional and Complementary Medicine** সংক্রান্ত জাতীয় আইন ও বিধিমালা প্রণয়ন করেছে এবং ১২৪টি সদস্য রাষ্ট্র **Herbal Medicine** এর উপর বিধিমালা বাস্তবায়ন করেছে। **WHO** এর ২০১৯ সালে রিপোর্টের তথ্যমতে, জরুরী স্বাস্থ্য সেবা খাতের মধ্যে **Traditional and Complementary Medicine** -কে অন্ড়র্ভূক্ত করা হলে তা সার্বজনীন স্বাস্থ্য ব্যবস্থা/**Universal Health Coverage** এর মূল উদ্দেশ্যকে বাস্তবায়ন করতে অগ্রণী ভূমিকা রাখতে সক্ষম হবে। **WHO Traditional Medicine Strategy 2014-2023** গ্রহণ করে তা বাস্ড়বায়নের লক্ষ্যে কাজ করে চলেছে।

বাংলাদেশে প্রস্তাবিত **Alternative Medicine System/**বিকল্প ধারার চিকিৎসা পদ্ধতি সংক্রান্ত কর্ম পরিকল্পনা (**Operational Plan for Alternative System of Medicine in Bangladesh) (Annexure-"17" of the First**

Supplementary Affidavit to the Affidavit-in-Opposition)এবং জাতীয় স্বাস্থ্য নীতি, ২০১১ (**National Health Policy, 2011)(Annexure-"18" of the First Supplementary Affidavit to the Affidavit-in-Opposition)** মূলত **Alternative Medicine Practice** এর বেশ কয়েকটি শাখার মধ্যে শুধুমাত্র হোমিওপ্যাথি, ইউনানী ও আয়ুর্বেদিক শাখাকেই উদাহরণ হিসেবে উলেণ্ঢখ করেছে, কিন্তু বিকল্প ধারার চিকিৎসা পদ্ধতির সম্পূর্ণ সংজ্ঞা প্রদান করা হয়নি। প্রস্ড়াবিত পরিকল্পনা এবং নীতিমালায় হোমিওপ্যাথি, ইউনানী ও আর্য়ুবেদিক চিকিৎসা শাস্ত্রের কথা উল্লেখ করা আছে, কিন্তু তা বিকল্প ধারার চিকিৎসা পদ্ধতিকে সম্পূর্ণরূপে সংজ্ঞায়িত করে না। অথচ জাতীয় স্বাস্থ্য নীতিতে সুনির্দিষ্ট ভাবে বলা আছে যে, সরকারের নীতিগত সিদ্ধান্ত হচ্ছে **Alternative Medicine Practice** তথা বিকল্প ধারার চিকিৎসা পদ্ধতিকে জাতীয় স্বাস্থ্য ব্যবস্থার মধ্যে অন্ড়র্ভূক্ত করে স্বাস্থ্যসেবার পরিসর বর্ধিত করা।

*দুঃখজনক ভাবে এটি লক্ষনীয় যে, এখানে বাংলাদেশ মেডিকেল ও ডেন্টাল কাউন্সিল আইন, ২০১০ এর ২৯ ধারা অনুযায়ী বিএমডিসি (**BMDC**) এর নিবন্ধনভুক্ত মেডিকেল বা ডেন্টাল ইনস্টিটিউট কর্তৃক এমবিবিএস অথবা বিডিএস ডিগ্রিধারী ছাড়া অন্য কেউ তাদের নামের পূর্বে ডাক্তার (**Dr.**) পদবী ব্যবহার করতে পারবেন না। সেখানে স্বাস্থ্য ও পরিবার পরিকল্পনা মন্ত্রণালয়ের স্বাস্থ্য সেবা বিভাগের বিগত ইংরেজী ০৩.০৯.২০১৪ তারিখের সংশোধিত বিজ্ঞপ্তিতে (**Annexure-Q)Alternative Medical Care** শীর্ষক অপারেশনাল প্লানের বিভিন্ন পদে কর্মরত হোমিওপ্যাথি, ইউনানী ও আয়ুর্বেদিক কর্মকর্তাদের স্ব-স্ব নামের পূর্বে ডাক্তর (ডাঃ) পদবী সংযোজনের অনুমতি প্রদান করেছে, যা এক কথায় আইনের কর্তৃত্ব ব্যতিত তথা বেআইনি। এ ছাড়াও বাংলাদেশ হোমিওপ্যাথিক বোর্ড কর্তৃক বিগত ইংরেজী ০৬.০২.২০২০ তারিখে (**Annexure -Q-1**) জারীকৃত বিজ্ঞপ্তিতে বিভিন্ন শাখায় হোমিওপ্যাথিক চিকিৎসকগণকে তাদের নামের পূর্বে পদবী হিসেবে ডাক্তার (**Dr.**) ব্যবহারের অনুমতি প্রদান করাও বেআইনি।*

