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POLICY ON HERBAL TRADITIONAL MEDICINES THERAPY IN THREE PROVINCES IN INDONESIA

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Abstract

A descriptive qualitative study on the implementation of MOH Decrees related to local herbal Traditional Medicine Therapy in Bali, West Java and Central Java, had been conducted cross-sectionally in 2011. Objectives of this study were to identify local licensing policy, perception of professional organization, and supports and obstacles of their implementation. Data were collected through in-depth interviews with one herbal CAM provider, purposively taken from each district, and Head of Health Resources Department of Provincial and District Health Office, whilst RTD participants were professional organizations like Indonesian Association of Herbal Medical Doctor, Indonesian Association of Traditional Therapist, Indonesian Pharmacist Association, Indonesian Association of Midwives and Indonesian National Nurse Union.

Results of the study showed that in Bali no Surat Bukti Registrasi-Tenaga Pengobat Komplementer Altenatif had been issued. In West Java it had been given to trained doctor and in Central Java given only to doctors in Puskesmas following Jamu Scientification program. MOH Decree no. 1109 of 2007 which controls CAM providers in health facilities were differently perceived by Provincial Health Offices and as a result, implementation and also local policy differed amongst provinces.

There were doctors providing herbal medicine services based on MOH Regulation no. 1076 of 2003. Nonetheless, few doctors had implemented Decree on Use of CAM, because there were no provincial collegiums of herbal medicine yet and no standard of competencies had been developed. The requirements to obtain licence for doctor were more complicated than for traditional provider.

Keywords: complementary alternative medicine, herbal traditional medicine, licence, policy

Abstrak

Telah dilakukan suatu studi kualitatif implementasi peraturan-peraturan tentang pengobatan tradisional herbal secara potong lintang di Bali, Jawa Barat dan Jawa Tengah, pada tahun 2011. Penelitian ini bertujuan untuk mengidentifikasi kebijakan lokal perijinan, persepsi organisasi profesi serta kendala dan dukungan dalam implementasi-nya. Data dikumpulkan melalui wawancara mendalam dengan satu orang pengobat herbal komplementer alternatif yang diambil secara purposif dari tiap kabupaten/kota dan Kepala Bagian Sumberdaya Dinkes Provinsi dan Kabupaten/Kota, sedangkan peserta RTD adalah organisasi profesi Perhimpunan Dokter Herbal Medik Indonesia (PDHMI), Asosiasi Pengobat Tradisional Indonesia (ASPETRI), Ikatan Apoteker Indonesia (IAI), Ikatan Bidan Indonesia (IBI) dan Persatuan Perawat Nasional Indonesia (PPNI).

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Hasil penelitian menunjukkan bahwa di Bali belum ada SBR-TPKA yang dikeluarkan. Di Jawa Barat SBR-TPKA diberikan kepada dokter yang telah dilatih dan di Jawa Tengah hanya diberikan kepada dokter puskesmas yang ikut program Saintifikasi Jamu. Permenkes nomor 1109 tahun 2007 yang mengatur pengobatan komplementer alternatif di fasilitas pelayanan kesehatan ditafsirkan berbeda-beda oleh Dinkes Provinsi dan akibatnya implementasi dan kebijakan lokal juga berbeda antar provinsi.

Berdasarkan Kepmenkes nomor 1076 tahun 2003 banyak dokter membuka praktek herbal, tetapi belum banyak yang memanfaatkan Permenkes 1109 tahun 2007 tentang penyelenggaraan pengobatan komplementer alternatif karena belum ada kolegium pengobatan tradisional dan standard kompetensinya. Persyaratan ijin untuk dokter herbal lebih rumit daripada untuk pengobat tradisional.

Kata Kunci: *kebijakan, pengobatan tradisional herbal, pengobatan komplementer alternatif, perijinan*

BACKGROUND

Traditional medicine is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies – if they involve use of herbal medicines, an animal parts and/or minerals– and nonmedication therapies - if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries like Indonesia, where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed "complementary", "alternative" or "non-conventional" medicine (CAM) [1].

