



OVERVIEW OF
 MECHANISMS OF RECOGNITION OF FOREIGN QUALIFICATIONS
 (Based on case studies in selected countries of South-East Asia)

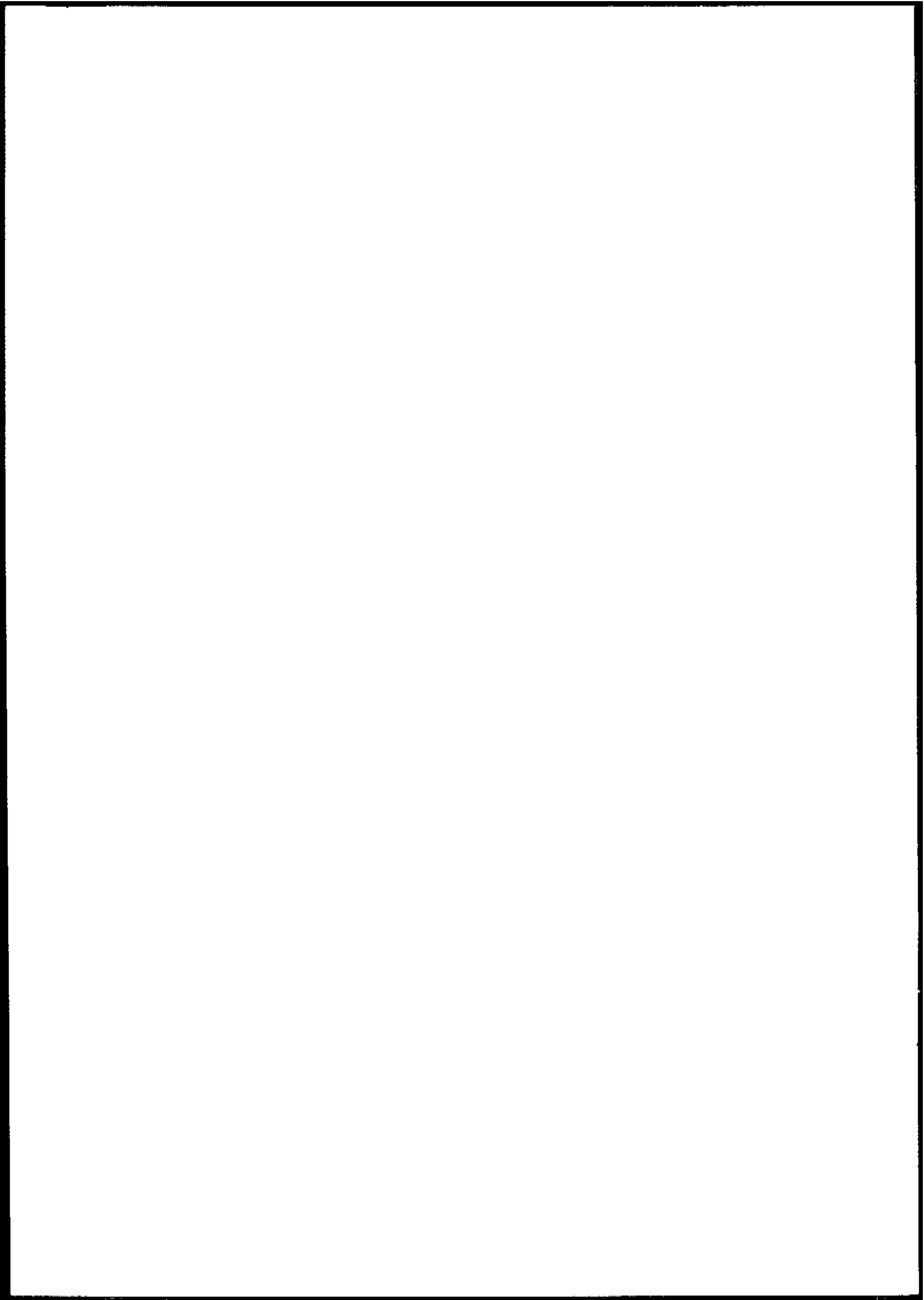
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INTRODUCTION/BACKGROUND

International organizations such as WHO have a responsibility to support, facilitate, and streamline the international movement of technical personnel and the transfer of appropriate technologies in conformity with the plans and necessities of the Member States of such organizations. In the health sector it has been observed that many professionals and technical personnel move from one country to another for the realization of their own career goals, and these may not always fall in line with national objectives and aspirations. This has been a major concern of a large number of developing countries that are adversely affected by such movements. However, as international organizations would find it rather difficult to have much impact on such movements, their primary focus would necessarily be on the planned or desired types of movements of professionals and technicians. The development of the concept of Technical Co-operation among Developing Countries (TCDC) and the strategies for its implementation reflect the actualization of such efforts.

For a number of years UNESCO has been involved in the development of strategies for the adoption of regional conventions by which the participating countries agree, mutually, to recognize the qualifications and experiences for admission to further study and for professional practice. To this end, a series of Regional and Interregional Conventions are presently in existence, the most recent being the "International Conference of States with a View to Adoption of the Regional Convention on the Recognition of Studies, Diplomas and Degrees in Higher Education in Asia and the Pacific", held in Bangkok in December 1983. Similar Conventions also exist among the countries of Latin America and the Caribbean, Europe, the Arab States, and the African States.