*বিকল্পধারার চিকিৎসা পদ্ধতির পেশাধারীরা নামের পূর্বে ১) **Integrated Physician** ২) **Complementary Physician** ৩) **Integrated Medicine Practitioner** এবং ৪) **Complementary Medicine Practitioner** পদবী ব্যবহার করতে পারেন। পাশের দেশ ভারতেও বিকল্প ধারার চিকিৎসকরা (**Dr.**) লিখতে পারে না।*

সংবিধানের অনুচ্ছেদ ১৫ মোতাবেক রাষ্ট্রের অন্যতম সাংবিধানিক মৌলিক দায়িত্ব হলো জনগণের জীবন ধারণের মৌলিক উপকরণ চিকিৎসার ব্যবস্থা করা। এছাড়াও সংবিধানের অনুচ্ছেদ ১৮ মোতাবেক অন্যতম প্রাথমিক কর্তব্য হিসেবে রাষ্ট্র জনস্বাস্থ্যের সার্বিক উন্নয়নে কার্যকর ব্যবস্থা গ্রহণ করবে।

সংবিধানের অনুচ্ছেদ ৩২ নাগরিকের জীবন ধারনের অধিকারকে নিশ্চিত করেছে। সাংবিধানিক ভাবে প্রত্যেক ব্যক্তির জীবন তথা বেঁচে থাকার অধিকার **(Right to life)** সংরক্ষিত। *সঠিক চিকিৎসা না পেলে নাগরিকের জীবনহানী অবিস্বম্ভাবী। সুতরাং সংবিধানের অনুচ্ছেদ ৩২ মোতাবেক চিকিৎসা পাওয়া প্রত্যেক নাগরিকের মৌলিক অধিকার।*

বিকল্প চিকিৎসা পদ্ধতি পাঁচ হাজার বছরের প্রাচীন। সুতরাং পাঁচ হাজার বছর যাবত সমগ্র পৃথিবীতে চলে আসা প্রাচীন বিকল্প চিকিৎসা পদ্ধতির যথাযথ এবং সঠিক ভাবে পঠন এবং প্রশিক্ষণ জনমানুষের সামগ্রিক চিকিৎসা ব্যবস্থার উন্নয়ন করবে।

প্রচলিত চিকিৎসা পদ্ধতি তথা পশ্চিমা চিকিৎসা পদ্ধতি আইনের মাধ্যমে নিয়ন্ত্রিত হওয়া শুরু হয় আজ থেকে মাত্র ১৬২ বৎসর পূর্বে। পৃথিবীর প্রথম প্রচলিত চিকিৎসা পদ্ধতির আইনটির নাম ***"The Medical Act, 1858"*** যা ইংল্যান্ডের সংসদ পাশ করেছিল। অর্থাৎ ১৮৫৮ সালের পূর্বে চিকিৎসা ব্যবস্থা আইন দ্বারা নিয়ন্ত্রীত ছিল না। অপরদিকে পাঁচ হাজার বৎসর পূর্ব হতে মানুষ বিকল্প চিকিৎসা পদ্ধতি গ্রহণ করে আসছে।