Traditional Medicine (TM) has been widely used and of rapidly growing health system and economic importance, especially in developing countries and where TM is used as a result of historical circumstances and cultural beliefs. Meanwhile, in many developed countries, CAM is becoming more and more popular and in many parts of the world, expenditure on TM/CAM is not only significant, but growing rapidly. Traditional Medicine (TM) in Indonesia has been used for centuries. Formerly, TM was prepared by housewives or traditional healers to be used by their own family or village community and was not widely spread out. Some of the traditional healers, known as jamu peddlers, sold the products usually in the form of concoction, around the village within a walking distance. Yet these products are not compulsory for evaluation and registration just like the non branded dried herbs which were modestly packed and available at traditional market. Products other than those two types mentioned above are subject to safety evaluation and registration [2]

Interest in traditional systems of medicine and, in particular, herbal medicines, has increased substantially in both developed and developing countries over the past two decades. Global and national markets for medicinal herbs have been growing rapidly, and significant economic gains are being realized. Unfortunately, the number of reports of patients experiencing negative health consequences caused by the use of herbal medicines has also been increasing. Some reported adverse events following the use of certain herbal medicines have been associated with a variety of possible explanations, including the inadvertent use of the wrong plant species, adulteration with undeclared other medicines and/or potent

substances, contamination with undeclared toxic and/or hazardous substances, overdosage, inappropriate use by health-care providers or consumers, and interaction with other medicines [3].

In many parts of the world, policymakers, health professionals and the public still doubt the safety, efficacy, quality, availability, preservation and further development of this type of health care [1]. Interestingly, much of the scientific literature for TM/CAM uses methodologies comparable to those used to support many modern surgical procedures : individual case reports and patient series, with no control or even comparison group. Nevertheless, scientific evidence from randomized clinical trials is strong for many uses of acupuncture, for some herbal medicines, and for some of the manual therapies. In general, however, increased use of TM/CAM has not been accompanied by an increase in the quantity, quality and accessibility of clinical evidence to support TM/CAM claims.

Rational use of TM/CAM includes aspects of qualification and licensing of providers ; proper use of products of assured quality ; good communication between TM/CAM providers, allopathic practitioners and patients; and provision of scientific information and guidance for the public. Challenges in education and training have to assure that the knowledge, qualifications and training of TM/CAM providers are adequate, as well as using training to warrant that TM/CAM providers and allopathic practitioners understand and appreciate the complementarity of the types of health care they offer. Proper use of products could also do much to reduce risks associated with TM/CAM products such as herbal medicines. However, regulation and registration of herbal medicines are not well developed in most countries, and the quality of herbal products sold is generally not guaranteed.

Traditional Medicine in Indonesia

Relatively few countries have developed a policy on TM and/or CAM - only 25 of WHO's 191 Member States. Yet such a policy provides a sound basis for defining the role of TM/CAM in national health care delivery, ensuring that the necessary regulatory and legal mechanisms are created for promoting and maintaining good practice, that access is equitable, and that the authenticity, safety and efficacy of therapies are assured. It can also help to ensure sufficient provision of financial resources for research, education and training. An increased number of national policies would have the added benefit of facilitating work on global issues such as development and implementation of internationally accepted norms and standards for research into safety and efficacy of TM/CAM, sustainable use of medicinal plants, and protection and equitable use of the knowledge of indigenous and traditional medicine.

According to the WHO Strategy of TM, Indonesia has developed National Policy on TM, issued in 2007 (Kotranas) [1, 4]. Indonesia has also developed scheme of quality control of TM products, through compulsory registration of the product in order to ensure the quality of the TM products. The development of Indonesian Herbal Pharmacopoeia (IHP) [5] is an effort to provide reliable evidence of TM. A clinic for complementary and alternative therapy has also been established at Dr. Sutomo General Hospital in Surabaya since 1999. It provides various complementary and alternative therapies, including herbal therapy, aromatherapy, massage and acupuncture. The practice is conducted in both conventional and traditional ways. There are medical doctors, pharmacists, masseurs, biologists, therapists and acupuncturists. Diagnosis of the diseases is conducted by doctors in a

conventional way, and doctors will prescribe herbal medicines and suggest other complimentary and alternative therapies.

The National Policy on Traditional Medicines is an official document setting forth the commitment of all parties in establishing the national objectives, goals, priorities, strategies and roles of related parties in achieving the essential components of the policy for national health development [4]. Herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products. Herbal drugs are mainly whole, fragmented or cut, plants, parts of plants, algae, fungi, lichen in an unprocessed state, usually in dried form but sometimes fresh [6]. Certain exudates that have not been subjected to a specific treatment are also considered to be herbal drugs. Herbal drugs are precisely defined by the botanical scientific name according to the binomial system (genus, species, variety and author).