The aims of the Conventions are to:

- (i) ensure mobility of students, research workers, and teachers so as to promote optimal utilization of existing educational and training facilities, human resources, and technical competence at regional and international levels;
- (ii) facilitate access to the various stages in advanced studies within a given education system for students and research workers coming or returning from abroad;
- (iii) facilitate the transformation of higher education so that "elitist" systems may progressively become more diversified; and
- (iv) bridge the scientific and cultural gap between countries at different stages of development.

The experience of UNESCO in this area has clearly shown the insurmountable difficulties that would arise if attempts were made to establish "equivalence" between degrees, diplomas, and experiences which are offered by different countries, even within the same region. Hence the acceptance of the concept of "recognition" as a more pragmatic objective, which enables the provision of avenues for purposes of study and practice in line with mutually agreed-upon goals.

The UNESCO Conventions by their nature and necessity are rather broad in perspective, and at first glance may prompt their being dismissed as having potentially little positive impact. But, on closer examination, it becomes clear that they hold promise as frameworks within which more specific arrangements could be made between and among countries in different professional and technical sectors. In any event, the issue requires and merits further attention and scrutiny.

A study was undertaken by WHO in collaboration with UNESCO in 1980 to "facilitate Member States developing appropriate mechanisms needed in recognizing foreign qualifications and experiences for the purposes of further study or professional

practice". This study reviewed the legislation and practices by which selected countries recognize qualifications and experiences gained outside their country, and entailed "the description and critical analysis of how recognition is granted in five countries (Egypt, France, Mexico, the United States of America, and Yugoslavia) for health professionals".

It was recognized that similar case studies conducted in a different region, in countries with comparable historical background and socio-cultural milieus, would shed further light on this question and would help WHO and Member States to further develop and establish suitable mechanisms.

Therefore, the overall purpose of this series of case studies of India, Sri Lanka, Nepal, and Indonesia was to collect and analyze the information concerning present mechanisms which these countries use for evaluation of competence and the recognition of foreign qualifications in health sciences.

Objectives

More specifically, the objectives were to:

- (1) describe present mechanisms which are in use in selected countries to recognize foreign qualifications and experiences in the health professions for further study or professional practice;
- (2) analyze changes that occur in these mechanisms and indicate major issues or problems encountered;
- (3) examine special mechanisms which have been developed to facilitate participation in a regional convention;
- (4) identify the possible follow-up actions that may be undertaken;
- (5) stimulate regional activity on conducting similar analytical country case studies to reproduce a picture of state of technical cooperation between Member States, the trends and untapped opportunities; and
- (6) offer particular methodology of the study tested in a number of countries and improved on the basis of accumulated experience.

Methodology:

The information was collected by a combination of documentary analyses, interviews and mail surveys. A focal point was established from each country on the basis of his/her involvement in health manpower development activities, past experience in similar work and the recommendations of the WHO Regional Office for South-East Asia, and each was provided with guidelines on the sets of items to be considered for the study and the possible methods of analysis. (See Annex 1).

Each study included information on all categories of health professionals utilized in the country. It became evident, however, that for the most part, of greater significance and interest was the data collected pertaining to the medical profession. A broad perspective was adopted for the case studies, and therefore a description and analysis of the status and trends of health manpower supply and demand in each country was also included.

Description of the existing situation

The country case studies are summarized individually in relation to each of the main objectives so as to provide a common base for the subsequent discussion and recommendations. A brief reference to the health manpower supply and demand trends

has been included so that the analysis in each case could be viewed in the proper perspective. As mentioned earlier, the description pertains mainly to the medical personnel but, wherever necessary and significant, reference to other health professionals has been made.

SRI LANKA

The first medical school in Sri Lanka, based on the British model, was established in 1870, aiming to train medical personnel for the provision of health care services. This prevailed with minimal changes, even after the country gained independence in 1948. The colonial influence on the educational system of the country continued almost unabated and this was particularly so in the case of medical and other health personnel education. The mechanisms used for recognition and registration of qualifications of health professionals also had strong links with the British system.

In 1984 Sri Lanka had a deficit of over 700 doctors (or 33% of positions available) and, in the case of nurses, there was a shortfall of nearly 5000 (over 50% of positions available). There were deficits in all other categories of health personnel also, to varying degrees. The annual output of doctors seemed to be able to barely replace those leaving service either through retirement or migration. The annual intake to the nursing schools has increased substantially in the past few years, but there does not seem to be any possibility of producing sufficient nurses to fill the available posts within the next ten years. The situation is similar in the case of other categories of health manpower.

