# AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

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# AFRO-ASIAN-CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

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# AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT

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## Chapter 1
# INTRODUCTION

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) has been established on the auspicious occasion of the United Nations Day coinciding with the World Development Information Day on 24 October 2015 as a Charity under the Central Act II of 1882, Government of India on 23 October 2015 at New Delhi.

ACCORD has been established with the main objective of locating avenues for alternative employment creation besides designing a neological as well as neocratic approach to skill development and entrepreneurship among the younger generation all over the world in general and in the countries situated in African, Asian and American continents in particular with a view to bringing peace on earth in the third millennium by having countrywise and countrywide appropriate solutions for the burning problems like peacelessness, insurgency, poverty, greed, unemployment, pollution, faulty educational and training methodologies, population explosion, religious intolerance, etc. The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) has decided to design a masterplan paradigm (2015-2025) for a new world order.

The ACCORD has been a part of the World Institution Building Programme (WIBP) for the last 15 years but now it has become an autonomous and independent organization.

The activities of ACCORD will include the strategies for creating more occupations besides transfer of appropriate technologies among the 54 countries in Africa, 49 countries in Asia and 39 countries in the American continents by also locating closer

ties with all countries in Europe as well as Australia and the Pacific Region for ensuring a balanced and a sustainable growth in all countries of the world by using clean as well as cleaning-up technologies through new and emerging techniques for climate change management, environmental and disaster education, geriatric care, waste management, green business and technologies besides strengthening of diplomatic relations among nations for protecting our Mother Earth.

The idea is also to promote entrepreneurial leadership among the school and the college going boys and girls by "Catching Them Young" and for designing appropriate messages for the educators to see that they produce a greater number of job givers rather than job seekers. This will be possible as ACCORD has the qualified inventory of experts for establishing universities, colleges, institutions, schools and other training enterprises in different countries with the latest equipment and infrastructure for conducting formal, informal, nonformal, open, distance, online, internet and web-based employment-centric programmes in all countries of the world.

**Aims and Goals :** The objectives for which the Trust has been formed are :

1. To help provide necessary support in the areas of the emerging and the appropriate technologies for their transfer among all the Afro-Asian-American countries with a view to having mutual as well as technical cooperation.

2. To collect data related to the existing business occupations and the proposed business opportunities in the third millennium in all countries of the world in general and in the Afro-Asian-American countries in particular.

3. To help the countries in diagnosing the societal weaknesses and needs and requirements in order to define the basic level of learning to meet the needs of its own population in different countries under the United Nations.

4. To make special plans for the studies and research in the areas of business development, rural and urban entrepreneurship, occupational research and empowerment by promoting ideas, plans and practices having social, technological, cultural, scientific, environmental, economic and positive contents for the optimum development of a global sustainable society.

5. To aid in organising conferences, congresses, conventions, summits, symposia, seminars, meetings, discussions, debates, study courses, collection of statistics, exhibitions, shows, tour trips and to establish endowments and scholarships for the promotion and furtherance of the aims and objectives of the Trust.

6. To organise and establish educational / business / technical / archaeological museums and parks in different countries of the world for enabling the

business houses, entrepreneurs, institution builders, governments, international bodies, educational institutions, etc. to use these facilities and infrastructure as training-cum-production-cum-rehabilitation centres.

7. To conduct sponsored as well as non-sponsored research programmes with the support of Ministries, Departments, Divisions, Inter-Governmental/ National / Transnational Bodies and International Organisations for coming out with appropriate findings for mitigating the disastrous effects of peacelessness, unemployment, poverty, pollution and population explosion.

8. To publish books, encyclopaedias and directories on different topics relating to international cooperation, diplomacy, education, health, science and technology, environmental and disaster education, sustainable development, peace studies, cleaning and greening, river, ocean and mountain development, glacier studies, employment generation, etc.

9. To establish institutions at primary, secondary and tertiary levels with the active cooperation and involvement of the federal and / or local governments and public / private sector organisations in different countries for teaching, training and research in different emerging fields and to award degrees, diplomas and certificates to that effect.

10. To organise different academic / vocational programmes in association with the universities and institutions in different countries by establishing countrywide and countrywise branches, centres and enterprises with a view to preparing a competent cadre of young boys and girls having expert knowledge of new and emerging specialisations for entering into new occupations and in order to save the fragile and endangered Mother Earth.

11. To institute a Chair(s) in the universities / colleges / institutions / schools and other teaching bodies to make appointments to teachership, professorship and fellowship in different countries by having the sponsorship / co-sponsorship from the leading industrial and business houses and international organisations.

12. To collaborate, affiliate, federate and cooperate with the federal / central / state / provincial / local governments, universities, public / private sector organisations, NGOs and international agencies for implementing the projects of developmental nature all over the world.

13. To design and implement action programmes in areas like health and family welfare, drugless therapies, educational planning and administration, science and technology, rural and urban development, water resources, river, ocean and mountain development, earth sciences, human rights, intellectual property

rights, tourism, hospitality, transportation, etc., with the academic, financial, technical and moral support from the governments, funding bodies, industrial houses, inter-governmental organisations, United Nations, etc.

14. To raise and borrow money for the purpose of the Trust in such a manner as may be decided from time to time to establish the consultancy fees, charges, grants-in-aid, etc.

15. To purchase, take on lease, hire or otherwise acquire properties, movable or immovable, rights and privileges all over the world which may be deemed necessary or convenient for the benefit of the Trust and to sell, lease, mortgage, dispose or otherwise deal with all or any part of the properties of the Trust.

16. To open collaborative branches, chapters and constituent centres in different parts of the world and get them registered with appropriate agencies and authorities if needed and felt necessary for the attainment of the aims and objectives of the Trust.

17. To invest the money of the Trust not immediately required, in such securities and in such manner as decided by the Trust including the money collected through fees, gifts, endowments, donations, grants, etc.

18. To strengthen the voluntary as well as non-governmental organisations in order to make them discharge the responsibility for the implementation of the need-based programmes with a view to protecting the Mother Earth by specially providing training in the areas of attitudinal as well as behavioural change and by educating the world citizenry regarding their rights and duties.

19. To provide consultancy to other institutions and organisations in all countries of the world for the establishment of new institutions with a view to bringing sustainability.

20. To strengthen employment-centric global education and development programmes with a neological as well as neocratric approach for ensuring that the training methodology in the institutions of learning does not produce unemployables.

21. To finally provide developmental action plans to different countries that will prepare the world citizenry for leadership and social responsibility enabling them to think and communicate effectively and develop a global awareness and sensitivity for better global understanding, world peace and unity.

## Chapter 2

# PRESENT ACTIVITIES OF THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

The following are the focus areas for implementing different developmental programmes in the selected countries in Asian, African and American continents:

1. Consultancy to the selected countries in the African as well as the Asian continents for the establishment of universities, colleges and centres of excellence besides skill development enterprises with a view to solving the problems of unemployment.

2. Launching of Bachelor's, Master's and Doctoral Degree Programmes through mutual and technical cooperation for initiating study and research based activities in the areas of hotel management, catering technology, information sciences, business and related issues of business and administration, geoinformatics, bioinformatics, human rights, intellectual property rights, engineering, medical sciences, geriatric care, disaster management, sustainable development, ecology and environment etc.

3. Establishing smart towns and cities for sustainable living and for ensuring climate change management for protecting our Mother Earth.

4. Conducting environmental impact assessment along with pollution monitoring and control in sugar, leather, petro-chemicals, pharmaceuticals, cement, paper, rubber, steel, thermal power plants and mining industries.

5. Establishing of primary, secondary and tertiary level schools and institutions with international collaborations.

6. Establishing computing facilities outfits by providing appropriate technologies for assembly and testing of hardware and software to be used in the governments, public and private sector organizations.

7. Establishing new Ministries for the Federal / State / Provincial Governments with a view to promoting human rights, disaster education, climate change management, remote sensing, glaciology, intellectual property rights, skill development, rural and urban entrepreneurship, peace studies, conflict resolution, etc.

8. Collaboration for scientific and industrial research for promoting technological innovations in the developing countries.

9. Promoting alternative, complementary, energetic, integrated and drugless therapies with a view to optimizing the health budgets of Governments.

10. Promoting ecological tourism, adventure tourism, sustainable tourism, religious tourism, sports tourism, rural tourism, folk tourism, etc. in all countries in the African, Asian and American continents.

11. Inviting the interested countries and their representatives for participating in national and continental summits from time to time including the "Commerce, Occupational Research and Development (CORD)" Summit being held at India International Centre, 40 Lodi Estate, New Delhi on 24 December 2015 at 10 am where there will be a brainstorming session on the sustainable development of the Afro-Asian-American Region besides locating partner countries for launching need based programmes for solving the problems of peacelessness, unemployment, poverty, pollution, educational system, and population explosion.

**OUR MOTO :**

- To produce a greater number of Job Givers, Rather Than Job Seekers
- To bring peace on earth in the Third Millennium
- To Catch the Children Young for making them agents of change
- To Plant Millions of Trees
- To Promote Cleanliness Education

**OUR CHIEF GUESTS IN THE PAST**

1. Hon'ble Shri Ram Naik, Governor of Uttar Pradesh who released our Book "Uttar Pradesh : Past, Present and Future.
2. Hon'ble Shri P. Sathasivam, Governor of Kerala who released our Book "Kerala : Past, Present and Future.
3. Hon'ble Shri Om Prakash Kohli, Governor of Gujarat who released our Book "Gujarat : Past, Present and Future".
4. Hon'ble Smt. Mridula Sinha, Governor of Goa who released our Book "Narendra Modi : The Man India Needs" and the Book "Goa : Past, Present and Future".
5. Hon'ble Shri Balramji Das Tandon, Governor of Chhattisgarh who released our Book "Chhattisgarh : Past, Present and Future".
6. Hon'ble Shri P.B. Acharya, Governor of Nagaland who released our Book "Open and Distance Education Worldwide".


*25 November 2014 : The Hon'ble Governor of Goa Smt. Mridula Sinha releasing the revised edition of the Book "Narendra Modi : The Man India Needs" authored by Dr. P R Trivedi.*


*20 December 2014 : The Book titled "Narendra Modi : The Man India Needs" authored by Dr. P R Trivedi being presented to the Governor of Gujarat Shri Om Prakash Kohli*


*5 October 2014 : Dr. P R Trivedi with the Governors of Uttar Pradesh and Kerala Shri Ram Naik and Justice P. Sathasivam during the Book Release Function at New Delhi*


*29 November 2014 : Release Function for the Book "Bihar : Past, Present and Future" in the presence of HRD Minister of Bihar Shri Brishen Patel, Industries Minister of Bihar Dr. Bhim Singh and other Members of the Editorial Board including Dr. P R Trivedi, Shri Vishwamohan Sharma, Dr. U K Singh, Shri Utkarsh Sharma and Shri Kaustubh Sourabh.*

*13 March 2015 : The Book "Chhattisgarh : Past, Present and Future" authored by Dr. P R Trivedi being released by the Governor of Chhattisgarh Shri Balramji Das Tadon*


*19 January 2015 : The Chief Minister of Haryana Shri Manohar Lal Khattar releasing the Book "Haryana : Past, Present and Future" authored by Dr. P R Trivedi*


*21 January 2015 : The Hindi version of the Book "Bihar : Past, Present and Future" being released by Hon'ble Union Minister of State for Micro and Small Industries Shri Giriraj Singh*

*2 October 2015 : The Governor of Nagaland Hon'ble Shri P B Acharya releasing the Book "Distance and Open Education Worldwide" authored by Dr. P R Trivedi*


***Hon'ble Governor of Tripura, Tathagata Roy lighting the lamp during the Summit organised by Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) at New Delhi on 24 December 2015.***

All the Action Programmes organized and implemented by "ACCORD" have the inputs relating to rural and urban entrepreneurship, employment generation, cleanliness, greening, recycling, institution building, national and international integration for ensuring optimum development of all countries in the Asian, African and American continents.

## Chapter 3

# COUNTRIES COVERED UNDER AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT(ACCORD)

### AFRICAN COUNTRIES

- Algeria
- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cape Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo, Republic of the
- Congo, Democratic Republic of the
- Cote d'Ivoire
- Djibouti
- Egypt
- Equatorial Guinea
- Eritrea
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Libya
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Morocco
- Mozambique

- Namibia
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- Sierra Leone
- Somalia
- South Africa
- South Sudan
- Sudan
- Swaziland
- Tanzania
- Togo
- Tunisia
- Uganda
- Zambia
- Zimbabwe

**ASIAN COUNTRIES**

- Afghanistan
- Armenia
- Azerbaijan
- Bahrain
- Bangladesh
- Bhutan
- Brunei
- Cambodia
- China
- Cyprus
- Georgia
- India
- Indonesia
- Iran
- Iraq
- Israel
- Japan
- Jordan
- Kazakhstan
- Kuwait
- Kyrgyzstan

- Laos
- Lebanon
- Malaysia
- Maldives
- Mongolia
- Myanmar (Burma)
- Nepal
- North Korea
- Oman
- Pakistan
- Palestine
- Philippines
- Qatar
- Russia
- Saudi Arabia
- Singapore
- South Korea
- Sri Lanka
- Syria
- Taiwan
- Tajikistan
- Thailand
- Timor-Leste
- Turkey
- Turkmenistan
- United Arab Emirates
- Uzbekistan
- Vietnam
- Yemen

**AMERICAN COUNTRIES**

**NORTH AMERICA**

- Canada
- Mexico
- United States of America

**CENTRAL AMERICA AND THE ANTILLES**

- Antigua and Barbuda
- Bahamas
- Barbados
- Belize

- Costa Rica
- Cuba
- Dominica
- Dominican Republic
- El Salvador
- Grenada
- Guatemala
- Haiti
- Honduras
- Jamaica
- Nicaragua
- Panama
- Puerto Rico
- Saint Kitts and Nevis
- Saint Lucia
- Saint Vincent and the Grenadines
- Trinidad and Tobago
- Turks and Caicos

**SOUTH AMERICA**

- Argentina
- Bolivia
- Brazil
- Chile
- Colombia
- Ecuador
- French Guiana
- Guyana
- Paraguay
- Peru
- Suriname
- Uruguay
- Venezuela

## Chapter 4

# CONFEDERATIVE APPROACH TO HIGHER EDUCATION : ACCORD'S POINT OF VIEW

It has often been taken for granted that universities are international. The universal nature of knowledge, a long tradition of international collegiality and cooperation in research, the comings and goings of faculty and students since Antiquity have all served to create this impression. Conscious that this impression only partially reflects the day to day reality of higher education institutions and noting that internationalisation of higher education is today more than ever a worthy goal, there is an urgent need to reaffirm the commitment and to urge all stakeholders to contribute to its realisation.

As we have entered the 21st Century, a number of major challenges face women and men as they interact with one another as individuals, groups, and with nature. Globalisation of trade, of production, and of communications has created a highly interconnected world. Yet the tremendous gaps between the rich and the poor continue to widen both within, and between nations. Sustainable development remains an elusive long-term goal, too often sacrificed for short-term gains.

It is imperative that higher education offers solutions to existing problems and innovate to avoid problems in the future. Whether in the economic, political, or social realms, higher education is expected to contribute to raising the overall quality of life. To fulfil its role effectively and maintain excellence, higher education must become far more internationalised; it must integrate an international and intercultural dimension into its teaching, research, and service functions.

Preparing future leaders and citizens for a highly interdependent world, requires a higher education system where internationalisation promotes cultural diversity and fosters intercultural understanding, respect, and tolerance among peoples. Such internationalisation of higher education contributes to building more than economically competitive and politically powerful regional blocks; it represents a commitment to international solidarity, human security and helps to build a climate of global peace.

Technological advances in communications are powerful instruments, which can serve to further internationalisation of higher education and to democratise access to opportunities. However, to the extent that access to new information technologies remains unevenly distributed in the world, the adverse side effects of their widespread use can threaten cultural diversity and widen the gaps in the production, dissemination, and appropriation of knowledge.

Highly educated manpower at the highest levels are essential to increasingly knowledge-based development. Internationalisation as well as international cooperation can serve to improve higher education by increasing efficiency in teaching and learning as well as in research through shared efforts and joint actions.

The ACCORD at this point of time thinks it proper to define the principle of Institutional Autonomy as the necessary degree of independence from external interference that the University requires in respect of its internal organisation and governance, the internal distribution of financial resources and the generation of income from non public sources, the recruitment of its staff, the setting of the conditions of study and, finally, the freedom to conduct teaching and research.

The ACCORD wishes to further define the principle of Academic Freedom as the freedom for members of the academic community that is, scholars, teachers and students to follow their scholarly activities within a framework determined by that community in respect of ethical rules and international standards, and without outside pressure.

Rights confer obligations. These obligations are as much incumbent on the individuals and on the University of which they are part, as they are upon the State and the Society.

Academic Freedom engages the obligation by each individual member of the academic profession to excellence, to innovation, and to advancing the frontiers of knowledge through research and the diffusion of its results through teaching and publications. Academic Freedom also engages the ethical responsibility of the individuals and the academic community in the conduct of research, both in determining the priorities of that research and in taking account of the implications, which its results may have for Humanity and Nature.

For its part, the University has the obligation to uphold and demonstrate to Society that it stands by its collective obligation to quality and ethics, to fairness and tolerance, to the setting and the upkeep of standards - academic when applied to research and teaching, administrative when applied to due process, to the rendering of accounts to Society, to self-verification, to institutional review and to transparency in the conduct of institutional self-government.

For their part, organising powers and stakeholders public or private, stand equally under the obligation to prevent arbitrary interference, to provide and to ensure those conditions necessary, in compliance with internationally recognised standards, for the exercise of Academic Freedom by individual members of the academic profession and for University Autonomy to be exercised by the institution.

In particular, the organising powers and stakeholders public or private, and the interests they represent, should recognise that by its very nature the obligation upon the academic profession to advance knowledge is inseparable from the examination, questioning and testing of accepted ideas and of established wisdom. And that the expression of views, which follows from scientific insight or scholarly investigation may often be contrary to popular conviction or judged as unacceptable and intolerable.

Hence, agencies which exercise responsibility for the advancement of knowledge as to particular interests which provide support for, or stand in a contractual relationship with, the University for the services it may furnish, must recognise that such expressions of scholarly judgement and scientific inquiry shall not place in jeopardy the career or the existence of the individual expressing them nor leave that individual open to pursual for *delit d'opinion* on account of such views being expressed.

If the free range of inquiry, examination and the advance of knowledge are held to be benefits Society derives from the University, the latter must assume the responsibility for the choices and the priorities it sets freely. Society for its part, must recognise its part in providing means appropriate for the achievement of that end.

Resources should be commensurate with expectations - especially those which, like fundamental research, demand a long-term commitment if they are to yield their full benefits.

The obligation to transmit and to advance knowledge is the basic purpose for which Academic Freedom and University Autonomy are required and recognised. Since knowledge is universal, so too is this obligation.

In practice, however, Universities fulfil this obligation primarily in respect of the Societies in which they are located. And it is these communities, cultural, regional, national and local, which establish with the University the terms by which such responsibilities are to be assumed, who is to assume them and by what means and procedures.

Responsibilities met within the setting of 'national' society, extend beyond the physical boundaries of that society. Since its earliest days, the University has professed intellectual and spiritual engagement to the principles of 'universalism' and to 'internationalism' whilst Academic Freedom and University Autonomy evolved within the setting of the historic national community.

For Universities to serve a world society requires that Academic Freedom and University Autonomy form the bedrock to a new Social Contract - a contract to

uphold values common to Humanity and to meet the expectations of a world where frontiers are rapidly dissolving.

In the context of international cooperation, the exercise of Academic Freedom and University Autonomy by some should not lead to intellectual hegemony over others. It should, on the contrary, be a means of strengthening the principles of pluralism, tolerance and academic solidarity between institutions of higher learning and between individual scholars and students. At a time when the ties, obligations and commitments between Society and the University are becoming more complex, more urgent and more direct, it appears desirable to establish a broadly recognised Charter of mutual rights and obligations governing the relationship between University and Society, including adequate monitoring mechanisms for its application.

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD), being founded to promote cooperation among higher education institutions, notes that despite the universality of knowledge, which has always served to affirm the nature of higher education, the level of internationalisation remains low and uneven. Furthermore, cooperation has had relatively little impact of global wealth and resource distribution even in the realm of higher education. Worse, the external brain drain and other negative consequences of poorly designed cooperative activities have, at times, even exacerbated the conditions in developing nations.

In more recent times, commercial and financial interests have gained prominence in the internationalisation process and threaten to displace the less utilitarian and equally valuable aspects of this enriching and necessary transformation of higher education.

## MASTERPLAN ENVISAGED BY THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

## INTRODUCTION

1. There is an unprecedented demand for and a great diversification in higher education, as well as an increased awareness of its vital importance for sociocultural and economic development, and for building the future, for which the younger generations will need to be equipped with new skills, knowledge and ideals.

2. Higher education includes ‘all types of studies, teaching, training and research at the post-secondary level, provided by universities or other

educational establishments that are approved as institutions of higher education by the Competent Authorities.

3. Everywhere higher education is faced with great challenges and difficulties related to financing, equity of conditions at access into and during the course of studies, improved staff development, skills-based training, enhancement and preservation of quality in teaching, research and services, relevance of programmes, employability of graduates, post-graduates and doctorates, establishment of efficient co-operation agreements and equitable access to the benefits of international co-operation.

4. At the same time, higher education is being challenged by new opportunities relating to technologies that are improving the ways in which knowledge can be produced, managed, disseminated, accessed and controlled. Equitable access to these technologies should be ensured at all levels of education systems.

5. The initial years of this century and the last 50 years of the twentieth century will go down in the history of higher education as the period of its most spectacular expansion: an over sixfold increase in student enrolments worldwide. But it is also the period which has seen the gap between the industrially developed, the developing countries and in particular the least developed countries with regard to access and resources for higher learning and research, already enormous, becoming even wider. It has also been a period of increased socio-economic stratification and greater difference in educational opportunity within countries, including in some of the most developed and wealthiest nations.

6. Without adequate higher education and research institutions providing a critical mass of skilled and educated people, no country can ensure genuine endogenous and sustainable development and, in particular, developing countries and the least developed countries cannot reduce the gap separating them from the industrially developed ones. Sharing knowledge, international co-operation and new technologies can offer new opportunities to reduce this gap.

7. Higher education has given ample proof of its viability over the centuries and of its ability to change and to induce change and progress in society. Owing to the scope and pace of change, society has become increasingly knowledge-based so that higher learning and research now act as essential components of cultural, socio-economic and environmentally sustainable development of individuals, communities and nations.

8. Higher education itself is confronted, therefore, with formidable challenges and must proceed to the most radical change and renewal it has ever been required to undertake, so that our society, which is currently undergoing a profound crisis of values, can transcend mere economic considerations and incorporate deeper dimensions of morality and spirituality.

9. It is with the aim of providing solutions to these challenges and of setting in motion a process of in-depth reform in higher education worldwide that the Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) is being established with a view to designing a Masterplan Paradigm for introducing development systems for strengthening the cause of higher education in the third millennium.

## ACCORD'S DECLARATION ON HIGHER EDUCATION

10. Recalling the Universal Declaration of Human Rights which states in Article 26, paragraph 1, that 'Everyone has the right to education' and that 'higher education shall be equally accessible to all on the basis of merit', and endorsing the basic principles of the Convention against Discrimination in Education (1960), which, by Article 4, commits the States Parties to it to 'make higher education equally accessible to all on the basis of individual capacity'.

11. Convinced that education is a fundamental pillar of human rights, democracy, sustainable development and peace, and shall therefore become accessible to all throughout life and that measures are required to ensure co-ordination and co-operation across and between the various sectors, particularly between general, technical and professional secondary and post-secondary education as well as between universities, colleges and technical institutions.

12. Believing that, in this context, the solution of the problems faced in the twenty-first century will be determined by the vision of the future society and by the role that is assigned to education in general and to higher education in particular.

13. Aware that at the beginning of a new millennium it is the duty of higher education to ensure that the values and ideals of a culture of peace prevail and that the intellectual community should be mobilized to that end.

14. Considering that a substantial change and development of higher education, the enhancement of its quality and relevance, and the solution to the major challenges it faces, require the strong involvement not only of governments and of higher education institutions, but also of all stakeholders, including

students and their families, teachers, business and industry, the public and private sectors of the economy, legislatures, the media, the community, professional associations and society as well as a greater responsibility of higher education institutions towards society and accountability in the use of public and private, national or international resources;

15. Emphasizing that higher education systems should enhance their capacity to live with uncertainty, to change and bring about change, and to address social needs and to promote solidarity and equity; should preserve and exercise scientific rigour and originality, in a spirit of impartiality, as a basic prerequisite for attaining and sustaining an indispensable level of quality; and should place students at the centre of their concerns, within a lifelong perspective, so as to allow their full integration into the global knowledge society of this new century; and

16. Also believing that international co-operation and exchange are major avenues for advancing higher education throughout the world.

Proclaim the following:

## MISSIONS AND FUNCTIONS OF THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD) RELATED TO TERTIARY EDUCATION

### MISSION TO EDUCATE, TO TRAIN AND TO UNDERTAKE RESEARCH

We affirm that the core missions and values of higher education, in particular the mission to contribute to the sustainable development and improvement of society as a whole, should be preserved, reinforced and further expanded, namely, to:

17. Educate highly qualified graduates and responsible citizens able to meet the needs of all sectors of human activity, by offering relevant qualifications, including professional training, which combine high-level knowledge and skills, using courses and content continually tailored to the present and future needs of society.

18. Provide opportunities for higher learning and for learning throughout life, giving to learners an optimal range of choice and a flexibility of entry and exit points within the system, as well as an opportunity for individual development and social mobility in order to educate for citizenship and for active participation in society, with a worldwide vision, for endogenous capacity-building, and for the consolidation of human rights, sustainable development, democracy and peace, in a context of justice.

19. Advance, create and disseminate knowledge through research and provide, as part of its service to the community, relevant expertise to assist societies in cultural, social and economic development, promoting and developing scientific and technological research as well as research in the social sciences, the humanities and the creative arts.

20. Help understand, interpret, preserve, enhance, promote and disseminate national and regional, international and historic cultures, in a context of cultural pluralism and diversity.

21. Help protect and enhance societal values by training young people in the values which form the basis of democratic citizenship and by providing critical and detached perspectives to assist in the discussion of strategic options and the reinforcement of humanistic perspectives; and

22. Contribute to the development and improvement of education at all levels, including through the training of teachers.

**ETHICAL ROLE, AUTONOMY, RESPONSIBILITY AND ANTICIPATORY FUNCTION**

Higher education institutions and their personnel and students should :

23. Preserve and develop their crucial functions, through the exercise of ethics and scientific and intellectual rigour in their various activities.

24. Be able to speak out on ethical, cultural and social problems completely independently and in full awareness of their responsibilities, exercising a kind of intellectual authority that society needs to help it to reflect, understand and act.

25. Enhance their critical and forward-looking functions, through continuing analysis of emerging social, economic, cultural and political trends, providing a focus for forecasting, warning and prevention.

26. Exercise their intellectual capacity and their moral prestige to defend and actively disseminate universally accepted values, including peace, justice, freedom, equality and solidarity.

27. Enjoy full academic autonomy and freedom, conceived as a set of rights and duties, while being fully responsible and accountable to society.

28. Play a role to help identify and to address issues that affect the well-being of communities, nations and global society.

## SHAPING A NEW VISION OF HIGHER EDUCATION
### Equity of Access

29. In keeping with Article 26.1 of the Universal Declaration of Human Rights, admission to higher education should be based on the merit, capacity, efforts, perseverance and devotion, showed by those seeking access to it, and can take place in a lifelong scheme, at any time, with due recognition of previously acquired skills. As a consequence, no discrimination can be accepted in granting access to higher education on grounds of race, gender, language or religion, or economic, cultural or social distinctions, or physical disabilities.

30. Equity of access to higher education should begin with the reinforcement and, if need be, the reordering of its links with all other levels of education, particularly with secondary education. Higher education institutions must be viewed as, and must also work within themselves to be a part of and encourage, a seamless system starting with early childhood and primary education and continuing through life. Higher education institutions must work in active partnership with parents, schools, students, socio-economic groups and communities.

31. Secondary education should not only prepare qualified candidates for access to higher education by developing the capacity to learn on a broad basis but also open the way to active life by providing training on a wide range of jobs. However, access to higher education should remain open to those successfully completing secondary school, or its equivalent, or presenting entry qualifications, as far as possible, at any age and without any discrimination.

32. As a consequence, the rapid and wide-reaching demand for higher education requires, where appropriate, all policies concerning access to higher education to give priority in the future to the approach based on the merit of the individual.

33. Access to higher education for members of some special target groups, such as indigenous peoples, cultural and linguistic minorities, disadvantaged groups, peoples living under occupation and those who suffer from disabilities, must be actively facilitated, since these groups as collectivities and as individuals may have both experience and talent that can be of great value for the development of societies and nations. Special material help and educational solutions can help overcome the obstacles that these groups face, both in accessing and in continuing higher education.

## ENHANCING PARTICIPATION AND PROMOTING THE ROLE OF WOMEN

34. Although significant progress has been achieved to enhance the access of women to higher education, various socio-economic, cultural and political obstacles continue in many places in the world to impede their full access and effective integration. To overcome them remains an urgent priority in the renewal process for ensuring an equitable and non-discriminatory system of higher education based on the principle of merit.

35. Further efforts are required to eliminate all gender stereotyping in higher education, to consider gender aspects in different disciplines and to consolidate women's participation at all levels and in all disciplines, in which they are under-represented and, in particular, to enhance their active involvement in decision-making.

36. Gender studies (women's studies) should be promoted as a field of knowledge, strategic for the transformation of higher education and society.

37. Efforts should be made to eliminate political and social barriers whereby women are under-represented and in particular to enhance their active involvement at policy and decision-making levels within higher education and society.

## ADVANCING KNOWLEDGE THROUGH RESEARCH IN SCIENCE, THE ARTS AND HUMANITIES AND THE DISSEMINATION OF ITS RESULTS

38. The advancement of knowledge through research is an essential function of all systems of higher education, which should promote postgraduate studies. Innovation, interdisciplinarity and transdisciplinarity should be promoted and reinforced in programmes with long-term orientations on social and cultural aims and needs. An appropriate balance should be established between basic and target-oriented research.

40. Institutions should ensure that all members of the academic community engaged in research are provided with appropriate training, resources and support. The intellectual and cultural rights on the results of research should be used to the benefit of humanity and should be protected so that they cannot be abused.

41. Research must be enhanced in all disciplines, including the social and human sciences, education (including higher education), engineering, natural sciences, mathematics, informatics and the arts within the framework of national, regional and international research and development policies. Of special importance is the enhancement of research capacities in higher

education research institutions, as mutual enhancement of quality takes place when higher education and research are conducted at a high level within the same institution. These institutions should find the material and financial support required, from both public and private sources.

## LONG-TERM ORIENTATION BASED ON RELEVANCE

42. Relevance in higher education should be assessed in terms of the fit between what society expects of institutions and what they do. This requires ethical standards, political impartiality, critical capacities and, at the same time, a better articulation with the problems of society and the world of work, basing long-term orientations on societal aims and needs, including respect for cultures and environmental protection. The concern is to provide access to both broad general education and targeted, career-specific education, often interdisciplinary, focusing on skills and aptitudes, both of which equip individuals to live in a variety of changing settings, and to be able to change occupations.

43. Higher education should reinforce its role of service to society, especially its activities aimed at eliminating poverty, intolerance, violence, illiteracy, hunger, environmental degradation and disease, mainly through an interdisciplinary and transdisciplinary approach in the analysis of problems and issues.

44. Higher education should enhance its contribution to the development of the whole education system, notably through improved teacher education, curriculum development and educational research.

45. Ultimately, higher education should aim at the creation of a new society - non-violent and non-exploitative - consisting of highly cultivated, motivated and integrated individuals, inspired by love for humanity and guided by wisdom.

## STRENGTHENING CO-OPERATION WITH THE WORLD OF WORK AND ANALYSING AND ANTICIPATING SOCIETAL NEEDS

46. In economies characterized by changes and the emergence of new production paradigms based on knowledge and its application, and on the handling of information, the links between higher education, the world of work and other parts of society should be strengthened and renewed.

47. Links with the world of work can be strengthened, through the participation of its representatives in the governance of institutions, the increased use of domestic and international apprenticeship/work-study opportunities for

students and teachers, the exchange of personnel between the world of work and higher education institutions and revised curricula more closely aligned with working practices.

48. As a lifelong source of professional training, updating and recycling, institutions of higher education should systematically take into account trends in the world of work and in the scientific, technological and economic sectors. In order to respond to the work requirements, higher education systems and the world of work should jointly develop and assess learning processes, bridging programmes and prior learning assessment and recognition programmes, which integrate theory and training on the job. Within the framework of their anticipatory function, higher education institutions could contribute to the creation of new jobs, although that is not their only function.

49. Developing entrepreneurial skills and initiative should become major concerns of higher education, in order to facilitate employability of graduates who will increasingly be called upon to be not only job seekers but also and above all to become job creators. Higher education institutions should give the opportunity to students to fully develop their own abilities with a sense of social responsibility, educating them to become full participants in democratic society and promoters of changes that will foster equity and justice.

## DIVERSIFICATION FOR ENHANCED EQUITY OF OPPORTUNITY

50. Diversifying higher education models and recruitment methods and criteria is essential both to meet increasing international demand and to provide access to various delivery modes and to extend access to an ever-wider public, in a lifelong perspective, based on flexible entry and exit points to and from the system of higher education.

51. More diversified systems of higher education are characterized by new types of tertiary institutions: public, private and non-profit institutions, amongst others. Institutions should be able to offer a wide variety of education and training opportunities: traditional degrees, short courses, part-time study, flexible schedules, modularized courses, supported learning at a distance, etc.

## INNOVATIVE EDUCATIONAL APPROACHES: CRITICAL THINKING AND CREATIVITY

52. In a world undergoing rapid changes, there is a perceived need for a new vision and paradigm of higher education, which should be student-oriented, calling in most countries for in-depth reforms and an open access policy so as

to cater to ever more diversified categories of people, and of its contents, methods, practices and means of delivery, based on new types of links and partnerships with the community and with the broadest sectors of society.

53. Higher education institutions should educate students to become well informed and deeply motivated citizens, who can think critically, analyse problems of society, look for solutions to the problems of society, apply them and accept social responsibilities.

54. To achieve these goals, it may be necessary to recast curricula, using new and appropriate methods, so as to go beyond cognitive mastery of disciplines. New pedagogical and didactical approaches should be accessible and promoted in order to facilitate the acquisition of skills, competencies and abilities for communication, creative and critical analysis, independent thinking and team work in multicultural contexts, where creativity also involves combining traditional or local knowledge and know-how with advanced science and technology. These recast curricula should take into account the gender dimension and the specific cultural, historic and economic context of each country. The teaching of human rights standards and education on the needs of communities in all parts of the world should be reflected in the curricula of all disciplines, particularly those preparing for entrepreneurship. Academic personnel should play a significant role in determining the curriculum.

55. New methods of education will also imply new types of teaching-learning materials. These have to be coupled with new methods of testing that will promote not only powers of memory but also powers of comprehension, skills for practical work and creativity.

## HIGHER EDUCATION PERSONNEL AND STUDENTS AS MAJOR ACTORS

56. A vigorous policy of staff development is an essential element of higher education institutions. Clear policies should be established concerning higher education teachers, who nowadays need to focus on teaching students how to learn and how to take initiatives rather than being exclusively founts of knowledge. Adequate provision should be made for research and for updating and improving pedagogical skills, through appropriate staff development programmes, encouraging constant innovation in curriculum, teaching and learning methods, and ensuring appropriate professional and financial status, and for excellence in research and teaching. Furthermore, in view of the role of higher education for lifelong learning, experience outside the institutions ought to be considered as a relevant qualification for higher educational staff.

57. Clear policies should be established by all higher education institutions preparing teachers of early childhood education and for primary and secondary schools, providing stimulus for constant innovation in curriculum, best practices in teaching methods and familiarity with diverse learning styles. It is vital to have appropriately trained administrative and technical personnel.

58. National and institutional decision-makers should place students and their needs at the centre of their concerns, and should consider them as major partners and responsible stakeholders in the renewal of higher education. This should include student involvement in issues that affect that level of education, in evaluation, the renovation of teaching methods and curricula and, in the institutional framework in force, in policy-formulation and institutional management. As students have the right to organize and represent themselves, students' involvement in these issues should be guaranteed.

59. Guidance and counselling services should be developed, in co-operation with student organizations, in order to assist students in the transition to higher education at whatever age and to take account of the needs of ever more diversified categories of learners. Apart from those entering higher education from schools or further education colleges, they should also take account of the needs of those leaving and returning in a lifelong process. Such support is important in ensuring a good match between student and course, reducing drop-out. Students who do drop out should have suitable opportunities to return to higher education if and when appropriate.

## FROM VISION TO ACTION

### Qualitative Evaluation

60. Quality in higher education is a multidimensional concept, which should embrace all its functions, and activities: teaching and academic programmes, research and scholarship, staffing, students, buildings, facilities, equipment, services to the community and the academic environment. Internal self-evaluation and external review, conducted openly by independent specialists, if possible with international expertise, are vital for enhancing quality. Independent national bodies should be established and comparative standards of quality, recognized at international level, should be defined. Due attention should be paid to specific institutional, national and regional contexts in order to take into account diversity and to avoid uniformity. Stakeholders should be an integral part of the institutional evaluation process.

61. Quality also requires that higher education should be characterized by its international dimension: exchange of knowledge, interactive networking, mobility of teachers and students, and international research projects, while taking into account the national cultural values and circumstances.

62. To attain and sustain national, regional or international quality, certain components are particularly relevant, notably careful selection of staff and continuous staff development, in particular through the promotion of appropriate programmes for academic staff development, including teaching/learning methodology and mobility between countries, between higher education institutions, and between higher education institutions and the world of work, as well as student mobility within and between countries. The new information technologies are an important tool in this process, owing to their impact on the acquisition of knowledge and know-how.

## THE POTENTIAL AND THE CHALLENGE OF TECHNOLOGY

63. The rapid breakthroughs in new information and communication technologies will further change the way knowledge is developed, acquired and delivered. It is also important to note that the new technologies offer opportunities to innovate on course content and teaching methods and to widen access to higher learning. However, it should be borne in mind that new information technology does not reduce the need for teachers but changes their role in relation to the learning process and that the continuous dialogue that converts information into knowledge and understanding becomes fundamental. Higher education institutions should lead in drawing on the advantages and potential of new information and communication technologies, ensuring quality and maintaining high standards for education practices and outcomes in a spirit of openness, equity and international co-operation by:

64. Engaging in networks, technology transfer, capacity-building, developing teaching materials and sharing experience of their application in teaching, training and research, and making knowledge accessible to all;

65. Creating new learning environments, ranging from distance education facilities to complete virtual higher education institutions and systems, capable of bridging distances and developing high-quality systems of education, thus serving social and economic advancement and democratization as well as other relevant priorities of society, while ensuring that these virtual education facilities, based on regional, continental or global networks, function in a way that respects cultural and social identities;

66. Noting that, in making full use of information and communication technology (ICT) for educational purposes, particular attention should be paid to removing the grave inequalities which exist among and also within the countries of the world with regard to access to new information and communication technologies and to the production of the corresponding resources;

67. Adapting ICT to national, regional and local needs and securing technical, educational, management and institutional systems to sustain it;

68. Facilitating, through international co-operation, the identification of the objectives and interests of all countries, particularly the developing countries, equitable access and the strengthening of infrastructures in this field and the dissemination of such technology throughout society;

69. Closely following the evolution of the 'knowledge society' in order to ensure high quality and equitable regulations for access to prevail;

70. Taking the new possibilities created by the use of ICTs into account, while realizing that it is, above all, institutions of higher education that are using ICTs in order to modernize their work, and not ICTs transforming institutions of higher education from real to virtual institutions.

**STRENGTHENING HIGHER EDUCATION MANAGEMENT AND FINANCING**

71. The management and financing of higher education require the development of appropriate planning and policy-analysis capacities and strategies, based on partnerships established between higher education institutions and state and national planning and co-ordination bodies, so as to secure appropriately streamlined management and the cost-effective use of resources. Higher education institutions should adopt forward-looking management practices that respond to the needs of their environments. Managers in higher education must be responsive, competent and able to evaluate regularly, by internal and external mechanisms, the effectiveness of procedures and administrative rules.

72. Higher education institutions must be given autonomy to manage their internal affairs, but with this autonomy must come clear and transparent accountability to the government, legislature, students and the wider society.

73. The ultimate goal of management should be to enhance the institutional mission by ensuring high-quality teaching, training and research, and services to the community. This objective requires governance that combines

social vision, including understanding of global issues, with efficient managerial skills. Leadership in higher education is thus a major social responsibility and can be significantly strengthened through dialogue with all stakeholders, especially teachers and students, in higher education. The participation of teaching faculty in the governing bodies of higher education institutions should be taken into account, within the framework of current institutional arrangements, bearing in mind the need to keep the size of these bodies within reasonable bounds.

74. The promotion of North-South co-operation to ensure the necessary financing for strengthening higher education in the developing countries is essential.

## FINANCING OF HIGHER EDUCATION AS A PUBLIC SERVICE

The funding of higher education requires both public and private resources. The role of the government remains essential in this regard.

75. The diversification of funding sources reflects the support that society provides to higher education and must be further strengthened to ensure the development of higher education, increase its efficiency and maintain its quality and relevance. Public support for higher education and research remains essential to ensure a balanced achievement of educational and social missions.

76. Society as a whole must support education at all levels, including higher education, given its role in promoting sustainable economic, social and cultural development. Mobilization for this purpose depends on public awareness and involvement of the public and private sectors of the economy, legislature, the media, governmental and non-governmental organizations, students as well as institutions, families and all the social actors involved with higher education.

## SHARING KNOWLEDGE AND KNOW-HOW ACROSS BORDERS AND CONTINENTS

77. The principle of solidarity and true partnership amongst higher education institutions worldwide is crucial for education and training in all fields that encourage an understanding of global issues, the role of democratic governance and skilled human resources in their resolution, and the need for living together with different cultures and values. The practice of multilingualism, faculty and student exchange programmes and institutional linkage to promote intellectual and scientific co-operation should be an integral part of all higher education systems.

78. The principles of international co-operation based on solidarity, recognition and mutual support, true partnership that equitably serves the interests of the partners and the value of sharing knowledge and know-how across borders should govern relationships among higher education institutions in both developed and developing countries and should benefit the least developed countries in particular. Consideration should be given to the need for safeguarding higher education institutional capacities in regions suffering from conflict or natural disasters. Consequently, an international dimension should permeate the curriculum, and the teaching and learning processes.

79. Regional and international normative instruments for the recognition of studies should be ratified and implemented, including certification of the skills, competencies and abilities of graduates, making it easier for students to change courses, in order to facilitate mobility within and between national systems.

## FROM 'BRAIN DRAIN' TO 'BRAIN GAIN'

80. The 'brain drain' has yet to be stemmed, since it continues to deprive the developing countries and those in transition, of the high-level expertise necessary to accelerate their socio-economic progress. International co-operation schemes should be based on long-term partnerships between institutions in the South and the North, and also promote South-South co-operation. Priority should be given to training programmes in the developing countries, in centres of excellence forming regional and international networks, with short periods of specialized and intensive study abroad.

81. Consideration should be given to creating an environment conducive to attracting and retaining skilled human capital, either through national policies or international arrangements to facilitate the return - permanent or temporary - of highly trained scholars and researchers to their countries of origin. At the same time, efforts must be directed towards a process of 'brain gain' through collaboration programmes that, by virtue of their international dimension, enhance the building and strengthening of institutions and facilitate full use of endogenous capacities.

## PARTNERSHIP AND ALLIANCES

82. Partnership and alliances amongst stakeholders - national and institutional policy-makers, teaching and related staff, researchers and students, and administrative and technical personnel in institutions of higher education, the world of work, community groups - is a powerful force in managing change. Also, non-governmental organizations are key actors in this process.

Henceforth, partnership, based on common interest, mutual respect and credibility, should be a prime matrix for renewal in higher education.

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) adopts this Declaration and reaffirms the right of all people to education and the right of access to higher education based on individual merit and capacity.

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) pledges to act together within the frame of our individual and collective responsibilities, by taking all necessary measures in order to realize the principles concerning higher education contained in the Universal Declaration of Human Rights and in the Convention against Discrimination in Education.

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) solemnly reaffirms the commitment to peace. To that end, ACCORD is determined to accord high priority to education for reducing peacelessness, unemployment, pollution and intolerance.

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) adopts, therefore, this Declaration on Higher Education and Development. To achieve the goals set forth in this Declaration and, in particular, for immediate action, ACCORD agrees on the following Framework for Priority Action for Change and Development of Higher Education.

## FRAMEWORK FOR PRIORITY ACTION FOR CHANGE AND DEVELOPMENT OF HIGHER EDUCATION

### Priority Actions at National Level

States, including their governments, legislatures and other decision-makers, should:

83. Establish, where appropriate, the legislative, political and financial framework for the reform and further development of higher education, in keeping with the terms of the Universal Declaration of Human Rights, which establishes that higher education shall be 'accessible to all on the basis of merit'. No discrimination can be accepted, no one can be excluded from higher education or its study fields, degree levels and types of institutions on grounds of race, gender, language, religion, or age or because of any economic or social distinctions or physical disabilities;

84. Reinforce the links between higher education and research;

85. Consider and use higher education as a catalyst for the entire education system;

86. Develop higher education institutions to include lifelong learning approaches, giving learners an optimal range of choice and a flexibility of entry and exit points within the system, and redefine their role accordingly, which implies the development of open and continuous access to higher learning and the need for bridging programmes and prior learning assessment and recognition;

87. Make efforts, when necessary, to establish close links between higher education and research institutions, taking into account the fact that education and research are two closely related elements in the establishment of knowledge;

88. Develop innovative schemes of collaboration between institutions of higher education and different sectors of society to ensure that higher education and research programmes effectively contribute to local, regional and national development;

89. Fulfil their commitments to higher education and be accountable for the pledges adopted with their concurrence, at several forums, particularly over the past decade, with regard to human, material and financial resources, human development and education in general, and to higher education in particular;

90. Have a policy framework to ensure new partnerships and the involvement of all relevant stakeholders in all aspects of higher education: the evaluation process, including curriculum and pedagogical renewal, and guidance and counselling services; and, in the framework of existing institutional arrangements, policy-making and institutional governance;

91. Define and implement policies to eliminate all gender stereotyping in higher education and to consolidate women's participation at all levels and in all disciplines in which they are under-represented at present and, in particular, to enhance their active involvement in decision-making;

92. Recognize students as the centre of attention of higher education, and one of its stakeholders. They should be involved, by means of adequate institutional structures, in the renewal of their level of education (including curriculum and pedagogical reform), and policy decision, in the framework of existing institutional arrangements;

93. Recognize that students have the right to organize themselves autonomously;

94. Promote and facilitate national and international mobility of teaching staff and students as an essential part of the quality and relevance of higher education;

95. Provide and ensure those conditions necessary for the exercise of academic freedom and institutional autonomy so as to allow institutions of higher education, as well as those individuals engaged in higher education and research, to fulfil their obligations to society.

96. States in which enrolment in higher education is low by internationally accepted comparative standards should strive to ensure a level of higher education adequate for relevant needs in the public and private sectors of society and to establish plans for diversifying and expanding access, particularly benefiting all minorities and disadvantaged groups.

97. The interface with general, technical and professional secondary education should be reviewed in depth, in the context of lifelong learning. Access to higher education in whatever form must remain open to those successfully completing secondary education or its equivalent or meeting entry qualifications at any age, while creating gateways to higher education, especially for older students without any formal secondary education certificates, by attaching more importance to their professional experience. However, preparation for higher education should not be the sole or primary purpose of secondary education, which should also prepare for the world of work, with complementary training whenever required, in order to provide knowledge, capacities and skills for a wide range of jobs. The concept of bridging programmes should be promoted to allow those entering the job market to return to studies at a later date.

98. Concrete steps should be taken to reduce the widening gap between industrially developed and developing countries, in particular the least developed countries, with regard to higher education and research. Concrete steps are also needed to encourage increased co-operation between countries at all levels of economic development with regard to higher education and research. Consideration should be given to making budgetary provisions for that purpose, and developing mutually beneficial agreements in order to sustain co-operative activities and projects through appropriate incentives and funding in education, research and the development of high-level experts.

## PRIORITY ACTIONS AT THE LEVEL OF SYSTEMS AND INSTITUTIONS

99. Each higher education institution should define its mission according to the present and future needs of society and base it on an awareness of the fact

that higher education is essential for any country or region to reach the necessary level of sustainable and environmentally sound economic and social development, cultural creativity nourished by better knowledge and understanding of the cultural heritage, higher living standards, and internal and international harmony and peace, based on human rights, democracy, tolerance and mutual respect. These missions should incorporate the concept of academic freedom.

In establishing priorities in their programmes and structures, higher education institutions should:

100. Take into account the need to abide by the rules of ethics and scientific and intellectual rigour, and the multidisciplinary and transdisciplinary approach;

101. Be primarily concerned to establish systems of access for the benefit of all persons who have the necessary abilities and motivations;

102. Use their autonomy and high academic standards to contribute to the sustainable development of society and to the resolution of the issues facing the society of the future. They should develop their capacity to give forewarning through the analysis of emerging social, cultural, economic and political trends, approached in a multidisciplinary and transdisciplinary manner, giving particular attention to:

high quality, a clear sense of the social pertinence of studies and their anticipatory function, based on scientific grounds;

knowledge of fundamental social questions, in particular related to the elimination of poverty, to sustainable development, to intercultural dialogue and to the shaping of a culture of peace;

the need for close connection with effective research organizations or institutions that perform well in the sphere of research; and

fundamentals of human ethics, applied to each profession and to all areas of human endeavour.

103. Ensure, especially in universities and as far as possible, that faculty members participate in teaching, research, tutoring students and steering institutional affairs.

104. Take all necessary measures to reinforce their service to the community, especially their activities aimed at eliminating poverty, intolerance, violence, illiteracy, hunger and disease, through an interdisciplinary and

transdisciplinary approach in the analysis of challenges, problems and different subjects.

105. Set their relations with the world of work on a new basis involving effective partnerships with all social actors concerned, starting from a reciprocal harmonization of action and the search for solutions to pressing problems of humanity, all this within a framework of responsible autonomy and academic freedom.

106. Ensure high quality of international standing, consider accountability and both internal and external evaluation, with due respect for autonomy and academic freedom, as being normal and inherent in their functioning, and institutionalize transparent systems, structures or mechanisms specific thereto.

107. As lifelong education requires academic staff to update and improve their teaching skills and learning methods, even more than in the present systems mainly based on short periods of higher teaching, establish appropriate academic staff development structures and/or mechanisms and programmes.

108. Promote and develop research, which is a necessary feature of all higher education systems, in all disciplines, including the human and social sciences and arts, given their relevance for development are needed to ensure continued progress towards such key national objectives as access, equity, quality, relevance and diversification.

109. Remove gender inequalities and biases in curricula and research, and take all appropriate measures to ensure balanced representation of both men and women among students and teachers, at all levels of management.

110. Provide, where appropriate, guidance and counselling, remedial courses, training in how to study and other forms of student support, including measures to improve student living conditions.

111. While the need for closer links between higher education and the world of work is important worldwide, it is particularly vital for the developing countries and especially the least developed countries, given their low level of economic development. Governments of these countries should take appropriate measures to reach this objective through appropriate measures such as strengthening institutions for higher / professional / vocational education. At the same time, international action is needed in order to help establish joint undertakings between higher education and industry in these countries. It will be necessary to give consideration to ways in which higher education graduates could be supported, through various schemes, following

the positive experience of the micro-credit system and other incentives, in order to start small- and medium-size enterprises. At the institutional level, developing entrepreneurial skills and initiative should become a major concern of higher education, in order to facilitate employability of graduates who will increasingly be required not only to be job-seekers but to become job-creators.

112. The use of new technologies should be generalized to the greatest extent possible to help higher education institutions, to reinforce academic development, to widen access, to attain universal scope and to extend knowledge, as well as to facilitate education throughout life. Governments, educational institutions and the private sector should ensure that informatics and communication network infrastructures, computer facilities and human resources training are adequately provided.

**INSTITUTIONS OF HIGHER EDUCATION SHOULD BE OPEN TO ADULT LEARNERS:**

113. By developing coherent mechanisms to recognize the outcomes of learning undertaken in different contexts, and to ensure that credit is transferable within and between institutions, sectors and states.

114. By establishing joint higher education/community research and training partnerships, and by bringing the services of higher education institutions to outside groups.

115. By carrying out interdisciplinary research in all aspects of adult education and learning with the participation of adult learners themselves.

116. By creating opportunities for adult learning in flexible, open and creative ways.

**ACTIONS TO BE TAKEN AT INTERNATIONAL LEVEL**

117. Co-operation should be conceived of as an integral part of the institutional missions of higher education institutions and systems. Intergovernmental organizations, donor agencies and non-governmental organizations should extend their action in order to develop inter-university co-operation projects in particular through twinning institutions, based on solidarity and partnership, as a means of bridging the gap between rich and poor countries in the vital areas of knowledge production and application. Each institution of higher education should envisage the creation of an appropriate structure and/or mechanism for promoting and managing international co-operation.

118. The intergovernmental organizations and non-governmental organizations active in higher education, the states through their bilateral and multilateral co-operation programmes, the academic community and all concerned partners in society should further promote international academic mobility as a means to advance knowledge and knowledge-sharing in order to bring about and promote solidarity as a main element of the global knowledge society of tomorrow, including through strong support a the joint work plan 2004-2010 on the recognition of studies, degrees and diplomas in higher education and through large-scale co-operative action involving, inter alia, the establishment of an educational credit transfer scheme, with particular emphasis on South-South co-operation, the needs of the least developed countries and of the small states with few higher education institutions or none at all.

119. Institutions of higher education in industrialized countries should strive to make arrangements for international co-operation with sister institutions in developing countries and in particular with those of poor countries. In their co-operation, the institutions should make efforts to ensure fair and just recognition of studies abroad. Initiatives should be taken to develop higher education throughout the world, setting itself clear-cut goals that could lead to tangible results. One method might be to implement projects in different regions renewing efforts towards creating and/or strengthening centres of excellence in developing countries relying on networks of national, regional and international higher education institutions.

120. All concerned parts of society, should also undertake action in order to alleviate the negative effects of 'brain drain' and to shift to a dynamic process of 'brain gain'. An overall analysis is required in all regions of the world of the causes and effects of brain drain.

    A vigorous campaign should be launched through the concerted effort of the international community and on the basis of academic solidarity and should encourage the return to their home country of expatriate academics, as well as the involvement of university volunteers - newly retired academics or young academics at the beginning of their career - who wish to teach and undertake research at higher education institutions in developing countries. At the same time it is essential to support the developing countries in their efforts to build and strengthen their own educational capacities.

**WITHIN THIS FRAMEWORK, INTERNATIONAL ORGANISATIONS SHOULD:**

121. Promote better co-ordination among intergovernmental, supranational and non-governmental organizations, agencies and foundations that sponsor

existing programmes and projects for international co-operation in higher education. Furthermore, co-ordination efforts should take place in the context of national priorities. This could be conducive to the pooling and sharing of resources, avoid overlapping and promote better identification of projects, greater impact of action and increased assurance of their validity through collective agreement and review. Programmes aiming at the rapid transfer of knowledge, supporting institutional development and establishing centres of excellence in all areas of knowledge, in particular for peace education, conflict resolution, human rights and democracy, should be supported by institutions and by public and private donors.

122. Jointly with the various intergovernmental and non-governmental organizations, become a forum of reflection on higher education issues aiming at:

(i) preparing update reports on the state of knowledge on higher education issues in all parts of the world;

(ii) promoting innovative projects of training and research, intended to enhance the specific role of higher education in lifelong education;

(iii) reinforcing international co-operation and emphasizing the role of higher education for citizenship education, sustainable development and peace; and

(iv) facilitating exchange of information and establishing, when appropriate, a database on successful experiences and innovations that can be consulted by institutions confronted with problems in their reforms of higher education.

123. Take specific action to support institutions of higher education in the least developed parts of the world and in regions suffering the effects of conflict or natural disasters.

124. Make renewed efforts towards creating or/and strengthening centres of excellence in developing countries.

125. Take the initiative to draw up an international instrument on academic freedom, autonomy and social responsibility.

Ensure follow-up of this Declaration jointly with other inter-governmental and non-governmental organizations and with all higher education stakeholders. It should have a crucial role in promoting international cooperation in the field of higher education in implementing this follow-up under the aegis of the Afro-Asian-

American Chamber of Commerce, Occupational Research and Development (ACCORD) and in the light of the following context :

126. At the start of the twenty-first century, universities nationwide and worldwide, though their circumstances differ, face important and common challenges.

127. The phenomenon of globalisation which affects diverse sectors - the economy, the media, etc. - also has its impact on higher education throughout the world. It demands change and an explicit policy of internationalisation by universities.

127. The unprecedented development of information and communication technologies is an important vehicle in the processes of globalisation and technological accleration which carry with them opportunities and challenges that are specific to universities and to the way they fulfil their missions.

128. More than ever, the creation of knowledge, access to knowledge and its development are central to the development of societies. The knowledge society requires a new generation of skilled people. In this context, demand for more differentiated higher and continuing education, including professional development as well as open and distance learning, is in all countries expanding and, in some regions, overwhelming.

129. The rapid production of knowledge and technological development spur on the quest for quality, excellence and relevance. The university has a special responsibility to ensure that attention is paid to solving ethical questions. In this setting, the university's critical role towards society assumes a new urgency.

130. The preconditions for universities and other types of higher education institutions to cope successfully with new challenges such as these remain, however, basically unchanged. These preconditions include autonomy of action, academic freedom and adequate human and financial resources.

131. For higher education of quality to be today and in the future a motor of social, cultural and economic development, other conditions are required, amongst which effective dialogue with external partners and responsible university governance.

As a social institution, the university cannot be replaced. Hence, it must continue to adapt and change if the challenges are to be met. It will remain an institution central to societies throughout the world as long as its activities make a difference to better the condition of humankind.

## AIMS AND OBJECTS

1. To encourage links between institutions of higher education throughout the country.

2. To base the mission of the ACCORD on the fundamental principles for which every university should stand, namely the right to pursue knowledge for its own sake, to follow wherever the search for truth may lead, the tolerance of divergent opinion and freedom from political interference.

3. To aim to give expression to the obligation of universities to promote, through teaching and research, the principles of freedom and justice, of human dignity and solidarity, and to contribute through regional, national and international cooperation to the development of national and moral assistance for the strengthening of higher education generally.

4. To link up its members, offer them quality services and provide a forum for the universities from all over the country to work together and to speak on behalf of universities, and of higher education in general, and to represent their concerns and interests in public debate and to outside parties.

5. To pursue its goals through future oriented collective action including information services, informed policy discussion, research and publications.

6. To facilitate the exchange of experience and learning.

7. To restate and defend the values that underlie and determine the proper functioning of universities in the Indian subcontinent.

8. To uphold and contribute to the development of a long term vision of universities' role and responsibility in society.

9. To voice the concerns for higher education with regard to policies of national and international bodies.

10. To contribute to a better understanding of current trends and developments through analysis, research and debate.

11. To provide comprehensive and authoritative information on higher education systems, institutions and qualifications worldwide.

12. To act as a cooperation and service-oriented organisation to promote the exchange of information, experience and ideas to facilitate academic mobility

and mutual, technical, national and international collaboration among universities, and to contribute through research and meetings to informed higher education policy debate.

13. To organise congress, conferences, seminars, round tables and workshops.

14. To conduct comparative studies and higher education policy research.

15. To strengthen cooperation and clearing-house activities.

16. To establish national information networks.

17. To provide consultancy, credential evaluation and advice.

18. To invite university level degree granting institutions whose main objective is higher education and research, irrespective of whether or not they carry the name of university.

19. To maintain and preserve university autonomy, academic freedom and mutual understanding.

20. To stand for the right to pursue knowledge for its own sake.

21. To remain free from political and economic interference, and give, room for divergent opinion.

22. To work for the advancement of ethical values in the work of the ACCORD and its members as well as in society and respect for diversity.

23. To remember the responsibility of universities and academies as guardians of free intellectual activity.

24. To stand for the universities' obligation as social institutions to deliver education, research and service to the community, and, in connection with this, to advance the principles of freedom and of justice, of sustainable development, human dignity and of solidarity.

25. To conserve the obligation of universities to foster constructive criticism and intellectual independence in the research for truth.

26. To contribute to the development of the long term vision of the university's role and responsibilities in society.

27. To strengthen solidarity and to contribute to reducing inequalities amongst universities, while keeping alive their cultural differences.

28. To promote access to higher education and equal opportunities for students.

29. To encourage quality and excellence worldwide, through sharing, knowledge, know-how and experience, through collaboration and through networking.

30. To help universities to become better learning organisations (for students, for teachers, for administrators).

31. To contribute to a better understanding of developments in higher education, through analysis, research and debate, as well as through the provision of information services on higher education.

32. To design and implement programmes for its members in partnership with other organisations working in the same field.

33. To pledge itself to be an open, inclusive and transparent organisation, the common voice of the university level institutions.

34. To provide a centre of cooperation among the universities and similar institutions of higher education, as well as organisations in the field of higher education generally, and to be an advocate for their concerns.

35. To facilitate the interchange of students and academic staff, and develop means for the better distribution and exchange of laboratory material, books and other equipment for university study and research.

36. To formulate the basic principles and higher education values for which the ACCORD will stand for.

37. To establish a strong structural relationship with the national as well as regional associations of universities and seek their direct involvement in the life and work of ACCORD.

38. To focus its activities on institutional examples regarding the use of new information and communication technologies in teaching and learning.

39. To encourage sustainability to be considered as being central to teaching, research, outreach and operations at universities and to identified exemplary practices and strategies.

40. To prepare comprehensive assessments periodically on how the principles of sustainable development can best be pursued and promoted by higher education institutions.

41. To identify the key issues of a future-oriented higher education policy debate, as well as concrete needs for support in academic exchange, knowledge transfer, and capacity building through international cooperation.

42. To assess our respective capacities to respond to such needs, the complementarity and uniqueness of our respective possibilities and responsibilities, as compared with what can be better done by others, bilaterally or multi-laterally, on the institutional, national, regional or international level.

43. To establish appropriate networking structures and facilities that will allow to serve better, through shared efforts, the needs and interests of our common higher education constituency.

44. To translate into action the services set out by ACCORD more clearly in terms of support to concrete cooperation needs, both of individual universities and of partner organisations, and to identify new services as best corresponding to the vocation and possibilities; and to give expression to its internal and external missions through a strengthened confederative life, including a broader interaction with other university organisations.

45. To disseminate relevant information on the world of higher education in an international perspective, on missions, policies and strategies, in the form of concise briefs and overviews, easily accessible and usable for higher education policy and decision-makers.

46. To have a similar approach in relation to issues of research and debate, comparison of experiences, publications or conjointly organised special meetings and seminars for university leaders and administrators.

47. To provide a link to consultancy, second opinions and referee networks for universities, particularly in developing countries, who wish to have access to independent advice, for example on directives from Governments and different agencies or on institutional development plans.

48. To maintain a pool of independent advisors to be made available for special tasks, third party assessments, legal advice, management advice, helping with analysis, formulation of strategic plans, governance strategies, and codes related to academic freedom, etc.

49. To offer consultancy to agencies related to university cooperation.

50. To evaluate the institutional impact of university links and collaborative programmes, independent from the usual evaluation by sponsors to be pointed to practical and ethical guidelines for collaboration and codes of good practice, which could serve universities in their interaction.

51. To benefit from academic freedom and institutional autonomy with regard to the Central Mission of research and teaching.

52. To assume, in carrying out the tasks, its responsibility to society and to promote the principles of freedom, justice, human dignity and solidarity.

53. To reduce the tensions arising within the universities between the requirements of technological and economic globalisation and the specificities of cultural and national roots.

54. To contribute to the production and dissemination of information and knowledge concerning facts, trends and developments in higher education.

55. To help contribute to the production and dissemination of reflection, research and debate concerning the universities.

56. To help clarify, disseminate and refine a vision of the university and of its value base.

57. To pay particular attention to strengthening solidarity and reducing inequalities between universities of different backgrounds, resources and capacities.

58. To express a common voice of the universities, on national as well as global level, vis-a-vis partners like national and international statutory bodies and UN agencies as well as the public opinion.

59. To catalyse the cooperation of universities and university organisations amongst themselves and with other partners, with regard to major questions of society, which are national as well as international in nature and to which universities must make an important contribution, such as: the construction of peace and democracy; sustainable development; the challenges and stakes of globalisation and accelerated change in society; the commitment to ethical standards in the conduct of science and technology.

60. To offer to other national and international university and higher education organisations a preferential platform for information, contacts and networking, and to participate itself in such international networks.

61. To stipulate the indissociable principles for which every university should stand, including the right to pursue knowledge for its own sake and to follow wherever the search for truth may lead; the tolerance of divergent opinion and freedom from political interference; the obligation as social institutions to promote, through teaching and research, the principles of freedom and justice, of human dignity and to develop mutually material and moral aid on both national as well as international levels.

62. To collect data regarding the new forms of higher education over the ensuing half century with special reference to the number of universities, of academic staff, of students, of the emergence of a world economy, of its benefits and its dangers with a view to locating the required practical nature of the university's historic and abiding commitment to universalism, pluralism and humanism.

63. To evaluate whether in the course of the twentieth century, which has seen an unparalleled growth in knowledge, in research and their diffusion, the universities have shouldered the responsibilities in the common endeavour of human development, social, economic, technical and cultural advancement, and in responding to the major planetary problems such as environmental protection and poverty eradication, violence and social exclusion.

64. To promote the philosophy that human development and the continued extension of knowledge depend upon the freedom to examine, to enquire, and that academic freedom and university autonomy are essential to that end.

65. To urge universities to seek, establish and disseminate a clearer understanding of Sustainable Development - "development which meets the needs of the present without compromising the needs of future generations" - and encourage more appropriate sustainable development principles and practices at the local, national and global levels, in ways consistent with their missions.

66. To utilise resources of the university to encourage a better understanding on the part of the Central and the State Governments and the public at large of the inter-related physical, biological and social dangers facing the planet Earth, and to recognise the significant interdependence and international dimensions of sustainable development.

67. To emphasise the ethical obligation of the present generation to overcome those practices of resource utilisation and those widespread disparities which lie at the root of environmental unsustainability.

68. To enhance the capacity of the university to teach and undertake research and action in society on sustainable development principles, to increase environmental literacy, and to enhance the understanding of environmental ethics within the university and with the public at large.

69. To cooperate with one another and with all segments of society in the pursuit of practical and policy measures to achieve sustainable development and thereby safeguard the interests of future generations.

70. To encourage universities to review their own operations to reflect best sustainable development practices.

71. To make an institutional commitment to the principle and practice of sustainable development within the academic milieu and to communicate that commitment to its students, its employees and to the public at large.

72. To promote sustainable consumption practices in its own operations.

73. To develop the capacities of its academic staff to teach environmental literacy.

74. To encourage among both staff and students an environmental perspective, whatever the field of study.

75. To utilise the intellectual resources of the university to build strong environmental education programmes.

76. To encourage interdisciplinary and collaborative research programmes related to sustainable development as part of the institution's central mission and to overcome traditional barriers between disciplines and departments.

77. To emphasise the ethical obligations of the university community - current students, faculty and staff - to understand and defeat the forces that lead to environmental degradation, and the inter-generational inequities; to work at ways that will help its academic community, and the graduates, and the governments that support it, to accept these ethical obligations.

78. To promote interdisciplinary networks of environmental experts at the local, national and international levels in order to disseminate knowledge and to collaborate on common environmental projects in both research and education.

79. To promote the mobility of staff and students as essential to the free trade of knowledge.

80. To forge partnerships with other sectors of society in transferring innovative and appropriate technologies that can benefit and enhance sustainable development practices.

81. To devote its activities to the study of systems, institutions and processes in higher education to specially focus on the historical role of higher education in society, contemporary policy problems, and how universities and colleges can change to meet the growing educational, research, and public service needs of a "knowledge" society.

82. To promote public confidence that quality of provision and standards of awards in higher education are being safeguarded and enhanced.

83. To help other confederal bodies of universities and higher education institutions in other countries aimed at providing quality education and at supporting synergistic ventures in teaching, examination, research and community service programmes.

84. To seek to make a significant contribution to the understanding of policy-making, governance and management of universities and other higher education institutions.

85. To emphasise equity and access and the improvement of educational experiences of people of all age levels and backgrounds.

86. To include partnerships with other like minded organisations to address a wide array of problems, drawing upon the insights of academic disciplines and professional perspectives.

87. To meet the widely felt need in the Indian subcontinent for a centre for policy research and cooperation in education in the Indian perspective, with the sole purpose to contribute to policy analysis in education and training, to carry out evaluation of systems, reforms, programmes and institutions, and to provide technical assistance and support to all interested actors in this field.

88. To help the member countries, universities and other organisations in designing new information and communications technologies for heralding as a revolution for the world of learning and to fulfil the promise of better and cheaper higher education for more students.

89. To review the open and distance learning in the context of present challenges and opportunities, describe relevant concepts and contribution, outline significant current global and regional trends, suggest policy and strategy

considerations and identify ACCORD's role in capacity building, national as well international cooperation.

89. To maintain an inventory of successful strategies to increase the participation of women in higher education and promote the principle of gender equity, and to increase access and retention as well as to improve the quality of education for all women in universities.

90. To serve as a clearing house of information for providing regular opportunities for the discussion on university development in general and on academic development in particular with a view to assisting the member countries, organizations and universities in the recruitment and placement of faculty and staff, exchange of teachers and students and in the development of cooperative arrangements.

91. To establish relations with significant players and opinion makers from education, business, culture, law, and government sectors in order to facilitate strategic alliances with other organisations.

92. To support preparation, production and widespread distribution of educational materials on higher education with a view to strengthen the employment generation movement.

92. To help promote such new Central and State legislation or amendments as may be deemed necessary for the development of higher education.

93. To encourage the students of all universities to be active, to emphasize the personal nature of learning, to accept that difference is desirable, to recognise student's right to make mistakes, to tolerate imperfection, to encourage openness of mind and trust in self, to make feel respected and accepted, to facilitate discovery, to put emphasis on self evaluation in cooperation, to permit confrontation of ideas.

94. To promote the hypothesis that learning is primarily controlled by the learner, is unique and individual, is affected by the total state of the learner, is cooperative and collaborative, is a consequence of experience, is not directly observable, is both an emotional and intellectual process, is evolutionary process, is development oriented, and, is quite sustainable.

95. To collaborate, affiliate and federate with the Central and the State Governments, agencies and bodies for implementing the projects on higher education.

96. To raise and borrow money for the purpose of the ACCORD in such a manner as may be decided from time to time and to prescribe the membership fees, charges, grants in aid etc.

97. To purchase, take on lease or exchange, hire or otherwise acquire properties, movable or immovable and rights and privileges all over the world, which may be deemed necessary or convenient for the benefit of the ACCORD and to sell, lease, mortgage, dispose or otherwise deal with all or any part of the property of the ACCORD.

98. To open branches, chapters and constitutent centres in different parts of the country and get them registered with appropriate authorities if needed and felt conducive for the attainment of the aims and objects of the ACCORD.

99. To invest the money of the ACCORD not immediately required in such securities and in such manner as may be decided from time to time, the money especially collected through subscriptions, advertisements, sponsorship, sale of publications, fees, gifts, endowments, donations, grants etc.

100. To finally provide information, knowledge, wisdom, and education that prepares every body for educational leadership and social responsibility enabling to think and communicate effectively and to develop a global awareness and sensitivity for a better global understanding, world peace and unity.

101. To motivate the Member Countries, Universities and Organisations to maintain integrity, honesty, fairness and impartiality in all the dealings and treat others with dignity and respect, care and curtesy.

102. To guide the Member Countries, Universities and Organisations for using University's funds, equipment, buildings, information and other resources with care and responsibility.

103. To educate the Member Countries, Universities and Organisations regarding their obligations to maintain confidentiality of information.

104. To train the Member Countries, Universities and Organisations to be fair and honest in their relationship with the suppliers and purchasers of the Univeristy's goods and services.

105. And to generally do all that is incidental and conducive to the attainment of the aims and objects mentioned above.

**INCOME OF AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)**

The income and the property of the Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) shall be utilized only for the purpose of the aims and objects as set forth above and no portion of the fund shall be directly or indirectly diverted to any other organisation(s) or person(s). This would identify the ACCORD as a Non Profit Making Organisation.

**POWERS AND FUNCTIONS OF THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)**

Without prejudice to the generality of the foregoing powers of the management and control, the ACCORD shall have the following functions it may consider necessary or desirable:

*a)* To purchase, hire, take on lease, land, movable or immovable properties and assets anywhere in the world, accept gifts, grants or loans on such terms and conditions and subjects to the payment of interest or otherwise as the ACCORD may consider necessary.

*b)* To enter into contracts, agreements and arrangements with any including the Government authorities, municipal, local and others for the purpose of obtaining concessions, privileges or other benefits or which may seem conducive to carrying out all the objects and purposes of the ACCORD or any of them to obtain and carry out, exercise and comply with any such contracts, agreements or arrangements.

*c)* To borrow or receive money with or without security or secured by bonds, mortgages, or other securities charged on the undertaking of all or any of the assets of the ACCORD.

*d)* To deal with, sell, mortgage, charge, lease, invest, open bank accounts, advance loans against adequate security and generally deal with the fund or any part thereof as the ACCORD may decide and consider desirable or necessary.

*e)* To invest money of the ACCORD in such a manner and in such investments as the ACCORD may in their absolute discretion from time to time deem fit so to be in confirmity with any law or provision of the relevant acts of the Government.

*f)* To open, operate and close such accounts with any bank or banks as the ACCORD may deem necessary.

*g)* To manage the ACCORD's fund and to collect and recover interest, dividends and income thereof and to pay the expenses for collection and other outgoings if any.

*h)* To pay or utilise the balance of such interest and dividends and income of the ACCORD and if the ACCORD so desires, to utilise the corpus of the ACCORD's Fund if any or part thereof for the ACCORD's purposes.

*i)* To maintain separate accounts of the ACCORD for facilities like provident funds, pension funds, or any other fund for the support or relief or maintenance of any employee or class of employees either full time or part time or their dependents or any other person/persons.

*j)* To institute, defend, compound, compromise or abandon any legal proceedings by or against the ACCORD or its officers or otherwise concerning the assets of the ACCORD and also to compound and allow time for payment or satisfaction of any debt due to be paid and claim or demands by or against the ACCORD.

*k)* To refer matters to arbitration.

*l)* To engage the services of any person or persons upon such remuneration and terms as the ACCORD may deem fit, to take disciplinary action against them and also to terminate their services.

*m)* The ACCORD may incur all costs and expenses considered necessay for the due and efficient management of the affairs and properties of the ACCORD.

*n)* To sign, endorse, transfer and negotiate all kinds of documents relating to the investment of the funds of the ACCORD.

*o)* To receive money and to grant receipts and discharge thereof.

*p)* To delegate to any person or persons all or any of the foregoing powers conferred on the ACCORD in so far as they may lawfully do, subject however to the ACCORD retaining the ultimate control and descretion over the delegated action and conduct.

*q)* To transfer any funds or property of the ACCORD with objects or purposes similar to those of the ACCORD and whose income is exempt from any liability by virtue of different sections related to the non profit making organisation.

*r)* To frame and implement from time to time rules and regulations for the administration of the ACCORD fund and carrying out of all/any of the ACCORD purposes.

*s)* To help organise full time, part time, weekend, correspondence and distance learning educational programmes for conferring secondary, post secondary, bachelor's, master's and doctoral level degrees, diplomas and certificates in different areas and subjects through the insitutions including universities, colleges and schools already existing anywhere in the world or established / to be established with the assistance/approval of the ACCORD.

*t)* To empanel the institutions, colleges and universities offering recognised degrees, diplomas and certificates.

*u)* To establish branch offices and campuses of ACCORD for educational planning, publication, study, training, research and consultancy as may be required for the benefit of regional, national as well as global society.

*v)* To do all such things as may be necessary for the effective functioning of the ACCORD.

## Chapter 5

# AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD) : ACTION PLAN FOR EMPLOYMENT GENERATION

The generation of productive and adequately remunerated employment is an indispensable component in the fight against poverty. While this task presents a major challenge for all the States and the UTs in India, it is by no means an insurmountable one. However, success depends on a number of key factors. It requires first and foremost, a restoration of higher and more stable rates of economic growth. But this will not be sufficient. It also requires that supporting policies and programmes be put in place to deliberately stimulate employment in all sectors of the economy which hold the greatest promise for employment and income generation on one hand, and on the other, the implementation of strategies which can, among other things, improve the access of all groups to education and training and income generating activities in a sustainable manner.

### MASTER PLAN OF THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD) : REGARDING EMPLOYMENT GENERATION

The task of employment generation requires concerted action by several ministries and departments of government both at the national as well as the state level. But it is not a task for governments alone. Employers' and workers' organizations, as well as other members of civil society must play an increasingly active role in the process. The support of the international community is also critical, not only in terms of resource flows, but in changing the rules of international economic systems in favour of poor producers and consumers. Let us know the present state of affairs regarding creation of employment opportunities :

1. Many labour market mechanisms and patterns are closely associated with poverty and give insights into the pattern and intensity of poverty and into the factors concentrating it among particular groups. Labour market policies, as well as those related to employment, labour institutions, social protection and human resource development must therefore be given prominence in poverty eradication strategies.

2. In attempting to analyze the labour market situation in the Indian Subcontinent and its impact on poverty, a distinction may be made between poverty due to exclusion from access to jobs and poverty associated with the nature of employment and the levels of income which it generates. Exclusion from regular income opportunities appears as open unemployment or as

marginality in one form or another. But it can also be hidden, if particular groups do not appear on the labour market, because their opportunities are limited, as is often true of women and persons with disabilities. The degree to which labour market exclusion is directly linked to poverty depends on the extent to which state or community safety nets or family support systems exist or whether it affects particular members of households like younger persons where there is another income source.

3. Exclusion may also operate within the labour market with respect to constraints on access to the more desirable jobs, or sectors. This may give rise to poverty because of the emergence of labour market segments in which jobs are irregular, insecure and low paid. These characteristics lead to poverty which then persists because individuals are trapped in these segments. Mobility between different segments is difficult, because of the credentials, contacts, capital or skills required to move up. Thus many groups are excluded from regular, protected jobs. So entry to low-end jobs virtually precludes subsequent career development. Because of the insecure and irregular nature of the work, workers in these segments are also particularly vulnerable to unemployment. These patterns show up in the casualization of employment relationships, in marginal self-employment and in various types of unprotected wage employment.

4. At the other extreme, there is the phenomenon of overemployment i.e. excessive work, because low productivity or low wages imply that very long hours have to be worked to achieve a subsistence income. This is the most frequent situation of the poor which cause them to be classified as working poor. Overemployment also involves labour force participation by groups for which it is undesirable, child labour for example, with subsequent consequences for personal development or health.

5. The way in which these relationships affect poverty depends on at least two additional factors. First, labour market outcomes usually refer to individuals, and the link with poverty depends on the pattern of earning, dependency and distribution in the income-sharing unit. Larger households with single earners are more vulnerable to poverty regardless of labour market characteristics. Also within the household, income may not be equitably shared. Secondly, relative deprivation may be closely related to labour market patterns: labour market inequality may be a primary element in felt deprivation, as some attain social integration and regular income through the market, while others survive in casual, precarious employment. If poverty is defined in relation to what societies regard as decent minima for all their citizens, then the labour market situation is likely to be an important element in the definition of poverty and, as indicated above, labour market policies a fundamental means of combating poverty.

6. Economic conditions overall and employment conditions in particular have deteriorated in India, as a consequence of, inter alia, the debt crises, declining commodity prices, and subsequent stabilization and adjustment problems. This has contributed to the increase in the extent and severity of poverty observed in a number of States in India. The broad issues to be detailed here relate to unemployment and underemployment, informalization and casualization of labour, and low wage and income levels. Issues related to the particular situation of women, youth, the disabled, and working children are highlighted. Finally, the issue of HIV/AIDS in the workplace is also raised. The discussion necessarily touches on the respective roles of the Central and the State Governments, trade unions and employers' organizations and other members of a civil society. As would be expected, the issues raised have varying degrees of relevance. However, they have been selected because they represent some of the most serious labour market problems confronting the in the Indian subcontinent and they have adverse effects, thereby contributing to poverty.

Unemployment remains a seemingly intractable problem for India. Unemployment rates have been high historically because of a complex of both internal and external factors. Crucial factors have been the small size and structure (industrial specialization) and openness of most of these economies, which render them highly vulnerable to external shocks. The volume of employment generated has been insufficient generally to keep pace with continuing increases in the labour force resulting from population pressure. At the same time, investments in education and training systems, often unrelated to national labour market needs, have not produced the desired results, thereby reducing labour market access for some, while leaving critical skill requirements unfilled.

8. But, given the ease of entry and minimal start-up capital required, the informal sector has also attracted other groups in the recent past, as a number of skilled, formal sector employees have started to operate informal sector businesses, as secondary activities to supplement their incomes. Some persons have quit their jobs in the formal sector to undertake activities in the informal sector which offers them better remuneration. Additionally, the process of industrial restructuring in the formal sector has resulted in a greater decentralization of production through subcontracting. The pressure to reduce costs and to find more flexible production methods implies that fewer jobs are being created in large-scale modern enterprises and that an increasing number of operations are carried out by subcontractors in small and micro-enterprises, many in the informal sector. Some of these activities are economically viable, and provide higher incomes than in the formal sector. The poverty eradication strategy must include efforts to fully exploit

the potential of these more dynamic components of the sector, while simultaneously reducing the sponge components.

9. There have been concerns about the increased incidence of part-time and temporary jobs and contract and home work. While some of this development may be voluntary, reflecting personal preference, much of it appears to be involuntary. The concerns arise because persons who work under these types of arrangements have limited, if any, social protection in the form of wage protection, employment security, health or pension benefits, which increases their vulnerability and in some cases makes their situation very precarious, with obvious links to poverty.