TM/CAM are widely used along with conventional medicines in Indonesia. The Act No. 36 of 2009 on Health [7], chapter 48 states traditional health services as a part of overall health care. It is then regulated further in some Decrees of Minister of Health such as Decree of Minister of Health no. 1186 0f 1996 on Utilization of Acupuncture in Health Facilities [8], no. 1076 of 2003 on Use of Traditional Health Services [9], and Decree of Minister of Health no. 1109 of 2007 on Use of Complimentary and Alternative Health Services in Health Facilities, Services and Providers including foreigners [10].

Traditional Medicine Therapies (TMT) refer to those based on inheritance, empirical approach or training implemented within living social norms. Traditional healers practise traditional or alternative medicine therapy and have to be registered as such by District Health Office (STPT : Surat Terdaftar Pengobat Tradisional) [9]. Complimentary and Alternative Medicine therapies are non conventional therapies to improve public health, including promotive, curative, preventive and rehabilitative services based on that obtained from structured education with high efficacy, safety and quality biomedically yet not accepted in conventional medical therapy. The providers have to register themselves to Provincial Health Office (SBR-TPKA: Surat Bukti Registrasi-Tenaga Pengobatan Komplementer Alternatif) and to District Health Office for a licence (ST-TPKA: Surat Tugas-Tenaga Pengobatan Komplementer Alternatif) [10]. Thus, CAM therapy is part of TM therapy provided by registered health personnel, particularly physicians and dentists, in either government or private health facilities (hospital, medical clinic and primary health centre). Licensing requirements for CAM therapist are more difficult than other traditional therapists. Furthermore, hospitals providing CAM therapy must fulfil the requirements stated in Decree of Minister of Health no. 1109 of 2007 [10]

METHODS

A descriptive qualitative study has been conducted cross-sectionally to identify local policy on license of herbal therapist as well as the perception of professional organization involved and to identify supports and obstacles of the implementation of the Decree of Minister of Health related to local herbal TMT. The study was done in Provinces of Bali (Denpasar City and Gianyar District), West Java (Bandung City and Bandung District) and Central Java (Semarang city and Kendal District) in the year of 2011. Selection of provinces was based on the existence of herbal medicine industry and from each province two districts were taken as recommended by provincial level.

Matrix of Participants in Round Table Discussion (RTD)

Province	Prov. HO	District HO	IDI	PAK-SI	PD-HMI	AS-PETRI	IAI	IBI	PPNI	∑
Central Java	1	2	2	2	2	2	2	2	2	17
West Java	1	2	2	2	2	2	2	2	2	17
Bali	1	2	2	2	2	2	2	2	2	17
Total	3	6	6	6	6	6	6	6	6	51

Data were collected by means of in-depth interviews and round table discussion (RTD). Informants for interviews were one herbal CAM provider which was taken purposively from each district because of scarcity. Head of Health Resources Department of Provincial and District Health Office were also interviewed, whilst participants in RTD were licence department of Provincial and District Health Office, Indonesian Association of Acupuncturist (PAKSI), Indonesian Association of Herbal Medical Doctor (PDHMI), Indonesian Association of Herbal Traditional Therapist (ASPETRI), Indonesian Pharmacist Association (IAI), Indonesian Association of Midwives (IBI) and Indonesian National Nurse Association (PPNI) from each province and district of the study location.

Data of health office policy on license and control of TM-CAM provider and professional organization policy on TM-CAM provider were collected by in-depth interviews and RTD. As secondary data, documents of prerequisite, TM-CAM licensing procedure, local policy on TM-CAM service, kind and number of TM-CAM services and their providers were also collected. Data were then analyzed descriptively using triangulation method regarding source of data, data collection method and data analysis.

RESULTS

Local policy :

In Bali, District Health Office had the responsibility on licensing TM/CAM service, Provincial Health Office just merely registered CAM providers (SBR-TPKA) which would be valid for five years and may be renewed or prolonged. However, no CAM provider has been registered because the requirement of structured educated acupuncture for at least three months training could not be met yet. This becomes an obstacle in the implementation of the Minister of Health Decree no. 1109 of 2007 on Use of Complimentary and Alter-native Health Services in Health facilities, Services and Providers including Foreigners. According to the Decree, CAM, including herbal medicine, can only be conducted by physician or dentist and nurses may only help them. In Denpasar CAM provider had to be health graduates. Furthermore, recommendation from professional organization or association is also needed.

The same situation was also found in West Java, where District Health Office had the responsibility on licensing TM/CAM service. Provincial Health Office in West Java had issued SBR-TPKA following professional organization recommendation, but so far just only for acupuncturist because no

other professional asked for it yet. It was considered unclear and an obstacle, because no minimal standard had been established. Supervision and control of TM/CAM service was done in collaboration with professional organization involved. There was no local regulation concerning charge of issuing SBR-TPKA, therefore it was given free of charge.