In Sri Lanka the Ceylon Medical Council, which is a statutory body set up by the National Legislature, is responsible for decisions pertaining to registration for practice as well as for further study.

a) Recognition for professional practice

Every person, a national or otherwise, who intends to carry out full or limited medical practice in the country, needs to obtain registration by the Ceylon Medical Council which maintains a register of medical practitioners qualified to practice in Sri Lanka. Degrees eligible for full registration in the United Kingdom (General Medical Council) were given automatic recognition. Those holding baccalaureate degrees or equivalent qualifications from a university or medical school of any country other than Ceylon (Sri Lanka) which is recognized by the Medical Council and has passed a special examination prescribed on that behalf by the Medical Council on completion of the stipulated internship, are registered as medical practitioners. However, if the Council is satisfied that the qualification is of a "high standard" and is obtained in a country that recognizes the basic degree of the University of Ceylon (Sri Lanka), it may exempt such persons from the requirement of passing the above special examination. In identifying "equivalent" qualifications for recognition, the Council studies the curricula of the training programmes carefully before a decision is made. In the case of institutions which have not been recognized, the holder of such degree should ask the Dean of the institution to write directly to the Registrar of the Medical Council giving the details of the curriculum so that acceptance to sit the special examination may be obtained.

In addition to the above provisions, if the Director of Health Services or a university or a government department invites any person (national or non-national) who has obtained a medical qualification outside Sri Lanka, to practice for a specific period of time, such persons are allowed "registration" under the Medical Council for that specific period of time on request made by the relevant authority.

Recognition of external qualifications to practice
a "speciality" in the Department of Health Services

The category of "Specialist" refers to those who have obtained a postgraduate degree in a specialized field, either clinical or in basic sciences. The identification of postgraduate qualification to be recognized as a specialist is made by the Ministry of Health on the advice of a "Health Council" established as a legislative enactment in the Health Services Act. In the 1970's the exclusive bias towards British postgraduate degrees had changed, and many such qualifications from other countries were recognized. The major change occurred in 1980, when it was decided that in the field of post-graduate study being conducted by the Postgraduate Institute of Sri Lanka, these qualifications alone would be recognized as "specialist" qualifications. This has reversed the situation that prevailed until then when local postgraduate qualifications received only "partial" recognition.

Recognition for further study

In the case of recognition for further study, until the setting up of the Postgraduate Institute of Medicine in 1979, all medical and dental practitioners had their postgraduate training in foreign countries, mainly in Britain. Since the establishment of the Postgraduate Institute, all persons with medical qualifications who are "registrable" by the Ceylon Medical Council are considered eligible to attend its programmes of study. Those medical officers who need to have clinical attachments and experience as a component of their postgraduate training are "temporarily attached" to the Department of Health Services and provision has been made in the legal enactments for this purpose.

In the case of nursing and other professions, there are no programmes of postgraduate training, and thus the question does not arise.

The changes which took place with regard to the conditions and criteria for recognition of foreign qualifications and experiences in the past five years relate to the establishment of the Postgraduate Institute of Medicine and have been described earlier.

b) UNESCO Convention and mutual recognition

Sri Lanka participated in the UNESCO Convention and, since then, a memorandum prepared by the Ministry of Education on this has been considered by the Cabinet (the Council of Ministers). It is expected that Sri Lanka will be a signatory in the near future. It is still premature therefore to attempt to determine the impact and the benefits or otherwise of participation in this Convention.

A bilateral agreement has been in existence between Sri Lanka and the USSR since 1982 on the "equivalence of degrees, diplomas and other academic distinctions", but this specifically excludes "medical qualification". The reason for this is that the Ceylon Medical Council is responsible for decisions pertaining to the recognition of qualifications of "medically qualified personnel". While Sri Lanka feels in general that such agreements are mutually beneficial as enhancing the mobility of professionals for training, work experience, and research, it is consciously aware that they could also lead to an increased outflow of health professionals essential to the country.

c) Movement of health personnel

The 1960's saw the migration of most Sri Lankan medical officers to the United Kingdom, Australia, and New Zealand, following the automatic registration granted by the General Medical Council. In the 1970's, however, the trend shifted, when the United States opened its doors to medical manpower, with the resultant large exodus of Sri Lankan medical officers to the United States. The pattern of migration has now changed, however, due to the more "protectionist" policies in most of these countries, and many seek employment opportunities in the Middle-Eastern and African countries.

There is no accurate information available on the quantum of migration of Sri Lankan medical officers, but one indication of its proportion is that, inspite of producing over 250 medical officers each year for the past twenty years or so, the number of positions in the Department of Health which are vacant at present exceed that of ten years ago. Though the immigration is mostly out of the country, in the past few years there has been a trend for these medical officers to return to Sri Lanka after variable periods of time. This is particularly true of those who have been in the Middle-Eastern and African countries, most of whom are employed in the private sectors.

The main contribution made by non-nationals with foreign medical qualifications came from the medical officers who were employed under the United Nations Volunteer Scheme by the Department of Health Services for periods up to five years.

Compared to the medical practitioners, the immigration of dentists has been less marked. The main reason for this may be that there was no "reciprocal" recognition facility for this category within the United Kingdom and other countries. In the past few years there has been a movement of dentists to the Middle-East and Africa, but yet the number of dentists available in the country slightly exceeds the number of posts available in the Department of Health Services.

The migration of nurses was not a major problem until recently when the movement of trained nurses to the countries of the Middle-East created a marked loss. The selections of nurses are somewhat on an individual and private basis, as there are no formal mechanisms for the recognition of education and experience for this category of health worker. The pattern in the case of other health professionals such as physiotherapists, radiographers, medical laboratory technicians, and pharmacists is very similar but accurate information on the numbers is not easy to obtain.