10. In order to target policies to the most vulnerable, it is important to identify the groups which are in a particularly disadvantaged position in the labour market. Such disadvantage relates to gaining labour market access and hence getting work; and once in the labour market, in finding work with reasonable remuneration and security, acceptable working conditions and opportunities for upward mobility. The position of three traditionally disadvantaged groups in the sub-region, namely, women, youth, and persons with disability, as well as a newly emerging one, working children needs to be studied. This does not imply that other groups are not important in poverty eradication strategies. Neither does it imply that the selected groups are homogenous in terms of their poverty status, for while virtually all face various forms of inequality and discrimation, not all members are poor. The situation of these groups is typically influenced by a complex of factors including macro-economic and labour market conditions and policies; labour market institutions; availability of social safety nets; family structure and the strength of the extended family; levels of education and human capital; degree of formalization of the labour market and the size of the informal sector; size of government and its ability to fund labour market programmes and enforce labour laws and regulations.

11. While women are not a minority group and are extremely heterogenous with respect to poverty, they warrant designation as a target group with respect to poverty eradication strategies. Higher proportions of the poor are found among the unemployed, the very young, indigenous people, the new poor, youth and the rural population, and that women profile highest in many of these categories. Research findings reveal that single female-headed households rank high among those household groups living in poverty. However female- headed households should not be considered as being synonymous with poor households. Women's access to and ownership of land, capital and productive resources are less than men's, their earning levels are lower, while their unemployment levels are higher. Women's economic empowerment is therefore critical to any effort aimed at eradicating poverty.

Moreover, women tend to have more socially positive expenditure patterns regarding overall household welfare and its distribution among household members resulting in better health, education, nutrition, and clothing. Assuming the same holds true, then acting to improve the situation of women in the labour market will have a positive impact on the status of women equity in the society, the welfare of households and the improvement of human development in the sub-region.

12. The position of women in the labour market, and their exclusion from it, must be examined within both the historical and current socio-economic contexts. The historical role of women as labourers in the sub-region should not be forgotten. Hence, their entry into the labour force is not new; and in fact women have had high participation rates in many States of the subcontinent for decades. Despite this reality, the position of women in the labour market has been vulnerable, less protected, less secure, less valued than that of men. This vulnerability appears to have been increased by structural adjustment and stabilization processes. Although, to date, no comprehensive study has been done on the precise gender impact of such processes, preliminary research suggests that they have imposed a heavy burden on women, not only with respect to their productive roles as reflected in unemployment, increased informal sector activity, and multiple jobs, decline in real income, but also with respect to their reproductive roles. With the declining role of governments in the economy, there have been cutbacks on public services such as health and education. As the role of care provision for children and the elderly tends to fall on women, they have had to spend more of their earnings on previously subsidized services or face greater demands on their time in order to provide these services themselves. For poor women, they have no choice but to increase their only productive resource, their labour, in performing both productive and reproductive tasks. These developments appear then to have exacerbated the already vulnerable position of women in the labour market.

13. Women continue to have the primary responsibility for child-rearing, food preparation, household cleaning, shopping and other aspects of family care. Child-care services remain below demand levels. Many of those in existence inadequately respond to the needs of working parents in terms of their hours of operation and their location. The inadequacy of support services puts working women under extreme pressures, and even discourages some from entering or remaining in the labour market. The location of job opportunities and the limited transportation services in India increase the pressures. In many cases, a woman may be compelled to trade off her time with the family for the financial security that an inconveniently located job can provide. In other cases, women vendors, for example, are forced to work with their children at their sides.

14. As with other socio-economic groups, open unemployment rates alone do not fully reflect the nature and magnitude of the employment problem of women. There is also disguised unemployment, as women who wish to work are unable to do so because of limited availability of and access to adequate child care and other family support facilities. These include cultural/religious factors and traditional values about the role of women in the society which is a fairly ethnically and racially diverse one, as well as the presence of a fairly large agricultural sector where women's economic participation tends to be largely under-counted either because of a definitional issue related to the concept and measurement of work, or because of the perception of women themselves about their economic status vis a vis that of men in this sector. The low participation rate, together with the migrant/refugee problems, in part explain why, despite relatively low open unemployment and visible underemployment rates, the incidence of poverty is among the highest in the subregion.

15. Labour market statistics also do not reflect the actual extent of women's economic contribution, which remains undervalued everywhere. Much of women's work, such as in subsistence production, the informal sector, domestic and household labour and related production remains invisible and is therefore not targeted for policy assistance.

16. Both men and women have suffered the consequences of downsizing, enterprise closures, staff reductions through terminations, layoffs and a lack of recruitment opportunities. The extent to which a disproportionate burden has fallen on either sex is difficult to assess without the adequate gender sensitive data. With respect to hours worked, statistics show that a higher percentage of women are found working shorter hours in their formal employment than men. The extent to which this pattern reflects choice or is imposed is not revealed by the figures.

17. Given the inadequate formal employment opportunities and wage levels, and despite constraints, women are increasingly seeking or falling into income generation through other activities such as micro and small businesses and to a lesser extent entrepreneurship. Women, especially poor women, face particular difficulties in this area due to their lack of property ownership, primary family and household responsibilities, inadequate transportation, time constraints, inadequate education or skill base, lack of self confidence and declining levels of support from family and community members.

18. High unemployment and underemployment levels and low wage rates and income levels among women is of great welfare significance in this subregion, since many women are primary workers with strong and continuous

attachment to the labour market, a high percentage of them are heads of households, and even where they are not characterized as household heads, household income and welfare is very much dependent on their contribution.

19. Youth unemployment stems, in part, from the problems which they face in accessing the labour market, related to inappropriate education and training, low skill levels, lack of work experience, absence of vocational guidance and counselling, the absence of well-functioning job placement mechanisms and inadequate demand. Their situation has been exacerbated by the cutbacks in social expenditure, especially on education in India, which have left public schools less equipped to perform their traditional functions, and even less capable of preparing students to adapt to the changes taking place in the job market. When this is combined with challenges faced by students like high costs for meals, transportation, books and other supplies, the result is that many students are leaving school even less equipped to enter employment, or to participate effectively in further education or training. At the same time, successful graduates of secondary schools and universities face difficulty in finding employment, thereby adding to their frustration.

20. Youth unemployment has become couched in a new context, that presented by the growing globalization of labour markets and the increased flexibility of labour market relations with traditional patterns of school-work-retirement giving way to more varied patterns. It is important to examine how such developments have influenced, or will influence, either directly or indirectly, the recruitment practices of employers and enterprises in relation to young persons and have impacted or will impact on their job entry and training experiences. It is also necessary to assess the extent to which, once employed, their relative lack of experience have made them particularly vulnerable to the kinds of precariousness.

21. The problem of youth unemployment is a particularly worrisome and sensitive socio-economic one for the sub-region, with potentially undesirable consequences for society and young people. One such consequence has been the emergence of a large and growing group of young persons who are becoming increasingly detached from the economic and social mainstream.

22. The situation of male youth is of significant concern, requiring specific interventions. Attention has been drawn to the difficulty which many face in finding employment because they leave school with very few skills. With only limited opportunities, many succumb to pressure to be involved in gangs, drugs and criminal activities.

23. The situation of young women is also of specific concern. They are at even greater disadvantage in the labour market than male youth, this greater

vulnerability arising from the combined effect of age and sex. As youth, they face the particular constraints that young persons have in accessing the labour market, which were mentioned above. As women, they face the challenges associated with their double burden. The result is that they are at even greater risk with respect to poverty, with teenage mothers facing the greatest risk. Given that this age group is the most fertile, and given the relationship between poverty and fertility, the increase in poverty could put unwanted pressure on fertility levels. The consequences of higher fertility levels for both individuals and societies would be enormous in India, and would serve to reinforce poverty. Specific strategies must be directed at this group, and must include those aimed at empowering them through among other things, improving their access to quality education and training, thereby facilitating their fuller integration in the job market and into productive and remunerative wage or self employment opportunities. As is the case for other groups and as will be discussed later, these strategies will need to be supplemented by demand-side approaches which stress a more direct and explicit approach to employment generation.

24. There are important links between disability and poverty; on average, disabled persons are poorer, although there is even less empirical evidence on this than for other groups. The linkage is bi-directional. Poverty helps cause disability, to the extent that it is more likely that poor households are not able to provide mothers, their unborn and children with appropriate nourishment to ensure healthy and strong children. It has been estimated that twenty-two per cent of causes of all disabilities result from lack of adequate nutrition of mothers and children. Additionally, it is more likely that poor households do not have access to health care systems nor the knowledge to detect a disability at an early stage so that individuals with disability can enjoy the highest level of functioning and independence later on in life. Disability thus helps cause poverty for families with a disabled member unless income transfers or other assistance is received. However, as with other vulnerable groups, disabled persons are a very heterogenous group. While poorer on average, there is much variation in their situation. Thus, as with other groups, it is important to keep this heterogeneity in mind to avoid stereotyping and labelling, and to devise appropriate targeted policies.

25. One option being pursued increasingly by a number of disabled youth and adults, who want to work and earn an income is self-employment. Despite problems being encountered, such self-employment initiatives appear to be an effective means for some to earn a livelihood. Policies designed to promote the development of small and micro-enterprises therefore must address the specific needs of disabled persons. The main emphasis of all policies has to be on integrating disabled persons into education and training activities and

subsequently into the labour market with efforts made to enable them to work along-side non-disabled persons, rather than emphasizing separate workshops barring the severely disabled persons.

26. Other options also have to be given consideration to ease the integration of disabled youth and adults into the labour market. These include on the job training, supported employment, and semi-sheltered employment.

27. The issue of child labour is one which is attracting increased attention in the subregion, mainly because of the more visible presence of street children. While limited information is available on its incidence, the phenomenon nevertheless appears to be growing in significance and hence needs to be addressed. The apparent growth is not surprising given the rise in poverty, since poverty is considered to be the single greatest force which influences child labour not only by forcing many children to work for their own survival, but also by making it nearly impossible for families to invest in alternative activities such as education. The acute need of poor households to keep many family members working to ensure income security impedes investing in their children's education. In this regard, it is often asserted that poverty and child economic participation are mutually reinforcing, with poverty generating child labour and child labour perpetuating poverty.

28. In an ILO study in India for example, it was found that female-headed households, especially those with single female heads, are most likely to have working children. The likelihood of children working declines with the increase in the educational level of the head of household. Parents considered that their child's work was very important for supplementing the household income. Given the high incidence of poverty in some, the large proportion of female-headed and single-parent households, among other factors, and even discounting for cultural differences, these findings suggest cause for some concern.

29. In assessing the magnitude of the problem, a distinction may be made between child labour and child work. The former is concerned with certain types of unacceptable work in industries and occupations that are hazardous and/or exploitative work in mines or heavy industry; and work done by especially young children less than 12 years old which precludes school. The latter consists of all other labour force activity and could be extended to include non-labour force work such as housework and child-care. Not only do children spend considerable time in these activities but, their positive and negative aspects are gender-related. Young girls are known to spend much more time on these activities as compared with young boys. Indeed, young girls are often responsible for the care of infants and siblings. In poor households, especially, girls are often the main caregivers because their

mothers need to earn money for family survival. However, household work and child-care should be considered as child labour when it prevents girls from attending school and/or gaining useful market and income-related skills.

30. Infection with the Human Immunodeficiency Virus (HIV) and the acquired immunodeficiency syndrome (AIDS) represents a significant regional problem with broad social, cultural, economic, political, ethical and legal dimensions and impact.

31. Economic impoverishment may come before sickness sets in, when employers, coworkers or clients learn of the HIV virus and the infected person loses his or her job or loses the chance of getting a job. In the workplace, fear generated by AIDS may account for an increasingly irrational behavior towards those infected or suspected of being infected. But the reasons behind a dismissal or refusal to hire may also be economic, involving the additional costs of future responsibility for a worker who has AIDS or who is likely to contract the disease. The reasons can also include the apprehension that work colleagues feel about an infected worker or the desire to protect the image of an enterprise against clients who harbour prejudices.

32. The rights of HIV positive persons or persons with AIDS, especially in the labour and employment field, need to be protected. This is not only a moral imperative, but a public health principle: discrimination and stigmatization drive infected people away from the income, support, care, and information they need, thus encouraging the spread of the infection and increasing the likelihood of their fall into poverty.

33. Thus, there is a need to ensure that HIV/AIDS infected persons are sheltered from discriminatory practices in employment. Information campaigns as well as affirmative strategies aimed specifically at preventing and counteracting discriminatory practices are necessary as shown by experiences elsewhere.

34. The developments, outlined above, have taken place against a growing trend of technological change and integration of the world economy through trade and investment flows, which will no doubt continue. The creation of a global market offers the potential for achieving higher growth of output and employment worldwide but is also a source of growing dislocation and insecurity. Indeed, there is growing anxiety over the job destroying effects of new technologies, the speed of information flows and the risks of job loss and job relocation in the wake of intensifying competitive pressures. It is therefore imperative to translate the potential benefits of rapid technological change and globalization into reality and to distribute these benefits widely.

35. The impact and implications of technological change for men and women are likely to be different. In industry and services, there could be at least three differences.

One, employment opportunities for women could increase where technology makes possible greater out-sourcing and sub-contracting. This has happened in industries ranging from printing and publishing to clothing and footwear both within and across the country. Telework, electronic homework, offshore data processing and office administration services are other possibilities. On the other hand, automation and advances in robotics makes technological unemployment a possibility for women, although probably less so than for men.

Two, the skill and job structure will continue to change with the introduction of modern technologies in industrial enterprises. There is a trend towards skill polarization, with the elite of technically-skilled, polyvalent, high status specialist workers coupled with a larger mass of technically, semi-skilled, flexible casual workers requiring minor training. Women are much more likely than men to be found in the latter group. Since little training or on-the-job learning and experience is required, employers are able to resort to using temporary workers, to job rotation or to expanding the number of tasks associated with a job. This breeds job insecurity as well as income and employment insecurity.

Three, technological innovations imply changing skill requirements, and it is here where women could be displaced by men. Because women tend to be concentrated in a small number of lower-skilled, labour-intensive jobs, they are usually disproportionately vulnerable to the quantitative and qualitative impact of technological change.

36. On the supply-side, the demographic pressure on labour supply is likely to continue, as projections indicate that the working age population will increase significantly up to the year 2020. Barring any significant changes in labour force participation, which are unlikely, this will translate into continuing increases in the labour force. More fundamentally, given the links between population issues and the crucial relationships which underlie poverty, increased attention will have to be given to the design and implementation of population policies.

37. The extent to which emigration will continue to provide a safety-valve in easing population and labour force pressure will be influenced by the immigration policies. Some movement is already taking place with respect to certain types of unskilled/manual labour, for specific skills in the professional and technical levels and in the sphere of arts and culture, and this should be

greatly facilitated by the appropriate changes in immigration/work permit requirements for some of these categories. Beyond this, any significant and immediate change in the flow is likely to be constrained by limited employment opportunities currently available within most of the States and UTs in the subcontinent.

38. The ageing of the population will continue to impact on societies within the region, and specifically on their labour markets. This will generate opportunities by creating additional demand for goods and services required by the aged. But it will also pose challenges. The welfare of the elderly has been severely affected by the weakening of traditional family support, inability to provide for their upkeep due to inflationary trends, absence of pensions/social security benefits and costly medical care. Many will need to keep working to support themselves. Over time, the full impact of some of the casualization of employment mentioned earlier will be felt, as even more persons will reach "retirement age" without provision for their upkeep. Retirement policy in India will therefore need to be reviewed to take account of the interplay of several factors including skill shortages and the extent of youth unemployment, as well as considerations relating to the cost and method(s) of financing old-age pension schemes in order to ensure an adequate standard of living for the growing elderly population.

39. The situation of older women is, and will be, of particular concern, since with their higher life-expectancy, they are outliving men. However, few women have pension rights either from occupational or community status, and few can depend on widows pensions. This means that the majority of women are potentially dependent in old-age on their offspring. Women's need for security and the lack of it from their occupational roles has important demographic implications and also calls attention to the need to review the laws and practices relating to social security schemes.

40. Increasing urbanization in India will continue to place pressure on the labour markets of cities. It will also add to problems related to the provision of education facilities and housing and transportation, and waste disposal, and water and power supply. Indeed, the inability to cope with these problems has already led to the increase in squatter settlements, thereby aggravating the poverty situation. The concentration of many unemployed youth in the urban areas has also contributed to the rising crime situation in urban areas. Efforts will therefore need to be intensified to reverse the rural/urban movement, which will need to involve more balanced regional development, with an emphasis both on agricultural and on rural non-farm employment. Within this context, there is need to address the critical issues of land tenure and ownership. This emphasis appears warranted in light of the high

proportion of the poor in rural areas, and the need therefore to generate more income-earning opportunities for both men and women.

41. Policies are complementary and not alternatives. Micro-interventions will be needed to raise labour capability and access, but these will be ineffective without a good macro-economic strategy that generates adequate labour demand. Similarly, programmes designed to directly reduce poverty in particular target groups can contribute to successful structural change in the distribution of assets and opportunities; but structural change may be itself necessary for targeted interventions to have more than marginal effects. There is therefore need for multi-dimensional and integrated approaches including policy reform, institutional development and direct interventions.

42. National action against poverty is essential but the financial capacity for action in India is tightly constrained. International support is also needed, not only in terms of resource flows, but also by changing the rules of international economic systems in favour of poor producers and consumers.

43. There is an indispensable role for the State in the redistribution of incomes and the reduction of poverty. Yet actions by the State alone will be insufficient. There is need for strategic alliances at the national level, involving the State, the private sector, trade unions, community-based organizations, other NGOs, and members of the civil society for promoting employment and combating poverty.

44. There is a crucial role for pressure groups and organizations of the poor in influencing priorities, forging alliances and sustaining results.

45. One major priority in reversing the deterioration in labour market conditions which has occurred, is to restore higher and more stable rates of growth. High economic growth and financial stability provide the only pre-conditions for a sufficiently high rate of productive employment. However, most States and UTs of the subcontinent still face considerable challenges in implementing economic reforms in order to move towards more open and market-oriented economies. Successfully implemented and enforced by appropriate programmes and policies, such reforms should lead to higher growth and an increased pace of productive job creation. Experience elsewhere suggests that successful reform has to be the cornerstone of efforts to put developing economies firmly on the path to achieving full employment.

46. Pursuing the coordination of macroeconomic policies so that they are mutually reinforcing and conducive to broad-based economic growth and sustainable development, as well as to substantial increases in productive employment".

47. However, as the experience in the India, as elsewhere, has shown, there is a high social cost associated with the reform process. Jobs in uncompetitive activities, which may be high status jobs are likely to be destroyed faster than new jobs, which may be worse paid, can be created in competitive sectors. For India, the costs and the adjustment period have proved to be much more painful and prolonged than at first expected. There is therefore need for a balanced and sustainable approach to be adopted in the move towards economic liberalization and any resulting labour force restructuring so as to mitigate any worsening of unemployment and poverty. The pace of progress towards market reform will vary from State to State, but experience shows that earlier success can be achieved where there is a high degree of social consensus.

48. While market reforms are essential for sustainable employment growth and poverty alleviation, they will not be sufficient. It is necessary for supporting policies and programmes to be designed. Such policies and programmes include those geared towards developing, among other things, access to education, especially at the primary level, and to training at all stages, rural infrastructure, especially transport and communications, credit schemes, extension services and public works programmes. Outside the rural sector, programmes to promote the growth of labour-intensive small enterprises are also important. These need to be extended to micro-enterprises and self-employment activities in the informal sector. Programmes to take children out of work and into training and education and to create employment opportunities for their parents also need to be developed. Programmes are also needed to assist women, and other vulnerable groups to overcome the barriers preventing them from finding productive and freely-chosen employment. In addition, the capacity to design and implement programmes to compensate for the adverse effects of economic reform and structural adjustment programmes needs to be strengthened.

49. In light of its specific economic, social and cultural characteristics, endowments and circumstances India must find its own path to the creation of productive and remunerative jobs in full respect of the basic rights of workers. But, whatever path is taken, there is need to put the issue of the generation of productive and remunerative employment at the centre of national strategies and policies. The adoption of this approach would represent a significant departure from current practice since they tend to treat the issue of employment generation in a subsidiary manner. Employment is expected to follow growth, but as pointed out earlier, this has not been the experience, as employment generation has been persistently weak, certainly too weak to cope with continued labour force growth as well

as to reduce the existing pool of unemployed and the share of low productivity jobs which is necessary for poverty eradication.

50. There also seems to be a perception on the part of many policymakers that acting on the supply side only, through education, training, health and physical infrastructure together with income transfer and nutritional support to the poor will be sufficient to relieve poverty in a sustainable manner. While these actions are, of course, indispensable to the poverty eradication efforts, they nevertheless need to be supplemented by efforts on the demand side to revitalize the cycle of production, income and investment. This involves examining the conditions under which various underproductive sectors can be revitalized to contribute both to production and to employment and income generation which in turn can increase the internal demand and generate a cycle of investment and production. This represents the only sustainable means in the medium to long-term for creating opportunities for quality employment and for enabling the poor to gain access to services beyond the minimum provided through safety-net programmes.

51. Promoting patterns of economic growth that maximize employment creation requires:

a) encouraging, as appropriate, labour-intensive investments in economic and social infrastructure;

b) promoting technological innovations and industrial policies that have the potential to stimulate short-term and long-term employment creation and considering their impact on vulnerable and disadvantaged groups.

52. India will need to adopt deliberate policies to enhance productivity and employment opportunities in sectors which hold most promise for employment and income-generation in both traditional and non-traditional areas. The particular areas with potential for growth and employment will vary from State to State, but specific mention may be made of rural farm and non-farm production, including animal husbandry, forestry, fisheries, agro-processing; the conservation and management of natural resources, promotion of alternative livelihoods in fragile eco-systems, rehabilitation and regeneration of critically affected and vulnerable land areas and natural resources; economic and social infrastructure in both rural and urban areas. There is also scope to exploit the potential of activities related to information technology and sports, culture and entertainment. There are several community-based initiatives which are ongoing in several States and UTs in India which are illustrative of the types of potential which currently exists in the subregion which can provide a basis for future action.

53. What will be critical is for India to recognize the linkage between poverty eradication and the broader production and employment generation

capability of its economy and hence the linkage between the strategies for poverty eradication and those of macro-economic and sectoral policies. This will not only reduce the vulnerability of India's economy but will contribute to employment growth and poverty eradication as well.

54. The policies promoting productive employment, are an immediate way of addressing high levels of unemployment and underemployment and the worst manifestations of poverty.

55. Labour-intensive public works programmes have been used effectively to create infrastructure and services, create employment and reduce poverty. The strategy rests first on employment-intensive methods of providing basic infrastructure and services development, and secondly, on improved productivity and working conditions within the informal sector. Infrastructure provides a foundation for sustainable employment once it is in place, but also represents an untapped potential for increasing its impact on employment during its construction, rehabilitation and maintenance through the use of labour-based delivery systems.

56. Labour-based methods cannot be applied in all situations. For many types of infrastructure investments, labour based methods are not appropriate. For example, for major infrastructure projects such as paved highways, power plants and airports, technical standards dictate that labour-based methods are not an alternative. However, these methods are appropriate and viable under some circumstances for drainage erosion control, roads, community-water supply and upgrading of informal settlements. These categories of infrastructure carry a triple advantage in terms of poverty eradication. They directly benefit the poor, they can be undertaken using employment-intensive methods thereby creating additional employment; and they have a beneficial impact on the environment.

57. Part of the reluctance in using these methods is that labour-intensive projects are often associated in the minds of policymakers with second-rate quality, and with politicized make work programmes. However, labour-intensive infrastructure programmes and therefore employment can be sustainable, if emphasis is placed on:

(a) the creation of high quality, cost-effective durable products and assets.

(b) the use of an appropriate mix of labour and light equipment to ensure that labour is productive.

(c) the adoption of a community-based approach to the selection process.

(d) the provision of an opportunity through which training and income generation for the development of small-scale contractors can take place.

(e) the provision of a positive policy environment in public agencies and the creation of new technical and managerial capacities in public and private sector agencies to cope with such tasks.

58. Beyond its immediate impact on unemployment, there have been benefits for the larger society, through the infrastructure constructed, which has had multiplier effects leading to secondary employment in other industries. Despite the continued public perception that this is a make work scheme, independent evaluations indicate that special initiatives of the Central Government has succeeded in creating some socially useful infrastructure, of relatively high technical standards and realized at competitive costs and with high labour productivity. Nonetheless, there are some issues to be addressed if the programme is to move beyond being a safety-net to generating sustainable employment. This is an imperative, since the country would be hardpressed to continue financing the safety-nets required to provide relief to growing numbers, not only of the unemployed, but also of the underemployed.

59. The establishment of a national umbrella organization to coordinate and provide a central thrust to the activities of the many players in the sector is essential. The harmonization of fragmented regulations, programmes and institutions is critical to the support of the sector. Fragmentation has been occurring at several levels in the Indian subcontinent at the local as well as national level, where policies affecting micro-and small enterprises involve a number of government departments dealing with issues such as industrial promotion, training, or export promotion; several NGOs with independent programmes and many international donor programmes and agencies have parallel schemes with different working modalities. The challenge is how to make best use of all these initiatives so that together they support and reinforce micro and small enterprise development rather than inhibit or stifle it.

60. Investments in education and training are a potentially powerful instrument for reducing inequality in the size and distribution of income and for raising the productivity and earnings of the poor. The human capital base of the poor can be improved through the spread of literacy and basic education. This raises capabilities because:

a) It raises productivity by enhancing the willingness to innovate and the capacity to absorb information on new techniques of production;

b) It offers an access route to training and through this to better jobs, and higher incomes.

61. Policy interventions are required at several levels:

a) At the macro level, policies are required to ensure that adequate provisions are made for expenditures in education and training and that these are allocated equitably. It is particularly important to ensure universal access to good basic education since this is most beneficial from the standpoint of poverty eradication;

b) At the meso level, policy interventions are required to ensure that school fees, books, and other cost-recovery measures do not prevent access to the poor to education and training. Positive measures are also required to promote greater school enrolment and attendance by the poor, and to remove barriers to the access of the poor to training opportunities;

c) At the micro-level, direct interventions are required to provide training to upgrade production among the poor especially in peasant agriculture and the informal sector. Such interventions serve to promote new income-generating activities among the poor.

62. Beyond the poor, all groups could benefit from the improvements in the content and delivery of training, since it remains the sine qua non of growth.

63. Establishment of closer linkages between training and the needs of the job-market requires continuous labour market analysis and the development and strengthening of labour market information systems.

64. Targeting training to a much wider audience than can be accommodated through pre-employment training in formal institutions. Greater outreach is needed to the informal sector, and greater emphasis needs to be placed on training for self-employment. The objective of this training should be to develop greater self-sufficiency among poor groups, thereby reducing their reliance on the government help.

65. Linking training programmes with other support measures, since training, by itself, will rarely succeed in raising the incomes of the poor. Also important will be occupational guidance and counselling services for enterprises, particularly small enterprises.

66. Placing greater emphasis on skill-upgrading and retraining for displaced and retrenched workers, new and revitalized partnerships between education,

and other government departments, NGOs, the private sector, trade unions, and local communities.

67. The role of employment services, both public and private, can be spelled out in terms of:

a) registering jobseekers' applications and employers' vacancies, and facilitating employment by reducing information and transaction costs for both sides;
b) improving access of marginalized groups, including women, to the labour market;
c) providing skills/aptitude testing, vocational guidance and counselling, and job-search skills for workers;
d) reducing employers' search and hiring costs;
e) developing human resources planning systems and ascertain their skill requirements so as to bring better focus to public and private training programmes;
f) organizing job fairs or career days to increase the flow of information on job applicants to the employers;
g) screening or identifying job candidates by aptitude and ability testing.

68. Public Employment Services in the subregion face a number of internal and external constraints. With respect to the former, these are usually related to low staffing and funding levels, poor physical surroundings, as well as limited technical expertise. As a result very few job seekers and employers are aware of the existence of this facility and even fewer make use of it.

69. The Programme calls for the strengthening of labour market information systems, particularly through development of appropriate data and indicators on employment, underemployment, unemployment and earnings, as well as dissemination of information concerning labour markets, including, as far as possible, work situations outside formal markets. All such data should be disaggregated by gender in order to monitor the status of women relative to men.

70. The dearth of reliable data and indicators on the labour market has often been much lamented, but bridging the gap remains a seeming elusive objective. Yet, the changes taking place both globally and nationally prescribe greatly stepped-up activity in this area as an urgent necessity. The absence of empirical work including on several aspects of regulation and their impact on the performance of the labour market like maternity leave, minimum wages, severance pay leaves policymaking at too speculative a level, and needs to be addressed. This should by no means be taken to suggest that action, particularly in relation to the poor, should be held back until accurate data

are available, but it should be taken as suggesting that reasonably accurate data provide a better basis for targeting and monitoring programmes. Tracking trends in poverty, their relationship with labour market trends and the effectiveness of policy efforts would provide powerful support for national and international action.

71. New ways needs to be explored in order to provide useful information for planning. Low cost ways of providing quick information especially for poverty monitoring are appealing in light of budgetary constraints. However, investments need to be made in new and emerging technology which can facilitate the collection, processing and analysis of data. Above all, investments need to be made in the development of data collection agencies so that they can undertake meaningful programmes of activities.

72. Finally, India needs to develop more of a culture of research work on labour market issues in the public and private sectors, and working in collaboration with universities and regional and international organizations.

73. With the current trend towards flexible and indirect forms of employment, discriminatory barriers and practices are harder to identify and address. Women with casual labour status, extended probationary or trainee status, part-time workers, contract workers or household workers may not be covered by existing legislation. Discrimination in recruitment could take the form of segregating women into these non-standard forms of employment. Legislative reform, including the elimination of restrictive provisions against women such as prohibitions against night work for women, therefore needs to be accompanied by legal literacy campaigns such as those being conducted to educate women at the community levels on the laws concerning employment and violence against women. Greater attention should be given to information and sensitization campaigns focusing on the forms of discrimination, their impact, the rationale for overcoming the prejudice and the means of doing so.

74. The establishment and functioning of a labour market information system that is gender sensitive would help in the elaboration of labour market policies which would improve women's access to employment. The types of policies required to help poor women must take account of the problems which they face in the labour market. This implies a focus on specific sub-target groups including household heads; unemployed women; women working in female-dominated occupations and industries which have low pay/income; women's family responsibilities and policies directed at the following issues/factors:

a) the so-called double (triple) burden which women face;

b) discrimination in human capital and technology acquisition;

c) damaging misconceptions and stereotypes regarding women and their need for income;

d) occupational stereotyping of women and men;

e) undervaluation of women's work;

75. Changing those policies and attitudes that reinforce the division of labour based on gender, and providing institutional support, such as social protection for maternity, parental leave, technologies that facilitate the sharing and reduce the burden of domestic chores, and flexible working arrangements, including parental voluntary part-time employment and work-sharing, as well as accessible and affordable quality child-care facilities, to enable working parents to reconcile work with family responsibilities, paying particular attention to the needs of single-parent households.

76. Action to reduce gender segregation with respect to both exclusion and concentration in the labour market and to enhance occupational choice is important to addressing women's high unemployment and low pay levels in the sub-region. The importance is two-fold; first, women should be able to enter sectors where job opportunities exist in order to move out of the ranks of the unemployed and to find employment; and secondly, women often find higher paying jobs in male dominated sectors and female dominated sectors often benefit from the entrance of males in terms of increasing the value of the job.

77. Improving women's access to technologies that facilitate their occupational and domestic work, encourage self-support, generate income, transform gender-prescribed roles within the productive process and enable them to move out of stereotyped, low-paying jobs.

78. Breaking down labour market segregation by gender includes skill development and facilitating policies as well as sensitization and the changing of biased preconceived notions of appropriate roles and abilities of male and female workers. To effectively implement this strategy, detailed occupational information is needed including the gender composition of occupations and changes in those compositions. Education, guidance, training and development of human capital needs to be stressed equally for boys and girls early in their lives.

79. Labour market policies also need to stress skill development and training in order to increase women's productivity and thus provide them with an equal chance in the labour market. This would include basic literacy courses where necessary, courses in how to be more effective self-employed businesswomen, introduction to use and acquisition of appropriate technology, and vocational training for non-traditional occupations. Monitoring and evaluation are needed to determine to what extent traditional patterns of labour market inequalities such as occupational segregation are being reinforced or broken down and how effective any of these efforts are in reaching the lowest economic group of women.

80. While women are being encouraged to take up traditionally male professions in order to tap into new job opportunities, the value of female dominated occupations must also be enhanced, in pay and status. Very low minimum wages could be revised and enforcement of minimum wage legislation could be enhanced. One known method of ensuring a more equitable valuation of women's waged work is through undertaking an objective job evaluation based on objective analytical job related criteria. These evaluations are intended, among other things, to reduce gender bias in job classifications and pay scales.

81. Action on the demand side of the labour market to increase jobs and employment for women may take many forms such as through subsidizing private sector schemes, public sector employment, direct wage employment creation schemes and self-employment, entrepreneurship development and small business support. The first type is not recommended nor feasible for this subregion. The second type, public sector employment, is already largely female-dominated due to expenditure cuts and male flight; and adjustment measures dictate against future increases rendering this option feasible for only demonstration effect such as by high level decision-making appointments of women. Direct wage employment schemes may be especially important for seriously disadvantaged groups of women as a means of addressing high levels of unemployment and underemployment, as well as the worst manifestations of poverty.

82. The greatest potential for women in the subregion may lie in terms of job creation in self-employment, entrepreneurship and small and micro business development. However, particularly in the case of low-income women, the approach taken should not be welfare-based, but should aim instead at developing self-sufficiency by building on their existing skills. They should also be encouraged to improve their productivity through cooperative efforts, technological innovation or the new application of an old skill. Overcoming the undervaluation of existing skills in the subregion, particularly those held

by women, is a vital link to enhancing women's, and the subregion's, competitiveness in export markets.

83. The role of employment services has not been given adequate attention by policy-makers. Efficiently run employment services provide information, bring potential workers and employers together and help to improve the access of marginalized groups, including women, to job vacancies. Gender sensitive employment services could help guard against employers restricting the range of opportunities to applicants by making assumptions about abilities on the basis of a particular group or sex.

84. Other measures to help women gain equal access in employment should begin in the home with parental advice and encouragement, followed by informal and formal guidance and counselling to avoid limiting options for economic activity. It is also important to ensure non-discrimination, both direct and indirect, in advertising, selection criteria, interviews and actual recruitment in jobs. At the enterprise level, there is a need to conduct gender sensitive surveys to assess employers perceptions, preferences and practices in respect of recruitment, hiring, promotion and termination of women and men to determine the impact of labour laws such as maternity benefits, collective bargaining provisions and the provision or lack of social services such as child care.

85. Action to empower women in the formal sector should also focus on improving their representation in labour market institutions and especially in decision-making and collective bargaining structures. Women's membership in trade unions lags behind that of men and their proportional numbers in the workforce. A few strong women are currently found in leadership positions throughout the subregion but they are a minority. At present, the trade unions remain male dominated in terms of membership, leadership, focus and culture. While many trade unions remain in the traditional mold of negotiating for bread and butter issues, important to all their workers, they must be credited for having successfully fought over the years for maternity protection in their collective agreements.

86. There has been very few systematic attempts made to assess the impact of such initiatives on the youth employment problems that they are intended to address. Such assessments appear warranted, given the persistent and changing nature of the problem. Experience drawn from successful initiatives suggest that there is need for the kind of comprehensive and coordinated approach as advocated in the Copenhagen Programme.. This approach requires the full participation of a number of actors including workers and employers organizations, as well as youth organizations in decisions

regarding policies and programmes. The full participation of these groups, especially employer organizations is also indispensable to success.

87. While it is crucial to take steps to improve the access of youth to employment it is also important to act on the demand side to increase the overall demand for labour. Thus, youth programmes need to be considered within the context of an overall employment promotion strategy. In this regard, youth need to be considered specifically in employment promotion programmes, including those designed to stimulate micro and small enterprise development.

88. Designing a national plan of action against child labour has to be one of the priority areas of the Central and the State Governments. Actions to combat child labour must form part of an overall national plan. The problem of child labour will not be solved overnight, since it is one of the many facets of poverty and underdevelopment. Resources available to reduce its extent and damaging effects are by definition scarcest in the country which needs them the most. Priorities must therefore be set.

89. Working children cannot be viewed simply within the context of labour law which requires the immediate dismissal or withdrawal from work of under-age children, as such action may in fact work against the children's immediate welfare. A broader approach is required. National plans of action must provide for suitable alternatives, including schools and vocational training facilities.

90. Besides the immediate measures required for the protection of child workers, the plan should include measures against the underlying causes of child labour and form an integral part of employment strategies that create viable income opportunities for the poor through poverty alleviation programmes.

91. Hard information is lacking on how many children are working, what they are doing, where and in what conditions. Without such data, it is virtually impossible to develop effective policies and programmes. Establishing, in some cases improving, data collection systems on child labour is an essential first step.

92 The centrality of strategies for employment, labour markets, labour institutions, social protection and human resource development for poverty eradication should become one of the central themes for national development.

93 The imperative for multi-dimensional and integrated approaches involving policy reform, institutional development and direct interventions should be recognised at all levels of planning.

94. The indispensable role of public policy in setting the agenda, creating the supportive policy environment and framework for productive employment growth and poverty eradication should be incorporated in the agenda for employment generation.

95. The extensive changes in political, economic, and social spheres, including the globalization of trade, finance and technology, and growing flexibilization of labour markets not only impact on the incidence and characteristics of poverty, but require a fresh consideration of strategies and new thinking about effective policies and mechanisms for its eradication.

96. Two fundamental objectives will be important for the future.

a) forging strategic alliances among different groups at the national and international levels for the promotion of productive employment and poverty eradication;

b) monitoring changes, analyzing new trends and appraising new dimensions of social injustice and developing new responses.

97. Political resolve in addressing these problems needs to be strengthened at the national levels.

98. the information base needs to be considerably strengthened to facilitate more effective monitoring of trends.

99. More information on successful initiatives related to employment generation and poverty eradication in the Indian Subcontinent needs to be documented and widely disseminated.

100. The major long-term activities for national employment generation should be :

a) creating a favourable climate within the country so as to include the whole population in establishing national goals and priorities;

b) working out a purposeful government policy for productivity improvement on the national scale, and coordinating policies for optimal use of national resources;

c) establishing the government statistical bodies which deal with data collection and analysis at the sectoral and macro-economic levels;

d) strengthening legislation on the relation between enterprises and between enterprises and government institutions;

e) increasing the role of such financial incentives as taxes, credit and incomes policy.

**STEP BY STEP METHODOLOGY FOR EMPLOYMENT GENERATION ADOPTED BY AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)**

There is an urgent need for creating an environment where there will be more number of job givers rather than job seekers by providing training and guidance in the areas of entrepreneurial leadership and managerial competence. Let us consider the following step by step methodologies for employment generation :

1. To collect data and information related to the existing publications including newspapers, journals and periodicals providing information and news regarding employment opportunities besides facilities regarding academic and professional training and research in different vocational fields.

2. To bring out daily, weekly, fortnightly, monthly, bimonthly, quarterly, six-monthly and yearly newspapers, journals, periodicals and other publications related to employment and training with a view to generating employment specially among the weekers sections of the society.

3. To publish books, encyclopaedias, directories and dictionaries on different topics related to entrepreneurship development including self-employment.

4. To connect the association with the labour market mechanisms and patterns to give into the pattern and intensity of poverty and into the factors concentrating it among particular groups.

5. To give prominance to labour market policies, as well as those related to employment, labour institutions, social protection and human resource development and poverty eradication strategies.

6. To distinguish between poverty due to exclusion from access to jobs and poverty associated with the nature of employment and the levels of income which it generates while attempting to analyze the labour market situation in the Indian Subcontinent and its impact on poverty.

7. To assess the degree to which labour market exclusion is directly linked to poverty and the extent to which state or community safety nets or family support systems exist or whether it affects particular members of households (younger persons, for example) where there is another income source.

8. To place the creation of employment at the centre of national strategies and policies, with the full participation of employers and trade unions and other parts of civil society.

9. To help and assist in the formulation of policies to expand work opportunities and increase productivity in both rural and urban sectors.

10. To provide education and training that enable workers and entrepreneurs to adapt to changing technologies and economic conditions.

11. To help generate quality jobs, with full respect for the basic rights of workers.

12. To give special priority, in the design of policies, to the problems of structural, long-term employment and underemployment of youth, women, persons with disabilities and all other disadvantaged groups and individuals.

13. To empower the women for gender balance in decision-making processes at all levels and gender analysis in policy development to ensure equal employment opportunities and wage rates for women and to enhance harmonious and mutually beneficial partnerships between women and men in sharing family and employment responsibilities.

14. To also empower members of vulnerable and disadvantaged groups through the provisions of proper and appropriate education and training.

15. To look for a broader recognition and understanding of work and employment and greater flexibility in working time arrangements for both men and women.

16. To assist in alleviating poverty and unemployment: either by focusing on the members of economically weaker sections of the society and other groups directly affected by the economic reform and adjustment policies such as retrenched workers, or more generally by addressing chronic and structural poverty and unemployment.

17. To strengthen the social acceptability and the political viability of adjustment and reform programmes.

18. To help in creating a new approach and culture of social service delivery based on a flexible institutional mechanism circumventing the bureaucratic structure and encouraging participatory and decentralized development with the participation of local groups and associations.

19. To develop strategies to assist the formation and strengthening of collective action in the informal sector by developing relations with trade associations.

20. To raise awareness on the importance of good working conditions and social security by extending workers' education programmes to the informal sector.

21. To assist in improving working conditions of their subcontractors in the informal sector with a view to enabling them to create more employment opportunities for trained and skilled persons.

22. To assist informal sector operators to take part in trade fairs.

23. To assist informal sector operators to organize themselves effectively.

24. To integrate issues on occupational safety and health and social security in programmes to raise productivity.

25. To assist informal sector self-help associations to integrate awareness raising on occupational safety and health into their activities.

26. To establish innovative market services for the development of adult workers, by expanding the role of employers and organized employees in the planning and delivery of services, including training, retraining, job search, placement, skills identification and counseling.

27. To increase the capacity of the private sector to perform its role in the training and development of the young men and women to acquire techno-managerial as well as entrepreneurial skills.

28. To improve the existing employment market information system.

29. To help adult workers to acquire new skills at the technical and supervisory levels in order to make them eligible for higher level jobs at higher wages in occupations essential to economic growth or in their own businesses.

30. To reduce the transition time to new jobs for displaced workers.

31. To accelerate the entry of female workers into skilled technician, master craftsperson or supervisory positions.

32. To establish a permanent private sector mechanism to fund a variety of workforce development activities and create a forum for workers and employers to collaborate in implementing human resource development strategies and programmes.

33. To provide skill and interests assessment and career and employment counselling to determine the training, placement or business development support, the employable persons need to acquire the job, promotion or suitable income generating activity.

34. To provide a comprehensive package of services to include brokering and referral of workers to jobs, on-the-job training, business development support services and specialized training at the craftsperson, artisan, supervisory or managerial level and appropriate entrepreneurial training to place workers in new jobs, better jobs or self-employment opportunity.

35. To promote the concept of establishing learning laboratories which would provide computer assisted training e.g. literacy, numeracy and workplace basics such as problem solving, oral communication and planning and organizing work.

36. To establish Employment and Training Market Services Centres to introduce innovative approaches in human resource development.

37. To establish the principle of equality between men and women as a basis for employment policy and promoting gender-sensitivity training to eliminate prejudice against the employment of women.

38. To eliminate gender discrimination, including by taking positive action, where appropriate, in hiring, wages, access to credit, benefits, promotion, training, career development, job assignment, working conditions, job security and social security benefits.

39. To encourage various actors to join forces in designing and carrying out comprehensive and coordinated programmes that stimulate the resourcefulness of youth, preparing them for durable employment or self-employment, providing them with guidance, vocational and managerial training, social skills, work experience and education in social values.

40. To cause research on the underlying factors which are most important in differing national contexts in determining the levels of youth unemployment.

41. To evaluate all types of policies and programmes tried in different five year plans with a view to designing a foolproof and long-term strategy for employment generation.

42. To locate the factors which influence the success or failure of specific policies and programmes relating to employment and training.

43. To prepare a Policy and Programme Manual for policy makers to aim primarily at national capacity building for the design, implementation and evaluation of policies and programmes for countering youth unemployment.

44. To help analyse the national background characteristics, financial constraints, current educational efforts and effects and present conditions of societal development in different States and UTs of India.

45. To help the Central Government establish appropriate targets for employment generation and derive suitable strategies for implementing policies and programmes to meet the needs of the educated unemployed.

46. To establish a Life and Career Advising Centre - a single point of contact for student counselling on academic, personal and career issues.

47. To create a learning environment all over the country that encourages students to become actively involved in their own education.

48. To help reduce unemployment in the country by assisting the Central and the State Governments and public institutions in the initiation of professional and job oriented courses and by introducing the urban as well as rural entrepreneurship programmes for self employment.

49. To encourage an employment policy that is free of prejudice and party politics which promotes new ideas relating to sustainability.

50. To strengthen the voluntary as well as non governmental organisations in order to make them available for the organisation and implementation of programmes having a positive, social, economic and educational content with a view to having more number of job givers than job seekers.

51. To serve as a centre of ideas and experience and dissemination of employment and training information on national as well as global job markets and its availabilities, reach, awareness, policy, law, research promotion, and preparedness in particular.

52. To help the Central and the State Governments in organising formal and non formal training programmes in attitudinal and behavioural change for bringing productivity and efficiency with the help of the trained employers and employees.

53. To publicize through the media an international network instances of successful policies, programmes and demonstrations regarding employment promotion and bring these success stories to the attention of policy makers.

54. To establish a national network of like minded NGOs with the ability to publicise the activities related to employment generation.

55. To strengthen international scientific organisations so that they can play a larger part in shaping and coordinating the research agenda on vocationalisation of careers.

56. To work closely with policy research centres focussing on global scale resource and development issues to bridge the gap between basic research and policy on employbility.

57. To evaluate the existing curricula of the undergraduate, graduate and postgraduate level courses and propose necessary changes for making these programmes fit for helping the alumnis to find self employment opportunities by acquiring entrepreneurial leadership techniques.

58. To address the universal shortage of trained personnel in new and emerging job oriented areas through a sharp increase in funds to be sanctioned to universities and institutions.

59. To advise the younger generation for acquiring appropriate knowledge and technologies from the aged persons and senior citizens and to popularise their proven ideas and experiences.

60. To use restructured educational and training programmes to reorient vocational education for creating jobs in the new and emerging fields.

61. To help initiate training cum production cum rehabilitation centres in the rural as well as urban areas for the benefit of the younger generation.

62. To create employment generation environment by updating the existing vocational training programmes in the polytechnics, institutions, colleges and universities.

63. To strengthen with adequate study materials the existing distance learning programmes for enabling the working persons to strengthen their qualification and encouraging earning while learning.

64. To prepare instructional texts including audio and video lessons on employment and training to be distributed through the existing institutions as well as through the new outfits in the country.

65. To use and popularise the existing and new satellite channels for teaching and training through the air for the benefit of the citizenry.

66. To aid in organising conferences, seminars, meetings, discussions, debates, study courses, collection of statistics, exhibitions, shows, tour trips and to establish endowments and scholarships for the promotion and furtherance of programmes related to popularising higher education programmes related to vocational and job oriented education for employment generation.

67. To organise employment museums for displaying the available vacancies besides the types of advertisements in the print and the electronic media.

68. To conduct sponsored as well as non sponsored research programmes with the support of Central and State Governments and publish such reports and case books.

69. To arouse in teachers and other educators a full awareness of our responsibilities in moulding future generations for a peaceful employment and work culture.

70. To promote that kind of education that will help each individual from earliest years to develop full human potential for constructive, peaceful living in the expanding communities in which one grows; family, neighbourhood, school, local community, country, in fact, the whole human world.

71. To seek to enable individuals through constant educational and career improvement to deal with and resolve misunderstanding, personal as well as social, in the spirit of wisdom, charity and duty.

72. To support production and wide spread distribution of educational materials for the furtherance of social progress, international understanding, and worldly stability.

73. To make the full use of mass media for the cause of education especially in the proper communication of controversial views and issues, local and global, so as to maximize cooperation and conciliation.

74. To make everybody aware regarding the need for national as well as international integration and cooperation.

75. To invite representatives of different countries including the universities, NGOs and regulatory bodies for discussing issues like labour, employment, entrepreneurship and education.

76. To seek support of the educational and scientific organisations for using their facilities and infrastructure for conducting different programmes related to clean as well as green jobs.

77. To help design courses on subjects and topics generally not covered by existing institutions but are of great importance viewing the changes in the societal systems.

78. To continue to be open in ideas, methods, systems, places with no cloisters.

79. To help people through appropriate training to lead a way of life that can be sustained by our Mother Earth.

80. To justify the creation of a Citizens Apex Body by uniting all the professionals of the country in order to influence the power structure through their function as counselling centres, and by placing them, whenever possible, in areas of conflict for equalizing the flow of knowledge, for reducing aggression and for generating attitudes of fraternization.

81. To suggest to the national and international leaders alternative approaches to the solution of problems relating to health, education, unemployment, pollution and peacelessness.

82. To encourage the establishment of institutions for learning that serves the spirit of employment generation and also by stimulating existing colleges and universities to implement courses of study related to virtual education for employment opportunities in the cyber related fields.

83. To cooperate with authorities at various levels in implementing the Universal Declaration of Human Rights and reminding the employers and the employees regarding their human rights as well as human duties.

84. To collaborate in the work of existing and functional organizations that have stated goals and purposes with a view to creating more employment opportunities in the country.

85. To propose to other developmental associations, programmes on peace problems that are flexible in nature and capable of being adopted and

modified according to cultural background, environment, and changing needs of people.

86. To update educational means for the reciprocal dissemination of culture and the elimination of illiteracy.

87. To disseminate information in the form of advertisements and/or articles regarding selection and recruitment in public as well as private sector organisations in the publications to be brought out by the Government and the Non-Government Organisations.

88. To conduct periodical analaysis of employment and unemployment data at both State level and all India level and projections of labour force, workforce, and unemployment in the country.

89. To suggest strategies and programmes for creating gainful employment opportunities and to look into sectoral issues and policies having a bearing on employment generation.

90. To identify gaps and to suggest necessary approach / strategies and the need based policies and programmes in the fields of occupational safety and health, skill development, social security, employment planning and policy.

91. To help provide opportunities for individuals seeking a green or ecologically responsible career available in many diverse catagories on the international, national, state and local levels; in private, public, and non-profit sectors; within different fields; and in different job functions.

92. To introduce responsible business practices fostering a competitive edge through efficiency in production, minimum generation of waste, and a more productive and healthy work force.

93. To advise the Government of India and the State Governments to constitute People's Commission on Employment Generation with a view to having immediate solution regarding unemployment as well as unemploybility.

94. To collaborate, affiliate and federate with the Central and the State Governments, agencies and bodies for implementing the projects of employment generations.

95. To raise and borrow money for the purposes of generating employment in such a manner as may be decided from time to time and to prescribe the membership fees, charges, grants in aid etc.

96. To purchase, take on lease or exchange, hire or otherwise acquire properties, movable or immovable and rights and privileges all over the world, which may be deemed necessary or convenient for the benefit of the unemployed as well as unemployable communities.

97. To open branches, chapters and constitutent centres of employment promotion programmes and projects in different parts of the country and get them registered with appropriate authorities if needed and felt conducive for the attainment of the milestone of employment generation.

98. To invest the surplus money available from employment generation bodies not immediately required in such securities and in such manner as may be decided from time to time, the money especially collected through subscriptions, advertisements, sponsorship, fees, gifts, endowments, donations, grants etc.

99. To finally provide information, knowledge, wisdom, and education that prepares everybody for leadership and social responsibility enabling to think and communicate effectively and to develop a global awareness and sensitivity for a better global understanding, world peace and unity.

100. And to generally do all that is incidental and conducive to the attainment of the milestone of generating employment in all the 602 Districts of our country.

We should ask ourselves regarding the burning problems of our country and find suitable solution by providing inputs through higher education. The problems are first : peacelessness, second : unemployment, third : pollution, fourth : obsolete educational system, and fifth : population explosion. The problem of peacelessness is because of unemployment and pollution. The solution lies in having a marriage of unemployment with pollution by creating environment friendly and sustainable jobs. We must vocationalise our existing careers by incorporating new and emerging subjects in higher education for employment generation and for protecting our mother earth by teaching subjects like environmental education as per the orders of the Hon'ble Supreme Court of India. We must control our population size with a view to optimising our budgets and for providing education, food, shelter and health facilities for all.

## Chapter 6

# CHILD CARE AND DEVELOPMENT RELATED POLICIES ADOPTED BY AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

As we know that child is the father of man, so we at Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) have dedicated ourselves for the cause of the overall development of the child by adopting the slogan “Catch Them Young” in order to prepare the children as didactics so that they may finally educate their fathers, mothers, guardians, teachers, colleagues, rather the entire neighbourhood. With full hope and optimism, the 101 Point Agenda of Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD), a People's Charter for the survival, protection and development of children in the twentyfirst century is being presented on the auspicious occasion of the compilation of the book titled “Distance and Open Education Worldwide : Contributions of Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD)” in the form of a GUIDE to private and public action in the interests of the children with the assertion that mankind owes to the child the best it has to give and that this Agenda will be treated as a moral framework for children's rights today and tomorrow for the emergence of an international consensus for strengthened cooperation focusing on children that could be a development of far reaching significance for creating the conditions in which children may take an active and creative part in the social and political life of their countries.

1. To provide a healthy and safe environment, access to medical care, and minimum standards of food, clothing and shelter for the development of the intellectual, moral and spiritual capacities of the children.

2. To establish the right of a child to be an actor in his or her own development, to express opinions and to have them taken into account in the making of decision relating to his or her life.

3. To acknowledge the primary role of the family and parents in the care and protection of children and the obligation of the government(s) to help them in carrying out these duties.

4. To promote the principle that every child has the inherent right to life and that the child survival and development must be ensured to the maximum.

5. To see that every child gets the right to a name and a nationality from birth.

6. To ensure that each child enjoys full rights without discrimination or distinctions of any kind.

7. To promote the practice that the children are not separated from their parents, unless by competent authorities for their well being.

8. To facilitate reunification of families by permitting travel into, or out of, their territories.

9. To fix the primary responsibility for a child's up-bringing with the parents with appropriate assistance of the Government(s), International Organisations, Public, Private and Independent Sectors for developing child-care institutions.

10. To protect the children from physical or mental harm and neglect including sexual abuse or exploitation.

11. To provide parentless children with suitable alternative care.

12. To provide special treatment, education and care to the disabled children.

13. To place emphasis on preventive measures for attaining the highest standard of health, health education and reduction of infant mortality.

14. To ensure that the discipline in schools respects the child's dignity and that education prepares the child for life in a spirit of understanding, peace and tolerance.

15. To provide facilities and time for enabling the children to rest and play and to further provide equal opportunities for cultural and artistic activities.

16. To protect the children from economic exploitation and work that may interfere with education or be harmful to health and well-being.

17. To protect the children from the illegal use of drugs and involvement in drug production or trafficking.

18. To eliminate the abduction and trafficking of children.

19. To provide facilities to separate the children from adults while in detention so that they are not tortured and that they must not suffer cruel and disregarding treatment.

20. To offer special protection to children exposed to armed conflict by also ensuring that no child under the age of 15 should take any part in hostilities.

21. To let the children of minority and indigenous populations enjoy their own culture, religion and language.

22. To enable the children, who have suffered maltreatment, neglect or detention, receive appropriate treatment or training for recovery and rehabilitation.

23. To treat the children involved in infringements of the penal law, for promoting their sense of dignity and worth that aims at reintegrating them into society.

24. To identify dangers to the well-being of the world's children.

25. To look for practical answers to the growing problems of the children.

26. To mobilize the human and financial resources for overall development of children.

27. To raise the level of public awareness and concern for the protection and promotion of children's rights.

28. To recognise that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.

29. To consider that the child should be fully prepared to live an individual life in society and brought up in the spirit of peace, dignity, tolerance, freedom, equality and solidarity.

30. To bear in mind that the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

31. To take due account of their importance of the traditions and cultural values of each people for the protection and harmonious development of the child.

32. To take all appropriate measures to promote physical and psychological recovery of a child victim of any form of neglect, exploitation or abuse, torture or any other form of cruelty, inhuman or degrading treatment or punishment.

33. To prevent the abduction of the sale of or traffic in children for any purpose or in any form.

34. To protect the children from inducement or coercion for engaging them in any unlawful sexual activity.

35. To protect the children from the exploitative use in prostitution or other unlawful sexual practices.

36. To take suitable measures for protecting the children from the exploitative use in pornographic performances and materials.

37. To take appropriate steps including legislative, administrative, social and educational steps, for protecting the children from the illicit use of narcotics and psychotropic substances.

38. To provide for a minimum age for admission to employment, appropriate regulation for the working houses and conditions of employment and penalties or other sanctions to ensure the effective enforcement relating to employment of children after attaining the required age.

39. To develop the child's personality, talents and mental abilities to their fullest potential.

40. To ensure that the education of the child be directed to the development of the respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may be originating and for civilizations different from his or her own.

41. To prepare the child for responsible life in a free society in the spirit of understanding, equality of sexes and friendships among all peoples, ethnic, national and religious groups.

42. To make the children educated with a view to developing among them the respect for the natural environment.

43. To make primary education free as well as compulsory for all.

44. To encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child.

45. To make higher education accessible to all children on the basis of capacity by every appropriate means.

46. To make educational and vocational information and guidance available and accessible to all children.

47. To take measures to encourage regular attendance at schools and the reduction of drop-out rates among children.

48. To recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

49. To make the parent(s) responsible for securing, within their abilities and financial capabilities the conditions of living necessary for the child's development.

50. To assist the parents for providing material assistance, particularly with regard to nutrition, clothing and housing for the children.

51. To recognise the right of children to benefit from social security, including insurance, and to take the necessary measures to achieve the full realisation of this right for their optimum development.

52. To enable the children to enjoy the highest attainable standard of health and the facilities for the treatment of illness and rehabilitation of health.

53. To take suitable measures for diminishing infant and child mortality.

54. To ensure the provision of necessary medical assistance to all children with emphasis on the development of primary health care.

55. To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious food and clean drinking water, taking into consideration the damages and risks of environmental pollution.

56. To ensure appropriate pre-natal and post-natal health care of mothers.

57. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition. The advantages of breast feeding, hygiene and environmental sanitation and the prevention of accidents be more popularised and made common.

58. To develop preventive health care, guidance for parents and family planning education and services.

59. To take all effective measures with a view to abolishing traditional practices pre-judicial to the children's health.

60. To recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community.

61. To accord special care to the disabled children with all assistance which is appropriate to the children's conditions and to the circumstances of the parents or others caring for the child.

62. To ensure that the disabled children have effective access to receiving education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to achieving the fullest possible social integration and individual development, including their cultural and spiritual development.

63. To promote the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services.

64. To take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee whether unaccompanied or accompanied by his or her parents or by any other person, receives appropriate protection and humanitarian assistance.

65. To ensure that the adoption of a child is authorized only by the competent authorities who determine, in accordance with the applicable laws and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their consent to the adoption on the basis of such counselling as may be necessary.

66. To recognise that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot, in any suitable manner, be cared for in the child's country of origin.

67. To ensure that the child concerned by the inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption.

68. To take all appropriate measures to ensure that, in inter-country adoption the placement does not result in improper financial gains for those involved in it.

69. To ensure special protection and assistance to all children temporarily or permanently deprived of their family environment or whose own best interests cannot be allowed to remain in that environment.

70. To include special care for the children like foster placement, Kafalah of Islamic law, adoption or if necessary placement is suitable institutions for the case of children viewing the desirability of the country their upbringing and to their ethnic, religious, cultural and linguistic backgrounds.

71. To take social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

72. To establish social programmes for providing necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment.

73. To recognise the principle that both parents have common responsibilities for the upbringing and development of the child.

74. To render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsbilites and to ensure the development of institutions, facilities and services for the care of children.

75. To ensure that children of working parents have the right to benefit from child-care and facilities for which they are eligible.

76. To ensure that children have the access to information and material from a diversity of national and international sources, especially those aimed at the promotion of their social and moral well being, physical and mental health.

77. To encourage the mass media to disseminate information and material of social and cultural benefit to the child.

78. To encourage international cooperation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources.

79. To encourage the production and dissemination of children's books.

80. To encourage the mass-media to have regard for the linguistic needs of the children who belong to the minority or indigenous groups.

81. To encourage the development of appropriate guidelines for the protection of children from information and material injurious to their well-being.

82. To ensure that children are not subjected to arbitrary or unlawful interference with their privacy, family, home or correspondence, nor to unlawful attacks on their honour and reputation.

83. To recognise the rights of the children to freedom of associations and to freedom of peaceful assembly.

84. To respect the right of the children to freedom of thought, conscience and religions.

85. To respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the children in the exercise of their rights in a manner consistent with the evolving capacities of the children.

86. To ensure the children's right to freedom of expressions including freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers either orally, in writing or in print, in the form of art, or through any other media of their choice with due respect of the rights or reputations of others and for the protection of national security or of public order, or of public health or morals.

87. To assure to the children who are capable of forming their own views the rights to express those views freely in all matters affecting the children, the views of the children being given due weight in accordance with the age and maturity of the child.

88. To take measures to combat the elicit transfer and non-return of children abroad.

89. To ensure the right of the children to maintain on a regular basis, direct contacts and personal relations with both parents in case they reside in different countries.

90. To ensure that children are not separated from their parents against their will, except when competent authorities subject to judicial review determine in accordance with applicable law, that such separation is necessary in the best interests of the children.

91. To respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis except if it is contrary to the child's best interests.

92. To respect the right of the children to preserve their identity including nationality, name and family relations as recognised by law without unlawful interference.

93. To ensure that the children are registered immediately after birth and that they have the right from birth to a name, and as far as possible, the right to know and be cared for by their parents.

94. To respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of their rights.

95. To take all appropriate steps to ensure that children are protected against all forms of discrimination or punishment on the basis of status, activities, expressed opinions, or beliefs of the child parents, legal guardians, or family members.

96. To ensure that all children have equal and same rights without discrimination of any kind, irrespective of the their own or their parents' or legal guardians' race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

97. To take due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the children.

98. To recognise that in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration.

99. To bear in mind that the children, by reason of their physical and mental immaturity, need special safeguards and care, including appropriate legal protection before as well as after birth.

100. To recognise that the children, for the full and harmonious development of their personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.

101. To finally promote the philosophy that the family as the fundamental group of society and the natural environment for the growth and well being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

## Chapter 7

# SCEHEME OF TEACHING PEACE, MERCY AND TOLERANCE THROUGH AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

### VALUE BASED EDUCATION AT AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD) BY TEACHING PEACE, MERCY AND TOLERANCE

Let us, first of all, try to discuss and diagnose intolerance among members of the society for locating respective critical paths for being merciful and tolerant for bringing peace on earth in the twentyfirst century and the third millennium. Viewing the growing peacelessness and intolerance all over the world, let us also discuss the need for disaster education including disaster preparedness, mitigation and management.

Educating the children and young people with a sense of openness and comprehension towards other people, their diverse culture and histories and their fundamental shared humanity; teaching them the importance of refusing violence and adopting peaceful means for resolving disagreements and conflicts; forging in the next generation feelings of altruism, openness and respect towards others, solidarity and sharing based on a sense of security in one's own identity and a capacity to recognise the many dimensions of being human in different cultural and social context should be the main thrust during the deliberations on peace, mercy and tolerance. Let us discuss these matters in a greater detail :

1. The manifestations of violence, racism, xenophobia, aggressive nationalism and violations of human rights, by religious intolerance, by the upsurge of terrorism in all its forms and manifestations and by the growing gap separating wealthy countries from poor countries, phenomena which threaten the consolidation of peace, tolerant behaviour and democracy both nationally and internationally and which are all obstacles to development are matters of deep concern.

2. The educational plans and policies have to contribute to the development of understanding, solidarity and tolerance among individuals and among ethnic, social, cultural and religious groups and sovereign nations. Education should promote knowledge, values, attitudes and skills conducive to respect for human rights and to an active commitment to the defence of such rights and to the building of a culture of peace, tolerance and mercy.

3. We are aware of the great responsibility incumbent not only on parents, but on society as a whole, to work together with all those involved in the educational system, and with non-governmental organisations, so as to achieve full implementation of the objectives of education for peace, human rights and civil liberty and to contribute in this way to sustainable development and to a culture of peace.

4. We understand the need to seek synergies between the formal education system and the various sectors of non-formal education, which are helping to make a reality of education that is in conformity with the aims of "Education for All". We know of the decisive role that also falls to non-formal educational organisations in the process of forming the personalities of young people.

5. Accordingly we should strive resolutely to base education on principles and methods that contribute to the development of the personality of pupils, students and adults who are respectful of their fellow human beings and determined to promote peace, non violence, mercy, compassion and tolerance; to take suitable steps to establish in educational institutions an atmosphere contributing to the success of education for international understanding, so that they become ideal places for the exercise of tolerance, respect for the rights, the practice of democracy and learning about the diversity and wealth of cultural identities.

6. Action should be taken to eliminate all direct and indirect discrimination against girls and women in education systems and to take specific measures to ensure that they achieve their full potential.

7. There is an urgent need to give special attention to improving curricula, the content of textbooks, and other educational materials including new technologies, with a view to educating caring and responsible citizens open to other cultures, able to appreciate the value of freedom, respectful of human dignity and differences, and able to prevent conflicts or resolve them by non-violent means.

8. Measures must be adopted to enhance the role and status of educators in formal and non-formal education and to give priority to pre-service and in-service training as well as the retraining of educational personnel, including planners and managers, oriented notably towards professional ethics, civic and moral education, cultural diversity, national codes and internationally recognised standards of human rights and fundamental freedoms.

9. The development of innovative strategies adapted to the new challenges of educating responsible citizens committed to peace, human rights, democracy

and sustainable development, and to apply appropriate measures of evaluation and assessment of these strategies should be encouraged.

10. In a period of transition and accelerated change marked by the expression of intolerance, manifestations of racial and ethnic hatred, the upsurge of terrorism in all its forms, discrimination, war, violence and the growing disparities between rich and poor, at international and national levels alike, action strategies must aim both at ensuring fundamental freedoms, peace, human rights, and democracy and at promoting sustainable and equitable economic and social development, all of which have an essential part to play in building a culture of peace. This calls for a transformation of the traditional styles of educational action.

11. The ultimate goal of education for peace, mercy and tolerance is the development in every individual of a sense of universal values and types of behaviour on which a culture of peace is predicated. It is possible to identify even in different socio-cultural context values that are likely to be universally recognised.

12. Education must develop the ability to value freedom and the skills to meet its challenges. This means preparing citizens to cope with difficult and uncertain situations and fitting them for personal autonomy and responsibility. Awareness of personal responsibility must be linked to recognition of the value of civic commitment, of joining together with others to solve problems and to work for a just, peaceful and democratic community.

13. Education must develop the ability to recognise and accept the values which exist in the diversity of individuals, genders, peoples and cultures and develop the ability to communicate, share and co-operate with others. The citizens of a pluralist society and multicultural world should be able to accept that their interpretation of situations and problems is rooted in their personal lives, in the history of their society and in their cultural traditions; that, consequently, no individual or group holds the only answer to problems; and that for each problem there may be more than one solution. Therefore, people should understand and respect each other and negotiate on an equal footing, with a view to seeking common ground. Thus education must reinforce personal identity and should encourage the convergence of ideas and solutions which strengthen peace, friendship and solidarity between individuals and people.

14. Education must develop the ability of non-violent conflict-resolution. It should therefore promote also the development of inner peace in the minds of learners so that they can establish more firmly the qualities of tolerance, compassion, sharing and caring.

15. Education must cultivate in citizens the ability to make informed choices, basing their judgements and actions not only on the analysis of present situations but also on the vision of a preferred future.

16. Education must teach citizens to respect the cultural heritage, protect the environment, and adopt methods of production and patterns of consumption, which lead to sustainable development. Harmony between individual and collective values and between immediate basic needs and long-term interests is also necessary. Education should cultivate feelings of solidarity and equity at the national and international levels in the perspective of a balanced and long-term development.

17. Strategies relating to education for peace, mercy, tolerance and disaster education must (a) be comprehensive and holistic, which means addressing a very broad range of factors; (b) be applicable to all types, levels and forms of education; (c) involve all educational partners and various agents of socialisation, including NGOs and community organisations; (d) be implemented locally, nationally, regionally and world-wide; (e) entail modes of management and administration, co-ordination and assessment that give greater autonomy to educational establishments so that they can work out specific forms of action and linkage with the local community, encourage the development of innovations and foster active and democratic participation by all those concerned in the life of the establishment; (f) be suited to the age and psychology of the target group and take account of the evolution of the learning capacity of each individual; (g) be applied on a continuous and consistent basis. Results and obstacles have to be assessed, in order to ensure that strategies can be continuously adapted to changing circumstances; (h) include proper resources for education as a whole and specially for marginalised and disadvantaged groups.

18. To strengthen the formation of values and abilities such as solidarity, creativity, civic responsibility, the ability to resolve conflicts by non-violent means, and critical acumen, it is necessary to introduce into curricula, at all levels, true education for citizenship which includes an international dimension. Teaching should particularly concern the conditions for the construction of peace; the various forms of conflict, their causes and effects; the ethical, religious and philosophical bases of human rights, their historical sources, the way they have developed and how they have been translated into national and international standards, such as in the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child; the bases of democracy and its various institutional models; the problem of racism and the history of the fight against sexism and all the

other forms of discrimination and exclusion. Particular attention should be devoted to culture, the problem of development and the history of every people, as well as to the role of the United Nations and international institutions. There must be education for peace, conflict resolution, non violence, mercy, compassion and tolerance. It cannot, however, be restricted to specialised subjects and knowledge. The whole of education must transmit this message and the atmosphere of the institution must be in harmony with the application of democratic standards. Likewise, curriculum reform should emphasise knowledge, understanding and respect for the culture of others at the national and global levels and should link the global interdependence of problems to local action. In view of religious and cultural differences, every country may decide which approach to ethical education best suits its cultural context.

19. All people engaged in educational action must have adequate teaching materials and resources at their disposal. In this connection, it is necessary to make the required revisions to textbooks to remove negative stereotypes and distorted views. International co-operation in producing textbooks could be encouraged. Whenever new teaching materials, textbooks and the like are to be produced, they should be designed with due consideration of new situations. The textbooks should offer different perspectives on a given subject and make transparent the national or cultural background against which they are written. Their content should be based on scientific findings. It would be desirable for the documents of United Nations institutions to be widely distributed and used in educational establishments, especially in countries where the production of teaching materials is proving slow owing to economic difficulties. Distance education technologies and all modern communication tools must be placed at the service of education for peace, non violence, mercy, compassion and tolerance.

20. It is essential for the development of education for peace, non violence, mercy, compassion and tolerance that reading and verbal and written expression programmes should be considerably strengthened. A comprehensive grasp of reading, writing and the spoken word enables citizens to gain access to information, to understand clearly the situation in which they are living, to express their needs, and to take part in activities in the social environment. In the same way, learning foreign languages offers a means of gaining a deeper understanding of other cultures, which can serve as a basis for building better understanding between communities and between nations.

21. Proposals for educational change find their natural place in schools and classrooms. Teaching and learning methods, forms of action and institutional policy lines have to make peace, non violence, mercy, compassion and tolerance both a matter of daily practice and something that is learned. With

regard to methods, the use of active methods, group work, the discussion of moral issues and personalised teaching should be encouraged. As for institutional policy lines, efficient forms of management and participation must promote the implementation of democratic school management, involving teachers, pupils, parents and the local community as a whole.

22. The reduction of failure must be a priority. Therefore, education should be adapted to the individual student's potential. The developments of self-esteem, as well as strengthening the will to succeed in learning, are also basic necessities for achieving a higher degree of social integration. Greater autonomy for schools implies greater responsibility on the part of teachers and the community for the results of education. However, the different development levels of education systems should determine the degree of autonomy in order to avoid a possible weakening of educational content.

23. The training of personnel at all levels of the education system: teachers, planners, managers, teacher educators has to include education for peace, non violence, mercy, compassion and tolerance. This pre-service and in-service training and retraining should introduce and apply *in situ* methodologies, observing experiments and evaluating their results. In order to perform their tasks successfully, schools, institutions of teacher education and those in charge of non-formal education programmes should seek the assistance of people with experience in the fields of peace, non violence, mercy, compassion and tolerance (politicians, jurists, sociologists and psychologists) and of the NGOs specialised in human rights, environment and disaster education. Similarly, pedagogy and the actual practice of exchanges should form part of the training courses of all educators.

24. Teacher education activities must fit into an overall policy to upgrade the teaching profession. International experts, professional bodies and teachers' unions should be associated with the preparation and implementation of action strategies because they have an important role to play in promoting a culture of peace among teachers themselves.

25. Specific strategies for the education of vulnerable groups and those recently exposed to conflict or in a situation of open conflict are required as a matter of urgency, giving particular attention to children at risk and to girls and women subjected to sexual abuse and other forms of violence. Possible practical measures could include, for example, the organisation outside the conflict zone of specialised forums and workshops for educators, family members and mass media professionals belonging to the conflicting groups and an intensive training activity for educators in post-conflict co-operation with governments whenever possible.

26. The organisations of education programmes for abandoned children, street children, refugee and displaced children and economically and sexually exploited children are a matter of urgency. It is equally urgent to organise special youth programmes laying emphasis on participation by children and young people in solidarity actions and environmental protection. In addition, efforts should be made to address the special needs of people with learning difficulties by providing them with relevant education in a non- exclusionary and integrated educational setting.

27. Furthermore, in order to create understanding between different groups in society, there must be respect for the educational rights of persons belonging to national or ethnic, religious and linguistic minorities, as well as indigenous people, and this must also have implications in the curricula and methods and in the way education is organised.

28. New problems require new solutions. It is essential to work out strategies for making better use of research findings, to develop new teaching methods and approaches and to improve co-ordination in choosing research themes between research institutes in the social sciences and education in order to address in a more relevant and effective way the complex nature of education for peace, non violence, mercy, compassion and tolerance. The effectiveness of educational management should be enhanced by research on decision-making by all those involved in the educational process (government, teachers, parents, etc.). Research should also be focused on finding new ways of changing public attitudes towards human rights, in particular towards women, and environmental issues. The impact of educational programmes may be better assessed by developing a system of indicators of results, setting up data banks on innovative experiments, and strengthening systems for disseminating and sharing information and research findings, nationally and internationally.

29. Tertiary / higher education institutions can contribute in many ways to education for peace, non violence, mercy, compassion and tolerance. In this connection, the introduction into the curricula of knowledge, values and skills relating to peace, human rights, justice, the practice of democracy, professional ethics, civic commitment and social responsibility should be envisaged. Educational institutions at this level should also ensure that students appreciate the interdependence of nations in an increasingly global society.

30. The education of citizens cannot be the exclusive responsibility of the education sector. If it is to be able to do its job effectively in this field, the education sector should closely co-operate, in particular, with the family, the

media, including traditional channels of communication, the world of voluntary organisations and NGOs.

31. Concerning co-ordination between school and family, measures should be taken to encourage the participation of parents in school activities. Furthermore, education programmes for adults and the community in general in order to strengthen the school's work are essential.

32. The influence of the media in the socialisation of children and young people is increasingly being acknowledged. It is, therefore, essential to train teachers and prepare students for the critical analysis and use of the media, and to develop their competence to profit from the media by a selective choice of programmes. On the other hand, the media should be urged to promote the values of peace, respect for human rights, democracy and tolerance, in particular by avoiding programmes and other products that incite hatred, violence, cruelty and disrespect for human dignity.

33. Young people who spend a lot of time outside school and who often do not have access to the formal education system, or to vocational training or a job, as well as young people doing their military service, are a very important target group of education programmes for peace, non violence, mercy, compassion and tolerance. While seeking improved access to formal education and vocational training, it is therefore essential for them to be able to receive non-formal education adapted to their needs, which would prepare them to assume their role as citizens in a responsible and effective way. In addition, education for peace, human rights and respect for the law has to be provided for young people in prisons, reformatories or treatment centres.

34. Adult education programmes where NGOs have an important role to play should make everyone aware of the link between local living conditions and world problems. Basic education programmes should attach particular importance to subject matter relating to peace. All culturally suitable media such as folklore, popular theatre, community discussion groups and radio should be used in mass education.

35. The promotion of peace will require regional co-operation, international solidarity and the strengthening of co-operation between international and governmental bodies, non-governmental organisations, the scientific community, business circles, industry and the media. This solidarity and co-operation must help the developing countries to meet their needs for promoting education for peace.

36. In the light of the information provided relating peace, mercy, tolerance and disaster education we must the following resolve :

i) Alarmed by the current rise in acts of intolerance, violence, terrorism, xenophobia, aggressive nationalism, racism, anti-semitism, exclusion, marginalisation and discrimination directed against national, ethnic, religious and linguistic minorities, refugees, migrant workers, immigrants and vulnerable groups within societies, as well as acts of violence and intimidation committed against individuals exercising their freedom of opinion and expression - all of which threaten the consolidation of peace, mercy, tolerance and disaster management efforts both nationally and internationally, and are obstacles to development.

ii) Resolving to take all positive measures necessary to promote peace, mercy and tolerance in our societies, because these are not only the cherished principles, but also a necessity for peace and for the economic and social advancement of all peoples.

iii) Mercy and Tolerance are respect, acceptance and appreciation of the rich diversity of our world's cultures, our forms of expression and ways of being human. It is fostered by knowledge, openness, communication, and freedom of thought, conscience and belief. Mercy and Tolerance are harmony in difference. These are not only a moral duty, but are also political and legal requirements. Mercy and Tolerance, the virtues that make peace possible, contribute to the replacement of the culture of war by a culture of peace.

iv) Mercy and Tolerance are not concession, condescension or indulgence. Mercy and Tolerance are, above all, active attitudes prompted by recognition of the universal human rights and fundamental freedoms of others. In no circumstance can these be used to justify infringements of these fundamental values. Mercy and Tolerance are to be exercised by individuals, groups and nations.

v) Mercy and Tolerance are the responsibility that upholds human rights, pluralism (including cultural pluralism), democracy and the rule of law. It involves the rejection of dogmatism and absolutism and affirms the standards set out in international human rights instruments.

vi) Consistent with respect for rights, the practice of mercy and tolerance does not mean toleration of social injustice or the abandonment or weakening of one's convictions. It means that one is free to adhere to one's own convictions and accepts that others adhere to theirs. It means accepting the fact that human beings, naturally diverse in their appearance, situation, speech, behaviour and values, have the right to

live in peace and to be as they are. It also means that one's views are not to be imposed on others.

vii) Mercy and Tolerance require just and impartial legislation, law enforcement, judicial and administrative processes. It also requires that economic and social opportunities be made available to each person without any discrimination. Exclusion and marginalisation can lead to frustration, hostility and fanaticism.

viii) In order to achieve a more tolerant society, nations should ratify existing international human rights conventions, and draft new legislation where necessary to ensure equality of treatment and of opportunity for all groups and individuals in society.

ix) It is essential for international harmony that individuals, communities and nations accept and respect the multicultural character of the human family. Without mercy and tolerance there can be no peace, and without peace there can be no development.

x) Intolerance may take the form of marginalization of vulnerable groups and their exclusion from social and political participation, as well as violence and discrimination against them. Declaration on Race and Racial Prejudice confirms 'All individuals and groups have the right to be different'.

xi) In the modern world, mercy and tolerance are more essential than ever before. It is an age marked by the globalisation of the economy and by rapidly increasing mobility, communication, integration and inter-dependence, large-scale migrations and displacement of populations, urbanisation and changing social patterns. Since every part of the world is characterised by diversity, escalating intolerance and strife potentially menaces every region. It is not confined to any country, but is a global threat.

xii) Mercy and Tolerance are necessary between individuals and at the family and community levels. Tolerance promotion and the shaping of attitudes of openness, mutual listening and solidarity should take place in schools and universities and through non-formal education, at home and in the workplace. The communication media are in a position to play a constructive role in facilitating free and open dialogue and discussion, disseminating the values of tolerance, and highlighting the dangers of indifference towards the rise in intolerant groups and ideologies.

xiii) Appropriate scientific studies and networking should be undertaken to co-ordinate the international community's response to this global challenge, including analysis by the social sciences of root causes and effective countermeasures, as well as research and monitoring in support of policy-making and standard-setting action by different countries

xiv) Education is the most effective means of preventing intolerance. The first step in mercy and tolerance education is to teach people what their shared rights and freedoms are, so that they may be respected, and to promote the will to protect those of others.

xv) Education for mercy and tolerance should be considered an urgent imperative; that is why it is necessary to promote systematic and rational mercy and tolerance teaching methods that will address the cultural, social, economic, political and religious sources of intolerance which are the major roots of violence and exclusion. Education policies and programmes should contribute to development of understanding, solidarity and tolerance among individuals as well as among ethnic, social, cultural, religious and linguistic groups and nations.

xvi) Education for mercy and tolerance should aim at countering influences that lead to fear and exclusion of others, and should help young people to develop capacities for independent judgement, critical thinking and ethical reasoning.

xvii) It is time to pledge to really support and implement programmes of social science research and education for mercy, tolerance, compassion, human rights and non-violence. This means devoting special attention to improving teacher training, curricula, the content of textbooks and lessons, and other educational materials including new educational technologies, with a view to educating caring and responsible citizens open to other cultures, able to appreciate the value of freedom, respectful of human dignity and differences, and able to prevent conflicts or resolve them by non-violent means.

xviii) It is essential that we commit ourselves to promoting mercy, tolerance as well as non-violence through programmes and institutions in the fields of education, science, culture and communication.

xix) In order to generate public awareness, emphasise the dangers of intolerance and disastrous actions and react with renewed commitment and action in support of tolerance promotion and education, pledge to design tailor made training programmes of short

as well as long duration in the areas of peace, mercy, tolerance, compassion, disaster education and related subjects.

xx) People should commit themselves to promote tolerance and non-violence through programmes and institutions by developing a neological as well as neocratic approach to governance and by designing a masterplan paradigm for peace on earth.

World Society, having emerged from the decades of the cold war, enjoyed for a short time the hopes that the end of this struggle was the beginning of an era in which the destructive consequences of that conflict and the deep divisions imposed by global economic inequities might be addressed. These hopes were sorely tested, however, by the eruption of regional conflicts and the hostilities between people which fragmented nations and drastically changed the political map of the world as it had been for nearly half a century. All over the globe, intergroup tensions, religious hostilities and ethnic conflicts have been erupting. Many long-standing conflicts previously overlooked have come to world attention.