According to Provincial Health Office in Central Java, the MoH Decree no. 1109 of 2007 cannot be implemented yet due to the requirement of structured education or training for three months that must be first followed by the providers. Nevertheless, they had licence to practice as medical practitioners or traditional acupuncturists. An exception for Jamu Scientification [11] which is practiced by participating physicians of public health centres, the PHO had issued SBR-TPKA. Competence requirement must be clearly stated and who has the responsibility to assess must also be determined just like the standard of competence. These things are still unclearly stated in the MoH Decree. The obstacles on the implementation of the decree lie on professional competence, where official professional organization of CAM is still unprepared as well as lack of standards of competencies. District Health Office will give CAM licence (ST –TPKA) if only they already have SBR–TPKA from the provincial level.

In Chapter 13 of the MoH Decree no. 1109 of 2007, physician, dentist or other health provider doing CAM therapy must have competence and licence according to standards developed by professional organization involved. This chapter was perceived differently at the provincial level because no minimal standards had been developed yet as reference, which professional CAM organization had the authority was still uncertain, lack of standard of competence, unpreparedness and dualism in professional organization. Therefore, which organization has the authority to give certificate of competence still has to be defined. At the District level, DHO still referred to the MoH Regulation no. 1076 of 2003 on use of traditional health services including licence procedure and was still unfamiliar with the Decree on CAM which was probably caused by lack of intense socialization.

Round Table Discussion (RTD):

Results of RTD in Denpasar city show that the MoH Decree on CAM was difficult to be implemented due to the requirement of structured CAM education of the provider. According to a participant, whenever physicians followed a three month course, they just got a licence of TM provider (SIPT: Surat Ijin Pengobat Tradisional). For herbal CAM they have to learn in Tawangmangu for 50 hours and practised research based CAM at public health center. Jamu Scientification in hospitals was limited to hypercholesterol, diabetes, uric acid and hypertension. In Bali there were just 5 facilities consisting of 4 public health centers and one hospital.

Round Table Discussion in Bandung showed that not all professional organizations have been familiar with the MoH Decree no. 1109 of 2007. The Ministry of Health expectation did not match with the real situation such that the local health office found difficulties such as dualism in the professional organization.

In Semarang it was revealed that the requirement of competencies from professional organization was an obstacle, many TM providers had no distinct or unofficially registered professional organization, lack of professional organization at the district level as well as standard treatment procedure and code of ethic. CAM education for physician was lacking and merely unstandardized training was there, except for acupuncturist. This was not the case with Jamu due to the

Jamu Scientification program; nonetheless the participants were limited to public health center physician.

Interview with physician :

A physician in Bandung said that the licence requirement for health personnel doing CAM therapy was so complicated that there was a tendency to practice acupuncture as traditional medicine therapist (Battra) rather than CAM terapist. The same thing was also revealed by a physician in Denpasar city. Nevertheless, according to a physician interviewed in Semarang conducting CAM therapy was hindered by registration requirement for CAM therapy (STR: Surat Tanda Registrasi) to obtain SBR-TPKA from the Provincial Health Office (PHO). In order to get STR, on the contrary, they must first have a certificate of competence from the Indonesian Doctor Association (IDI) but collegiums of CAM therapy was still lacking. IDI issues STR for CAM in relation to Jamu Scientification which is for now only limited in public health center. For acupuncture professional organization at provincial level in Central Java was not yet prepared and a physician interviewed in District Kendal said that to obtain STR, they must follow Jamu Scientification program.

Support for the implementation of MoH Decree on CAM comes from doctor or other health personnel who intend to do CAM therapy and their antusiasm to meet the requirements. Support also came from PHO in West Java because through SBR-TPKA they had access to data of CAM provider and did not merely rely on the report from District Health Office.

Professional Organization :

Indonesian Association of Herbal Medical Doctor (PDHMI) in West and Central Java was not yet familiar with the policy of CAM licensing and was still at the stage of SBR-TPKA. There was dualism in professional organization such that the requirements for recommendation varied and therefore, the Ministry of Health has to decide which organization is responsible and has the authority. IDI in Central Java had not given any recommendation because lack of collegiums for acupuncture and herbal TM there.

Indonesian National Nurse Association (PPNI) in Central Java argued and wondered how to integrate the MoH Decree no. 1109 of 2007 on CAM with MoH Decree no. 148 of 2010 on Nursing Practice, because so far the latter is their base to practice.