NEPAL

Until 1972, the Ministry of Health was responsible for the training of health workers in Nepal. The Institute of Medicine was established in 1972, and since then the academic education of all categories of health personnel is conducted by the Institute of Medicine. There are four levels of courses being conducted at the present time: Extension; Certificate; Bachelors; and Postgraduate. The physician and nurses education are at the Bachelor's level and the only postgraduate programme trains generalist physicians. The Bachelors and Postgraduate level programmes are conducted in English, while the Certificate level uses a "combination" of Nepali and English. At the Certificate level education is in the Nepali language only.

The first batch of medical officers graduated in 1983 and are presently engaged in their internship. None has graduated from the postgraduate generalist programme as yet, while two cohorts of nurses have received their Bachelor's degree in nursing.

Nepal is experiencing a significant shortfall in nearly all categories of health manpower and does not consider itself to be in a position to provide training opportunities for students from other countries. However, a few places in the programme for Certificate in General Medicine will be offered to students from Bhutan commencing in 1986. In a few years' time it will also be possible to offer a few places in the Bachelor of Nursing programmes to other countries of the region.

Nepal does not have any facilities for training in a number of health fields such as dentistry, sanitation, and health education. There are no Bachelors' level programmes for laboratory technicians, pharmacists, and radiographers. The Bachelors programme in medicine will not be able to satisfy the present and anticipated demand for many years to come and postgraduate training in many specialized fields would continue to be required to bridge the wide gap that exists today. Thus, there is a considerable need for education outside the country.

The Government policy on external training is based on the actual requirement of health manpower for Nepal. Scholarships are solicited from different countries on an inter-governmental level, but the Government does not place any restrictions on candidates who obtain admission in foreign institutions on their own. This number, in comparison to the official candidates, is quite considerable and often exceeds the latter.

But with respect to postgraduate training, the Government of Nepal tends to follow a carefully designed closed policy, restricting the numbers to the availability of positions. Nevertheless, rather often enterprising individuals manage to circumvent this restriction.

India is the main recipient of Nepali health manpower for training followed by the UK and the USA. While placement itself is not a major problem due to the inter-governmental agreements, recognition of the Nepali qualifications prior to placement is a major problem as the Certificate level courses are not recognized in most of the co-receiving countries.

a) Recognition of foreign qualifications and experiences

External qualifications must be recognized and their equivalence established before the qualification holders can use the qualifications to gain employment and obtain promotion. The usual criteria for recognition and equivalence are based on:

1. Bilateral or multi-lateral agreements between the countries in the forms of protocol, decree, international council, etc.
2. Academic considerations such as entry requirements, duration of studies, teaching and learning methodologies employed, grading schemes, and the nature of the universities themselves. The candidates or the relevant ministry or agency would submit the documents to the Ministry of Education; the documents would then be scrutinized by the Board of Assessment for Academic Equivalence constituted by the Ministry of Education under the Civil Service Code. This Board is to receive full legal status very soon.

In the case of recognition for further study, this is handled by the Tribhuvan University Equivalence Committee with representation from the University (Rector), Education Ministry, University Service Commission Controller of Examinations, and the Dean concerned, which forwards its recommendations to the Vice-Chancellor for approval.

Most of the Chartered Universities of India, the UK and the USA are already recognized, and their degrees do not require individual attention. This Committee interacts with and is inter-represented by the Board of Assessment for Academic Equivalence.

A bilateral agreement already exists between Nepal and the USSR on the basis of a protocol that has been signed on the Equivalence of Diplomas of Secondary, Secondary Special and Higher Education and Academic Ranks. Nepal is considering the signing of bilateral agreements with some countries of the South-East Asia Region - China, Bangladesh, India, Pakistan, Sri Lanka, and Thailand. This protocol will enable recognition to be granted on a reciprocal basis and will be ratified by the domestic legislatures; it will also enable the creation of a national body to undertake this work and maintain contact with similar bodies in the countries concerned. Credit will probably be given for partial study in these countries and it will enable Nepali students to have easier access to further education in the participating countries. At the same time it will expedite the absorption and utilization of the manpower trained in other countries.

The Board of Assessment for Academic Equivalence and the Equivalence Committee that is empowered to recognize degrees and experience for further study are clearly demarcated. Thus they have complementary roles in recognition and the establishment of equivalence of external qualifications.

b) UNESCO Convention and mutual recognition

Nepal has signed the UNESCO Regional Convention on the Recognition of Studies, Diplomas and Degrees in Higher Education in Asia and the Pacific held in 1983. Government ratification is forthcoming.

As mentioned earlier, Nepal has already signed a (bilateral) protocol with the USSR on the equivalence of Diplomas, Secondary, Secondary Special and Higher Education and Academic Ranks. There were problems initially. For example, the first degree in medicine in USSR was considered a postgraduate degree while such degrees from other countries were considered as baccalaureate degrees only. This discrepancy has since been removed, but there are similar problems with other degrees, that are being reviewed.