Deep hatreds, some of which had previously healed over through reconciliations that permitted ethnic groups to live together in peace and cooperation have surfaced in social behaviour and political movements, and are voiced in the media and at conferences; communities exploded into warfare. The process of settling the disputes, reconciling the hostilities and reconstructing the societies will be one of the most difficult human society has ever undertaken. It may be one of the greatest challenges ever faced by those who seek to educate for peace. Educators should not shrink from facing the realities of history, nor can they avoid the responsibility to taking up the challenge posed by the reconciliation process to those who plan and carry out the social learning process.

Mercy and Tolerance are but the beginning, the first stage in a longer, deeper process of developing a culture of peace. It is the minimal essential quality of social relations that eschew violence and coercion. Without mercy and tolerance, peace is not possible. With mercy and tolerance, a panoply of positive human and social possibilities can be pursued, including the evolution of a culture of peace and the convivial communities that comprise it.

Religion has been a significant factor in the evolution of cultures, peace and nonviolence providing behavioural and social codes. Sadly, it has also been the basis of divisions, intolerance, war and conflict. As we have seen many man made disasters during last few years, teaching for religious tolerance has become an urgent necessity. We must identify a range of strategies and services to help both the perpetrators of violence and victims.

This will require of religious people repentance and humility : a recognition that we have hurt one another, we have misused religion to seek power over others, we have allowed institutional self-interest to hide the spiritual heritage entrusted to our care. Too easily we have passed fine resolutions, but failed to live by them ourselves. In this gathering it is we ourselves who need to change. This Global Assembly is a celebration and a thanks giving for all who have pioneered this work and enthused us with their dreams; but it is also a time of dedication, when strengthened by each other's encouragement, we shall commit ourselves to be used in the building of the new and spiritual world home, in which all people enjoy a fully human life.

It is hard to assess the impact that religious people can have on political processes, especially as politicians seldom acknowledge those who have influenced them. Modern communications have given added weight to popular opinion. Religious leaders may play an important role in forming public opinion. They can insist on the relevance of spiritual and moral considerations. They have helped to maintain public alarm at the enormous stockpile of nuclear weapons and other means of mass destruction. They have voiced public outrage at the starvation of millions of people, as a result of hunger, war, injustice and an unfair pattern of international trade. They have upheld human dignity and protested against torture and racism. They have underpinned efforts to develop internationally agreed standards of human rights and have helped to monitor their application.

In all religions there is an increase of extremism, which also alienates others from any religious allegiance. Religious differences sometimes enflame political and economic divisions and sometimes religion is exploited by the powerful as an instrument of social control.

It is easy to deplore intolerance – especially in others. It is harder to understand its causes, which may be psychological or related to a group feeling politically, culturally or economically marginalised. Intolerance may be caused by fear or ignorance or it may be based on exclusive claims to truth.

The educational task is still far from complete. Increasingly formal and non-formal training, teaching and research will become more practical with an emphasis on ways of cooperating to face urgent problems and to seek a global ethic or consensus on moral values. We should be trying to show that people of all religions and races can agree on the importance of peace, mercy, compassion and tolerance. Only together will prejudice and discrimination be removed, violence and injustice ended, poverty relieved and the planet preserved. In our contemporary world, we are very conscious of the persistence of injustice, war, hunger and environmental damage; and we are conscious too of the many ways in which religions can be use to perpetuate division and misunderstanding. Why not long for a world where men and women of faith strive to know and respect one another's beliefs and ways of life,

to work together for the common good of all, to build up a true world community from our diverse communities.

World Peace can be restored at the earliest if we propose the creation of an "Inter-religious Spiritual Forum for Cooperation with United Nations" with a view to having all the important religious leaders of different faiths for discussing and resolving to be compassionate, tolerant, humanitarian and good to others.

Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) has decided to assist and cooperate with all the schools, colleges and universities in the Afro-Asian as well as American continent region for designing curriculum as well as instructional materials related to peace, mercy, tolerance and disaster education.

Let us remember what we read in Upnishad – "From the unreal, lead me to the Real; From darkness, lead me to the Light; From death, lead me to Immortality".

## Chapter 8

# COMMUNITY COLLEGE SCHEME FOR SKILL DEVELOPMENT BY THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

A Community College is an alternative system of education and training aimed at the empowerment of the disadvantaged and the under-privileged (Urban Poor, Rural Poor, SC / ST Poor and Women) through appropriate skills development leading to gainful employment in association with the local industry and the community and achieve skills for employment and self employability of the above sections of people in the society. It is an innovative educational and training alternative that is rooted in the community providing holistic education and eligibility for employment to the disadvantaged.

The Vision of the Community College (CC) is to be of the Community, for the Community and by the Community and to produce responsible citizens. The Community College (CC) promotes job oriented, work related, skill-based and life coping education and training. This initiative is in conformity with the Indian political will that prioritises in education, primary education, information technology education and vocational education.

The key words of the Community College system are access, flexibility in curriculum and teaching methodology, cost effectiveness and equal opportunity in association with industrial, commercial and service sectors of the local area and responding to the social needs and issues of the local community, internship and job placement within the local area, promotion of self employment and small business development, declaration of competence and eligibility for employment.

The ideas and the objectives behind the establishment of the Community Colleges are the following:

i) To suggest the establishment of the Community Colleges as an Alternative System in India.

ii) To prove as to how it will help towards the positive performance in assisting the Community and the beneficiaries, the trainees and the parents by either providing gainful employment to the trainees or by making them entrepreneurial leaders.

iii) To provide inputs to exploit the untapped resources in the industrial establishments, factories, hotels, hospitals and other enterprises.

iv) To assess the needs of the school dropouts and others to enable them acquire the necessary skills for livelihood and formal qualifications for social status and societal recognition.

v) To consolidate the experiences of existing Community Colleges in different countries.

vi) To prepare a blueprint and policy framework for the establishment of the Community College all over the Country under the aegis of different Universities.

**HISTORY OF COMMUNITY COLLEGES IN INDIA**

The concept of the Community College in India was conceived by the young scientists and educational entrepreneurs Dr. Priya Ranjan Trivedi and Dr. Uttam Kumar Singh in the year 1985 when the then Ministry of Welfare, Government of India allocated funds under the Special Component Plan specially for the training of scheduled caste communities. Accordingly the first Community College was established at Mandar Vidyapith in the foothills of Mandar Parvat in Bihar followed by the second Community College at Patna under the aegis of Dr. Zakir Husain Institute for Non-Formal and Continuing Education with a view to rehabilitating the young boys and girls belonging to the scheduled caste community. The funds of the Central Government were routed through the State Department of Industries for the establishment of training cum production cum rehabilitation centres.

The Community College Movement further got strengthened in South India in October 1995 with the beginning of the Pondicherry University Community College. It was taken forward by the Inauguration of the Madras Community College by the Archdiocese of Mylapore - Mylapore in August 1996. It was strengthened by the Manonmaniam Sundaranar University, Tirunelveli, by giving approval to five Community Colleges in September 1998. It spread to Andhra Pradesh with the starting of JMJ Community College in Tenali in July 1999. It also now spread to many States and Union Territories. The Government of India should help establish and implement the project with a minimum of 1000 National Community Colleges with a view to developing the skills of young boys and girls in the country at the earliest.

The Community College, envisaged by Dr. Priya Ranjan Trivedi is an alternative system of education, training and development with a view to empowering the disadvantaged and the underprivileged through appropriate skills development leading to gainful employment in collaboration with the local industry and the community and to achieve skills for employment and self employability of the above sections of people in the society. It is an innovative educational alternative that is rooted in the community providing holistic education and eligibility for employment to the disadvantaged.

Out of the students getting enrolled in the primary school, only about 30 percent are found in middle school and about 16 percent in high / higher secondary schools of children in the age group 6-11 years. About 90-95 percent enroll in primary school, at the secondary stage, that is, age group 11-15 years, only 48 percent continue and at the higher secondary stage, that is, age group 15-17 years, only about 24 per cent are found to pursue studies. In the age group 17 to 23, only about eight percent are in the higher educational institutions. From these statistics, we can see that roughly, about 50 per cent of students drop out at every stage, in the school. The questions that arise are, what happens to all those youth who drop out of the educational system between the age group 11-17 years? This was what got published in The Hindu Newspaper on 26 July 2002.
Though 63.04 lakh students get admitted in 31,052 schools across the State of Tamilnadu, the dropout ratio is almost 36 percent by the time they get to high school of which 90 percent are girls. Around 48 lakh 'non-school going' children (in the 6-14 age group) are in Tamilnadu, according to The New Indian Express dated 9 January 2022.

Let us examine whether the Community Colleges can help generate employment:
Let us suggest Community College in India as an Alternative System in India.

Let us prove how it has helped towards the positive performance in assisting the Community and the beneficiaries, the student and the parents through an objective evaluation of the existing Community Colleges.

Let us provide inputs to exploit the untapped resources namely industrial establishments, factories, etc.

Let us assess the needs of the school dropouts and others to enable them acquire the necessary skills for livelihood and formal qualifications for social status and societal recognition.

Let us consolidate the experiences of existing Community Colleges

Let us prepare a blueprint and policy framework for the establishment of Community Colleges all over the Country.

The Community Colleges should be established by non-profit making, non-commercial and community based organisation with proven years of service to the local community. The establishment of the Community Colleges should be preceded by an extensive Need Analysis of the employment opportunities available in the local area and also the social needs of the Community. The Target group of the Community Colleges is $10^{th}$ passed students, school drop out, rural youth, rural women, existing workforce that wants to update its skills and all who want skill based and need based education at an affordable price.
There is no age limit for admission into a Community College. The close and active linkage between Industries and Community College is a must for the success of the Community College System. The industrial partners help the College in designing the curriculum, providing part time instructors, serving as members of the Advisory Board and the Governing Board, taking students for internship and helping them to find job placement. The Community College is a Multi-campus reality. The Community is permitted to the optimum utilisation of the existing Infrastructural facilities available to the community-based organisation that establishes the Community College.

The Community College tries to respond to the deficiencies of the Vocational system through industry-institutional linkage, competence assessment, proper certification, training on site, life skills training and job oriented programmes decided on the basis of the local needs. It is in the above areas that the Community College is an improvement and departure from earlier initiatives such as it is Community Polytechnics and apprenticeship training. The curriculum of the Community College has four distinct parts: life skills, work skills, internship and preparation for employment. The Certificate programmes for the school dropouts consists of 300 hours of training, the Diploma programmes of 400 hours of training, and the Advanced Diploma programmes consists of 500 hours for the $10^{th}$ and $12^{th}$ passed students and all others who want skill-based education. The evaluation and assessment of skills done by the Community College has four dimensions: self-assessment, assessment by the life skills and work skills teachers and internship supervisor at the works spot.

Need Analysis is the backbone of the Community College. It is considered to be the Gospel of the Community College. The Community College is established on the firm footing and foundation of the thorough Need Analysis of the Employment and Self-Employment Opportunities in the Local Area.

There has been a lot of struggle in discovering the relevant and the needed curriculum to be given to the students of the Community Colleges. So, what is offered as the Curriculum taught in the Community Colleges is a result of the

collective search and it is based on the actual teaching experience of many of the Community College Teachers.

The Curriculum of a Community College for a Job oriented Certificate / Diploma / Advanced Diploma programme. Given below is a suggested course outline: Duration of the programme is for 300-500 hours and it has 4 distinct Parts.

Part – I Life Skills
Part – II Work Skill
Part – III Internship and Hands on Experience
Part – IV Preparation for Employment and Evaluation

- Depending on the learning level of the target groups in the local areas, the College could conduct classes from the minimum of Three Hours (for part timers) to maximum of Six Hours per day (for full timers).
- The curriculum for every Job-Oriented Programme should be designed in collaboration with the practitioners of the Industry / Commerce / Service Agriculture / Rural Sectors.

- The College should help the students to attain their Entry-Level Skills required for the Job-Oriented Programmes.

- For the Certificate Courses, the Life Skills should be compulsory and the duration of the Work skill course could be modified according to the job requirements.

- For all the students of the Community College whatever might be their specialised programmes, Courses on Life Skills are mandatory.

- It is advisable to have 25 to 30 students maximum for skills – development in specific Job-Oriented Programmes.

- The presence Job Placement Cell and Placement Officer is a must in every Community College for effective internship training and subsequent Job Placement.

**PART I - LIFE SKILLS**
**PART II - WORK SKILLS**
**PART III - INTERNSHIP AND HANDS ON EXPERIENCE**
**PART IV - PREPARATION FOR EMPLOYMENT**
**AND EVALUATION**
**TOTAL NUMBER OF CREDITS**
**One Credit = 30 Hours of work.**

The Evaluation and Assessment of the Skills of the incumbents of the Community College is completely internal and done by the Community College with the help of technical and field experts. The evaluation is aimed at the testing of the skills rather than the absorption of information. The evaluation is jointly done by the Life Skill Instructor, Work Skills Instructor, Industrial Supervisor supplemented by the self-assessment of the student of the Community College, thus making the evaluation comprehensive and purposeful, determining the attainment of skills.

The knowledge and skills components should be given equal weightage. This evaluation is to be continuous, transparent and should contain checks and balances within the system to ensure credibility.

The Certificate / Diploma / Advanced Diploma is issued by the Community College. The transcripts may also be issued under the joint signatures of the University Authorities, the Director of the Community College and the Industry Partner where the actual training has been provided.

The Community College cannot succeed without the active participation and collaboration of the industrial, rural, agricultural, commercial and service organisations of the locality. The above sectors come to assist the Community College in the following five ways.

- Designing the curriculum for various job oriented courses.
- Serving as members of the Advisory Board.
- Being part time instructors for teaching and assessment in the College.
- On the job training for the students in the work place.
- Job placement for students who have been trained in the Community Colleges.
- Memorandum of Understanding (MoU) could be signed with the industries for all the above five areas of collaboration.
- A few representatives from the above sectors industrial, commerce and service sectors could also serve as the Members of the Governing Body of the College.

The Community College ensures that the participation of the members of the agency that establishes the Community College, Administrators, Industrial Partners, Community Leaders, Consultants to the Community College etc.

The authorities of the College make sure of the proper management of Life Skills, Work Skills, Placement for Training, Financial and General Administrative matters and also the needed infrastructural facilities necessary for training.

The Community Colleges should decide to: include the Excluded; give the Best to the least; match Education with Employment; have close Linkage with Industries;

ensure the participation of the Community and the Development of Skills and Competencies; enhance the employability of the poor and the marginalised; respond to the dynamism of the Community College Movement in India; provide a resource centre with books and study materials; help in the process of curriculum development; have training Programmes for the Community College teachers and administrators; evolve methods of evaluation and assessment of skills; publish books and articles; popularise the concept all over the country; help in the preparation of Community Colleges; document the process and evolution of the Community College Movement; influence the State and Central Governments; recognise and accept the Community College System as an educational alternative; replicate the model all over the country; enter into International networking of Community Colleges in USA, UK, Germany, Australia, South Africa and Canada.

The unique feature of Community College System is the training given for Life Coping Skills. The Life Coping Skills that have proved beneficial to the students are transformative skills that have added value to the personhood and given them a definite focus and praise direction in their lives such as an understanding of theirselves, management of stress and time, skills in community. Problem solving and decision making increased in theirself confidence and self esteem, a clear understanding of goals leading to self motivation and basic computing skills and ability to communicate with reasonable fluency in English. It has also developed in them Coping Skills such as coping with anger, sexuality, loneliness, failure, shyness, criticism, etc.

The trainees have learnt a few useful skills to help them in the work environment like Pre School Teacher, Computer Software, Office Management, Nursing Assistant, Automobile Technology including Repairing of Two Wheelers, Three Wheelers and Four Wheelers.

Since the selection of right Industrial Partners is an important factor in the overall success of the Community College Movement. The following criteria is used by the Community Colleges for selecting the Industrial Partners:

- Willingness of the Industrial Partners
- Willingness to allow girls to work in order to gain experience.
- Safety, distance and accessibility to the work spot.Experience in Work skills.
- Sharing of vision for the poor
- Interested to train the trainees
- Commitment for Job placements in their Companies
- Having good infrastructure.
- Good Trainers concerned with the upliftment of the students
- Frequency of the visits of the industrial Partners to the College
- Serving as the Members of the Advisory Board
- Ready to provide apprenticeship training

- Skill based training
- Helping in the Designing the Curriculum
- Part time instructors
- Allowing the trainees to work with advanced equipments
- Authorised Service Centres

The Governing Body of the Community College should have a few Industrial Partners as its members. The entire system is kept going by the qualified life skills, work skill staff and guest faculty. The Advisory Board for each of the course should be in place in every College. The Colleges must send their trainees for internship for at least two months. Planning, Monitoring, Evaluation, Training and Placement all should be done by the Community College. The Community College must improve the living standards of those who are excluded and uplift the downtrodden. They should also update the courses every year with the experts from different fields.

The Colleges need to access the need of the various potential employers. As Community College awards the Certificates, these are fully professional qualifications. Professional Enrichment Workshop and sharpening the teaching skills and ways to improve industrial collaboration should be explored.
The problem of school dropouts can be handled by the Community Colleges by providing them multi–skills since they already have the experience – 8th Passed and below $10^{th}$. These trainees can be given Certificate courses.
The model of the Community College system would be replicated all over the country even one College in 650 Districts of the country.
The Community College should try to address the deficiencies in the vocational educational system in the following manner:

i) It is aiming at the employability of the individual trained.
ii) It is evolving a system to declare the competency level and duly certify the same.
iii) It is promoting strong Industry–Institutional linkage and ties. It involves the Industry to articulate the skills it wants and works in close collaboration with the industries, to make the individuals skill oriented that is needed by the employer.
iv) It emphasizes the teaching of life skills, communication skills and English to the takers of the system.
v) The Community College System certainly lessens the burden on higher education.
vi) It is evolving a system of evaluation and assessment of skills, which are personal, social, language, communication, work and creativity.

The various components of the Life Skills Programme such as Life Coping Skills, Communication Skills, English, Basic Computing Skills preparation for

employment could be included in the whole stream of vocational education with the expertise of the Community College and by training teachers of vocational schools. There is a need to promote active industrial partnership with agencies like the Indian Chamber of Commerce, Confederation of Indian Industry etc. in order to stabilise the internship and job placement.

The same Life Skills could be introduced as an integral component to the Arts and Science college students to enhance their employability.

The whole movement has been a non-governmental initiative. Hence the Governments could provide external support through awarding of scholarship and stipends to the deserving students.

This help could come from the following Ministries / Departments of the Central and / or the State Governments:

a) Rural Development
b) Social Justice and Empowerment / Welfare
c) Health and Family Welfare
d) Women and Child Development
e) Youth Welfare and Sports
f) The Quasi Government Organisations
g) Public Sector Agencies to ensure placements
h) Ministry of Tribal Affairs
i) Ministry of the Development of North Eastern Region
j) Ministry of Science and Technology
k) Ministry of Human Resource Development

Our country has come to a point of no return when we have unemployment, peacelessness, insurgency, pollution, poverty, greed and population explosion.

The Community College under the auspices of the leading and statutory training authorities should decide to solve the above mentioned problems by creating environment friendly and sustainable jobs by developing skills of the young boys and girls with a view to generating employment besides having a competent cadre of entrepreneurial leaders so that we may prove that India very soon will have more number of job givers rather than job seekers.

The Community College should vocationalise the careers of young boys and girls from all States and Union Territories in general through training in the areas of vocational and skill development.

A Community College is generally a type of educational institution basically for catering to the growing needs of the community members including young and old men and women who have less facilities for undergoing postsecondary and tertiary

education and who are wanting to settle themselves by acquiring specialised skills for seeking jobs or for becoming entrepreneurs.

The term can have different meanings in different countries.

## COMMUNITY COLLEGES IN AUSTRALIA

Community Colleges in Australia carry on the tradition of adult education, which was established in Australia around mid 19th century when evening classes were held to help adults enhance their numeracy and literacy skills. Today, courses are designed for personal development of an individual and/or for employment outcomes. The educational programme covers a variety of topics such as arts, languages, business and lifestyle; and are usually timetabled to be conducted in the evenings or weekends to accommodate people working full-time. Funding for Community Colleges may come from government grants and course fees; and most Community Colleges are not-for-profit organisations. There are Community Colleges located in metropolitan, regional and rural locations of Australia.

Learning offered by Community Colleges has changed over the years. By the 1980s many colleges had recognised a community need for computer training and since then thousands of people have been up-skilled through IT courses. The majority of colleges by the late 20th century had also become Registered Training Organisations; recognising the need to offer individuals a nurturing, non-traditional education venue to gain skills that would better prepare them for the workplace and potential job openings. Qualifications such as undergraduate degrees and higher are not offered at Community Colleges, though some Community Colleges do offer Certificate and Diploma courses.

## COMMUNITY COLLEGES IN CANADA

In Canada, the 150 institutions that are the rough equivalent of the US Community College are usually referred to simply as "Colleges" since in common usage a degree granting institution is, almost, exclusively a university. In the province of Quebec, even when speaking in English, colleges are called Cégeps for Collège d'enseignement général et professionnel, meaning "College of General and Vocational Education". (The word College can also refer to a private High School in Quebec).

Colleges are educational institutions providing higher education and tertiary education, granting Certificates, and Diplomas. Associate's degrees and Bachelor's Degrees are granted by universities, but, in some courses of study, there may be an agreement between colleges and universities to collaborate on the education requirements toward a degree. Only in Western Canada is the term Associates degree used as in the United States. In other parts of Canada a degree is usually

attained as a 4 year study programme, and to a much lesser degree now (except in Quebec, where it is the norm), in 3 years.

Each Province has its own Educational system reflecting the decentralisation of the Canadian provinces and therefore of the Education system. However most of the colleges began in the mid-1960s as a response education and training for the then emerging baby boom generation, and to provide training to the post second World War II European immigrants and newer immigrants from around the world, that were starting to enter the country.

The motivation for Community Colleges was a new way of thinking about education and training in Canada (more specifically in Ontario), and was economically based as opposed to the much earlier start in the United States of Junior and Community Colleges which was driven by an integrative social policy. Some programmes are still economically based, as to the needs of the area, province and country. All programmes are reviewed regularly, or every few years for relevancy. Programmes and courses are changed, added or deleted according to projected economic future, while many programmes are relatively stable and have been around as long as the colleges, such as various business administration programmes.

**COMMUNITY COLLEGES IN INDIA**

The HRD Ministry along with the University Grants Commission (UGC) is currently working on a proposal to start as many as 200 Community Colleges in the country within the next one year to "address skill shortage".

They are likely to be based on the Community College model in the United States. A team of Education Ministers from seven States, led by Madhya Pradesh's Education Minister Shri Laxmikant Sharma, visited the US to understand the model. The team submitted a review report in May 2012. All States have been asked to submit concrete proposals to the Ministry. The Cultural Attaché for Education and Exchanges at the US Embassy in New Delhi, Stephanie Forman Morimura, said, "We've been supportive and encouraging of the Indian interest in implementing a Community College system that's right for India. As Secretary of State Hillary Clinton said in her recent speech at the US-India Higher Education Dialogue, 'I believe Community Colleges are one of the reasons, often unheralded, that the United States has been so successful'."

In the US, Community Colleges provide an important additional layer of education where students can learn practical skills and get the theoretical knowledge to continue on to university if they like.

In the mean time, Dr. P R Trivedi has decided to establish 1000 National Community Colleges. He has envisaged a five-year Action Plan for launching

different types of skill development numbering 1800 vocational and employment centric skills in association with the existing institutions in the country including NGOs, ITIs, Colleges, Schools, Residents Welfare Associations, Geriatric Care Centres, Hospitals, Nursing Homes, Health Care Centres, Farmers, Civil, Mechanical, Electrical, Electronics, Instrumentation, Fashion, Media, Textiles, Chemical, Cosmetological, Tourism and Travel, Paramedical, Printing, Food Processing, Agriculture, Animal Husbandry, Hydropower Engineering related organisations etc.

## Chapter 9

# SKILL DEVELOPMENT COURSES UNDER THE COMMUNITY COLLEGE SCHEME ADVOCATED BY AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) has been successful in designing the following skill based training programmes with a view to generating employment in all the countries under Asian, African and American continents :

### AGRICULTURE AND ALLIED SERVICES

0001 : Basic Tractor Servicing
0002 : Basic Cultivation of Cereal Crops
0003 : Basic Cultivation of Spices
0004 : Repair, Maintenance and Operation of Energy Equipment
0005 : Repair, Maintenance and Field Operation of Tillage Equipment
0006 : Repair and Maintenance of Irrigation Equipment
0007 : Repair, Maintenance and Field Operation of Soil Farming Equipment
0008 : Repair, Maintenance and Field Operation of Seed Drills
0009 : Repair, Maintenance and Field Operation of Planters
0010 : Repair Maintenance of Harvesting and Threshing Equipment
0011 : Repair, Maintenance and Field Operation of Root Harvesting Equipment
0012 : Repair and Maintenance of Spraying and Dusting Equipment
0013 : Repair and Maintenance of Tyre Tube
0014 : Repair and Maintenance of Radiator
0015 : Repair and Overhauling of Tractor
0016 : Repair, Maintenance and Operation of Power Tiller
0017 : Repair and Overhauling of Hydraulic System
0018 : Repair Maintenance and Operation of Post Harvesting Equipment
0019 : Repair, Maintenance and Operation of Combine Harvester
0020 : Repair, Maintenance and Operation of Processing Equipment
0021 : Repair, Maintenance and Field Operation of Land Shaping & Develop Machinery
0022 : Custom Hiring of Agriculture Machinery

0023 : Cultivation of Oil Seeds and Pulses
0024 : Cultivation of Vegetables
0025 : Cultivation of Orchards with Special Reference to Citers
0026 : Cultivation of Potato
0027 : Cultivation of Cotton
0028 : Cultivation of Groundnut and Sunflower
0029 : Cultivation of Fodder
0030 : Landscaping and Floriculture
0031 : Fruit Cultivation
0032 : Seed Production
0033 : Mushroom Cultivation
0034 : Apiary
0035 : Bio Fertilizer
0036 : Medicinal Plants
0037 : Agro Forestry
0038 : Vermiculturing and Vermicomposting
0039 : Preservation of Fruits and Vegetables
0040 : Gardeners
0041 : Entrepreneurship Development in Agri Business

**ACCOUNTING, BANKING AND FINANCE**

0042 : Accounting
0043 : Banking Associate
0044 : Banking Sales Representative
0045 : Mutual Fund Associate

**ANIMAL HUSBANDRY AND MEET PROCESSING**

0046 : Pultry Farming
0047 : Sheep and Goat Rearing
0048 : Dairy Farming
0049 : Dairy Development Worker
0050 : Entrepreneurship on Dairy Management
0051 : Bird Handler (Lifter)
0052 : Driver for Transporting Birds
0053 : Slaughterman – Poultry Slaughter House
0054 : Poultry Dresser
0055 : Meat Handler (Poultry Slaughter House)
0056 : Meat Processor (Poultry Slaughter House)

0057 : By-Product Handler and Processor (Poultry Slaughter House)
0058 : Lairage Assistant and Animal Grader
0059 : Humane Slaughter
0060 : Slaughter Man - Buffalo
0061 : Pig Slaughter Man
0062 : Sheep and Goat Slaughterer
0063 : Carcass Dresser
0064 : Pig Carcass Dresser
0065 : Carcass Handler
0066 : Blood Collectector
0067 : Cleaner of Slaughter Equipments
0068 : Sanitation and Disinfectant Assistant
0069 : Pest Control Operator
0070 : By-Product Handler and Processor (Slaughter House)
0071 : Piggery Farm Assistant
0072 : Sheep Farm Assistant / Attendant
0073 : Clinical Assistant / Animal Attendant
0074 : Cattle Attendant / Dairy Cattle Assistant
0075 : Cow Boy
0076 : Animal Handler
0077 : Animal Groomers
0078 : Animal Care Givers
0079 : Kennel Attendants
0080 : Pet Sitters
0081 : Animal Shoer
0082 : Syces of Horses
0083 : Dog Breeder Assistant
0084 : Aviary Assistants
0085 : Snake Catcher
0086 : Post Mortem Assistants
0087 : Cow Milker-Grade 1
0088 : Animal Food Preparation Assistant
0089 : Pet Taxi Driver
0090 : Animal Assessor and Ante Mortem Inspector
0091 : Feeder in Dairy Farm
0092 : Cow Milker – Grade 2
0093 : Veterinary Hospital Attendant

0094 : Dog Breeder

0095 : Driver for Transporting – Birds, Pets and Large Ruminants, Small Ruminants and Pigs.

0096 : Vaccinator

0097 : Dystocia Assistant

0098 : Castration Assistant

0099 : Herd Man

0100 : Pre Slaughter Care Supervisor

0101 : Meat Processor

0102 : Dairy Farm Assistant

0103 : Meat Inspectors Assistant

0104 : Meat Handler – Fabrication of Carcass-Chilling-Freezing

0105 : Artificial Insemination Service Provider

**APICULTURE**

0106 : Basic Bee Keeping Assistant

0107 : Colony Multiplication Assistant in Bee Keeping

0108 : Beehive Products, Honey Collector and Producer

0109 : Attender of Bee Diseases, Pests, Predators and Enemies

0110 : Bee Hive Manufacturer

**ARTIFICIAL FLOWERS DESIGN AND TECHNOLOGY**

0111 : Artificial Flowers Kits Maker

0112 : Sateen Flowers Maker

0113 : Polyester Flowers Maker

0114 : Japanese Ribbon Flowers Maker

0115 : Stocking Flowers Maker

0116 : Cotton Flower Maker

0117 : Artificial Flower Arrangement (Free Style) Maker

**AUTOMOBILE REPAIR**

0118 : Basic Automotive Servicing (4 Wheelers)

0119 : Basic Automotive Servicing (2-3 Wheelers)

0120 : Repair and Overhauling of 2 Wheelers (Moped)

0121 : Repair and Overhauling of 2 Wheelers (Scooter)

0122 : Repair and Overhauling of 2 Wheelers (Motr Cycle)

0123 : Repair and Overhauling of 3 Wheelers

0124 : Repair and Overhauling of Engine Systems (Petrol/Diesel)

0125 : Repair and Overhauling of Classic System (Light Vehicle)

0126 : Repair and Overhauling of Classis System (Heavy Vehicle)
0127 : Repairing of Auto Air Conditioning System
0128 : Wheel Alignment and Balancing
0129 : Minor Repair of Auto Body
0130 : Auto Body Painting
0131 : Diesel Fuel Injection Technician
0132 : Repair and Overhauling of Auto Electrical and Electronic System
0133 : Bicycle and Tricycle Repair
0134 : Sun Control Film Fixing
0135 : Driver cum Peon

**BAMBOO FABRICATION**

0136 : Bamboo Processing
0137 : Mechanic for Bamboo Machineries
0138 : Secondary Processing of Bamboo
0139 : Bamboo Construction
0140 : Bamboo Handicraft and Furniture Making
0141 : Mat Weaving

**BEAUTY SCIENCES, HAIR DRESSING AND COSMETOLOGY**

0142 : Basics of Beauty and Hair Dressing
0143 : Massage Therapist
0144 : Make up Artist
0145 : Facial Therapist
0146 : Hair Stylist
0147 : Hair Colorist
0148 : Hair Cutting Specialist
0149 : Beauty Therapist
0150 : Hair Therapist

**BUSINESS INCLUDING HR / MARKETING TRAINING**

0151 : Small Office / Home Office Coordinator
0152 : Junior Marketing Associate
0153 : Junior Human Resource Associate
0154 : Junior Finance Associate
0155 : Small Office / Home Office Entrepreneur
0156 : Marketing Associate

0157 : Human Resource Associate
0158 : Finance Associate

**BRASSWARE AND ALLIED SCIENCES**

0159 : Basic Art of Engraving
0160 : Basic Art of Etching
0161 : Advanced Art of Engraving

**CARPET TECHNOLOGY**

0162 : Hand Knotted Woolen Carpet Manufacturing
0163 : Tibetan Carpet Manufacturing
0164 : Flat Woven Durries Manufacturing
0165 : Hand Spinning of Woolen Carpet Yarn
0166 : Hand Spinning of Cotton Carpet Yan
0167 : Hand Tufted Carpet Manufacturing
0168 : Hand Tufted Carpet Manufacturing
0169 : Broadloom Carpet Manufacturing
0170 : Carpet Yarn Dyeing
0171 : Carpet Finishing
0172 : Hand Knotted Silk Carpet Manufacturing
0173 : Natural Fibers for Carpets
0174 : Manufacture of Fabric related to Carpet
0175 : Spinning of Woolen Carpet Yarn
0176 : Entrepreneurship and Export Management
0177 : Spinning of Cotton Carpet Yarn
0178 : Carpet Backing
0179 : Carpet Yarn Dyeing with Natural Dyes
0180 : Carpet Finishing
0181 : Designing of Fabric related to Carpet
0182 : Modern Carpet Yarn Manufacturing
0183 : Carpet Designing CAD
0184 : Fundamentals of I.T. & its Application in Carpet Industry

**CHEMICAL TECHNOLOGY**

0185 : Safety and General Awareness in Chemical Industry
0186 : Process Attendant Chemical Plant
0187 : Mechanical Operation Attendant in Chemical Plant
0188 : Maintenance Attendant Chemical Plant
0189 : Instrument Attendant Chemical Plant

0190 : Lab Attendant (Chemical Plant)
0191 : Industrial Chemical Manufacturing Attendant
0192 : Heat Transfer Equipment Attendant (Chemical Plant)
0193 : Mass Transfer Equipment Operator
0194 : Maintenance of Pumps & Valves (Chemical Plant)
0195 : Industrial Chemical Manufacturing Assistant
0196 : Maintenance and Repairs of Pressure, Flow, Temperature & Level Instruments
0197 : Advance Instrumentation and Control Attendant

**CLOCK AND WATCH REPAIR**

0198 : Basic Clock and Watch Repair
0199 : Basic Clock Repair – Analog and Digital
0200 : Automatic Watch Repair

**CONSTRUCTION TECHNOLOGY**

0201 : Assistant Shuttering Carpenter and Scaffolder
0202 : System Shuttering Carpenter
0203 : Conventional Shuttering Carpenter
0204 : Scaffolder
0205 : Building Carpenter
0206 : Assistant Bar Bender and Steel Fixer
0207 : Bar Bender
0208 : Assistant Mason
0209 : Mason
0210 : Tiler (Ceramic)
0211 : Assistant Plumber
0212 : Plumber
0213 : Assistant Works Supervisor
0214 : Assistant Storekeeper
0215 : Junior Land Surveyor
0216 : Works Supervisor
0217 : Storekeeper
0218 : Senior Land Surveyor
0219 : Junior Rural Road Layer
0220 : Work Supervisor
0221 : Storekeeper
0222 : Senior Land Surveyor

0223 : Junior Rural Road Layer
0224 : Assistant Highway Works Supervisor
0225 : Highway Works Supervisor
0226 : 3D Designer Using ProE
0227 : 3D Advanced Designer Using ProE
0228 : Construction Electrician-I
0229 : Construction Electrician-II
0230 : Construction Electrician-III
0231 : Building Security System Mechanic
0232 : Rigger
0233 : Electrical Wireman
0234 : Control Panel Assembler
0235 : Electrical Fitter
0236 : Overhead Linesman
0237 : Cable Jointer (Power)
0238 : Communication System Mechanic
0239 : Refrigeration/Art Conditioning/Ventilation Mechanic (Electrical Control)
0240 : Fire Services Electrical Fitter
0241 : Construction Electrician – IV
0242 : Helper
0243 : Earth Work Excavator
0244 : Granite Stone Dresser – I
0245 : Granite Stone Dresser – II
0246 : Granolithic Flooring Mason

**COURIER AND LOGISTICS MANAGEMENT**

0247 : Loader
0248 : Courier
0249 : Driver cum Courier
0250 : Office Assistant
0251 : Operation Supervisor / Executive
0252 : Marketing / Channel (Vendor / Franchise) / Sales Executive

**CERAMIC ART AND CRAFT**

0253 : Basic Ceramic Work (Dolls/Flowers/Fruits) Maker
0254 : Pot Ceramic Work Maker
0255 : Wall Ceramic Work Maker

0256 : Wood Ceramic Work Maker
0257 : Chinese Ceramic Work Maker
0258 : Japanese Ceramic Work Maker
0259 : Miniature Ceramic Work Maker
0260 : Fruits Ceramic Work Maker
0261 : 3D Ceramic Work Maker

**ELECTRICAL ENGINEERING**

0262 : Basic Electrical Training
0263 : Repair of Home Appliance
0264 : House Wiring
0265 : Electronic Choke and CFL Assembling
0266 : Transformer Winding
0267 : Armature Winding
0268 : Rewinding of AC/DC Motors
0269 : Repair of Electrical Power Tools
0270 : Maintenance of Batteries
0271 : Power Transmission Line Tower Erection
0272 : Power Transmission Line Stringing

**ELECTRONICS ENGINEERING**

0273 : Basic Electronics (Repair and Maintenance of Power Supply, Inverters and UPS)
0274 : Installation and Maintenance of DTH System
0275 : Digital Videography (Editing and Mixing)
0276 : Repair and Maint. of Washing Machine and Microwave Oven
0277 : Repair and Maintenance of TV Receiver
0278 : Maintenance and Repair of Electronic Test Equipment
0279 : Repair and Maintenance of Cellular Phone
0280 : Repair and Maintenance of Intercom System
0281 : Installation and Maintenance of Electronic Equipments in Cell Phone Towers
0282 : Repair and Maintenance PA & Audio Systems
0283 : Repair and Maintenance Photocopier and Fax Machine
0284 : Operation of Clinical Equipment
0285 : Operation of ECG and ICCU Instruments
0286 : Maintenance of ECG and ICCU Equipment
0287 : Operation of X-Ray Machine and Dark Room Assistance

0288 : Maintenance of X-Ray Machine
0289 : Operation of Physiotherapy Equipment
0290 : Maintenance of X-Ray Machine
0291 : Operation of Physiotherapy Equipment
0292 : Maintenance of Physiotherapy Equipment

**ELECTRO-MECHANICAL SCIENCES**

0293 : Junior Assistant – Elevator Installation
0294 : Assistant Elevator Installer
0295 : Elevator Installer

**ENVIRONMENT AND POLLUTION CONTROL**

0296 : Nursery Development
0297 : Environmental Education
0298 : Repair and Maintenance of Pollution Control Equipment
0299 : Disaster Preparedness
0300 : Vermicomposting
0301 : Social Forestry
0302 : Horticulture and Pomology
0303 : Floriculture

**FABRICATION TECHNOLOGY**

0304 : Basic Welding (Gas)
0305 : Basic Welding (Arc)
0306 : Gas Cutting
0307 : TIG Welding
0308 : MAG / CO2 Welding
0309 : Fabrication Welding
0310 : Pipe Welding (TIG and ARC)
0311 : Basic Fitting Work
0312 : Basic Sheet Metal Work
0313 : Structural Fabrication
0314 : Pipe Fabrication

**FAST MOVING CONSUMER GOODS**

0315 : FMCG Sales Representative
0316 : Consumer Packaged Goods (CPG) Marketing Representative
0317 : Supermarket Sales Assistant
0318 : Destination Management Representative

## FASHION DESIGN AND TECHNOLOGY

0319 : Assistant Fashion Sales Representative
0320 : Assistant Showroom Sales Representative
0321 : Assistant Fashion Merchandiser
0322 : Showroom Sales Executive
0323 : CAD Illustrator – Fashion Designing
0324 : Apparel Ornamentalist - Grade I
0325 : Fashion Designer – Grade I
0326 : Batik Printing Specialist
0327 : Tie and Dye Specialist
0328 : Block Printer
0329 : Fashion Entrepreneur
0330 : Formal Wear Designer - Grade I
0331 : Casual Wear Designer – Graded I
0332 : Gown Designer – Grade I
0333 : Ethnic Wear Designer – Grade I
0334 : Theatre Costume Designer – Grade I
0335 : Summer and Winter Wear Designer – Grade I
0336 : Beach Wear Designer – Grade I
0337 : Fashion Accessories Designer
0338 : Fashion Sales Representative
0339 : Textile Designer – Grade - I

## FOOD PROCESSING AND PRESERVATION

0340 : Basic Food Preservation
0341 : Baker and Confectioner
0342 : Milk and Dairy Products Making Assistant
0343 : Agro Products Maker
0344 : Food Beverages Making Assistant
0345 : Processed Food Products Making Assistant
0346 : Fruits and Vegetables Processor
0347 : Fruits and Vegetables Processor
0348 : Cereals, Pulses and Oilseeds Processor (Milling and Baking)
0349 : Food Beverage Maker
0350 : Milk and Milk Products Maker
0351 : Meat, Fish and Poultry Processor

**FISHERIES AND ALLIED SECTORS**

0356 : Fishing Operation
0357 : Aquarium Fabrication and Maintenance
0358 : Operation, Maintenance and Repair of Fishing Boat Engines
0359 : Crab Culture and Fattening
0360 : Fish Feed Preparation
0361 : Breeding of Ornamental Fish
0362 : Breeding of Carps
0363 : Fish Boat Building
0364 : Multiplication of Aquatic Ornamental Plant
0365 : Operation and Maintenance of Marine Refrigeration Equipment
0366 : Mussel Culture
0367 : Shrimp Hatchery
0368 : Shrimp Farming
0369 : Fish Processing
0370 : Preparation of Value Added Seafood Product

**FILM PRODUCTION AND ALLIED WORKS**

0371 : Clap Person
0372 : Continuity Person
0373 : Art Assistant – 1
0374 : Art Assistant – 2
0375 : Dubbing Artist
0376 : Make Up Artist
0377 : Script Assistant
0378 : Lyric Writer
0379 : Dialogue Writer
0380 : Film Press Relations Officer–1 (Publicity Offices / Centres / Digital Design Studios)

**FRAGRANCE, FLAVOUR AND PERFUMERY**

0381 : Perfume Blender
0382 : Perfumer
0383 : Perfume Tester
0384 : Distillation Unit Operator
0385 : Fractional Distillation Operator
0386 : Solvent Extraction Operator
0387 : Aroma Chemical Assistant

0388 : Processing Assistant

**GEM AND JEWELLERY**

0389 : Gem Cutting Assistant

0390 : Foundation Course for Jewellery

0391 : Rubber Mould Packing, Vulcanizing, Mould Cutting, Course Wax Injection and Tree

0392 : Casting

0393 : Basic Stone Setting

0394 : Advanced Stone Setting

0395 : Pave Stone Setting

0396 : Enameling

0397 : Basic Metal Model Making

0398 : Advanced Metal Model Making

0399 : Embossing

0400 : Finishing and Polishing of Jewellery Pieces

0401 : Manual Jewellery Design

0402 : Jewellery CAD Design using Rhinoceros

0403 : Jewellery CAD Design using Matrix

0404 : Advanced Jewellery CAD Design Using Matrix

0405 : Diamond Grading (Revised)

0406 : Cut Deisgning

0407 : Cut Optimisation and Analysis

0408 : Jewellery in Organised Retail Management

0409 : International System of Diamond Grading

0410 : Jewellery Sales Personnel

0411 : Assistant Designer

0412 : Production Assistant

0413 : Gem Appraisal Assistant

0414 : Jewellery Designer

0415 : Production Supervisor

0416 : Gemologist

0417 : Quality Control Assistant

0418 : Assistant Assorter (Commercially used Gemstones)

0419 : Sales Executive (Gems and Jewellery)

**GLASSWARE AND ALLIED SCIENCES**

0420 : Kiln Formed Glass

0421 : Design with Glass (Assistant)
0422 : Glass Batch Maker
0423 : Glass Ball Maker
0424 : Glass Cutting and Polishing
0425 : Glass Painting
0426 : Glass Toy Making
0427 : Sand Blasting of Glass
0428 : Annealing Oven / Lehr Operator
0429 : Glass Furnance Operator

**HANDMADE PAPER AND ALLIED PRODUCTS**

0430 : Manufacturing of Envelopes
0431 : Manufacturing of Donnas and Plates
0432 : Manufacturing of Cup and Tumbler
0433 : Segregator (Raw Material Sorting)
0434 : Rag Chopper
0435 : Pulp Beater
0436 : Agitator – Pulp QC
0437 : Agitator – Pulp QC
0438 : Mould Vat Operator
0439 : Sheet Formation of Vat (Dipping)
0440 : Sheet Formation of Auto-Vat (Lifting)
0441 : Hydraulic Press Operator
0442 : Dryer
0443 : Calendaring Operator
0444 : Paper Cutter
0444 : Packer
0445 : Material Organiser / Helper
0446 : Fabricator / Folder
0447 : Fabricator / Assembler
0448 : Fabricator / Skinner
0449 : Fabricator / Aligner
0450 : Packer (M/C)
0451 : Fabricator / Sculpture
0452 : Fabricator / Template Maker
0453 : Fabricator / Specks Designer
0454 : Marketing Assistant

## INFORMATION AND COMMUNICATION TECHNOLOGY

0456 : Computer Fundamentals, MS-Office and Internet
0457 : Tally
0458 : Desk Top Publishing
0459 : Telecom Sales
0460 : Computer Hardware
0461 : Computer Networking
0462 : Domestic BPO
0463 : Internet Kiosk Operators
0464 : Web Designing
0465 : 2D Pre-Production Animator
0466 : 3D Animation Production
0467 : Fundamentals of JAVA Programming Languages-SL110
0468 : BPO Non Voice Business Training
0469 : BPO Voice Business Training
0470 : 3D-Visualisation in Architecture
0471 : Architectural and Civil 2D-Drafting with AutoCAD
0472 : Classical Animation
0473 : Advanced 3D Animation Production
0474 : Print Publishing
0475 : Web Publishing
0476 : UNIX (R) Essentails Featuring of SOLARIS TM 10 Operating System
0477 : E-Commerce-Start an On Line Business
0478 : LINUX Operating System
0479 : Mechanical Drafting & Modelling with Autodesk Inventor (includes AUTOCAD)
0480 : Architectural Drafting and 3D Design with Autodesk Revit
0481 : Advanced Web Publishing
0482 : System Administration for the SOLARIS TM 10 Operating
0483 : Advanced Architectural Drafting and 3D Design with Auto Desk Revit
0484 : Behavioural Basics
0485 : Advanced Behavioural Basics
0486 : JAVA Programming Language – SL 275 (Advance)
0487 : Software Testing
0488 : Interactive Media Design
0489 : Character Animation
0490 : Clean Up for 2D Animation

0491 : In Betweening for 2D Animation
0492 : Ink and Paint for 2D Animation

**INSURANCE MANAGEMENT**

0493 : Insurance Sales Advisor
0499 : Senior Sales Person (Non Life Insurance)
0500 : Senior Sales Person (Life Insurance)
0501 : Insurance Sales Associate

**IMITATION JEWELLERY**

0502 : Imitation Jewellery Kit Maker
0503 : Kundan Jewellery Maker
0504 : Kundan Jewellery Set Maker
0505 : Temple Jewellery Set Maker
0506 : Bridal Jewellery Set Maker
0507 : Gujarati Jewellery Set Maker

**JUTE TECHNOLOGY**

0508 : Mazdoor
0509 : Root Cutter, Heckler cum Selector
0510 : Jute Spreader / Softener (Feeder / Receiver / Pliers)
0511 : Breaker / Teaser Card Feeder
0512 : Finisher Card Receiver cum First Drawing Feeder
0513 : Jute Drawing Operator
0514 : Spinner / Twister
0515 : Silver Feeder / Bobbin Shifter
0516 : Spool Winder
0517 : Cop Winder
0518 : Pre-Beamer
0519 : Beamer / Dresser
0520 : Weaver
0521 : Weaver – Modern Shuttleness Looms
0522 : Damping / Calendar / Lapping Operator
0523 : Cutting Machine Operator
0524 : Sewer
0525 : Press Operator
0526 : Jute Braided Products Maker

0527 : Jute Footwears Maker
0528 : Weaver
0529 : Dyer
0530 : Designer cum Maker of Fabric Bags
0531 : Designer cum Maker Decorative Items

**KHADI AND VILLAGE INDUSTRIES**

0532 : Spinning on New Model Charkha
0533 : Plain Weaving on Frame Loom
0534 : Advance Spinning (Woolen)
0535 : Advance Spinning (Cotton and Muslin)
0536 : Advance Spinning (Silk)
0537 : Advance Weaving (Woolen)
0538 : Advance Weaving (Silk)
0539 : Advance Weaving (Cotton / Polyvastra)

**LEATHER AND SPORTS GOODS MANUFACTURING**

0540 : Leather and Rexene Goods Maker
0541 : Manufacturing Process of Leather
0542 : Leather Garments Maker
0543 : Leather Goods Maker (Travels)
0544 : Leather Footwear and Sports Shoes Maker
0545 : Pattern and Template Maker (Leather and Sports)
0546 : Pattern and Template Maker (Leather Shoe & Leather Sports Shoes)
0547 : Leather Goods Salesman
0548 : Leather Goods Supervisor / Administrator
0549 : Leather Footwear Machine Operators (Closing)
0550 : Leather Footwear Machine Operators (Clicking)

**MATERIALS MANAGEMENT**

0551 : Store Attendant
0552 : Material Handling
0553 : Finish Goods Keeper
0554 : Assistant Storekeeper
0555 : Storekeeper
0556 : Manufacturing of Envelopes
0557 : Manufacturing of Donnas and Plates
0558 : Manufacturing of Cup and Tumbler

0559 : Segregator (Raw Material Sorting)
0560 : Rag Chopper
0561 : Pulp Beater
0562 : Agitator – Pulp QC
0563 : Mould Vat Operator
0564 : Sheet Formation on Vat (Dipping)
0565 : Sheet Formation on Auto-Vat (Lifting)
0566 : Hydraulic Press Operator
0567 : Dryer
0568 : Calendaring Operator
0569 : Paper Cutter
0570 : Packer
0571 : Material Organiser / Helpler
0572 : Fabricator / Folder
0573 : Fabricator / Assembler
0574 : Fabricator / Glue Coater
0575 : Fabricator / Skinner
0576 : Fabricator / Aligner
0577 : Packer (M/C)
0578 : Fabricator / Sculpture
0579 : Fabricator / Specks Designer
0580 : Marketing Assistant

**MARINE ENGINEERING**

0581 : Basic Marine Mechanic
0582 : Marine Engine Mechanic
0583 : Valve Mechanic
0584 : Pump and Pumping System Mechanic
0585 : Ship Air Conditioning System Mechanic
0586 : Duck Machineries Mechanic
0587 : Propeller and Shaft Mechanic

**MEDIA MANAGEMENT**

0588 : Digital Camera Photography
0589 : Videography
0590 : Mass Communication
0591 : Digital Audio Recording
0592 : Lighting Assistant

0593 : Assistant Video Editor

**MEHANDI MAKING**

0594 : Mehandi Maker
0595 : Colour Mehandi Maker
0596 : Kundan Colour Mehandi Maker

**PAINT AND WARNISH**

0597 : Painter Assistant / Helper
0598 : Wall Painter
0599 : Wood Painter
0600 : Metal Surface Painter
0601 : Spray Painter
0602 : Painter (Application, Testing, Handling and Storing)

**PAINTING TECHNOLOGY**

0603 : Nib Painting Maker
0604 : Tube Painting Maker
0605 : Cone Painting Maker
0606 : Deco-Painting Maker
0607 : Ceco-Ceramic Painting Maker
0608 : Zaso Painting Maker
0609 : Tanjore Painting Maker
0610 : Emboss Painting Maker
0611 : Glass Painting Maker
0612 : Nirmal Painting Maker
0613 : Nirmal Gold Painting Maker
0614 : Nirmal Painting on Cream Board Maker
0615 : Nirmal Emboss Painting Maker

**POLYPATHIC, ENERGETIC AND COMPLEMENTARY THERAPIES**

0616 : Absent Healing
0617 : Active Imagery
0618 : Acupressure
0619 : Acupuncture
0620 : Adlerian Therapy
0621 : Aerial Therapy
0622 : Agnihotra
0623 : Aikido Therapy

0624 : Akabane
0625 : Alexander Technique (Better Posture)
0626 : Alphabiotics
0627 : Anabolic Treatment
0628 : Antineoplaston Therapy
0629 : Anthrosophical Medicine
0630 : Apitherapy
0631 : Applied Kiesiology
0631 : Armouring
0632 : Aromatherapy
0633 : Art Therapy
0634 : Asklepios
0635 : Astropathy
0636 : Aston Patterning
0637 : Aura - Soma
0638 : Aura Therapy
0639 : Auricular Therapy
0640 : Autogenic Training
0641 : Autosuggestion
0642 : Aversion Therapy
0643 : Ayurveda
0644 : Adventure Therapy
0645 : Animal-assisted Therapy
0646 : Authentic Movement
0647 : Bach Remedies
0648 : Bates Method (Improving Eyesight)
0649 : Behavioural Therapy
0650 : Biochemic
0651 : Bio-Ching
0652 : Bioenergetics Therapy
0653 : Biofeedback
0654 : Biorhythms
0655 : Bioharmonics
0656 : Bio-Transmission
0657 : Biodynamic Massage
0658 : Biomagnetic Therapy
0659 : Bowen Technique

0660 : Brain Training Therapy
0661 : Brief Therapy
0662 : Buteyko
0663 : Bibliotherapy
0664 : Cell Therapy
0665 : Chanting
0666 : Charismatic Healing (Prayer)
0667 : Chi Gung
0668 : Chi Kung
0669 : Chiropody
0670 : Chiropractic (Pain Relieving)
0671 : Chinese Herbalism
0672 : Chelation Therapy
0673 : Chinese Martial Arts
0674 : Clinical Ecology
0675 : Coenzyme Q10
0676 : Cognitive Therapy
0677 : Coin Rubbing
0678 : Colour Therapy
0679 : Colonic Irrigation
0680 : Colonic Hydro Therapy
0681 : Colour Illumination Therapy
0682 : Colloidal Siver Therapy
0683 : Consegrity
0684 : Conscientiotherapy
0685 : Conybio FIR (Ear Infra Red)
0686 : Copper Therapy
0687 : Co-Counselling
0688 : Coverts Sensitisation
0689 : Cranial Osteopathy
0690 : CranioSacral Therapy
0691 : Crisis Intervention
0692 : Cromopathy
0693 : Crystal Therapy
0694 : Cupping
0695 : Cymatics
0696 : Cytotoxic Therapy (Tumor Cell Modulation)

0697 : Coherance Therapy
0698 : Conversion Therapy
0699 : Counselling Therapy
0700 : Dance Movement Therapy
0701 : Deep Muscle Therapy
0702 : Deep Tissue Therapy
0703 : Dermovision
0704 : Diet Therapy
0705 : Doctrine of Signatures
0706 : Dr. Fritz's - "Energy Healing"
0707 : Dolphin-assisted Therapy
0708 : Douching Therapy
0709 : Dowsing Therapy
0710 : Do-In Therapy
0711 : Distructotherapy
0712 : Dialectical Behavioural Therapy
0713 : Diversional Therapy
0714 : Drama Therapy
0715 : Dyadic Developmental Psychotherapy
0716 : Ear Candling Therapy
0717 : Ecological Medicine
0718 : Electro Therapy
0719 : Electro-Convulsive Therapy
0720 : Electro Homeopathy
0721 : Electro Mignative Therapy
0722 : Electicism Therapy
0723 : Electrodermal Screening
0724 : Emmotional Freedom Technique
0725 : Eurhythmy
0726 : Erotic Healing
0727 : Energetic Medicine
0728 : Entony
0729 : Enzymatic Therapy
0730 : Equine Massage
0731 : Existential Therapy
0732 : External Beam Radition Therapy
0733 : Eye Movement Desensitisation

0734 : Eyology
0735 : Equine-assisted Therapy
0736 : Facilitated Communication
0737 : Facial Diagnosis
0738 : Faith Healing
0739 : Family Therapy
0740 : Fasting
0741 : Feldenkrais Method
0742 : Feng-Shui
0743 : Fire Therapy
0744 : Floatation Therapy
0745 : Fluoridation Therapy
0746 : Flooding (Implosion)
0747 : Focal Psychodynamic Therapy
0748 : Folk Medicine
0749 : Footbath
0750 : Fronteir Medicine
0751 : Fruits and Vegetable Therapy
0752 : Galacto Therapy
0753 : Gem Essence Therapy
0754 : Gene Therapy
0755 : Grif Therapy
0756 : Geomancy
0757 : Gerson Therapy
0758 : Gestalt Therapy
0759 : Group Therapy
0760 : Group Psychotherapy
0761 : Guasha
0762 : Hair Transmission Therapy
0763 : Hair Analysis
0764 : Haelan Therapy
0765 : Halographic Repatterning
0766 : Hakomi
0767 : Harpatopathy
0768 : Hellerwork
0769 : Herbal Medicine
0770 : Heroic Medicine

0771 : Helio Therapy
0772 : Hilarious Laughter Therapy
0773 : Homeopathy
0774 : Holistic Medicine
0775 : Hora Diagnosis
0776 : Hormonal Therapy
0777 : Humanistic Psychology
0778 : Hydro Therapy
0779 : Hyperthermia (Heat Therapy)
0780 : Hyperbaric Oxygen Therapy
0781 : Hippotherapy
0782 : Hypno Therapy
0783 : Immunopathy
0784 : Inhalation Therapy
0785 : Integrative Medicine
0786 : Intuitive Healing
0787 : Inner and Self Healing
0788 : Insight Therapy
0789 : Internal Radiation Therapy (Brachytherapy)
0790 : Ionisation Therapy
0791 : Iridology
0792 : Ichthyotherapy
0793 : Immunosuppressive Therapy
0794 : Information Therapy
0795 : Interpersonal Therapy
0796 : Interavenous Therapy
0797 : Isopathic Treatment
0798 : Jin Shin Do
0799 : Jin Shin Jyutsu
0800 : Jogging
0801 : J J Dechane'sHarbo Mineral Therapy
0802 : Jungian Therapy (Analytical Psychology)
0803 : Joy Touch
0804 : Kahuna Bodywork
0805 : Kahune
0806 : Kanpo
0807 : Kinesiology

0808 : Kirlian Photography
0809 : Kinesiology
0810 : Keni's Charismatic Karishma
0811 : Laughter Therapy
0812 : Laetrile Therapy
0813 : Liquorice
0814 : Light Therapy
0815 : Life Coaching
0816 : Life Enrichment Therpay
0817 : Lomi Lomi
0818 : Logo Therapy
0819 : Lymphatic Pumping
0820 : Macrobiotics
0821 : Manipulative Therapy
0822 : Martial Arts Therapy
0823 : Manual Lymph Drainage
0824 : Manual Therapy
0825 : Massage Therapy
0826 : Magical Thinking
0827 : Magneto Therapy
0828 : Maintenance Therapy
0829 : Meso Therapy
0830 : McTimoney Chiropractic
0830 : Meditation
0831 : Medical Aromatherapy
0832 : Medau Movement
0833 : Megavitamin Therapy
0834 : Melos's Medicare
0835 : Mentastics
0836 : Meridian Investigation
0837 : Mesmerism
0838 : Metamorphic Technique
0839 : Metabolic Typing
0840 : Metabolic Therapy
0841 : Miasm Theory
0842 : Moxibustion
0843 : Mud Therapy

0844 : Muscoskeletal Therapy
0845 : Music Therapy
0846 : Myofascial Therapy
0847 : Naturopathy
0848 : Narrative Therapy
0849 : Neuropathy
0850 : Neuro-linguistic Programming
0851 : Neurofeedback Therapy
0852 : Norris Technique
0853 : Nosode
0854 : Nutritional Testing
0855 : Nutritional Therapy
0856 : Nyasa Healing
0857 : Occupational Therapy
0858 : Ortho Bionomy
0859 : Orthodics
0860 : Orgone Therapy
0861 : Osteopathy / Skull Osteopathy
0862 : Orthomolecular Therapy
0863 : Oxygen / Ozone Therapy
0864 : Past Life Therapy
0865 : Pilates
0866 : Phage Therapy
0867 : Pharmaco Therapy
0868 : Physical Therapy
0869 : Physio Therapy
0870 : Play Therapy
0871 : Polarity Therapy
0872 : Poison Therapy
0873 : Positive Thinking Therapy
0874 : Primal Therapy
0875 : Progressive Relaxation
0876 : Prolotherapy
0877 : Psionics
0878 : Psionic Medicine
0879 : Psycho Therapy
0880 : Psychoanalytic Psychotherapy

0881 : Psychopharmaco Therapy
0882 : Pulse Diagnosis
0883 : Pyramid Power
0884 : Qigong
0885 : Radio Therapy
0886 : Radionics
0887 : Rational Emotive Therapy
0888 : Reality Therapy
0889 : Recrational Therapy
0890 : Reflexology
0891 : Reichian Therapy
0892 : Reiki
0893 : Reinforcement Therapy
0894 : Rogerian Therapy
0895 : Respiratory Therapy
0896 : Rolfing
0897 : Sand Play Therapy
0898 : Sand Tray Therapy
0899 : Sauna Bath
0900 : Sea Water Treatment
0901 : Sclerology
0902 : Seiki
0893 : Seitai
0894 : Sex Therapy
0895 : Shamanism Testing
0896 : Shen Therapy
0897 : Shiatsu
0898 : Shruti Chikitsa
0899 : Shock Therapy
0900 : Sitz Bath
0901 : Silva Method
0902 : Socio Therapy
0903 : Somatography
0904 : Sonopuncture
0905 : Sound Therapy
0906 : Spas
0907 : Speech Therapy

0908 : Spiritual Healing
0909 : Stool Therapy
0910 : Sleep Therapy
0911 : Surgery
0912 : Sun Therapy
0913 : Sweat Therapy
0914 : Systemic Therapy
0915 : Tai-Chi-Chuan (Meditation in Motion)
0916 : Tanra Mantra Yantra Therapy
0917 : Thai Massage
0918 : Thalassotherapy
0919 : Therapentic Touch
0920 : The Bower Technique
0921 : The Journey
0922 : Theatre Therapy
0923 : Thought Field Therapy
0924 : Tibetan Medicine
0925 : Tongue Diagnosis
0926 : Touch Therapy
0927 : Toyochari
0928 : Tragerork
0929 : Transpersonal Therapy
0930 : Transcendental Meditation
0931 : Transmission Therapy
0932 : Transactional Therapy
0933 : Trepanation
0934 : Trigger Point and Myotherapy
0935 : Tuina
0936 : Turkish Bath
0937 : Ultrasound Therapy
0938 : Unani or Tibbi Hikmat
0939 : Urine Therapy
0940 : Vibration Therapy
0941 : Visualisation Therapy
0942 : Visceral Manipulation
0943 : Voice Therapy
0944 : Wheat Grass Therapy

0945 : Writing Therapy
0946 : Yoga
0947 : Zen/Zen Garden (Buddhist Path to Self-Discovery)
0948 : Zero Balancing
0949 : Zone Therapy

**PRINTING TECHNOLOGY**

0950 : Basic for Printing Sector (Except Book Binding)
0951 : Basic Book Binding
0952 : Screen Printing
0953 : Book Binding
0954 : Offset Machine Operator – Sheet Fed (Single and Multi Colour)
0955 : Offset Plate Maker
0956 : DTPO
0957 : Advanced / Supervisory (Except Book Binding)
0958 : Advanced Supervisory (Book Binding)

**PLASTICS ENGINEERING**

0959 : Basic Fitting and Measurement
0960 : Basic Electrical Joints and Fitting
0961 : Plastic Mould Assistant for Injection Moulding
0962 : Plastic Mould Assistant for Extrusion Moulding
0963 : Plastic Mould Assistant for Blow Moulding
0964 : Auto Plastic Mould Assistant (Injection Moulding)
0965 : Auto Plastic Mould Assistant (Compression Moulding)
0966 : Auto Plastic Mould Assistant (Extrusion Moulding)
0967 : Auto Plastic Mould Assistant (Blow Moulding)

**PROCESS INSTRUMENTATION**

0968 : Instrumentation Panel Fabrication and Installation of Pipe Line
0969 : Process Instrumentation Machinery and Equipment Mechanic
0970 : Maintenance of Recorders, Transmitters and Installation
0971 : Repair and Maintenance of Pressure Gauge Installation
0972 : Repair and Maintenance of Temperature Measuring Instruments Installation
0973 : Repair and Maintenance of Level Measuring Instruments Installation
0974 : Repair and Maintenance of Flow Measuring Instruments

**PRODUCTION ENGINEERING**

0975 : Turning
0976 : Advance Turning
0977 : Milling
0978 : Advance Milling
0979 : Surface Grinding
0980 : Cylindrical Grinding
0981 : CNC Turning
0982 : CNC Milling
0983 : Basics of Forging Technology and Process
0984 : Die Manufacturing, Inspection of Die and Handling
0985 : Advanced Forging Technology and Heat Treatment
0986 : Basic Mechanical Drafting
0987 : Advanced Mechanical Drafting

**POULTRY, HATCHERY AND BROILER FARMING**

***(Broiler Farming)***

0988 : Cleaning Assistant – Cleaning of Shed
0989 : Brooding Assisatn-I-Preparation of Brooding Room
0990 : Feeding Assistant – Poultry Worker
0991 : Bio Security Assistant Poultary Worker – Bio Sedcurity and Disinfections
0992 : Assistant Poultry Worker – Outbreak and Crisis Management
0993 : Poultary Assistant – Carcass, Debris, Waste & Litter Disposal
0994 : Broiler Disposal and Selling Assistant
0995 : Vaccination Assistant
0996 : Records Assistant / Writer

***(Layer Farming)***

0997 : Cleaning Assistant – Cleaning of Shed
0998 : Brooding Assistant-I-Preparation of Brooding Room
0999 : Feeding Assistant – Poultry Worker
1000 : Bio Security Assistant Poultry Worker – Bio Security and Disinfections
1001 : Assistant Poultry Worker – Outbreak and crisis Management
1002 : Poultry Assistant – Carcass, Debris, Waste and Litter Disposal
1003 : Medication Assistant
1004 : PM Assistant
1005 : Supervisor (Vaccinations and Debeaking)

***(Poultry)***

1006 : Egg Selling Assistant

1007 : Raw Material Warehouse Assistant

1008 : Feed Mixing Assistant

1009 : Premix Assistant

1010 : Disease Prevention Bio Security Supervisor (Terminal Cleaning)

***(Hatachery)***

1011 : Hatchery Operations Assistant

1012 : Poultry Bio Security Assistant

1013 : Hatchery Operations Supervisor

***(Breeding)***

1014 : Brooder House Assistant

1015 : Selection and Culling Assistant

1016 : Healthcare Service Assistant

1017 : Inseminators

1018 : Poultry Farm Supervisor

***(Brassware)***

1019 : Basic Art of Engraving

1020 : Basic Art of Etching

1021 : Advanced Art of Engraving

**RAIN WATER HARVESTING**

1022 : Assistant Rain Water Harvester

1023 : Rain Water Harvester

**REFRIGERATION AND AIR CONDITIONING**

1024 : Basic Refrigeration and Air Conditioning

1025 : Repair and Maintenance of Refrigerators and Deep

1026 : Service and Maintenance of Water Cooler and Bottle Cooler

1027 : Repair and Maintenance of Air Conditioner

1028 : Repair and Maintenance of Car Air Conditioning Unit

1029 : Service and Maintenance of Air Conditioning Plant

**RETAIL TRADE AND MANAGEMENT**

1030 : Sales Person (Retail)

1031 : Senior Sales Person (Retail)

1032 : Retail Operations

1033 : Sales Person (Door to Door)

**RENEWABLE ENERGY**

1034 : Basic of Solar Electricity
1035 : Solar Hot Water Tank Technician
1036 : Grooving and Collar Making Operator
1037 : Puffing and Tank Cleaner
1038 : Packer (Total Solar Water Heater System
1039 : Repair and Maintenance of Alternate Energy Resource Equipment
1040 : Solar Heater and Solar Cooker System
1041 : Solar Lighting System
1042 : Small Power Generation by using Water
1043 : Solar Electric System Installer and Service Provider
1044 : Solar Hot Water System Installer (Domestic System up to 200L) – Including Servicing

**SECURITY AND SAFETY AND FIRE MANAGEMENT**

1045 : Personal Security Guard
1046 : Industrial Security Guard
1047 : Event/Conference Security Guard
1048 : Security Guard (General)
1049 : Security Guard (General) and Personal Security Guard
1050 : Security Guard (General) and Event Conference Security Guard
1051 : Security Guard (General) and Event/Conference Security Guard
1052 : Assistant Security Officer Incharge : Security (General) : Industrial Security : Event / Conference Security

**SWEETS, SNACKS AND FOOD TECHNOLOGY**

1053 : Attendant-Ethnic Indian Sweets, Snacks and Food
1054 : Assistant Craftsman-Bengali Sweets
1055 : Assistant Craftsman-Ghee Based Sweets
1056 : Craftsman-Ghee Based Sweets
1057 : Assistant Craftsman-Kaju and Dry Fruits Based Sweets
1058 : Craftsman-Kaju and Dry Fruits Based Sweets
1059 : Assistant Craftsman – Milk and Khoa Sweets
1060 : Craftsman-Milk and Khoa Sweets
1061 : Assistant Craftsman – Namkeens and Savouries
1062 : Craftsman – Namkeens and Savouries

1063 : Assistant Craftsman – Indian Snacks
1064 : Craftsman – North Indian Food
1065 : Assistant Craftsman – South Indian Food
1066 : Craftsman – South Indian Food
1067 : Assistant Craftsman – Indian Chinese Food
1068 : Craftsman – Indian Chinese Food
1069 : Assistant Craftsman – Continental Food
1070 : Craftsman – Continental Food
1071 : Assistant Craftsman – Indian Chat
1072 : Craftsman – Indian Chat
1073 : Assistant Craftsman – Retail Counter Indian Chat
1074 : Craftsman – Retail Counter Indian Chat
1075 : Assistant Craftsman – Retail Counter Indian Sweets
1076 : Craftsman – Retail Counter Indian Sweets
1077 : Assistant Craftsman – Retail Counter Restaurant
1078 : Craftsman – Retail Counter Restaurant
1079 : Assistant Craftsman – Indian Desserts
1080 : Craftsman – Indian Desserts
1081 : Assistant Craftsman – Indian Syrups and Thandai
1082 : Craftsman – Indian Syrups and Thandai
1083 : Assistant Craftsman – South Indian Snacks
1084 : Craftsman – South Indian Snacks
1085 : Assistant Craftsman – Bengali Sweets

**SOFT SKILLS / ENGLISH CONVERSATION / PERSONALITY DEVELOPMENT**

1086 : Soft Skills for Base Line Staff in Service Sector
1087 : Spoken English and Communication Skill
1088 : Soft Skills for Front Line Assistant
1089 : Soft Skills for Supervisors

**SPA AND WELLNESS MANAGEMENT**

1090 : Spa Therapist – I
1091 : Spa Therapist - II

**SHIP CONSTRUCTION TECHNOLOGY**

1092 : Junior Shipwright Assistant
1093 : Junior Shipwright

1094 : Assistant Shipwright
1095 : Shipwright

**TAILORING AND GARMENT TECHNOLOGY**

1096 : Hand Embroider
1097 : Machine Embroidery Operator
1098 : Garment Packer
1099 : Garment Ironer
1100 : Tailor (Basic Sewing Operator)
1101 : Maintenance of Machines in Garment Sectors
1102 : Computerised Embroidery Machine Operator
1103 : Garment Cutter
1104 : Garment Checkers
1105 : Skilled Sewing Operators
1106 : Tailor Children
1107 : Tailor Ladies
1108 : Tailor Gent's
1109 : Tailor Suits
1110 : Numbering Helper
1111 : Panel Checker
1112 : Sorter
1113 : Issuer – Cutting Section
1114 : Fusing Operator
1115 : Bit Layer
1116 : Re Layer
1117 : Feeding Helper
1118 : Production Writer
1119 : Sewing Helper
1120 : Data Entry Operator
1121 : Finishing Helper
1122 : Feeding Helper
1123 : Stock Keeper – Parts Bank Asistant
1124 : Document Assistant
1125 : Stationary Assistant
1126 : Stock Distributor
1127 : Stock Keeper
1128 : Trim Quality Checker

1129 : Assistant Fabric Checker
1130 : Cutting Quality Controller
1131 : Loader and Unloader
1132 : Office Assistant
1133 : Visual Display Assistant
1134 : Printing Asssitant
1135 : Helper Washing
1136 : Fabric Checker
1137 : Sampling Tailor
1138 : Kaza (Button Hole) and Button Operator
1139 : Final Checker _ Finishing Checker
1140 : Spot Washer
1141 : Heat Sealer / Heat Transfer Printing Machine Operator
1142 : Darner
1143 : Production Coordinator
1144 : Data Collection Operator – Costing
1145 : Printing Operator – Screen Printing
1146 : Printing Operator – Hand Roller
1147 : Washing Machine Operator
1148 : Hydro-Extractor Operator
1149 : Denim Washing Operator
1150 : Logistic Clerk
1151 : Cutter – Bank Knife / Bladed Cutting
1152 : Gerber Cutting Machine Operator
1153 : CAD Operator
1154 : Re-Cutter
1155 : Printing Operator – MHM Machine
1156 : Curing Machine Operator
1157 : Colour Mixer – Printing
1158 : Stone Wash Machine Operator
1159 : Sand Wash Machine Operator
1160 : Bio Polishing Machine Operator
1161 : Sand Blasting Machine Operator
1162 : Grinding Machine Operator
1163 : Nicking Operator
1164 : Mud Wash Operator
1165 : Gerber Mechanic

1166 : Fabric Quality Inspector / Sourcing Farbic QC
1167 : Mechanic – Garment Machines (Sewing Machines)
1168 : Mechanic General
1169 : Assistant Finishing Supervisor
1170 : Assistant System Controller
1171 : Finishing Supervisor
1172 : System Controller
1173 : Training Instructor
1174 : Junior Executive
1175 : Senior Executive
1176 : Ornamentalist – Bead Work for Garments
1177 : Ornamentalist – Ikkat Designer
1178 : Ornamentalist – Chikkan Kari Designer
1179 : Ornamentalist – Kasuti Designer
1180 : Ornamentalist – Kantha Designer
1181 : Ornamentalist – Kashida Kari Designer
1182 : Ornamentalist – Phulkari Designer
1183 : Ornamentalist – Chamba Rumal Designer
1184 : Ornamentalist – Zardosi Specialist – Zari
1185 : Ornamentalist – Zardosi Specialist – Sequence
1186 : Ornamentalist – Zardosi Specialist – Glass
1187 : Ornamentalist – Zardosi Specialist – Metal Zardosi
1188 : Ornamentalist – Zardosi Specialist – Woolen / Pique
1189 : Ornamentalist – Zardosi Specialist – Mirror
1190 : Ornamentalist – Hand Work Specialist – Applique
1191 : Ornamentalist – Hand Work Specialist – Patch Work
1192 : Ornamentalist – Hand Work Specialist – Combination of Different Skills

**TEXTILE ENGINEERING AND MANAGEMENT**

***(Textile – Cotton Ginning)***

1193 : Pre-Cleaner of Kapas
1194 : Sweeper cum Fly Gatherer
1195 : Ginning Operator
1196 : Post Cleaner of Cotton Lint and Seed
1197 : Bale Packer

***(Textile – Cotton Spinning)***

1198 : Contamination Sorter – Cotton Blues

1199 : Mixing Operator – Cotton Mixing
1200 : Willow Machine Operator
1201 : Hard Waste Opener Machine Operator
1202 : Roving Waste Opener Machine Operator
1203 : Rotary Filter Operator and Waste Handler
1204 : Saleable Waste Handler and Packer
1205 : Lattice Man Cum Cobbler
1206 : Lap Carrier
1207 : Can Carrier
1208 : Apron Joiner
1209 : Cobbler – Belt Stitcher
1210 : Tape Stitcher
1211 : Sweeper cum Fly Gatherer
1212 : Can Assembler
1213 : Bale Plucker Operator
1214 : Bale Breaker Tenter and Cotton Feeder
1215 : Blow Room Oiler
1216 : Card Tenter – Semi High Speed Cards
1217 : Card Fitter – End Milling, Mounting and Grinding of Flats
1218 : Card Fitter – Licker-in Mounting
1219 : Card Oiler
1220 : Draw Frame Tenter
1221 : Silver Lap Tenter
1222 : Ribbon Lap Tenter
1223 : Comber Needler
1224 : Speed Frame Doffer
1225 : Speed Frame Cleaner
1226 : Ring Frame Doffer
1227 : Ring Frame Cleaner
1228 : Roller Coverer
1229 : Ring Frame Assistant Fitter – Creel and Bobbin Holder Maintenance
1230 : Button Fitting in Plug Type Spindles
1231 : Ring Buffing and Reconditioning
1232 : Open end Machine Tenter
1233 : Mixing Mukaddam – Cotton Mixing
1234 : Scutcher Operator in Blow Room

1235 : Card Tenter-High Speed / Super High Speed Cards

1236 : Card Fitter – Mounting and Grinding of Cylinder, Doffer and Flats

1237 : Card Fitter – Semi High Speed Cards

1238 : Combing Tenter

1239 : Speed Frame Machine Operator

1240 : Ring Frame Sider – (Operator)

1241 : Ring Frame Assistant Fitter – Spindle Gauging

1242 : Ring Frame Assistant Fitter – Spindle Gaugzing

1243 : Ring Frame Assistant Fitter – Roller Truing

1244 : Ring Frame Assistant Fitter – Drafting Roller and Top Arm Maintenance

1245 : Ring Frame Asst. Fitter–Pneumatic Ducts, Filter and Over Head Cleaners Maintenance

1246 : Cots Mounting and Buffing Operator

1247 : Blow Room Fitter

1248 : Card Fitter – High Speeds and Super High Speed Cards

1249 : Draw Frame Fitter

1250 : Comber Fitter

1251 : Speed Frame Fitter

1252 : Ring Frame Fitter

1253 : Open end Machine Fitter

***(Textiles – Doubling)***

1254 : Ring Doubling Doffer

1255 : Ring Doubling – Tenter

1256 : Two-for-One Twister Operator

1257 : Two-for-One Twister Fitter

1258 : Ring Doubling Machine Fitter

***(Textiles – Winding)***

1259 : Reconditioning of Old Paper Cones

1260 : Yarn Conditioning Machine Operator (Xorella, Autoclave)

1261 : Winder – Manual Winding Machine

1262 : Winder – Soft Package Winding

1263 : Winder – Dyed Yarn

1264 : Winder – Automatic Winding Machine

1265 : Winder – Assembly Winding

1266 : Yarn Packer – Bag Packing

1267 : Yarn Packer – Carton Packing
1268 : Yarn Packer – Shrink Packing
1269 : Fitter – Manual Winding
1270 : Fitter – Automatic Winding

***(Textiles – Reeling)***

1271 : Conditioning Coolie – Water Conditioning
1272 : Conditioning Coolie-Steam Conditioning
1273 : Reeler – Hand Reeling Machines
1274 : Reeler – Reeling on Machines
1275 : Hank Dresser
1276 : Knotter, Weigher cum Bundling Machine
1277 : Baling Press Machine Operator

***(Textiles – Weaving Preparation)***

1278 : Creel Attendant – Warping
1279 : Bach Attendant – Back Sizer
1280 : Warper – Sectional Warping
1281 : Warper – Beam Warping – Slow Speed
1282 : Warper – Beam Warping – High Speed
1283 : Warper – Beam Warping – Super High Speed
1284 : Size Cooker
1285 : Front Attendant – Two Cylinder Sizing
1286 : Front Attendant – Multi Cylinder Sizing
1287 : Fitter – Warping
1288 : Fitter – Sizing
1289 : Drawer in
1290 : Reacher
1291 : Pirn Winder
1292 : Warp Dressor for Typign Machine
1293 : Heald and Reed Cleaner
1294 : Reedman
1295 : Healdman
1296 : Beam Coolie
1297 : Welt Distributor
1298 : Sweeper cum Fly Gatherer
1299 : Cleaner
1300 : Pirn Winding – Automatic Machine

1301 : Warp Typing Operator – Machine-man
1302 : Auto Reaching Machine Attendant
1303 : Weaver – 2 Looms – Plain Power Loom
1304 : Weaver – 4 Looms – Plain Power Loom
1305 : Waver – Auto Loom
1306 : Weaver – Drop Box Loom
1307 : Weaver – Dobby Loom
1308 : Weaver – Jacquard Loom
1309 : Jacquard Card Punching
1310 : Jacquard Card Punching
1311 : Comber – Board Man
1312 : Lattice Man
1313 : Line Man (Nakshiwala)
1314 : Card Cutter and Lacer
1315 : Jacquard Lineman
1316 : Slay Maker
1317 : Carpenter
1318 : Shuttle Man
1319 : Oiler
1320 : Fabric Packer
1321 : Weaver – Shuttless Repier Looms
1322 : Weaver – Shuttleless Gripper / Projectile Looms
1323 : Weaver – Shuttless Water Jet Looms
1324 : Weaver – Shuttleless Water Jet Looms
1325 : Drop Box Fitter
1326 : Loom Fitter

***(Textiles – Chemical Processing)***

1327 : Water Softening Plant Operator
1328 : Effluent Water Treatment Plant Operator
1329 : Laundering Operator
1330 : Loose Cotton Bleaching Operator
1331 : Yarn Bleaching in Hank from Operator
1332 : Grey Fabric Marking and Counting
1333 : Grey Fabric Stitching
1334 : Electrolysers Operator
1335 : Preparing Bleaching Solution – Operator

1336 : Scutcher Machine Man
1337 : Scutcher Plaiter
1338 : Colour Mixer / Chemical Presentation Operator
1339 : Yarn Dyeing in Hanks – Operator
1340 : Fibre Dyeing in Machine Operator
1331 : Loose Cotton Dyeing in Vats Operator
1332 : Wet Cotton Opening – Operator
1333 : Hot Air Dryer Operator
1334 : Screen Printing – Manual Operation
1335 : Screen Preparer – Manual
1336 : Batching Machine Operator
1337 : Screen Preparer – Manual
1338 : Batching Machine Operator
1339 : Colour Mixer – Printing
1340 : Soaper Machine Operator
1341 : Curing Machine Operator
1342 : Yarn Printing by Hand
1343 : After / Post Processing of Printed Yarn Operator
1344 : Back Grey Washing and Drying Operator
1345 : Starch Kitchen Operator
1346 : Selvedge Stamping Operator
1347 : Hand Folding Operator
1348 : Role Folding – Hand Operator
1349 : Plaiter – Cloth by Machine
1350 : Role Folding Machine Operator
1351 : Split Cutting Operator
1352 : Terry Towel Cutting Operator
1353 : Hand Folding of Plaited Cloth
1354 : Selvedge Stamping of Folded Cloth by Hand
1355 : Packer and Bundler of Stamped Pieces
1356 : Baling Press Helper
1357 : Case Packing Operator
1358 : Sample Cutting Machine Operator
1359 : Straw Board Cutter
1360 : Yarn Boiling – Kier Operator
1361 : Yarn Singeing Machine Operator – Electrical