সংবিধানের অনুচ্ছেদ ৩৯ মোতাবেক প্রত্যেক নাগরিকের চিন্তা ও বিবেকের স্বাধীনতার নিশ্চয়তা দান করা হয়েছে। অর্থাৎ চিন্তা ও বিবেকের স্বাধীনতা প্রত্যেক নাগরিকের অন্যতম মৌলিক অধিকার। প্রত্যেক নাগরিক তার বিবেকের মাধ্যমে এবং চিন্তার মাধ্যমে কোন পদ্ধতির চিকিৎসা তথা প্রচলিত/পশ্চিমা/এ্যালোপেথী চিকিৎসা গ্রহণ করবে না কিনা বিকল্প চিকিৎসা পদ্ধতি গ্রহণ করবে এটি সম্পূর্ণ তাঁর মৌলিক অধিকার।

অপরদিকে সংবিধানের অনুচ্ছেদ ৪০ মোতাবেক আইনের দ্বারা অরোপিত বাধা নিষেধ সাপেক্ষে প্রত্যেক নাগরিকের যে কোন পেশা **(Profession)** গ্রহণের অধিকার তার মৌলিক অধিকার। একজন নাগরিক প্রচলিত চিকিৎসক হবেন না বিকল্প ধারার চিকিৎসক হবেন এটি তার মৌলিক অধিকার।

সুতরাং বিকল্প ধারার কিংবা প্রচলিত চিকিৎসক হওয়ার নিমিত্তে প্রয়োজনীয় আইনী কাঠামো প্রস্তুত করে দেওয়া সরকারের অন্যতম দায়িত্ব।

উপরিল্লিখিত আলোচনা ও পর্যালোচনায় অত্র রুলটি কতিপয় পরামর্শ প্রদান পূর্বক খারিজ যোগ্য।

অতএব, আদেশ হয় যে, অত্র রুলটি বিনা খরচায় খারিজ করা হলো।

যেহেতু সংবিধানের অনুচ্ছেদ ৩২ মোতাবেক চিকিৎসা পাওয়া প্রত্যেক নাগরিকের মৌলিক অধিকার সেহেতু আমরা, অতঃপর নিম্নেবর্নিত পরামর্শ সমূহ প্রদান করলাম।

১। *"সবার জন্য স্বাস্থ্য"* নিশ্চিত করণের লক্ষ্যে *"কাজাখাস্তান ঘোষণা"* থেকে *"আলমাআটা ঘোষণা"* বাস্তবায়নের লক্ষ্যে সার্বিক পরিকল্পনা, নীতিমালা এবং প্রয়োজনীয় আইন দ্রুত প্রণয়েনের জন্য সংশ্লিষ্ট সকলকে পরামর্শ প্রদান করা হলো।

২। সার্বিক চিকিৎসা ব্যবস্থাপনায় তথা প্রচলিত এবং বিকল্প ধারার চিকিৎসা ব্যবস্থাপনায় *"রোগী কেন্দ্রিক চিকিৎসা সেবা"* **(Patient-Centered Care)** নীতিমালা অনুসরনের পরামর্শ প্রদান করা হলো।

৩। প্রয়োজনে বিকল্প ধারার চিকিৎসা পদ্ধতির পৃথক মন্ত্রণালয় তথা **"Ministry of Ayush Government of India"** এর আদলে বাংলাদেশের একটি পৃথক মন্ত্রণালয় সৃষ্টি করার পরামর্শ প্রদান করা হলো।

৪। বিকল্প ধারার চিকিৎসাশাস্ত্র সম্পর্কিত শিক্ষা, প্রশিক্ষণ ও সেবার মান নির্ধারণ ও উন্নয়ন এবং বিকল্প ধারার চিকিৎসা শাস্ত্র সংশ্লিষ্ট বিশেষায়িত বিশ্ববিদ্যালয়, কলেজও অন্যান্য শিক্ষা প্রতিষ্ঠান ও তৎপ্রদত্ত ডিগ্রিসমূহকে স্বীকৃতি প্রদান করার পদ্ধতি নির্ধারণ করার পরামর্শ প্রদান করা হলো।

অত্র রায় ও আদেশের অবিকল অনুলিপি প্রয়োজনীয় ব্যবস্থা গ্রহণের নিমিত্তে সকল পক্ষকে দ্রুত অবহিত করা হোক।

বিচারপতি রাজিক-আল-জলিল

আমি একমত