As already mentioned, Nepal is moving towards the establishment of bilateral agreements with the countries of the South Asian region. However, Nepal feels that conventions and protocols require periodic review and revisions, as systems and conditions are necessarily dynamic in higher education.

c) Movement of health personnel

There is no definite information about the exact number of Nepali doctors studying abroad for work or training but conservative estimates indicate this to be in excess of a quarter of the total number of doctors in Nepal at present - and this in a country that has a doctor population ratio of 1:30,000. This external movement is not related to any agreements for recognition or their absence, as there has been only one bilateral agreement so far and there has been no difficulty in obtaining recognition of the qualifications Nepali doctors obtained in foreign countries. The first group of doctors produced by the Institute of Medicine in Nepal is presently engaged in their mandatory internship training programme and as their degree is not yet recognized by any other country, there is no prospect of a large-scale outward movement in the immediate future. There are three main ways in which the "brain drain" occurs. Firstly, many doctors sent abroad by the Government for further training, particularly in the Western countries, either do not return at all or overstay their authorized period of leave considerably. Secondly, doctors manage to go out for employment or study on their own with or without sanctioned leave. Thirdly, some of them do not return to Nepal after their undergraduate education, preferring to continue education or undertake employment in other countries. The trend of the movement for employment is now towards the Middle-Eastern countries while previously it was towards the Western countries.

INDIA

Medical education commenced in India in 1835 with the establishment of the first Medical School in Calcutta. At present there are 112 medical schools in the country, of which 105 are recognized by the Medical Council of India. The number of medical graduates qualifying each year has levelled off at around 12,000 since there is no increase either in the number of schools or the number of entrants. There are at present over two hundred thousand registered doctors in the country and nearly twenty thousand, both graduates and postgraduates, were on the live Employment Exchange Register in the different States in 1983. Postgraduate studies are available in almost all major branches of medicine and range in duration from three to five years. India has a professed objective of achieving self-sufficiency in the training of all health professionals and has been remarkably successful in coming very near to

its achievement. Dental education follows the same pattern as medical education in all the main respects but in the case of dental surgeons there is an expressed deficit in the numbers required for the services. The Dental Council of India is deeply concerned about this situation that has resulted mainly from the emigration of dental personnel over the past two decades. India expresses the confidence that it will be able to provide training opportunities for medical and nursing personnel from the region in the fields of undergraduate training, postgraduate training up to Master's degree level in most disciplines and content areas, including pre- and post-clinical areas. It is also felt that medical personnel from India would benefit from training in Community Medicine and Primary Health Care if exchange programmes could be organized in the countries of the region such as Thailand, Indonesia, and Sri Lanka. Most of the Schools of Nursing are attached to hospitals and the educational programme is directed and organized for hospital-based services. College-level nursing programmes have been available since 1946; post-graduate nursing education has just commenced in some of the university-affiliated colleges. A study of the breakdown of the number of candidates qualified in different courses, both male and female, over the past ten years shows a steady increase in all categories of personnel except in general nursing for males.

a) Recognition of degrees and qualifications for practice and study

The Medical Council of India, a statutory body created in 1956 by an Act of Parliament, maintains the schedules of the recognized qualifications. Further, it is charged with:

1. Recognition of medical qualifications granted by other universities or medical institutions in India.
2. Recognition of medical qualifications granted by medical institutes in countries in which there is no scheme of reciprocity.

However, a careful study of the Act indicates that all requests for recognition are to be addressed to the Central Government of India which initiates consultation with the Indian Medical Council and acts upon the recommendation submitted by this Statutory Body. Generally, qualifications are recognized on the basis of their being adequate for recognition for practice. There has been no change in this policy over the past five years.

There is no clear distinction between the criteria, the mechanisms, or the responsible organization for the recognition of qualifications and experience for the purpose of further study or practice. The Indian Medical Council is the statutory body that is empowered for these purposes and makes its recommendation to the Central Government. Government policy provides the opportunity for practice within India for non-nationals provided the qualifications are recognizable but there has been little demand for such opportunity. There is no definite government policy which determines the advantages and disadvantages of mutual recognition of degrees; the national policy document is silent on this issue.

The Government has an open attitude towards the movement of nationals out of the country for study, with the exception that foreign exchange is released only for certain specialized areas. No indication has been made of any conflict of views about international training and experience for health professionals and their relevance to meet local needs. However, there is no policy document on this matter.

Data with respect to nationals and non-nationals in difficult health professions entering and/or leaving the country for either further study or over the past five years is not yet available.

Postgraduate study is available in almost all major branches of medicine and is open to all medical graduates after the completion of their internship. With the large pool of trained manpower and training institutions, India could perhaps play a significant role in training health personnel from the countries of the region. For this, the mutual recognition of degrees would be a pre-requisite. Although provisions for reciprocal arrangements exist in the Acts of all the Regulating Councils these have been under-utilized due, probably, to the fact that there has been very little expressed demand either from the countries of the region or from the citizens of India itself. In setting up a scheme for mutual recognition of qualifications and experience the role of the Councils is undeniable, but it would be imperative to obtain the final approval of the Central Government.