1362 : Yarn Singeing Machine Operator – Gassing
1363 : Yarn Mercerising Machine Operator
1364 : Shearing Machine Operator
1365 : Grey Fabric Cropping Operator
1366 : Desizing Machine Operator
1367 : Kier Operator – Fabric
1368 : Fabric Singeing Machine Operator
1369 : Fabric Mercerising Machine Operator
1370 : Drying Machine Operator – Cylinder Dryer
1371 : Water Mangle Machine Operator
1372 : Jigger Machine Operator
1373 : Padding Mangle cum Float Drier Machine Operator
1374 : HT-HP Cheese Dyeing of Yarns – Machine Operator
1375 : HT-HP Beam Dyeing of Yarns – Machine Operator
1376 : Colour Matching Operator
1377 : Loose Cotton Drying in Continuous Drying Machine Operator
1378 : Flat Bed Screen Printing Machine Operator
1379 : Rotary Screen Printing Machine Operator
1380 : Engraver – Roller Printing Machine
1381 : Roller Printing – Machine Operator
1382 : Ager Machine Operator
1383 : Short Clip Stenter Operator
1384 : Starch Mangle and Back Filling Mangle Operator
1385 : Breaking Machine Operator
1386 : Damping Machine Operator – Brush Type, Nozzle Type and Pneumatic Type
1387 : Calendar Machine Operator – Swissing, Chasing, Shreiner and Embossing
1388 : Pre-Shrinking Machine Operator – Zero-Zero Finishing or Felt Calendar
1389 : Stenter of Fionishing Machine Operator – Cylindar Dryer
1390 : Single Folding / Double Folding / Full Width Machine Operator (Back and Front)
1391 : Combined Double Folding and Plaiting Operator
1392 : Shrink Packing / Sealing Machine Operator
1393 : Bailing Press Machine Operator
1394 : Inspection Operator / Piece Checker (near Bailing)
1395 : Inspection Operator. Piece Checker (near Bailing)
1396 : Raising Machine Operator

1397 : Grey Room Inspection Operator (Piece Checker)
1398 : Bleaching Department Inspection Operator (Piece Checker)
1399 : Continuous Bleaching Plant – Machine Operator
1400 : HT-HP Beam Dyeing Machine Operator
1401 : Jet Dyeing Machine Operator
1402 : Folding Department Jobber

***(Textile – Quality Control)***

1403 : Tester – Wraping Boy
1404 : Tester – Cotton Trash Analyser
1405 : Tester – Classimat / Classifault Tester
1406 : Inspector – Fabric – Visual Inspection for Quality
1407 : Cone Quality Inspection
1408 : Tester – Cotton-Length, Strength, Micronaire, Rd, Neps
1409 : Tester – Yarn Count, Strength and Twist
1410 : Tester – Evennes Tester
1411 : Tester – Fabric-Dimensions and Construction-Woven Fabrics
1412 : Tester – Fabric-Dimensions and Construction-Woven Fabrics
1413 : Tester – Fabric-Dimensions and Construction-Knitted Fabrics
1414 : Tester – Blend Analysis
1415 : Tester – Colour Fastness Testing
1416 : Tester – Dimensional Stability, Pilling, Abrasion, Drape and Handle

***(Textiles – Knitting)***

1417 : Knitting Runner – Helper
1418 : Lab Assistant
1419 : Yarn Stores Assistant
1420 : Hand Knitter – Flat Knitting
1421 : Fabric Inspector
1422 : Peaching Machine Operator
1423 : Roll Packer
1424 : Knitter – Circular Knitting
1425 : Knitter – Flat Knitting Machine
1426 : Knitting Mechanic

***(Textiles – Non-Woven)***

1427 : Opening Machine Operator
1428 : Randomizer Machine Operator

1429 : Hydro Entanglement Operator
1430 : pH Controller
1431 : Lap Slitting Machine Operator
1432 : Punching Machine Operator
1433 : Blade Cutting Machine Operator
1434 : Ear Bud Machine Operator
1435 : Ball Making Operator
1436 : Surgical Cotton Roll Operator
1437 : Surgical Cotton Pleats Operator
1438 : Ear Bud Packer
1439 : Numbering and Heat Sealing Operator – Packed Bags
1440 : Carton Packer – Balls and Pads
1441 : Drying Range Operator
1442 : Lap Former Operator

***(Textiles – Wool)***

1443 : Helpers – Sorting and Cleaning
1444 : Helper Blow Room
1445 : Helper – Carding
1446 : Helper – Grill Box
1447 : Helper – Combing
1448 : Helper – Draw Frame
1449 : Helper – Doffers Roving Frames
1450 : Helpers – Doffers Ring Frames
1451 : Helper – Winding
1452 : Helper / Creeler – Warping
1453 : Helper – Weft Feeder
1454 : Helper – Gaiter Weaving
1455 : Helper – Wet Processing
1456 : Wool Sorter
1457 : Wool Washing and Scouring Operator
1458 : Fibre Opening – Blending Operator
1459 : Blow Room Chute Feeding Operator
1460 : Carding Operator
1461 : Operator – Gill Box
1462 : Operator – Comber
1463 : Operator – Finisher Draw Frame

1464 : Operator – Roving Frame
1465 : Operator – Automatic Winding
1466 : Operator – Cheese Winding
1467 : Warper
1468 : Weft Winder
1469 : Weaver
1470 : Grey Fabric Mender
1471 : Grey Fabric Checker
1472 : Fabric Processing Operator
1473 : Maintenance Helpers – Blow Room
1474 : Machine Cleaners – Blow Room
1475 : Maintenance Helpers – Carding
1476 : Machine Cleaners – Carding
1477 : Maintenance Helpers – Gill Box
1478 : Machine Cleaners – Gill Box
1479 : Maintenance Helpers – Combing
1480 : Machine Cleaners – Comber
1481 : Maintenance Helpers – Speed Frames
1482 : Machine Cleaners – Speed Frames
1483 : Maintenance Helpers – Ring Frames
1484 : Machine Cleaners – Ring Frame
1485 : Maintenance Helpers – Winding Machines
1486 : Machine Cleaners – Winding Machine
1487 : Maintenance Helpers cum Cleaners – Weaving
1488 : Maintenance Helpers cum Cleaners – Wet Processing
1489 : Maintenance Fitter – Blow Room
1490 : Maintenance Fitter – Carding
1491 : Maintenance Fitter – Gill Box
1492 : Maintenance Fitter – Comber
1493 : Maintenance Fitter – Speed Frame
1494 : Maintenance Fitter – Ring Frame
1495 : Maintenance Servicing Operations
1496 : Maintenance Fitter – Automatic Winding
1497 : Maintenance Fitter – Cheese Winding
1498 : Maintenance Fitter – Weaving
1499 : Maintenance Fitter – Wet Processing

***(Textiles – Silk)***

1500 : Cocoon Sorter
1501 : Cone and Cheese Winder
1502 : Fabric Checker
1503 : Packer
1504 : Raw Waste Sorter / Blender
1505 : Waste Stapler
1506 : De-Gumming Operator
1507 : Drying Operator
1508 : Neutraliser
1509 : Bailing Operator
1510 : Maintenance Helpers cum Cleaners – Weaving Preparatory
1511 : Maintenance Helpers cum Cleaners – Weaving
1512 : Cocoon Cooking Operator
1513 : Reeler
1514 : Re-Reeler
1515 : Soaking Operator
1516 : Drying Operator
1517 : Winders
1518 : Twisting Operator
1519 : Doubling Operator
1520 : Yarn Singeing Machine Operator
1521 : Auto Clave Operator
1522 : Re-Winder
1523 : Reeler – Preparatory Section
1524 : Dyer – Assistant
1525 : Dryer Operator for Dyed Silk
1526 : Yarn Store Assistant
1527 : Winders (Dyed Yarn)
1528 : Cone and Cheese Winder
1529 : Pirn Winder
1530 : Warping Operator
1531 : Warp Drawer
1532 : Beam Gaiter
1533 : Knotter
1534 : Carding Tenter
1535 : Draw Frame / Gill Box Tenter

1536 : Comber Tenter
1537 : Roving Frame Tenter
1538 : Ring Frame Tenter
1539 : Bundling Operator
1540 : Ring Doubling Operator
1541 : Yarn and Silk Tester
1542 : Raw Silk Yarn Store Assistant
1543 : Cocoon Stifling / Drying Operator
1544 : Twist Setting Operator
1545 : Weaver
1546 : CAD Operator
1547 : General Fitter
1548 : Fitter – Twisting Machine
1549 : General Fitter – Preparatory Section
1550 : Dyeing Operator
1551 : Lab – Assistant
1552 : Dyeing Machine Fitter
1553 : Loom Fitter
1554 : Carding Oiler cum Fitter
1555 : Gill Box / Draw Frame Fitter
1556 : Roving Frame / Ring Frame / Ring Double Fitter

***(Textile – HDPE/PP)***

1557 : Raw Material Blender
1558 : Helper
1559 : Lamination Helper
1560 : Stacker
1561 : Trimmer
1562 : Slit Tape Extruder Operator
1563 : Winder Mechanic
1564 : Slit Tape Extruder Winder
1565 : Circular Loom Weaver
1566 : Lamination Operator
1567 : Heavy Duty Fabric Cutting Operator
1568 : Heavy Duty Tailor
1569 : Reeler
1570 : Bobbin Winder

1571 : Sectional Warper
1572 : Reed Mounter
1573 : Pirn Winder
1574 : Weaver
1575 : Quality Inspector
1576 : Packing Operator
1577 : Circular Looms Jobbers
1578 : Looms Jobbers

***(Sericulture)***

1579 : Mulberry Sampling Producer
1580 : Mulberry Crop Protection Assistant
1581 : Chawki Rearer
1582 : Pre-Emergence Grainage Operator
1583 : Post Emergence Grainage Operator
1584 : Silk Handicraft Maker
1585 : Mulberry Cosmetic Assistant
1586 : Mulberry Snack Maker
1587 : Silk Garland Maker
1588 : Mulberry Garden Establisher
1589 : Mulberry Garden Maintainer
1590 : Vermicompost Producer
1591 : Sanitation and Disinfection Assistant
1592 : Late Age Silkworm Rearing Assistant
1593 : Silkworm Protector
1594 : Acid Treatment Technician
1595 : Silk Worm Cold Storage Operator
1596 : Silk Worm Egg Marketing Assistant
1597 : Bamboo Appliances Maker for Silkworm Rearing
1598 : Wooden Appliances Maker for Sericulture
1599 : Mulberry Crop Protector
1600 : Seed Cocoon Procurer
1601 : Pupa and Moth Tester
1602 : Egg Production Supervisor
1603 : Sericulture Extension Worker
1604 : Egg Production Manager

**TELECOMMUNICATION**

1605 : Telecom DTH Installation Technician Tourism, Travel and Hospitality Management
1606 : Tour Salesman
1607 : Tour Office Assistant
1608 : Accommodation Assistant
1609 : Ticket Reservation Assistant
1610 : Tour Guide for Domestic Tourist
1611 : Driver cum Tour Guide
1612 : Tour Programme Coordinoatr
1613 : Tour Guide for International Tourist
1614 : Tour Agent / Travel and Tour Operator
1615 : Tourism and Travel Executive
1616 : Hospitality Assistant
1617 : Household Assistant (General)
1618 : Household Assistant (Kitchen and Service)
1619 : Assistant Cook
1620 : Bellboy
1621 : Assistant Waiter / Barmen
1622 : Houseman (Basic)
1623 : Cook-Fast Food
1624 : Cook-Indian Cuisine
1625 : Cook-Tandoori Cuisine
1626 : Cook-Chinese (Veg. & Non Veg.)
1627 : Cook-South Indian Cuisine
1628 : Cook-Continental Cuisine
1629 : Cook-Halwaie
1630 : Cook-Amritsar Punjabi
1631 : Cook-Baker
1632 : Room Attendant
1633 : Head Houseman
1634 : Reservation Assistant and Telephone Assistant
1635 : Reception Assistant and Information Assistant
1636 : Steward/Waiter
1637 : Bar Tender
1638 : Public Area Supervisor

1639 : Linen/Uniform Room Supervisor
1640 : Head Cook
1641 : Household Help (Cleaning)
1642 : Household Help (Washing)
1643 : Household Help (General)
1644 : Household Child Care
1645 : Household Elderly Care
1646 : Household Baby Care
1647 : Household Infirm Adult Care
1648 : Assistant Steward
1649 : Assistant Waiter
1650 : Assistant Barmen
1651 : Pantry Man
1652 : Geriatrics Assistant
1653 : Hotel Billing Clerk
1654 : Door Man
1655 : Domestic Higher Level House Keepers
1656 : Assistant Bell Captain
1657 : House Keeping – Room Boy
1658 : House Keeping – Chamber Maids
1659 : Assistant House Keepers
1660 : Dosa Maker
1661 : Anna Ambhar Maker
1662 : The Biryani Specialist
1663 : The Kabab Maker
1664 : Seekh Kabab and Beef Grill Maker
1665 : The Chat Maker
1666 : Cook-Chinese (Veg. and Non Veg.)
1667 : Tea Stall Vendor
1668 : Room Service Operator
1669 : Infant Nursing Care – Creche Assistant / Genetic Care
1670 : Buchery
1671 : Restaurant Cook – Chettinad
1672 : Restaurant Cook – Continental
1673 : Restaurant Cook – Italian
1674 : Restaurant Cook – Japanese
1675 : Restaurant Cook – Kerala

1676 : Restaurant Cook – Korean
1677 : Restaurant Cook – Mangalore
1678 : Restaurant Cook – North Indian Tandoori
1679 : Restaurant Cook – Thai
1680 : Restaurant Cook – Western
1681 : Restaurant Cook – South Indian
1682 : Idli Sambhar Maker
1683 : Care Giver for Differently Abled Children (Physical and Mental)
1684 : Care Taker – Day Care
1685 : Hotel Casheir
1686 : Food and Beverage Service – Star Hotels and Fine Dining
1687 : Handy Man
1688 : Bell Captain
1689 : Steward / Head Waiter
1690 : Food and Beverage Service
1691 : Language Coordinator
1692 : Captains
1693 : Pre School Child Support Associate
1694 : Steward – Supervisor
1695 : Senior Captain

**TOY MAKING**

1696 : Pattern and Mould Maker (Soft Toy)
1697 : Cutter and Fixer of Toys Parts (Soft Toy)
1698 : General Sewing Machine Operator (Soft Toy)
1699 : Stuffer and Willower (Soft Toy)
1700 : Finisher and Painter (Soft Toy)
1701 : Packer (Soft Toy)
1702 : Special Sewing Machine Operator (Soft Toy)

**WATER FALLS MAKING**

1703 : Waterfalls Maker
1704 : Ceramic Waterfalls Maker
1705 : Crystal Waterfalls Maker
1706 : Waterfalls with Landscape Maker
1707 : Waterfalls with Landscape and Bonsai Maker

**WOOD WORK**

1708 : Basic Wood Work
1709 : Wooden Furniture

**WOODEN HANDICRAFT**

1710 : Basic Wooden Framework
1711 : Silhouette Wall Decorative Craft Maker
1712 : Wall Decorative Figurative Craft Maker
1713 : 3D Creative Craft Maker

***(Art Bonsoi)***

1714 : Bonsai Kits Maker
1715 : Bonsai Maker – Indian Style
1716 : Imitation Bonsai Maker
1717 : Chinese Bonsai Maker
1718 : Wooden Base Bonsai Maker
1719 : Crystal Base Bonsai Maker
1720 : Indo Chinese Bonsai Maker
1721 : Double Twist Bonsai Maker
1722 : Bonsai and Stone Mural Maker
1723 : Bonsai and Lacquer Wooden Pot Maker
1724 : Bonsai with Wooden Lacquer Dolls Maker
1725 : Landscape with Bonsai Maker
1726 : Bonsai Nest and Bird Maker

**WET-NURSING, HEALTH CARE AND PARAMEDICAL SCIENCE**

1727 : Beside Assistant
1728 : Basic of Anatomy and Physiology
1729 : Dietician Assistant
1730 : Inoculator
1731 : Vaccination Technician
1732 : Dresser
1733 : Midwifery Assistant
1734 : Operation Theatre Technician
1735 : Physical Modality Operator
1736 : Diathermy Operator
1737 : Bio Electrical Modality Operator
1738 : Chiropractic Operator

1739 : Bio Mobility Technician
1740 : Therapeutic Massage Technician
1741 : Therapeutic Laser Technician
1742 : EMG Technician
1743 : Occupational Therapy Assistant
1744 : Dental Ceramic Assistant
1745 : Dental Ceramic Technician
1746 : Dental Hygiene Assistant
1747 : Dental Mechanic
1748 : Optician
1749 : Optometrist
1750 : Pharmacy Assistant
1751 : Basic Testing Equipments (Pharmacy)
1752 : Yoga Therapist
1753 : Advanced Yoga Therapist
1754 : Naturotherapist – I
1755 : Naturotherapist – II
1756 : External Therapist
1757 : Dialysis Assistant
1758 : Medical Record Technician
1759 : Health Care Multipurpose Worker
1760 : Nursing Aides
1761 : Infection Control Assistant
1762 : Central Sterile Supply Department (CSSD) Assistant
1763 : Laboratory Assistant
1764 : Dialysis Technician
1765 : Radiology Technician
1766 : Central Sterile Supply Department (CSSD) Technician
1767 : Operation Theatre (OT) Technician
1768 : Laboratory Technician

**YOUTH'S SPECIAL SKILL DEVELOPMENT PROGRAMMES**

1769 : News Production Assistant
1770 : Counselling Assistant
1771 : Social Activists
1772 : Risk Assessment Assistant
1773 : Volunteers for Social Action

1774 : Call Centre Assistants
1775 : E-Commerce Assistants
1776 : Hotel Engineering Assistants
1777 : Food Microbiology Assistants
1778 : Aviation Ground Handling Assistants
1779 : Vastu Science Assistants
1780 : Green Building Assistants
1781 : Real Estate Supervisors
1782 : Paralegal Document Writers
1783 : Folk Medicine and Ethnobiology Assistants
1784 : Remote Sensing Assistants
1785 : Ecotourism Guides
1786 : Sustainable Tourism Guides
1787 : Adventure Tourism Guides
1788 : Medical Tourism Guides
1789 : Sports Tourism Guides
1790 : Wildlife Tourism Guides
1791 : Integrated Pest Management Supervisors
1792 : Valuation and Survey Assistants
1793 : Interior Landscaping Supervisors
1794 : Medicinal Plants Cultivators
1795 : Public Health Assistants
1796 : Psychotherapy Assistants
1797 : Nutritional Healers
1798 : Sick Building Syndrome Mitigation Assistants
1799 : Exhibition and Set Design Assistants
1800 : Window Display Supervisors

**ZEAL BASED SPECIAL SKILL DEVELOPMENT PROGRAMMES**

1801 : Adult Literacy
1802 : Advertising
1803 : Air Ticketing
1804 : Airline and Flight Services
1805 : Analytical Techniques in Food Analysis
1806 : Anchoring
1807 : Ante and Post Natal Care
1808 : Ante Natal Care

1809 : Apparel Export Merchandising
1810 : Apparel Manufacturing
1811 : Apparel Pattern Making and CAD
1812 : Apparel Quality Assurance and Compliance
1813 : Applied Arts
1814 : Aquaculture
1815 : Arabic Language
1816 : Astrology
1817 : Audiometric and Speech Language Therapy
1818 : Autism and Spectrum Disorders
1819 : AutoCAD
1820 : Ayurvedic Pharmacy
1821 : Banking and Finance
1822 : Bar Bending and Steel Fixing
1823 : Basic Computer Course
1824 : Beautician Assistant
1825 : Beauty Culture
1826 : Beauty Parlour Training
1827 : Bedside Assistant
1828 : Bee Keeping
1829 : Bioinformatics
1830 : Blood Bank Technician
1831 : Book Keeping
1832 : Building Maintenance
1833 : Business Administration
1834 : Business Research Analyst
1835 : Business Skill Development
1836 : C Langauge
1837 : C++
1838 : Call Centre Management
1839 : Care Giving (Hearing Impairment)
1840 : Care Giving (Mental Retardation)
1841 : Care Giving (Visual Impairment)
1842 : Carpentry
1843 : Chinese Language
1844 : Civil Engineering
1845 : Classical Dance

1846 : Clay Modelling
1847 : Clinical Office Receptionist
1848 : CNG
1849 : Commerce and Accounts
1850 : Communication Skills for BPOs
1851 : Community Health Worker
1852 : Community Health Worker
1853 : Computer Accounting
1854 : Computer Applications
1855 : Computer Programming Languages
1856 : Computer Repairing
1857 : Computer Typing (Hindi / English)
1858 : Consumer Protection
1859 : Cosmetic Chemistry
1860 : Counselling Techniques
1861 : Cyber Law
1862 : Dairy Technician
1863 : Data Entry Operator
1864 : Day Care Centre
1865 : Dental Hygienist
1866 : Detergent Powder Making
1867 : Diabetes Care
1868 : Dialysis Technique
1869 : Digital Photocopy and Mixing
1870 : Disability Rehabilitation Administration
1871 : Disaster Management
1872 : Dresser and Compounder
1873 : Driving and Road Safety
1874 : DTP and Photoshop
1875 : Early Childhood Care and Education
1876 : Early Childhood Education
1877 : Elderly Care
1878 : Electrical Engineering
1879 : Electronic Media
1880 : Entrepreneurship Development
1881 : Environmental Aareness
1882 : Event Management

1883 : Export Marketing
1884 : Eye Care Technician
1885 : Family Bussiness Management
1886 : Fashion Design
1887 : Financial Research Analyst
1888 : Fine Arts
1889 : Fire and Safety Management
1890 : First Aid and Nursing Assistance
1891 : Fishermen's Training
1892 : Flower Culture
1893 : Food and Nutrition
1894 : Food Safety and Quality Management
1895 : Footwear Technology
1896 : French Language
1897 : Front Office Management
1898 : Garment Construction Techniques
1899 : Genitourinary Surgical Care and OT Management
1900 : German Language
1901 : Gram Panchayat Worker
1902 : Gym Assistant
1903 : Gynecology and Labour Room Assistant
1904 : Hardware and Networking
1905 : Health Assistant for Palliative Care
1906 : Herbal Medicine - Siddha
1907 : Hill Farming
1908 : HIV and Family Education
1909 : Hospital Attendant
1910 : Hospital Care Assistant
1911 : Hospital Waste Management
1912 : Hotel Management
1913 : Human Resource Development
1914 : Human Rights
1915 : Industrial Safety
1916 : Infrastructural Management
1917 : Institutional Management
1918 : Instrumentation
1919 : Insurance Services

1920 : Integrated Coir Processing
1921 : Intellectual Property Rights
1922 : Interior Decoration
1923 : International Marketing
1924 : Internet Education
1925 : Interview Skills
1926 : Japanese Language
1927 : Knitwear Manufacturing Technology
1928 : Korean Language
1929 : Lamp Technology
1930 : Land Surveying and Mapping
1931 : Laptop Repairing and Maintenance
1932 : Leadership
1933 : Leather Technology
1934 : Legal Literacy and RTI
1935 : Library and Information Services
1936 : Linux Administration
1937 : Livestock Management
1938 : Logistics Management
1939 : Masonry Brick Work
1940 : Medical Records Management
1941 : Medical Transcriptions
1942 : Medicinal and Herbal Plants
1943 : Micro Finance
1944 : Mobile Repairing
1945 : Montessori Method of Education
1946 : MRI Technician
1947 : Multimedia and Animation
1948 : Mushroom Cultivation
1949 : Net Banking
1953 : NGO Management
1950 : Nursery Teachers Training
1951 : Occupational Therapy
1952 : Office Automation
1953 : Optometry
1954 : Oracle
1955 : Organic Farming

1956 : Pagemaker and MS Word
1957 : Panchkarma
1958 : Paralegal Practice
1959 : Parenting and Child Care
1960 : PC Assembly
1961 : Peace and Non-Violence
1962 : Pharma Sales Management
1963 : Pharmacy
1964 : Phlebotomist and Specimen Collection Assistant
1965 : Photography
1966 : Physical Education
1967 : Physiotherapy
1968 : Plumbing
1969 : Portfolio Management
1970 : Poultry Farming
1971 : Pre and Post Natal Care
1972 : Pre School Teachers' Training
1973 : Proof Reading and Copywriting
1974 : Public Relations
1975 : Publishing Services
1976 : Pulp and Paper Industry Worker
1977 : Radio Jockey
1978 : Rain Water Harvesting
1979 : Rehabilitation Psychology
1980 : Renewable Energy Development
1981 : Rescue Operations
1982 : Retail Marketing
1983 : Rural Development
1984 : Rural Tourism
1985 : Sales Management
1986 : Salon Management and Hair Dressing
1987 : Sanitary Inspectors Course
1988 : Scaffolding
1989 : School Lab Assistant
1990 : Screen Printing
1991 : Security and Safety Management
1992 : Security Guard Training

1993 : Self Help Group Federation and Micro Enterprise Management
1994 : Sewage Treatment Technician
1995 : Simultaneous Interpretation
1996 : Six Sigma
1997 : Skin Treatment
1998 : Soft Skills
1999 : Software Management
2000 : Soil and Crop Management
2001 : Solar Devices Repairing
2002 : Sound Engineering
2003 : Spanish Language
2004 : Special Education for Differently Abled
2005 : Spoken English and Personality Development
2006 : Stage Management
2007 : Stenography
2008 : Stock Market Operations
2009 : Stores Management
2010 : Structural Skills and Habitat Making
2011 : Sugar Mills Worker
2012 : Supply Chain Management
2013 : Sustainable Farm Management
2014 : Swimming and Life Saving
2015 : Tailoring
2016 : Tally
2017 : Telecom Sales
2018 : Tissue Culture
2019 : Tour Guide
2020 : Tourism
2021 : Translation Technique
2022 : Treasury and Forex Management
2023 : TV Camera Man
2024 : Ultrasonography
2025 : Unani Assistant
2026 : Urdu Teachers Training
2027 : Value Added Products from Fruits and Vegetables
2028 : Vermi Composting
2029 : Veterinary Care

2030 : Veterinary Pharmacy
2031 : VFX Pro.
2032 : Video Film Production and Direction
2033 : Visual Arts
2034 : Visual Merchandising
2035 : Water Harvesting
2036 : Watershed Management
2037 : Web Designing and Graphics
2038 : Women's Empowerment
2039 : Yoga and Naturopathy
2040 : Yoga Therapist
2041 : Tele Marketing
2042 : Online Tele Marketing
2043 : Pre-School Education
2044 : Early Childhood Care and Education

The Afro-Asian-American Chamber of Commerce, Occupational Research and Development (ACCORD) accordingly invites requests and expression of interest from different countries for launching the above mentioned skill based programmes for enabling the officials of ACCORD to visit those countries for signing a Memorandum of Understanding (MoU) for implementing this need based programme.

**Chapter 10**

# NON FORMAL VOCATIONAL EDUCATION FOR YOUTH EMPOWERMENT ENVISAGED BY THE AFRO-ASIAN-AMERICAN CHAMBER OF COMMERCE, OCCUPATIONAL RESEARCH AND DEVELOPMENT (ACCORD)

Vocational Education is an education that prepares people for specific trades, crafts and careers at various levels from a trade, a craft, technician, or a professional position in engineering, accountancy, nursing, medicine, and other healing arts, architecture, pharmacy, law etc. Craft vocations are usually based on manual or practical activities, traditionally non-academic, related to a specific trade, occupation, or *vocation*. It is sometimes referred to as *technical education* as the trainee directly develops expertise in a particular group of techniques. In the UK some higher technician engineering positions that require 4-5 year apprenticeship require academic study to HNC / HND or higher City and Guilds level.

Vocational education may be classified as teaching procedural knowledge. This can be contrasted with declarative knowledge, as used in education in a usually broader scientific field, which might concentrate on theory and abstract conceptual knowledge, characteristic of tertiary education. Vocational education can be at the secondary, post-secondary level, further education level and can interact with the apprenticeship system. Increasingly, vocational education can be recognised in terms of recognition of prior learning and partial academic credit towards tertiary education (e.g., at a university) as credit; however, it is rarely considered in its own form to fall under the traditional definition of higher education.

Vocational education is related to the age-old apprenticeship system of learning. Apprenticeships are designed for many levels of work from manual trades to high knowledge work.

However, as the labour market becomes more specialised and economies demand higher levels of skill, governments and businesses are increasingly investing in the future of vocational education through publicly funded training organisations and subsidised apprenticeship or traineeship initiatives for businesses. At the post-secondary level vocational education is typically provided by an institute of technology, university, or by a local community college.

Vocational education has diversified over the 20th century and now exists in industries such as retail, tourism, information technology, funeral services and cosmetics, as well as in the traditional crafts and cottage industries.

## VOCATIONAL EDUCATION IN AUSTRALIA

In Australia vocational education and training is mostly post-secondary and provided through the Vocational Education and Training (VET) system by registered training organisations. This system encompasses both public, TAFE, and private providers in a national training framework consisting of the Australian Quality Training Framework, Australian Qualifications Framework and Industry Training Packages which define the assessment standards for the different vocational qualifications.

Australia's apprenticeship system includes both traditional apprenticeships in traditional trades and "traineeships" in other more service-oriented occupations. Both involve a legal contract between the employer and the apprentice and provide a combination of school-based and workplace training.

Apprenticeships typically last three to four years, traineeships only one to two years. Apprentices and trainees receive a wage which increases as they progress.

Since the states and territories are responsible for most public delivery and all regulation of providers, a central concept of the system is "national recognition" whereby the assessments and awards of any one registered training organisation must be recognised by all others and the decisions of any state or territory training authority must be recognised by the other states and territories.

This allows national portability of qualifications and units of competency. A crucial feature of the training package (which accounts for about 60% of publicly funded training and almost all apprenticeship training) is that the content of the vocational qualifications is theoretically defined by industry and not by government or training providers.

A Training Package is "owned" by one of 11 Industry Skills Councils which are responsible for developing and reviewing the qualifications. The National Centre for Vocational Education Research or NCVER is a not-for-profit company owned by the federal, state and territory ministers responsible for training. It is responsible for collecting, managing, analysing, evaluating and communicating research and statistics about Vocational Education and Training (VET).

The boundaries between Vocational education and tertiary education are becoming more blurred. A number of vocational training providers such as NMIT, BHI and

WAI are now offering specialised Bachelor degrees in specific areas not being adequately provided by Universities.

Such Applied Courses include in the areas of Equine studies, Winemaking and viticulture, aquaculture, Information Technology, Music, Illustration, Culinary Management and many more.

## COMMONWEALTH OF INDEPENDENT STATES

The largest and the most unified system of vocational education was created in the Soviet Union with the Professional'no-tehnicheskoye uchilische and, Tehnikum. But it became less effective with the transition of the economies of post-Soviet countries to a market economy.

## FINLAND

In Finland, vocational education belongs to secondary education. After the nine-year comprehensive school, almost all students choose to go to either a *lukio* (high school), which is an institution preparing students for tertiary education, or to a vocational school. Both forms of secondary education last three years, and give a formal qualification to enter university or *ammattikorkeakoulu*, i.e. Finnish polytechnics. In certain fields (e.g. the police school, air traffic control personnel training), the entrance requirements of vocational schools include completion of the *lukio*, thus causing the students to complete their secondary education twice.

The education in vocational school is free, and the students from low-income families are eligible for a state student grant. The curriculum is primarily vocational, and the academic part of the curriculum is adapted to the needs of a given course. The vocational schools are mostly maintained by municipalities.

After completing secondary education, one can enter higher vocational schools (*ammattikorkeakoulu*, or *AMK*) or universities.

It is also possible for a student to choose both lukio and vocational schooling. The education in such cases last usually from 3 to 4 years.

## GERMAN LANGUAGE AREAS

Vocational education is an important part of the education systems in Austria, Germany, Liechtenstein and Switzerland (including the French and the Italian speaking parts of the country) and one element of the German model.

For example, in Germany a law (the *Berufsausbild-ungsgesetz*) was passed in 1969 which regulated and unified the vocational training system and codified the shared

responsibility of the state, the unions, associations and chambers of trade and industry. The system is very popular in modern Germany: in 2001, two thirds of young people aged under 22 began an apprenticeship, and 78% of them completed it, meaning that approximately 51% of all young people under 22 have completed an apprenticeship. One in three companies offered apprenticeships in 2003; in 2004 the government signed a pledge with industrial unions that all companies except very small ones must take on apprentices.

The vocational education systems in the other German speaking countries are very similar to the German system and a vocational qualification from one country is generally also recognised in the other states within this area.

**HONG KONG**

In Hong Kong, vocational education is usually for post-secondary 3, 5 and 7 students. The Hong Kong Institute of Vocational Education (IVE) provides training in nine different vocational fields, namely: Applied Science; Business Administration; Child Education and Community Services; Construction; Design; Printing, Textiles and Clothing; Hotel, Service and Tourism Studies; Information Technology; Electrical and Electronic Engineering; and Mechanical, Manufacturing and Industrial Engineering.

**HUNGARY**

Normally at the end of elementary school (at age 14) students are directed to one of three types of upper secondary education: one academic track (gymnasium) and two vocational tracks. Vocational secondary schools (szakközépiskola) provide four years of general education and also prepare students for the maturata. These schools combine general education with some specific subjects, referred to as pre-vocational education and career orientation. At that point many students enrol in a post-secondary VET programme often at the same institution, to obtain a vocational qualification, although they may also seek entry to tertiary education.

Vocational training schools (szakiskola) initially provide two years of general education, combined with some pre-vocational education and career orientation, they then choose an occupation, and then receive two or three years of vocational education and training focusing on that occupation – such as bricklayer. Students do not obtain the maturata but a vocational qualification at the end of a successfully completed programme.

Demand for vocational training schools, both from the labour market and among students, has declined while it has increased for upper secondary schools delivering the maturata.

## INDIA

Vocational training in India is provided on a full-time as well as part-time basis. Full-time programmes are generally offered through Community Colleges and Industrial Training Institutes (ITIs). The nodal agency for grant the recognition to the I.T.I.s is NCVT which is under the Ministry of Labour, Government of India. Part-time programmes are offered through state technical education boards or universities who also offer full-time courses. Vocational training has been successful in India in Industrial Training Institutes in engineering trades only. There are many private institutes in India which offer courses in vocational training and finishing, but most of them have not been recognised by the Government. All the State Governments runs vocational schools. In kerala state 389 vocational schools are there with 42 different courses. Commerce and Business, Tourism, Agriculture, Automobile, Air conditioning, Live stock management, Lab Technician are some prominent courses. There is an urgent need that the selected Universities in India offer Certificate / Diploma / Advanced Diploma courses in different areas of specialisation for employment generation and entrepreneurship development. The salient feature of the University based courses is that these are fully recognised and the students passing out are preferred for Private as well as Government jobs. The World Institution Building Programme have offered around 1800 Vocational and Employment Centric courses under the auspices of its Community Colleges.

## JAPAN

Japanese vocational schools are known as *senmon gakkô*. They are part of Japan's higher education system. They are two year schools that many students study at after finishing high school (although it is not always required that students graduate from high school). Some have a wide range of majors, others only a few majors. Some examples are computer technology, fashion and English.

## KOREA

Vocational high schools offer programmes in five fields: agriculture, technology / engineering, commerce/business, maritime/fishery, and home economics. In principle, all students in the first year of high school (10th grade) follow a common national curriculum, In the second and third years (11th and 12th grades) students are offered courses relevant to their specialisation. In some programmes, students may participate in workplace training through co-operation between schools and local employers. The government is now piloting Vocational Meister Schools in which workplace training is an important part of the programme. Around half of all vocational high schools are private. Private and public schools operate according to similar rules; for example, they charge the same fees for high school education, with an exemption for poorer families.

The number of students in vocational high schools has decreased, from about half of students in 1995 down to about one-quarter today. To make vocational high schools more attractive, in April 2007 the Korean government changed the name of vocational high schools into professional high schools. With the change of the name the government also facilitated the entry of vocational high school graduates to colleges and universities.

Most vocational high school students continue into tertiary education; in 2007 43% transferred to junior colleges and 25% to university. At tertiary level, vocational education and training is provided in junior colleges (two- and three-year programmes) and at polytechnic colleges. Education at junior colleges and in two-year programmes in polytechnic colleges leads to an Industrial Associate degree. Polytechnics also provide one-year programmes for craftsmen and master craftsmen and short programmes for employed workers. The requirements for admission to these institutions are in principle the same as those in the rest of tertiary sector (on the basis of the College Scholastic Aptitude Test) but candidates with vocational qualifications are given priority in the admission process. Junior colleges have expanded rapidly in response to demand and in 2006 enrolled around 27% of all tertiary students.

95% of junior college students are in private institutions. Fees charged by private colleges are approximately twice those of public institutions. Polytechnic colleges are state-run institutions under the responsibility of the Ministry of Labour; government funding keeps student fees much lower than those charged by other tertiary institutions. Around 5% of students are enrolled in polytechnic colleges.

**MEXICO**

In Mexico, both federal and state governments are responsible for the administration of vocational education. Federal schools are funded by the federal budget, in addition to their own funding sources. The state governments are responsible for the management of decentralised institutions, such as the State Centres for Scientific and Technological Studies (CECyTE) and Institutes of Training for Work (ICAT). These institutions are funded 50% from the federal budget and 50% from the state budget. The state governments also manage and fund "decentralised institutions of the federation", such as CONALEP schools.

Compulsory education (including primary and lower secondary education) finishes at the age of 15 and about half of those aged 15-to-19 are enrolled full-time or part-time in education. All programmes at upper secondary level require the payment of a tuition fee.

The upper secondary vocational education system in Mexico includes over a dozen subsystems (administrative units within the Upper Secondary Education

Undersecretariat of the Ministry of Public Education, responsible for vocational programmes) which differ from each other to varying degrees in content, administration, and target group. The large number of school types and corresponding administrative units within the Ministry of Public Education makes the institutional landscape of vocational education and training complex by international standards.

Vocational education and training provided under the Upper Secondary Education Under secretariat includes three main types of programme:

- "Training for work" (formación para el trabajo) courses at ISCED 2 level are short training programmes, taking typically 3 to 6 months to complete. The curriculum includes 50% theory and 50% practice. After completing the programme, students may enter the labour market. This programme does not provide direct access to tertiary education. Those who complete lower secondary education may choose between two broad options of vocational upper secondary education at ISCED 3 level. Both programmes normally take three years to complete and offer a vocational degree as well as the baccalaureate, which is required for entry into tertiary education.

- The title "technical professional – baccalaureate" (profesional técnico — bachiller) is offered by various subsystems though one subsystem (CONALEP) includes two thirds of the students. The programme involves 35% general subjects and 65% vocational subjects. Students are required to complete 360 hours of practical training.

- The programme awarding the "technological baccalaureate" (bachillerato tecnológico) and the title "professional technician" (técnico professional) is offered by various subsystems. It includes more general and less vocational education: 60% general subjects and 40% vocational subjects.

**THE NETHERLANDS**

Nearly all of those leaving lower secondary school enter upper secondary education, and around 50% of them follow one of 4 vocational programmes; technology, economics, agricultural, personal/social services & health care. These programmes vary from 1 to 4 years (by level; only levels 2,3 and 4 diplomas are considered formal 'start qualifications' for successfully entering the labour market). The programmes can be attended in either of two pathways. One either involving a minimum of 20% of school time (apprenticeship pathway; BBL-BeroepsBegeleidende Leerweg) or the other, involving a maximum of 80% schooltime (BOL-BeroepsOpleidende Leerweg). The remaining time is both cases is apprenticeship/work in a company.

So in effect, students have a choice out of 32 trajectories, leading to over 600 professional qualifications. BBL-Apprentices usually receive a wage negotiated in collective agreements. Employers taking on these apprentices receive a subsidy in the form of a tax reduction on the wages of the apprentice. (WVA-Wet vermindering afdracht). Level 4 graduates of senior secondary VET may go directly to institutes for Higher Profession Education and Training (HBO-Hoger beroepsonderwijs), after which entering university is a possibility. The social partners participate actively in the development of policy.

As of January 1, 2012 they formed a foundation for Co operation Vocational Education and Entrepreneurship (St. SBB – stichting Samenwerking Beroepsonderwijs Bedrijfsleven; www.s-bb.nl). Its responsibility is to advise the Minister on the development of the national vocational education and training system, based on the full consensus of the constituent members (the representative organisations of schools and of entrepreneurship and their centres of expertise). Special topics are Qualification and Examination, Apprenticeships (BPV-Beroepspraktijkvorming) and (labourmarket) Efficiency of VET. The Centres of Expertices are linked to the four vocational education programmes provided in senior secondary VET on the content of VET programmes and on trends and future skill needs. The Local County Vocational Training (MBO Raad www.mboraad.nl) represents the VET schools in this foundation and advise on the quality, operations and provision of VET.

**NEW ZEALAND**

New Zealand is served by 39 Industry Training Organisations (ITO). The unique element is that ITOs purchase training as well as set standards and aggregate industry opinion about skills in the labour market. Industry Training, as organised by ITOs, has expanded from apprenticeships to a more true lifelong learning situation with, for example, over 10% of trainees aged 50 or over. Moreover much of the training is generic. This challenges the prevailing idea of vocational education and the standard layperson view that it focuses on apprenticeships.

One source for information in New Zealand is the Industry Training Federation. Another is the Ministry of Education.

Polytechnics, Private Training Establishments, Wananga and others also deliver vocational training, amongst other areas.

**NORWAY**

Nearly all those leaving lower secondary school enter upper secondary education, and around half follow one of 9 vocational programmes. These programmes typically involve two years in school followed by two years of apprenticeship in a company.

The first year provides general education alongside introductory knowledge of the vocational area. During the second year, courses become more trade-specific.

Apprentices receive a wage negotiated in collective agreements ranging between 30% and 80% of the wage of a qualified worker; the percentage increasing over the apprenticeship period. Employers taking on apprentices receive a subsidy, equivalent to the cost of one year in school. After the two years vocational school programme some students opt for a third year in the 'general' programme as an alternative to an apprenticeship.

Both apprenticeship and a third year of practical training in school lead to the same vocational qualifications. Upper secondary VET graduates may go directly to Vocational Technical Colleges, while those who wish to enter university need to take a supplementary year of education.

The social partners participate actively in the development of policy. The National Council for Vocational Education and Training advises the Minister on the development of the national vocational education and training system.

The Advisory Councils for Vocational Education and Training are linked to the nine vocational education programmes provided in upper secondary education and advise on the content of VET programmes and on trends and future skill needs. The National Curriculum groups assist in deciding the contents of the vocational training within the specific occupations. The Local County Vocational Training Committees advise on the quality, provision of VET and career guidance.

**PARAGUAY**

In Paraguay, vocational education is known as *Bachillerato Técnico* and is part of the secondary education system. These schools combine general education with some specific subjects, referred to as pre-vocational education and career orientation. After nine year of *Educación Escolar Básica* (Primary School), the student can choose to go to either a *Bachillerato Técnico* (Vocational School) or a *Bachillerato Científico* (High School). Both forms of secondary education last three years, and are usually located in the same campus called *Colegio*.

After completing secondary education, one can enter to the universities. It is also possible for a student to choose both Técnico and Científico schooling.

**SWEDEN**

Nearly all of those leaving compulsory schooling immediately enter upper secondary schools, and most complete their upper secondary education in three years. Upper secondary education is divided into 13 vocationally oriented and 4 academic

national programmes. Slightly more than half of all students follow vocational programmes. All programmes offer broad general education and basic eligibility to continue studies at the post-secondary level. In addition, there are local programmes specially designed to meet local needs and 'individual' programmes.

A 1992 school reform extended vocational upper secondary programmes by one year, aligning them with three years of general upper secondary education, increasing their general education content, and making core subjects compulsory in all programmes. The core subjects (which occupy around one-third of total teaching time in both vocational and academic programmes) include English, artistic activities, physical education and health, mathematics, natural science, social studies, Swedish or Swedish as a second language, and religious studies. In addition to the core subjects, students pursue optional courses, subjects which are specific to each programme and a special project.

Vocational programmes include 15 weeks of workplace training (Arbetsplatsförlagd utbildning – APU) over the three-year period. Schools are responsible for arranging workplace training and verifying its quality. Most municipalities have advisory bodies: programme councils (programmråd) and vocational councils (yrkesråd) composed of employers' and employees' representatives from the locality. The councils advise schools on matters such as provision of workplace training courses, equipment purchase and training of supervisors in APU.

**SWITZERLAND**

Nearly two thirds of those entering upper secondary education enter the vocational education and training system. At this level, vocational education and training is mainly provided through the 'dual system'. Students spend some of their time in a vocational school; some of their time doing an apprenticeship at a host company; and for most programmes, students attend industry courses at an industry training centre to develop complementary practical skills relating to the occupation at hand. Common patterns are for students to spend one- two days per week at the vocational school and three-four days doing the apprenticeship at the host company; alternatively they alternate between some weeks attending classes at the vocational school and some weeks attending industry courses at an industry training centre.

A different pattern is to begin the programme with most of the time devoted to in-school education and gradually diminishing the amount of in-school education in favour of more in-company training.

Switzerland draws a distinction between vocational education and training (VET) programmes at upper-secondary level, and professional education and training (PET) programmes, which take place at tertiary B level. In 2007, more than half of the population aged 25–64 had a VET or PET qualification as their highest level of

education. In addition, universities of applied sciences (Fachhochschulen) offer vocational education at tertiary A level. Pathways enable people to shift from one part of the education system to another.

## TURKEY

Students in Turkey may choose vocational high schools after completing the 8-year-long compulsory primary education. Vocational high school graduates may pursue 2 year-long polytechnics or may continue with a related tertiary degree. Municipalities in Turkey also offer vocational training. The metropolitan municipality of Istanbul, the most populous city in Turkey, offers year long free vocational programmes in a wide range of topics through ISMEK, an umbrella organisation formed under the municipality.

## UNITED KINGDOM

The first "Trades School" in the UK was *Stanley Technical Trades School* (now Harris Academy South Norwood) which was designed, built and set up by William Stanley. The initial idea was thought of in 1901, and the school opened in 1907.

The system of vocational education in the UK initially developed independently of the state, with bodies such as the RSA and City & Guilds setting examinations for technical subjects. The Education Act 1944 made provision for a Tripartite System of grammar schools, secondary technical schools and secondary modern schools, but by 1975 only 0.5% of British senior pupils were in technical schools, compared to two-thirds of the equivalent German age group.

Successive recent British Governments have made attempts to promote and expand vocational education. In the 1970s, the Business And Technology Education Council was founded to confer further and higher education awards, particularly to further education colleges in the United Kingdom. In the 1980s and 1990s, the Conservative Government promoted the Youth Training Scheme, National Vocational Qualifications and General National Vocational Qualifications. However, youth training was marginalised as the proportion of young people staying on in full-time education increased.

In 1994, publicly funded Modern Apprenticeships were introduced to provide "quality training on a work-based (educational) route". Numbers of apprentices have grown in recent years and the Department for Children, Schools and Families has stated its intention to make apprenticeships a "mainstream" part of England's education system.

## CONCLUSION

India has a population of more than 1300 million and out of that 800 million are young people wanting immediate employment or business leadership qualities. This is possible only after effective training is provided at the secondary and post secondary levels. The Community College concept is the best idea for providing employment centric vocational training and guidance to the young boys and girls. They can further complete their Bachelor's or Master's Degrees but initial training through vocationalisation will enable them to either seek jobs or to become entrepreneurial leaders in future.

These 800 million trained persons may not only work in India but they can be exported to all parts of the world wherever their requirements are today or tomorrow.

## Chapter 11

# HEALTH FOR ALL STRATEGY THROUGH DRUGLESS THERAPY AND HEALING UNDER THE AEGIS OF "ACCORD"

The Afro-Asian-American Chambter of Commerce, Occupational Research and Development (ACCORD) has collaborated with the World Institute for Scientific Development of Oriental Medicine (WISDOM) and the World Initiative for Drugless Therapy and Healing (WIDTH) for launching the unique action programme of treating ailing patients all over the world through drugless therapies. This will be possible by designing a master plan for training and development of these therapies.

The World Institute for Scientific Development of Oriental Medicine (WISDOM) was inaugurated on the occasion of the International Day of Peace i.e. on 21 September 2000 at India International Centre, New Delhi by the then Union Minister for Health and Family Welfare, Government of India, Padmashri Dr. C.P. Thakur.


*Union Minister for Health and Family Welfare, Government of India Padmashri Dr. C.P. Thakur inaugurating the World Institute for Scientific Development of Oriental Medicine (WISDOM) on the Occasion of the International Day of Peace on 21 September 2000.*

The motivation for the establishment of the World Institute for Scientific Development of Oriental Medicine (WISDOM) has been based on the deliberations held on 21-25 January 1997 during the World Congress of Drugless, Oriental and Polypathic Medicine and Therapies in the presence of the Ministers of Health from different countries besides the Parliamentarians, Policy Makers, Bureaucrats, Health Professionals, Practitioners of different alternative, complementary, integrated, polypathic and drugless therapies.

Before we discuss the 525 oriental therapies which are also drugless in nature, it is essential that we discuss and trace the opinion of the World Health Organisation (WHO) regarding the traditional and oriental medicine and therapies :

## WORLD HEALTH ORGANIZATION (WHO) REPORT ON TRADITIONAL, ORIENTAL, DRUGLESS, ALTERNATIVE, COMPLEMENTARY AND INTEGRATED MEDICINE AND THERAPIES

The World Health Organization (WHO) acknowledges its indebtedness to our Member States, regional offices, and WHO Member State representative offices for actively providing data on the practice and legal status of traditional and complementary / alternative medicine in their countries and regions. Thanks are also expressed to those international professional organizations, such as the World Federation of Acupuncture and Moxibustion Societies, World Federation of Chiropractic, World Chiropractic Alliance, and Liga Medicorum Homeopathica Internationalis, who provided valuable information specific to their relevant therapies. We especially thank Mr Neil Cummings (Canada), Mr Josh Gagne (USA), Ms Sophie Lasseur (France), Ms Yong Li (China), Mr Stefano Maddalena (Switzerland), Ms Magali Ramillien (France), Ms Valerie Truong (Canada), and Mr Guoliang Zhang (China) for drafting and revising the document and Ms Kathleen Sheridan (Netherlands) and Ms Diane Whitney (USA) for editing the final draft. Appreciation is extended to the Norwegian Royal Ministry of Health and Social Affairs for providing the financial support to print this review.

## FOREWORD

National policies are the basis for defining the role of traditional and complementary / alternative medicine in national health care programmes, ensuring that the necessary regulatory and legal mechanisms are created for promoting and maintaining good practice; assuring authenticity, safety and efficacy of traditional and complementary / alternative therapies; and providing equitable access to health care resources and information about those resources.

As seen in this review, national recognition and regulation of traditional and complementary / alternative medicine vary considerably. The World Health

Organization works with countries to develop policies most appropriate for their situations. This document provides information on the legal status of traditional and complementary / alternative medicine in a number of countries. It is intended to facilitate the development of legal frameworks and the sharing of experiences between countries by introducing what some countries have done in terms of regulating traditional and complementary / alternative medicine. This information will be beneficial not only to policy-makers, but also to researchers, universities, the public, insurance companies and pharmaceutical industries. The preparation of this document took almost 10 years, largely because of a lack of financial resources. Not only was it difficult to obtain accurate, precise information on the policies of all of the World Health Organization's 191 Member States, but because of the constant work of policy-makers on health-related issues, it was impossible for us to collect current data and keep it current throughout the preparation and publication process. Although we have worked tirelessly to collect data and keep it as up to date as possible, new policies have made some information included here obsolete and basic information for many countries is still lacking. Regrettably, we were only able to include 123 countries in this review. Some countries are not included as we were unable to find sufficient information and, for some countries that are included, we may have mistakenly provided inaccurate or misleading information. We deeply apologize for any omissions or errors.

In this regard, we would sincerely appreciate countries and organizations providing necessary corrections and keeping us updated as their policies change, so that our next edition of this important document will be as accurate and complete as possible.

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## TERMINOLOGY

In this document, medical providers and practices are generally described as traditional, complementary/alternative, or allopathic. "Provider" and "practitioner" are used interchangeably. In a few cases, particularly in the European section, the cumbersome term "non-allopathic physician" is used to refer to medical practitioners who are either not allopathic practitioners or who are allopathic providers but not physicians.

## ALLOPATHIC MEDICINE

Allopathic medicine, in this document, refers to the broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific

medicine, or modern medicine. This term has been used solely for convenience and does not refer to the treatment principles of any form of medicine described in this document.

## COMPLEMENTARY / ALTERNATIVE MEDICINE

The terms "complementary medicine" and "alternative medicine" are used interchangeably with "traditional medicine" in some countries. Complementary / alternative medicine often refers to traditional medicine that is practiced in a country but is not part of the country's own traditions. As the terms "complementary" and "alternative" suggest, they are sometimes used to refer to health care that is considered supplementary to allopathic medicine. However, this can be misleading. In some countries, the legal standing of complementary / alternative medicine is equivalent to that of allopathic medicine, many practitioners are certified in both complementary / alternative medicine and allopathic medicine, and the primary care provider for many patients is a complementary / alternative practitioner.

## HERBAL PREPARATIONS AND PRODUCTS

Herbal preparations are produced by subjecting herbal materials to extraction, fractionation, purification, concentration, or other physical or biological processes. They may be produced for immediate consumption or as the basis for herbal products. Herbal products may contain excipients, or inert ingredients, in addition to the active ingredients. They are generally produced in larger quantities for the purpose of retail sale.

## TRADITIONAL MEDICINE

Traditional medicine includes a diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines; spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness. The comprehensiveness of the term "traditional medicine" and the wide range of practices it encompasses make it difficult to define or describe, especially in a global context. Traditional medical knowledge may be passed on orally from generation to generation, in some cases with families specializing in specific treatments, or it may be taught in officially recognized universities. Sometimes its practice is quite restricted geographically, and it may also be found in diverse regions of the world (see the section on complementary/alternative medicine, above). However, in most cases, a medical system is called "traditional" when it is practiced within the country of origin.

## WIDESPREAD SYSTEMS OF TRADITIONAL AND COMPLEMENTARY / ALTERNATIVE MEDICINE

### AYURVEDA

Ayurveda originated in the 10th century BC, but its current form took shape between the 5th century BC and the 5th century AD. In Sanskrit, *ayurveda* means "science of life". Ayurvedic philosophy is attached to sacred texts, the Vedas, and based on the theory of Panchmahabhutas - all objects and living bodies are composed of the five basic elements: earth, water, fire, air, and sky. Similarly, there is a fundamental harmony between the environment and individuals, which is perceived as a macrocosm and microcosm relationship. As such, acting on one influences the other. Ayurveda is not only a system of medicine, but also a way of living. It is used to both prevent and cure diseases. Ayurvedic medicine includes herbal medicines and medicinal baths. It is widely practiced in South Asia, especially in Bangladesh, India, Nepal, Pakistan, and Sri Lanka.

### CHINESE TRADITIONAL MEDICINE

The earliest records of traditional Chinese medicine date back to the 8th century BC. Diagnosis and treatment are based on a holistic view of the patient and the patient's symptoms, expressed in terms of the balance of yin and yang. Yin represents the earth, cold, and femininity. Yang represents the sky, heat, and masculinity. The actions of yin and yang influence the interactions of the five elements composing the universe: metal, wood, water, fire, and earth. Practitioners of Chinese traditional medicine seek to control the levels of yin and yang through 12 meridians, which bring energy to the body. Chinese traditional medicine can be used for promoting health as well as preventing and curing diseases. Chinese traditional medicine encompasses a range of practices, including acupuncture, moxibustion, herbal medicines, manual therapies, exercises, breathing techniques, and diets. Surgery is rarely used. Chinese medicine, particularly acupuncture, is the most widely used traditional medicine. It is practiced in every region of the world.

### CHIROPRACTIC

Chiropractic was founded at the end of the 19th century by Daniel David Palmer, a magnetic therapist practicing in Iowa, USA. Chiropractic is based on an association between the spine and the nervous system and on the self-healing properties of the human body. It is practiced in every region of the world. Chiropractic training programmes are recognized by the World Federation of Chiropractic if they adopt international standards of education and require a minimum of four years of full-time university-level education following entrance requirements.

## HOMEOPATHY

Homeopathy was first mentioned by Hippocrates (462-377 BC), but it was a German physician, Hahnemann (1755-1843), who established homeopathy's basic principles: law of similarity, direction of cure, principle of single remedy, the theory of minimum diluted dose, and the theory of chronic disease. In homeopathy, diseases are treated with remedies that in a healthy person would produce symptoms similar to those of the disease. Rather than fighting the disease directly, medicines are intended to stimulate the body to fight the disease. By the latter half of the 19$^{th}$ century, homeopathy was practiced throughout Europe as well as in Asia and North America. Homeopathy has been integrated into the national health care systems of many countries, including India, Mexico, Pakistan, Sri Lanka, and the United Kingdom.

## UNANI

Unani is based on Hippocrates' (462-377 BC) theory of the four bodily humours: blood, phlegm, yellow bile, and black bile. Galen (131-210 AD), Rhazes (850-925 AD), and Avicenna (980-1037 AD) heavily influenced unani's foundation and formed its structure. Unani draws from the traditional systems of medicine of China, Egypt, India, Iraq, Persia, and the Syrian Arab Republic. It is also called Arabic medicine.

## THE SITUATION IN THE USE OF TRADITIONAL AND COMPLEMENTARY / ALTERNATIVE MEDICINE

Traditional and complementary / alternative medicine is widely used in the prevention, diagnosis, and treatment of an extensive range of ailments. There are numerous factors that have led to the widespread and increasing appeal of traditional and complementary / alternative medicine throughout the world, particularly in the past 20 years. In some regions, traditional and complementary / alternative medicine is more accessible. In fact, one-third of the world's population and over half of the populations of the poorest parts of Asia and Africa do not have regular access to essential drugs. However, the most commonly reported reasons for using traditional and complementary / alternative medicine are that it is more affordable, more closely corresponds to the patient's ideology, and is less paternalistic than allopathic medicine. Regardless of why an individual uses it, traditional and complementary / alternative medicine provides an important health care service to persons both with and without geographic or financial access to allopathic medicine.

Traditional and complementary / alternative medicine has demonstrated efficacy in areas such as mental health, disease prevention, treatment of non-communicable diseases, and improvement of the quality of life for persons living with chronic

diseases as well as for the ageing population. Although further research, clinical trials, and evaluations are needed, traditional and complementary / alternative medicine has shown great potential to meet a broad spectrum of health care needs.

Recognizing the widespread use of traditional and complementary/alternative medicine and the tremendous expansion of international markets for herbal products, it is all the more important to ensure that the health care provided by traditional and complementary / alternative medicine is safe and reliable; that standards for the safety, efficacy, and quality control of herbal products and traditional and complementary / alternative therapies are established and upheld; that practitioners have the qualifications they profess; and that the claims made for products and practices are valid. These issues have become important concerns for both health authorities and the public. National policies are a key part of addressing these concerns.

Each year the World Health Organization receives an increasing number of requests to provide standards, technical guidance, and informational support to Member States elaborating national policies on traditional and complementary/alternative medicine. The World Health Organization encourages and supports Member States to integrate traditional and complementary / alternative medicine into national health care systems and to ensure their rational use. Facilitating the exchange of information between Member States through regional meetings and the publication of documents, the World Health Organization assists countries in sharing and learning from one another's experiences in forming national policies on traditional and complementary/alternative medicine and developing appropriate innovative approaches to integrated health care.

In 1998, the World Health Organization Traditional Medicine Team issued the publication *Regulatory situation of Herbal Medicines: A Worldwide Review*. Although it only includes information concerning the regulation of herbal medicines, this document attracted the attention of the national health authorities of World Health Organization Member States as well as of the general public.

*Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review* is much more comprehensive. Both an update and an expansion of the 1998 document, it includes information on the regulation and registration of herbal medicines as well as of non-medication therapies and traditional and complementary / alternative medical practitioners. It is an easy reference, providing summaries of the policies enacted in different countries and indications of the variety of models of integration adopted by national policy-makers. Through country-specific sections on Background information, Statistics, Regulatory situation, Education and training, and Insurance coverage, it is designed to facilitate the sharing of information between nations as they elaborate policies

regulating traditional medicine and complementary / alternative medicine and as they develop integrated national health care systems.

## AFRICA

### ANGOLA

### REGULATORY SITUATION

Although there is a registry of traditional health practitioners, there are no official legislative or regulatory texts governing the practice of traditional medicine, no licensing procedures for traditional medicine practitioners, no system for the official approval of traditional medical practices and remedies, and no local or national councils in charge of reviewing any problems concerning traditional medicine.

Traditional medicine practitioners are not involved in Angola's primary health care programme at the local or national level.

### EDUCATION AND TRAINING

Angola does not have any official training facilities or programmes for traditional medicine.

### BENIN

### BACKGROUND INFORMATION

Widespread reliance on traditional medicines can be partially attributed to the high cost of allopathic pharmaceuticals, particularly after the devaluation of the Central African franc. Numerous persons from other countries use Beninese traditional medicine.

### STATISTICS

Eighty per cent of the population relies on traditional medicine.

In the Regular Budget 1998-1999, US$ 14 000 was allocated to traditional medicine.

### REGULATORY SITUATION

There is a licensing process and a registry of traditional medicine practitioners in Benin. Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions. Some traditional medicine practitioners are involved in the primary health care programme in Benin. There

are national as well as provincial intersectoral councils and groups in charge of reviewing problems concerning traditional medicine.

Section 3 of Code 3.4, Quality of Health Care and Health Technology, relates to traditional medicine. One objective under this section is the promotion of traditional pharmacopoeia through the following:

- updating and distributing a national list of traditional medicine practitioners by field of speciality - US$ 5000 is set aside for this task;
- developing and distributing a guide for the rational use of traditional pharmacopoeia - US$ 9000 is allocated for this task.

The Ministry of Health perceives obstacles to the promotion of traditional medicine in Benin to include the following :

- lack of means to evaluate the quality, safety, and efficacy of traditional medicine products;
- lack of training in proper sanitation techniques for practitioners of traditional medicine, leading to unfavourable conditions in the practice of traditional medicine.

In consideration of these obstacles and in order to protect consumers, the Government has prioritized the following projects:

- a census of non-governmental organizations operating in the field of traditional medicine;
- a census of practitioners of traditional medicine;
- evaluation of the possibilities of integrating traditional medicine into the national health care system, particularly into health centres at the sub-prefecture level;
- training traditional medicine practitioners to refer serious cases of certain illnesses, such as malaria and HIV/AIDS, to allopathic health centres.

The Government envisions many opportunities for traditional medicine in Benin; these projects are just the first steps in a long process.

## BOTSWANA

## BACKGROUND INFORMATION

Practitioners of traditional medicine provided the only health care services available in most of Botswana until the first part of the decade following independence in 1966. The recent introduction of allopathic services throughout the country appears to have reduced the influence and activities of traditional medicine

practitioners, but only to a limited extent and mainly with respect to younger and more formally educated population groups. Traditional health practitioners are well respected and influential in rural areas and remain central figures in the everyday lives of the majority of the rural population.

## STATISTICS

There are about 3100 traditional health practitioners in Botswana, approximately 95% of whom reside in rural areas.

## REGULATORY SITUATION

The first reference to the official acceptance of traditional medicine practitioners in Botswana appears in Section 14.86 of the National Development Plan of 1976-1981:

Although not part of the modern health care system the traditional healer (*ngaka*) performs a significant role in Botswana, especially in the rural areas... The policy of the Ministry is to evaluate further the contribution of traditional healers to the health care system of the country and possibly then to seek ways of closer cooperation and consultation.

Similarly, Section 13.28 of Chapter 13 of the National Development Plan of 1979-1984 reads:

There are a large number of traditional practitioners of various types who are frequently consulted on health and personal matters. The Ministry of Health will continue its policy of gradually strengthening links with traditional practitioners - both diviners, herbalists, and faith healers. The emphasis will be put on improving mutual understanding, especially about the practices and techniques of the traditional practitioners. No full-scale integration is envisaged, but referrals between modern health care services and traditional practitioners will be encouraged where appropriate.

The Medical, Dental, and Pharmacy (Amendment) Act of 1987 outlines registration requirements for chiropractors, osteopaths, naturopaths, acupuncturists, and other complementary / alternative medical professionals in Botswana.

# BURKINA FASO

## BACKGROUND INFORMATION

Under colonialism, traditional medical practices were outlawed as harmful and dangerous. Only after independence did the Government promote traditional medicine and begin to restore esteem to traditional medical practices. However, due

to a lack of political initiative and significant mistrust between allopathic practitioners and traditional medicine practitioners, it was not until the 1980s that noticeable efforts were made. In 1983, the Government encouraged the formation of associations of traditional medicine practitioners as well as pharmacopoeia units within decentralized sanitary structures of the health system.

According to the Burkina Faso Government, traditional medicine will always remain an important source of health care for the majority of the population since traditional medicine is part of African sociocultural foundations.

## STATISTICS

More than 80% of the population in Burkina Faso use traditional medicine.

## REGULATORY SITUATION

The Natural Substances Research Institute and a Health Ministry service were created in 1978 to promote traditional medicine and pharmacopoeia. In 1979, traditional medicine practitioners were officially recognized in Burkina Faso. Title IV of the Public Health Code of 28 December 1970 pertains to traditional medicine. Section 49 states:

The practice of traditional medicine by persons of known repute shall be provisionally tolerated; such persons shall remain responsible, under civil and penal law, for the acts which they perform.

Subsequent items of legislation shall define the practice of this form of medicine and the status of persons engaged therein.

A medical and scientific commission appointed by the Minister responsible for Public Health shall conduct a study of the practice of traditional medicine and shall undertake investigations, notably in respect to traditional therapeutics, in order to identify the mode of action and posology of the drugs involved.

The Practice and Organization of Traditional Medicine, Chapter IV of Law 23/94/ADP of 19 May 1994, promulgates the Public Health Code. This chapter defines traditional medicine and traditional medicine practitioners and reiterates their official recognition in Burkina Faso.

In July 1996, the Government approved the National Pharmaceutical Policy. In 1997, the National Pharmaceutical Directive Plan was adopted to define the global objectives of the National Pharmaceutical Policy in concrete terms. One of the aims, as designated by the Ministry of Health, was the development and promotion of traditional medicine and traditional pharmacopoeia within the official Burkina

Faso health care system in order to improve the health care delivered to the population. The Plan will be taken into consideration in the development of the National Sanitary Policies, which will cover the years 2001-2010.

Decrees on the following issues are currently being elaborated: the modalities of private practice of traditional medicine, the creation of and assignments to the National Commission of Traditional Medicine and Traditional Pharmacopoeia, and an inventory of improved traditional medications.

In an effort to balance conservation of natural resources and the development of traditional medicines, the Government is also in the process of developing regulations on the exploitation of traditional pharmacopoeia products with the collaboration of national and international partners, such as the World Health Organization.

Burkina Faso has local and national intersectoral councils in charge of reviewing problems related to traditional medicine. Local officials in Burkina Faso are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions. Some practitioners of traditional medicine are involved in the primary health care programme.

## EDUCATION AND TRAINING

There is no official recognition for the qualifications of traditional health practitioners. However, there is a formal training programme in traditional medicine.

## BURUNDI

## REGULATORY SITUATION

There are no procedures for the official approval of traditional medical practices or remedies. Traditional health practitioners are not licenced, and local officials are not allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions, nor are traditional medicine practitioners involved in primary health care programmes at the local or national level in Burundi. Burundi does not have any official or legislative texts regulating traditional medicine. However, in Burundi's Public Health Code of 1982, which limits medical licences to those persons with formal training in tropical medicine, it is stated that practitioners currently treating patients by means of traditional medicine may continue to practice under the conditions and in accordance with the detailed regulations laid down by the Minister responsible for public health.

## EDUCATION AND TRAINING

Burundi does not have any official training facilities or programmes for traditional medicine.

## CAMEROON

## REGULATORY SITUATION

Law 81/12 of 27 November 1981 approved the Fifth Five-Year Social, Economic, and Political Development Plan (1981-1986) of Cameroon. Section 16-1.3.1.5 states the following:

During the Fifth Plan, measures will be taken to lay down a joint strategy and method to effectively integrate traditional medicine into the national health plan by implementing a program on traditional medicine in conjunction with some of our neighbouring countries.

Under this plan, Cameroon created the Traditional Medicine Service within the Unit of Community Medicine in the Yaounde Central Hospital and set up the Office of Traditional Medicine in the Ministry of Public Health. A number of research projects on traditional medicine and training programmes for traditional medicine practitioners have also taken place.

Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions, and some traditional medicine practitioners are involved in Cameroon's primary health care programme.

## CAPE VERDE

## REGULATORY SITUATION

Cape Verde does not have any official legislative or regulatory texts governing the practice of traditional medicine. There are no licensing procedures for traditional medicine practitioners, nor are there any procedures for the official approval of traditional medical practices and remedies. Traditional medicine practitioners are not involved in Cape Verde's primary health care programme at either the local or national level.

## EDUCATION AND TRAINING

Cape Verde does not have any official training facilities or programmes for traditional medicine.

## CENTRAL AFRICAN REPUBLIC

### REGULATORY SITUATION

The Central African Republic has local intersectoral councils for traditional medicine and a registry of traditional health practitioners. However, there are no official legislative or regulatory texts governing the practice of traditional medicine. There are no licensing procedures for traditional medicine practitioners, nor are there any procedures for the official approval of traditional medical practices and remedies. Traditional medicine practitioners are not involved in the Central African Republic's primary health care programme at the local or national level.

### EDUCATION AND TRAINING

The Central African Republic does not have official training facilities or programmes for traditional medicine.

## CHAD

### REGULATORY SITUATION

Although traditional medicine practitioners are involved in Chad's primary health care programme, Chad does not have any official legislative or regulatory texts governing the practice of traditional medicine. There is no licensing process for traditional medicine practitioners, nor are there procedures for the official approval of traditional medical practices and remedies.

### EDUCATION AND TRAINING

Chad has no official training facilities or programmes for traditional medicine.

## COMOROS

### REGULATORY SITUATION

Comoros does not have official legislative or regulatory texts governing the practice of traditional medicine. There is no licensing process for traditional health practitioners, nor are there procedures for the official approval of traditional medical practices and remedies.

Traditional medicine practitioners are not involved in the primary health care programme in Comoros at either the local or national level.

## EDUCATION AND TRAINING

Comoros does not have official training facilities or programmes for traditional medicine.

## CONGO

## BACKGROUND INFORMATION

In rural areas, herbalists and spiritualists are the two most common practitioners of traditional medicine. In urban areas, acupuncturists and natural medicine providers - medical practitioners who treat with mineral and animal products - are more common.

Through scientific analysis, independent researchers have confirmed the efficacy of a number of Congolese traditional medical products - such as manadiar, antougine, meyamium, and diazostimul - leading to their distribution throughout Africa.

## STATISTICS

For the treatment of pathologies of the reproductive system, 59.9% of Congolese women use traditional medicine. Of these women, 38.2% report having experienced complications or side effects after using these medicines.

## REGULATORY SITUATION

The traditional medicine branch of the Ministry of Health and Social Affairs was created in 1974 to develop a national herbarium and determine the number of traditional medicine practitioners in the country. In 1980, the National Union of Traditional Therapists of Congo was founded. In 1982, the traditional medicine branch was expanded, becoming the Traditional Medicine Service. The Service, led by a pharmacist, was charged with conducting research, enriching the national herbarium, gathering medicinal formulas, popularizing traditional medicine, and integrating traditional and allopathic medicine.

In 1987, the National Centre of Traditional Medicine was established to promote research, manufacture traditional medical products, exchange information with other traditional medicine institutions, train allopathic doctors and students in traditional medicine, and teach techniques for the aseptic preparation of medicines to practitioners of traditional medicine. Failure to collaborate with traditional medicine practitioners and a poor relationship between traditional medicine practitioners and allopathic practitioners proved to be obstacles to the Centre's work.

Congo has official legislative/regulatory texts governing the practice of traditional medicine. It also has local and national intersectoral councils for traditional medicine. Local officials in Congo are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions. Some traditional medicine practitioners are also involved in the primary health care programme of Congo; however, in certain centres this integration is very weak.

There is a licensing process, a national association, and a registry of traditional health practitioners. The Management of Health Services of the Ministry of Health, the National Union of Traditional Therapists, and other professional traditional medicine associations review the qualifications of traditional medicine practitioners, although there are no set criteria for these qualifications.

Traditional medicine practitioners are recognized by the Government and are well tolerated. In 1996, legislation on the recognition of traditional medicine and complementary/alternative medicine was drafted, but it has not yet been finalized because of the 1997-1999 armed conflict. Under current regulations, only herbalists are permitted to practice in the official health care system.

## EDUCATION AND TRAINING

No training in traditional medicine is integrated into the university medical curriculum.

## INSURANCE COVERAGE

An attempt has been made to standardize the fees of traditional medicine practitioners in Congo, although no patient reimbursement exists for such fees.

# CÔTE D'IVOIRE

## REGULATORY SITUATION

Cote d'Ivoire has neither official legislative nor regulatory texts governing traditional medicine. There is no licensing process for traditional health practitioners, nor are there procedures for the official approval of traditional practices or remedies. Traditional medicine practitioners are not involved with primary health care in Cote d'Ivoire on either the local or national level.

## EDUCATION AND TRAINING

Cote d'Ivoire does not have official training facilities or programmes for traditional medicine.

## DEMOCRATIC REPUBLIC OF THE CONGO

### REGULATORY SITUATION

The Democratic Republic of the Congo retains health care legislation from the colonial era, including the Decree of 19 March 1952 on the practice of medicine, as amended. The Decree grants exemplary status for traditional medicine practitioners, but also places limitations on their practice. Section 15 states the following:

The provisions of this Decree shall not be applicable to nationals of the Belgian Congo or of neighbouring African territories who, in population groups where such customs prevail, carry out treatments and administer drugs in accordance with the usage custom provided they do not constitute a breach of public order.

The Second Ordinary Congress of the Popular Revolutionary Movement in Zaire adopted a resolution in November 1977 encouraging research into the rehabilitation and recognition of traditional medicine as a complement to allopathic medicine and urging the establishment of a division dedicated to traditional medicine within the Department of Health.

## EQUATORIAL GUINEA

### REGULATORY SITUATION

Equatorial Guinea has official legislative/regulatory texts governing the practice of traditional medicine. There is a licensing process and a registry of traditional health practitioners. However, Equatorial Guinea does not have procedures for the official approval of traditional medical practices or remedies. Local officials in Equatorial Guinea are not allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions. Traditional medicine practitioners are not involved in Equatorial Guinea's primary health care programme.

### EDUCATION AND TRAINING

Equatorial Guinea has training facilities and programmes in traditional medicine for both health providers and lay persons.

### INSURANCE COVERAGE

An attempt has been made to standardize the fees of traditional medicine practitioners in Equatorial Guinea, although no patient reimbursement exists for such fees.

## ETHIOPIA

## BACKGROUND INFORMATION

Traditional medicine in Ethiopia includes medicinal preparations from plant, animal, and mineral substances, as well as spiritual healing, traditional midwifery, hydrotherapy, massage, cupping, counter-irritation, surgery, and bonesetting. Traditional medical practices and remedies are recorded in oral tradition and in early medico-religious manuscripts and traditional pharmacopoeias, which, according to the estimates of some historians, date back to the 15$^{th}$ century AD.

Traditional medicine is largely practiced by traditional medicine practitioners, although, particularly for certain common health problems, it is also practiced at home by the elderly and by mothers.

The Ethiopian Traditional Healers Association was organized to review the qualifications of practitioners where no regulations exist.

## STATISTICS

Over 80% of the Ethiopian population rely on traditional medicine. This represents the majority of the rural population and sectors of the urban population where there is little or no access to allopathic health care.

In 1986, over 6000 practitioners of traditional medicine were registered with the Ethiopian Ministry of Health.

## REGULATORY SITUATION

Proclamation 100 of 1948, Penal Code 512/1957, and Civil Code 8/1987 all state conditions for the practice of traditional medicine and the importance of the development and use of traditional remedies. The 1974 change of government in Ethiopia was followed by official attention to the promotion and development of traditional medicine, particularly after the adoption of the Primary Health Care Strategy in 1978. In November 1979, the Office for the Coordination of Traditional Medicine (*21, 23),* which is now a full-fledged department directly under the Vice-Minister of Health, was established to organize, train, and register traditional medicine practitioners, and to identify, describe, and register those traditional medicines with actual or potential efficacy. The Ministry of Health also incorporated traditional medicine into the National Ten-Year Perspective Plan 1984-1994, which called for the organization, training, and supervised use of traditional medicine practitioners in strengthening and expanding primary health care services.

The Health Policy and the Drug Policy of 1993 both emphasize the need to develop the beneficial aspects of traditional medicine through research and through its use in the official health delivery services. Proclamation 1999 was issued based on the National Drug Policy. In Article 6, Sub-Article 8 of the Proclamation, it is stated that the Drug Administration and Control Authority shall prepare standards of safety, efficacy, and quality of traditional medicines and shall evaluate laboratory and clinical studies in order to ensure that these standards are met. The Authority shall also issue licences for the use of traditional medicines in the official health services.

**EDUCATION AND TRAINING**

No officially recognized education is provided in traditional or complementary / alternative medicine.

**INSURANCE COVERAGE**

There is no national health care insurance or private insurance covering traditional medicine.

**GABON**

**REGULATORY SITUATION**

Practitioners of traditional medicine in Gabon are involved in the country's primary health care programme. However, Gabon does not have official legislative or regulatory texts governing the practice of traditional medicine. There are no licensing procedures for traditional health practitioners, nor are there procedures for the official approval of traditional medical practices and remedies.

**EDUCATION AND TRAINING**

Gabon does not have any official training facilities or programmes for traditional medicine.

**GAMBIA**

**REGULATORY SITUATION**

Gambia has official legislative/regulatory texts governing the practice of traditional medicine. There is a licensing process for traditional health practitioners and some traditional medicine practitioners are involved in Gambia's primary health care programme.

## EDUCATION AND TRAINING

Gambia has a training programme in traditional medicine for health workers.

## GHANA

## BACKGROUND INFORMATION

Missionaries introduced allopathic medicine to Ghana during the colonial period. After independence in 1957, the Government initiated a number of medical projects, promoting allopathic medicine as Ghana's official medical system. However, successive governments have recognized both traditional and complementary / alternative medicine, including acupuncture, homeopathy, naturopathy, osteopathy, and hydropathy.

Traditional medicine practitioners use herbs, spiritual beliefs, and local wisdom in providing health care.

There are a number of associations of traditional medicine practitioners, including the Ghana Psychic and Traditional Medicine Practitioners' Association, which was formed in 1961.

In 1999, the Government brought all the traditional medicine associations together under one umbrella organization, the Ghana Federation of Traditional Medicine Practitioners' Associations.

## STATISTICS

In Ghana, about 70% of the population depend exclusively on traditional medicine for their health care. There is approximately one traditional medicine practitioner for every 400 people, compared to one allopathic doctor for every 12 000 people. With over 100 000 traditional medicine practitioners uniformly distributed nationally, they are not only more accessible to the public, but also the backbone of the health care delivery system.

## REGULATORY SITUATION

Restrictions contained in the Poisons Order 1952 limit the use of the substances listed in the Order to registered medical practitioners.

The Medical and Dental Decree of 1972 and the Nurses and Midwives Decree of 1972 allow indigenous inhabitants of Ghana to practice traditional medicine, provided they do not practice life-endangering procedures.

The Centre for Scientific Research into Plant Medicine was established in 1975. In addition to its research capacity, the Centre operates a hospital providing both traditional and allopathic medicine.

Until the passage of the Traditional Medicine Practice Act, the Government worked with the Ghana Psychic and Traditional Medicine Practitioners' Association to license and register traditional medicine practitioners and to ensure a standard of care (*29, 30*). The Traditional Medicine Practice Act 595 was drafted by traditional medical practitioners, placed before the Parliament in 1999. and passed on 23 February 2000. The Act establishes a council to regulate the practice of traditional medicine, register practitioners and license them to practice and to regulate the preparation and sale of herbal medicines.

The Act defines traditional medicine as "practice based on beliefs and ideas recognized by the community to provide health care by using herbs and other naturally occurring substances" and herbal medicines as "any finished labelled medicinal products that contain as active ingredients aerial or underground parts of plants or other plant materials or the combination of them whether in crude state or plant preparation". The Act is divided into four parts.

Part I concerns the Traditional Medicine Practice Council, including its establishment; function; membership; tenure of members; meetings; the appointment of committees such as Finance, General Purposes, Research, Training, Ethics, and Professional Standards; granting of allowances to members; and the establishment of regional and district offices.

Part II covers the registration of traditional medical practitioners. Clause 9 states that no person shall operate or own a practice or produce herbal medicines for sale unless registered under this act. The qualifications for registration are given in Clause 10. Clause 11 provides for the temporary registration of foreigners who have a work permit, satisfy the requirements for registration under this act, and have a good working knowledge of English or a Ghanaian language. The rest of Part II deals with matters concerning renewal of the certificate of registration, suspension of registration of practitioners, cancellation of registration, and representation to the Council. In Clause 13, it is provided that the Minister of Health, on the recommendation of the Council in consultation with recognized associations of traditional medicine practitioners, may regulate the titles used by traditional medicine practitioners based on the types of services rendered and the qualifications of the practitioners.

Part III covers matters concerning the licensing of practices: mandatory licensing; method of application and conditions for licensing; issuance and renewal of licences; acquisition and display of licences; ownership and operation of a practice by a foreign practitioner; revocation, suspension, and refusal to renew a licence and

representations to the Council by aggrieved persons; powers of entry and inspection by an authorized inspector; and notification of death to a coroner.

Part IV concerns staff for the Traditional Medicine Practice Council as well as financial and miscellaneous provisions, such as the appointment of a registrar, the provision of the Register of Traditional Medicine Practitioners, offences, and regulations. Clause 41 states categorically that the Act shall not derogate from the provisions of the Food and Drugs Board Law PNDCL 305B.