Indonesian Association of Acupuncturist (PAKSI) in Central Java said that PAKSI is a great umbrella over Indonesian acupuncturists with members either health or non-health professionals conducting acupuncture practice although licensed as TM provider (SIPT). In the year of 2010 Indonesian Acupuncturist Doctor was established and in their national meeting issued certificate for doctor who also practise acupuncture. In Bali health office and professional organization observed no socialization of MoH Decree no 1109 of 2007 from central to local level. Further-more, more clear definition of Traditional Medicine and Complemetary Alternative Medicine provider was needed and terms in the decree should not overlap and make confusion. In West Java not all professional organization have been socialized with Surat Tugas – Tenaga Pengobatan Komplementer Alternatif (ST-TPKA) and dualism in professional organization became a problem concerning who sbould assess competencies, especially when a doctor combines acupuncture and herbal therapy in practice.

DISCUSSION

Regulation of MoH no. 1076 of 2003 on Use of Traditional Health Services

controls the licence of TM providers at District Health Office and chapter 4 states that all TM providers have to register themselves to Head of District Health Office to obtain STPT (Surat Terdaftar Pengobat Tradisional). Furthermore, chapter 9 states that TM providers whose method has met the requirements of screening, analysis, research and evaluation as well as proved to be safe and useful from evidence may be given licence (SIPT: Surat Izin Pengobat Tradisional) by Head of DHO. The issue of Decree of MoH no. 1109 of 2007 made them unsure which licence should be given, SIPT such as regulated in MoH Regulation no.1076 of 2003 or SITPKA after registration to PHO (SBR-TPKA). This obviously concerns with clarity of CAM definition and coverage. Thus, it also brings difficulties or uncertainty to professional organization responsible to recommend.

The differences between licensing procedure of STPT/SIPT and STTPKA/ SBRTPKA make stand-alone practicing professional, such as acupuncturists, choose to be registered as TM provider rather than as CAM provider. It was simpler for them, because they did not have to register themselves to PHO and even to Ministry of Health at times. Hence, licensing procedure for CAM provider must be simplified especially concerning competence certification by CAM collegiums because they were unprepared and officially varied.

Chapter 12 of MoH Decree no. 1109 of 2007 requires that the providers in health facilities are medical doctor, dentist or other health personnels who have had structured education in CAM. This chapter was viewed differently by Provincial Health Offices such that its implementation varied. In Bali province no SBR-TPKA was issued due to the requirement of structured education or at least a three month training concerning acupuncture; whilst in West Java SBR-TPKA had been given to doctors having training conducted by popular universities in addition to recommendation from professional organization. Provincial Health Office (PHO) in Central Java issued SBR-TPKA merely for Jamu Scientification in public health center.

Chapter 13 of the above mentioned Decree states that doctor, dentist or other health personnel doing CAM therapy should have competence and licence according to standards developed by professional organization involved. This will bring uncertainty at the executive level (Provincial Health Office), because there were lack of minimal standard as reference and standar of competence, and which official professional organization was still unclear as well as the unpreparedness of professional organization. Thus, it is unavoidable to fix responsible organization.

District Health Office was not familiar with MoH Decree no. 1109 of 2007 and still referred to MoH Regulation no. 1076 of 2003 on Use of Traditional Health Services including licence issue. The regulations should clarify the authority of STPT and SIPT holder. The competence of traditional therapist with medical and non-medical background is different and therefore the licence should be different too. The existing problem that recommendation from professional organization was varied concerning whether competence assessment should be a prerequisite or not, so it is necessary to revise the MoH Regulation no. 1076 of 2003 on Use of Traditional Health Services with no such grey area. Professional organizations have to be distinguished from association. The Indonesian Pharmacist Association suggested an association accreditation system and development of standard of competence. The public have the right to differentiate easily between TM and CAM therapist including their competencies.

CONCLUSION

Based on Regulation of Minister of Health, RI no. 1076 of 2003 on Use of Traditional Health Services, there were already many medical doctors providing herbal medicine services. Nonetheless, few doctors had implemented Decree of Minister of Health, RI no. 1109 of 2007 on Use of Complimentary and Alternative Health Services in Health Facilities, Services and Providers including Foreigners, because there were no collegiums of herbal medicine yet at provincial level and no standard of competencies for herbal medicine therapist had been developed.

The requirements to obtain licence for health personnel were more difficult and complicated than for traditional medicine provider.

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