b) The UNESCO Convention

India is a signatory to the UNESCO Convention, and since then a cell has been initiated within the Ministry of Education to plan and execute action. To date there has been little or no impact of the Convention in the health sector. At present there is no bilateral or multi-lateral protocol or agreement for mutual recognition of qualifications or experiences. It appears that mutual recognition of professional qualifications between India and other countries is of minimal importance to those concerned with decision-making at the Government level and the level of regulating bodies, and so far there is no proposal or initiative coming from either of them in this regard. At the same time, there is a large number of universities whose views about mutual recognition of professional qualifications need to be ascertained; it is probable that they would favour some such mechanisms. Therefore, future policy action and administrative measures in India are unclear at this stage and require further clarifications. The process of dissemination of information on the acceptance of the Convention in India has not yet gathered momentum; the pace therefore may not fulfill the aspirations expressed in the document.

c) Movement in and out of the country

India adopts an open policy with regard to movement of nationals out of the country. The large number of medical graduates being produced may have been able to prevent a serious impact stemming from the loss due to brain-drain. The Dental Council alone felt that it was the functions of the Government to counteract this. The fact that there is a surplus of medical officers in relation to the positions available in most States may be considered as an indication that no specific restrictions are requested nor required in the case of the medical sector. The same applies to the nursing sector, and there has been an increasing exodus of qualified nurses, particularly to the countries of the Middle-East.

As regards the movement of foreign nationals into the country, the policy is open. However, foreign nationals would be required to possess qualifications which are recognized for practice. But in actual fact, very few foreign nationals do apply for the right to practice in India, owing to the economic realities involved in such action. There is no governmental or non-governmental organization that maintain reliable information regarding nationals and non-nationals in different health professions coming into and leaving the country over the past five-year period.

INDONESIA

As in most of the countries of the Region, the responsibility of producing health manpower in Indonesia is shared by the Ministry of Education and Culture and the Ministry of Health. Medical, Dental, Planning, and Public Health higher education are conducted by the University System under the Ministry of Education, while nursing and the other paramedical education and training programmes are under the Ministry of Health.

There are approximately 13,000 medical personnel in Indonesia in the Government and private sectors and the output from the twenty-five medical schools (fourteen Government and eleven private) is around 1,500 each year. The medium of instruction is the Schools of Health Personnel, including the medical faculties in Bahasa Indonesia. The medical curriculum is 6-7 years, but the consortium of Health Sciences, which is the body responsible for coordinating and controlling the quality of higher education in the health sciences, has been able to develop a core curriculum for the country and gain the acceptance of all the Schools. This is in its third year of operation and should bring the educational aims, the competencies of the graduates, and the assessment and evaluation procedures, into a uniform pattern in all the medical schools in the country.

The Dental Schools have also adopted a core curriculum and this is in a stage very similar to the medical curriculum.

The postgraduate training of medical graduates in most of the specialties of medicine is also conducted by the Ministry of Education within the University System. According to the projections of manpower requirements and supply, Indonesia appears to be successfully geared to meeting the needs of the country for the remainder of this century. New postgraduate programmes are being opened in response to the newer demands that seem to be emerging, and the system is flexible enough to make on-going adjustments in the numbers and the quality of the training. Physicians are sent overseas for orientation and training in very selected areas of study, particularly for the purpose of upgrading the quality of the teachers.

Postgraduate training programmes in dentistry are just being opened and should be fully operational in the next year or two.

Indonesian doctors, both graduate and postgraduate, receive medical education in foreign countries and often apply to return to Indonesia for professional practice. There were about fifty such applications between 1980-1985 from graduates and nearly the same number from specialists. One of the problems noted in the earlier stages was that the nature of training in some of the countries was dissimilar to the Indonesian system. For example, in the European countries the academic aspects of training seem to predominate, while the practical, service-based training component is much less than in the Indonesian programmes. This prompted the Government of Indonesia to devise a scheme of adjustment and orientation for these doctors before they were considered equivalent to the doctors trained in the country. This is a requirement for the recognition of their training and is described later.

In the nursing and the paramedical sectors the issue of recognition of foreign qualifications does not seem to be of major relevance as very few paramedical personnel receive graduate level education in foreign countries and would wish to return to Indonesia for their professional practice. At the present time there are no degree level programmes in any of the paramedical disciplines except in public health, which offers a post-basic degree. A faculty of nursing is due to open in the near future and it is planned that some of the other disciplines will follow in the years to come.

a) Recognition of foreign degrees and qualifications

The policy and practice adopted by the Ministry of Education and Culture has provided for a mandatory adjustment period for medical personnel returning to the country with foreign qualifications. This provision exists for both graduates as

well as postgraduates. For graduate physicians the mandatory period of adjustment is one year and is organized by the medical schools. The objectives are to ensure that these physicians are -

- aware of the health system and the health services in Indonesia;
- familiar with the socio-cultural milieu in which they will practice;
- able to handle the spectrum of diseases prevalent in the country; and
- introduced to the practice of community health.

The appointments and learning experiences are arranged in rotation and the individual medical school is expected to recommend that the candidates are suitable for registration for practice and/or further study. However, further study in Indonesia is usually available after a minimum period of professional practice in a health centre, ranging from two to five years, or teaching in a medical school.

The recognition of the diploma or degree is the responsibility of the Commission for Recognition of Foreign Diplomas.

In the case of "specialists" with foreign postgraduate degrees and diplomas, the period of adjustment is six months and the objectives of this mandatory requirement are similar to those mentioned earlier. However, emphasis is more on the patterns of disease and the management systems being practiced in the country.