The Traditional Medicine Unit (*26, 31*) under Ghana's Ministry of Health was created in 1991. In 1999, this was upgraded to the status of a directorate. The Ministry, in collaboration with the Ghana Federation of Traditional Medicine Practitioners' Associations and other stakeholders, has developed a five-year strategic plan for traditional medicine, which outlines activities to be carried out from 2000 to 2004. It proposes, among other things, the development of a comprehensive training programme in traditional medicine from basic to tertiary levels.

Volume 1 of the *Ghana Herbal Pharmacopoeia* contains scientific information on 50 medicinal plants. A second volume is currently in preparation. Efforts are being made to integrate traditional medicine into the official public health system. It is expected that by the year 2004, certified efficacious herbal medicines will be prescribed and dispensed in hospitals and pharmacies.

Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions.

The Government of Ghana has set aside the third week of March every year as Traditional Medicine Week, starting from the year 2000.

## EDUCATION AND TRAINING

Training by apprenticeship is required, accepted, and promoted for practitioners of traditional medicine. The Ministry of Health is working towards including traditional medicine in the curricula of allopathic medical schools and towards the introduction of a diploma course in traditional medicine at the postgraduate level. As a step in this direction, in the year 2000, the Ministry is planning to assess the training needs for traditional medicine practitioners. There are official training programmes for traditional birth attendants.

## GUINEA

## REGULATORY SITUATION

In Guinea, Ordinance 189 PRG of 18 September 1984 states that the profession of physician can only be practiced by persons with a Guinean diploma of Doctor of Medicine, a foreign diploma granting equivalent status, or a foreign diploma that entitles its holder to practice medicine in his or her country of origin. Various activities that constitute the unlawful practice of medicine are set out in Section 9. However, traditional medicine seems relatively unaffected by this ordinance. Guinea has official, applied, legislative/regulatory texts governing the practice of traditional medicine.

There is a licensing process and a registry of traditional health practitioners as well as local and national intersectoral councils for traditional medicine. Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions, and some traditional medicine practitioners are involved in Guinea's primary health care programme.

## GUINEA-BISSAU

### REGULATORY SITUATION

Guinea-Bissau has local and national intersectoral councils for traditional medicine. However, Guinea-Bissau does not have any official legislative or regulatory texts governing the practice of traditional medicine and there is no licensing process for traditional health practitioners. Local officials are not allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions and traditional medicine practitioners are not involved with Guinea-Bissau's primary health care programme.

## KENYA

### STATISTICS

Traditional birth attendants deliver most of the babies born in Kenya - up to 75% in some regions.

### REGULATORY SITUATION

Traditional medicine started being incorporated into Kenya's national health policy framework in the late 1970s. Kenya's Development Plan 1989-1993 recognized traditional medicine and made a commitment to promoting the welfare of traditional medicine practitioners.

The Ministry of Health and provincial authorities require the registration of traditional medicine practitioners. In 1999, Kenya's patent law was revised to include protection for traditional medicines.

## EDUCATION AND TRAINING

Traditional birth attendants participate in official training programmes in some districts.

## LESOTHO

## REGULATORY SITUATION

Lesotho has two statutes that regulate the practice of traditional medicine and limit it to registered practitioners. Section 2 of the Natural Therapeutic Practitioners Act of 1976 defines natural therapeutics as the provision of services for the purpose of preventing, healing, or alleviating sickness or disease or alleviating, preventing, or curing pain "by any means other than those normally recognized by the medical profession". Natural therapeutics includes methods commonly employed by homeopaths, naturopaths, osteopaths, chiropractors, and acupuncturists. Section 3 prohibits non-registered persons from practicing as natural therapeutic practitioners.

Applicants for registration must be at least 21 years of age, citizens of Lesotho, and recommended as qualified by the Natural Therapeutic Practitioners Association of Lesotho. The Registrar of the register of natural therapeutics must be satisfied that it is in the public interest to permit the applicant to practice. Persons who were practicing prior to the date of commencement of the Act are deemed to be qualified. Authorised persons under the Act are prohibited from carrying out certain procedures, including performing operations or administering injections, practicing midwifery, withdrawing blood, treating or offering to treat cancer, performing internal examinations, or claiming to be or leading people to infer that the individual is an allopathic physician. The Act also prohibits preventing any person from being treated by an allopathic physician or improperly influencing any person to abstain from such treatment.

The Lesotho Universal Medicinemen and Herbalists Council Act of 1978 followed the Act of 1976. It provides for the establishment of the Universal Medicinemen and Herbalists Council. Section 5 states the objectives of the Council: to promote and control the activities of traditional medicine practitioners, to provide facilities for the improvement of skills of traditional medicine practitioners, and to bring together all traditional medicine practitioners into one associated group.

The Council is required to do all that is necessary to attain these objectives and to ensure that every traditional medicine practitioner has a valid licence to practice as such. The Council must also keep a register of all its members. Membership is open to every traditional medicine practitioner who pays the prescribed fee. It is an

offence to form or encourage the formation of any other association of traditional medicine practitioners.

## EDUCATION AND TRAINING

Lesotho has a training programme in traditional medicine for health workers.

# LIBERIA

## REGULATORY SITUATION

Liberia has official legislative/regulatory texts governing the practice of traditional medicine. There is a registry of traditional health practitioners and there are local and national councils for traditional medicine. Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions, and some traditional medicine practitioners are involved in Liberia's primary health care programme. However, Liberia does not have licensing procedures for traditional health practitioners or procedures for the official approval of traditional medical practices and remedies.

## EDUCATION AND TRAINING

Liberia has a training programme in traditional medicine for health workers.

# MADAGASCAR

## BACKGROUND INFORMATION

The National Centre of Applied Pharmaceutical Research (NCAPR), founded in 1976, is composed of five technical departments: ethnobotanical and botanical, chemistry, pharmacodynamics, galenic pharmacy, and experimental clinics. NCAPR has the capacity to analyse herbal medicines from their ethnobotanical form to their manufactured form.

NCAPR received financial support from the United Nations Development Programme in 1984 to undertake several projects. In 1985, NCAPR and the World Health Organization agreed to a four-year collaborative project on research into traditional medicines.

The main objectives were to establish an inventory of medicinal plants and their indications, investigate the therapeutic and toxic effects of the registered plants, and undertake research standardizing and improving the presentation of traditional medicines.

In 1995, NCAPR began reviewing the practice of traditional medicine as a whole by analysing the role of traditional medicine practitioners in the primary health care system.

The National Tradi-Therapist Association of Madagascar was formed in 1997.

## STATISTICS

Serving a population of 12.3 million, there are 4500 allopathic physicians, 220 pharmacists, 360 dentists, 1635 midwives, 3124 nurses, 1282 sanitary aides, and more than 10 000 practitioners of traditional medicine.

## REGULATORY SITUATION

Traditional medicine practitioners are involved in Madagascar's primary health care programme.

In 1992, Madagascar had no legislative/regulatory texts governing the practice of traditional medicine, no licensing process for traditional health practitioners, and no procedures for the official approval of traditional medical practices or remedies. In 1996, a commission was created to study the legal aspects of traditional medicine with the intention of regulating its practice. In 1998, a project to grant official legal recognition to traditional medical practice was launched. In the same year, a census of traditional medicine practitioners was conducted, and, in addition, a project in the eastern and northern parts of Madagascar began integrating traditional medicine practitioners into the official health system. In 1999, regulations for herbal medicines were drafted. These were approved by Parliament in 2000.

## EDUCATION AND TRAINING

Madagascar does not have any official training facilities or programmes for traditional medicine for either health workers or lay persons.

# MALAWI

## REGULATORY SITUATION

The Malawi Medical Practitioners and Dentists Act of 1987 makes detailed provisions for the registration, licensing, and training of allopathic physicians and dentists. Regarding traditional medicine practitioners, Section 61 reads:

Nothing contained in this act will be construed to prohibit or prevent the practice of any African system of therapeutics by such persons in Malawi, provided that

nothing in this section shall be construed to authorize performance by a person practicing any African system of therapeutics of any act which is dangerous to life.

Some traditional medicine practitioners are involved in Malawi's primary health care programme.

## EDUCATION AND TRAINING

Malawi has a training programme in traditional medicine for health workers.

## MALI

## STATISTICS

Seventy-five per cent of the population of Mali uses traditional medicine. There is approximately one traditional medicine practitioner for every 500 inhabitants. Around 180 Herbalist Cards, 200 Therapist Cards, and 1000 Collaboration with the Traditional Medicine Department Certificates have been issued. There are 32 associations for practitioners of traditional medicine in the country.

## REGULATORY SITUATION

The Department of Traditional Medicine and the National Research Institute of Medicine and Traditional Medicine were created in 1973. They were designated to demonstrate the value of traditional medicine resources through scientific research and to differentiate the roles of herbalists from those of other traditional medicine practitioners, which included defining their respective status, regulations, and code of ethics.

The Department of Traditional Medicine is mandated to inventory medicinal plants and their indications, verify the therapeutic and toxic effects of the recorded plants, undertake studies to improve and standardize the forms of presentation of traditional medicines, train researchers in the fields of traditional medicine and traditional pharmacopoeia, involve traditional medicine practitioners in the politics of primary health care, write technical notices related to traditional medicine, and set up expert advisory missions for national and international institutions interested in traditional medicine in Mali.

In order to fulfill this mandate, the Department has planned the following: a census of traditional medical practitioners; an umbrella association to bring together the 32 traditional medicine practitioner associations; the production of improved traditional medicines, some of which have status as essential medicine in Mali and are indexed in the National Therapeutic List; the set up of phytochemical analyses as well as pharmacological and clinical tests of medicinal plants; the training of

national and foreign researchers; and participation in symposiums, seminars, and workshops.

An order issued by the Minister of Public Health and Social Affairs on 16 May 1980 (*38, 39*) established a Scientific and Technical Committee to work in conjunction with the National Research Institute of Medicine and Traditional Medicine. The Committee, whose functions are defined in relation to the overall health care needs of the country, has drawn up draft regulations on the practice of traditional medicine.

By Decree 94/282/P-RM of 15 August 1994, the Government of Mali regulated the opening of private consultation clinics for traditional medicine, medicinal herbs stores, and improved production units for traditional medicine. According to the Decree, private consultation clinics for traditional medicine are establishments that provide traditional medical care to patients. Medicinal herbs stores are airy and clean premises, which possess shelves and a counter and are run by a chartered person. The only purpose of the stores is to sell medicinal plants or medicines made from plants. However, conventional pharmacists are also allowed to sell herbs. Improved production units for traditional medicine are semi-industrial or industrial units that transform raw materials into herbal preparations and herbal products.

Decree 95/1319/MSS-PA/SG of 22 June 1995 establishes organizational and functional rules for the private consultation clinics, medicinal herbs stores, and improved production units. Under this decree, membership in a registered and recognized traditional health practitioner association facilitates one's ability to obtain a certificate of notoriety and morality. Chartered traditional medical practitioners, medical staff, and retired traditional medicine paramedical staff may open private traditional medicine consultation clinics. Chartered medicinal plant sellers, graduates from the Katibougou Rural Polytechnic Institute (which specializes in water and forests) or its equivalent, and graduates from the Superior Normal School (which specializes in biology) or its equivalent are allowed to open medicinal herbs stores. Industrial exploitation of medicinal plants is authorized only when it involves herbs, leaves, sterns, barks, and/or fruits and is permitted only when the plants are cultivated. Collection of wild plants for industrial exploitation is not permitted. Improved traditional medicine production units must be supervised by a pharmacist, and a pharmacist, chemical engineer, or biologist must monitor the control procedures.

Article 8 of Decree 95/009/P-RM of January 1995, establishing permits for pharmaceutical products, outlines special rules for requests involving traditional medicines made from plants. These requests should include the name and address of the person in charge of putting the product on the market, and if the latter is not the manufacturer, the name and address of the manufacturer: a summary of the product's characteristics (name, form, pharmacological properties, therapeutic

indications, posologies, and administration); chemical and pharmaceutical files; toxicological and pharmacological files; a clinical file; 10 samples of the product; and a receipt for the registration fee.

Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions. Some traditional medicine practitioners are involved in Mali's primary health care programme.

## EDUCATION AND TRAINING

Created in 1996, the Faculty of Medicine, Pharmacy, and Odonto-Stomatology of the University of Mali is responsible for training allopathic physicians and pharmacists. Among the requirements for students and researchers are courses directly related to traditional medicine and traditional pharmacopoeia, such as Botany, Pharmacognosy, Vegetal Substances, Chemistry, Pharmaceutical Legislation, and Public Health. Other schools, faculties, and institutes that collaborate with the Department of Traditional Medicine on training and research in traditional medicine include the Rural Polytechnic Institute, the Superior School of Health, the Central School of Commerce and Industry, the Rural Economy School, the Faculty of Science and Technology, and the Faculty of Arts, Languages, and Human Sciences.

Universities, organizations, and international and foreign research centres - such as universities in Burkina Faso, Cote d'Ivoire, France, Italy, Norway, and Senegal; the Centers for Disease Control and the National Institutes of Health, both in the United States; and ACCT, GAMES, and the World Health Organization - collaborate together on postgraduate training, research, thesis supervision, and examination boards.

Periodic meetings, seminars, and workshops have been organized with traditional medicine practitioners, sometimes through their associations. The main points of national health programmes on AIDS, mental health, and family health have been presented with the intention that traditional medicine practitioners act as intermediaries, informing the public, and in recognition of the fact that traditional medicine practitioners are involved in patient care. The Department of Traditional Medicine organizes and supervises exploratory meetings and missions between associations of traditional medicine practitioners and their foreign partners.

Each year the Department of Traditional Medicine organizes open houses on health information, education, and communication in traditional medicine. Radio and television programmes on traditional medicine with independent traditional medicine practitioners, representatives of associations, or persons in charge of technical services are regularly transmitted on public and private stations.

## INSURANCE COVERAGE

National health insurance covers allopathic medical care for only 500 000 to 1 000 000 of Mali's 11 000 000 inhabitants. It does not cover traditional or complementary / alternative medical care.

## MAURITANIA

## REGULATORY SITUATION

Adopted in 1981, Decision 1831 established a working group to examine problems concerning traditional medicine and traditional pharmacopoeia. Section 2 of the Decision reads:

The task of the working group shall be to determine the situation of traditional medicine and the traditional pharmacopoeia in Mauritania and, in particular:

- To examine the most appropriate and realistic ways and means of establishing an honest dialogue between the official health services and traditional practitioners in the spirit of the objective of health for all by the year 2000 through primary health care; and
- To propose the most appropriate mechanisms for identifying traditional practitioners who are amenable to such dialogue in order to determine and acknowledge the part that they can play in the system of comprehensive health care (health promotion, prevention of disease and disability, diagnosis and early treatment of disease, and rehabilitation).

Section 56 of Ordinance 83-136 on the practice of medical professions states that the Ordinance does not apply to traditional medicine and traditional pharmacopoeia, as they are to be covered by separate legislation. However, as of 1992, Mauritania did not have official legislative/regulatory texts governing the practice of traditional medicine, any licensing process for traditional practitioners, or procedures for the official approval of traditional medical practices and remedies. Traditional medicine practitioners are not involved in Mauritania's primary health care programme.

## EDUCATION AND TRAINING

Mauritania does not have any official training facilities or programmes for traditional medicine.

## MAURITIUS

## REGULATORY SITUATION

The Ayurvedic and Other Traditional Medicines Act of 1989 governs traditional medicine in Mauritius. In this Act. traditional medicine is defined as "the practice of systems of therapeutics according to homeopathy, Ayurvedic, and Chinese methods". The central provisions of the legislation include the establishment of a regulatory body, the Traditional Medicine Board, and a registration system that requires practitioners to obtain a diploma in traditional medicine.

The Traditional Medicine Board, established in Section 3 of the Act, is composed of Government officials, medical practitioners, persons knowledgeable in traditional medicine, and laypersons. The Board's functions, set out in Section 8, include disciplinary responsibilities, publication of a code of practice governing standards of professional conduct and ethics, and compilation of an annual list of traditional medicine practitioners.

The registration system for traditional Chinese medicine practitioners requires applicants to hold a diploma in traditional medicine. Under Section 24, non-registered persons are not entitled to practice any act of traditional medicine for gain, unless exempted from registration. However, no exemptions are listed in the Act. Unregistered persons are also prohibited from presenting themselves as registered practitioners. The Minister responsible for health has the power to make regulations, set out the basic qualifications required for studying traditional medicine, and establish the terms and conditions under which it may be practiced. The Minister also has the power to impose restrictions on the practice of any aspect of traditional medicine.

Local officials are allowed to authorize the practice of traditional medicine in their administrative and/or health subdivisions in Mauritius. There is no chiropractic law.

## MOZAMBIQUE

## REGULATORY SITUATION

Mozambique does not have official legislative/regulatory texts governing the practice of traditional medicine, any licensing process for traditional health practitioners, or procedures for the official approval of traditional medical practices and remedies. However, in 1991, a proposal was put forward for a three-year programme to establish a foundation for collaboration between the National Health Service and the practitioners of traditional medicine in Mozambique. The proposal suggested that traditional medicine practitioners constitute a separate, parallel, and self-regulating health service that collaborates with the Mozambique Government in the realization of specific public health goals. In this regard, the three-year programme would do the following:

- establish workshops to train traditional medicine practitioners in the treatment of priority diseases;
- establish a research-derived information base about traditional beliefs and practices;
- educate Government health workers at all levels in traditional beliefs and practices;
- coordinate research in traditional medicines, although, due to a tight budget, this research would not be funded by the Government itself.

Collaborative programmes with traditional medicine practitioners also take place under the umbrella of the Department of Health. In addition, there are a number of programmes sponsored by non-governmental organizations, most of which collaborate with either district or provincial health authorities.

## NAMIBIA

### BACKGROUND INFORMATION

Before independence, health services were fragmented along racial lines, and traditional medicine was outlawed. After Namibia's independence in 1990, traditional medicine was legalised. Since then, the Ministry of Health and Social Services has adopted the primary health care approach to the delivery of health services, and major restructuring has been undertaken. The Namibia Eagle Traditional Healers Association was created in 1990.

### STATISTICS

According to the 1994 Lumpkin Report, there is at least one traditional medicine practitioner per 500 people in the Kavango and Owambo regions. In the Caprivi region, there is about one traditional medicine practitioner per 300 people. In Windhoek (Katutura), the ratio is one traditional medicine practitioner per 1000 people. There are three chiropractors practicing in Namibia.

A joint study by the Ministry of Health and Social Services and World Health Organization in 1997 reported that traditional medicine practitioners in Namibia can be classified as herbalists, faith-herbalists, diviner-herbalists, diviners, faith healers, and traditional birth attendants.

### REGULATORY SITUATION

The Official National Primary Health Care/Community-based Health Care Guidelines were launched in 1992.

In 1994, Lumpkin carried out a preliminary survey on the use of traditional medicine in the country. The resulting report, *Traditional Healers and Community Use of Traditional Medicine in Namibia,* was submitted to the Ministry of Health and Social Services. Also in 1994, the Namibian Parliament passed an act requiring all health workers, including traditional medicine practitioners, to become legally registered. The act delegated each professional group to elect a board to facilitate the registration process. In 1996, the Namibian Traditional Medical Practitioners Board was created.

In 1997, the Ministry of Health and Social Services and the World Health Organization jointly undertook a study entitled *Scientific Evaluation, Standardization, and Regulation of Traditional Medical Practices in Namibia.* The findings of this study guided the development of the 1998 draft Traditional Healers Bill. They were also used to prioritize activities and to inform the planning process for the 2000-2002 programme on the regulation and integration of traditional medicine.

The Traditional Healers Bill will establish the Traditional Healers Council to oversee the registration and regulation of the practice of traditional medicine providers. The Council will be given the task of supervising and controlling the practice of traditional medicine practitioners, fostering research into traditional medicines, and making loans or grants available to traditional health practitioners. Traditional medicine practitioners in Namibia, many of whom come from other African countries, are not currently registered and operate without any guidelines from the Ministry of Health and Social Services. The aim of the Bill is to protect the public from dangerous and opportunistic practices as well as to promote acceptable aspects of traditional medicine in Namibia.

Once legislation is in place, the Government intends to include traditional medicine practitioners in community-based health care programmes and incorporate the traditional medical system into the country's official health services referral system.

The Allied Health Service Professions Act of 1993 permits the relevant Minister to create a professional board to regulate the chiropractic profession. The objectives of the board, stated in Section 2, shall be to assist in promoting health, oversee professional training, and control the practice of chiropractic.

## EDUCATION AND TRAINING

According to the joint study by the Ministry of Health and Social Services and World Health Organization in 1997, all traditional medicine practitioners, except traditional birth attendants, undergo apprenticeships ranging from one to three years.

## NIGER

### REGULATORY SITUATION

In Niger, candidates for the licence to practice traditional medicine are assigned to the National Hospital in Niamey, where they practice under the supervision of the Chief Physician.

Once satisfied with the skills of the traditional medicine practitioner, the Chief Physician then recommends that the Ministry of Public Health and Social Affairs issue a licence.

A 1989 order established the Committee for Studies on Traditional Medicine and Traditional Pharmacopoeia.

The Committee's tasks include formulating the basic premises for a national policy on traditional medicine, preparing statutes for a national institution to be responsible for improving and developing the regulation of traditional medicine, and drafting legislation governing the practice of traditional medicine.

## NIGERIA

### BACKGROUND INFORMATION

There has been a rapid expansion of allopathic health care in Nigeria over the last three decades, including an increase in the number of allopathic health care providers. At the same time, because the majority of Nigerians use traditional medicine, the Government of Nigeria has shown appreciation for the importance of traditional medicine in the delivery of health care.

### REGULATORY SITUATION

Though informal interaction between the Government and traditional medicine practitioners can be traced back to the 19th century, formal legislation promoting traditional medicine dates to 1966 when the Ministry of Health authorized the University of Ibadan to conduct research into the medicinal properties of local herbs. Efforts to promote traditional medicine continued throughout the 1970s in the form of conferences and training programmes. In the 1980s, policies were established to accredit and register traditional medicine practitioners and regulate the practice of traditional medicine. In 1984, the Federal Ministry of Health established the National Investigative Committee on Traditional and Alternative Medicine. A committee to research and develop traditional and complementary/alternative medicine was formed by the Federal Ministry of Science and Technology in 1988.

The Nigerian Medical and Dental Practitioners Act of 1988 forbids the practice of medicine or dentistry by unregistered practitioners, specifically the issuance of death certificates, performance of post-mortems, or certification of leprosy or mental disability. However, traditional medical activities are protected by a provision in Section 17.6, which reads as follows:

Where any person is acknowledged by the members generally of the community to which he belongs as having been trained in a system of therapeutics traditionally in use in that community, nothing in [the provisions of the Act dealing with offences] shall be construed as making it an offence for that person to practice or hold himself out to practice that system; but the exemption conferred by this subsection shall not extend to any activity (other than circumcision) involving an incision in human tissue or to administering, supplying, or recommending the use of any dangerous drug within the meaning of Part V of the Dangerous Drugs Act.

Registration requirements for chiropractors and osteopaths are outlined in the Medical Rehabilitation Therapists (Registration, etc.) Decree of 1988.

A 1992 decree created the National Primary Health Care Development Agency with a broad mandate concerning health matters, including the endorsement of traditional birth attendants. Among other things, the Agency is responsible for supporting village health care systems by

- paying special attention to and providing maximum support for the training, development, logistic support, and supervision of village health workers and traditional birth assistants, along with the relationship between those workers and their communities and the mechanisms that link those workers to other levels of the health system;

- paying special attention to the involvement of women and grassroots organization of women in the village health system.

In 1994, all state health ministries were mandated to set up boards of traditional medicine in order to enhance the contribution of traditional medicine to the nation's official health care delivery system.

The National Traditional Medicine Development Programme was established in 1997. Since then, the Federal Ministry of Health has been instituting measures to formally recognize and enhance the practice of traditional medicine. These measures include the constitution and inauguration of the National Technical Working Group on Traditional Medicine; development of policy documents on traditional medicine, including the National Policy on Traditional Medicine, National Code of Ethics for the Practice of Traditional Medicine, the Federal Traditional Medicine Board Decree, and Minimum Standards for Traditional

Medicine Practice in Nigeria; and advocacy for traditional medicine at all levels and in relevant forums, such as the National Council on Health (since 1997), Consultative Meetings of the Honourable Minister of Health with State Commissioners for Health and Local Government Chairmen (in 1999), and the Presidential Think Tank Forum (in 1999).

In 2000, the Traditional Medicine Council of Nigeria Act was proposed. The functions of the Council include facilitating the practice and development of traditional medicine; establishing guidelines for the regulation of traditional medical practice to protect the population from quackery, fraud, and incompetence; liaising with state boards of traditional medicine to ensure adherence to the policies and guidelines outlined in the Federal Traditional Medicine Board Act; establishing model traditional medicine clinics, herbal farms, botanical gardens, and traditional medicine manufacturing units in the geopolitical zones of the country; and collaborating with organizations with similar objectives within and outside Nigeria. The Nigeria Medical Council is contemplating integrating homeopathy into the country's health care delivery system.

## RWANDA

### REGULATORY SITUATION

Rwanda has local and national intersectoral councils for traditional medicine and a registry of traditional health practitioners. However, Rwanda does not have official legislative/regulatory texts governing the practice of traditional medicine, a licensing process for traditional health practitioners, or procedures for the official approval of traditional medical practices and remedies.

### EDUCATION AND TRAINING

Rwanda has traditional medicine training facilities for lay persons.

## SAO TOME AND PRINCIPE

### REGULATORY SITUATION

Sao Tome and Principe has local and national intersectoral councils for traditional medicine. However, there are no official legislative / regulatory texts governing the practice of traditional medicine, no licensing process for traditional health practitioners, and no procedures for the official approval of traditional medical practices or remedies.

Traditional medicine practitioners are not involved in Sao Tome and Principe's primary health care programme.

## EDUCATION AND TRAINING

Sao Tome and Principe does not have any official training facilities or programmes for traditional medicine.

## SENEGAL

## BACKGROUND INFORMATION

Despite repressive laws against the practice of traditional medicine during the colonial period, almost every village in Senegal has a traditional medicine practitioner. The Experimental Centre for Traditional Medicine was established in Senegal in 1987. It now has an active patient roster of over 30 000 persons and is made up of a professional staff of both allopathic and traditional medicine practitioners. Whether or not spiritualists should be considered as traditional medicine practitioners is currently being debated in Senegal.

## REGULATORY SITUATION

Traditional medicine was officially recognized by the Government of Senegal in 1985. Senegal has a registry of traditional health practitioners. The Health Ministry advocates the promotion and rehabilitation of traditional medicine and traditional pharmacopoeia. There are official strategies and activities to encourage collaboration between traditional and allopathic medical practitioners.

## EDUCATION AND TRAINING

Senegal has traditional medicine training facilities for lay persons.

## SEYCHELLES

## REGULATORY SITUATION

Seychelles does not have official legislative/regulatory texts governing the practice of traditional medicine, a licensing process for traditional health practitioners, or procedures for the official approval of traditional medical practices and remedies. Practitioners of traditional medicine are not involved in Seychelles' primary health care programme.

## EDUCATION AND TRAINING

Seychelles has no official training facilities or programmes in traditional medicine.

## SIERRA LEONE

## REGULATORY SITUATION

In Sierra Leone, the Medical and Dental Surgeons Act of 1966 states that nothing in the Act is to be construed as prohibiting or preventing the practice of "customary systems of therapeutics", provided that such systems are not dangerous to life or health. The Medical Practitioners and Dental Surgeons Decree of 1994 repeals the Medical and Dental Surgeons Act of 1966. However, it retains exemptions for traditional medical practitioners. Section 43 reads as follows:

Nothing in this Decree shall be construed to prohibit or prevent the practice of customary systems of therapeutics or the practice of druggists authorized by any law; but nothing in this Decree shall be construed to authorize the practice of any customary system of therapeutics which is dangerous to life or health. In Sierra Leone, some traditional medicine practitioners are involved with the primary health care programme. The Traditional Medicine Act of 1996 regulates the profession of traditional medicine and controls the supply, manufacture, storage, and transportation of herbal medicines. The Act establishes the Scientific and Technical Board on Traditional Medicine and two committees under it: the Disciplinary Committee to advise the Board on matters relating to the professional conduct of traditional medicine practitioners and the Drugs Committee to advise the Board on the classification and standardization of traditional medicines.

The Scientific and Technical Board is charged with securing the highest practicable standards in the provision of traditional medicine in Sierra Leone by promoting the proper training and examination of students of traditional medicine, controlling the registration of traditional health practitioners, and regulating the premises where traditional medicine is practiced.

It is provided in the Traditional Medicine Act that the Board shall have a registrar who shall make and keep the Register of Traditional Medical Practitioners. Anyone whose name is entered in this Register shall be regarded as a member of the Sierra Leone Traditional Healers Association. Cancellation and suspension of registration, annual publication of the list of registered traditional medicine practitioners, restriction on use of the title "Traditional Medical Practitioner", and the provision of medical aid by traditional medicine practitioners are also covered by the law. Part IV of the Act contains a list of the diseases for which traditional medical providers may not advertise treatments.

## EDUCATION AND TRAINING

Sierra Leone has no official training facilities or programmes in traditional medicine.

## SOUTH AFRICA

## BACKGROUND INFORMATION

Traditional healers - in South Africa known as *inyangas, sangomas,* and witchdoctors - have a crucial role in providing health care to the majority of South Africans. They are deeply interwoven into the fabric of cultural and spiritual life. In 1980, the Traditional Healers' Organization was created.

The National Department of Arts, Culture, Science, and Technology funds consortium research projects into traditional medicines.

## STATISTICS

Traditional healers are present in almost every community. They are the first health providers to be consulted in up to 80% of cases, especially in rural areas. There are over 200 000 traditional healers in South Africa and only 27000 allopathic medical practitioners. The Traditional Healers' Organization currently represents more than 180 000 traditional healers from South Africa and a number of neighbouring countries, including Swaziland, Zambia, and Zimbabwe. There are approximately 200 chiropractors practicing in South Africa.

Every year 1500 tons of traditional medicines are sold in medicine markets in Durban alone. The traditional medicine industry is worth up to 2300000 South African rand per year.

## REGULATORY SITUATION

South Africa regulates general traditional healers, herbalists, chiropractors, homeopaths, osteopaths, and naturopaths under the Associated Health Service Professions Act of 1982, as amended. This Act sets up a registration and licensing scheme for various professions. Registration entitles medical providers to practice for gain and call themselves members of that profession. Practice for gain by a non-registered person is an offence punishable by a fine and/or imprisonment of up to one year.

To qualify as a traditional healer, one has to serve an apprenticeship of between one and five years and must be well known within the community one serves and amongst other traditional healers. Qualified traditional healers register with the Traditional Healers' Organization and are given a book to certify that they are qualified healers. The qualifications are valid in Africa, Asia, Latin America, Europe, and Australia. However, Section 41 of the Associated Health Service Professions Act of 1982 states that the provisions of the Act shall not be read to "derogate from the right which a medicine man or herbalist contemplated in the

Code of Zulu Law may have to practice his profession". The South African law also imposes restrictions on the professional nomenclature that can be adopted by traditional healers. Use of the title "Medical Practitioner", or a title suggesting that its holder is qualified as an allopathic medical practitioner, is prohibited.

Applicants for registration as chiropractors must show they hold a degree, diploma, or certificate demonstrating sufficient proficiency in chiropractic. Such qualifications are not, in contrast, required for the registration of an osteopath or naturopath. The Associated Health Service Professions Board may, on an individual basis, impose restrictions on the kind of work that can be carried out by chiropractors or require applicants for registration to obtain further practical experience, on terms stipulated by the Board.

Chiropractors and osteopaths are prohibited from performing operations, administering injections (other than intramuscular or hypodermic injections), practicing obstetrics, and taking or analysing blood samples. Additionally, chiropractors and osteopaths may not "treat or offer to treat cancer or prescribe a remedy for cancer or pretend that any article, apparatus, or substance will or may be of value for the alleviation of the effects or for the curing or treatment of cancer". There is also a prohibition against preventing or improperly discouraging a person from obtaining treatment by an allopathic physician or health care professional. Osteopaths are subject to further restrictions, which, among other things, bar them from performing internal examinations or reading or interpreting Roentgen plates as part of a clinical diagnostic procedure.

In August 1998, the South African Parliament decided to enlist the help of traditional healers in achieving major goals in primary health care. However, whether traditional healers should become part of the Department of Health itself or belong to their own association in affiliation with the Department of Health remains controversial.

The National Department of Agriculture governs traditional medicines via the National Plant Genetic Resource Committee, of which a traditional healer is a member. The National Department of Health produced the National Drug Policy. For the purpose of implementing the National Drug Policy with respect to traditional medicines, the National Department of Health established the National Reference Centre for Traditional Medicines. Traditional medicines are included in the Drug Policy section of the Government's Reconstruction and Development Programme.

The goals of the Traditional Medicines Programme of the Department of Pharmacology, University of Cape Town (*62, 63),* are to promote the use of safe, effective, and high-quality essential traditional medicines; to promote the documentation and scientific; validation of traditional medicines; to contribute to

primary health care by providing appropriate information to traditional healers and other health professionals; to support industrial development in this sector; and to contribute to the training of traditional healers. In 1994, the Programme participated in formulating an outline proposal on the registration and control of traditional medicines.

In 1998, the Parliament passed Act 132, the South African Medicines and Medical Devices Regulatory Authority Bill, covering the registration and regulation of traditional medicines and changing the regulation of medicines in the country. The Bill establishes the South African Medicines and Medical Devices Regulatory Authority to replace the Medicines Control Council, which was set up in 1965. The Medicines Control Council held allopathic, traditional, and complementary/alternative medicines to the same set of standards and procedures. The South African Medicines and Medical Devices Regulatory Authority Bill, in contrast, makes provisions for different procedures to be applied when registering allopathic medicines and traditional and complementary/alternative medicines. This is done by establishing separate expert committees for the two major types of medicine. In the case of traditional medicines, issues of safety and quality take precedence over demonstrations of efficacy. The aim is to regulate and not to prevent access to what many people use in preference to allopathic medicines.

## EDUCATION AND TRAINING

In the 1960s, due to pressure from the South African Medical Council, non-allopathic medical colleges were closed. Those practicing at the time were 'grandfathered' into a closed register. Allopathic medical doctors retained the right to practice homeopathy regardless of their level of homeopathic education. The Homeopathic Association of South Africa is currently working to gain recognition for homeopathic education as a pre-graduate and postgraduate university subject. The long-term vision is a chair of homeopathy at one of the universities. As a first step, there are overtures to the South African College of Medicine for accreditation and application for registration of a South African Faculty of Homeopathy. There are two institutions offering six-year chiropractic programmes leading to a Master's Degree.

# SWAZILAND

## REGULATORY SITUATION

In Swaziland, the Control of Natural Therapeutic Practitioners Regulations of 1978 limits the definition of "natural therapeutic practitioner" to persons practicing chiropractic, homeopathy, naturopathy, or electropathy. The prohibitions on professional practice are similar to those in force in Lesotho. Some traditional

medicine practitioners are involved with Swaziland's primary health care programme.

## EDUCATION AND TRAINING

Swaziland has no official training facilities or programmes in traditional medicine.

# TOGO

## REGULATORY SITUATION

Togo's law on health practitioners holds exemptions in favour of providers of traditional medicine. In the first paragraph of Section 68 of the Criminal Code of 1980, the definition of the illegal practice of medicine very closely reflects Article L 372 of the French Code of Public Health. However, the second paragraph of Section 68, states the following: "The above provisions do not apply to medical practitioners who practice according to traditional methods."

Togo has a registry of traditional health practitioners. Some traditional medicine practitioners are involved with Togo's primary health care programme.

# UGANDA

## BACKGROUND INFORMATION

Practitioners of traditional medicine vastly outnumber allopathic doctors in Uganda. The National Traditional Healers and Herbalists Association has recently put forth a proposal to establish a hospital in Mengo, Kampala, where traditional health care will be offered. This proposed 20-bed hospital would operate with facilities worth US$ 8.9 million.

Traditional and Modern Health Practitioners Together against AIDS and other diseases (THETA) is an indigenous non-governmental organization dedicated to improving mutually respectful collaboration between traditional and allopathic health practitioners in Uganda. THETA is working with traditional medicine practitioners in education, counselling, and improved clinical care for people with sexually transmitted diseases, including HIV/AIDS.

## REGULATORY SITUATION

The Medical Practitioners and Dental Surgeons Act 10 of 1968 prohibits unlicensed persons from practicing medicine, dentistry, or surgery. However, Section 36 allows the practice of any system of therapeutics by persons recognized to be duly trained in such practice by the community to which they belong, provided the practice is

limited to that person and that community. In Uganda, the Ministry of Health presides over allopathic practitioners, while the Ministry of Women in Development, Culture, and Youth presides over traditional medicine practitioners.

The Government of Uganda has expressed interest in recognizing traditional health systems and has set up, under the Ministry of Health, the Natural Chemotherapeutics Research Laboratory to study the therapeutic potential of natural products. The intention is eventually to include in the National Health Service those products deemed efficacious. Research is conducted jointly with traditional medicine practitioners.

The Government of Uganda is in the process of developing a health policy emphasizing primary health care. The Health Review Commission recommended that the Ministry of Health work closely with traditional medicine practitioners to achieve the objectives of health for all by the year 2000. The Commission specifically recommended including traditional health practitioners as members of community health teams and welcoming them to participate in primary health care.

## EDUCATION AND TRAINING

THETA organizes training programmes for traditional medicine practitioners and is establishing and managing a resource and training centre to facilitate the collection and dissemination of information on traditional medicine.

## UNITED REPUBLIC OF TANZANIA

## BACKGROUND INFORMATION

Traditional medicine has been practiced separately from allopathic medicine since the colonial period. The practice of traditional medicine is threatened by a lack of written documentation on traditional medical practices, which has made its promotion difficult, and by a decline in biodiversity, including traditional medicinal resources, in certain localities. There has also been a decline in the number of practitioners of traditional medicine. Beginning in the 1990s, complementary / alternative systems of health care have emerged in Tanzania. These new medical options include magnetic therapy, homeopathic medicine, massage, and traditional Chinese, Korean, and Indian medicines.

## REGULATORY SITUATION

The Medical Practitioners and Dentists Ordinance, which was constituted before Tanzania's independence and is still in operation, holds exemplary status for traditional practitioners. Chapter 92.20 states the following:

Nothing contained in this ordinance shall be construed to prohibit or prevent the practice of systems of therapeutics according to native methods by persons recognized by the community to which they belong to be duly trained in such practice.

Provided that nothing in this section shall be construed to authorize any person to practice native systems of therapeutics except amongst the community to which he belongs, or the performance of an act on the part of any persons practicing any such system which is dangerous to life.

In an effort to promote and standardize traditional medicine, the Government established the Traditional Medicine Research Unit in 1974 as part of the University of Dar es Salaam and the Muhimbili Medical Centre. In 1985, the Government of Tanzania was in the process of developing a law to register and license traditional practitioners.

In 1989, governance of traditional health services was shifted from the ministry responsible for culture to the Ministry of Health, which has established a Traditional Health Services Unit. This Unit is working to unify traditional health practitioners and mobilize them to form their own association. The Unit is also involved in the formation of a traditional medicine policy, the overall goal of which is to improve the health status of the people through the use of effective and safe elements of traditional health care. Traditional health services are officially recognized in the National Health Policy of 1990.

## EDUCATION AND TRAINING

There has been no attempt to introduce or incorporate traditional medicine into the training curricula of allopathic medical students.

## ZAMBIA

## BACKGROUND INFORMATION

During the colonial period, traditional medicine was denigrated. After independence in 1964, the Zambian Government did not enact legislation to regulate traditional medicine, nor was a clear policy on the practice of traditional medicine postulated. Nevertheless, traditional medicine continued to be practiced and was tolerated by the authorities.

Currently, herbal medicine, naturopathy, traditional Chinese medicine, reflexology, spiritualism, and other forms of medicine are practiced in Zambia. Both Zambians and foreign nationals practice traditional and complementary/alternative medicine.

## STATISTICS

At least 70% of Zambians use traditional medicine. Traditional and complementary / alternative medicine is used and accepted by a great majority of the population, regardless of ethnic, religious, or social background. There are more than 35 000 members of the Traditional Health Practitioners' Association of Zambia, founded in 1978, and thousands of non-members.

## REGULATORY SITUATION

The Government recognizes traditional and complementary/alternative medicine and there are national policies on traditional and complementary/alternative medicine. The Traditional Health Practitioners' Association reviews and registers traditional practitioners for licensing. Although there are no official regulatory measures for recognizing the qualifications of practitioners, plans are under way to develop such regulations.

Traditional medicine and complementary/alternative medicine are neither integrated with allopathic medicine nor into the national health system. However, Traditional Birth Attendants and Community Health Care Workers practice at the level of primary health care.

The National Drug Policy has a chapter on traditional medicines, which discusses the *materia medica* but not the practice of traditional medicine.

## EDUCATION AND TRAINING

There is no formal training in traditional or complementary/alternative medicine at any allopathic training institutions.

## INSURANCE COVERAGE

Traditional and complementary/alternative medicine are not covered by insurance in Zambia.

## ZIMBABWE

## BACKGROUND INFORMATION

During the colonial period, although huge amounts of funds were allocated to the allopathic medical sector, no budgetary provisions were made for the traditional medical sector. Zimbabwe's independence in 1980 marked a turning point in the long antagonistic relationship between allopathic and traditional medicine. The Zimbabwe National Traditional Healers Association (ZINATHA) was formed the

same year (*76, 77*), having been proposed at a meeting of 100 prominent traditional medical practitioners and Government officials organized by the then Minister of Health, Dr H. Ushewokunze.

The goals of ZINATHA are to promote traditional medicine and practice, promote research into traditional medicine and methods of healing, promote training in the art of herbal and spiritual healing, supervise the practice of traditional medicine and prevent abuse and quackery, and cooperate with the Ministry of Health to establish better working relations between traditional and allopathic practitioners.

## STATISTICS

In 1994, there were 11 000 workers in the allopathic health system in Zimbabwe. At the same time, ZINATHA had 24 000 qualified members. There are now over 55 000 traditional medicine practitioners registered with ZINATHA. There are four chiropractors practicing in Zimbabwe.

## REGULATORY SITUATION

In Zimbabwe, the Minister of Health presides over both allopathic and traditional health sectors. In 1981, two significant statutes on the practice of traditional medicine were enacted in Zimbabwe. The comprehensive scope of these acts provides a sharp contrast to the general legalisation on the practice of traditional medicine adopted in other jurisdictions. The Natural Therapists Act of 1981 regulates the organization and registration of *natural therapists,* a term that includes homeopaths, naturopaths, and osteopaths. It is an offence for an unregistered person to engage in the practice of these professions for gain or to claim to be a registered natural therapist. Licensing legislation regulates the educational standards and practice of chiropractic.

The Traditional Medical Practitioners Council Act of 1981 is one of the most comprehensive pieces of legislation on the practice of traditional medicine that has been enacted anywhere in the world. Under the terms of the Act, the practice of traditional medicine includes every act the object of which is to treat, identify, analyse, or diagnose, without the application of operative surgery, any illness of the body or mind by traditional methods. The Traditional Medical Practitioners Council Act recognizes ZINATHA as the association for traditional medicine practitioners in Zimbabwe. This legislation also created the Traditional Medical Practitioners Council.

The objectives of the Traditional Medical Practitioners Council are to supervise the control and practice of traditional medical practitioners, promote the practice of traditional medical practitioners, foster research into traditional medical practice, develop knowledge of traditional medical practice, hold inquiries for the purpose of

the Traditional Medical Practitioners Council Act, and make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the purposes of the Council.

The Minister of Health is to appoint a registrar to establish a register of traditional medicine practitioners. The Traditional Medical Practitioners Council is to grant an application for registration if it is satisfied that the applicant possesses sufficient skill and ability to practice traditional medicine and is of good character. Where appropriate, the Council may grant the applicant a qualification as a spirit medium. The Minister of Health may also grant registration as an honorary traditional medical practitioner, with or without qualification as a spirit medium, to traditional practitioners of special standing. Registered practitioners may use the title "Registered Traditional Medical Practitioner" or "Registered Spirit Medium".

An unregistered person commits an offence punishable by up to two years imprisonment and/or a fine if he or she practices or carries on business for gain as a traditional medical practitioner, whether or not purporting to be registered; pretends, or by any means whatsoever holds himself or herself out to be a registered traditional medical practitioner; or uses the title "Registered Traditional Medical Practitioner" or any name, title, description, or symbol indicating or calculated to lead persons to infer that he or she is registered as a traditional medical practitioner. Falsely claiming to be a registered spirit medium constitutes a similar offence. The Council has the authority to make by-laws to define "improper and disgraceful conduct" in the case of registered traditional medical practitioners. A registered practitioner who is found guilty of such conduct or who is grossly incompetent is liable to disciplinary measures, which include cancellation or temporary suspension of registration.

## THE AMERICAS

### ARGENTINA

### STATISTICS

In Argentina, an estimated 3000 physicians and 500 pharmacists practice homeopathic medicine. There are three practicing chiropractors. Some kinesiologists are also members of the chiropractic association.

### REGULATORY SITUATION

Traditional medicine is regulated by Article 75-17 of the Constitution, Ley 23.302, Decreto 1269-96, and Resolution 83-94. Only professionally qualified doctors who have graduated from recognized medical schools may legally practice homeopathy.

In November 1997, the Chamber of Deputies of Cordoba Province regulated the prescription of homeopathic medications. There is no chiropractic law.

## EDUCATION AND TRAINING

There are seven homeopathic schools offering regular three-year degree programmes as well as intensive programmes. A chiropractic college is being established.

# BOLIVIA

## BACKGROUND INFORMATION

The principal specialities of traditional medicine practitioners are *coca qawiri,* midwifery, *aysiri, materos, qulliri, milluris, qaquidores, paqos, layqiri,* and *rezadores.*

## STATISTICS

In Bolivia, where 50.5% of the population is indigenous, the proportion of the population with access to allopathic medicine ranges from 11% to 70%. depending on the region. There is a strong preference for traditional medicine. In southern Cochabamba, over 55% of the population prefer to use traditional medicine. There are an estimated 5000 practicing traditional health providers. There is one practicing chiropractor.

## REGULATORY SITUATION

In 1985, the practice of traditional medicine was legally recognized. Laws governing traditional medicine in Bolivia include Traditional Medicine Practice Regulation 198771-1984, Resolución Suprema 198771-84, and Personería Juridica de la Sociedad Boliviana de Medicina Tradicional. In order to practice traditional medicine in Bolivia, it is necessary to have an official licence granted by the Ministry of Human Development. However, only an estimated 500 traditional medicine practitioners have this permit. Revalidation of one's Doctor of Chiropractic degree is required to practice chiropractic.

The National Division of Maternal and Child Health was established in 1982 with regulations on the conduct of family health activities. This division is authorized to regulate traditional birth attendants.

There is no official programme linking traditional medicine with allopathic medicine. There is no formal registry of traditional medicine practitioners.

In 1982, the Ministry of Health established regulations on herbal medicines, and as of January 2001, all homeopathic medicines must be registered.

## EDUCATION AND TRAINING

In 1982, the Ministry of Health set up a training programme for traditional practitioners at allopathic medical schools. KUSKA (a civil organization devoted to multi-disciplinary research in health, education, agriculture, ecology, and eco-tourism) has two schools of traditional medicine: INKARI in Cochabamba and the Kallawaya Institute in La Paz. At these schools, experienced traditional health practitioners offer seminars, workshops, lectures, meetings, and trimester courses, as well as opportunities for students to observe and practice consultations and treatments.

Formal courses, workshops, and seminars in traditional medicine are also available through the official health sector. Workshops, principally sponsored by the Catholic Church, are offered for nurses and health promoters. Traditional medical knowledge may also be acquired through personal revelations and inspiration. In Rahay Pampa, traditional medicine is frequently taught to successive generations within a family.

# BRAZIL

## STATISTICS

In Brazil, there are an estimated 12 000 homeopathic physicians, 200 homeopathic veterinarians, 100 homeopathic dentists, 1300 homeopathic pharmacists, and six homeopathic laboratories. There is a chiropractic association in Brazil.

## REGULATORY SITUATION

Regulations governing traditional medicine in Brazil include La Política de Atención Integral a la Salud Indígena de FUNASA, which promotes respect for the traditional systems of health of indigenous communities. In 1980, the Brazilian Medical Association recognized homeopathy as a medical speciality.

In 1988, the Government recognized homeopathy and included it in the National Health System. Since 1995, the Federal Council of Pharmacy has recognized and standardized the title of "Specialist in Homeopathic Pharmacy".

## EDUCATION AND TRAINING

As of 1991, physicians seeking homeopathic specialization must complete a 1200-hour course: 450 hours of theory, 450 hours of practice, and 300 hours of

monographs. The Feevale Central University and University of Anhembi Morumbi offer chiropractic programmes recognized by the World Federation of Chiropractic.

## CANADA

## BACKGROUND INFORMATION

In Canada, complementary/alternative and traditional medicines are known as natural health products and are subject to food and drug regulations. Natural health products include herbal medicines; traditional Chinese, ayurvedic, and native North American medicines; homeopathic preparations; and vitamin and mineral supplements.

There are a number of associations of complementary/alternative medical practitioners. In 1983, the Chinese Medicine and Acupuncture Association of Canada (CMAAC) was established as a national organization. CMAAC works to unite practitioners and to lobby the Government for the regulation of traditional Chinese medicine and acupuncture.

In 1987, the World Federation of Acupuncture and Moxibustion Societies was formed with the support of the World Health Organization. In 1996, allopathic physicians interested in traditional and complementary/alternative medicine in Canada created the Canadian Complementary Medical Association.

## STATISTICS

Several reports from the late 1990s found that between 15% and 70% of the Canadian population had used complementary/alternative medicine in the proceeding six to 12 months (*89, 90, 91*). A 1999 study, for example, reported 70% of Canadians had used one or more natural health products in the preceding six months, but only 24% consulted one or more complementary/alternative health practitioners.

The use of complementary/alternative medicine is increasing in Canada (*92, 93*). The following chart represents findings of the 1999 Berger Monitor survey on the six-month use of complementary/alternative health practitioners in 1993 and 1999. According to a study by the Fraser Institute, of the Canadians who have used complementary / alternative medicine, 36% have consulted a chiropractor, 23% have used relaxation techniques, 23% massage. 21% prayer, 17% herbal therapies, 12% special diet, 12% folk remedies, 12% acupuncture, 10% yoga, 8% self-help groups, 8% lifestyle diets, and 8% homeopathy.

| **Complementary/Alternative medicine** | **Respondents who had consulted a practitioner of complementary/alternative** |
|---|---|

| | medicine | |
|---|---|---|
| | **1993** | **1999** |
| Chiropractors | 9% | 12% |
| Massage/masseuses | 4% | 10% |
| Herbalists | 1% | 3% |
| Acupuncturists | 1% | 2% |
| Homeopaths | 1% | 2% |
| Reflexologists | 1% | 2% |

A significant proportion of Canadians report spending 30 Canadian dollars or more per month on complementary/alternative health services or natural health products. From 1996 to 1997, a total of 3.8 billion Canadian dollars was spent on complementary / alternative health care in Canada. The amount spent on vitamins and food supplements is rising by 20% a year.

In general, the use of complementary/alternative health care in Canada is higher at younger ages, among women, among people with higher formal education and higher incomes, and in the West. Canadian users of complementary/alternative medicine have more good health habits and better overall health. However, these differences are partly minimized when adjusted for age, education, and household income. Users of complementary/alternative medicine make fewer visits than non-users to both allopathic general practitioners and specialists.

The most common reasons for which patients consult complementary/alternative practitioners are problems of the musculoskeletal system and connective tissue. These complaints account for 56% of consultations. Other problems include respiratory diseases, injuries, poisonings, ill-defined conditions, and special investigations.

Complementary / alternative practitioners provide most complementary / alternative treatments. However, allopathic physicians are increasingly involved in the provision of complementary/alternative medicine. There are approximately 4500 chiropractors practicing in Canada.

## REGULATORY SITUATION

Canadian physicians choosing to provide alternative treatments must comply with guidelines set by the relevant province's College of Physicians and Surgeons. The Federal Food and Drug Act does not recognize traditional Chinese doctors, naturopaths, homeopaths, or herbalists. However, the recent Federal Report (supra) noted that access to quality health care is tied to the education, training, and

licensing of practitioners and products. As such, it seems likely that Canada will soon give formal recognition to more complementary/alternative practitioners.

Most of the health care legislation, such as the Canada Health Act, focuses on allopathic medical practitioners. However, the regulation of professionals is a provincial matter, and many provinces have become tolerant of non-allopathic health care providers. Ontario's Regulated Health Professions Act, S.O. 1991, c.18 is an example of the more inclusive legislation adopted by a number of provinces.

On 26 March 1999, the Federal Government accepted all 53 recommendations made by the Standing Committee on Health in their report, *Natural Health Products: A New Vision.* While the Health Minister's formal acceptance of these recommendations will not immediately change the status of natural health products in Canada, the policy direction has been set. A transition team was created and it is now working to implement these recommendations. One of the recommendations led to the creation of the Office of Natural Health Products, which regulates the safety, quality, and proper labelling of these products. It is also responsible for supporting epidemiological and social science research and for the dissemination of information to Canadian consumers to enable them to make informed self-care decisions.

Beginning in the spring of 2000, the Office of Natural Health Products invited comments and suggestions from a wide range of interested Canadians - including manufacturers, distributors, and retailers of natural health products - on the formation of a regulatory framework for natural health products, covering their production, import, sale, and use in Canada. In March 2001, the Proposed Regulatory Framework for Natural Health Products was drafted.

The Framework contains provisions for natural products sold in Canada, including licensing of products and sites, good manufacturing practices, labelling and packaging, and reporting of adverse reactions. The intent is to address consumers' concerns for safety and product quality without being unduly restrictive of the natural health product industry.

The Expert Advisory Committee on Complementary Medicines was recently formed to provide scientific advice to the Therapeutic Products Programme of Health Canada on issues regarding the safety, quality, and efficacy of natural health products.

## TRADITIONAL NATIVE NORTH AMERICAN MEDICINE

In the Yukon Territory, the Health Act of 1990 endorses traditional native North American medical practices. Section 5 includes provisions to secure "aboriginal control over traditional aboriginal nutritional and healing practices and to protect

these healing practices as a viable alternative for seekers of health and healing services". The Minister of Health also "promote(s) mutual understanding, knowledge, and respect between providers of health and social services offered within the health and social service system and the providers of aboriginal nutrition and healing".

In Ontario, traditional birth attendants providing midwifery services to aboriginal persons or members of an aboriginal community are exempt from the general rule that restricts "managing labour or conducting the delivery of a baby" to allopathic physicians, nurses, and midwives. Traditional birth attendants can adopt the title "Aboriginal Midwife" as a professional designation and portray themselves as qualified to practice in Ontario.

## MANIPULATIVE THERAPY

In at least nine Canadian provinces, special statutes restrict the practice of manipulative therapy to persons who fulfil specific requirements and have been registered and/or licensed. All provinces have laws regulating the practice of chiropractic. In Ontario, manipulative therapy is regulated under the Regulated Health Professions Act of 1991 and the Chiropractic Act of 1991. The Health Professions Act states that it is an offence for a person to "move the joints of the spine beyond the individual's usual physiological range of motion using a fast, low-amplitude thrust" unless the person is authorized by one of the listed health profession acts, such as the Chiropractic Act. The Chiropractic Act limits the practice of chiropractic to members of the College of Chiropractors. The legislation permits the use of the title "Doctor" by members of the College of Chiropractors of Ontario.

No offence is committed under the Health Professions Act when an otherwise impermissible joint movement is performed in the course of "treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment" or where the treatment is performed by an aboriginal medical practitioner providing traditional medicine services to aboriginal persons or members of an aboriginal community.

Chiropractors have professional status in Alberta. In 1994, Alberta introduced requirements for the continuing education of licensed chiropractors. Practitioners must acquire 75 hours of continuing education every three years as a condition for renewal of their annual licence. Full credit is given for participation in programmes accredited with listed professional bodies. Credit may also be given for other educational activities with an emphasis in chiropractic, such as research or university studies.

In Saskatchewan, the Chiropractic Act of 1994 repeals the 1978 Act on the same subject and prohibits anyone other than a member of the Chiropractors' Association from using the titles "Chiropractor", "Doctor of Chiropractic", or "any word, title or designation, abbreviated or otherwise, to imply that the person is engaged in or qualified to engage in the practice of chiropractic." Section 22 of the Act lays out the restrictions on and exemptions to the practice of chiropractic in Saskatchewan:

1. No person other than a practicing member shall engage, for fee or reward, in the practice of chiropractic.

2. Subsection 1 does not apply to a person providing first aid or temporary assistance in cases of emergency.

3. Nothing in this Act extends to or interferes with the privileges conferred on any person who practices a profession, trade or calling that the person is licensed or authorized to practice pursuant to any other Act.

**TRADITIONAL CHINESE MEDICINE AND ACUPUNCTURE**

Health Canada, through the Therapeutic Products Programme, is actively pursuing the National Initiative on Traditional Chinese Medicine. British Columbia, Alberta, and Quebec include acupuncture among their regulated health professions. Saskatchewan and the Yukon Territory have guidelines on the practice of acupuncture.

A 1993 report by the British Columbia Health Professions Council recommended the designation of acupuncture as a health profession with three limitations: acupuncture should not be used in the treatment of serious illnesses, such as cancer; acupuncture should not be used as anaesthesia during surgery, unless supervised by a physician or dentist; and the patient must be told to consult an allopathic physician, dentist, or naturopath if acupuncture fails to improve the patient's condition within two months.

The Ministry of Health in British Columbia has agreed that traditional Chinese medicine and acupuncture should be regulated. In April 1998, the British Columbia Health Professions Council recommended designating "the profession of traditional Chinese medicine as a health profession under the Health Professions Act." The Council also recommended that a college be established to govern both practitioners of acupuncture and practitioners of traditional Chinese medicine. This college will ensure that practitioners complete adequate training based on Government standards.

The Health Disciplines Act of 1980 sets out a framework for the recognition and regulation of health disciplines in Alberta. Acupuncture is governed by the

accompanying Acupuncture Regulation. In order to be registered as a member of the acupuncture health profession, an applicant, who need not be an allopathic physician, must complete both an approved programme of study and an examination. Competence in English must also be demonstrated. However, this requirement may be waived where the applicant practices under the supervision of an English-speaking acupuncturist.

Before acupuncture treatment is administered in Alberta, the patient must have consulted with an allopathic physician or dentist and informed the acupuncturist of this. Acupuncturists are prohibited from implying to patients that acupuncture cures diseases or advising patients to discontinue treatment recommended by an allopathic physician or dentist. If an improvement in the patient's condition does not occur within six months, the patient must be referred to an allopathic physician or dentist.

In Alberta, permissible technical modes of practice are restricted to needle acupuncture, electro-acupuncture, moxibustion, cupping, and acupressure. Only non-invasive measuring equipment may be used in patient examinations. The Acupuncture Regulation also lists a number of procedures that cannot be delegated to non-acupuncturists, including taking patients' medical histories, using diagnostic instruments or therapeutic devices on patients, and inserting or removing acupuncture needles.

The Quebec Medical Act of 1973 required the Bureau of the Ordre des Médecins to enact rules for the training, practice, and annual registration of allopathic physicians practicing acupuncture. Rules were also introduced concerning the practice of acupuncture by non-physicians. Non-physician practitioners must hold a recognized college diploma and pass an acupuncture exam set by the Quebec medical regulatory body. Detailed patient records must be kept covering matters such as diagnoses made, treatments rendered, and details of patient consultations with other medical professionals, including allopathic physicians.

Under Section 44 of the Medical Act of Quebec, no person can claim to be an acupuncturist unless he or she is a registered non-physician or allopathic physician who has undergone the required training in acupuncture. Moreover, non-physician practitioners are precluded from using the title "Doctor" or any title that may infer that status unless they have a doctorate in acupuncture, in which case they may use the title "Doctor of Acupuncture".

A number of medical professional regulatory bodies in Canada have published guidelines relating to acupuncture. In Saskatchewan, such guidelines were drawn up by the College of Physicians and Surgeons. These permit the practice of acupuncture by allopathic physicians who hold a recognized diploma. The guidelines do not mention the practice of acupuncture by non-physicians.

Guidelines issued by the Yukon Medical Council, however, state that acupuncture is a medical procedure that should only be performed by allopathic physicians or dentists with an appropriate level of training. The guidelines do not permit physicians to delegate acupuncture procedures to others, such as physiotherapists, "except in an approved institutional setting such as a public hospital". The reasoning behind this is that the Yukon guidelines acknowledge that acupuncture has a "valid role" in patient management but warn that, based on current knowledge, "it does not have a curative effect on the fundamental disease process". The guidelines strongly endorse two training programmes recognized by the College of Physicians and Surgeons in British Columbia, but stop short of requiring completion of a programme of study.

## NATUROPATHY

Naturopathy is regulated in Alberta, Manitoba, and Saskatchewan. In each of these three provinces, naturopaths must meet specified educational requirements and be registered in order to practice naturopathy or use the title of "Naturopath". Educational requirements include the completion of a four-year college programme. Manitoba and Saskatchewan also require an examination in anatomy, physiology, chemistry, general diagnosis, and the principles of naturopathy. In all provinces, naturopaths are prohibited from performing certain health care activities, such as the prescription and administration of allopathic drugs, obstetrical practice, and surgery.

In Alberta, two corresponding provisions in the Chiropractic Profession Act of 1984 forbid dual registration as a naturopath and chiropractor. One states that registered chiropractors cannot practice naturopathy and the other that practicing naturopaths cannot be registered as chiropractors.

## EDUCATION AND TRAINING

Complementary/alternative training programmes are provided by private institutes, universities, and community colleges, but there is no universal system of accrediting and validating programmes. Though there is no standardized complementary / alternative component in allopathic curricula, most medical schools offer some form of training in complementary / alternative medicine to their students of allopathic medicine, but this usually takes the form of a two-hour to four-hour lecture. The 1998 Standing Committee Report states that there is increasing interest in having more training programmes and more standardized training curricula in complementary / alternative medicine for both complementary/alternative and allopathic providers.

In 1985, the Institute of Chinese Medicine and Acupuncture was established to promote the training standards of the Chinese Medicine and Acupuncture

Association of Canada. Students interested in entering the four-year programme offered by the Institute are required to have first completed three years of coursework in the sciences at a recognized university. There are two chiropractic colleges in Canada recognized by the World Federation of Chiropractic.

## INSURANCE COVERAGE

Coverage of complementary / alternative therapies by provincial health insurance plans and workers' compensation boards is selective and minimal. Some provincial health insurance plans cover chiropractic (Alberta, British Columbia, Manitoba, Ontario, Saskatchewan, and New Brunswick only for seniors who purchase extended coverage), and one covers naturopathy (British Columbia). Osteopathy is covered in Alberta.

Workers' compensation boards cover chiropractic in all provinces and territories. Workers' compensation boards in British Columbia, Newfoundland, Ontario, Prince Edward Island, Quebec, and the Yukon Territory cover acupuncture on a case-by-case basis or on prescription by an allopathic physician (*92, 116*).

The Alberta Health Care Insurance Plan discontinued its coverage of acupuncture on 1 March 1994. Patients are now solely responsible for the cost of acupuncture treatment.

About 96% of the private health insurance coverage in Canada is group policies purchased primarily by employers.

This insurance is a non-taxable benefit so long as, among other things, reimbursement is only provided for qualified medical practitioners, which include chiropractors, osteopaths, naturopaths, therapists, acupuncturists, and dieticians.

# CHILE

## BACKGROUND INFORMATION

The Mapuche Community Hospital offers traditional and allopathic treatment options. Practicing at the hospital are traditional medical providers, bonesetters, and two allopathic doctors. The hospital is affiliated with Mapuche University. Both the hospital and the university receive financial support from the Ministry of Health.

## STATISTICS

In Chile, 10% to 12% of the population is indigenous. Seventy-one per cent of the population uses complementary / alternative medicine. There are between 2000 and

10 000 traditional health practitioners in Chile. Principal traditional medical specialities are herbalism, spiritualism, traditional birth attendance, aromatherapy, bach flowers, acupuncture, bonesetting, and chiropractic.

## REGULATORY SITUATION

National policies emphasize equal treatment for traditional and allopathic medicine. Homeopathy and the *Homeopathic Pharmacopoeia* are legally recognized. The Public Health Institute recognizes homeopathic remedies. Traditional and complementary / alternative medicine are regulated by Ley 19.253 of October 1993, which takes into consideration their role in public health.

The Ministry of Health oversees the Unit of Traditional Medicine, which also governs complementary/alternative medicine, and the Unit of Indigenous Community Health. The Unit of Traditional Medicine was established in August 1992. Its objectives are to set standards for the safety and efficacy of traditional medicines and to encourage the use of proven traditional medicines, including incorporating them into allopathic health programmes. The Unit of Indigenous Community Health develops the primary health care system at the community level.

The Health Ministry issues licences for the practice of traditional medicine, but very few traditional medicine practitioners are licensed. Unlicensed traditional health practitioners risk fines or the closure of their offices. There is no official registry of traditional medicine practitioners.

## EDUCATION AND TRAINING

Mapuche University offers programmes in traditional knowledge leading to Bachelor's, Master's, and Doctorate degrees. Students of these programmes may choose to specialize in traditional medicine. The university also cultivates medicinal plants and conducts research on traditional medicine. Most students of traditional medicine learn through apprenticeships with experienced providers. In some cases, these are family members. Some practitioners receive medical insight through personal revelations.

Traditional medical training for official allopathic health personnel is not very extensive and consists of occasional informative events that may or may not be included in official training programmes.

The Government has recognized homeopathy as a medical system, but there are no officially recognized training programmes or examinations. A chiropractic college is being established.

## COLOMBIA

### BACKGROUND INFORMATION

Traditional medicine is widely practiced in Colombia.

### STATISTICS

Forty per cent of the population has used complementary/alternative medicine. There are six chiropractors practicing in Colombia.

### REGULATORY SITUATION

The Congress of Deputies officially recognized homeopathy as a system of medicine in 1905. In 1914, the Government standardized training requirements for homeopathic doctors and established a system of title protection. Only allopathic physicians may practice homeopathy. The Institute of Medicaments and Food regulates the manufacturing of homeopathic remedies. Integration of homeopathy into the Public Health Services is planned. Chiropractors are not permitted to use X-ray equipment. However, chiropractors may request radiologists to provide X-ray services for their patients.

### EDUCATION AND TRAINING

Homeopathy is taught in three schools authorized by the Ministry of Education. The regular three-year courses are limited to licensed allopathic physicians.

## COSTA RICA

### BACKGROUND INFORMATION

There are no associations of traditional medicine practitioners in Costa Rica. Women do not practice traditional medicine.

### STATISTICS

There are at least 19 practitioners practicing indigenous traditional medicine. There are two chiropractors practicing in Costa Rica.

### REGULATORY SITUATION

Though the production of traditional medications is regulated, the practice of traditional medicine is ignored in official health laws. There is no registry of traditional health practitioners in Costa Rica. Traditional medicine practitioners

are not licensed, nor are they sanctioned for practicing medicine. This may soon change, however, as the Legislative Assembly is currently considering a bill that would regulate traditional medicine.

There are no official programmes linking traditional medicine with allopathic medicine.

The College of Physicians and Surgeons recognized homeopathy as a medical speciality in 1994. By a pronouncement of the Sala de Jurisdicción Constitucional of the Supreme Court on 9 January 1998, allopathic medical doctors can be accredited postgraduate homeopathic studies under the Medical Speciality Regulations. Homeopathy is thereby treated as a branch of allopathic medicine and governed by the same regulations as other allopathic specialities. A chiropractic law is pending. In 1996, a multidisciplinary committee composed of representatives from the Ministry of Health and colleges of pharmacy in Costa Rican universities convened to formulate regulations on herbal medicines. In 1998, the committee published Decree 26782S regulating the industrialization, registration, commercialization, and publication of herbal preparations and herbal products.

## EDUCATION AND TRAINING

There are no institutions officially responsible for teaching traditional medicine. Postgraduate homeopathic studies are available through an institution recognized by the College of Physicians and Surgeons.

## CUBA

## STATISTICS

Sixty per cent of the population use traditional or complementary/alternative medicine. Sixty per cent of allopathic physicians are trained in traditional or complementary / alternative medicine. There are 579 registered herbal products made in Cuba. An additional 295 registered herbal products are imported.

## REGULATORY SITUATION

Following the 1959 revolution, Cuban health authorities forbade the practice of traditional medicine by anyone except traditional birth attendants. Traditional birth attendants were slowly integrated into Cuba's health services as ancillary staff. The 1983 Cuban Public Health Law puts forth strict requirements for the qualification of health care workers. Traditional medicine practitioners are not granted exemplary status. Section 90 states the following:

Medical, dental, and pharmaceutical activities and other health professions shall be practiced by persons who have followed special courses and hold a qualification conferred by a centre of higher education in Cuba (or an equivalent foreign qualification); the activities of health technicians, qualified staff, and other health workers shall be practiced by persons who have followed special courses and hold a qualification granted by an institute, school, polytechnic, or centre for technical training in health.

A 1988 decree, which contains regulations for the implementation of the Public Health Law, prohibits the practice of medicine by persons who do not meet these qualification criteria. In 1992, the Ministry of Health officially recognized homeopathy. National and international homeopathic congresses were scheduled during 1997 and 1998, and there are an increasing number of physicians using homeopathic remedies. Homeopathic dispensaries are spread all over the country. A standard good manufacturing practice for the manufacture of homeopathic remedies has been accepted. In 1992, acupuncture was integrated into the Cuban health care system. In 1995, the Traditional Medicine Programme was instituted, prioritizing the cultivation of medicinal plants, the education of practitioners, research into traditional medicine, and the integration of traditional medicine into the national health care system.

## EDUCATION AND TRAINING

Courses on introductory and advanced homeopathy are given at the medical and pharmaceutical schools.

## DOMINICAN REPUBLIC

## BACKGROUND INFORMATION

The principal traditional medical specialities are *vodun, ensalmadorismo,* and herbalism.

## STATISTICS

There are between 2000 and 3000 practitioners practicing traditional health in the Dominican Republic.

## REGULATORY SITUATION

Although there is an official programme linking traditional medicine with allopathic medicine, there is no official registry of traditional health practitioners, and traditional medicine practitioners are not licensed in the Dominican Republic.

## EDUCATION AND TRAINING

The Ministry of Health and Social Welfare offers training programmes for traditional birth attendants in hospitals and health centres throughout the Dominican Republic. The Pan American Health Organization assisted in revising these programmes in 1973 (*120, 126*). There are no other institutions that teach traditional medicine. Instead, traditional medicine is taught through apprenticeships with experienced practitioners. Traditional medical knowledge may also be transmitted through dreams and personal revelations. There are no official training programmes in traditional medicine for allopathic health personnel.

# ECUADOR

## BACKGROUND INFORMATION

In Ecuador, there are associations of traditional medicine practitioners that work at regional and local levels. Some of these associations were created by indigenous organizations and others by state initiatives.

## STATISTICS

There are nine chiropractors practicing in Ecuador.

## REGULATORY SITUATION

Section 174 of the Ecuadorian Health Code of 1971 limited the practice of physicians, pharmacists, dentists, midwives, and other health practitioners to persons holding qualifications "granted or validated by the University of Ecuador". Under Section 179, health authorities were responsible for the detection and suppression of the illegal practice of medicine and allied professions "without prejudice to normal judicial proceedings". By Section 180, "It shall be automatically assumed that a person is illegally practicing [medicine]... if, without holding a legally conferred qualification, diploma, or certificate, he possesses equipment or materials for such practice."

In the beginning of 1998, indigenous peoples proposed a bill to regulate traditional medicine. This bill was passed in June and came into force in August 1998. Based on this bill, the Constitutional Assembly included two articles in the Constitution that stipulate principles on which the practice of traditional medicine must be based. Chapter 4, Section 4, Article 44 reads as follows:

The State will formulate national health policy and will monitor its application. It will control the operation of the entities of this sector. It will acknowledge, respect and promote the development of traditional and alternative medicine, the practice

of which will be regulated by law and will promote scientific and technological advancement in the health area subject to bio-ethical principles.

The Constitution of the Republic, Chapter 5, Article 84, Numeral 12 establishes collective rights:

to the systems, knowledge and practice of Traditional Medicine, including the right to the protection of ritual and sacred places, plants, animals, minerals and ecosystems of interest to the State from the point of view of traditional medicine.

There is no registry of traditional medicine practitioners in Ecuador and no licensing procedure for practitioners of traditional medicine. There is no official institution in charge of regulating traditional medical practice. There is, however, the National Division of Indigenous Health, which was created by a ministerial resolution to promote the development of traditional medicine.

In Ecuador, there are no specific programmes linking traditional medicine with allopathic medicine. But, with increasing interest in traditional medicine, particularly Quichua medicine, the State is focusing more attention on official linkages. Some efforts have been made to coordinate with institutions and organizations affiliated with traditional medicine in Ecuador.

In 1983, the Government recognized homeopathy as a medical practice. The Ecuadorian Medical Federation began officially recognizing homeopathy as a medical speciality in 1988. It is also recognized in the Constitution of the National Assembly. There is no chiropractic law.

## EDUCATION AND TRAINING

Universidad Andina Simón Bolívar, a private Andean university in the city of Quito, is responsible for teaching traditional medicine in Ecuador. Offerings include certificate programmes, seminars, workshops, and meetings.

The Ministry of Public Health established training courses for traditional birth attendants in 1974 with the aim of incorporating them into the health services of rural areas. There is no official training in traditional medicine offered to allopathic health personnel.

# GUATEMALA

## BACKGROUND INFORMATION

The principal traditional medicine specialists in Guatemala are traditional birth attendants, bonesetters, herbalists, spiritualists, *chupadores,* massage therapists,

and practitioners who specialize in muscle tears. A 1977 order established the Guatemalan Association of Acupuncture. The Association promotes the knowledge and the study of acupuncture and facilitates professional contacts with acupuncturists in other countries. Membership in this association does not license individuals to practice acupuncture.

The University of San Carlos is undertaking research on medicinal plants.

## STATISTICS

There are approximately three traditional health practitioners per municipality. About 250 traditional health practitioners are registered with the TOTO-Integrado Association.

## REGULATORY SITUATION

The laws regulating traditional medicine in Guatemala include Acuerdos de Paz, the Political Constitution, the Health Code, and Regulations for the Quality Control of Herbal Products (*82, 129*). The Health Code defines, classifies, and outlines registration and licensing requirements for all medicines. The Regulations for the Quality Control of Herbal Products classifies herbal products and registration procedures for them.

Although there is no official licence to practice traditional medicine, 10% of traditional medicine practitioners have a permit to practice. These permits are issued upon completion of a training course organized by the Public Health Ministry and local health centres. The permits are not available throughout the country. Traditional medicine practitioners without permits may practice within their own communities, but they are rejected by institutions and risk being sued for malpractice. A registry of traditional health practitioners is currently being developed.

The programme of the Integral Healthcare System links traditional and allopathic medicine.

## EDUCATION AND TRAINING

Courses in traditional medicine are available through the Public Health Ministry. Additionally, CDRO in Totonicapan, Barefoot Doctors in Chinique, and Quiche Guatemala offer technical studies, seminars, informal presentations, and workshops that include instruction in traditional medicine. Traditional medicine is also learned through apprenticeships, which may include practice, observation, readings, workshops, and videos. How to treat a particular illness is sometimes

learned as a result of having suffered from it oneself. Personnel in the official health services do not receive training in traditional medicine.

## HONDURAS

### REGULATORY SITUATION

Section 130 of the Honduran Health Code of 1966 States the following:

The practice of naturopathy, homeopathy, empiricism, and other occupations considered to be harmful or useless by the Secretariat for Public Health and Social Welfare shall be prohibited in the country.

Practitioners of traditional medicine are not granted exemplary status. There is no chiropractic law.

## JAMAICA

### STATISTICS

More than 8000 medicinal products, including 610 vitamins, 90 minerals, and 60 herbal remedies, were registered and licensed in Jamaica between 1975 and 2000. Of the 403 medicinal products registered in 1999, 9.5% were of herbal origin. Herbal products are a multi-million dollar industry in Jamaica.

### REGULATORY SITUATION

In 2000, the Parliament considered revisions to the Food and Drugs Act of 1964 and the Food and Drugs Regulations of 1974. The revisions were aimed at ensuring the safety, efficacy, and quality control of herbal products. In 2001, the Parliament approved the revisions, under which the following applied:

- Products are subject to approval, requirements for which are similar to, but not as elaborate as, those for pharmaceuticals. The onus is on manufacturers to substantiate quality, efficacy, and safety.
- Products containing vitamins and minerals in less than three times the recommended daily amount are classified as foods and do not require formal registration.
- Vitamins containing more than three times the recommended daily amount are classified as drugs.
- Herbal products require registration if they contain substances used for conditions that normally need medical intervention.
- Herbal products containing substances used for self-limiting conditions that do not normally require medical intervention do not require registration.

- Registered products, like drugs, require a permit for importation.
- Products that are not registered do not require a permit for importation; however, proof of quality is required annually or such other time, as deemed necessary.

The revisions define an herbal medicine as "a medicinal product consisting of a substance produced by subjecting a plant or plants to drying, crushing, or any other process or of a mixture whose sole ingredients are two or more substances so produced or of a mixture whose sole ingredients are one or more substances so produced and water or some other inert substance". This definition is adapted from Section 132 of the United Kingdom's Medicines-Act of 1968. There is no chiropractic law. Chiropractors are recognized as medical practitioners but prohibited from providing physical therapy services and from using the title of "Doctor".

## MEXICO

### BACKGROUND INFORMATION

The principal traditional medical specialists are traditional birth attendants, herbalists, bonesetters, *curanderos,* snake *culebreros,* shamans, spiritualists, and *sobadores.*

### STATISTICS

Traditional birth attendants preside over more than two-thirds of childbirths in Mexico. There are 55 to 60 chiropractors practicing in Mexico. There are about 3000 homeopathic physicians.

### REGULATORY SITUATION

In 1980, the Mexican Institute of Social Security created a unit to study traditional medicine and medicinal plants. Later, a programme was introduced to foster the integration of traditional and allopathic systems of medicine. The programme was designed to involve traditional practitioners in the health activities of 3500 rural medical units within the Social Security System. The Mexican Institute of Social Security is also working with the national plan for depressed zones and marginalized groups (Coplamar) to integrate allopathic and traditional medicine.

Mexico's registry of traditional medicine practitioners is kept by the National Indigenous Institute and the Mexican Institute of Social Security.

Traditional medicine forms an integral part of the health care delivery system. Although there is no official licence for the practice of traditional medicine, other than for traditional birth attendants, the authorities are currently working on

creating such a licence. Proposals for a bill to regulate traditional medical practice, aside from that of traditional birth attendants, have been made since 1989.

The Regulations of 20 October 1976 established a distinct sector of the health field for qualified traditional birth attendants. Section 2 of the Regulations define qualified traditional birth attendants as persons who have been attending deliveries without training and are licensed and qualified under the Regulations. Licences are issued by health centres following the completion of a training course. Section 9 states that entry to the course is restricted to persons who have attained majority, are literate, and are recognized by the communities in which they work as carrying out obstetric activities. Section 13 specifies that traditional birth attendants may attend women in their community during normal pregnancy, delivery, and the puerperium provided that they notify a health centre. They may also prescribe appropriate medications in accordance with the instructions of the Secretariat for Health and Welfare.

There is a proposal to add provisions to the General Health Law that would regulate the quality control of medical activities, establishments, products, and services. Chapter 4 of these proposed changes covers herbal medicines.

Homeopathy has been accepted and integrated into the national health system in Mexico. In 1895, a presidential decree was issued to establish a national homeopathic school; to regulate training requirements for homeopathic doctors, including title protection; and to establish a national homeopathic hospital. In 1996, the Government recognized homeopathy as a medical speciality. Licensing legislation regulates chiropractic educational standards and practice. Chiropractors have been licensed since 1988. Credentials must be periodically revalidated.

## EDUCATION AND TRAINING

The National Indigenous Institute has a unit dedicated to the organization, coordination, and instruction of traditional medicine. In some states, the Institute coordinates with associations of traditional medicine practitioners to provide workshops, courses, and other activities where practitioners can gather and share their knowledge. Traditional medicine is taught through apprentice programmes, including practice, observation, and workshops. In some cases, families are known for a particular speciality.

The Mexican Institute of Social Security offers informal presentations and workshops on traditional medicine, medical anthropology, and community work techniques to personnel working in the official health services.

There are several schools and hospitals teaching homeopathy. Homeopatia de Mexico, an association for homeopathic practitioners, obtained official recognition

for its postgraduate school in 1996. A chiropractic college is presently being established.

## NICARAGUA

### STATISTICS

There are 2500 persons registered in the registry of traditional medical practitioners. The principal traditional medical specialities are traditional birth attendance, herbalism, spiritualism, and massage.

### REGULATORY SITUATION

The Department of Traditional and Popular Medicine of the Ministry of Health regulates traditional medicine in Nicaragua. No licence is required to practice traditional medicine. While there are no restrictions or legal barriers that limit its practice, the Nicaraguan Academy of Homeopathic Medicine is working towards gaining official status for homeopathy. The National Council of Universities supports homeopathy and accepts its practice by allopathic doctors.

A regulation on the use of plant medicines is currently being developed and will eventually be under the responsibility of the Department of Drugstores of the Ministry of Health according to the General Law of Medication and Drugstores.

### EDUCATION AND TRAINING

In 1989, the Ministry of Health established the National Centre of Popular and Traditional Medicine with the objective of training health promoters and allopathic medical and paramedical persons in these fields. In 1991, courses in traditional medicine were introduced into allopathic nursing schools, and allopathic nurses began being trained in basic plant therapy and medical anthropology.

After the change of government in the same year, the Centre became a non-profit foundation independent from the Ministry of Health. Along with the National Autonomous University of Nicaragua and several institutions under the leadership of the Ministry of Health, the Centre forms a part of the National Commission for Essential Investigation.

Cecalli, Soynica, the School of Agriculture, UNAN, Real Nicaraguense de Sistemas Traditionales, and MINSA also offer training in traditional medicine. Though allopathic health personnel may follow these courses, training in traditional medicine is not offered through the official health services.

## PANAMA

## BACKGROUND INFORMATION

The Government of Panama has made considerable efforts to register and train traditional birth attendants and to integrate them into the country's health care system.

## STATISTICS

Although there is only one chiropractor practicing in Panama, both the United States and Canada have been sending chiropractic missions to Panama since 1997.