Those with foreign dental qualifications also have to undergo a year's period of adjustment similar to the above before they are allowed to undertake independent practice.

With respect to foreign nationals, either with base or postgraduate degrees or diplomas, there are no specific requirements for recognition. The permission for practice or further study is granted by the Education Commission on the recommendations of the Consortium of Medical Sciences and, where relevant, the Faculty of Medicine. For those with basic degrees or diplomas alone, a period of internship is usually necessary before such recommendation is made.

b) UNESCO Convention

Indonesia is a signatory to the UNESCO Convention held in 1983. Action has been initiated in implementing some of the agreements made through this Convention in some of the non-health sciences, particularly at the undergraduate level. No specific action have been initiated in the health personnel sector so far but this is being studied by the concerned authority. The need for such examination is becoming clear at this moment as Indonesia is planning to obtain post-basic education for a large number of paramedical health personnel in the next decade. The projected increases in health manpower which are being attempted would require the development of teachers on a massive scale, and it is likely that the UNESCO Convention will facilitate the implementation of some of these programmes for training teachers outside the country. Bilateral mechanisms will also be brought into play for specific issues, but the UNESCO Convention could serve as a broad umbrella for such negotiations. However, this issue requires further clarification and exploration in Indonesia.

c) Movement of health personnel in and out of the country

Indonesia is one of the countries of the Region that has been spared the negative effects of a massive exodus of health personnel in the recent past. Many factors have contributed to this being the Indonesian experience - the absence of a close historical link with any established system of medical education that opened the gates to Indonesian graduates in other countries; the medium of instruction; the relatively high standard of living available to an Indonesian doctor or dentist after

an initial period of training and experience; and the socio-cultural influences that negate migration in general - have all contributed to this state of affairs. It is possible that in the years to come this may emerge as a more serious issue as socio-economic conditions and the opportunities for career advancement undergo change.

There are very few foreign nationals who apply to live and practice medicine in Indonesia and therefore recognition of their degrees and qualifications has not created any serious problems. Whenever such applications are made they are taken up on an individual case-by-case basis and preference is given to those intending to undertake further study. Professional practice by foreign nationals is generally not encouraged.

RECOMMENDATIONS

The analysis of the situation, the needs and issues in the countries that were studied, enables the establishment of certain premises which could be used for considering further action regarding the main concerns.

1. Undergraduate and postgraduate education and training, particularly the latter, should be the primary focus in pursuing the question of recognition of foreign medical qualifications by different countries, to serve as a means of exchange of experiences, promote the development and transfer of technology between countries, and boost self-reliance.
2. Mobility of health personnel should be supported and encouraged in the context and with the ultimate aim of assisting the achievement of national and collective regional self-reliance in health manpower and greater regional integration.
3. The movement of health personnel, students, teachers, and researchers should promote access to, and facilitate the optimal utilization of, the available education and training facilities, human resources and technical competence at national, regional and international levels.
4. It would not be possible for countries to address themselves to all movements of health personnel for training or for practice. Rather, their main concern should be to ensure and promote such technology transfer within, and in conformity with, a planned and organized system that is desired by them.

The following general and specific recommendations are therefore made in the above context. The similarities revealed by these case studies in the fact that most of the other countries of the Region possess similar historical, socio-cultural and economic characteristics lead to the belief that these recommendations would apply equally validly for most of these other countries also.

Conventions

The UNESCO Convention for Asia and the Pacific adopted in late 1983 is now being taken up for country-level follow-up action in the countries under study. The "universalistic" nature of this Convention (and similar conventions) might lead one to imagine that this generality itself would hinder such conventions being practical as speedy mechanisms. However, viewed in the proper perspective as a starting point and a framework for achieving the aims and objectives for which it was created in the first place, there is room for much hope of its utility. For this potential to be realized certain follow-up actions seem warranted from UNESCO, WHO, and the countries themselves to identify ways and means of assimilating these recommendations.

1. Review and utilize the experiences and positive results gained by countries in other regions which have previously adopted similar conventions and devise appropriate strategies for operation of the Asia and Pacific Convention.
2. Within the broad framework of the Convention, identify the specific areas and issues that call for priority attention and design plans of action for them.
3. Develop any bilateral agreements necessary on the basis of the guidelines of the UNESCO Convention so that a degree of uniformity could be ensured in the mechanisms and regulations for the recognition of foreign qualifications and degrees for facilitating greater mobility of personnel.
4. The application of the Convention should be more specifically aimed at fostering collaboration and mutual support among those countries with similar socio-cultural and educational characteristics.
5. A focal point should be established to coordinate the work required in implementing the Convention in the regions that are involved.

Possible roles for WHO and UNESCO

It bears reiteration that in general the collaborative efforts of WHO (and UNESCO) should be to encourage and facilitate international, particularly regional, mobility for human resource development to achieve national and regional self-reliance in health manpower.