## REGULATORY SITUATION

Law 4376 of August 1999 created the Area of Traditional Medicine under the National Directorate of Health Promotion. The Area is charged with developing a strategy of action for the incorporation of traditional medicine into primary health care, including research on medicinal plants.

The Carta Organica Administrativa de la Comarca, following Executive Decree 194 of 26 August 1999, governs traditional medicine in the Ngöbe-Buglé region. Article 258 of the Carta classifies traditional medical specialities, the services they offer, and their legal status regarding diagnosing ailments and dispensing medicines.

This same article recommends that traditional and allopathic medical practitioners cooperate and collaborate together.

Article 257 creates the Special Medical and Technical Commission to bring together traditional medicine and allopathic medicine. Articles 261 and 262 refer to the organization of botanical gardens for the scientific study of medicinal plants and propose the publication of texts and health manuals.

Article 266 defines the functions of the Special Medical and Technical Commission, including the following:

- coordinating with the national health system:
- certifying traditional health practitioners;
- organizing the methodology for a study of traditional medical practice;
- educating the public about scientific investigations into the methods, uses, and effects of traditional medicine;
- preparing a health infrastructure plan for the community;
- studying the medical history of the Ngöbe-Buglé.

In recognition of the existence, contribution, and importance of traditional medicine to the health of indigenous communities, Article 3 of Law 36 of 3 October 2000, *a* nationally applicable law, created an autonomous institute of indigenous traditional medicine. The institute recognizes, protects, and promotes traditional knowledge related to the medicinal properties of plants, access to genetic resources in indigenous regions, and the return and distribution of benefits from the commercial application of this knowledge.

In Article 4 of Law 36, it is stated that at the institute there will be one representative of each indigenous community, one representative of traditional medicine practitioners, the Minister of Health or designate, and one representative of the Panamanian Medical Association.

Article 7 establishes traditional medicine as the patrimony of the communities from which it comes and advances the conservation and promotion of traditional medicine in indigenous areas. It also states that allopathic medicine should not be forced upon these communities. Article 8 recognizes traditional health systems in indigenous communities. Article 10 mandates indigenous authorities to mount a campaign of protection, promotion, and conservation of traditional medical practices.

Article 21 orders the establishment of a Faculty of Medicine and a Faculty of Pharmacy of indigenous *materia medica* and their use in the treatment of sickness. The rest of the articles of Law 36 refer to access to resources, benefit sharing, intellectual property, and the commercialization of medicinal plants.

Licensing legislation regulates chiropractic educational standards and practice. A chiropractic law was adopted in 1967, permitting chiropractors to "examine, analyse and diagnose the human body by way of any method physical, chemical, electrical, or the use of x-ray" and provides for "the adjusting, manipulation and treating of the human body".

## PERU

## BACKGROUND INFORMATION

The principal traditional medical specialities are herbalism, traditional birth attendance, and bonesetting. The National Institute of Traditional Medicine has 17 branches throughout the country. It disseminates information and conducts research on traditional medicine. In particular, the Institute is responsible for a research programme in traditional medicine known as the General Direction of Research and Technology.

This programme is responsible for carrying out clinical research, conducting medical anthropological research, gathering demographic statistics, and facilitating the integration of traditional and allopathic medicine. It is also charged with promoting the protection, control, and cultivation of medicinal plants.

## REGULATORY SITUATION

Traditional medicine was officially prohibited in Peru in 1969, but the prohibition was not enforced. The National Institute of Traditional Medicine is the official institution working on the regulation of traditional medicine. The Congress of the Republic is discussing potential laws and statutes for the regulation of traditional medicine. A bill on traditional medicine was proposed in 1999, but has not yet been passed.

Although there is no official licence in Peru for the practice of traditional medicine, the Ministry of Health issues practice permits. A registry of traditional medicine practitioners is currently being developed in Peru.

The Ministerial Decree for the Creation of Rural and Urban Peripheral Health Services places priority on the investigation and preservation of traditional medicine.

Section 4 of the Supreme Decree 010-97-SA of 1997 regulates plant medicines and natural resources of medicinal value. It defines and classifies plant medicines and natural resources of medicinal value, outlines procedures and requirements for their registration, and details the requirements that must be met for the manufacture and sale of plant medicines.

## EDUCATION AND TRAINING

Students of traditional medicine learn via apprenticeships involving practice, observation, and videos as well as from personal experiences, revelations, and dreams. In some cases, medical skills are passed down within families. The National Institute of Traditional Medicine provides official training programmes in traditional medicine.

In addition, some universities and non-governmental organizations registered with the Ministry of Health offer programmes in traditional medicine for traditional medicine practitioners. Some universities offer seminars, workshops, meetings, and conferences in traditional medicine for students studying allopathic medicine. Courses, workshops, and informal presentations are also offered to official health personnel.

## UNITED STATES OF AMERICA

## BACKGROUND INFORMATION

Complementary/alternative medicine has a substantial presence in the United States health care system. Both public and professional interest in these therapies is increasing. The College of Physicians and Surgeons at Columbia University and the Falk Institute of Pittsburgh University have research projects devoted to assigning an integrative role in the health care system to complementary/alternative therapies.

In 1991, Congress established the Office of Alternative Medicine within the National Institutes of Health to encourage scientific research in the field. The National Institutes of Health Revitalization Act of June 1993 was a landmark. It expanded the Office of Alternative Medicine within the National Institutes of Health from a staff of six to a staff of 12. The Office's objectives include the facilitation and evaluation of "alternative medical treatment modalities, including acupuncture and Oriental medicine, homeopathic medicine, and physical manipulative therapies". The Office is mandated to set up an advisory council, establish an information clearinghouse to exchange information on traditional medicine, support research and training, and provide biennial reports on the Office's activities to the Director of the National Institutes of Health. These reports are then included in biennial reports to the President and Congress.

## STATISTICS

A 1997 national survey estimated that in the previous year 42.1% of the adult population in the United States had used at least one of the complementary/alternative therapies included in the survey. This is an increase from 33.8% in 1990. The therapies included in the survey were relaxation techniques, herbal medicines, massage, chiropractic, spiritual healing by others, megavitamins, self-help groups, imagery, commercial diets, folk remedies, lifestyle diets, energy healing, homeopathy, hypnosis, biofeedback, and acupuncture. Rates of use of complementary/alternative therapies in 1997 ranged from 32% to 54% in the socio-demographic groups examined. The therapies with the greatest increases in use included herbal medicines, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. Visits to chiropractors and massage therapists accounted for nearly half of all visits to complementary/alternative medical practitioners in 1997.

The probability of patients visiting a complementary/alternative medical practitioner increased from 36.3% to 46.3% between 1990 and 1997. The total number of visits to complementary/alternative medicine practitioners increased

from 427 million in 1990 to 629 million in 1997, thereby exceeding total visits to all primary care allopathic physicians.

Estimated expenditures for professional complementary/alternative medical services increased 45.2% between 1990 and 1997. For 1997, these expenditures are conservatively estimated at $21.2 billion with at least $12.2 billion of this paid out-of-pocket. Total 1997 out-of-pocket expenditures relating to complementary / alternative therapies are conservatively estimated at $27 billion, which is comparable with the projected 1997 out-of-pocket expenditures for all physician services. Just over half of patients (64% in 1990 and 58.3% in 1997) of complementary/alternative medical practitioners pay entirely out-of-pocket for the services.

Approximately 3000 allopathic physicians and other health care practitioners currently use homeopathy.

In 1993, more than 45 000 licensed chiropractors and 32 000 Doctors of Osteopathy were practicing in the United States. More than 60% of osteopathic physicians are involved in primary care. The profession is responsible for approximately 10% of the total health care delivered in the United States. Chiropractors currently see 10% to 15% of the population of the United States. There are about 6000 acupuncture practitioners in the United States. An estimated 3000 allopathic physicians have taken courses in acupuncture with the intention of incorporating it into their medical practices. There are over 1000 licensed naturopathic doctors in the United States. There are approximately 50 000 biofield practitioners providing 18 million sessions annually. There are approximately 50 000 qualified massage therapists in the United States, providing 45 million one-hour massage sessions per year. There are 10 ayurvedic clinics in North America, including one hospital-based clinic that served 25 000 patients between 1985 and 1994.

## REGULATORY SITUATION

In the United States, regulatory controls surrounding complementary / alternative medicine involve six related areas of law: licensing, scope of practice, malpractice, professional discipline, third-party reimbursement, and access to treatments. State laws dominate the first five areas. Federal laws, particularly food and drug laws, largely control the sixth. In each of these areas, legal rules aim to safeguard consumers against fraud and to ensure patient protection against dangerous practices and practitioners. Because allopathic medicine has historically dominated licensing, accreditation, reimbursement, and other regulatory structures, however, existing legal rules governing complementary/alternative therapies and providers arguably favour allopathic medicine and paternalism at the expense of concerns for patient choice and autonomy.

Licensing laws in each state provide that the unlicensed practice of medicine is a crime, with medicine being broadly defined to include such matters as diagnosis and treatment of disease or any human condition. Both non-licensed providers of complementary/alternative care (such as non-allopathic physician homeopaths, herbalists, iridologists, nutritionists, and spiritualists not practicing within the tenets of a specific recognized religion) *and* licensed complementary/alternative care providers (such as chiropractors and, in many states, acupuncturists, massage therapists, and naturopaths) who exceed their legislatively authorized scope of practice risk prosecution for unlicensed medical practice.

Under malpractice rules, practitioners are liable when their professional practices deviate from standards of care applicable to their locale and speciality and when patient injury results. This is problematic since complementary / alternative care by definition deviates from allopathic standards of care. Professional disciplinary cases are frequently brought against allopathic providers integrating complementary/alternative practices, often in tandem with civil malpractice lawsuits. Third-party reimbursement is regularly denied to patients receiving such treatments because the third parties consider the treatments to be experimental and/or not medically necessary. Patients find access to complementary/alternative treatments restricted further on the grounds that the medicinal substances used to diagnose, cure, or mitigate disease are classified under federal law as new drugs and are thus subject to extensive premarketing approval to show safety and efficacy before they may be used.

Although more and more complementary/alternative medical providers are being licensed in the United States, legal rules must continue to evolve to accommodate widespread consumer and provider use of therapies that have historically fallen outside the scope of allopathic medicine.

## TRADITIONAL NATIVE NORTH AMERICAN MEDICINE

Traditional Native North American medicine in the United States is regulated under the Self-Determination Act.

## HOMEOPATHY

Arizona, Connecticut, and Nevada have specific licensing boards for homeopathic physicians.

The market for homeopathic medicine in the United States is a multi-million dollar industry. Homeopathic remedies are recognized and regulated by the Food and Drug Administration and are manufactured by pharmaceutical companies under strict guidelines.

## MANIPULATIVE THERAPY

Statutes regulating the practice of manipulative therapy exist in every state of the United States. Practice is restricted to persons who fulfil certain requirements and have been registered and/or licensed. In many cases, practicing without a licence is an offence.

Licensing legislation regulates chiropractic educational standards. An example of such legislation is found in Sections 6551-6556 of Book 16 of the Consolidated Laws of New York. The New York statute states that chiropractors may not treat specified diseases; perform operations; reduce fractures or dislocations; or prescribe, administer, dispense, or otherwise use medicines or medicaments in their practice. Only licensed persons may practice chiropractic and use the title of "Chiropractor". To be eligible for a professional licence, an applicant must have completed two years of pre-professional college study and a four-year chiropractic resident programme as well as obtaining satisfactory experience and passing the licensing examinations.

In the United States, practitioners of manipulative therapy are sometimes considered on the same professional level as allopathic physicians. Part 59 of Title 57 of the United States Code of Federal Regulations includes osteopathic general practice in the definition of allopathic family medicine. However, with the exceptions of South Carolina and Arizona, all states require chiropractors to add an accompanying qualifying reference to chiropractic following the use of the title "Doctor" or "Physician".

## ACUPUNCTURE

Section 355 of the Federal Food, Drug, and Cosmetic Act covers the labelling of medicines and devices, including acupuncture needles and equipment. In 1973, acupuncture was declared by the Food and Drug Administration to be a method of treatment for investigational use by licensed practitioners only until "substantial scientific evidence is obtained by valid research studies supporting the safety and therapeutic usefulness of acupuncture devices". The Food and Drug Administration at that time published a notice calling for labeling requirements for such devices, including the following warning: "Caution: experimental device limited to investigational use by or under the direct supervision of a medical or dental practitioner."

States have an array of provisions regarding the practice of acupuncture. In New York, legislation was passed in 1974 on the recommendation of the State Commission on Acupuncture. The legislation allowed state boards responsible for medicine and dentistry to formulate rules and regulations governing the provision of acupuncture and to establish licensing procedures for its practice in New York. The main prerequisites for a licence were that the applicant had practiced

acupuncture for at least 10 years and had a licence as "a doctor of acupuncture, herb physician, or doctor of traditional Chinese medicine duly issued by the licensing board of any foreign country".

A 1991 statute altered the above position by substituting licensing rules; creating a board of acupuncture made up of acupuncturists, licensed allopathic physicians, and members of the public; and obliging licensed acupuncturists to advise patients about the importance of consulting a licensed allopathic physician concerning their prognosis, and keep a record of the dispensation of this advice.

To qualify for a licence to practice acupuncture, applicants must satisfy a pre-professional education requirement of at least 60 hours in an approved university or college, including a minimum of nine hours in the biosciences. They must then complete a professional programme, lasting a minimum of 450 hours, which involves classroom instruction in the biosciences and acupuncture and supervised clinical acupuncture experience. Applicants must pass a licensing exam set by the National Commission for the Certification of Acupuncturists or other approved body. Finally, applicants must be at least 21 years of age. Section 8216 permits the enactment of rules for the certification of allopathic physicians and dentists as acupuncturists. Limited permits for applicants who meet the requirements for admission to the licensing exam can be issued. However, practice under a limited permit must be under the supervision of a licensed acupuncturist.

During the 1970s, the legislatures of several other states established conditions for the licensing of acupuncturists who were not allopathic physicians. As of 1981, non-allopathic physicians have been permitted to practice acupuncture under various conditions in at least 15 states.

Under a 1978 act in Rhode Island *:*

[No treatment by acupuncture] shall be performed unless within a period of 12 months preceding the treatment the patient shall have undergone a diagnostic examination by a duly licensed and registered physician with regard to his illness or malady. The doctor of acupuncture [as defined in the act] or the licensed acupuncture assistant [likewise defined] shall first... be familiar with the results of the said diagnostic examination.

The act provides for the establishment of the State Board of Acupuncture and also defines the conditions under which the Board may issue licences to practice acupuncture or to perform as an acupuncture assistant. The conditions for the issue of a licence in Rhode Island are as follows: the applicant must have successfully completed a course of study of 36 months in acupuncture at a college in the Hong Kong Special Administrative Region of China or have qualifications considered equivalent by the State Board of Acupuncture, the applicant must have practiced

acupuncture for 10 years, and the applicant must have passed examinations set by the Board.

In Florida, only persons certified by the Department of Professional Regulation may practice acupuncture. Some of the conditions for certification are that the applicant must be at least 18 years of age, have undertaken two years of education in acupuncture at a school or college approved by the Department (experience may be substituted for a part of this training), and pass an examination. It is a misdemeanour to practice acupuncture without a valid certificate in Florida.

California's Business and Professions Code lays down an extensive set of provisions regulating the acupuncture profession. California has appointed an Acupuncture Board, which consists of nine members. By law, four of these members must be acupuncturists with at least five years of experience who are not also allopathic surgeons or physicians, one must be an allopathic physician or surgeon with two years of experience in acupuncture, the remaining four must be members of the public who are neither acupuncturists nor allopathic physicians or surgeons.

In California, in order to receive a licence to practice, applicants must be at least 18 years of age, have completed an approved course in acupuncture or a tutorial programme in the practice of acupuncture, passed an examination administered by the appropriate Board, and completed a clinical internship programme of up to nine months. The length of the internship depends on the applicant's examination results and prior clinical training. Internship requirements are waived for applicants who have previously completed 800 hours of clinical training. Practicing acupuncture without a licence is a misdemeanour.

A previous requirement that acupuncture treatments cannot be performed on a patient without a prior diagnosis or referral from a licensed physician, surgeon, dentist, podiatrist, or chiropractor has been removed from the legislation. The completion of 30 hours of continuing education every two years is required for renewal of the annual practicing licence.

## NATUROPATHY

Naturopathy remains relatively marginalized in the United States. Few states license naturopaths. Although legislation on naturopathy varies between states, a number of general regulations do exist. Under state licensing procedures, naturopaths have a limited range of treatment options.

The use of electricity, heat, water, vibration, and muscular articulation are permitted as therapeutic modalities, but the general practice of medicine and surgery are prohibited. The administration of toxic drugs is similarly prohibited.

## HYPNOSIS

Treatment involving the use of hypnosis is characterized as the practice of medicine and surgery and is therefore subject to licensing requirements.

## BIOFIELD THERAPY

No state has licensing requirements for biofield practitioners. Since legal constraints in many states restrict the use of the terms "patient" and "treatment", most biofield practitioners use the terms "receiver" and "session" in describing their work.

## EDUCATION AND TRAINING

The majority of allopathic medical schools in the United States now offer courses on complementary/alternative medicine. Beginning in 1997, primary care allopathic physicians have been able to take courses designed to introduce them to homeopathy and to encourage them to incorporate homeopathy in their practices. The United States has the largest number of chiropractic colleges of any country. Sixteen colleges are recognized by the World Federation of Chiropractic and accredited by the Council on Chiropractic Education, the United States accrediting agency for the chiropractic profession. The Council on Chiropractic Education establishes minimum standards and assesses institutional compliance with these standards as well as overall effectiveness.

With only a few states licensing naturopaths, all except two naturopathic colleges have closed. Entry to these colleges is conditional on two years of pre-professional coursework. The programmes are four years in length.

## INSURANCE COVERAGE

Complementary/alternative therapies are infrequently included in benefit packages, although the number of insurers and managed care organizations offering coverage is increasing. When complementary/alternative therapies are covered, they tend to have high deductibles and co-payments that are subject to stringent limits on the number of visits or total dollar coverage.

Chiropractic care is the exception. In many states, chiropractic is covered in full or in part by Medicaid, Medicare, and other Social Security programmes as well as private health insurance. The cost of chiropractic treatment can also be reclaimed under workers' compensation legislation designed to reimburse, at least in part, medical expenses incurred by injured workers.

## VENEZUELA

### STATISTICS

The Liga Medicorum Homeopathica Internationalis has 41 members in Venezuela. There are approximately 10 chiropractors practicing in Venezuela.

### REGULATORY SITUATION

In Venezuela, health care is restricted to formally educated medical professionals. Section 13 of the 1975 Venezuelan law on the practice of medicine states that persons who perform any act that is restricted to medical practitioners, without having fulfilled the requirements of the law, are deemed to be practicing medicine illegally. Only traditional birth attendants who have received a ministerial permit are exempted. Allopathic physicians may practice homeopathic medicine after completing specialized postgraduate studies. There is no chiropractic law, although the practice of chiropractic is permitted under common law by officially recognized health care providers.

### EDUCATION AND TRAINING

The School of Homeopathic Medicine of the Venezuelan Homeopathic Medical Association is responsible for training allopathic physicians specializing in homeopathy.

## EASTERN MEDITERRANEAN

## ALGERIA

### REGULATORY SITUATION

The Algerian Public Health Code of 23 October 1976 rendered the practice of medicine without a licence an offence. Apart from Section 364 on the practice of herbalists, no exceptions were made for the practice of traditional medicine. Section 47 explicitly prohibited medical auxiliaries from using "secret or occult procedures".

This monopoly on the practice of medicine was retained and fortified in Law 85-05 of 16 February 1985 relating to health protection and promotion, which repealed the 1976 Code, among other things. Under Section 197, in order to practice as an allopathic physician or dentist, a person must be licensed and hold an Algerian diploma of Doctor of Medicine or Dentistry or a recognized foreign equivalent.

The exclusion of traditional medicine is underscored by the broad language of provisions contained in Section 214 that define the activities constituting the illegal

practice of medicine or dentistry. These include acting as a physician or dentist without a licence and further circumscribe the activities of Persons who habitually take part, whether for consideration or not, even in the presence of a physician or dentist, in making a diagnosis or in treating diseases or surgical or dental conditions, congenital or acquired, real or supposed, by personal acts, oral or written advice, or by any other means whatsoever, without fulfilling the conditions prescribed in Sections 197 or 198 [governing the mandatory qualifications for medical and dental specialists].

Section 225 includes provisions prohibiting medical auxiliaries from "announcing or applying technical procedures other than those that are taught in national training programs". Despite these restrictions, traditional medicine practitioners seem to be tolerated.

## CYPRUS

### BACKGROUND INFORMATION

Written records, especially from monasteries, record different types of traditional medicine and herbal preparations that were practiced from the Middle Ages through the 19th century in Cyprus. Most traditional forms of medicine involve mixing herbs and abiding by certain behavioural rules promoting healthy diets and habits. Since British colonization, allopathic doctors have provided health services.

### STATISTICS

Although most patients use allopathic medicine, some consult homeopaths and other complementary/alternative medical practitioners. Only a few allopathic doctors practice homeopathy, acupuncture, or other forms of complementary / alternative medicine.

There are fewer than 10 complementary/alternative medical practitioners who are not also allopathic doctors. These practitioners offer curative courses focused on using relaxation techniques or herbs to alleviate stress or stop smoking.

### REGULATORY SITUATION

Only allopathic doctors can provide medical treatment in Cyprus. It is a criminal offence for others to practice medicine or give medications. There is no official recognition of any kind of traditional or complementary/alternative medicine other than chiropractic.

Again except for chiropractic, there are no national policies regulating traditional or complementary / alternative medicine, nor have traditional or complementary / alternative medicine been integrated with allopathic medicine.

A compulsory registration scheme for chiropractors was introduced in Cyprus in 1991. Registration is limited to persons holding a recognized degree, diploma, or certificate. It is a criminal offence to practice chiropractic without being registered.

## EDUCATION AND TRAINING

There are no official training courses in traditional or complementary/alternative medicine.

## INSURANCE COVERAGE

No national or private health care insurance covers traditional or complementary / alternative medicine. Traditional medicine is not included in the proposed National Health Insurance Scheme.

# DJIBOUTI

## BACKGROUND INFORMATION

Traditional medicine practitioners include *cheiks,* medical providers who use the Koran or other Islamic scriptures to treat patients, and herbalists. Some practitioners combine both methods.

## REGULATORY SITUATION

With the exception of traditional birth attendants, the Government tolerates, but does not officially recognize, traditional medicine. Lacking legal status in Djibouti, no clear regulations control its practice. A 1999 law advocating the necessity to legislate traditional medicine may lead to changes in this regard. Only one category of traditional health practitioner has been integrated into the public health system: traditional birth attendants. Traditional birth attendants work under the supervision of public health staff in the rural structure of the primary health care system.

# EGYPT

## STATISTICS

The practice of traditional medicine in Egypt is limited to a very few traditional medical providers. There is one chiropractor practicing in Egypt.

## REGULATORY SITUATION

The National Drug Policy was promulgated at the beginning of 1999 as an essential part of the National Health Policy. Within the framework of the National Drug Policy, reforms have been carried out in the following five areas: rational use of drugs, issues related to the drug industry, quality assurance and quality control, management of drug supplies, and human resource development.

In Egypt, all herbal preparations and herbal products must meet the same standards as manufactured chemical preparations, according to the law on practicing pharmacy. Herbal preparations and herbal products must be manufactured in a licensed pharmaceutical plant according to local and international good manufacturing practices. They must also be registered with the Central Administration of Pharmaceutical Affairs. The National Organization for Drug Control and Research analyses medicinal plants and inspects herbal preparations and herbal products to ensure their safety. Herbal preparations and herbal products are priced according to the law and are distributed only to pharmacies.

There is no chiropractic law.

# ISLAMIC REPUBLIC OF IRAN

## BACKGROUND INFORMATION

Traditional medicine and Islamic medicine are practiced in Iran through *hokama* who have small shops where they not only recommend medicines, but also prepare and sell them. With the expansion of allopathic medicine and services, however, the number of *hokama* has diminished greatly.

The Shaheed Beheshti University of Medical Sciences has done a lot of research on medicinal plants. It has also organized an international congress on traditional medicine and *materia medica.* Most of the research done on medicinal plants has been pre-clinical. In Iran, there is no specific hospital for conducting clinical trials of herbal medicines.

## STATISTICS

Over the last 10 years, the Government has undertaken an inventory of medicinal plants. So far, 2500 flora of Iran's 8000 medicinal plants have been inventoried and recorded in 20 volumes of 125 herbs each. One hundred fifty certificates for herbal medicine have been issued. Eighty-four herbal products have undergone clinical trials and been licensed. These are included in Iran's list of essential drugs. By the

end of 2004, the Government intends to have issued licences for 300 herbal products.

Seven faculties of pharmacy are conducting research on medicinal plants in seven provinces. There are 30 pharmaceutical companies producing herbal medicines, 20 of which produce herbal products and 10 produce herbal preparations. There are also many small herbal shops that supply herbal materials and spices for medicinal use.

There are 14 chiropractors practicing in Iran.

## REGULATORY SITUATION

Traditional medicine practitioners are neither supported nor banned by the Government, provided patients are not harmed. A chiropractic law is pending. Currently, chiropractors may practice in conjunction with allopathic physicians.

The Government of Iran is very interested in traditional medicines and has initiated a number of programmes related to them. Since 1991, the Food and Drug Control Agency has been working in the field of herbal medicines.

In 1991, the National Academy of Traditional Medicine in Iran and Islam was established. It is mandated to support research on herbal medicines; to study the history of Iranian traditional medicine; to preserve Iranian traditional medicine; to investigate education in traditional medicine and recommend an education plan to the Ministry of Health and Medical Education, including the incorporation of traditional medicine training and research into allopathic medical programmes; to educate the public on the rational use of traditional medicine; and to republish famous Iranian books on traditional medicine. In 2001, the Academy recommended that the Ministry of Health and Medical Education officially begin training allopathic medical students in Iranian traditional medicine.

In 1996, the Ministry of Health and Medical Education established the Council Committee of Medicinal Herbs and Products. The Committee consists of a panel of experts charged with evaluating the safety and efficacy of herbs and herbal products and issuing rules and regulations for the packaging of herbal medicines.

In order to make allopathic drugs affordable, the Government subsidizes the pharmaceutical industry's importation of raw materials. As the Government does not subsidize herbal products or locally produced herbal raw materials, herbal products are often more expensive than generic drugs. There is no national patent office and no national patent law in Iran. In 2000, a draft patent law was submitted to the Parliament, but it has not yet been approved.

## EDUCATION AND TRAINING

All pharmacy students must study pharmacognosy. In the Universities of Tehran and Isfahan, pharmacy students are required to write a thesis on research related to a medicinal plant.

## INSURANCE COVERAGE

The Government health insurance covers 90% of the Iranian population, but only a few registered herbal products are covered by the insurance.

## JORDAN

## BACKGROUND INFORMATION

Traditional medicine is deeply rooted in the history and culture of Jordan. Traditional medical practitioners and remedies ensure equitable access to primary health care, particularly where a large portion of the population relies on it. Over the last decade, there has been a growing interest in traditional and complementary/alternative medicine, including Chinese traditional medicine, acupuncture, phytotherapy, homeopathy, and chiropractic. Traditional medicine is practiced by herbalists, practitioners of traditional medicine, and allopathic doctors and other health professionals.

## STATISTICS

There is one chiropractor practicing in Jordan.

## REGULATORY SITUATION

There are no national policies recognizing traditional or complementary / alternative medicine. Traditional and complementary/alternative medicine are not integrated into allopathic medicine or into the national health system. However, some traditional and complementary/alternative medicine doctors and health professionals have been approved to practice in primary health care. A chiropractic law is pending.

## KUWAIT

## REGULATORY SITUATION

Laws in Kuwait prohibit traditional medicine providers from practicing medicine. However, herbal medicines are not banned. The use of medicinal plants in the official health sector began in 1978. Supplementing a ministerial resolution on the

registration of all drugs, a document and guidelines were issued on the safety and quality assurance of herbal medicines. This document describes the main principles that should be observed when registering herbal medicines, particularly in regard to safety, efficacy, and consistency. This document categorizes medicinal plants into three groups: plants used on a daily basis, plants subject to large-scale scientific studies and registered in pharmacopoeias, and new plants that need to be studied. For each of these plant types, there are specific registration requirements intended to encourage people to use plants that do not cause adverse reactions or require allopathic medical advice, as well as to protect people from plants with toxic elements and about which there are no published studies. Following the document and guidelines, the Minister of Health issued a ministerial resolution organizing the handling and registration of herbal medicines in Kuwait. A ministerial decree, based on World Health Organization recommendations, established the Centre for Islamic Medicine to undertake the registration of herbal medicines and to introduce the use of medicinal plants in the treatment of some diseases. Among its various tasks, the Centre

- provides therapeutic services;
- undertakes the registration of herbal medicines imported into Kuwait, as decreed by the relevant ministerial decision;
- analyses and tests the efficacy and suitability of all medicinal plants that enter into the country for human consumption;
- undertakes the importation of medicinal plants necessary for the preparation of drugs used in the treatment of some diseases;
- studies and evaluates the best pharmaceutical rendering of each herbal preparation and herbal product;
- carries out various studies on each plant, preparation, and product so as to identify the stability, efficacy, and safety of the active substances therein.

In 1986, together with the Islamic Organization for Medical Sciences and the World Health Organization Eastern Mediterranean Regional Office, Kuwait worked to establish regional standards for herbal medicines. Kuwait's registration policy was reviewed and endorsed by the Ministers of Health of the World Health Organization Eastern Mediterranean Region Member States and has become a reference and basis for the registration of herbal medicines throughout the region. The Council of Arab Ministers of Health and the Council of Health Ministers of the Gulf also endorsed the registration policy.

## PAKISTAN

## BACKGROUND INFORMATION

Pakistan's traditional unani and ayurvedic systems of medicine came to the United India via Arab physicians. However, the unani medicine currently practiced in

Pakistan is vastly different from its Greek roots. Most Pakistanis rely on unani medicine, finding it efficacious, safe, and cost effective. The use of herbal medicines and homeopathy is also widespread. The National Institute for Health has established a section on traditional medicine (*tibb*).

## STATISTICS

Unani medicine is widely used throughout the country. About 70% of the population, particularly in rural areas, use traditional and complementary / alternative medicine. Approximately 52 600 registered unani medical practitioners serve the nation through both the public and private sectors in urban and rural areas.

About 360 *tibb* dispensaries and clinics provide free medication to the public under the control of the health departments of provincial governments. About 95 dispensaries have been established under provincial departments of Local Bodies and Rural Development, and one *tibb* clinic is working under the Provincial Department of Auqaf. A separate Directorate of Hakims has also been established under the Federal Ministry of Population Welfare Programme, and 16 000 diploma-holding unani physicians of traditional medicine have been involved in the National Population Welfare Programme. About 40 000 homeopathic physicians are registered with the National Council for Homeopathy.

## REGULATORY SITUATION

Unani, tibb, ayurveda, and homeopathy have been accepted and integrated into the national health system in Pakistan.

Ordinance 65 of 7 June 1962 was issued "to prevent the misuse of the allopathic system". It provided that only registered medical practitioners were entitled to use the title "Doctor", to perform surgery, or to prescribe any specially listed antibiotics or dangerous drugs. These prohibitions were also applicable to practitioners of traditional medicine, it being prescribed that "no person practicing the allopathic, homeopathic, ayurvedic, etc., system of medicine may use the title of 'doctor', unless he is a registered practitioner".

Subsequently, the Unani, Ayurvedic and Homeopathic Practitioners Act of 1965 was passed to regulate qualifications and to provide for the registration of practitioners of the unani and ayurvedic systems of medicine. The Act applied to *tabibs,* practitioners of unani medicine, and to *voids,* practitioners of ayurvedic medicine, both being prohibited from using the title "Doctor". Under the Act, the Board of Unani and Ayurvedic Systems of Medicine was established in order to arrange for the registration of qualified persons, to maintain adequate standards at recognized institutions, to conduct research, and to perform other activities.

Requirements for the registration of practitioners were laid down, and training at recognized institutions was fixed at four years.

The Act established that the following persons might apply for registration: persons passing the qualifying examinations for the award of a diploma in the unani and ayurvedic systems; any *tabib* or *void* with not less than seven years of practice; any *tabib* or *void* with five to seven years of practice, who either satisfied the Board as to his or her knowledge or skill or passed, within a specified period, an approved test in the theory and practice of the unani and ayurvedic systems; and any person who passed a written and practical examination in the subject of the "old system" of medicine.

The Government thereafter issued the Unani, Ayurvedic and Homeopathic Systems of Medicine Rules of 1965, which included implementing provisions on the registration of practitioners, elections to the boards, and recognition of teaching institutions. The Act introduced the title of "Homeopathic Doctor" for registered homeopaths, although the use of analogous titles was forbidden to practitioners of ayurvedic and unani medicine. Under this Act, courses in homeopathy provided by recognized institutions must be four years in duration, culminating in a qualifying examination. Persons who have passed this examination, persons holding qualifications from an approved homeopathic institution, and certain practitioners of long standing, "possessing the requisite knowledge and skill", are eligible for registration as homeopathic doctors. The Board of Homeopathic Systems of Medicine was established in order, *inter alia,* to maintain adequate standards in recognized institutions and to make arrangements for the registration of duly qualified persons. The legislation referred to above was also applicable in what was then known as East Pakistan, now Bangladesh.

The Ministry of Health, through the National Council for Tibb oversees the qualifications of practitioners. After successful completion of *tibb* qualifications, candidates are registered with the National Council for Tibb, allowing them to practice traditional medicine lawfully.

## EDUCATION AND TRAINING

Tibbia colleges, Pakistan's unani teaching institutions, are recognized by the Government and are under the direct control of the National Council for Tibb, Ministry of Health, which is responsible for maintaining standards of education in recognized teaching institutions, revising/modifying curricula and syllabuses, and holding annual examinations. Twenty-six colleges in the private sector and one college in the public sector offer four-year diploma courses in Pakistani traditional unani and ayurvedic systems of medicine that follow the prescribed curriculum and conditions laid down in the regulations.

Hamdard University has recently introduced a five-year programme to follow intermediate (FSc) training. About 5000 students are enrolled in its Faculty of Unani Medicine. Annually about 950 persons graduate from the programme. Seventy-six colleges of homeopathic medicine offer officially recognized programmes for the four-year Diploma of Homeopathic Medical Science. Several hospitals, outpatient clinics, and dispensaries are attached to the homeopathic medical colleges.

## SAUDI ARABIA

## BACKGROUND INFORMATION

Traditional medicine in Saudi Arabia is based on herbal remedies and spiritual healing. There is hardly a city or village in the country where traditional medicines are not used or sold. They are also commonly used in home remedies for certain ailments.

In 1940, allopathic medicine began being used in large cities. Since then, the health authorities have taken all possible measures to develop highly sophisticated allopathic hospitals. The population of Saudi Arabia today enjoys very good health facilities.

There was official resistance to complementary/alternative medicine until the 1990s when more Saudi Arabians demanded access to complementary / alternative medicine, and some professionals who had been trained abroad began to practice. The most popular therapies are acupuncture; herbal, nutritional, and health food products; and homeopathy.

## REGULATORY SITUATION

A scientific research project on the merits and demerits of Saudi Arabian traditional medicines was undertaken as a precursor to drafting a regulatory framework and statutory provisions for the practice of Saudi Arabian traditional medicine and the sale and manufacture of the medicines used in it.

An act governing the practice of pharmacy and trade in medicines and medical products was issued by Royal Decree M/18 dated 18/3/1398 H (equivalent to 26 February 1978). Articles 44 and 50 of this act prohibit the handling of locally produced or imported products prior to their registration with the Ministry of Health. Paragraph 13A of the special provisions on registration regulations for pharmaceutical companies and their products, which was amended through Ministerial Resolution 1214/20 dated 17/6/1409 H (equivalent to 25 January 1989), requires the registration of medicines and all products having medical claims,

including herbal preparations containing active ingredients that possess medicinal effects.

The License Committee established under the Ministry of Health is responsible for approving or disapproving, mainly on the basis of safety and efficacy, the marketing and use of herbal preparations and herbal products, health food products, and natural health products, including items for cosmetic use.

The Ministry of Health has approved guidelines restricting licences to practice acupuncture to those persons who have at least 200 hours of training, are anaesthetists, rheumatologists, or orthopaedists, and who comply with hygienic standards. Licensing legislation also regulates chiropractic educational standards and practice.

## EDUCATION AND TRAINING

No formal education exists in traditional or complementary/alternative medicine in Saudi Arabia; interested allopathic physicians go abroad to receive such training.

## INSURANCE COVERAGE

Traditional medicine is not covered by the health insurance system; however, some traditional medicine practitioners, especially spiritualists, practice free of charge.

## SUDAN

## BACKGROUND INFORMATION

Traditional medicine in Sudan has roots in Islamic and West African medicine. People in many areas of the country depend on herbal medicines, which are an integral part of the health care system. There is wide experience with the use of herbs in medical treatment. Many families specialize in herbal medicines and this knowledge is passed on from one generation to another. Patients travel from the capital to rural regions to consult herbalists, especially for difficult diseases.

The Medicinal and Aromatic Herbs Research Institute was created 25 years ago and has trained a considerable number of specialists in different fields required for research in medicinal plants.

## STATISTICS

The Sudan Atlas of Medicinal Plants records the scientific name of more than 2000 medicinal herbs collected from different parts of the country, many native to Sudan. All of these herbs are in current use in traditional medicine.

## REGULATORY SITUATION

There is legislation for the registration of herbal preparations and herbal products.

## SYRIAN ARAB REPUBLIC

## REGULATORY SITUATION

No licences are issued to providers of herbal medicine; such practices are limited to specialists.

In 1997, the Ministry of Health issued decisions on the technical prerequisites necessary for the establishment of laboratories for herbal medicine. In 1998, the Ministry issued decisions on the manufacture and distribution of herbal medicines and on a system of controls. The manufacture of herbal medicines has been included in the national drug policy. Both public and private laboratories have been active in processing medicinal herbs, and the Ministry of Health has given preliminary approval for the establishment of laboratories that would manufacture herbal medicines. A file concerning the manufacturing of herbal medicines has been developed in preparation for their registration.

Three draft laws covering herbal medicine have been prepared. One concerns herbal medicines that would be used in primary health care.

## EDUCATION AND TRAINING

A syllabus on treatment with herbal medicines has been recommended for inclusion in the curricula of faculties of medicine.

A syllabus on medicinal plants and herbal medicines has been introduced into the curricula of pharmacy faculties and at health institutes for technical assistant pharmacists.

## UNITED ARAB EMIRATES

## BACKGROUND INFORMATION

In 1989, the Ministry of Health's Zayed Centre for Herbal Research and Traditional Medicine was established in Abu Dhabi to conduct research on medicinal plants and traditional medicine practitioners. Similar research is conducted by the Desert Section of the Desert Marine Environment Research Centre, the Department of Pharmacology at the Faculty of Medicine of the University of Al-Ain, the Society of National Culture, and the History and Culture Centre.

There is high consumer demand for herbal preparations and herbal products in the United Arab Emirates.

## REGULATORY SITUATION

Section 1 of Federal Law 7 of 1975 put in place licensing and registration requirements for the practice of medicine. Only an allopathic physician who holds a medical degree may apply for a licence to practice medicine. Under Section 2, non-citizens who seek to practice as general practitioners must complete an additional two years of post-internship medical practice.

In the United Arab Emirates, birth attendants are designated as medical professionals by Federal Law 5/1984, the practice of which is open to physicians, pharmacists, and other licensed individuals. By Section 3, the Minister of Health is to publish licensing qualifications and outline the powers and duties of licensees.

In order to provide a legal framework to ensure that their benefits could be enjoyed without unnecessary risks, registration criteria for herbal medicines were published in January 1998. These criteria were established by a committee of allopathic physicians and personnel from the Zayed Centre and Emirates University. The registration criteria include the following:

- documentation, including detailed monographs, for the herb;
- reference sample of the active ingredient of the herb;
- laboratory analysis for identity, purity, and quantity.

Priority in registration is given to single-ingredient products. Products containing more than one herb must have a logical justification for the combination based on the uses of the finished product. Therapeutic claims beyond traditional uses are not accepted unless scientifically justified.

As of April 1999, 27 applications had been received. Seven of the applications were completed and approved, seven had completed the laboratory screening process, and 13 were waiting for laboratory analysis. These 27 applications had come from companies located in a number of countries, including Germany, Switzerland, Austria, India, Indonesia, and China.

A 1999 report outlined several problems with the criteria. Companies had difficulty fulfilling the documentary requirements, especially relating to stability data, and many companies wanted to register traditional products with more than 10 active ingredients, such as ayurvedic medicines. Analysis of the active ingredients in the final products proved technically difficult because of both qualitative and quantitative interference in the assays. Enforcing the law has also posed challenges.

## EUROPE

## AUSTRIA

### STATISTICS

The chart below lists the distribution of allopathic physicians practicing complementary / alternative medicine in Vienna in 1997.

| Complementary/Alternative Medicine | Number of Practicing Allopathic Physicians |
|---|---|
| Acupuncture | 100 |
| Homeopathy | 87 |
| Neuraltherapy | 87 |
| Bioresonance | 40 |
| Other | 200 |

In 2000, the Liga Medicorum Homeopathica Internationalis had 670 members in Austria. While there are no homeopathic hospitals, homeopathic consultation takes place regularly in five allopathic hospitals in Vienna and in one allopathic hospital in Klagenfurt. Austria has one academy of holistic medicine.

### REGULATORY SITUATION

Only legally qualified and authorized medical professionals may practice medicine in Austria. Under Section 1.2 of the Federal Medical Law, medical acts are defined as "all activities based on medico-scientific knowledge carried out directly or indirectly on human beings" performed for the purposes of diagnosis, treatment, and prophylaxis. Under the Law on Physicians of 1984 (*173, 174*), medical acts that are not provided by authorized medical professionals, such as midwives, medical-technical assistants, and nurses, are reserved for allopathic physicians. Article 184 of the Penal Code states that unskilled persons who practice medical acts or activities reserved for allopathic physicians risk a fine or imprisonment of up to three months. However, the courts have been tolerant with regard to complementary/alternative medical practitioners and charges of charlatanism. In practice, Article 184 is enforced only when practitioners use methods that do not have any scientific support, such as mystic water treatment.

According to the Law on Health Services, only scientifically recognized medical care can be provided in hospitals. Acupuncture, neuraltherapy, and chiropractic are recognized, but not homeopathy. However, homeopathy is recognized by the National Committee of Medicals. Nonetheless, and despite the fact that there are

neither specific legal or paralegal regulations nor draft regulations on the use of complementary/alternative medicine in the country, allopathic physicians are implicitly permitted to use any medical technique they deem appropriate, provided they obtain the consent of their patients. Under their own responsibility, therefore, allopathic physicians may use complementary/alternative medicine in their treatment regimes.

## EDUCATION AND TRAINING

The Council of the Order of Physicians issues diplomas officially recognized as medical qualifications in acupuncture, homeopathy, manual therapy, and neuraltherapy. Training courses for these diplomas last between two and three years (from 140 to 350 hours). Neuraltherapy and chiropractic are taught in universities.

The National Medical Association recognizes the examination and title of "Homeopathic Doctor". A three-year postgraduate homeopathic curriculum is available and leads to a diploma awarded by the official Medical Society of Austria. Advanced training is offered through seminars, lectures, and conferences with Austrian and international scholars. There are activities and associations for students interested in homeopathy at universities in Vienna, Graz, and Innsbruck.

As of 1 August 1996, the creation of a new educational institution of complementary / alternative medicine is punishable by imprisonment.

## INSURANCE COVERAGE

Public insurance funds have the following reimbursement criteria for medical treatments: scientific proof of effectiveness, cost-effectiveness, and appropriateness. Complementary/alternative medicine is generally not covered. Exceptions are made, however, for homeopathy and, for purposes of pain relief, massage, balneotherapy, and electrotherapy. Exceptions are also made when allopathic treatments are unsuccessful and relatively recognized complementary / alternative treatments are the last resort. The Oberösterreichische Gebietskrankenkasse partially reimburses acupuncture treatments.

Some private insurance companies cover complementary/alternative medicine.

# BELGIUM

## STATISTICS

According to a 1998 poll, almost 40% of the Belgian population - women more than men - have used complementary/alternative medicine at least once. Of these

persons, 77% were satisfied with their treatment. While the general public is in favour of the Ministry of Health giving official recognition to homeopathy, acupuncture, osteopathy, and chiropractic, allopathic physicians are evenly divided: 43% are in favour and 43% are opposed to such recognition.

The most widely consulted complementary/alternative therapies in Belgium are homeopathy, accounting for 81% of complementary/alternative consultations; acupuncture, accounting for 38%; osteopathy, 27%; phytotherapy, 25%; and chiropractic, 21%. One allopathic physician out of four believes that these therapies should be reimbursed. Fifty-nine per cent of patients who use complementary/alternative medicine and 36% of patients who do not use complementary/alternative medicine are willing to pay higher premiums to cover this reimbursement.

Most providers of complementary/alternative treatments are allopathic doctors or physiotherapists. One allopathic physician out of four provides complementary / alternative treatments; these are mostly general practitioners. The most commonly practiced forms of complementary/alternative medicine are homeopathy, practiced by 59% of providers of complementary/alternative medicine; acupuncture, practiced by 40%; and phytotherapy, 28%. Thirty-three per cent of manipulative treatments are provided by physiotherapists and 34% by non-allopathic practitioners.

There are three homeopathic organizations for allopathic physicians and pharmacists and two for patients. The Union of Acupuncturists Physicians was created in 1981.

## REGULATORY SITUATION

A monopoly on the practice of medicine was introduced by the Practice of Medicine Act of 1967. Under this act, the practice of medicine, which includes diagnosis, treatment, prescriptions, surgery, and preventive medicine, was the exclusive domain of legally qualified allopathic physicians. After the intervention of the European Commission with regard to the (non) enforcement of European Directives on homeopathic products, the Government of Belgium asked the Federal Department of Public Health to draft legislation on complementary/alternative medicine. On 29 April 1999, the new law was adopted by the Belgian Parliament. In November 1999, the Government enacted bylaws to ensure enforcement of the law.

Article 2 of the new law introduces provisions for homeopathy, chiropractic, osteopathy, and acupuncture and provides for the recognition of other complementary/alternative techniques.

Article 3 establishes a commission to advise the Government on the practice of complementary/alternative medicine, particularly registration of practitioners,

membership in recognized professional organizations, insurance for professionals, regulation of advertising, and restrictions on medical acts. In order to register, practitioners must demonstrate that they provide high-quality and accessible care that has a positive influence on their patients' health.

Article 6, Paragraph 1 requires the commission to be composed of five allopathic practitioners (with at least one being a general practitioner), nominated by faculties of medicine, and five complementary/alternative practitioners, nominated by recognized professional organizations. The commission, in Article 6, Paragraph 2, is also designated to advise the Government on organizing a peer-review system and a code of professional ethics.

By Article 8, the practice of a registered complementary/alternative form of medicine is allowed only when the practitioner is licensed for that practice by the Ministry of Social Affairs, Public Health, and Environment.

In Article 9, complementary/alternative practitioners are required to maintain medical records for each patient. Complementary/alternative practitioners who are not also allopathic physicians must obtain a recent allopathic physician's diagnosis from their patient prior to commencing treatment. If patients choose not to consult an allopathic physician before seeing a complementary/alternative practitioner, they must put their wishes in writing. Registered complementary/alternative practitioners must take precautions to ensure that patients are not deprived of allopathic treatment. As a result, complementary / alternative practitioners who are not also allopathic physicians must keep allopathic physicians informed of the health of their patients. With patient consent, complementary/alternative practitioners are permitted to seek the advice of other complementary/alternative practitioners who are not allopathic physicians.

Infringement of the law - in particular, practicing complementary/alternative medicine without a licence or treating a patient without having obtained an allopathic physician's diagnosis or without having the patient's desire to avoid such diagnosis in writing - risks a fine (under Article 11) or the suspension or withdrawal of the provider's licence to practice (under Article 8).

## EDUCATION AND TRAINING

Complementary/alternative medicine is not taught in Belgian medical schools; however, the Belgian Medical Faculty of Homeopathy offers courses for allopathic physicians, surgeons, dentists, pharmacists, and veterinarians. These courses comply with standards set by the European Committee for Homeopathy.

The Belgian Acupuncture Federation is authorized by the Belgian Government to train acupuncturists to practice under the new licensing law. In order to be

permitted to practice acupuncture, a provider must be certified as an allopathic medical doctor, dentist, physiotherapist, nurse, or midwife, as well as having completed at least 750 hours of acupuncture training - 250 hours of basic theoretical principles of traditional Chinese medicine, 250 hours of traditional Chinese medicine pathology, and 250 hours of clinical practice - and having written a thesis. There are two associations of acupuncturists offering three-year training programmes; however, most practitioners using acupuncture are trained in East Asia or France.

## INSURANCE COVERAGE

The Belgian social security system does not officially reimburse complementary / alternative treatments, regardless of whether they are provided by allopathic physicians or not. Practically speaking, however, allopathic physicians using complementary/alternative medicine may assure their patients that at least part of their fees will be reimbursed. Osteopathic treatments are reimbursed so long as physiotherapists use a classic designation to prescribe them.

In March 1997, the Socialist Mutual Insurance of Tournai-Ath was the first company to partially reimburse specific complementary/alternative treatments. They reimburse 25% of homeopathic remedies up to a maximum cost of 6000 Belgian francs per year and per beneficiary. They also reimburse 400 Belgian francs for each osteopathic treatment with a maximum of six treatments, but only if they have been provided by an allopathic physician, nurse, or physiotherapist. The list of reimbursed homeopathic remedies is adapted from the European Union Directive on homeopathic products. Reimbursement may soon be extended to other techniques, such as acupuncture and phytotherapy.

Private insurance companies reimburse chiropractic care and, partially, acupuncture treatments.

## DENMARK

## STATISTICS

The complementary/alternative treatments most used by the Danish population are reflexology, acupuncture, massage, natural medicine, homeopathy, natural healing, kinesiology, and chiropractic.

A 1994 study reported that 33% of the adult population of Denmark had used complementary/alternative medicine during the previous year, women used it more frequently than men, and the average age of patients of complementary/alternative medicine decreased in the period from 1970 to 1994. The study also found that of those who used complementary/alternative treatments, 77% considered themselves

cured, 17% experienced no effect from the therapy, and 1% considered their health problems to have worsened as a result of their treatment. People most often sought complementary/alternative therapies for joint and muscular problems.

Approximately 700 physicians are members of the Danish Society for Medical Acupuncture; 116 of these are newly certified. There are 265 chiropractors practicing in Denmark. The Danish Chiropractic Association has 300 members. There are 16 000 allopathic medical doctors in Denmark. There are also several associations of non-allopathic physician providers.

## REGULATORY SITUATION

In Denmark, allopathic physicians holding an academic degree in medicine, having taken the Hippocratic oath before a faculty of medicine, and authorized by the National Health Service are not restricted as to the medical techniques they may use. The title of "Physician" is protected and only licensed allopathic physicians may call themselves such. Public-sector medical positions are reserved for authorized doctors. Two laws regulate the practice of complementary/alternative medicine. The Medicine Act legislates the making and marketing of natural remedies and includes criteria for packaging, providing information to patients, and advertising. The Practice of Medicine Act of 1970 permits non-allopathic physicians to practice medicine regardless of their training and without previous authorization. However, non-allopathic physicians are not recognized as official health care providers, their titles are not protected, and they are not integrated into the national health care system.

By Articles 23-26 of Order 426 of the Practice of Medicine Act of 1976, issued by the Minister of the Interior on 19 August 1976, non-physicians may not perform specific medical acts that are reserved for licensed allopathic physicians, nor are they permitted to use needles except under the supervision of an allopathic physician. The medical acts reserved for licensed physicians are the following: treating persons for venereal diseases, tuberculosis, or any other infectious disease; performing surgery; administering general or local anaesthetics; providing obstetric aid; applying medicines that may be dispensed only with a physician's prescription; using X-ray or radium treatments; or practicing therapies using electric machines. Violation of this limited monopoly is punishable by up to 12 months in prison. However, non-allopathic practitioners are only prosecuted for selling harmful products, otherwise exposing patients to a provable danger, or causing the serious deterioration or death of their patients. Sentencing is particularly severe in cases where the patient is mentally ill or handicapped, under 18 years of age, or considered incapable of managing his/her own affairs. Ancillary staff, by contrast, may practice complementary/alternative medicine without restriction. Chiropractors are the exception to this law. They are regulated by a 1992 law. Whenever patients consult a chiropractor without an allopathic physician's referral,

the chiropractor must inform the patient's practitioner of the diagnosis and treatment, whether the practitioner is an allopathic physician or not. A Danish study on complementary/alternative treatments concluded that current legislation in this field is sufficient and further regulations are not necessary.

## EDUCATION AND TRAINING

The Danish Society for Medical Acupuncture offers a 120-hour diploma course in acupuncture for allopathic physicians. The Danish Chiropractic Association provides training for non-allopathic physicians. Membership in the Danish Chiropractic Association is restricted to those persons trained at a college accredited by the American Council on Chiropractic Education who have completed a six-month apprenticeship with a member of the Association and have passed the Association exam.

## INSURANCE COVERAGE

The Danish Chiropractic Association is working to obtain official recognition and full social insurance reimbursement for chiropractic treatments. In the meantime, reimbursement is determined by a 1975 agreement between public insurance schemes and chiropractors.

Under this agreement, public insurance covers one-third of the costs of up to five chiropractic consultations and one X-ray examination per year, on the condition that these are provided by chiropractors recognized by the Danish Chiropractic Council. When patients are referred by licensed allopathic physicians, some acupuncture and osteopathic treatments are also reimbursed.

# FINLAND

## BACKGROUND INFORMATION

The Ministry of Social Affairs and Health recognizes the increasing contribution of complementary/alternative therapies to the Finnish Health Care System. Among older rural Finns, massage, bonesetting, and cupping are popular; among younger urban Finns, natural medicine, manipulation, acupuncture, and hypnosis are popular.

## STATISTICS

About 50% of the adult Finnish population have used complementary/alternative medicine at least once. There are 30 chiropractors practicing in Finland. In 1987, there were 200 local health centres providing acupuncture treatment.

## REGULATORY SITUATION

Act 559 of 28 June 1994 regulates the licensing of medical practitioners. By Article 4, the right to practice as an independent allopathic medical doctor can be granted to practitioners who have completed basic medical training and who have additional training in primary health care or special training in an allopathic medical speciality. Professional allopathic medical providers who fulfil the required conditions have a number of rights, including the right to use a protected occupational title.

Only allopathic doctors and, by Decree 564/1994, registered chiropractors, naprapaths, and osteopaths are recognized health practitioners and allowed to practice medicine - specifically, to diagnose patients and charge fees. However, according to Act 559, other medical practitioners may treat patients if they do not practice within public services and do not pretend to be health care professionals. As a result, only allopathic doctors and registered chiropractors, naprapaths, and osteopaths are supervised by the medical authorities in practicing complementary/alternative medicine. Other medical practitioners are not supervised, nor is their licensing regulated.

While anyone can use an unqualified title, such as "Chiropractor", by Act 559 only registered chiropractors, naprapaths, and osteopaths may use the descriptor "Trained" in describing themselves. Act 559 also confers title protection to allopathic physicians. Articles 34 and 35 of Act 559 relate to the illegal practice of medicine, punishable by fine or up to six months in prison, although prosecution is rare. The objective of these articles is to protect patients and medical professionals working within public services.

A licence is necessary to market homeopathic products with a degree of dilution less than one million.

## EDUCATION AND TRAINING

Since 1975, acupuncture has been an accepted part of allopathic medical practice, and training in acupuncture is a component of the medical curriculum of allopathic physicians. Chiropractors, naprapaths, and osteopaths must complete at least four consecutive years of training approved by the National Board of Medico-Legal Affairs. Chiropractors generally train in the United States. Other complementary / alternative therapists often attend schools in Sweden.

## INSURANCE COVERAGE

When provided by an allopathic physician, acupuncture is covered by the Social Insurance Institution (SII). In general, other complementary/alternative therapies

are also reimbursed by the SII, provided they are given by medically qualified allopathic doctors during their normal sessions and provided the doctors do not specify which treatment they used. The SII covers treatments given by recognized chiropractors, naprapaths, and osteopaths when the following conditions are met:

- Patients can show that they first obtained a diagnosis and statement of required treatment from a licensed allopathic physician.
- Patients are referred to the complementary/alternative therapist by a licensed allopathic physician.
- The complementary/alternative therapist works in an institution led by a physiotherapist or an allopathic physician.

Complementary/alternative medications, however, are not covered by the SII.

In Finland, no private insurance companies reimburse complementary / alternative medicine except in some cases of chiropractic treatment, where reimbursement follows the same criteria used by the SII.

**FRANCE**

**BACKGROUND INFORMATION**

Homeopathic and herbal health care products are very popular in France. The most popular forms of complementary/alternative medicine are, in order of popularity, homeopathy, acupuncture, herbal medicines, water cures, chiropractic, thalasso-therapy, osteopathy, and iridology.

**STATISTICS**

A 1987 survey found that 36% of allopathic doctors, mostly general practitioners, used at least one complementary/alternative technique in their medical practices. Among allopathic physicians using complementary/alternative medicine, 5.4% used it exclusively; 20.7%, often; and 72.8%, occasionally. The social security system qualifies allopathic physicians using complementary / alternative medicines as "doctors with a particular type of practice (MEP)". Any doctor can be so designated. In 1993, physicians who were registered as MEPs represented 6.2% of the whole medical corpus. Thirty per cent of MEPs provide acupuncture treatments. Twenty per cent provide homeopathic therapies.

An additional 50 000 non-allopathic practitioners provide complementary / alternative therapy in France. There are approximately 390 chiropractors practicing in France. There are between 2000 and 4000 kinesiotherapists. One survey found 49% of the people questioned - 53% of the women surveyed and 44% of the men - had used complementary/alternative medicine at least once, 16% during the

previous year. Complementary/alternative medicine is most popular among people between the ages of 35 and 45,59% of persons in this age group having reported using complementary/alternative medicine. Sixty-eight per cent of executives and academics had used complementary/alternative medicine, compared to 60% of middle managers and intermediate professionals and 40% of farmers, the least likely group to use complementary/alternative medicine. Those surveyed reported using a complementary / alternative medicine for minor diseases (49%), chronic symptoms (54%), serious illnesses (3%), and the prevention of disease and promotion of a healthy lifestyle (17%). Seventy per cent of patients of complementary/alternative medicine considered it effective for minor diseases; 65%, for chronic diseases; and 9%, for serious illnesses. Only 11% of patients considered these therapies ineffective for minor diseases; 15%, for chronic diseases; and 38%, for serious illnesses. France has many organizations for practitioners and patients of complementary / alternative medicine.

## REGULATORY SITUATION

Under Articles L 372 through L 376 of the Code of Public Health, persons other than licensed allopathic physicians who habitually or continuously diagnose or treat illnesses, real or supposed, or who perform activities constituting medical procedures are illegally practicing medicine. Persons wishing to obtain a licence to practice medicine must possess a State certificate; hold French, Tunisian, Moroccan, or European Union citizenship; and be registered by the professional society of physicians.

Despite prosecution, non-allopathic practitioners - particularly physiotherapists using complementary/alternative methods such as chiropractic and osteopathy - continue to practice, and the number of allopathic physicians using complementary/alternative medicine is increasing.

Allopathic physicians providing complementary/alternative treatments either assist persons practicing medicine illegally or practice complementary/alternative medicine themselves. In both cases, they risk being tried for penal and disciplinary infractions. Recent decisions, however, suggest that the courts are becoming more tolerant towards the practice of complementary/alternative medicine.

## EDUCATION AND TRAINING

Teaching complementary/alternative medicine to non-allopathic physicians is permitted. The number of schools and courses in complementary/alternative medicine has recently increased, although they vary widely in quality. Private schools, however, may not issue diplomas to their graduates. According to Article 4 of the Act of 18 March 1880, only the State has this power.

Despite the allopathic medical establishment's opposition to the recognition of chiropractic, the Decree of 11 February 1953 provides for the incorporation of chiropractic into medical schools. However, the Decree has not been applied and chiropractic has never been taught in French medical schools. In fact, the practice of chiropractic is illegal in France. Nonetheless, there is a school of chiropractic.

The University of Bobigny established the Department of Natural Medicines in 1982. Since then, diplomas have been awarded in acupuncture, homeopathy, phytotherapy, osteopathy, auriculotherapy, naturopathy, oligotherapy, and mesotherapy.

In 1990, the University Diploma in Natural Medicines - training leading to an inter-university certification recognized by the French National Order of Physicians - was created for acupuncture and osteopathy. Recognition of a certification in homeopathy is under consideration. Phytotherapy is already incorporated into training in pharmacy. However, these therapies are not considered medical specialities. In order to obtain recognition as a medical speciality, the discipline must be taught according to the criteria followed for an allopathic speciality, i.e., the training should be full-time and include periods of clinical practice.

Some non-allopathic practitioners receive their training at foreign schools. For example, kinesiotherapists / physiotherapists who also provide chiropractic treatments are usually trained in the United Kingdom or Germany.

## INSURANCE COVERAGE

In France, social security and private insurance reimburse some forms of complementary / alternative medicine so long as an allopathic medical practitioner provides them. Social security reimburses homeopathic prescriptions written by authorized physicians and specific medical activities and products, including chiropractic, medical phytotherapy consultations, and complementary/alternative technical sessions with an approved kinesiotherapist. Acupuncture treatments given by MEP physicians are also reimbursed, provided that the physicians observe regulations regarding allopathic consultations.

## GERMANY

## BACKGROUND INFORMATION

In 1992, the Federal German Ministry of Research and Technology initiated an extensive research programme on complementary/alternative medicine coordinated by the University of Written/Herdecke.

## STATISTICS

Three-fourths of allopathic physicians use complementary/alternative medicine and 77% of pain clinics provide acupuncture treatments.

In 1994, there were between 10 000 and 13 000 practitioners of complementary / alternative medicine, or *Heilpraktikers,* 8000 of whom were members of professional associations. There are approximately 40 chiropractors practicing in Germany.

There were 20 million patient contacts with complementary/alternative medicine in 1992. The most frequently sought complementary/alternative therapies are, in order of popularity, homeopathy (accounting for 27.4% of patient contacts), acupuncture (15.4%), procaine injection therapy, chiropractic, ozone and oxygen therapy, herbal medicines, humoural pathology, massage, and cell therapy.

According to a 1992 poll, between 20% and 30% of the population had used complementary/alternative medicine, with 5% to 12% having used it during the previous year. Complementary/alternative therapies are more popular with women than men. Most complementary/alternative patients are between the ages of 18 and 65 and have a relatively high level of education. In most cases, patients have first sought treatment with allopathic medicine.

There are many organizations for practitioners and patients of complementary / alternative medicine.

**REGULATORY SITUATION**

In Germany, there is no legal monopoly on the practice of medicine. Thus, licensed non-allopathic physicians may practice medicine, and all licensed medical practitioners are allowed to use complementary/alternative medicine.

There are, however, some restrictions on the performance of particular medical acts. Only allopathic physicians and dentists are allowed to practice dentistry. Only allopathic physicians are allowed to treat sexual diseases, treat communicable and epidemic diseases, deliver specific medications, give or provide anaesthetics and narcotics, practice obstetrics and gynaecology, take X-rays, perform autopsies, and deliver death certificates. Infringement may result in penal punishment. In order to obtain a title as an allopathic physician, a person must have an academic degree in medicine, practical experience, a licence from public authorities, and a medical certificate confirming that there are no indications of physical or mental disability or addiction to drugs.

Licensed *Heilpraktikers* may practice medicine with the exclusion of these specific medical acts. To qualify for a *Heilpraktiker's* licence, a candidate must be at least 25 years old, have German or European Union citizenship, have completed primary school, have a good reputation in order to guarantee a normal professional practice,

have a medical certificate confirming that there are no indications of physical or mental disability or addiction to drugs, and pass an examination before a health commission proving that the candidate has sufficient knowledge and ability to practice as a *Heilpraktiker* and that the candidate's treatments do not negatively affect public health.

The exam verifies the candidate's basic knowledge of anatomy, physiology, hygiene, pathology, sterilization, disinfecting, diagnosis, and health regulations, particularly the epidemic law. However, the questions are required to be basic and understandable.

Chiropractors must obtain a *Heilpraktiker* licence regardless of whether or not they have a degree from an accredited institution.

## EDUCATION AND TRAINING

As part of the standard curriculum, allopathic medical schools are required to test students on their knowledge of complementary/alternative medicine. Students may also select a postgraduate specialization in complementary/alternative medicine. *Heilpraktiker* candidates do not have to follow standardized training in order to pass the licensing exam, which has resulted in a wide variety of teaching methods as well as variations in the length and quality of training. According to a recent poll, only 10% of *Heilpraktikers* did not have any form of training, while 88% had from one to four years of training.

The German Federal Association of Heilpraktikers organizes training in 29 cities for persons who desire to obtain a *Heilpraktiker* licence. Some of this training lasts three years or 350 hours.

In Germany, the title "Homeopathic Physician" is legally protected. The Medical Chamber bestows this title after a three-year training programme. Advanced obligatory training courses for homeopathic professors are given on a regular basis. Official homeopathic teaching contracts exist with the medical faculties in Berlin, Dusseldorf, Hannover, Heidelberg, and Freiburg. Chiropractors holding a degree from a regionally accredited institution may use the title "Doctor of Chiropractic".

## INSURANCE COVERAGE

In Germany, public and private insurance provides the same kind of coverage. Both currently reimburse some complementary/alternative treatments and are moving towards broadening this coverage. Even though there is no constitutional right to obtain reimbursement, the following criteria have been established to determine the coverage of complementary/alternative medicine by both social insurance and private insurance:

- If no allopathic treatment is available to treat a specific illness or to reduce its pain or if the aetiology is unknown - for example, for multiple sclerosis or certain forms of cancer - the use of complementary/alternative medicine is reimbursed provided the treatment has a minimum chance of success whether or not the method of treatment is generally scientifically recognized.

- If the aetiology is known, but no allopathic treatment is available, the recourse to complementary/alternative medicine is allowed, provided there is a minimum chance of success according to the aetiology. The same allowance is given when a previous allopathic treatment has been unsuccessful.

- When an allopathic treatment and a complementary/alternative treatment are both available but the allopathic treatment has side effects or risks for the patient, in general or in particular, the use of complementary/alternative medicine is reimbursed. However, in this case, it is necessary to balance the risks and the cost-effectiveness of the treatment.

- If there are safe allopathic and non-allopathic treatments at a patient's disposal, he/she may choose the less expensive treatment.

Anthroposophic, phytotherapeutic, and homeopathic products are reimbursed. By Articles 92 al. 1 and 135 al. 1 Sozialgestezbuch, in order to be reimbursed, experimental treatments have to be recognized, in broad terms, as useful and safe.

Some private insurance companies also reimburse treatments not scientifically recognized if they are provided by *Heilpraktikers* and if their effectiveness is not completely rejected.

## HUNGARY

### STATISTICS

The Hungarian Homeopathic Medical Association has 340 members. There are three practicing chiropractors in Hungary.

### REGULATORY SITUATION

Although allopathic physicians are the most common providers of complementary / alternative medicine, non-allopathic physicians and non-allopathic practitioners may provide specific complementary/alternative treatments. In February 1997, the Hungarian legislature passed two pieces of comprehensive legislation on natural medicine: Government Decree 40/1997 (IV 5) Korm. r. on natural medicine and the Decree of the Minister of Welfare 11/1997 (V 28) on some aspects of the practice of natural medicine. These two decrees clearly and officially integrate allopathic and

non-allopathic physicians who practice complementary/alternative medicine into the national health care system. The Decrees came into force on 1 July 1997.

The Decrees outline precise rules regarding the curriculum of complementary / alternative medical training as well as its practice. Each complementary / alternative discipline has its own training requirements and State exam. Within a legal framework, non-allopathic physicians are allowed to use complementary/alternative medicine once they have passed the exam.

Articles 1 through 7 of the Decrees regulate conditions for practicing complementary / alternative medicine. Annexes 1 through 4 list the specific requirements for each form of complementary/alternative medicine.

Article 1 identifies three categories of authorized medical practitioners: allopathic physicians, practitioners with a non-academic higher medical qualification, and other non-allopathic practitioners. Natural doctors are authorized practitioners who have passed the required exams and are permitted to use complementary / alternative medicine.

Article 1 also contains restrictions on the use of complementary/alternative medicine. Only allopathic physicians may practice homeopathy, Chinese and Tibetan medicine (including acupuncture), biologic dentistry, therapies using oxygenation, neural-therapy, anthroposophy, and magnetic bioresonance. Both allopathic physicians and medical practitioners with a non-academic higher health qualification may provide manual therapies. Practitioners who do not hold a higher health qualification may provide acupressure, massage therapy, lifestyle counselling, reflexotherapy, bio-energy, phytotherapy, and auriculotherapy.

Article 2 clarifies the legal framework in which natural doctors are allowed to practice. Paragraph 1 of Article 2 states that allopathic physicians are in charge of diagnosis, therapy planning, and patient follow-up. Other practitioners who have the necessary qualifications may participate in patient care at the request of the patient or through an allopathic physician's referral. Natural doctors who are non-allopathic physicians are allowed either to practice under the supervision of an allopathic physician or, more independently, to provide care after an allopathic physician has made a diagnosis. Consulting allopathic physicians may not oppose a patient's choice to seek treatment from a natural doctor.

Article 2 Paragraph 2 delineates medical acts that may not be performed by non-allopathic physicians. If a patient is under the treatment of an allopathic physician, natural doctors must consult the patient's allopathic physician.

Article 2 Paragraph 3 stipulates that only qualified psychologists or allopathic physicians with a qualification as psychotherapists are allowed to provide psychotherapeutic care based on natural medicine.

By Article 3, natural doctors must submit to the same directives as other medical practitioners, such as respecting obligations, abiding by ethical rules, and keeping patient records.

Article 4 permits the use of all regular drugs under the provision of complementary / alternative medicine. Homeopathic products not registered in Hungary can be used if the registration procedure is in process.

Article 5 gives the Institute of Health, under the authority of the Ministry of Social Welfare, the responsibility of regulating the training and examination of natural doctors.

Under Article 7, allopathic physicians with an academic degree in medicine may ask for a licence to practice as natural doctors without being required to take another exam. They are also allowed to use the title of "Natural Doctor", but to use the title of specialists in particular therapies, they must take the exam. Allopathic physicians are the only practitioners who do not have to pass the exams to practice complementary/alternative medicine. Psychologists with higher health qualifications and other practitioners must take a specific examination in natural medicine before they may use the title of "Natural Doctor". Natural doctors are registered and supervised by a special commission.

Annex 1 contains a complete list of authorized complementary/alternative treatments and of the medical practitioners who are allowed to provide them.

Annex 2 outlines the information that natural doctors must record, such as patient histories and a description of the current treatment.

Annex 4 gives the theoretical and practical requirements for examinations in acupuncture, massage techniques, lifestyle counselling, reflexology, physiotherapy, bioenergy, and auriculotherapy. For each therapy, the Annex lists the definition of the technique, practical and theoretical requirements, rules on ethics, and specific topics for examination.

In 1977, the Government recognized homeopathy as a medical method, but there is no officially recognized training programme or examination. Chiropractic is regulated, but not defined, by law. The Ministry of Education recognizes the Doctor of Chiropractic degree.

## IRELAND

### STATISTICS

There are 55 chiropractors practicing in Ireland. There are numerous associations of professional complementary/alternative practitioners.

### REGULATORY SITUATION

As in the United Kingdom, the Medical Council is the statutory body that regulates the medical profession. In order to practice medicine as an allopathic physician, a provider must possess a certificate of qualification from a medical school and be registered with the Medical Council. Although allopathic physicians do not have a legal monopoly on medical practice, registered allopathic practitioners have some exclusive rights. Only those who are registered as doctors are permitted to treat venereal diseases, practice obstetrics, certify death, issue medical certificates for official purposes, prescribe a wide range of controlled drugs, give advice in court on specific issues, supply services to police for alcohol-linked traffic offences, and administer anaesthetics. All medical positions in State services, the army, civil service, or private industry are restricted to registered allopathic medical practitioners.

Persons without an allopathic medical degree are tolerated by law to practice complementary/alternative medicine; however, only medical practitioners with a university degree in allopathic medicine are recognized. Under Section 61 of Part V, Fitness to Practice, of the Medical Practitioners Act of 1978, it is an offence for non-registered practitioners to provide medical treatment under the pretence of being a registered practitioner. People who make false declarations for the purpose of obtaining registration are punishable by a fine and/or imprisonment.

There is no chiropractic law, although the practice of chiropractic is permitted under common law. Chiropractors may obtain a licence to operate X-ray equipment.

### EDUCATION AND TRAINING

There is no postgraduate training for allopathic physicians in complementary / alternative medicine.

### INSURANCE COVERAGE

When a registered allopathic doctor provides complementary/alternative treatment, it is not distinguished from other medical care and is covered by the General Medical Services.

## ITALY

## BACKGROUND INFORMATION

The private sector ensures the availability of complementary/alternative medicine. The Societa Italiana di Omeopatia, founded in 1947, links the different societies and schools of homeopathy.

## STATISTICS

Of Italy's 250 000 allopathic physicians, 5000 use complementary/alternative techniques. Of those using complementary / alternative techniques, around 1300 practice acupuncture. There are approximately 200 chiropractors practicing in Italy.

Twenty-four per cent of adults have used complementary/alternative medicine at least once. Women, particularly those between 25 and 50 years of age, are the most likely to use complementary / alternative medicine. In order of popularity, homeopathy, acupuncture, herbal remedies, prana therapy, anthroposophic medicine, and chiropractic are the most popular complementary / alternative therapies.

More than three million people, 5.25% of the population, use homeopathy. Ninety-two per cent of these patients are female, 79% are adults, and 69% are middle class. There are about 5000 homeopathic doctors, 7000 pharmacies selling homeopathic products, and 20 companies that produce or distribute homeopathic medicines. The market for homeopathic products in Italy grew from 10 billion lira in 1982 to 120 billion lira in 1994. In September 1996, a petition enclosing 300 000 signatures of patients of homeopathic medicine asked the Italian Parliament to give official recognition to homeopathy.

## REGULATORY SITUATION

In order to practice as an allopathic physician, *a* person must have a degree in medicine or surgery, must have passed the corresponding State exam, and must be registered in a professional register. Paramedics are specifically excluded from practicing complementary/alternative medicine. According to a decision by the Criminal Supreme Court of Appeals in Perugia, only registered allopathic physicians may practice complementary/alternative medicine. Allopathic physicians using complementary / alternative, rather than allopathic, techniques are responsible for any consequences to their patients. Allopathic physicians are not permitted to aid or cooperate with non-allopathic practitioners to illegally provide medical care of any kind.

However, the courts have also ruled that chiropractic is a profession, even though it is not licensed. Chiropractors are considered medical auxiliaries rather than medical specialists and must work under the supervision of an allopathic doctor.

Complementary / alternative practitioners who are not also allopathic physicians can be prosecuted under Article 348 of the Italian Penal Code, although this rarely occurs. Indeed, the Criminal Supreme Court of Appeals in Perugia's decision noted that even if acupuncture is taught in Italian universities, only physicians and surgeons are allowed to practice it. The Court considers medical and/or surgical expertise necessary to establish an exact diagnosis and avoid prejudicial consequences to patients.

Law 175 of 5 February 1992 expressly prohibits the use of titles that are not recognized by the State. No forms of complementary/alternative medicine are recognized as medical specialities under this law.

Specific regulations on complementary/alternative medicine currently cover only homeopathy and anthroposophic medicine. Homeopathy has a long history in Italy; attempts to regulate it began in the middle of the nineteenth century. On 17 March 1995, legislative Decree 185 was adopted, executing Directive 92/73/CEE, which regulates the marketing and registration of homeopathic and anthroposophic products.

## EDUCATION AND TRAINING

Acupuncture training is available for both allopathic physicians and non-allopathic physicians. Some anaesthesiology programmes include specialities in acupuncture. The University of Catania, Sicily, offers a postgraduate programme in acupuncture. The Society of Italian Acupuncturists and the Paracelse Institute also offer training. The latter is a member of the World Federation of Acupuncturists and Moxibustion Society. However, training programmes in complementary/alternative medicine, even when offered at the university level, are not legally recognized.

## INSURANCE COVERAGE

Each Italian region has its own regulations on the reimbursement of health care. In Lombardy, for example, there is a co-payment of 70 000 Italian lira for complementary/alternative medicine. The National Health Service pays the remainder. When provided by an allopathic doctor holding a university medical degree, acupuncture, hypnosis, antalgic lasertherapy, pressing massotherapy, lymphatic drainage, reflexive massotherapy, biofeedback, and vertebral manipulation and other articulation massage are reimbursed.

Since the Italian Government is working to reduce National Health Service expenses, this information is likely to change soon.

Not all private insurance programmes reimburse complementary/alternative medicine services. Those that do vary in the amount they reimburse and they generally require treatments to be provided by allopathic physicians, except in the case of articulation manipulation. Insurance premiums vary according to the age, sex, and health status of the patient. They are approximately 500 000 Italian lira annually for a child and 1 500 000 Italian lira annually for an adult.

## LATVIA

### BACKGROUND INFORMATION

Several methods of complementary/alternative medicine are integrated into the social welfare system of Latvia.

### STATISTICS

Homeopathy and acupuncture are the most popular types of complementary / alternative medicine. Most complementary / alternative practitioners are allopathic physicians. There are several complementary/alternative medical associations.

### REGULATORY SITUATION

The Council of Ministers of the Republic of Latvia has delegated the power to regulate and supervise all medical specialities to the Medical Society of the Republic of Latvia. The Cabinet of Ministers' Regulations on the Certification of Health Professionals of 1995 provides procedures for licensing medical professionals.

In order to practice legally as a recognized physician, a candidate must have graduated from a local medical academy or from any other medical college delivering a recognized diploma. Candidates must also obtain authorization according to local legislation.

Before allopathic physicians can legally practice complementary / alternative medicine, they must complete the requisite course and exam for the State licence, which is valid for five years. In order to renew a licence, a practitioner must complete a new course and examination. Allopathic physicians providing complementary / alternative treatments - such as acupuncture, homeopathy, auriculotherapy, iridology, magnetotherapy, osteoreflexotherapy, phytotherapy, naturopathy, laser-therapy, biofeedback, Ci-Gun, and Su-Jok - are supervised by a commission of experts that includes members of medical associations and the Medical Society of the Republic of Latvia.

Acupuncture and homeopathy have the same clinical speciality status as allopathic specialities.

Local laws regulate complementary/alternative medicine.

The Administrative Codex prohibits non-allopathic practitioners from practicing medicine of any kind. However, patient lawsuits are uncommon except in cases of serious harm to their health.

## EDUCATION AND TRAINING

Since 1990, over 300 physicians from the Scandinavian and Baltic States of Latvia, Estonia, and Lithuania have completed training in acupuncture and traditional Chinese medicine.

There are a few special programmes for non-allopathic physicians intended to give them basic medical knowledge. These programmes consist of between one and two years of medical courses at a medical school. Qualification courses in the Reiki method and medical astrology are also offered.

## INSURANCE COVERAGE

Complementary/alternative treatments are generally not covered by the compulsory health insurance. Acupuncture and homeopathy are exceptions: in 1994 they were included in the list of medical specialities reimbursable by social insurance.

In September 1998, two insurance companies, Balta and Parex, began coverage of legally provided complementary/alternative medicine. They cover two-thirds of expenses for consultations and treatments by acupuncture, homeopathy, Dr R. Voll electropuncture, iridodiagnosis, and bioresonance when are provided by authorized allopathic physicians. Treatments given by non-physicians are not covered.

# LIECHTENSTEIN

## STATISTICS

There are three chiropractors practicing in Liechtenstein.

## REGULATORY SITUATION

According to Order I and Article 49 of the Health Law, to practice medicine in Liechtenstein, a candidate must be a citizen of Liechtenstein; live in Liechtenstein; be a graduate of a Swiss, German, or Austrian school of medicine; have the necessary capacity, reputation, and hygienic knowledge; respect the duties of a

general physician; and obtain a licence to practice. The right to work as an independent allopathic general practitioner and the right to use a specialist title require postgraduate studies followed by an internship.

According to Article 22 of the Health Law, chiropractors are considered medical professionals.

The practice of complementary/alternative medicine by allopathic physicians is not regulated. Allopathic physicians may use complementary/alternative therapies without having to pass a supplementary exam. However, Article 9 of Order I states that "physicians have to practice only in their speciality and according to their knowledge, with the exception of emergencies". Paramedics are also permitted to provide complementary/alternative medicine.

By Article 24 Paragraph A Lit. I of the Health Law of 18 December 1985 (*178, 179, 180*), complementary/alternative practitioners may provide health care so long as they refrain from those acts reserved for allopathic physicians. Although there are no court rulings on this point, none of the medical acts included in Article 24 Paragraph A Lit. I are considered to be reserved for allopathic physicians (in particular those related to natural medicine). Therefore complementary/alternative providers only need a business licence to provide treatment legally, even though they are not allowed to provide care in the national health care system. A new medical department is in charge of issuing licences and controlling conditions of practice. Although complementary/alternative practitioners have yet to be subject to prosecution, Article 184 of the Penal Code specifies that an unqualified person who performs medical acts that are legally reserved for allopathic physicians - such as surgery, treatment of infectious diseases, or prescription of controlled medications - can be punished with a fine or a prison sentence of up to three months. The State health authorities perceive a contradiction between Article 24 Paragraph A Lit. I of the Health Law and Article 184 of the Penal Code. They are considering two ways of resolving it: either introducing a law to cover practitioners of natural medicine or abolishing Article 24 Lit. I of the Health Law. There is currently a controversial draft Law on Natural Medicine that, if passed, would resolve the contradiction by loosening the restrictions on the right to perform medical acts.

## EDUCATION AND TRAINING

Complementary/alternative practitioners are generally trained in foreign countries.

## INSURANCE COVERAGE

Complementary/alternative treatments are not covered by compulsory social insurance. To obtain reimbursement for such services, it is necessary to have

complementary/alternative medical insurance. Coverage under this insurance is limited to 500-1500 Swiss francs per year.

## LUXEMBOURG

### REGULATORY SITUATION

In order to practice medicine as a physician, a candidate must hold a university certificate, obtain authorization from the Minister of Health, and have the consent of the Medical College. Treatment, diagnosis, and prevention of disease are restricted to members of the allopathic medical corpus. Article 7 of the Law of 29 April 1983 stipulates that persons without the required qualifications who practice or participate in the diagnosis or treatment of real or supposed pathological disorders through personal acts, verbal or written consultations, or other methods, can be prosecuted. Non-allopathic practitioners using complementary/alternative medicine are regularly prosecuted.

Though not legally binding, the Code of Professional Ethics states that it is unethical for allopathic physicians to recommend, to either their patients or acquaintances, therapies that are based on illusory methods or which are not scientifically proven.

The Medical College is unequivocally opposed to the practice of complementary / alternative medicine in Luxembourg. It considers practitioners of complementary / alternative medicine to be quacks and crooks. Nevertheless, members of Parliament are in favour of granting official recognition to complementary / alternative practitioners and techniques.

### EDUCATION AND TRAINING

There is no officially recognized complementary/alternative medical training in Luxembourg.

### INSURANCE COVERAGE

Reimbursed at 80% of fees, homeopathy is the only officially covered complementary / alternative practice. In the case of other complementary / alternative therapies, there is no specific reimbursement rate in the list of publicly covered medical acts and services, meaning that theoretically, they are not covered by public health insurance. However, when they are legally provided by a recognized allopathic health care professional, complementary/alternative treatments are unofficially reimbursed in the context of a normal consultation. Approved allopathic physicians are thereby free to choose the treatment they provide.

There are no private insurance companies offering coverage for complementary / alternative medicine.

## MALTA

### BACKGROUND INFORMATION

Traditional Chinese medicine, chiropractic, and osteopathy are widely practiced.

### STATISTICS

There are no established professional organizations or self-regulating bodies for complementary/alternative practitioners in Malta.

### REGULATORY SITUATION

The medical professions are regulated by Part II of the Medical and Kindred Professions Ordinance (Chapter 31 of the Laws of Malta) and Part IV of the Department of Health Ordinance (Chapter 94 of the Laws of Malta). Only registered allopathic medical professionals are allowed to practice medicine. In order to practice, a candidate must have a licence issued by the President of Malta and be registered in the Medical Register. To obtain this licence, the candidate must have successfully completed a university programme leading to a degree as an allopathic medical doctor or the equivalent. Allopathic physicians may practice complementary/alternative medicine.

Non-allopathic practitioners are not legally recognized in Malta, and at present, there is no registration system for such practitioners. As stipulated in Chapter 31 of the Laws of Malta, non-allopathic practitioners are not allowed to perform procedures reserved for recognized allopathic medical professionals such as physiotherapists, physicians, and pharmacists. However, they are not prohibited from practicing medicine.

Although there are no legal sanctions on complementary/alternative practitioners themselves, a breach of the regulations outlined in Chapter 31 usually constitutes a criminal offence and is punishable by a fine, imprisonment, or both, according to the specific article breached. There are also restrictions on advertising treatments and clinics. The court exercises its discretion when determining appropriate punishment.

By Section 98 of Chapter 31 of the Laws of Malta, the only forms of complementary / alternative medicine licensed by the Ministry of Health are acupuncture, moxibustion, and traditional Chinese medicine. Conditions of licensing are imposed by the Ministry of Health as deemed fit.

Article 3 of the provisions requires clinics for traditional Chinese medicine to provide only traditional Chinese medicine. It further stipulates that patients diagnosed with an infectious disease must be referred to a registered allopathic medical practitioner for treatment and that no treatment for infectious diseases can be given at the clinics.

Article 6 of the provisions outlines hygienic standards for the clinics, and Article 7 states that all persons treated by traditional Chinese medicine, including acupuncture, must be referred by an allopathic doctor registered to practice in Malta. The Public Health Department must be informed of the name and qualifications of every person employed under licence. The Department is also responsible for carrying out inspections.

Acupuncture is not registered as a profession in Malta. Acupuncture licences are conditional upon proof of adequate training and experience. The licensee must renew the licence annually via a written application. Acupuncturists employed by the Mediterranean Centre for Traditional Chinese Medicine are usually qualified allopathic doctors as well as acupuncturists.

Malta is considering allowing specific complementary/alternative providers, particularly chiropractors and osteopaths, to be registered by the local Board of Professions Supplementary to Medicine alongside allopathic professions.

## EDUCATION AND TRAINING

Bonesetters are usually taught through family training. Some chiropractors and osteopaths are certified by overseas teaching institutions. As there is no local registration of these practitioners, there are no standardized qualifications to practice.

## INSURANCE COVERAGE

The State runs acupuncture clinics within the public health services. Treatment at these clinics is provided free of charge. Private acupuncture clinics provide their treatment on a fee-for-service basis.

The costs of acupuncture and other complementary / alternative medical services obtained privately are not reimbursed.

Private insurance does not cover complementary/alternative care.

## NETHERLANDS

## BACKGROUND INFORMATION

The Dutch Association of Homeopathic Doctors was established in 1898.

## STATISTICS

According to a 1985 study, 18% of the population has used complementary / alternative medicine at least once - 6% to 7% during the previous 12 months. In 1990, over 900 000 people consulted a complementary / alternative practitioner other than their own allopathic general practitioner. More women than men use complementary/alternative medicine, especially those between the ages of 35 to 50. Most patients treated with herbal medicines and by paranormal healing have little formal education; most patients of other forms of complementary/alternative medicine are executives and professionals.

The 1985 survey reported more than 4000 complementary / alternative practitioners in the Netherlands: 735 naturopaths, 300 paranormal healers, 220 homeopaths, 475 anthroposophical professionals (either allopathic doctors or other professionals, such as anthroposophical nurses), 945 acupuncturists, and 1450 manual therapists. There are 125 chiropractors practicing in the Netherlands. In addition to these providers, according to a 1992 survey, almost half of Dutch general practitioners have provided complementary/alternative treatment at least once - 40% have used homeopathy, 9% manipulative medicine, 4% acupuncture, and 4% naturopathy.

The most popular forms of complementary/alternative medicine are, in order of popularity: homeopathy, herbal medicine, manual therapies, paranormal healing, acupuncture, diet therapy, naturopathy, and anthroposophical medicine. The most common conditions presented to complementary/alternative practitioners are musculoskeletal pain and complaints of nervous origin. Patients most often report that they use complementary/alternative therapy because allopathic methods are ineffective for their chronic disorders. Only 14% of patients seek complementary/alternative care without having first consulted an allopathic practitioner. In one survey of patients treated with complementary/alternative medicine, 56% said that their health condition improved quite a lot, 22% felt that some improvement had occurred, and 22% saw no improvement at all. According to a consumer survey, about 80% of the Dutch population would like to have complete freedom of choice over their medical treatments; specifically, they would like health insurance schemes to recognize complementary/alternative medicine. Sixty per cent of the Dutch population is ready to pay higher insurance premiums in order to have this choice.

## REGULATORY SITUATION

Since 1993, when the Medical Practice Act of 1865 was replaced by the Individual Health Care Professionals Act, non-allopathic providers have been allowed to

practice medicine in the Netherlands. The new act came into force on 1 December 1997, bringing the legal status of non-allopathic practitioners in line with that of allopathic paramedics: they may practice medicine provided they do not perform specific medical acts reserved for allopathic physicians, except under the orders of an allopathic physician. Violation of this limited monopoly can be prosecuted. The medical acts reserved for physicians are surgical procedures, obstetric procedures, catheterizations and endoscopies, punctures and injections, general anaesthesia, procedures involving the use of radioactive substances and ionizing radiation, cardioversion, defibrillation, electroconvulsive therapy, lithotripsy, and artificial insemination.

The Individual Health Care Professions Act also introduces a system to protect the titles of a limited number of professional groups, with the possibility of creating new medical specialities under specific conditions. It also defines the training requirements necessary for registration as one of these medical professionals. The eight professions regulated are allopathic medical doctor, dentist, pharmaceutical chemist, health care psychologist, psychotherapist, physiotherapist, midwife, and nurse. While non-allopathic practitioners are not allowed to use these titles or to work in the national health services, procedures are now in place for them to obtain recognition for their speciality, including a protected title.

There are also legal registers in which qualified medical practitioners of homeopathy, herbal medicine, manual therapies (such as chiropractic and osteopathy), paranormal healing, acupuncture, diet therapy, naturopathy, and anthroposophical medicine are entitled to be registered once they satisfy specific legal requirements. This registration gives them the right to practice under a protected title, with the aim of insuring they are qualified in a specific field of health care.

## EDUCATION AND TRAINING

According to the Dutch Health Council, complementary/alternative medical institutions have organized a number of training courses, taken steps to develop standards of training and professionalism, and established national registration systems.

About 60% of the members of complementary/alternative professional organizations have undergone training in a field of allopathic medicine, often as a physician, physical therapist, or nurse. Introductory courses on complementary/alternative medicine are included in the curriculum of several Dutch medical schools. Allopathic doctors wishing to be trained in anthroposophical medicine, acupuncture, homeopathy, or manipulative therapy can attend part-time courses for one to four years. There are also postgraduate programmes for physical therapists, most of whom study acupuncture or manipulative therapy.

Without allopathic medical or paramedical training, individuals may register in one of the three academies for naturopathy offering full-time courses of three to four years. Students completing the three-year basic course in homeopathy earn the designation "Homeopathic Physician". Registration must be renewed every five years, based on proof of participation in compulsory continuing-education courses. A disciplinary committee monitors and penalizes homeopathic malpractice.

## INSURANCE COVERAGE

Officially, only homeopathic and anthroposophic medicines are reimbursed by social insurance. However, private health insurance reimburses all care given by allopathic general practitioners, whether allopathic or complementary / alternative. Two-thirds of the population have private health insurance.

In 1988, all large private insurance companies began covering homeopathy, acupuncture, and manipulative therapy as part of their standard or supplementary packages. In addition to the legally defined standard package, which is the same for all 45 health insurance funds, the funds also offer a supplementary package to which their clients can voluntarily subscribe. Under the supplementary coverage, 26 of the 45 health insurance funds reimburse some kinds of complementary/alternative medicine if provided by an allopathic physician or a physiotherapist, usually homeopathy, acupuncture, and anthroposophical treatments. In many cases, reimbursement was given only when care was provided by allopathic physicians or physical therapists who were members of a professional organization.

In 1991, in response to consumer demand, many packages were expanded to cover more types of complementary/alternative medicine and to cover care provided by non-allopathic practitioners. As of 1998, 47 private insurance companies cover between 25% and 100% of complementary/alternative treatments provided by allopathic physicians or members of professional organizations - to a maximum of 300 to 2500 Dutch florins per year. This coverage generally includes homeopathy, anthroposophy, acupuncture, manual therapies, chiropractic, naturopathy, and neuraltherapy.

# NORWAY

## BACKGROUND INFORMATION

Although some authorised allopathic doctors and other health personnel in Norway have integrated acupuncture and/or homeopathy into their practice, most usually do not use complementary/alternative therapies. Some persons with authorization to practice as health personnel, such as nurses, have complementary/alternative medicine practices.

## STATISTICS

A 1994 poll reported that 23% of men and 30% of women had used complementary / alternative medicine at least once. Most respondents in this group were middle-aged persons living in towns. The most popular therapies are acupuncture, accounting for 35% of consultations for complementary/alternative treatments; homeopathy, accounting for 33%; reflexology, 29%; natural medicine, 29%; chiropractic, 16%; kinesiology, 7%; natural healing, 3%; and iridology, 3%.

The Norwegian Association of Chiropractors has about 100 members.

## REGULATORY SITUATION

In principle, everyone in Norway is allowed to treat patients, regardless of training or profession. However, only allopathic physicians, and to some extent dentists and persons assisting physicians and under the guidance of a physician, are allowed to use the title "Doctor of Medicine", use a title indicating a speciality in a specific illness, or advertise - although anyone can place an announcement in the press that contains only a name, address, consultation hours, and general information on services provided. Specific medical acts are similarly restricted. These include the use of controlled medications in treatment, surgical procedures, injections, general or local anaesthesia, diagnostic or therapeutic methods restricted to physicians, treatment of cancer, diabetes, dangerous anaemia, struma/goitre with sticky forms, and some contagious/infectious diseases mentioned in Act 55 of 5 August 1994 on contagious/infectious diseases (such as venereal diseases, tuberculosis, infectious hepatitis, HIV, poliomyelitis, and infectious meningitis), as well as practicing in an itinerant way. To receive authorization to practice as an allopathic medical doctor, a candidate must possess a medical degree from a Norwegian or other recognized university and have undergone an 18-month internship.

Norway has the oldest regulations in Europe on the practice of medicine by non-allopathic physicians. The first legislation of this kind in Norway dates back to 1619. A new law was adopted in 1871. The Act of 1871 was to some extent less restrictive than the current Act 9 of 19 June 1936 on the limitations of the right of persons who are not allopathic physicians or dentists to undertake treatment of ill persons. Act 9 was used as a model for legislation in Sweden and Denmark.

Aside from allopathic physicians or dentists, anyone who wants to practice complementary/alternative medicine is subject to Act 9 of 19 June 1936. Under the law, non-physicians and non-dentists who treat patients are subject to a jail sentence of up to three months if the patient's life or health is exposed to serious danger either by the treatment or because the patient did not seek a health care provider who could have prevented the danger. Anyone sentenced to prison for such

violations can no longer practice medicine. Except in the most serious cases, criminal sanctions are rarely used.

Allopathic practitioners are restricted from using complementary/alternative therapies unless the therapies are considered to be responsible practice within the practitioner's profession, the patient is informed about the method and its status, and the patient agrees to the treatment.

The insertion of acupuncture needles is considered a surgical intervention and can only be performed by allopathic physicians, dentists, or persons delegated by physicians.

Since 1990, chiropractors have been officially recognized as health care professionals. Only licensed chiropractors are permitted to use the title of "Chiropractor". To be licensed, a candidate must have completed a training programme and passed examinations at an approved institution; undertaken additional training in Norwegian health law and chiropractic disciplines; completed one year of practical training; and not be in a position that would lead to withdrawal of the authorization - for instance, the candidate must not be found unsuitable for practicing chiropractic due to old age, illness, alcohol/drug abuse, or other circumstances. To become a member of the Norwegian Association of Chiropractors, chiropractors must have completed a course approved by the American Council on Chiropractic Education and undergone three months of clinical training.

With some exceptions, homeopathic medicines may only be sold from pharmacies. A licence is necessary to market homeopathic products when the degree of dilution is less than one million.

In June 1995, the *Storting* (parliament) examined the place of complementary / alternative medicine in the Norwegian health service. Among other things, the *Storting* decided to consider introducing certification of the various types of training and education available for complementary/alternative medical professions. In 1997, with the intention of revising the 1936 law, the Ministry of Health appointed a committee to write a report on complementary/alternative medicine. The report was delivered to the Ministry in December 1998. It describes the situation of complementary/alternative medicine in Norway and includes a discussion of the clinical effects of treatments, possible legal measures, and means of communicating research results and other information to the public. The Government has not yet decided how to follow up on the report.

In Beijing on 6 April 1999, the Ministers of Health of Norway and China signed a memorandum of understanding on Chinese/Norwegian cooperation in the field of

health to increase the knowledge and understanding of traditional Chinese medicine among Norwegian health personnel.

## EDUCATION AND TRAINING

The 1990 chiropractic law regulates the training of chiropractors; however, there are no recognized schools of chiropractic in the country. There are two schools of homeopathy in Norway. One offers courses to all persons with some education in allopathic medicine. Beginning with the basics, it is a five-year programme with classes taught one weekend each month. The other school only offers courses to persons who have the minimum qualifications to practice allopathic nursing.

## INSURANCE COVERAGE

Public reimbursement is not available for what is regarded in Norway as complementary/alternative medicine. Coverage for homeopathic treatments, for example, is not included under the official health care system. However, by the regulations governing the national insurance scheme, partial reimbursement is available for chiropractic treatment provided the chiropractor is authorized as a health care professional (although not necessarily a member of the Norwegian Association on Chiropractic) and the patient was referred to the chiropractor by an allopathic physician. This coverage is limited to a maximum of between 10 and 14 consultations per year.

In Norway, Norsk Helseforsikring, which is connected to International Health Insurance Denmark AS, is the only private insurance company offering partial reimbursement for complementary/alternative medicine.

The insurance covers chiropractic and, when performed by a licensed allopathic physician as part of medical treatment, acupuncture.

# RUSSIAN FEDERATION

## STATISTICS

There are one or two chiropractors practicing in the Russian Federation.

## REGULATORY SITUATION

The Russian Federation provides a striking example of a change in policy towards complementary/alternative medicine that may be followed in other former socialist countries. Section 34 of the Fundamental Principles of the Health Legislation of the Union of the Soviet Socialist Republics and of the Union Republics required physicians to use only those diagnostic, prophylactic, and therapeutic methods and

pharmaceutical products authorized by the Ministry of Health. Neither homeopathy nor homeopathic medicines were authorized.

By contrast, the right to practice the art of healing by "popular" medicine is protected by Section 57 of the Russian Federation legislation governing health care. It remains to be seen how this provision will be interpreted, but its general open-ended language suggests that it is likely that complementary/alternative practitioners will have wide powers to practice.

A 1995 decree refers to homeopathy in the Russian Federation. It permits the use of homeopathy in every clinic and hospital, giving it official recognition. There is no law specifically regulating chiropractic, although some chiropractors have been permitted to practice.

## EDUCATION AND TRAINING

The State Scientific and Practical Centre of Traditional Medicine and Homeopathy of the Ministry of Public Health of the Russian Federation was created in 1999. The Centre's goals include organizing and conducting scientific research and coordinating and realizing educational activities in complementary/alternative medicine.

A standard Government education programme in homeopathy has been developed by the Committee for Homeopathy of Russia and approved by the Ministry of Health. Homeopathy has also been introduced at the Russian Medical Academy as a postgraduate speciality.

# SPAIN

## BACKGROUND INFORMATION

Homeopathy was introduced into Spain in the beginning of the 19th century. The first Spanish homeopathic hospital, the Fundacion Instituto Homeopatico y Hospital de San Jose in Madrid, was founded in 1878. The Academia Medico Homeopatica de Barcelona was founded in 1890. There is an outpatient homeopathic clinic at the Hospital del Nen Deu of Barcelona. The Spanish Society of Homeopathic Medicine was founded in 1996. It represents all homeopathic associations.

In addition to homeopathy, popular complementary/alternative therapies include acupuncture, auriculotherapy, neuraltherapy, and biological medicine. However, until 1987, complementary/alternative medicine (with the exception of homeopathy) had only a minor role in the Spanish health care system.

There are several associations linked to complementary/alternative medicine in Spain. Since 1996, the Spanish Medical Council has supported complementary/alternative medicine, provided it is practiced by licensed physicians.

## STATISTICS

There are 50 chiropractors practicing in Spain.

## REGULATORY SITUATION

In Spain, the practice of medicine is the exclusive right of allopathic doctors. In order to obtain the right to practice medicine, a candidate must hold an academic degree in medicine, have authorization from a medical college, pledge professional secrecy, be current in his or her taxes, and as outlined in the Statutes of the Collegial Medical Organization, respect the Spanish Code of Professional Ethics of 1990. Natural medicine, by the Royal Decree of 27 March 1926, may only be practiced by licensed allopathic physicians.

On 16 June 1997, the Code of Medical Professional Ethics was adopted in Catalonia. Article 44 of this code stipulates that doctors using complementary / alternative medicine must inform their patients of the importance of continuing necessary allopathic treatments and of the non-conventional character of the complementary/alternative therapy. Furthermore, doctors must coordinate their supplementary therapy with the allopathic physician in charge of the patient's basic treatment. Article 44 forbids using methods that have not been scientifically validated to make a diagnosis or treat a patient.

Royal Decree 127/1984 does not include branches of complementary/alternative medicine as medical specialities. Opposing this, professional associations registered with the Ministry of the Interior are seeking recognition from the Spanish Government for graduate practitioners using complementary / alternative medical techniques. The Council of Medical Colleges of Catalonia wants to make homeopathy, acupuncture, and natural medicine official.

Under Article 62 of Royal Decree 3166/1966 of 23 December 1966, licensed paramedics are allowed to perform medical acts only under the supervision of an allopathic physician. The three categories of paramedic professions are practitioners of odontology, psychologists, and university graduates in nursing, which include, for example, physiotherapists. Some paramedics illegally practice complementary / alternative medicine.

The illegal practice of medicine is regulated by Article 403 of the Penal Code, approved on 23 November 1995. This article states that if persons without relevant academic certificates practice acts specific to a profession, they risk imprisonment

for a period of up to 12 months. This includes all intrusions made by non-allopathic physicians in the field of medicine.

State authorities are relatively tolerant with private allopathic doctors and non-allopathic practitioners using complementary/alternative medicine. On 23 January 1984, in response to a case regarding acupuncture and reflexology, the Spanish Supreme Court declared that it is not necessary to have a degree in medicine in order to practice medicine. However, only approved medical professionals may make a diagnosis, give a clinical or medical examination, or decide to apply a specific therapy.

On 19 June 1989, in a Supreme Court decision, a non-allopathic practitioner of acupuncture-moxibustion was found not guilty of intrusion into the field of medicine on the basis of two points *:* first, the practitioner had several foreign certificates and was a member of the Latin American Association of Research on Acupuncture-Moxibustion; second, as complementary/alternative medicine is not taught within Spanish medical faculties and as there is no official certificate authorizing and legitimizing complementary/alternative medical practice, it does not legally exist. Consequently, it does not correspond to any legally determined profession and therefore its practice cannot be the object of intrusion.

In January 1993, the Supreme Court released a non-physician acupuncturist. The argument was the same: complementary/alternative medicine is not included within the official list of medical specialities and therefore practicing complementary / alternative medicine is not an intrusion into the field of medicine.

Similarly, the Spanish Association of Physiotherapists denounced certain chiropractors for intrusion into the field of medicine. However, in an 18 March 1997 decision, the regional Court of Valencia stated that chiropractors and other practitioners using complementary/alternative medicine are not committing intrusion.

Article 54 of the Law on Medicaments 25/1990 of 20 December 1990 and Royal Decree 2208/1994 of 16 November 1994 regulate homeopathic remedies and the commercialization of homeopathic products.

## EDUCATION AND TRAINING

The medical universities of Madrid, Sevilla, Murcia, Zaragoza, Valladolid, Barcelona, and Santiago offer certificate courses in homeopathy, naturist medicine, and acupuncture to allopathic physicians. The universities of Barcelona, Sevilla, Valladolid, and Murcia offer postgraduate training in homeopathy for physicians. For pharmacists and veterinarians, some universities offer basic and advanced homeopathic training programmes as well as other courses and certificates.

Sociedad Española Acupunctura and Sociedad Española de Medicos Acupunctores in Madrid offer two-week introductory courses, three 90-day training courses, and a complete three-year training programme. With the sponsorship of the Council of Europe and the World Health Organization, the Teaching Centre of Traditional Chinese Medicine in Spain provides comprehensive training for both physicians and non-physicians in acupuncture with the intention of gaining professional status for acupuncture. Other professional organizations also provide courses in complementary/alternative medicine.

## INSURANCE COVERAGE

Two public hospitals, Hospital del Nen Deu in Barcelona and Fundacion Instituto Homeopaticoy Hospital de San Jose in Madrid, provide homeopathic care to outpatients on a fee-for-service basis. Under Article 94 of Law 26/1990 of 20 December 1990, there is no justification for homeopathic products to be financed through the State insurance system, INSALUD. Efforts by the Homeopathic Physicians Charter of the State of Spain to gain social security coverage for homeopathic medications have been unsuccessful.

In Spain, only a few private insurance companies provide coverage for any complementary / alternative medicines.

## SWEDEN

## STATISTICS

In a 1989 survey, 20% of adults reported having received complementary / alternative medical treatment. Forty per cent of patients of complementary / alternative medicine stated they had chosen these treatments because they were not satisfied with the National Health Service. Seventy per cent stated that through their complementary/alternative treatment their health had improved or they had been cured of their illness; 1% stated their health had deteriorated.

Chiropractic is the most commonly consulted complementary/alternative medicine in Sweden. Thirteen per cent of the population has consulted one of the 130 practicing chiropractors at least once. The next most popular form of complementary/alternative medicine is homeopathy, accounting for 4% of consultations, followed by acupuncture, naturopathy, and herbal medicine.

## REGULATORY SITUATION

In Sweden, the National Board of Health and Welfare maintains a registry of public health and medical personnel. Practitioners who are not included in the Supervision of Health and Medical Personnel list of medical practitioners (which

includes only allopathic doctors, dentists, nurses, midwives, and physiotherapists) may not be registered. Thus, officially only recognized medical practitioners are under public scrutiny.

The requirements for practicing medicine are included in the Act on Competence 542 of 1984 and the Medical Care Act 786 of 1996. Although non-registered persons may treat patients, specific medical acts are restricted to allopathic physicians. The specific treatments reserved for physicians are outlined in the Quackery Act - Law 409 of 1960, modified in 1982. Only a physician is allowed to act as a doctor in medicine; practice general or local anaesthesia; provide care with radiological methods; practice in an itinerant way; treat specific contagious diseases; treat cancer, diabetes, epilepsy, or pathological conditions associated with pregnancy or childbirth; treat a child who is younger than eight years old; issue written recommendations or instructions for the treatment of patients who are not personally examined by them; provide acupuncture; and test or supply contact lenses. The violation of these restrictions is an offence and may be prosecuted.

Non-allopathic practitioners who damage a person's health by using inappropriate therapies may be charged with charlatanism constituting a danger to health. Practitioners found guilty of this charge are punishable under the penal law and may be prohibited from working in the health care field.

In 1989, Sweden granted recognition to chiropractors satisfying the standards of the Council of Chiropractic Education. By Government Bill 1988/89:96, those chiropractors completing studies as doctors of chiropractic have the right to obtain a licence and to be registered under the National Health Service. However, no Swedish training programme has so far been certified as meeting the appropriate standards. Currently, all registered practitioners have been trained abroad. Chiropractors trained at the Scandinavian College of Chiropractic in Stockholm are working to be included among the recognized practitioners.

Homeopathic remedies are legal and are manufactured according to good manufacturing practices.

In 1994, official recognition was extended to naturopaths. The Swedish Commission on Competence does not intend to amend the rules of authorization for them. Osteopaths remain unrecognised and the Swedish Commission on Competence does not have any proposals regarding osteopathy.

The Swedish Commission on Competence was delegated to undertake a comprehensive review of the principles governing authorization and competence and, in the light of this review, to put forward proposals concerning, for example, rules of authorization and competence for various categories of professional medical care, including the Quackery Act.

The Swedish Parliament mandated the Commission on Alternative Medicine to examine issues concerning the position of complementary/alternative medicine in Swedish society. The recommendations of the Commission on Alternative Medicine (1989) and the proposals of the Swedish Commission on Competence (1996) can be summarized as follows:

- create an association of non-allopathic practitioners who have had at least one year of training and are registered by the National Board of Health and Welfare;
- create a State register of all non-allopathic practitioners who have passed their exams;
- create professional titles;
- uphold the law reserving specific medical acts for allopathic physicians;
- introduce some types of complementary/alternative medicine into the National Health Service and incorporate complementary/alternative practitioners into the National Health Service, provided specific conditions are fulfilled;
- strictly control the advertising of natural remedies;
- plan scientific studies on the effectiveness of complementary / alternative medicine.

## EDUCATION AND TRAINING

Most of the increasing numbers of homeopaths working in Sweden today have been educated at private institutions. This education corresponds to that of allopathic physicians in many ways. There are three private schools providing homeopathic training. There is also a four-year basic medicine course taught by professors from the University of Upssala. No Swedish chiropractic training programme is officially recognized.

## INSURANCE COVERAGE

While non-allopathic practitioners may treat patients in Sweden, their care is not reimbursed by the health care system. Only acupuncture provided by an allopathic physician is reimbursed by social insurance, and then only partially. The Commission on Complementary / Alternative Medicine did not propose the reimbursement of treatments obtained from practitioners of complementary / alternative medicine.

## SWITZERLAND

## BACKGROUND INFORMATION

Patients of complementary/alternative medicine who are ill report that they use complementary/alternative medicine because the therapies do not involve treatment with drugs or chemicals, there are no side effects, and allopathic medicine was unsuccessful in treating their illness. Patients of complementary/alternative medicine who are not ill report that they use complementary/alternative medicine to improve their well-being and to keep from falling ill.

## STATISTICS

A 1992-1993 study showed that the use of complementary/alternative medicine within the previous 12 months was closely related to whether or not a patient had complementary/alternative health insurance:

- Of those surveyed who had insurance covering complementary/alternative medicine, 20.7% did not use complementary/alternative medicine; 18.9% used one form of complementary/alternative medicine; 21.5%, two forms; and 39.0%, three or more forms.
- Those without insurance covering complementary/alternative medicine reported the following: 56.4% did not use complementary/alternative medicine; 20.5% used one form of complementary/alternative medicine; 13.4%, two forms; and 9.7%, three or more forms.

Persons living in the German-speaking and French-speaking parts of the country used complementary/alternative medicine more extensively than those living in the Italian-speaking region. Women and persons with higher levels of formal education were more likely to consult a complementary/alternative medical practitioner than were men and persons with lower levels of formal education. The most commonly consulted forms of complementary/alternative medicine are shown in the chart below.

| **Type of Complementary/Alternative Medicine Consulted** | **Patients with insurance coverage[a]** | **Patients without insurance coverage[a]** |
|---|---|---|
| Homeopathy | 63% | 26% |
| Alternative massage therapies | 41% | 19% |
| Phytotherapy | 27% | 14% |
| Nutrition therapy | 22% | 9% |
| Acupuncture | 18% | 4% |
| Anthroposophic medicine | 13% | 3% |
| Magnetotherapy | 8% | 3% |

[a] The percentages are the proportion of respondents who consulted a complementary/alternative practitioner, not the total number of people surveyed.

There are approximately 180 chiropractors practicing in Switzerland. Complementary / alternative therapies are provided by allopathic physicians, natural doctors, non-allopathic practitioners, pharmacists, and patients themselves. There are many organizations linked to complementary/alternative medicine in the country.

## REGULATORY SITUATION

In Switzerland, cantons (similar to states or provinces) make their own public health regulations, including the regulation of local medical practice. Nonetheless, some degree programmes and professions, such as allopathic physicians or chiropractors, are recognized throughout the country, and the titles of some professions, including "Medical Doctor" and "Chiropractor", are protected. The cantons allowing only allopathic physicians to practice medicine are Appenzell internal Rhodes, Jura, Nidwalden, Uri, and, with the provisions noted, the following:

- Aargau: a licence is not required to provide care to healthy persons (when treating nervousness, stress, sleeplessness, or phobias, for example).
- Basel Stadt: authorized physiotherapists and masseurs are permitted to use reflexology.
- Bern: the practice of acupuncture by non-allopathic practitioners is tolerated when provided under the orders of an allopathic physician.
- Fribourg: the Department of Health may issue licences to practice complementary/alternative medicine on condition that practitioners do not use methods and techniques restricted to authorized health care professionals.
- Geneva: recently, the authorities have been relatively tolerant of non-allopathic practitioners.
- Glarus: reflexology, acupressure, and other similar forms of massage may be freely provided.
- Schwyz: non-physicians may obtain a licence to practice acupuncture.
- Solthurn: a draft law would enable the practice of complementary/alternative medicine as a self-employed profession.
- Vaud: recently, the authorities have been relatively tolerant of non-allopathic practitioners.
- Zug: under the supervision of the health authority, reflexology, sport massage, acupressure, and health advising may be freely provided. Acupuncture may be provided by persons who have completed three years of training, including comprehensive theoretical and practical courses, and who have passed a cantonal exam.
- Zurich: magnetism is not considered a form of medicine and, therefore, its practice does not require official authorization.

Although the law in these cantons is typically monopolistic, the authorities are relatively tolerant with regard to non-allopathic practitioners.

In order to be allowed to practice in German-speaking cantons (Appenzell external Rhodes, Basel Landschaft, Graubünden, Luzern, Obwalden, St. Gallen, Shaffhausen, and Thurgau), non-allopathic providers must pass the State exam and obtain a licence from State authorities. In most German-speaking cantons, there are specific medical acts that are reserved for physicians.

In non-German-speaking cantons, the situation is slightly different. In the canton of Neuchâtel, since the introduction of a 1995 law, non-allopathic practitioners are permitted to provide non-dangerous complementary/alternative therapies. While a licence to practice is not required, complementary/alternative medical providers may not advertise their services. In Valais, the same restrictions apply, with two additional requirements: complementary/alternative providers must clearly inform their patients that they do not have any allopathic education and they must have a licence from the health department. In the canton of Ticino, non-allopathic practitioners may practice medicine without a licence; however, they must clearly inform their patients that they do not have an allopathic education. And, they are not permitted to advertise; use optical, mechanical, electrical, or ionizing equipment; or prescribe medications or drugs.

Homeopathy is among the most frequently practiced complementary/alternative therapies in Switzerland. All persons legally providing health care may apply homeopathy according to the standards of good medical practice. In some cantons, those not medically qualified may practice homeopathy as well. In 1998, the National Medical Association recognized homeopathy as a medical sub-speciality.

Chiropractic is considered an independent medical profession that is federally regulated and recognized throughout the country. There are several requirements that must be met to be allowed to practice as a chiropractor, including limited competence in medical diagnosis and treatment. To practice chiropractic, a person must have Swiss citizenship, hold a diploma giving access to a university, have studied at least four years in a chiropractic college recognized by the American Council on Chiropractic Education, have passed the American commission exam, have passed the Swiss intercantonal exam, have passed the Swiss federal exam to be allowed to X-ray, and have completed at least a one-year internship with a Swiss-authorized chiropractor.

## EDUCATION AND TRAINING

The universities of Zurich and Bern include an introductory course on complementary/alternative medicine in the standard curriculum for allopathic physicians. In Bern there are also more extensive courses on homeopathy,

neuraltherapy, traditional Chinese medicine, phytotherapy, anthroposophic medicine, hydrotherapy, and bio-resonance.

The Swiss Medical Association has been aware of the need to establish complementary/alternative medical specialities. In 1999 and 2000, it set up a new training programme for allopathic physicians. Homeopathy, Chinese medicine, acupuncture, anthroposophic medicine, and neural therapy are now granted speciality titles for allopathic physicians.

Training for these techniques, as with allopathic specialities such as cardiology or rheumatology, lasts between eight and 10 years.

Students who are not allopathic practitioners may study at any one of several private institutions offering training programmes in complementary/alternative medicine, including the following:

- Swiss Association of Natural Doctors: the programme, which lasts six semesters and is provided on weekends, includes introductions to anatomy, physiology, and biochemistry; seminars in physiology and pathology; and seminars on diagnostic and treatment techniques.
- School for Natural Medicine in Zurich: two training options are available, both include basic courses in anatomy, physiology, and pathology. Students then specialize either in homeopathy and traditional Chinese medicine or in several forms of complementary/alternative massage. The programme lasts four years.
- Academy for Natural Medicine in Basel: the school offers a basic common course in anatomy, physiology, pathology, psychiatry, neurology, and physical diagnosis. After completing this common course, students choose from among three specializations: homeopathy, phytotherapy and natural medicine; traditional Chinese medicine; or acupuncture. The programme lasts four years plus a required four-month internship.
- Swiss School for Osteopathy of Belmont/Lausanne: this school is working to obtain official recognition equivalent to a university faculty. It offers a five-year diploma and a six-year doctorate programme.

Although chiropractic is a recognized profession in Switzerland, there are no recognized chiropractic schools in the country. Practitioners must train abroad.

Some cantons - Appenzell external Rhodes, Basel Landschaft, Graubünden, Obwalden, St. Gallen, Shaffhausen, and Thurgau - have specific rules concerning the exam that candidates must pass to be allowed to practice complementary / alternative medicine.

## INSURANCE COVERAGE

There are several levels of health care protection in Switzerland. Insured persons are free to choose between minimum basic coverage and extensive coverage provided through policies that provide coverage for complementary/alternative health care and medications.

Since July 1999, five commonly used complementary/alternative therapies - homeopathy, Chinese medicine, anthroposophic medicine, neural therapy, and phytotherapy - have been reimbursed by compulsory social insurance when they are provided by an allopathic physician with a postgraduate education recognized by the Swiss Medical Association. Treatments provided by non-allopathic physicians are not reimbursed. Except for acupuncture, in order for these therapies to continue to be reimbursable after 2005, their efficacy and cost-effectiveness have to be proven by that year.

The complementary/alternative medicine policies of private insurance companies influenced the Swiss Government's decision to cover the most commonly used therapies. Private insurance companies, such as Caisse Vaudoise, generally offer complementary/alternative health care policies covering acupuncture, acupressure, Alexander technique, anthroposophy (when provided by a physician), audiopsycho-phonology, auriculotherapy, lymphatic drainage, etiopathy, curative eurythmy, eutony, homeopathy, postural integration, iridology, colonic irrigation, Kneipp therapy, kinesiology, anthroposophic medicine, mesotherapy, naturopathy, osteopathy, polarity, energetic balancing, reflexology, relaxation, breathing techniques, shiatsu, sophrology, and sympathicotherapy. The supplementary fee for complementary/alternative policies varies between 10 and 20 Swiss francs per month. Reimbursement varies between 30 and 100 Swiss francs per consultation; three to 10 consultations are covered per year.

## UKRAINE

## STATISTICS

There are no hospitals in Ukraine in which only complementary/alternative therapies are used.

## REGULATORY SITUATION

Though allopathic physicians may use allopathic or complementary/alternative therapies, only allopathic physicians and registered non-allopathic practitioners working under physicians are allowed to provide medical treatments. The Ministry of Health authorizes licences for physicians. It requires an authenticated copy of documents attesting to the level of education and necessary qualifications for the

practice of medicine, such as a medical diploma or a certificate of specialization, a letter of reference issued by a former employer, and approval from the designated local authority.

Complementary/alternative medicine is covered under general regulations. In order to be registered as a legal non-allopathic practitioner, it is necessary to complete a special programme given by the Academy of Physicians Postgraduate Education or by the Ukrainian National Medicine Association, which is under the supervision of the Ukrainian Ministry of Public Health. Some specific branches of complementary/alternative medicine, such as reflexotherapy, have their own code of speciality.

Steps are being taken to introduce an official specialization in homeopathy for allopathic physicians.

Homeopathic remedies are officially recognized by the Decree on Medicines of the Ministry of Health. Quality control of homeopathic remedies is based on the *German Pharmacopoeia.*

The Ukrainian Ministry of Public Health regulates the production of homeopathic medicines, and the Comission of the Pharmacological Committee on Homeopatic Medicines under the supervision of the Ukrainian Office for Public Health is responsible for delivering licences for their sale. Specialised homeopathic chemist shops exist in Ukraine. People can also buy homeopathic medicines from Germany and Austria.

## EDUCATION AND TRAINING

The Academy of Physicians Postgraduate Education and the Ukrainian National Medicine Association offer special courses for non-allopathic practitioners in homeopathy, iridology, reflexotherapy, aromatherapy, and phytotherapy.

## INSURANCE COVERAGE

There is no public or private reimbursement of complementary/alternative medicine. Patients seeking complementary / alternative treatment must pay for the care themselves.

# UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

## BACKGROUND INFORMATION

Successive governments have ensured that as long as patients require complementary / alternative treatment, access to it will be guaranteed. As a result,

the United Kingdom is the only country in the European Union with public-sector hospitals for complementary/alternative medicine. Indeed, there are National Health Service homeopathic hospitals in London, Glasgow, Liverpool, Bristol, and Tunbridge Wells. At Saint Mary's Hospital, where relaxation, dietetic, yoga, and meditation therapies are available, allopathic physicians work closely with non-physicians. Homeopathy provided by allopathic physicians is included in the National Health Service.

Complementary/alternative medications, homeopathic products, and other natural remedies are becoming increasingly popular and are now widely available in health food stores and pharmacies.

In response to the increased use of complementary/alternative medicine by the public and the Government's concern over its effectiveness, the British Research Council on Complementary Medicines was formed in 1982. Among other things, it noticed the major role of complementary/alternative medicine in reducing the costs of the health care system.

In general, in order to become a member of a professional organization, non-allopathic practitioners must be covered by insurance and adhere to the Code of Professional Ethics.

**STATISTICS**

During the past 20 years, interest in complementary/alternative medicine has increased. Seventy per cent of the public is in favour of complementary/alternative medicine becoming widely available in the National Health Service - particularly osteopathy, acupuncture, chiropractic, and homeopathy.

One-eighth of the British population has tried complementary/alternative medicine, and 90% of these people are ready to use it again. Complementary/alternative medicine is most popular with middle-aged, middle-class women. The complementary/alternative therapies most used are herbal medicines, osteopathy, homeopathy, acupuncture, hypnotherapy, and spiritual healing. Much complementary/alternative medical practice centres on treating chronic diseases. Most patients of complementary/alternative medicine are also patients of allopathic medicine.

Complementary/alternative practitioners without an academic degree provide the largest proportion of complementary/alternative medicine. In 1987, there were about 2000 non-allopathic medical practitioners. In 1999, there were 50 000 complementary/alternative medical providers. Approximately 10 000 of these are officially registered health professionals. In 1998, up to five million patients

consulted a complementary/alternative practitioner. Patients spend about 1.6 billion pounds sterling each year on complementary/alternative medicine.

There are approximately 1300 chiropractors practicing in the United Kingdom. There are several professional associations of complementary/alternative practitioners.

## REGULATORY SITUATION

Although complementary/alternative medical practitioners without an allopathic medical degree are tolerated by law, only medical providers holding a university degree in allopathic medicine are officially recognized *:* to practice medicine as a physician, a person must posses *a* certificate or qualification from the faculty of medicine of a university and complete one year of general clinical training. During the clinical training period, a physician candidate has provisional registration. After satisfactorily completing the training, the candidate may obtain full registration. Being a registered medical practitioner confers privileges and responsibilities, including the right to use the title or describe oneself as a registered practitioner, to be recognized by law as a physician or surgeon, to recover fees for medical attendance or advice in a court of law, to hold specific posts, to provide general medical services in the National Health Service, and to give some statutory certificates. The General Medical Council, a statutory body that regulates the medical profession, maintains the register of qualified allopathic doctors.

Although registration, for which specific training is required, provides certain privileges to non-allopathic practitioners as well, the right to practice medicine without formal recognition is established in British Common Law. This right protects an individual's freedom to carry out medical activities not specifically prohibited by an act of Parliament. As a result, given some restrictions and provided they do not breach the Medical Act of 1983, non-allopathic providers can practice medicine regardless of their training. In principle, non-registered persons are even allowed to perform surgical acts with the consent of patients. If such acts result in maltreatment, however, non-allopathic practitioners may be prosecuted under the penal law and the tort-based common law of negligence. And if a patient dies, the practitioner may be prosecuted for involuntary homicide. Registered physicians cannot be so prosecuted.

Under the terms of the Venereal Disease Act of 1917 and Section 4 of the Cancer Act of 1939, there are some limitations on the rights of non-allopathic practitioners. Non-allopathic practitioners may not perform certain medical acts, practice specific professions, or use particular titles. Only registered allopathic doctors may treat cancer, diabetes, epilepsy, glaucoma, and tuberculosis; prescribe controlled drugs; perform specific medical acts such as abortion; or treat venereal diseases. Unqualified practitioners may not claim to be or practice as pharmacists, midwives,

or dentists, or imply that they are State-registered allopathic practitioners whose legal status is regulated by the Professions Supplementary to Medicine Act of 1960. This Act regulates dieticians, medical laboratory technicians, occupational therapists, physiotherapists, radiographers, and orthopaedists. Further, commercial use of the term "health care centre" in relation to any premises where no allopathic doctors and nurses are employed is prohibited.

Allopathic physicians referring patients to non-allopathic practitioners for treatment retain clinical responsibility for their patients. The Medical Act of 1983 does not regulate which forms of therapy may be practiced by registered physicians. Thus, there is no restriction on registered allopathic physicians using complementary/alternative medicine if they have the requisite skills and/or qualifications. Further, the agreement of 1 April 1990 between allopathic general practitioners and the Family Health Service Authorities does not define the staff that may work with an allopathic physician. Thus, a physician's staff may include physiotherapists, chiropractors, and dieticians.

In 1950, the Government gave official recognition to homeopathy in the Faculty of Homeopathy Act. The Government regulates osteopathy and chiropractic through the quite similar Osteopath and Chiropractor Acts of 1993 and 1994. While registered practitioners of these two professions have special rights, including title protection, they, like other non-allopathic practitioners, are not recognized as official health care providers and may not work in National Health Service hospitals. Nonetheless, these two acts are considered to be important developments in complementary / alternative medicine. Other practitioners, including acupuncturists, homeopaths, and herbalists, are now pursuing the same level of recognition.

The regulation of chiropractors and osteopaths, as with all health care professionals, is based upon a register. The right to use the title of "Chiropractor" or "Osteopath" is restricted to registered chiropractors and osteopaths, and registration depends on having recognized qualifications, although there are transitional provisions for experienced practitioners.

The General Chiropractic Council, which includes a significant number of non-chiropractors, is publishing its own Code of Professional Ethics. Under the Osteopath and Chiropractor Acts of 1993 and 1994, the principal criteria for disciplinary action are professional incompetence, conduct that falls short of the standards required of a registered osteopath or chiropractor, conviction of a criminal offence, and serious health impairment affecting the ability to work as an osteopath or chiropractor. Under this Code, practitioners facing disciplinary action from the Committee may be admonished, suspended, or dismissed. The right to practice is initially granted for a period of up to three years, then for periods of two to three years. However, this is not yet in effect.

Homeopathic and other natural remedies are sold by many independent pharmacies. The European Directive on Homeopathic Products regulates the making and marketing of homeopathic products in the United Kingdom, The licensing of other medicines is regulated by the Medicines Act of 1968. Applications for drug registration must be accompanied by details of relevant research and clinical trials. Requirements are less stringent if the medicines do not contain a new chemical substance or if they are herbal preparations.

The Health Act of 1999 provides two options for achieving statutory regulation for a profession or therapy. The first option allows associations representing a profession to apply for statutory regulation. The second option allows professions to join the Health Professions Council; membership in the Council confers title protection.

## EDUCATION AND TRAINING

The British Medical Association recommends incorporating complementary / alternative medicine into the undergraduate curriculum of medical schools and making accredited postgraduate training available.

While most non-allopathic practitioners have good training, the quality of complementary / alternative medical programmes varies. The Institute of Complementary / Alternative Medicines is working with the Training Desk to establish national standards of training acceptable to both the public and the Government.

There are 54 professional associations representing complementary/alternative practitioners and offering comprehensive full-time courses in anthroposophy, chiropractic, homeopathy, phytotherapy, naturopathy, and osteopathy, lasting for a minimum of three years.

The Faculty of Homeopathy Act empowers the Faculty of Homeopathy to train, examine, and confer diplomas in homeopathy to allopathic physicians and other statutorily recognized health professionals. There are four schools of chiropractic in the United Kingdom.

## INSURANCE COVERAGE

With some exceptions, fees for complementary/alternative therapies are not reimbursed by the social security system. Exceptions are made for treatments available within National Health Service hospitals, which are provided free of charge, and occasionally for acupuncture, osteopathy, and chiropractic treatments. An allopathic general practitioner may claim reimbursement for a wide range of staff, including physiotherapists, chiropractors, and dieticians; however, the

authorities have the freedom to reimburse all, part, or none of these costs. Some private insurance programmes reimburse the five most popular forms of complementary / alternative therapy - homeopathy, osteopathy, herbalism, acupuncture, and naturopathy - when they are provided by allopathic physicians. The services of chiropractors and osteopaths are reimbursed by trade bodies and by several associations, such as industrial and veterans' associations.

## SOUTH-EAST ASIA

### BANGLADESH

### BACKGROUND INFORMATION

Ayurvedic medicine is widely practiced in Bangladesh.

### REGULATORY SITUATION

When Bangladesh constituted the eastern part of Pakistan, the Pakistani Board of Unani and Ayurvedic Systems of Medicine was operative in the country. Following independence, the Bangladesh Unani and Ayurvedic Practitioners Ordinance of 1972 restructured this body as the Board of Unani and Ayurvedic Systems of Medicine, Bangladesh. The Board is responsible for maintaining educational standards at teaching institutions, arranging for the registration of duly qualified persons (including appointing a registrar), and arranging for the standardization of unani and ayurvedic systems of medicine. A research institute has been functioning under the Board since 1976.

The Bangladesh Unani and Ayurvedic Practitioners Ordinance of 1983 prohibits the practice of unani and ayurvedic systems of medicine by unregistered persons. A significant feature of the Ordinance is the deliberate omission of *a* provision contained in preceding legislation that made it an offence for an ayurvedic or unani practitioner to sign birth, medical, and physical-fitness certificates.

### EDUCATION AND TRAINING

Control over the teaching of unani and ayurvedic medicine rests with the Board of Unani and Ayurvedic Systems of Medicine. There are nine teaching institutions under the Board, five for unani medicine and four for ayurvedic medicine. They offer diplomas upon completion of a four-year programme. The Registrar of the Board also serves as the Controller of Examinations.

### BHUTAN

### BACKGROUND INFORMATION

What is now classified as Bhutanese traditional medicine was introduced into Bhutan in the beginning of the 16th century by Lam Shabdrung Ngawang Namgyal. This medical system has roots in Buddhism and Tibetan traditional medicine. During its early practice in Bhutan, providers of traditional medicine were trained in Tibet.

In addition to medications, Bhutanese traditional medicine includes acupressure, acupuncture, moxibustion, cupping, cauterization, medicated oil massage, herbal and steam baths, and the application of cold and warm poultices to the body.

In 1988, a research unit was established in the Institute of Traditional Medicine Services. This unit conducts research for further quality control of raw materials and finished products for traditional medicines as well as developing new products. It also ensures the sustainability of traditional medicine services and looks for ways to increase the cost-effectiveness of traditional medicine.

## STATISTICS

There is a hospital for traditional medicine in Thimphy, the capital city of Bhutan. An additional 15 traditional medicine units across the country provide services to about 60% of the country's population. The Government plans to establish more units, to cover all 20 districts in the country.

There are more than 2990 different medicinal plants used in Bhutanese traditional medicines. About 130 traditionally used formularies are made from 110 different herbal preparations. About 70% of the raw materials used in these preparations are available in the country, both as wild and cultivated stocks. The remaining 30% are imported from India. There are more than 300 herbal products produced in Bhutan. Most are compound forms, with three to 90 ingredients.

## REGULATORY SITUATION

In 1967, in an effort to promote and preserve traditional medicine, it was formally recognized and institutionalized as an integral part of the national health system of Bhutan. In 1979, the Institute of Traditional Medicine Services was founded. It is housed in an allopathic hospital in order to encourage the integration of traditional and allopathic medicine, particularly mutual consultation, treatment, and referrals, and to enable patients to have greater access to a range of health care choices.

Bhutan's Institute of Traditional Medicine Services is charged with establishing a traditional medicine system that is scientifically sound and technologically appropriate, and which meets the needs of the population. To fulfil this mandate, the Institute works to provide access to traditional medicine for the entire population; to attain self-reliance in raw materials for the production of traditional

medicines, including the conservation, cultivation, rotational collection, and preservation of rare and endangered species of medicinal plants; to improve the quality of traditional medical services through training practitioners; and to increase the production of traditional medicines for export. Profits from exporting traditional medicines are to be used to strengthen traditional medicine within Bhutan.

Small-scale mechanised production of traditional medicines started in 1982 with the assistance of the World Health Organization; previously, all medicines had been prepared manually. All herbal products are now produced mechanically following good manufacturing practices, with an emphasis on quality control. Herbal products take the form of pills, tablets, medicated ointments, syrups, and capsules and are purely natural - no artificial chemicals are used.

## EDUCATION AND TRAINING

Officially recognized formal training of traditional medical doctors (*drungtsho*) began in 1971 with the establishment of a five-year *drungtsho* programme. In 1978, the training curriculum was standardized. In 1979, the programme became part of the National Institute of Traditional Medicine. The course now consists of five years of institutional training followed by a six-month internship: three months in an allopathic hospital and three months in the traditional medicine hospital and a traditional medicine unit. During the three-month internship in the allopathic hospital, interns are introduced to allopathic medicine and the health sciences.

# DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

## REGULATORY SITUATION

In the Democratic People's Republic of Korea, traditional medicine is integrated into the official health care system. This policy of integration is reflected in a number of policy declarations since 1947. It was a prominent feature of the Government's 1967 political programme and was reiterated in a 1980 public health law. Under Article 15 of this law, with a view to preserving national therapeutic traditions, the State is required to combine traditional medical practices with allopathic diagnosis in medical establishments.

# INDIA

## BACKGROUND INFORMATION

For centuries, ayurveda, siddha, and unani systems of medicine have coexisted with yoga, naturopathy, and homeopathy.

Siddha is one of the oldest systems of medicine in India. In Tamil, *siddha* means "perfection" and a *siddha* was a saintly figure who practiced medicine. Siddha has close similarities to ayurveda, the difference between these two systems being more linguistic - Tamil versus Sanskrit - than doctrinal. In siddha, as in ayurveda, all objects in the universe, including the human body, are composed of the five basic elements: earth, water, fire, air, and sky.

Yoga was propounded by Patanjali and is based upon observance of austerity, physical postures, breathing exercises, restraining of sense organs, contemplation, meditation, and *samadhi.*

Naturopathy is a system of drugless treatment and a way of life. It is very close to ayurveda.

The introduction of allopathic medicine during the colonial period led to the Government's neglect of traditional medical systems. Now, however, ayurveda, unani, siddha, naturopathy, homeopathy, and yoga are well integrated into the national health care system. There are State hospitals and dispensaries for both traditional medicine and homeopathy; however, traditional medicine and homeopathy are not always well integrated with allopathic medicine, particularly in allopathic hospitals.

## STATISTICS

Traditional medicine is widely used in India, especially in rural areas where 70% of the Indian population lives.

There are 2860 hospitals, with a total of 45 720 beds, providing traditional Indian systems of medicine and homeopathy in India. In 1998, more than 75% of these beds were occupied by patients receiving ayurvedic treatment, which is by far the most commonly practiced form of traditional medicine in India. There are 22 100 dispensaries of traditional medicine. There are 587 536 registered traditional medicine practitioners and homeopaths, who are both institutionally and non-institutionally qualified.

## REGULATORY SITUATION

Ayurveda, unani, siddha, naturopathy, homeopathy, and yoga are all recognized by the Government of India. The first step in granting this recognition was the creation of the Central Council of Indian Medicine Act of 1970. The main mandates of the Central Council are as follows:

- to standardize training by prescribing minimum standards of education in traditional medicine, although not all traditional medicine practitioners and homeopaths need be institutionally trained to practice;
- to advise the central Government in matters relating to recognition / withdrawal of medical qualifications in traditional medicine in India;
- to maintain the central register of Indian medicine, revise the register from time to time, prescribe standards of professional conduct and etiquette, and develop a code of ethics to be observed by practitioners of traditional medicine in India. All traditional medicine practitioners and homeopaths must be registered to practice.

The Central Council of Homeopathy, constituted in 1973, has the same mandates. The Indian Government created the Department of Indian Systems of Medicine & Homeopathy in March 1995. The primary areas of work for the Department are education, standardization of medicines, enhancement of availability of raw materials, research and development, information dissemination, communication, and the involvement of traditional medicine and homeopathy in national health care. More than 4000 personnel work in these areas.

The Indian Government seeks the active and positive use of traditional medicine and homeopathy in national health programmes, family welfare programmes, and primary health care.

**EDUCATION AND TRAINING**

Through the Central Council of Indian Medicine and the Central Council of Homeopathy, the Indian Government is working to standardize the training of traditional medicine practitioners and homeopaths. In support of this, seven national institutes are under the control of the Department of Indian Systems of Medicine & Homeopathy:

- National Institute of Ayurveda: established in 1976, located in Jaïpur, offers a PhD MD in ayurveda;
- National Institute of Homeopathy: established in 1975, located in Calcutta, offers Bachelor's and MD degrees in homeopathy;
- National Institute of Naturopathy: established in 1984, located in Pune, offers talks in Hindi and Marathi and programmes for teachers and doctors;
- National Institute of Unani Medicine: established in 1984, located in Bangalore, offers postgraduate research opportunities in unani;
- National Institute of Postgraduate Teaching and Research in Ayurveda: located in New Delhi, offers PhD and MD degrees in ayurveda;
- National Academy of Ayurveda: established in 1988, located in New Delhi, offers a Degree of Membership Certificate in ayurveda;

- National Institute of Yoga: established in 1976, located in New Delhi, offers a one-year diploma in yoga.

An institution for siddha medicine is planned.

In addition to these national institutes, there are a number of facilities for medical education under the Department of Indian Systems of Medicine & Homeopathy *:*

| **Facilities** | **Ayurveda** | **Unani** | **Siddha** | **Homeopathy** | **Total** |
|---|---|---|---|---|---|
| Undergraduate Colleges | 154 | 32 | 2 | 118 | 305 |
| *Admission Capacity* | 6117 | 1239 | 155 | 4318 | 11829 |
| Postgraduate Colleges | 33 | 3 | 1 | 10 | 47 |
| *Admission Capacity* | 462 | 55 | 35 | 69 | 621 |

The health authorities review the qualifications of practitioners through the Central Council of Indian Medicine and the Central Council of Homeopathy, which can both determine whether these colleges and universities may continue to admit students.

## INSURANCE COVERAGE

Few people besides State employees have medical insurance, although this insurance does cover traditional medicine.

## INDONESIA

## BACKGROUND INFORMATION

Indonesian practitioners of traditional medicine may be divided into four groups: herbalists; skilled practitioners, including traditional birth attendants, circumcisers, bonesetters, masseuses, and traditional dentists; spiritualists; and supernaturalists.

## STATISTICS

The use of traditional medicine is increasing each year. Traditional medicine provides an important resource for self-care within the health services and through traditional medicine practitioners. Forty per cent of Indonesia's population uses traditional medicine, 70% in rural areas.

A 1995 Ministry of Health survey reported 281 492 practitioners of traditional medicine practicing in Indonesia, a significant increase over the 112 974 reported in 1990 (*189, 190*). Of these practitioners, 96.2% use traditional Indonesian methods of treatment. The rest use medical treatments, such as acupuncture, that belong to

the traditions of other countries. Among the 281 492 traditional medicine practitioners in Indonesia, 122 944 are traditional birth attendants, 51 383 are general traditional medicine practitioners, 25 077 are masseuses, 18 456 are circumcisers, 18 237 are *tukang jamu gendong,* 14 000 are herbalists, 12 496 are spiritualists, 10 118 are supernaturalists, and 8781 are bonesetters.

Traditional birth attendants are an important feature of Indonesian health care. According to national figures for the period 1983 to 1987, allopathic providers attended only 43% of childbirths. The remainder were either unattended or attended by traditional birth attendants. At least 91 427 traditional birth attendants have completed a training programme offered by the Ministry of Health.

At the end of 1999, there were 723 manufacturers of traditional medicines in Indonesia, 92 of which were large-scale industries. These companies produce thousands of registered traditional medicines.

## REGULATORY SITUATION

Article 1 of Indonesia's Health Law Act 23-1992 places traditional medicine as an integral part of curative and nursing care. Article 2 emphasizes the need for supervision of traditional medicine to ensure its safety and efficacy. Article 3 supports further development and improvement of forms of traditional medicine deemed safe and efficacious in order to fulfill the goal of optimal health for the community. The Health Law Act classifies traditional medicines (*jamu*) into two groups:

- The first group consists of traditional medicines produced by individual persons or by home industries. These medicines need not be registered. They are made by traditional medicine practitioners for use by their own patients. They may not be labelled or marked except with the empirical name. The Minister of Health is responsible for helping the producers of these medicines ensure the quality of their products. To this end, the Ministry permits the use of only 54 species of plants in these medicines. The safety of all 54 species is known through traditional experience.

- The second group consists of traditional medicines produced and packed on a commercial scale, whether large or small. These medicines must be registered and licensed before they may be sold. In order to be registered, *jamu* (and traditional medicines not indigenous to Indonesia) must have undergone scientific study, including microbiological testing. These studies are to ensure the safety and efficacy, composition and rationality of the composition, dosage form, and claimed indications for the medicines. For use in formal health services, clinical trials must be carried out. The Ministry of Health of Indonesia

has produced a publication, *Guidance for Clinical Trial of Traditional Drug,* to help manufacturers fulfill these requirements.

In accordance with the 1993 General Guidelines, health efforts, including those for traditional medicine, have been strengthened within the framework of the national health care legislation.

Traditional birth attendants are permitted to practice without registration or a licence, Allopathic physicians with appropriate training in acupuncture are able to practice acupuncture in public hospitals.

## EDUCATION AND TRAINING

The Centre for Traditional Medicine Research, under the Ministry of Health and Social Welfare, provides training in traditional medicine. The Directorate of Selected Community Health Development, also under the Ministry of Health and Social Welfare, offers training programmes in primary health care for traditional practitioners of acupressure.

# MYANMAR

## BACKGROUND INFORMATION

Traditional medicine in Myanmar is based on ayurvedic concepts and influenced by Buddhist philosophy. From 1885, the beginning of the colonial period in Myanmar, until the Second World War, allopathic medicine was promoted over traditional medicine. During the Second World War, however, allopathic medicines were scarce and traditional medicine regained prominence.

## STATISTICS

The Department of Indigenous Medicine was established in August 1989. It houses more than 4000 ancient palm-leaf and parchment writings and books on traditional Myanmar medicine. Since the promulgation of the Traditional Medicine Law in 1996, a total of 3962 medicinal items have been registered and 632 manufacturers have been issued production licences.

Over 8000 practitioners of traditional medicine are registered in Myanmar.

There is one 50-bed hospital for traditional medicine in Mandalay, one 25-bed hospital in Yangon, and three 16-bed hospitals in other parts of the country. There are 194 township-level traditional medicine departments, each with its own outpatient clinic.

## REGULATORY SITUATION

Prior to the Second World War, several national committees recommended that the Government recognize traditional medicine, but no action resulted.

Four years after Myanmar's independence in 1948, the Myanmar Indigenous Medical Committee was formed. The Committee drafted the Indigenous Myanmar Medical Practitioners Board Act 74, which was passed in 1953 and amended in 1955, 1962, and 1987. The Act established the Indigenous Myanmar Medical Practitioners Board, which advises the Government on the revival and development of traditional Myanmar medicine, related research, and the promotion of public health, among other things. Section 11 specifies "suppression of charlatans or quacks who are earning their living by means of indigenous Myanmar medicine" as a particular function of the Board. Subject to the sanction of the Head of State, the Board is also empowered to prescribe topics for examination in traditional Myanmar medicine, register practitioners, and remove practitioners from the register if a defect in character or undesirable conduct is established. Section 24 of the Act prescribes that subject to the provisions of Section 23 of the Myanmar Medical Act, practitioners of traditional medicine must be registered in order to sign medical certificates, which by law must be signed by a medical practitioner. Similarly, unless he or she has obtained the prior sanction of the Head of State, an indigenous medical practitioner who is not registered may not hold certain specified appointments in publicly supported hospitals or other health facilities.

Section 7 of the Indigenous Myanmar Medical Practitioners Board Rules of 1955 provides for the registration of traditional medicine practitioners under six categories. The system of classification is essentially based on the division of Myanmar medicine into four branches: dhatu, ayurveda, astrology, and witchcraft. In Section 9 of the Rules, details are given of the knowledge required for registration in each specific category. Provision is made, in Section 10, for authors of works on indigenous medicine to be registered in one of three groups. Section 10 also prohibits the registration of monks as medical practitioners.

Under Section 12 of the Rules, the Board is mandated to find ways to consolidate the four branches of medicine currently practiced into a single system. The Board is also mandated to conduct research and advise the authorities on standardizing methods of treatment provided in Government-operated dispensaries. The Indigenous Myanmar Medical Practitioners Board Amendment Act 48 of 1962 introduced Sections 22-A and 28-A empowering the Chairman of the Revolutionary Council of Myanmar to cancel the registration of indigenous medical practitioners, prescribe qualifications for registration, and terminate the services of any or all of the members of the Board and appoint new members in their place. Under these powers, a new Board was appointed to initiate the re-registration of practitioners.

In 1996, the Government promulgated the Traditional Medicine Law in order to control the production and sale of traditional medicines. The Ministry of Health has updated and revised the Indigenous Myanmar Medical Practitioners Board Amendment Act and renamed it the Traditional Medical Council Law. It is now in the process of receiving State approval.

## EDUCATION AND TRAINING

The Ministry of Health established an educational institution known as the Institute of Indigenous Medicine in 1976. It offers a three-year training programme followed by a one-year internship. The Institute also conducts a one-year course in primary health care for traditional medicine practitioners who have no certificate or licence to treat patients. Those who are successful in the course receive a licence to practice traditional medicine.

# NEPAL

## BACKGROUND INFORMATION

The use of medicinal herbs in Nepal's traditional medical system dates back to at least 500 AD. In Nepal, traditional medicine, although low profile, has been an integral part of the national health system. Parallel to the allopathic system, traditional medicine is encouraged in all spheres because of its efficacy, availability, safety, and affordability when compared to allopathic drugs.

## STATISTICS

Ayurvedic medicine is widely practiced in Nepal. It is the national medical system. More than 75% of the population use traditional medicine, mainly that based on the ayurvedic system. There are 141 ayurvedic dispensaries, 14 zonal dispensaries, 15 district ayurvedic health centres, and two ayurvedic hospitals. One of these hospitals is centrally located in Naradevi, Kathmandu, and the other is regionally located in Dang. They have 50 and 15 beds, respectively.

There are 623 institutionally qualified practitioners of traditional medicine and about 4000 traditionally trained practitioners. Homeopathy has been recently introduced into Nepal.

## REGULATORY SITUATION

The policy of the Government, based on five-year plans, involves a system of integrated health services in which both allopathic and ayurvedic medicine are practiced. Ayurvedic clinics are considered to be part of the basic health services, and there is a section responsible for ayurvedic medicine in the Office of the

Director General of Health Services. The programmes for health services included in the Fifth Five-Year Plan make provision for four ayurvedic hospitals, one in each of the four development regions. The Ayurvedic Governmental Pharmaceutical Unit works to provide inexpensive medicaments.

The Ayurvedic Medical Council was created through legislation passed in 1988. Section 2.1 of this Act gives the Council's mandate as, among other things, steering the ayurvedic medical system efficiently and registering suitably qualified physicians to practice ayurvedic medicine.

In Section 4, the legislation sets out highly detailed provisions for registration that classify applicant practitioners into four groups according to their qualifications and experience in ayurvedic science. By Section 5.2.2, membership in a particular group fixes the range of ayurvedic medicines that a practitioner is permitted to prescribe. Registered practitioners enjoy a monopoly over the practice of ayurvedic medicine: direct or indirect practice of ayurvedic medicine by other medical practitioners is forbidden by Section 5.1.1. Section 5 of the Act enables registered ayurvedic practitioners to issue birth and death certificates as well as certificates concerning the ayurvedic medical system and patients' physical and mental fitness.

## EDUCATION AND TRAINING

Formal education in the ayurvedic system is under the supervision of the Institute of Medicine of Tribhuvon University. The Auxiliary Ayurveda Worker training programme is run from the Department of Ayurveda under the Council for Technical Training and Vocational Education.

# SRI LANKA

## BACKGROUND INFORMATION

Traditional medicine forms an integral part of the health care delivery system in Sri Lanka. Traditional and natural medicine founded on the concept of three humours has a long anecdotal history of effective diagnosis and treatment. Unfortunately, there is a lack of scientific research to support this history.

Ayurvedic medicine is widely practiced in Sri Lanka.

## STATISTICS

In Sri Lanka, 60% to 70% of the rural population relies on traditional and natural medicine for their primary health care.

## REGULATORY SITUATION

The popularity of traditional medicine led to the promulgation of the Indigenous Medicine Ordinance in 1941. This Ordinance provided for the establishment of the Board of Indigenous Medicine, whose duties include the registration of traditional medicine practitioners, and oversight of the College of Indigenous Medicine and the Hospital of Indigenous Medicine.

The establishment of the Department of Ayurveda within the Ministry of Health by Ayurveda Act 31 of 1961 constituted a landmark in the modern history of ayurveda. Ayurveda, as defined in the Act, encompasses all medical systems indigenous to Asia, including siddha and unani.

The Act defined the Department's objectives as provision of establishments and services necessary for the treatment of disease and the preservation and promotion of the health of the people through ayurveda; encouraging the study of, and research into, ayurveda via scholarships and other facilities to persons employed, or proposed to be employed, in the Department and by the grant of financial aid and other assistance to institutions providing courses of study or engaging in research into ayurveda; and taking, developing, or encouraging measures for the investigation of disease and the improvement of public health through ayurveda.

The Ayurveda Act 31 of 1961 also specified the duties of the Ayurvedic Medical Council, which include registration of ayurvedic practitioners, pharmacists, and nurses and regulation of their professional conduct as well as authority over the Ayurvedic College and Hospital Board and the Ayurvedic Research Committee.

The Ayurvedic Physicians Professional Conduct Rules of 1971 were made by the Ayurvedic Medical Council under Section 18 of the 1961 Act and approved by the Ministry of Health. They establish a code of ethics for ayurvedic physicians. Professional misconduct includes procuring or attempting to procure an abortion or miscarriage; issuing any certificate regarding the efficacy of any ayurvedic medicine or any ayurvedic pharmaceutical product containing statements that the practitioner knows to be untrue or misleading; conviction of an offence under the Poisons, Opium and Dangerous Drugs Ordinance that was committed in the practitioner's professional capacity; selling to the public, either directly or indirectly, any ayurvedic pharmaceutical product for which the prior sanction of the Ayurvedic Formulary Committee has not been obtained; and exhibiting or displaying any medical degree or medical diploma that has not been approved by the Ayurvedic Medical Council.

In early 1980, the Ministry of Indigenous Medicine was established as a separate department to be led by a senior parliamentarian - who is an ayurvedic practitioner by profession. Responsibility for the Department of Ayurveda was transferred to the

Ministry. A central feature of the Ministry's operation has been the establishment of traditional medical dispensaries and hospitals that provide medical care at no cost.

The Cabinet Ministry for Indigenous Medicine was established in 1994; there was previously a State Minister for Indigenous Medicine. Research and development activities are undertaken on behalf of these ministerial offices by the Department of Ayurveda and the Bandaranaike Memorial Ayurvedic Research Institute, founded June 1962.

The Homeopathy Act of 1970 recognized homeopathy as a system of medicine and established the Homeopathic Council appointed by the Minister of Health in 1979. The Homeopathic Council is responsible for regulating and controlling the practice of homeopathic medicine and maintaining the Homeopathic Medical College. The 1970 Act exempted persons practicing homeopathic medicine, pharmacy, or nursing from the provisions of the Medical Ordinance and empowered the relevant Minister to make regulations for the control of professional conduct and other matters. In particular, the Council is empowered to register and recognize homeopathic medical practitioners; recognize homeopathic teaching institutes, dispensaries, and hospitals; hold examinations and award degrees in homeopathic medicine; and arrange for postgraduate study in homeopathy. The Council also maintains a register of homeopathic practitioners. With some exceptions, qualification following a course of study of not less than four years is a prerequisite for registration. Only registered practitioners may practice homeopathy for gain and use the title "Registered Homeopathic Practitioner". Such practitioners are also entitled to issue certificates or other documents required to be issued by medical practitioners; hold posts as medical officers in public medical institutions; and sign birth or death certificates, medical certificates, and certificates of physical fitness.

## EDUCATION AND TRAINING

A World Health Organization/United Nations Development Programme project for the development of traditional medicine in Sri Lanka (SRL/84/020) was implemented in the 1980s. Phase I began in October 1985 and ended in May 1988. Phase II (SRL/87/029) began in 1989. The importance of human resource development in the traditional and natural medicine sector was highlighted in this project. The project enhanced the teaching capability of eight instructors of traditional medical practice and the professional capability of 1217 general practitioners of traditional medicine to provide advice at the community level on the preventive and promotive aspects of primary health care and treating common ailments.

The same project provided incentives to establish the National Institute of Traditional Medicine, which carries out educational and training programmes for

traditional and ayurvedic practitioners, school children, and the general public. The Institute does not offer opportunities for advanced training or postgraduate education, so in 1993 the Department of Ayurveda began to provide alternative resources for Ayurvedic Medical Officers to obtain postgraduate qualifications through the Institute of Indigenous Medicine at the University of Colombo, Rajagiriya.

## THAILAND

### BACKGROUND INFORMATION

Thai traditional medicine draws from Indian and Chinese systems of traditional medicine. It encompasses a holistic philosophy and is based principally on plants, including the use of herbal saunas, herbal medicines, herbal steam baths, and hot compresses; traditional massage; acupressure; and reflexology. Practitioners of traditional medicine represent an important resource for the Thai health care system. Traditional Thai medicine is also practiced in Cambodia, Lao, and Myanmar.

### STATISTICS

In 1998, Thailand imported more than 35% of its allopathic medicines and about 30% of its traditional medicines.

### REGULATORY SITUATION

Official policy towards traditional medicine in Thailand has a well-recorded history:

- 1182-1186: 102 hospitals were established, and at least 30 kinds of herbs were used in treatments.
- 1504: traditional medicine formularies received official endorsement.
- 1767: Thai traditional medicine and allopathic medicine were separated for the first time since the introduction of allopathic medicine.
- 1782-1809: herbal medicine formularies were inscribed on the wall of the temple Wat Potharam.
- 1824-1851: protocols for diagnosis and treatment were inscribed on the wall of the temple.
- Allopathic medicine was reintroduced by missionaries who used quinine to treat malaria.
- 1888: the Siriraj Hospital, which combined both allopathic and traditional medicine, was established.
- 1913: Thai traditional medicine and allopathic medicine were separated for the second time by the discontinuation of formal education in traditional medicine.

- 1929: a law classifying medical practitioners increased the separation between traditional and allopathic medicine: "Traditional medicine practitioners were defined as those who practice medicine based on their observations and experiences that were passed on by word and in traditional textbooks but were not based on scientific grounds".
- 1941: the production and sale of 10 traditional medicine formulas by the Government dispensary were stopped.

In the last few decades, particularly following the Alma-Ata Declaration and a World Health Organization conference on traditional medicine, Thai traditional medicine has received renewed interest. The National Institute of Thai Traditional Medicine was established on 24 March 1993 as a division of the Department of Medical Services. The Institute is charged with facilitating the integration of Thai traditional medicine into the public health services.

In 1987, an amendment to a royal decree enabled the Ministry of Public Health to integrate ayurvedic doctors into the medical work force of both State-run hospitals and private clinics. Ayurvedic doctors and Thai traditional practitioners are allowed to use some basic allopathic medical tools in their practice, such as the thermometer and sphygmomanometer, but are not allowed to prescribe allopathic medicines.

The Government is currently working on developing the use of herbal medicines. The goals of the Eighth Public Health Development Plan 1997-2001 are to increase the use of allopathic medicine, increase the use of traditional medicine, curb the use of extravagant medical and pharmaceutical technology, and promote traditional treatments within the national public health care system. Included in this policy is the development of research into medicinal herbs, training of traditional medicine practitioners, and use of medicinal herbs and traditional medicine practitioners in an official capacity. Specific objectives are as follows:

- support and promote Thai traditional medicine in the national health care system as a means to improve health through self-reliance at the personal, family, community, and national levels;
- upgrade the standard of Thai traditional medicine for acceptance and integration into the national health system;
- support the basis of Thai traditional medicine by developing a comprehensive system and strategy for its official use, including academic development, integration of administrative services into the national health care system, production of medicinal herbs and Thai traditional medicines, dissemination of information, and promotion of the use of Thai traditional medicine;
- support organizations and agencies that deal with Thai traditional medicine in both the Government and private sectors;

- increase the use of medicinal herbs by supporting the production of plants, developing the pharmacopoeia, and collaborating with traditional medicine practitioners.

By 1999, Thai traditional medicine was integrated into the facilities of 1120 health centres. Most of these health centres are health stations at the sub-district level, which represent more than 75% of health facilities.

All types of traditional medicine practitioners are registered with the Medical Registration of the Ministry of Public Health.

## EDUCATION AND TRAINING

The first school for Thai traditional medicine was established in 1957 at Wat Po. Since 1962, graduates from such schools have been licensed to practice general traditional medicine. In December 1997, the Ministry of Health's National Institute of Thai Traditional Medicine established the Thai Traditional Medicine Training Centre, where programmes in pharmacy, Thai traditional healing, Thai traditional massage, and reflexology are offered.

For people who do not have the opportunity to attend a university, the National Institute of Thai Traditional Medicine, in collaboration with the Department of Non-Formal Education, offers courses in Thai traditional medicine at non-formal education centres at the primary and secondary school levels.

An ayurved-vidyalaya college was established in 1982 by the Foundation for the Promotion of Thai Traditional Medicine, a private organization supported by the Government. During its three-year programme, students study not only aspects of Thai traditional medicine, but also basic science and allopathic diagnostics. This later training is intended to facilitate their ability to communicate with other health care professionals. Students of allopathic medicine receive no training in traditional medicine. Act 7 of 30 December 1966, however, enables allopathic physicians, pharmacists, nurses, and midwives who want to practice Thai traditional medicine to do so. To be eligible to practice traditional medicine, allopathic practitioners are required to follow a three-year course of training and instruction with a registered and licensed traditional medicine practitioner and to pass an examination set by the Commission for the Control of the Practice of the Art of Healing.

# WESTERN PACIFIC

## AUSTRALIA

## BACKGROUND INFORMATION

Traditional Chinese medicine has been practiced in Australia since the influx of Chinese migrants to the Australian gold fields in the 19th century. Its popularity is growing, as reflected by the proliferation of traditional Chinese medicine practitioners, training courses, and professional associations during the last decade.

## STATISTICS

Approximately one billion Australian dollars are spent on complementary / alternative medicine each year. A 1996 study reported that 48% of the population has used complementary/alternative medicine at least once, There are approximately 2500 chiropractors practicing in Australia.

In December 1995, the Victorian Department of Human Services commissioned a study on the practice of traditional Chinese medicine. The study found that traditional Chinese medicine accounts for an increasing percentage of total health care services. There are at least 2.8 million consultations each year, representing an annual turnover of over 84 million Australian dollars. In 1995, over 1500 primary practitioners reported their principal health occupation as traditional Chinese medicine. This number was expected to almost double by the year 2000, with the graduation of over 1100 students from qualifying programmes for traditional Chinese medicine. There are 23 professional associations representing different segments of traditional Chinese medicine.

Traditional Chinese medicine is provided to patients of all ages, including infants. Two out of three patients are female, 50% have a tertiary education, and over 80% have English as their first language. Although 44% of cases are rheumatological or neurological in origin, traditional Chinese medicine treats a broad range of complaints. Over 75% of patients are treated for a recurrent problem of at least three months' duration.

## REGULATORY SITUATION

Seven Australian territories - Capital Territory, Northern Territory, Territory of Christmas Island, Territory of the Cogos (Keeling) Islands, Norfolk Island, South Australia, and Western Australia - grant allopathic physicians an exclusive monopoly on medical care by prohibiting the practice of medicine by unregistered or unqualified persons. No provisions directly govern the practice of traditional Chinese medicine, although practitioners are regulated in part by various state and/or federal regulations and guidelines.

In New South Wales, Queensland, Tasmania, and Victoria, there is general freedom to practice medicine or surgery, but it is tempered by a number of restrictions. For instance, unqualified persons may not recover fees or treat venereal diseases. In addition, New South Wales makes it an offence to treat cancer (a similar prohibition

exists in Victoria), tuberculosis, poliomyelitis, epilepsy, diabetes, and other specific diseases.

In Australia, there is a long history of efforts by associations of chiropractors and osteopaths to obtain statutory recognition for their professions. This is reflected in the laws regulating chiropractic and osteopathy. In certain Australian states, chiropractors are specifically exempted from the allopathic physicians' monopoly to practice medicine. For instance, the Medical Act 1894-1968 of Western Australia prohibits persons other than allopathic medical practitioners from practicing medicine or surgery, "provided that this paragraph shall not apply to a person practicing as a... chiropractor who gives... chiropractic advice or service". Chiropractic and osteopathy are the subject of specific legislation in South Australia, Capital Territory, Victoria, and New South Wales. In Victoria, chiropractors and osteopaths must hold an approved degree or diploma in order to be registered by the territorial board. Although registration is not compulsory, only registered persons and allopathic medical practitioners are permitted to recover fees or charge for their professional services.

In 1974, the Australian Parliament set up the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy, and Naturopathy. The Committee published an extensive report in 1977.

In New South Wales, the re-enactment of the Medical Practitioners Act 1938 as the Medical Practice Act 1992 resulted in several amendments to the 1938 text. The growing acceptance of traditional medicine was at the root of changes to a number of prohibitions on the cures and treatments offered of by non-allopathic practitioners.

In 1998, the Therapeutic Goods Act was established with the objective of providing a national framework for the regulation of therapeutic goods in Australia, particularly to ensure their quality, safety, efficacy, and timely availability. Most products claiming therapeutic benefit must be registered with the Australian Register of Therapeutic Goods before being sold in Australia. The Therapeutic Goods Administration is responsible for administering the Act.

In 2000, the Therapeutic Goods Administration developed the Guidelines for Levels and Kinds of Evidence to Support Claims for Therapeutic Goods. The Complementary Medicines Evaluation Committee recognizes two types of evidence to support claims on therapeutic goods: scientific evidence and traditional use. The extent of required evidence depends on the claims made for the product. For the Committee, traditional use refers to written or orally recorded evidence that a substance has been used for three or more generations for specific health-related or medicinal purposes. Some exceptions to this requirement are made for homeopathy. The regulations include clauses for the use of medicines as one component of a

multifaceted treatment, the use of treatments that combine a number of traditions, and the use of treatments that are recent modifications of traditional therapies. Traditional therapies are considered to include traditional Chinese medicine, traditional ayurvedic medicine, traditional European herbal medicine, traditional homeopathic medicine, aromatherapy, and other traditional medicines.

## EDUCATION AND TRAINING

The number of traditional Chinese medicine programmes offered by universities and private colleges is growing. Programmes, some of which lead to diplomas, range from 50 hours to over 300 hours. There are also traditional Chinese medicine programmes available for qualified allopathic practitioners. These range from 50 to 250 hours. The Royal Melbourne Institute of Technology, the University of Technology at Sydney, and the Victoria University of Technology have degree programmes in traditional Chinese medicine. These programmes are offered within the schools of Applied Science or Health Science.

Acupuncture was first offered as a formal education programme in Sydney in 1969 with the founding of the privately owned school, Acupuncture Colleges, Australia. This programme subsequently formed the basis of the Diploma of Applied Science (Acupuncture) accredited by the New South Wales Higher Education Board in 1987 and the four-year Bachelor of Applied Science (Acupuncture) accredited by the New South Wales Higher Education Unit in 1992. Following the same programme, the Victoria University of Technology began offering a Bachelor of Health Science (Acupuncture) in 1992. The Royal Melbourne Institute of Technology, the University of Technology at Sydney, and the Victoria University of Technology also offer Master's degrees and graduate diplomas in acupuncture.

With growing acceptance of acupuncture by the public and by allopathic practitioners, graduates are able to play a larger part in the public-health sector of the community, working in allopathic hospitals, community health centres, and in areas of specialized health services. The Bachelor of Health Sciences in Acupuncture prepares graduates for this role in general health care. Training in homeopathy has been from the level of the FHom of London. There are two chiropractic colleges recognized by the World Federation of Chiropractic. Naturopathy, European herbalism, homeopathy, and nutrition are taught at the Southern Cross University in New South Wales.

# CAMBODIA

## BACKGROUND INFORMATION

The Ministry of Health has established the Centre for Traditional Medicine, which is limited to basic work in a few botanical medicines and has little input into

pharmaceutical issues. Much of the knowledge available on botanical specimens is based on their use in neighbouring countries. Shops throughout the country sell traditional medicines from around the world.

## REGULATORY SITUATION

A law on the organization of traditional therapeutics and traditional pharmacopoeia was enacted in 1964. This law defines traditional therapeutics as treatment and care using traditional methods, excluding surgical and obstetrical procedures, dental surgery, and electrical, chemical, or bacteriological methods of therapy and analysis. To practice, traditional medicine practitioners must be at least 25 years old, have completed a three-year apprenticeship, and possess a licence issued by the Minister of Health. Traditional medicine may not be practiced on the premises of allopathic health care establishments.

The National Drug Policy, developed with technical collaboration from the World Health Organization, is intended to increase the importance of traditional medicine and encourage traditional medical practice as a complement to allopathic medicine. The Policy states that fundamental and applied research on traditional remedies will be pursued and diseases that can be treated effectively with traditional medicines will be identified. The Law on the Management of Pharmaceuticals was adopted on 9 May 1996, replacing relevant existing legislation. Following the adoption of this law by the National Assembly, a draft decree pertaining to the manufacture, importation, exportation, and supply of traditional medicines was submitted by the Ministry of Health to the Council of Ministers.

## EDUCATION AND TRAINING

There is no officially recognized curriculum incorporating the use of traditional medicines.

# CHINA

## BACKGROUND INFORMATION

Over the last century, traditional Chinese medicine has co-existed with allopathic medicine. (See the Introduction for a description of traditional Chinese medicine.)

## STATISTICS

There are 350 000 staff working at more than 2500 hospitals of traditional medicine in China. In addition, 95% of general hospitals have units for traditional medicine and 50% of rural doctors are able to provide both traditional and allopathic medicine. In 1949, there were 276 000 practitioners of traditional medicine in

China. The figure increased to 393 000 in 1965 and 525 000 in 1995. Among these traditional medicine practitioners are 257 000 traditional medical doctors who graduated from traditional medical universities with a knowledge of both traditional and allopathic medicine, 10 000 allopathic medical doctors retrained in traditional medicine, 83 000 pharmacists who are specialists in herbal medicines and who have graduated from traditional medicine universities, 72 000 assistant traditional medicine doctors, and 55 000 assistant herbal pharmacists trained in traditional medicine secondary schools.

In China, traditional medicines account for 30% to 50% of total consumption. There are 800 manufacturers of herbal products, with a total annual output worth US$ 1800 million. There are over 600 manufacturing bases and 13 000 central farms specialized in the production of materials for traditional medicines. There are 340 000 farmers who cultivate medicinal plants. The total planting area for medicinal herbs is 348 000 acres.

There are 170 research institutions across the country with perhaps the most prestigious being the Academy of Traditional Medicine in Beijing.

## REGULATORY SITUATION

In China, the integration of traditional medicine into the national health care system and the integrated training of health practitioners are both officially promoted. The Government of China has reinforced its commitment to the integration of traditional and allopathic medicine on a number of occasions. Adopted in 1982, Article 21 of the Constitution of the People's Republic of China promotes both allopathic and traditional Chinese medicine. The Bureau of Traditional Medicine was set up as part of the Central Health Administration in 1984. In 1986, the State Administration of Traditional Chinese Medicine was established. In 1988, the Central Secretariat of the Chinese Communist Party stated the following *:*

Traditional Chinese medicine and Western medicine should be given equal importance. On the one hand, our unique successes in public health and hygiene can be attributed to traditional Chinese medicine. Hence, traditional medicine should not be abandoned. Instead, it is to be well preserved and developed further. On the other hand, traditional Chinese medicine must make full active use of advanced science and technology to ensure its further development. The policy of integration of traditional Chinese medicine and Western medicine should persist. Both systems should cooperate with each other, learning from each other's merit to make up their own shortcomings. Both should strive for the full play of their own predominance.

Again in 1997, the Government reiterated that one of its guiding principles in the field of health care is equality in policies related to traditional and allopathic medicine. The integrated nature of the Chinese medical system is underscored by the fact that traditional and allopathic medicine are practiced alongside each other at every level of the health care system *:*

Western-style and traditional Chinese doctors work together at the [township] centre according to the policy of integrating the two systems of medicine. Patients may see either type of doctor.

The 1985 Management Stipulations for Physicians and Assistants of Traditional Chinese Medicine requires traditional medicine practitioners to learn and make use of innovations in allopathic medical technology.

The criteria for qualification as a traditional Chinese medical physician or assistant are also set out in the Management Stipulations. Qualification as a traditional medical physician can be achieved through a number of routes, typically combining post-secondary academic studies and one to two years of practicing, teaching, or researching traditional medicine. By Article 5 of the Stipulations, the academic component can be undertaken at a university or college devoted to traditional medicine, within a department of traditional medicine at a school of allopathic medicine, or by completion of a State-approved diploma or certificate. Under Article 7, a similar, but less demanding, combination of academic studies and one year of practical involvement in traditional medicine is typically needed for qualification as a traditional medicine assistant.

Under a 1985 circular issued by the Chinese Ministry of Public Health's Department of Traditional Chinese Medicine, persons who studied under the former apprenticeship system - in place before the 1960s when formal examinations were not required - may take the formal examinations leading to qualification as a traditional medical physician or assistant. The examinations follow the completion of courses administered by private institutions with Government recognition. The courses may be taken as correspondence courses, night classes, or at workers' universities. Candidates who fail these tests, or persons who decide not to take them, must pass a unified examination offered by the Health Department before their qualifications to practice as traditional Chinese medicine assistants or physicians will be recognized. For assistants, the examination is based on information taught at the secondary school level. There is a more demanding unified exam based on a three-year post-secondary education for those in the apprenticeship system who wish to convert their existing status to the level of pharmacist or physician of traditional medicine.

In addition to physicians and assistants, a third tier of health professional exists in traditional Chinese medicine: individuals examined and officially recognized as

proficient in a particular branch of traditional medicine. However, the absence of a uniform method of assessment for these practitioners has led to some unqualified individuals being able to obtain official recognition, according to a 1989 circular issued by the State Administration of Traditional Chinese Medicine. Motivated by a desire to protect the integrity of traditional medicine and to safeguard patients' interests, the response of the State Administration has been to introduce annual testing of practitioners in this third tier. Tests are administered by a group of senior traditional medicine practitioners. The annual testing involves both a theoretical component and a clinical examination. Successful completion of the annual testing leads to a certificate, which details the candidate's specific skills and the range of diseases that can be treated. Failing the annual test results in cancellation of the candidate's certificate and right to practice, pending re-examination.

Released in 1988, a series of Provisional Management Stipulations regulates private health care offered by traditional Chinese medical physicians within the State-sponsored socialist health-care system. Article 4 of the Stipulations endorses an official policy favouring preventive care and instructs private-sector physicians to undertake primary health care as designated by the local health authority. The right to practice traditional Chinese medicine privately is restricted to those who have passed the unified examination and technical assessment or who have met the Ministry of Public Health's requirements for regulation as a health professional and have practiced medicine in State-owned or collective medical institutions for three years. A licence must be obtained to open a private practice and the licence holder "shall strictly observe the approved practice, place, range of service and business limits to the practice".

Under 1989 regulations, traditional Chinese medical assistants are only permitted to open their own practice in rural towns, which include county-level townships and villages. In small towns and cities, they may only serve in private physicians' clinics. Under Article 2, persons with a certified proficiency in a particular branch of traditional Chinese medicine, subject to annual retesting, are only permitted to open a practice at the local county or district level.

Prompted by a desire to protect patients from abuse and deception, regulations concerning medical qigong were enacted in China in 1989. Qigong is described in the preamble to the regulations as "a self-cultivation approach to keep fit through dredging meridians, adjusting the mind, and balancing yin, yang, *qi,* and blood to get rid of diseases". The regulations provide that practitioners of qigong must obtain approval from the local health authority to teach qigong in public places. By Article 1, teaching must be based on scientific approaches. Under Article 2, qigong practitioners working in medical institutions must possess medical qigong skills and be qualified as traditional Chinese medical physicians or assistants under the Management Stipulations described above. According to Article 4, those who intend to treat patients with emitted *qi* (energy) must have their methodology and the

claimed curative effect approved by the city health authority. If the curative effect is shown to be tenable, based on a study of 30 cases of the same type of illness by a designated medical institution, a licence will be issued. Article 6 prohibits non-medical institutions, including the army, from rendering medical treatment.

## EDUCATION AND TRAINING

Traditional Chinese medicine used to be taught through apprenticeships. Now, there are 57 secondary schools teaching traditional Chinese medicine, with an enrolment of 29 000 students. These schools train medical personnel for rural and basic units. There are also 28 universities and colleges of Chinese traditional medicine and pharmacology, with a total enrolment of 46 000 students, including 2800 undergraduates. Together, these universities and colleges provide 14 professional undergraduate programmes along with programmes for Master's and Doctorate degrees. A chiropractic college is presently being established.

To qualify as a physician of traditional Chinese medicine, a candidate must typically complete five years of study. Admissions standards to colleges or universities generally require completion of middle school (seven grades), but there is some flexibility: in some colleges, a primary school education (four grades) is sufficient.

As mentioned above, medical education is integrated in China. Although there are more allopathic medical schools in China than traditional medical schools, every allopathic medical school contains a department of traditional medicine and every traditional medical school contains a department of allopathic medicine. Between 10% and 20% of the teaching in allopathic medical schools is allocated to traditional medicine. A somewhat greater emphasis is placed on allopathic medicine in colleges of traditional medicine. The Division of Traditional Medicine in the Ministry of Public Health suggests orienting 30% of teaching in these schools to allopathic medicine.

## INSURANCE COVERAGE

Health insurance covers both allopathic and traditional medicine.

## HONG KONG SPECIAL ADMINISTRATIVE REGION OF CHINA

## BACKGROUND INFORMATION

Although traditional Chinese medicine is widely used, allopathic medicine has been the focus of the health care system in the Hong Kong Special Administrative Region of China (Hong Kong SAR).

## STATISTICS

In a general household survey conducted by the Census and Statistics Department of the Government of Hong Kong SAR in 1996, it was reported that traditional Chinese medicine practitioners provide 10.5% of medical consultations. An earlier survey showed that up to 60% of Hong Kong SAR's population had used traditional Chinese medicine either for treatment of disease or maintenance of health. According to the 1996 survey, there are 6890 traditional Chinese medicine practitioners in Hong Kong SAR, of whom 66% are full-time practitioners. There are 37 chiropractors practicing in Hong Kong SAR.

There are approximately 2000 types of Chinese medicinal herbs for sale in Hong Kong SAR. About 3300 brands of proprietary traditional Chinese medicines are available, of which 500 brands are manufactured locally. Information provided by the Government's Census and Statistics Department showed that in 1998, 500 trading organizations were involved in the import/export, wholesale distribution, and retail sales of traditional Chinese medicines.

## REGULATORY SITUATION

Until recently, there was no specific legal control or recognition of traditional Chinese medicine in Hong Kong SAR. Regulations fell under the Public Health and Municipal Services Ordinance, which controls the sale of drugs unfit for human consumption, and the Pharmacy and Poisons Ordinance, which prohibits the adulteration of traditional Chinese medicines with allopathic drugs.

The Basic Law of Hong Kong SAR provides that the Government shall formulate policies to develop allopathic and traditional Chinese medicine and to improve medical and health services. In 1989, to promote the proper use and good practice of traditional Chinese medicine, the Secretary for Health and Welfare set up the Working Party on Chinese Medicine. The Party was mandated to review the use and practice of traditional Chinese medicine in Hong Kong SAR. In 1995, the Secretary for Health and Welfare appointed the Preparatory Committee on Chinese Medicine. In March 1997 and March 1999, the Committee submitted reports on the regulation and development of traditional Chinese medicine in Hong Kong SAR.

In his 1997 policy address, the Chief Executive of Hong Kong SAR announced that for the protection of public health, a statutory framework providing legal recognition to traditional Chinese medicine and appropriate regulation of its practice, use, and trade would be established. The Chinese Medicine Bill was drawn up in 1998 and was introduced in the Legislative Council in February 1999.

The Legislative Council passed the Chinese Medicine Ordinance, which is based on self-regulation, in July 1999. The Chinese Medicine Council - a regulatory body

comprised of traditional Chinese medicine providers, trade professionals, academics, lay persons, and Government officials - is responsible for implementing the regulatory measures. The Department of Health will provide administrative support and enforce the regulations.

A registration system for practitioners of traditional Chinese medicine will be created in 2000. Likewise, a registration and licensing system to regulate the manufacture and trade of traditional Chinese medicines will be set up in phases in 2000. The safety, efficacy, and quality of proprietary traditional Chinese medicines will be assessed before they are registered. The dispensation, storage, and labelling of traditional Chinese medicines will also be regulated.

## EDUCATION AND TRAINING

Educational institutions offer refresher courses for providers and dispensers of traditional Chinese medicine to upgrade their knowledge and skills. Undergraduate courses in traditional Chinese medicine practice and pharmacy have recently been introduced at local universities.

# FIJI

## BACKGROUND INFORMATION

In Fiji, both the traditional medicine of the indigenous population and that of Indo-Fijians who brought with them their own medicinal plants and medicinal plant knowledge are practiced. Rural Fijians are the primary users of traditional medicine, though its popularity in urban areas is increasing. Traditional medicine practitioners are often consulted before allopathic medical providers. Many allopathic providers also practice traditional medicine.

## STATISTICS

Founded in 1993, the Women's Association for Natural Medicinal Therapy, a non-governmental organization promoting traditional medicine, has begun a survey of over 2000 practicing providers of traditional medicine in 13 of the 14 provinces in Fiji. In two of these provinces, the surveys have been completed. These surveys and conversations with local people indicate great faith in allopathic medicine even though villagers may find traditional medicine to be more effective and cost efficient. The surveys further suggest that many people, including practitioners of allopathic medicine, use traditional medicine but hesitate to call it such because traditional medicine is associated with witchcraft.

Between 60% and 80% of the population use traditional medicine. According to Fiji's Biodiversity Strategy and Action Plan, the average Fijian household uses US$ 200

worth of medicinal plants annually. If these traditional medicines were replaced by allopathic medicines, this would amount to a total of US$ 75 million annually.

## REGULATORY SITUATION

The Medical and Dental Practitioners Act of 1971 empowers the Minister of Health to issue regulations governing chiropractic, acupuncture, and chiropody. Such regulations were issued in 1976.

In 2000, the Cabinet of the Government of Fiji instructed the Minister of Health to develop a national policy on traditional medicine.

In Fiji, the lawful practice of acupuncture is subject to registration by the Permanent Secretary for Health. Applicants for registration must prove either that they are licensed as acupuncturists in the United Kingdom, Canada, New Zealand, or any of the states of the United States or that they possess a certificate from the health authorities of China, the Province of Taiwan, Hong Kong Special Administrative Region of China, Singapore, or the Philippines to the effect that they have practiced acupuncture in any of those locations for a period of not less than three years.

## EDUCATION AND TRAINING

Most students of traditional medicine receive their training through oral instruction from established practitioners. No great importance is attached to formal education in either traditional medicine or complementary/alternative medicine at universities or medical schools, although some training is done through primary health care.

The Government and medical associations review the qualifications of practitioners, but there is no regulatory measure for recognizing the qualifications. Licensing legislation regulates educational standards for chiropractic.

## INSURANCE COVERAGE

Practiced outside of the national health care system, traditional medicine is not covered by insurance.

# JAPAN

## BACKGROUND INFORMATION

In Japan, traditional medicines are classified into two broad groups: kampo medicine and traditional medicine indigenous to Japan. Traditional Chinese

medicine, introduced to Japan between the 3rd and 8th centuries, was modified to meet local needs and became known as kampo medicine. For about 10 centuries, from the time of its introduction until it was superseded by allopathic medicine in 1875, kampo medicine was the mainstream Japanese medicine.

Following the Meiji Restoration in 1886, the newly established Japanese Government endorsed German allopathic medicine over kampo medicine. After 1885, new doctors were trained only in allopathic medicine, with the result that kampo medicine almost disappeared. By 1920, fewer than 100 doctors were practicing kampo medicine, but after the Second World War, there was a resurgence of public interest in kampo medicine and today it is practiced extensively.

Acupuncture, moxibustion, Japanese traditional massage/finger pressure, and judo-therapy are also widely practiced in Japan.

## STATISTICS

The 1998 production value of kampo medicines in Japan was 97 708 million yen, or 1.7% of total medicine production. Of this, prescription kampo medicines accounted for 83.2%; proprietary medicines, for 15.9%; and household distribution, 0.9%. A nationwide survey conducted in October 2000 found that 72% of registered allopathic doctors currently use kampo medicines in their clinical services.

In addition to the 268 611 registered allopathic medical doctors, the number of registered medical practitioners at the end of 1998 included 69 236 acupuncturists, 67 746 moxacauterists, 94 655 massage practitioners, and 29 087 judotherapists. There were also 125 953 registered pharmacists at the end of 1998.

## REGULATORY SITUATION

Under the Medical Practitioners Law 201 of 1948, only allopathic physicians may practice medicine, including kampo medicine. However, there are no restrictions on the types of medical procedures allopathic physicians may use in their practice. According to the Pharmacists Law 146 of 1960, a person must be qualified as a pharmacist in order to engage in services related to traditional medicines.

The Subcommittee on Kampo Medicines and Products of Animal and Plant Origin of the Central Pharmaceutical Affairs Council has developed regulations governing kampo medicines as proprietary medicines. These regulations also apply, with necessary modifications, to prescription medicines. The Pharmaceutical Affairs Law in Japan does not distinguish between traditional and allopathic medicines; both types of preparations are subject to the same regulations.

Kampo medicines are products prepared for use in accordance with kampo medicine formulae, which, according to the principles set out by the Central Pharmaceutical Affairs Council, are formulae described in established books on kampo medicine currently and frequently used in Japan. The formulae include standard formulae, added or subtracted formulae, and combined formulae. They include formulae containing vitamins B1, B2, and/or C for nutritional supplementation. The extracts prepared from kampo medicine formulae should be limited to those that have previously been used as decoctions. Any ingredient, efficacy, or indication that is not appropriate for proprietary medicines is not accepted.

Standards for medicinal plant materials are included in *Japanese Pharmacopoeia,* the *Japanese Herbal Medicine Codex,* and *Japanese Standards for Herbal Medicines.*

### *JAPANESE PHARMACOPOEIA*

First established in 1886 by the Minister of Health and Welfare, and in accordance with Article 41 of the Pharmaceutical Affairs Law 145 of 1960, the *Japanese Pharmacopoeia* is an official standard regulating the properties and qualities of medicines. Some herbal medicines are included in *the Japanese Pharmacopoeia.* The 14th edition is expected in 2001 (*239, 241*).

### *JAPANESE HERBAL MEDICINE CODEX*

Standards have been established separately for herbal medicines not included in the *Japanese Pharmacopoeia.* Herbal medicines in frequent use, which are not in the *Japanese Pharmacopoeia,* are examined according to specific criteria and made official by inclusion in the *Japanese Herbal Medicine Codex.*

### JAPANESE STANDARDS FOR HERBAL MEDICINES

Published in 1993, *Japanese Standards for Herbal Medicines* contains 248 articles: 165 from the *Japanese Pharmacopoeia* (XII) and 83 from the *Japanese Herbal Medicine Codex.* When using substances listed in *Japanese Standards for Herbal Medicines* as materials or ingredients of pharmaceutical products to be manufactured in, or imported into, Japan, manufacturers and importers should comply with the provisions in this book.

When the Pharmaceutical Affairs Law was amended in April 1993, the Regulations for Manufacturing Control and Quality Control of Drugs were changed from manufacturing requirements for drug companies to a prerequisite for licences to manufacture drugs. The Regulations, including new validation requirements, came into effect in April 1996. Moreover, good manufacturing practices for investigational

products were adopted via a notice issued by the Director-General of the Pharmaceutical Affairs Bureau of the Ministry of Health and Welfare in April 1997.

The Japan Pharmacists Education Centre issues a certificate for pharmacists specializing in kampo medicines and herbal materials in accordance with its own qualification criteria. Renewal of this certification is required every three years.

In 1990, the Society of Japanese Oriental Medicine started a registration system of allopathic physicians specializing in kampo medicine. This system requires all registered specialists to attend authorized meetings of the Society and to present relevant scientific papers and medical journals at the meetings. This registration system requires registration as a specialist in kampo medicine to be renewed every five years, in accordance with the rules set out by the Society.

The Practitioners of Massage, Finger Pressure, Acupuncture and Moxibustion, etc. Law 217 of 1947 stipulates in Article 1 that anyone other than an allopathic physician who wishes to practice acupuncture, moxibustion, or massage/finger pressure must pass the relevant national examination and obtain either a licence in massage/finger pressure alone or a combination licence in acupuncture, moxibustion, and massage/finger pressure from the Minister of Health and Welfare.

Article 2 outlines the requirements that must be met in order to take the national exams: candidates must be eligible to enter a university according to Article 56 of the School Education Law 26 of 1947; have studied more than three years at a school recognized by the Minister of Education, Science, and Culture or at a training institution recognized by the Minister of Health and Welfare; and have obtained the knowledge and technical skill necessary to be an acupuncturist, moxacauterist, or massage practitioner, including knowledge of anatomy, physiology, pathology, and hygiene.

In Article 18.2, an exception to these criteria is made for persons with visual impairment; persons with visual impairment, as defined by a Ministry of Health and Welfare ordinance, may take the exams if they are eligible to enter a high school according to Article 47 of the School Education Law 26 of 1947; have studied at a school recognized by the Minister of Education, Science, and Culture or at a training institution recognized by the Minister of Health and Welfare; and have obtained the knowledge and technical skill necessary to be an acupuncturist, moxacauterist, or massage practitioner, including at least three years of study in anatomy, physiology, pathology, and hygiene for certification as a massage practitioner only or five years of study in anatomy, physiology, pathology, and hygiene for joint certification as an acupuncturist, moxacauterist, and massage practitioner.

In 1999, the Japan Society for Acupuncture and Moxibustion began a registration system for allopathic medical doctors specializing in acupuncture and moxibustion. The rules for qualification set out by the Society require registration to be renewed every five years.

Judotherapists are regulated under the Judo Therapists Law 19 of 1970. By Article 3, in order to become qualified as a judotherapist, a candidate must pass the national judotherapist examination and obtain a licence from the Minister of Health and Welfare. Under Article 12, candidates must be eligible to enter a university according to Article 56 of the School Education Law 26 of 1947; have studied more than three years at a school recognized by the Minister of Education, Science, and Culture or at a training institution recognized by the Minister of Health and Welfare; and have obtained the knowledge and technical skill necessary to be a judotherapist, including knowledge of anatomy, physiology, pathology, and hygiene.

## EDUCATION AND TRAINING

As of 2000, there are 80 medical schools offering six-year allopathic medical programmes in Japan. Though there is no systematic programme exclusively teaching kampo medicine, the Toyama Medical and Pharmaceutical University offers a four-year postgraduate Doctorate programme in kampo medicine as well as the only officially recognized undergraduate medical curriculum where kampo medicine is taught alongside allopathic medicine.

A 1998 national survey reported that 18 medical schools have either an elective or required class on complementary/alternative medicine, mainly kampo medicine and/or acupuncture. Beginning in 1998, each year the Japan Society for Oriental Medicine offers a summer programme in kampo medicine for 60 undergraduate students of allopathic medical schools.

Forty-six colleges and universities across Japan provide four-year undergraduate programmes in pharmaceutical sciences with traditional medicines as part of the curriculum, with a new enrolment of 7720 students in these programmes each year. The Research Institute for Natural Medicines, established in 1963 as part of the national Toyama Medical and Pharmaceutical University, is a unique national research institute in the fields of kampo medicine and pharmaceutical sciences. It provides undergraduate, two-year Master's, and four-year Doctorate programmes. In April 2000, the Japan Pharmacists Education Centre launched a special training course on kampo medicine and herbal materials in collaboration with the Japanese Society of Pharmacognosy.

Both acupuncturists and moxacauterists must complete a minimum three-year training programme. Twenty-two schools and training institutions offer three-year programmes in acupuncture and moxibustion. One university offers a four-year

programme. Eighty-seven schools and training institutions offer joint programmes in acupuncture, moxibustion, and Japanese traditional massage/finger pressure. Seven of these are five-year programmes and 22 are three-year programmes. There are 91 schools and training institutions offering a three-year programme in only Japanese traditional massage/finger pressure. Twenty-five schools and training institutions offer three-year programmes in judotherapy.

For visually impaired persons, 31 schools and training institutions offer three-year programmes in Japanese traditional massage/finger pressure alone and seven schools and training institutions offer five-year joint programmes in acupuncture, moxibustion, and Japanese traditional massage/finger pressure.

## INSURANCE COVERAGE

As of April 2000, the National Health Insurance Reimbursement List included 147 prescription kampo formulae and 192 herbal materials used in prescription kampo formulae. Acupuncture, moxibustion, Japanese traditional massage, and judotherapy are also covered by national health insurance.

# KIRIBATI

## BACKGROUND INFORMATION

Kiribati traditional medicine includes bonesetting, herbal medicine, massage, traditional birth attendance, and word and wind medicine. Allopathic medicine was introduced to Kiribati during the colonial period in the early 1890s. In the 1940s, traditional medicine was outlawed on the grounds that there was no scientific evidence as to its efficacy. Despite the prohibition, traditional medicine continued to be practiced.

## REGULATORY SITUATION

The Medical and Dental Practitioners (Amended) Act of 1981 authorizes some aspects of traditional medicine in Section 37, which states, "Nothing in the Medical and Dental Practitioners Ordinance shall affect the right of anyone of Kiribati to practice in a responsible manner Kiribati traditional healing by means of herbal therapy, bonesetting and massage, and to demand and recover reasonable charges in respect of such practice."

# LAO PEOPLE'S DEMOCRATIC REPUBLIC

## BACKGROUND INFORMATION

The Lao phrase for traditional medicine is *ya phurn meung,* which translated literally means "medicine from the foundation of the country". Lao traditional medicine dates back to at least the 12th century, when the country was united. With unification, traditional Buddhist and Indian medical systems were integrated into the society, quickly influencing traditional Laotian medicine. Allopathic medicine came to the Lao People's Democratic Republic in 1893 when the French invaded the country. Lao traditional medicine remains an important element in the prevention and treatment of disease.

## STATISTICS

Thirty to forty per cent of both allopathic and traditional medicines are produced domestically. There are seven factories producing allopathic medicines in Laos. Three factories in the Vientiane municipality produce traditional medicines. There are traditional medicine hospitals at all levels.

## REGULATORY SITUATION

The Lao People's Democratic Republic has a national programme on traditional medicine with a five-year work plan. The third in a series of national seminars on traditional medicine was held in February 1993 to review the use of traditional medicine in primary health care at the provincial and district levels.

A draft national policy on traditional medicine was discussed at a national workshop on traditional medicine held in December 1995 and thereafter submitted to the Ministry of Health.

## EDUCATION AND TRAINING

In 1996, training courses were held in Sayaboury and Champasack provinces on the use of traditional medicine in communities. The courses were intended to promote the rational use of traditional medicine.

# MALAYSIA

## BACKGROUND INFORMATION

Traditional medical practices brought by Indian and Chinese traders and migrants complemented, but did not replace, the indigenous medical system in Malaysia. The introduction of Islam by Indians and Arabs, on the other hand, led to major changes in the traditional medical system. Among them was treatment by recitation of verses from the Koran.

The diversity in medical systems in Malaysia reflects the diverse population of Malay, Chinese, Indian, and indigenous heritage. In addition to allopathic medicine, the major systems of medicine practiced in Malaysia include ayurveda, siddha, unani, traditional Chinese medicine, and traditional systems of medicine, such as that provided by traditional medicine practitioners, spiritualists, bonesetters, traditional birth attendants, and others who use home remedies. Medical options also include homeopathy, naturopathy, reflexology, aromatherapy, and chiropractic.

Traditional Malay medical practices can be traced mainly to Indonesia. These medical practices are especially popular among Malay in rural areas and rely on practical experience and observation handed down orally and in writing from generation to generation. Medical treatment may include reciting incantations over water and giving it to the patient to drink, administering herbs internally or externally, giving amulets, and prescribing special baths, with lime flowers or holy water, for example. More than one of these options may be used and more than one traditional medicine practitioner may be called upon.

Chinese traditional medicine is believed to have been introduced into Malaysia by Chinese migrants working in the tin mines. These migrants brought herbal medicines as well as other forms of treatment, including acupuncture. Chinese medical practitioners hold high status and are known as *sinseh*. Today, traditional Chinese medicine is also used in urban centres.

Siddha, ayurveda, and unani - all traditional Indian medical systems - are practiced in Malaysia. The majority of medicines used in these systems are of vegetable, mineral, and animal origin. Herbal preparations and herbal products are imported from India as medical tablets, oils, ointments, metals, mineral concoctions, and herbal powders.

## STATISTICS

The 1996 National Health & Morbidity Survey II found that 2.3% of the people sampled consulted a traditional or complementary/alternative medical practitioner and 3.8% used both allopathic medicine and traditional Chinese medicine. Although no statistics are available, traditional medicine is mainly practiced by providers of traditional medicine, whereas allopathic medical providers practice complementary/alternative medicine as well as allopathic medicine.

In Malaysia, sales of traditional and complementary/alternative medicines are estimated to be 1000 million Malaysian ringgit annually, compared with a market of 900 million Malaysian ringgit for allopathic pharmaceuticals.

There are 12 chiropractors practicing in Malaysia.

## REGULATORY SITUATION

The official health care system adopted and implemented by the Malaysian Government is an allopathic one. Subsection 1 of Section 34 of the Medical Act of 1971 contains the following broad general exemption *:*

Subject to the provisions of subsection 2 and regulations made under this Act, nothing in this Act shall be deemed to affect the right of any person, not being a person taking or using any name, title, addition or description calculated to induce any person to believe that he is qualified to practice medicine or surgery according to modern scientific methods, to practice systems of therapeutics or surgery according to purely Malay, Chinese, Indian or other native methods, and to demand and recover reasonable charges in respect of such practice.

Subsection 2 limits the treatment of eye diseases to practitioners of allopathic medicine. Likewise, the Poisons Ordinance of 1952 restricts the use of certain substances to practitioners of allopathic medicine.

The Midwives (Registration) Regulations of 1971 legalize the practice of eligible traditional birth attendants. Subsection 2 of Section 11 of the Regulations permits midwifery to be practiced by the following:

Any person untrained in the practice of midwifery, who within four years of the commencement of [the Midwives Act of 1966] satisfies the Registrar that such person has during a period of two years immediately preceding application for registration... attended to women during childbirth.

There are no other laws affecting traditional medical practice in Malaysia; however, there are a number of laws that regulate the production and sale of traditional medicines. These are the Poison Act of 1952, Sale of Drug Act of 1952, Advertisement and Sale Act of 1956, and the Control of Drugs and Cosmetics Regulations of 1984. Since 1992, traditional medicine products have been registered.

The Drug Control Authority is responsible for product registration, including quality and safety. Every manufacturer of traditional medicine is required to comply with good manufacturing practices, and importers are required to comply with good storage practices. All homeopathic medicines have to be registered with the National Pharmaceutical and Drug Control Board.

In the past, the Government has taken a neutral stand on the practice of traditional Chinese medicine. However, in recognition of the current and potential contribution of traditional and complementary/alternative medicine to health care, the Government is now considering bringing traditional Chinese medicine into the

official health care system. The Ministry of Health has set up the Steering Committee on Complementary Medicine with a multisectoral membership to advise and assist the Minister in formulating policies and strategies for monitoring the practice of traditional Chinese medicine in the country.

A national policy is being drafted on traditional Chinese medicine to encourage established practitioners to form their own self-regulatory bodies. These bodies will enable a system of official recognition of member-practitioners. To ensure that the qualifications of practitioners are recognized and can be accredited for formal registration, the bodies are required to set formal standards, including training, for their own practices. They are also encouraged to update the skills and knowledge of their members. The Unit of Traditional Chinese Medicine has been established at the Primary Health Care Section, Family Health Development Division, Ministry of Health. It will be responsible for monitoring and facilitating the implementation of the Ministry's policies as well as strengthening national and international collaboration.

There is no chiropractic law.

## EDUCATION AND TRAINING

Recently, the umbrella body for traditional Chinese medicine has issued a Practice Approval Certificate for practitioners who have taken its courses or courses from a recognized university. This certificate is needed for a Business License Certificate.

Homeopathy will be introduced as a discipline at the newly established Faculty of Biomedicine.

## INSURANCE COVERAGE

Neither national healthcare insurance nor private insurance covers traditional Chinese medicine in Malaysia.

# MONGOLIA

## BACKGROUND INFORMATION

Traditional Mongolian medicine has a known history of more than 2500 years. Rooted in Tibetan and Indian medicine, traditional Mongolian medicine is part of the broader cultural heritage of the people and reflects their lifestyle as well as geographic and climatic conditions.

From the 1930s until the end of the 1980s, traditional medicine was officially ignored. Socio-economic changes in Mongolia during the 1990s led to the

development of the national culture, including revival of the traditional medical heritage. Traditional medicine is now more popular and accessible to communities.

Acupuncture and moxibustion have gradually been recognized as clinically effective in the treatment of disease and in the promotion of health. In 1991, two non-governmental organizations, the Association of Acupuncture and the Association of Traditional Medicine, were established.

## STATISTICS

There is one 100-bed hospital for traditional medicine, 15 small traditional medicine hospitals with 10 to 20 beds, 19 outpatient clinics for traditional medicine near Government health centres, and 81 private clinics and units of traditional medicine. There are also five manufacturing units for traditional medicines. Including those who have taken short-term courses in traditional medicine, there are about 600 - from a total of 5875 - allopathic physicians providing traditional medicine, acupuncture, and glass-cupping therapy.

## REGULATORY SITUATION

The Government of Mongolia considers traditional medicine to be an important health care resource for the population and is therefore working to incorporate traditional medical remedies into the official health service. In 1991, the Health Minister issued an order to begin developing traditional medicine from 1991 to 1995. This led to the establishment of an official structure for traditional medical care within the overall health system. In 1996, the Ministry of Health and Social Welfare worked out a development plan for traditional medicine for 1997-2000, focusing on training new personnel, standardizing training curricula, improving research, and expanding the manufacture of herbal medicines. A draft policy on the development of Mongolian traditional medicine was discussed at the Conference on National Policy on Traditional Medicine in 1998 and was adopted by the State Great Khural Parliament on 2 July 1999. This document contains plans for developing Mongolian traditional medicine over the next 10 to 15 years and covers 19 areas of work, including the following:

- developing the structure and organization of hospitals of traditional medicine further;
- interrelating the activities of training and re-training of traditional medicine personnel;
- producing safe herbal medicines with naturally extracted herbs, in line with good manufacturing practices;
- providing support to doctors of traditional medicine and to private health institutions;
- exploring possibilities of curing critical diseases with traditional methods;

- applying some methods of traditional medicine to ambulance services as well as primary health care.

## EDUCATION AND TRAINING

Before 1989, there were no formally qualified doctors of traditional medicine. Since then, 24 to 26 students have been admitted and enrolled each year in the Department of Traditional Medicine at the national medical university. Many of the teaching materials, including acupuncture textbooks and facilities, are from neighbouring countries. In both the three-year programme and the six-year programme, many hours are allotted to traditional medicine but only a minimal amount of time is set aside for acupuncture.

# NEW ZEALAND

## STATISTICS

There are 170 chiropractors practicing in New Zealand.

## REGULATORY SITUATION

The Government of New Zealand recognizes homeopathy, osteopathy, and chiropractic. Chiropractic has been regulated by law since 1962, and chiropractors are permitted to use X-ray equipment.

## EDUCATION AND TRAINING

There is one school of chiropractic in New Zealand.

# PAPUA NEW GUINEA

## BACKGROUND INFORMATION

Traditional medicine is widely accepted and practiced in rural areas where the majority of the population lives. The use of traditional plants for curing common ailments and afflictions in village communities is encouraged by private and non-governmental organizations on the grounds that it is a sensible option in the face of the rising costs of allopathic medicine, transport difficulties, and the poor facilities at aid posts and rural health centres.

## REGULATORY SITUATION

Although important for individuals and communities, traditional medicine remains outside the formal health system. It is expected that a policy in support of the

rational use of traditional medicine will be developed soon and that a role for traditional medicine will be embodied in the new National Health Plan 2001-2010. Provisions for the introduction of proven traditional medicines have already been made in the recently approved National Drug Policy.

## PHILIPPINES

### BACKGROUND INFORMATION

The National Health Care Delivery System in the Philippines is predominantly allopathic.

### STATISTICS

There are about 250000 practitioners of traditional medicine in the country. Approximately five to eight chiropractors are practicing in the Philippines. There are no privately owned hospitals providing formal traditional or complementary/alternative medical services. As of 1999, only a handful of Government hospitals offered acupuncture services to the general public.

Natural medicines are marketed over the counter in dozens of health food stores and in a limited number of pharmacies.

### REGULATORY SITUATION

The Department of Health has developed a national programme on traditional medicine together with a six-year plan of work. In 1993, a traditional medicine division was established within the Department of Health to support the integration of traditional medicine into the national health care system as appropriate, with technical support from the World Health Organization.

The Traditional and Alternative Medicine Act was signed by the President in December 1997. It states that it is the policy of the Government to improve the quality and delivery of health care services to the Filipino people through the development of traditional and complementary/alternative medicine and its integration into the national health care delivery system. The Act created the Philippine Institute of Traditional and Complementary/Alternative Health Care, which will be established as an autonomous agency of the Department of Health. The Institute's mission is to accelerate the development of traditional and complementary/alternative health care in the Philippines, provide for a development fund for traditional and complementary / alternative health care, and support traditional and complementary/alternative medicine in other ways.

Training in traditional medicine for allopathic practitioners is a priority in the country. Collaboration on education and research between institutions in the Philippines and other countries has also been established.

In the Philippines, traditional birth attendants may legally work only in areas where physicians or registered midwives are not available.

The Board of Medicine Resolution 31 of 2 March 1983 recognizes acupuncture as "a modality of treatment for certain ailments to be practiced only by registered physicians in the Philippines". The Board is mandated to promulgate rules and regulations to govern the practice of acupuncture and to evaluate and assess the annual reports submitted by practitioners "on their experiences and the results of their clinical treatment of cases" to determine if they may continue to practice legally.

There is no chiropractic law.

## EDUCATION AND TRAINING

More than 200 Government allopathic physicians have been trained in acupuncture.

## REPUBLIC OF KOREA

## BACKGROUND INFORMATION

In the Republic of Korea, the oldest record of traditional medicine, known as oriental medicine, dates to the Gochosun period, about 4332 years ago. Oriental medicine flourished until 1894 when the Gab-O Reform abolished the law of oriental medicine, leading to its decline in favour of allopathic medicine. In 1945, oriental medicine was revitalised and is very popular today.

Intended to represent oriental medical doctors and foster legal order, the Korean Oriental Medical Association (KOMA) was organized on 16 December 1952 to promote health through the development of oriental medical science and by facilitating cooperation among its members. KOMA has 16 branch offices established under the National Medical Treatment Law in 1952. These are located in both cities and provinces.

The establishment of the Korea Institute of Oriental Medicine was initiated on 24 March 1994 by National Act 4758. The Institute opened on 10 October 1994. It employs over 30 persons, and in 2000, it had a budget of 5047 million won. Among other things, the Institute focuses on clinical trials of oriental medicine, research on the standardization and development of oriental medicines, investigation and analysis of acupuncture, and research to assist in the development of the oriental

medicine industry. Plans for expanding the Institute are expected to make it a major research institute for oriental medicine and a worldwide centre for research and study of traditional and complementary / alternative medicine.

## STATISTICS

There are 107 oriental medical hospitals and 6590 oriental medical clinics. There are 9914 oriental medical doctors. Public health doctors of oriental medicine work at 69 provincial Government health centres. Oriental medicine doctors have worked for the Surgeon General in the army since 1989. There are about 133 acupuncturists, 41 moxibustion practitioners, and 76 acupuncture/moxibustion clinics. Approximately 30 chiropractors are practicing in the Republic of Korea. The Korean Oriental Medical Association has about 10 000 members.

According to national medical insurance records, 13 907 000 persons received oriental medical treatment in 1998. This represents 4.8% of the total number of people receiving medical treatment.

## REGULATORY SITUATION

The Civil Medical Treatment Law, brought into force in 1951, established a dual system of medical treatment comprised of oriental and allopathic medicine. In 1969, the Ministry of Public Health and Welfare published a notification permitting pharmaceutical companies to produce herbal preparations whose formula is described in the 11 classic books on traditional Korean and Chinese medicine, without first having to submit clinical or toxicological data.

The Medical Affairs Division under the Medical Bureau of the Ministry of Health and Welfare was in charge of the administrative management of oriental medical treatment until 1993, when the Oriental Medicine Division was established. In November 1996, this Division was expanded into the Oriental Medicine Bureau, *a* major bureau of the Ministry of Health and Welfare, with two of its own divisions. The Oriental Medicine Bureau works on short-term and long-term policy planning, research on oriental medical systems, and the administration of oriental medicine. One project is a programme of cooperation with China involving collaborative scientific research and the exchange of researchers and research information. Another project, intended to promote oriental medicine abroad, offers free medical examinations and treatment by oriental medicine in the World Health Organization Western Pacific Region Member States. Future plans for the Bureau emphasize the importance of quality control in manufacturing and distributing oriental medicines, particularly through licensing. Research will also be carried out to index materials and develop methods of chemical analysis of oriental medicines.

In 1993, an advisory council on oriental medical policy was established in the Ministry of Health and Welfare. Oriental medical doctors are allowed to perform medical acts, including acupuncture and moxibustion. However, they do not have the right to order X-rays and pathological tests. To get an oriental medical doctor's licence, one must graduate from an oriental medical college and pass the national examination for oriental medical doctors. Under the Medical Treatment Act, acupuncture can only be practiced by persons holding a certificate of qualification. The policy of cultivating acupuncturists was abolished in 1962 and since then only oriental medicine doctors can practice acupuncture.

Under the Pharmacist Law, which became effective on 1 July 1994, pharmacists must pass the national oriental medicine exam in order to practice oriental medicine.

There is no chiropractic law.

## EDUCATION AND TRAINING

The education system for oriental medicine in Korea was established in 1964. Oriental medical studies consist of a preparatory two-year programme and a regular four-year programme covering the basic subjects of oriental and allopathic medicine. In 1994, there were 3922 students majoring in oriental medical sciences enrolled in six-year programmes at 11 colleges throughout the country. Every graduate school has a Master's and Doctorate programme in oriental medical sciences. In each case there is an affiliated oriental medicine hospital providing clinical education. In 1996, the Government approved the establishment of oriental pharmacy departments at several universities.

## INSURANCE COVERAGE

A national medical insurance programme covering oriental medical services has been in effect since 1 February 1987. Included in the coverage are oriental medical diagnosis, acupuncture, moxibustion, and 56 kinds of medicines based on herbal extracts. Total medical insurance payments for oriental medicine treatments in 1998 were 315.55 billion won, or 3% of the total medical insurance payments for medical treatment. Patients treated with unauthorised complementary/alternative medicine are not covered by the medical insurance scheme.

# SAMOA

## BACKGROUND INFORMATION

Traditional medical practitioners in Samoa have used medicinal plants and other forms of non-drug treatment for centuries. This knowledge is typically passed down within families.

## STATISTICS

The exact number of traditional medicine practitioners in Samoa is unknown, but a recent survey concerning primary health care workers estimated that there are about 150 full-time practitioners of traditional medicine. Visiting acupuncturists from the People's Republic of China have been providing acupuncture treatments in the country for about 10 years. Approximately 55 000 patients have been treated.

## REGULATORY SITUATION

There is no legislation on traditional medicine in Samoa. Although the Medical Practitioner's Act states that only registered persons can practice medicine, practitioners of traditional medicine are not considered to be breaking the law. The Health Sector Reform has included traditional medicine as a sub-component for institutional strengthening/reform.

# SINGAPORE

## BACKGROUND INFORMATION

Singapore's health services are based on allopathic medicine. However, it is common practice among the various ethnic groups to consult traditional practitioners for general ailments. Chinese, Indian, and Malay traditional therapies all have a part in complementary/alternative health care in Singapore.

## STATISTICS

About 45% of the population have consulted traditional medicine providers. Traditional Chinese medicine is the most prominent traditional therapy, both in terms of the number of its practitioners and patients and in its far-reaching appeal. A list published by the local traditional Chinese medicine community in 1997 reported 1807 practitioners of traditional Chinese medicine in Singapore, most of whom were more than 40 years old. Half of them practiced traditional Chinese medicine on a full-time basis, one-third practiced part-time, and the remainder were not practicing at the time of the listing. Approximately 10 chiropractors practice in Singapore.

Traditional Chinese medical practice is restricted to outpatient services in Singapore. About 10 000 persons visit traditional Chinese medicine clinics each day, compared to 74 000 persons who visit allopathic clinics.

## REGULATORY SITUATION

The health authorities recognize the importance of traditional medicine in the provision of health care and have initiated efforts to promote and ensure the safe practice of traditional medicine. A traditional medicine unit was set up in the Ministry of Health in November 1995.

Act 34, the Traditional Chinese Medicine Practitioners Act of 2000, was passed by Parliament on 14 November 2000 and assented to by the President on 2 December 2000. The Act provides for the establishment of the Traditional Chinese Medicine Practitioner Board to approve or reject applications for registration and to accredit courses in the practice of traditional Chinese medicine, among other things. This accreditation is intended to facilitate registration. The Register of Traditional Chinese Medicine Practitioners shall be kept by the Registrar appointed by the Board. A registered practitioner who desires to obtain a certificate to practice must make an application to the Board. Unlawful engagement in prescribed practices of traditional Chinese medicine is punishable by a fine, imprisonment, or both.

Under the power conferred by the Traditional Chinese Medicine Practitioners Act of 2000, the Minister for Health issued the Traditional Chinese Medicine Practitioners (Registration of Acupuncturists) Regulations of 2001, which came into effect 23 February 2001. The Traditional Chinese Medicine Practitioners Board, with the approval of the Minister for Health, issued the Traditional Chinese Medicine Practitioners (Register and Practicing Certificates) Regulations of 2001, which came into effect on 18 April 2001.

There is no chiropractic law.

## EDUCATION AND TRAINING

Schools of traditional Chinese medicine have made valuable contributions to the training of traditional Chinese medicine practitioners in the past. Singapore has adopted a standardized six-year part-time training programme in traditional Chinese medicine. National examinations for both acupuncture and traditional Chinese medicine will soon be required for practitioners.

# SOLOMON ISLANDS

## BACKGROUND INFORMATION

There is very little documentation on traditional medicine in the Solomon Islands. Traditional medicine practitioners regard the medicines they use as their personal property and conduct their practices under very strict confidence. Many of the

natural materials used to make the traditional medicines can only be collected at specific times.

## REGULATORY SITUATION

In 1979, the Government officially recognized and accepted the use of traditional medicine as a supplement to allopathic medicine in rural communities where the availability of allopathic drugs is limited. The policy states that traditional medical practice is not to be institutionalized but, rather, is to remain largely in the hands of individual practitioners.

# VANUATU

## REGULATORY SITUATION

In Vanuatu, under the Health Practitioners Act of 1984, amended in 1985, osteopathy and chiropractic are designated as ancillary allopathic medical professions subject to registration. By Section 5 of the Act, a person is eligible to be registered if, in the opinion of the Health Practitioners Board, he or she has sufficient training, skill, and practical experience. At its discretion, the Board can require applicants who do not meet these criteria to complete a recognized training course. Section 18 makes it an offence for a non-registered person to practice medicine or claim to be registered to practice medicine.

# VIET NAM

## BACKGROUND INFORMATION

In Viet Nam, traditional medicine can be divided into two categories: Vietnamese traditional medicine, which is influenced by Chinese traditional medicine, and oriental medicine. In the countryside and in remote and mountainous areas, Vietnamese traditional medicine is more commonly used. In the delta, lowlands, and cities, patients more commonly use a combination of Vietnamese traditional medicine and oriental medicine.

Both Vietnamese traditional medicine and oriental medicine form an integral part of the national health care system in Viet Nam and have an important role in promoting the health of the Vietnamese people, particularly in difficult cases, geriatric diseases, and primary health care at the commune level. Allopathic doctors who have graduated from medical universities and who have been trained in traditional medicine have become some of the most outspoken supporters of traditional medicine. They are actively engaged in promoting the rational use of traditional medicine in their institutes and hospitals.

## STATISTICS

According to Ministry of Health statistics, about 30% of patients receive treatment with traditional medicine. Treatment is provided by traditional medicine practitioners (who have not received any formal education) and by traditional medical doctors (who have graduated from a department of traditional medicine at one of the medical universities in Hanoi, Ho Chi Minh City, or Haiphong). There are about 1000 traditional medicine practitioners, 5000 traditional medical doctors, 2000 assistant traditional medical doctors, and 209 traditional medicine pharmacists. Additionally, there are approximately 8000 private practitioners of traditional medicine. Of this number, about 1400 are acupuncturists.

The Viet Nam Association of Traditional Medicine Practitioners has 24 000 members. Of this number, 461 work in public hospitals. The Viet Nam National Association of Acupuncture has 18 000 members, 4500 of whom work in public hospitals.

A Traditional Medicine Hospital of the Ministry of Interior Affairs was inaugurated at the end of 1996. Additionally, there are 286 departments of traditional medicine in general hospitals, 45 provincial hospitals of traditional medicine, and four institutes of traditional medicine in Viet Nam. There are three medical colleges that have a faculty of traditional medicine, two pharmaceutical colleges, two secondary schools of traditional medicine, two State pharmaceutical companies, two State pharmaceutical manufacturers of herbal medicine, and three national research institutes for traditional medicine.

An Army Institute of Traditional Medicine was established in 1978, with a staff of 100 doctors and pharmacists. The tasks of the Institute include clinical work, research, training, and the manufacture of herbal products. It serves about 20 000 outpatients and 2500 inpatients each year.

The Viet Nam Acupuncture Institute operates under the authority of the Ministry of Health. The Institute is responsible for giving nationwide guidance on acupuncture and other medical therapies that reduce or avoid the use of drugs in treatment. It has 350 beds and serves approximately 2500 inpatients and 8500 outpatients each year.

## REGULATORY SITUATION

The Government supports public-sector facilities for traditional medicine and encourages people to mobilize resources for the development of traditional medicine, especially for primary health care. Government programmes include training health workers at the community level in using traditional medical methods to treat common and recently defined diseases and encouraging people to plant medicinal

vegetables, ornamental plants, and fruit trees. These three groups of plants are intended for use in treating common diseases in the community as well as improving family incomes. This model has become a countrywide programme.

A number of official documents indicate clear support for traditional medicine. There is official recognition for a number of traditional therapies, including medications made from plants and animals, massage, acupuncture, acupressure, moxibustion, vital preservation, cupping, and thread embedding.

Article 39 of the Constitution of the Socialist Republic of Viet Nam outlines State undertakings to develop and integrate allopathic and traditional medical and pharmaceutical practices as well as to develop and integrate official health care, traditional medicine, and private medical care. More detailed provisions on traditional medicine can be found in a 1989 public health law and 1991 regulations made under it.

Among the objectives of health care, Section 2 of the 1989 law lists the development of official Vietnamese medicine on the basis of traditional medicine and pharmacy and the integration of allopathic and traditional medicine. The promotion of these objectives is the shared responsibility of the Ministry of Health, the Vietnamese Traditional Medicine Association, and the Viet Nam General Union of Medicine and Pharmacy. Under Section 34.1, these organizations are additionally charged with ensuring conditions for the operation of all major hospitals and institutes of traditional medicine. Section 34.2 provides that the medical services and the people's committees at all levels are to consolidate and broaden the health-care network using traditional medicine. Section 35 permits licensed traditional medicine practitioners to practice in any State, collective, or private health care institution. This includes acupuncturists who have been trained, who have attended courses in traditional medicine, or whose knowledge of traditional medicine was passed down to them through their family. Traditional medicine practitioners may examine and treat patients as well as offer preventive advice. However, before new treatment methods can be used, they must be approved by the Ministry of Health or provincial health office and the Traditional Medicine Association. Superstitious practice is forbidden by Section 36. Private practice of traditional medicine is subject to management by the Government and the Ministry of Health.

The 1991 regulations specify required qualifications for traditional medicine practitioners as well as the permitted range of procedures practitioners may use. A breach of any of these rules that results in serious harm to life or health of another person is punishable under the Criminal Code by imprisonment.

The 1993 Vietnamese Ordinance on Private Medical and Pharmaceutical Practice includes detailed provisions on the private practice of traditional medicine. The Ordinance permits certified practitioners of traditional medicine to privately

practice the range of activities for which they are certified, provided they have a permit to do so and subject to State overview.

Article 5 lists permitted activities as including practice in a traditional medical hospital or clinic and providing traditional forms of treatment such as acupuncture, massage, acupressure, and herbal saunas. Article 7 requires traditional practitioners to hold a diploma of Doctor of Medicine or Assistant Doctor Specialising in Traditional Medicine and to have practiced traditional medicine for a minimum period that varies between two and five years.

A number of measures are included in the Ordinance to further safeguard patients' interests. Under Article 17, practitioners must put up a name board that sets out the activities they are permitted to practice. Private practitioners must obtain the permission of the Ministry of Health to use novel treatment techniques or drugs. Superstitious practices are not permitted according to Article 19. Private practice without a certificate or practice that exceeds the range of permitted activities is subject to administrative, disciplinary, or criminal sanctions under Article 34.

The Government entrusts the health service system with issuing licences to traditional practitioners through an assessing committee. Anyone who has 13 certificates issued by an assessing committee and the Ministry of Health can privately practice traditional medicine. In the area of acupuncture, the regulatory qualifications of practitioners include Professor, Associate Professor, PhD, Acupuncture Speciality Doctor Level I, Acupuncture Speciality Doctor Level II, and Acupuncture-Oriented Doctor.

The Ministry of Health advocates socialization and diversification of traditional medicine.

## EDUCATION AND TRAINING

There is no college or university of traditional medicine in Viet Nam. Although Hanoi Medical University has a department of traditional medicine, it does not meet the needs of developing traditional medicine in Viet Nam. Two secondary schools are the main seats of learning in traditional medicine. There is strong support for a facility of higher education in traditional medicine, and the Government is planning to create a university of traditional medicine to provide programmes for secondary, undergraduate, and postgraduate study (*278, 279*).

## INSURANCE COVERAGE

Health insurance covers costs for both allopathic and traditional medicine *;* however, this is not on an equal basis in all areas because of differential access to care.

## THE EUROPEAN UNION

### GENERAL PRINCIPLES

The Treaty on the European Union (EU) came into force 1 November 1993. The Treaty instituting the European Economic Community (EEC) was intended to open a large market zone without borders, enabling the free movement of persons, goods, services, and capital. It is Treaty regulations on the movement of persons and goods, in particular, which affect health services and medications (*172, 280, 281*).

For the purpose of employment or for activities as a self-employed person, citizens of the European Union, under Articles 39 to 55 of the Treaty, have the right to move and take residence freely within the European Union. Some limitations and conditions on this freedom are outlined in Articles 12 and 39 of the Treaty. Moreover, by Directive 65/221/EEC, individual countries can limit the right of free movement on justified grounds of public health.

Specific directives ensure the mutual recognition of diplomas of allopathic doctors, dentists, pharmacists, midwives, and nurses. Similarly, directives based on Article 95 of the Treaty regarding Union-wide harmonization of legislation regulate, among other things, pharmaceuticals, blood products, medical devices, foodstuffs, dangerous substances and preparations, cosmetics, safety of products, precursors, tobacco products, personal protective equipment, and the protection of personal medical data.

### DIRECTIVES ON HOMEOPATHIC PRODUCTS

The first phase of European Union legislative harmonization in homeopathy was the adoption of two European Directives that came into force on 1 January 1994 - one on homeopathic products for humans and one on homeopathic veterinary products. These Directives ensure a single European Market for homeopathic products and outline provisions regulating their manufacture, inspection, marketing, and labelling. They also establish a simplified registration procedure for medications containing less than one part per 10 000 of undiluted tincture or less than 1/100th of the smallest dose used in allopathic medicine. According to the 1995 European Commission report to the Parliament and the Council on the application of Directives 92/73 and 92/74, however, the existing level of legislative harmonization is insufficient.

The EEC Directive regulates the marketing of proprietary medicinal products. However, individual countries are free to restrict the licensing of herbal medicines.

Germany and the United Kingdom have chosen to restrict such licences in order to protect their populations from the possible carcinogenic effects of pyrolizidine alkaloids, which occur in a number of medicinal herbs.

## FREE MOVEMENT OF PATIENTS AND PRACTITIONERS AND INSURANCE COVERAGE OF COMPLEMENTARY/ALTERNATIVE MEDICINE PRODUCTS AND TREATMENTS

Directives on the free movement of patients and practitioners and on insurance coverage of complementary/alternative medicine are more difficult to implement.

Although the free movement of persons within the European Union is a cornerstone of the Treaty of Rome, the diversity of national policies severely limits its applicability to practitioners of complementary/alternative medicine. Case 61/89 of the European Court of Justice involved an acupuncturist without allopathic medical qualifications practicing in France. The Court's decision confirmed the right of individual countries to make their own legislation on whether or not to reserve the practice of medicine to allopathic doctors.

As social insurance remains the province of national governments rather than an issue for European Union consideration, insurance coverage of complementary / alternative products and treatments is unlikely to become the subject of a European Directive.

Nonetheless, in April 1994, European Deputy Paul Lannoye presented a proposal on the status of complementary/alternative medicine to the European Parliament Committee on the Environment, Public Health, and Consumer Protection. He asked for provisions for complementary/alternative medicine within social security systems, the incorporation of complementary/alternative medical systems into the *European Pharmacopoeia,* an end to prosecutions of non-allopathic practitioners in countries where the practice of medicine is the exclusive domain of allopathic providers, and a pan-European system of recognition and regulation of complementary/alternative medical practitioners along the lines of the British Osteopath and Chiropractor Acts. He also requested a research budget of 10 million Euros per year for five years. At the last moment, the European Parliament cancelled the vote on the proposal.

At the end of 1995, the Conference of Presidents of the European Parliament put forward a report intended to engage the European Commission in the process of recognizing complementary/alternative medicine.

On 27 February 1997 the Committee on the Environment, Public Health, and Consumer Protection began a study of complementary/alternative medicine. On 29 May 1997 the European Parliament passed a resolution,

Calling on the Commission, if the results of the study allow, to start the process for the recognition of non-conventional medicines and, for this purpose, to take the necessary steps to encourage the establishment of appropriate committees;

Calling on the Commission to carry out a thorough study on the safety, effectiveness, scope of application and the complementarity and alternative nature of all non-conventional medicines, and to prepare a comparative study of the various national legal models to which non-conventional medical practitioners are subjected;

Calling on the Commission, in formulating European legislation on non-conventional forms of medicine, to make a clear distinction between non-conventional medicines which are "complementary" in nature and ones which are "alternative" in the sense that they replace conventional medicine;

Calling on the Council, after completion of the preliminary works referred to in paragraph 2 above, to encourage the development of research programmes in the field of non-conventional medicines covering the individual and holistic approach, the preventive role and the specific characteristics of the non-conventional medicine;

Calling on the Commission to submit a proposal for a Directive on food supplements which are frequently situated on the boundaries between dietary and medicinal products. Such legislation should help guarantee good manufacturing practices to secure consumer protection without restricting freedom of access or choice and ensure the freedom of all practitioners to recommend such products;

Calling on the Commission to remove trade barriers between Member States by giving manufacturers of health products free access to all markets in the EU....

A Resolution of the European Parliament, however, is not a binding act, but a declaration of policy. Nonetheless, the adoption of the resolution has led several countries to consider revising their legislation.

The European Commission's COST (European Cooperation in the Field of Scientific and Technical Research) programme undertook Project B4, a European initiative for comprehensive research on complementary/alternative medicine. The Governments of Belgium, Croatia, Denmark, Finland, Germany, Hungary, Italy, Netherlands, Norway, Slovenia, Spain, Sweden, Switzerland (the project's initiator), and the United Kingdom all participated in the project. The goals of the project were to demonstrate the possibilities, limitations and significance of complementary / alternative medicine by establishing a common scientific background, helping to control health care costs, and harmonizing legislation. The project was completed in 1998.

**LIST OF 525 DRUGLESS THERAPIES LOCATED BY THE WORLD INSTITUTE FOR SCIENTIFIC DEVELOPMENT OF ORIENTAL MEDICINE (WISDOM) AND THE WORLD INITIATIVE FOR DRUGLESS THERAPIES AND HEALING (WIDTH)**

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| 1. | ABORTIVE THERAPY |
| 2. | ABREACTION THERAPY |
| 3. | ABSENT HEALING |
| 4. | ACCEPTANCE & COMMITMENT THERAPY |
| 5. | ACTIVE IMAGERY |
| 6. | ACUPRESSURE |
| 7. | ACUPUNCTURE |
| 8. | ADLERIAN THERAPY |
| 9. | ADVENTURE THERAPY |
| 10. | AEROBIC EXERCISE |
| 11. | AEROBICS |
| 12. | AFFIRMATIVE PRAYER |
| 13. | AGNIHOTRA |
| 14. | ALEXANDER TECHNIQUE |
| 15. | ANALYTICAL PSYCHOLOGICAL THERAPY |
| 16. | ANIMAL ASSISTED THERAPY |
| 17. | ANTHROSOPHICAL MEDICINE |
| 18. | ANTIFUNGAL MEDITATION |
| 19. | ANXIETY MANAGEMENT TRAINING THERAPY |
| 20. | API THERAPY |
| 21. | APPLIED BEHAVIOURAL ANALYSIS |
| 22. | APPLIED KINESIOLOGY |
| 23. | AQUARIUM THERAPY |
| 24. | AQUATIC THERAPY |
| 25. | ARICULO THERAPY |
| 26. | AROMA THERAPY |
| 27. | ART AND DEMENTIA THERAPY |
| 28. | ART THERAPY |
| 29. | ASFEDIC TUNING |
| 30. | ASTANG VINYASA YOGA |
| 31. | ASTANG YOGA |
| 32. | ASTROLOGY |
| 33. | ATTACHMENT THERAPY |
| 34. | ATTACK THERAPY |

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| 35. | ATTITUDINAL HEALING |
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| 40. | AVERSION THERAPY |
| 41. | AYURVEDA |
| 42. | BACH FLOWER THERAPY |
| 43. | BALNEO THERAPY |
| 44. | BATES METHOD |
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| 46. | BEHAVIOURAL MODIFICATION |
| 47. | BEHAVIOURAL PSYCHOTHERAPY |
| 48. | BEHAVIOURAL THERAPY |
| 49. | BI- AURA THERAPY |
| 50. | BIBLIOTHERAPY |
| 51. | BIO DYNAMIC PSYCHOTHERAPY |
| 52. | BIO THERAPY |
| 53. | BIODANZA |
| 54. | BIOELECTRO MIGANETICS |
| 55. | BIOENERGETIC ANALYSIS |
| 56. | BIOFEEDBACK |
| 57. | BIORESONENCE THERAPY |
| 58. | BLOOD IRRADIATION THERAPY |
| 59. | BODY BASED MANIPULATING THERAPY |
| 60. | BODY PSYCHOTHERAPY |
| 61. | BODY WORK |
| 62. | BOWEN TECHNIQUE |
| 63. | BRACHY THERAPY |
| 64. | BRAINWAVE ENTRAINMENT THERAPY |
| 65. | BRATHARIAN |
| 66. | BRIEF PSYCHOTHERAPY |
| 67. | BRUSHING TECHNIQUE |
| 68. | BUTEYKO METHOD |
| 69. | CELL THERAPY |
| 70. | CENTERING PRAYER THERAPY |
| 71. | CHAKRA BALANCING |
| 72. | CHELATION THERAPY |
| 73. | CHESS THERAPY |
| 74. | CHINESE FOOD THERAPY |
| 75. | CHINESE MARTIAL ARTS |

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| 76. | CHINESE MEDICINE |
| 77. | CHINESE PULSE DIAGNOSIS |
| 78. | CHIROPRACTIC |
| 79. | CHRISTIAN SCIENCES |
| 80. | CHROMO THERAPY |
| 81. | CHUA K'A |
| 82. | CLASSICAL ADLERIAN PSYCHOLOGY |
| 83. | CLINICAL ECOLOGY THERAPY |
| 84. | CO - COUNSELLING |
| 85. | CODE PROCESS PSYCHOTHERAPY |
| 86. | CODING THERAPY |
| 87. | COGNITIVE ANALYTIC THERAPY |
| 88. | COGNITIVE BEHAVIOURAL ANALYSIS |
| 89. | COGNITIVE BEHAVIOURAL THERAPY |
| 90. | COGNITIVE EMOTIONAL BEHAVIOUR THERAPY |
| 91. | COGNITIVE PROCESSING THERAPY |
| 92. | COGNITIVE THERAPY |
| 93. | COHERENCE THERAPY |
| 94. | COIN RUBBING |
| 95. | COLLABORATIVE THERAPY |
| 96. | COLLOIDAL SILVER THERAPY |
| 97. | COLON HYDROTHERAPY |
| 98. | COLOUR PUNCTURE |
| 99. | COLOUR THERAPY |
| 100. | CONCENTRATIVE MOVEMENT THERAPY |
| 101. | CONTEMPLATIVE PSYCHOTHERAPY |
| 102. | CONTEXTUAL THERAPY |
| 103. | CONTINGENCY MANAGEMENT THERAPY |
| 104. | CONVERSATIONAL MODEL THERAPY |
| 105. | CONVERSION THERAPY |
| 106. | COSMIC BOOK THERAPY |
| 107. | CRANIOSACRAL THERAPY |
| 108. | CREATIVE VISUALIZATION |
| 109. | CRYOTHERAPY |
| 110. | CRYSTAL HEALING |
| 111. | CUPPING |
| 112. | CYMATIC THERAPY |
| 113. | DANCE THERAPY |
| 114. | DANTIAN THERAPY |

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| 115. | DASEINS ANALYSIS |
| 116. | DEEP SLEEP THERAPY |
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| 120. | DEVELOPMENTAL NEEDS MEETING STRATEGY |
| 121. | DIALECTICAL BEHAVIOURAL THERAPY |
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| 123. | DIET THERAPY |
| 124. | DIETARY SUPPLEMENTS |
| 125. | DIRECT THERAPEUTIC EXPOSURE THERAPY |
| 126. | DOCTRINE OF SIGNATURES |
| 127. | DOLPHIN ASSISTED THERAPY |
| 128. | DOWSING |
| 129. | DRAMA THERAPY |
| 130. | DREAMWORK |
| 131. | DYADIC DEVELOPMENTAL PSYCHOTHERAPY |
| 132. | DYNAMIC DEVELOPMENTAL PSYCHOTHERAPY |
| 133. | EAR CANDLING |
| 134. | ECLECTIC MEDICINE |
| 135. | ECOLOGICAL COUNSELLING |
| 136. | EDEN ENERGY MEDICINE |
| 137. | ELECTO CONVULSIVE THERAPY |
| 138. | ELECTRO HOMEOPATHY |
| 139. | ELECTRO MAGNETIC THERAPY |
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| 145. | ENERGY PSYCHOLOGY |
| 146. | ENERGY THERAPY |
| 147. | ENZYME THERAPY |
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| 151. | EXISTENTIAL THERAPY |

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| 157. | FAMILY THERAPY |
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| 160. | FELDENKRAIS METHOD |
| 161. | FEMINIST THERAPY |
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| 163. | FLOORTIME THERAPY |
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| 169. | FREUDIAN PSYCHOTHERAPY |
| 170. | FRUITARIANISM |
| 171. | FUNCTIONAL ANALYTIC PSYCHOTHERAPY |
| 172. | FUNCTIONAL MEDICINE |
| 173. | FUTURE ORIENTED THERAPY |
| 174. | GELOTOLOGY |
| 175. | GEN THERAPY |
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| 178. | GEORGIAN FOLK MEDICINE THERAPY |
| 179. | GERSON THERAPY |
| 180. | GESALT THERAPY |
| 181. | GRAHAMISM |
| 182. | GREYHOUND THERAPY |
| 183. | GRIEF THERAPY |
| 184. | GROUP ANALYSIS |
| 185. | GROUP THERAPY |
| 186. | GUA SHA |
| 187. | GUIDED AFFECTIVE IMAGERY |
| 188. | HAIR ANALYSIS |
| 189. | HAKOMI |
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| 191. | HAWAIIAN MASSAGE |
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| 197. | HEROIC MEDICINE |
| 198. | HIPPOTHERAPY |
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| 200. | HOLISM |
| 201. | HOLISTIC LIVING |
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| 204. | HOME REMEDIES |
| 205. | HOMEOPATHY |
| 206. | HORMONE THERAPY |
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| 208. | HUMAN GIVENS THERAPY |
| 209. | HUMANISTIC THERAPY |
| 210. | HYDRO THERAPY |
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| 212. | HYPNO THERAPY |
| 213. | HYPNOSIS |
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| 255. | MAGNETIC HEALING |
| 256. | MAGOT THERAPY |
| 257. | MANIPULATIVE THERAPY |
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| 306. | NORRIS TECHNIQUE THERAPY |
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## Chapter 12

# LESSONS FROM THE INAUGURAL SPEECH OF THE PRIME MINISTER HON'BLE SHRI NARENDRA MODI DURING THE INDIA-AFRICA FORUM SUMMIT 2015

The following is the extract of the inaugural speech of our Prime Minister Hon'ble Shri Narendra Modi during the India-Africa Forum Summit held on 26-30 October 2015 at New Delhi :

Your Majesties, Chairperson of the African Union, His Excellency Robert Mugabe Chairperson of the African Union Commission, Madam Dlamini-Zuma, Excellencies,

The fabric of this world is richer because of the 54 sovereign flags of Africa. Today, their brilliant colours have made Delhi the most special place in the world.

To the 41 Heads of State and Government and the other eminent leaders; to the hundreds of senior officials, business leaders and journalists from Africa, I say this: we are deeply, deeply honoured by your presence today.

To our visitors from the land where history began, humanity grew and new hope rises;

From the deserts of the north, where the glory of human civilization shines through the shifting sands of time;

From the south, where the conscience of our age has been forged - from Mahatma Gandhi to Albert Luthuli to Nelson Mandela;

From the shores of Atlantic that has been at history's tragic crossroads and now at the frontiers of many successes; From our neighbours on the resurgent east coast; From Africa's heart, where Nature is generous and culture is rich; And, from the sparkling gems of island states;

A very warm embrace of welcome and friendship from India. Today, it is not just a meeting of India and Africa. Today, the dreams of one-third of humanity have come together under one roof. Today, the heart beat of 1.25 billion Indians and 1.25 billion Africans are in rhythm.

We are among the world's oldest civilisations. We are each a vibrant mosaic of languages, religions and cultures.

Our histories have intersected since ages. Once united by geography, we are now linked by the Indian Ocean. The currents of the mighty ocean have nurtured the ties of kinship, commerce, and culture through centuries.

Generations of Indians and Africans have travelled to each other's land in search of their destiny or by the force of circumstances. Either way, we have enriched each other and strengthened our ties.

We have lived in the long shadow of colonialism. And, we have fought for our liberty and our dignity. We have struggled for opportunity, and also for justice, which, the African wisdom describes, is the prime condition of humanity.

We have spoken in one voice in the world; and, we have formed a partnership for prosperity among ourselves.

We have stood together under blue helmets to keep peace. And, we have fought together against hunger and disease.

And, as we look to the future, there is something precious that unites us: it is our youth.

Two-thirds of India and two-thirds of Africa is under the age of 35 years. And, if the future belongs to the youth, then this century is ours to shape and build.

Excellencies, Africa is already on that path.

We are all familiar with Africa's ancient achievements. Now, its modern strides are catching the attention of the world.

The continent is more settled and stable. African nations are coming together to take responsibility for their development, peace and security.

African struggles and sacrifices are upholding democracy, combating extremism and empowering women. Women now constitute around 20% of the elected Members of Parliament in Africa.

To one who has played a role in that, President Sirleaf, I extend our best wishes on your birthday today.

Africa's economic growth has gathered momentum and has a more diversified base. African initiatives are replacing old fault lines with new bridges of regional economic integration.

We see many successful examples of economic reforms, infrastructure development and sustainable use of resources. They are turning adrift economies into dynamic ones.

Four hundred thousand new businesses were registered in Africa in 2013; and, mobile telephone now reaches 95% of the population in many places.

Africa is now joining the global mainstream of innovation. The mobile banking of M-Pesa, the healthcare innovation of MedAfrica, or the agriculture innovation of AgriManagr and Kilimo Salama, are using mobile and digital technology to transform lives in Africa.

We see strong measures that are radically improving healthcare, education and agriculture. Primary school enrolment in Africa now exceeds 90%.

And, across its magnificent landscape, Africa is setting standards in wildlife conservation and eco-tourism.

Africa's sports, art and music delight the entire world.

Yes, Africa, like the rest of the developing world, has its development challenges. And, like others in the world, it has its own concerns of security and stability, especially from terrorism and extremism.

But, I have confidence in African leadership and the African people to rise to those challenges.

Excellencies,

for the past six decades, so much of our independent journeys have been together.

Now, so much of India's development priorities and Africa's lofty vision for its future are aligned.

Today, Africa and India are two bright spots of hope and opportunities in the global economy.

India is honoured to be a development partner for Africa. It is a partnership beyond strategic concerns and economic benefits. It is formed from the emotional bonds we share and the solidarity we feel for each other.

In less than a decade, our trade has more than doubled to over 70 billion dollars. India is now a major source of business investments in Africa. Today, 34 African countries enjoy duty free access to the Indian market.

African energy helps run the engine of the Indian economy; its resources are powering our industries; and, African prosperity offers growing market for Indian products.

India has committed 7.4 billion dollars in concessional credit and 1.2 billion dollars in grant since the first India-Africa Summit in 2008. It is creating 100 capacity building institutions, and developing infrastructure, public transport, clean energy, irrigation, agriculture and manufacturing capacity across Africa.

In the last three years alone, nearly 25,000 young Africans have been trained and educated in India. They are the 25,000 new links between us.

Excellencies,

There are times when we have not done as well as you have wanted us to. There have been occasions when we have not been as attentive as we should be. There are commitments we have not fulfilled as quickly as we should have.

But, you have always embraced India with warmth, and without judgement. You have rejoiced in our success, and taken pride in our achievements. And, you have stood for us in the world.

This is the strength of our partnership and our friendship.

And, as we travel on the road ahead, we will do so with the wisdom of our experience and the benefit of your guidance.

We will raise the level of our support for your vision of a prosperous,integrated, and united Africa that is a major partner for the world.

We will help connect Africa from Cairo to Cape Town, from Marakesh to Mombassa; help develop your infrastructure, power and irrigation; help add value to your resources in Africa; and, set up industrial and information technology parks.

Excellencies,

As the great Nigerian Nobel Laureate Wole Soyinka insisted, human entity remains the primary asset in overall development.

Our approach is based on the same belief: that the best partnership is one that develops human capital and institutions; that equips and empowers a nation to have the freedom to make its own choices and shoulder the responsibility for its own progress. It also opens doors to opportunities for the youth.

So, development of human capital in every walk of life will be at the heart of our partnership. We will open our doors more;we will expand tele-education; and we will continue to build institutions in Africa.

The Egyptian Nobel Prize winning writer Naguib Mahfouz said, "Science brings people together with the light of its ideas...and prods us towards a better future."

There can be no better expression of the ability of science to unify people and advance progress.

So, technology will be a strong foundation of our partnership.

It will help develop Africa's agriculture sector. Africa has 60% of the world's arable land reserves, and just 10% of the global output. Agriculture in Africa can drive the continent's march to prosperity, and also support global food security.

India's expertise in healthcare and affordable medicines can offer new hope in the fight against many diseases; and give a newborn a better chance to survive. We will also collaborate to develop Indian and African treasures of traditional knowledge and medicines.

We will make available our space assets and technology. We will use the possibilities of digital technology to transform development, public services, governance, disaster response, resource management and quality of life.

We will expand and extend the Pan Africa E-Network, conceived by late President APJ Abdul Kalam, which links 48 African countries to India and to each other. This will alsohelp set up your Pan Africa Virtual University.

We will work to reduce digital divide within Africa and between Africa and rest of the world.

We will cooperate for sustainable development of Blue Economy that will become important future drivers of our prosperity.

For me, Blue Economy is part of a larger Blue Revolution to reclaim our blue skies and blue waters, as we move on the path of clean development.

Excellencies,

When the sun sets, tens of millions of homes in India and Africa become dark. We want to light up lives of our people and power their future.

But, we want to do it in a way that the snow on Kilimanjaro does not disappear, the glacier that feeds the River Ganges does not retreat and our islands are not doomed.

No one has done less to contribute to global warming than India and Africa. No one can be more conscious of climate change than Indians and Africans.

This is because we are the inheritors of Nature's most precious gifts, and of traditions that respect them the most; and, our lives remain most connected to Mother Earth.

We are each making enormous efforts with our modest resources to combat climate change. For India, 175 Gigawatts of additional renewable energy capacity by 2022 and reduction in emission intensity by 33-35% by 2030 are just two aspects of our efforts.

We will also deepen India-Africa partnership on clean energy, sustainable habitats, public transport and climate resilient agriculture.

But, it is also true that the excess of few cannot become the burden of many. So, when the world meets in Paris in December, we look to see a comprehensive and concrete outcome that is based on the well established principles in the UN Convention on Climate Change. We will all do our part for it. But, we also want to see a genuine global public partnership that makes clean energy affordable; provides finance and technology to developing countries to access it; and the means to adapt to the impact of climate change.

I also invite you to join an alliance of solar-rich countries that I have proposed to launch in Paris on November 30 at the time of COP-21 meeting. Our goal is to make solar energy an integral part of our life and reach it to the most unconnected villages and communities.

India and Africa seek also seek a global trading regime that serves our development goals and improves our trade prospects.

When we meet at Nairobi Ministerial of the WTO in December, we must ensure that the Doha Development Agenda of 2001 is not closed without achieving these fundamental objectives.

We should also achieve a permanent solution on public stockholding for food security and special safeguard mechanism in agriculture for the developing countries.

Excellencies,

This is a milestone year when we are setting the agenda for our future and celebrating the 70th anniversary of the United Nations. The world is undergoing political, economic, technological and security transition on a scale and speed rarely

seen in recent history. Yet our global institutions reflect the circumstances of the century that we left behind, not the one we are in today.

These institutions have served us well, but unless they adjust to the changing world, they risk becoming irrelevant. We cannot say what will replace them in an uncertain future.

But, we might have a more fragmented world that is less capable of dealing with the challenges of our era. That is why India advocates reforms in global institutions.

This is a world of free nations and awakened aspirations. Our institutions cannot be representative of our world, if they do not give voice to Africa, with more than a quarter of UN members, or the world's largest democracy with one-sixth of humanity.

That is why India and Africa must speak in one voice for reforms of the United Nations, including its Security Council.

Excellencies,

Today, in many parts of the world, the light of a bright future flickers in the storm of violence and instability. When terror snuffs out life on the streets and beaches, and in malls and schools of Africa, we feel your pain as our own. And, we see the links that unite us against this threat.

We also see that when our oceans are no longer safe for trade, we all suffer together.

And, when nations are caught in conflict within, no one around remains untouched.

And, we know that our cyber networks bring opportunities, but also carry huge risks.

So, when it comes to security, distance no longer insulates us from each other. That is why we wish to deepen our cooperation in maritime security and hydrography, and countering terrorism and extremism; and, why we must have a UN Comprehensive Convention on International Terrorism. We will also provide support for Africa Union's peacekeeping efforts. And, we will train African peacekeepers here and in Africa. We must also have a stronger voice in decisions on UN Peacekeeping Missions.

Excellencies,

From connecting lives to collaborating for our prosperity, from keeping our people safe to advancing our global interests, the agenda of our partnership stretches across the vast territory of our linked aspirations.

To add strength to our partnership, India will offer concessional credit of 10 billion U.S. dollars over the next five years. This will be in addition to our ongoing credit programme.

We will also offer a grant assistance of 600 million U.S. dollars. This will include an India-Africa Development Fund of 100 million U.S. dollars and an India-Africa Health Fund of 10 million U.S. dollars.

It will also include 50,000 scholarships in India over the next five years. And, it will support the expansion of the Pan Africa E-Network and institutions of skilling, training and learning across Africa.

Excellencies,

If this century is going to be one in which all humans have a life of opportunity, equality and dignity; stand in peace with each other; and live in balance with nature, then India and Africa must rise together.

We will work together:

From the memory of our common struggles; and, the tide of our collective hopes;

From the richness of our heritage; and, the commitment to our planet;

From the pledge to our people; and, the faith in our future;

From the generosity of the African saying that a small home can hold hundred friends;

From the spirit of India's ancient belief: सन्तः स्वयं परहिते निहिताभियोगाः that great souls are always taking the initiatives to do good to others;

From the inspiration of Mandela's call to live in a way that respects and enhances the freedom of others.

Today, we pledge to walk together, with our steps in rhythm and our voices in harmony.