1. One of the possibilities that emerge from the expressed needs of the countries is the desirability of WHO serving as a clearing house to collect and disseminate information speedily on the possibilities and mechanisms for the mutual acceptance of degrees and similar qualifications of health personnel by Member States. This should also include appraisals of the health manpower and relevant health laws of the countries and the development of an up-to-date reference library. This could very productively be undertaken on a regional level as a joint WHO/UNESCO endeavour and would conform with the WHO objectives of technical support to, and collaboration with, Member States.
2. It conforms to the objectives of WHO and Member States collaboration for WHO to coordinate education and training, and training capacity, particularly at the postgraduate level, on a regional basis. This would require the development of an inventory of advanced training possibilities that are presently available in the region, establishing priorities for the filling-up of the existing gaps and identification of regional training programmes/institutions of excellence and the phased creation and/or strengthening of institutions/courses capable of carrying out required training as appropriate. Regional plans could be developed on the basis of this type of information.
3. Case studies similar to the ones already conducted could be developed in other selected countries, both in South-East Asia as well as in other regions so that commonalities and issues could be further clarified. This information will facilitate the formulation of long-term regional and inter-regional plans. As an initial step in this endeavour, overviews covering all the country situations in each WHO Region should be recommended.

General

1. Countries would benefit from a clearer identification of the positive aspects of the movement of health personnel from one country to another and by the strengthening and streamlining of the existing procedures and the development of new mechanisms, when necessary, in order to devise the maximal benefit from such mobility.
2. Training capacities should be developed and utilized primarily on a national and regional basis as a coordinated system; the efforts of developing and developed countries together with international organizations should be synthesized toward the achievement of this goal.
3. Training in developed countries should be limited to specific purposes and to orientation to newer technologies; it should ideally follow initial training in the country itself or in the region.
4. Existing protocols and agreements for the recognition of degrees and qualifications should be reviewed periodically in order to revise and update them to suit national requirements.
5. There should be periodic meetings and regular contacts between the countries of the region to achieve the goal of training systems development and to resolve any issues that might emerge in the application of mechanisms for mutual recognition of degrees and qualifications.
6. The countries of the region should explore further the possibility of interchange of students from the courses of a similar nature among different countries.

ANNEX I

METHODOLOGY

The case study is to include all categories of health professionals utilized in the country.

The sources of information should include:

- legal documents
- descriptions of operations, mechanisms
- records of decisions taken
- interviews with organizations responsible for granting recognition
- interviews with professional and other relevant organizations.

The process of collection of information should consist of:

- documentary analyses
- mail survey
- site visits
- preliminary analyses.

The information to be collected and analyzed should cover at least the set of items as listed below. Moreover, if in the execution of the study it would prove valuable to add some other information which will make the study more comprehensive or illustrative, it would be welcomed.

RECOMMENDED SET OF ITEMS OF INFORMATION TO BE COLLECTED

1. The output of doctors and other categories of health professionals in the country over the last decade.
2. Regulations in effect for the recognition of the external qualifications and experiences of health professionals entering the country for purposes of study and/or full or limited practice. Are these regulations the same for nationals and non-nationals? If not, the difference needs to be described.
3. The organizations responsible for carrying out these regulations (2 above) and their method of functioning.
4. To expand and explain the chief difficulties encountered by responsible authorities and institutions in evaluating foreign qualifications and experiences.
5. The primary ways in which information on higher education in the health professions in other countries is collected and disseminated in the country.
6. The primary ways in which information on higher education in the health professions in the country, and access to it, is communicated to concerned authorities and persons in other countries.

7. Is the government already a signatory, or taking part in discussions directed toward that end, of a UNESCO-supported Convention on the recognition of studies, diplomas and degrees in higher education? Has joining this Convention had any effects as yet in the health area? If so, it needs to be described.
8. Country participation in any other bilateral or multilateral agreements concerned with the mutual recognition of the qualifications and/or experiences of health professionals: indicate the initial impetus for the creation of these agreements.
9. The major issues, positive aspects, and problems arising out of these agreements (7 and 8 above): Have any policy measures been taken by the Government in response to the perceived positive and negative aspects of the agreements?
10. Is the 'medical brain drain' considered to be an issue/problem by the Government? If so, does the question arise in connection with these agreements? (7 and 8 above).
11. Does the Government consider there is a national need for external training and/or experience for the country's health professionals (doctors, dentists, pharmacists, nurses, others)? If there is a need, in which professions and specialities?
12. Does the Government consider there is any potential conflict between international training and experience for national health professionals and the relevance to national needs of that training?
13. Does the Government tend to follow a generally 'open' or 'closed' policy with regard to the movement of nationals to other countries for basic medical (or other health professional) training, postgraduate training, or the practice of medicine (or dentistry etc.)? Does the Government tend to follow a generally 'open' or 'closed' policy with regard to the movement of foreigners to the country for basic medical (or other health professional) training, postgraduate training, or the practice of medicine (or dentistry etc.)?
14. Are there any recent major changes in the last five years in these overall policies (13 above) or are there any now which are under consideration: what has been the direction of those changes and why have they occurred.
15. Government consideration in respect of the major advantages and disadvantages of mutual recognition between this country and others of the qualifications and experiences of health professionals for purposes of study and/or practice: Is mutual recognition likely to be more or less advantageous/disadvantageous if between differing groups of countries and if applied to different types of qualifications and experiences? If so, which types of country groupings and which types of qualifications and experiences would be most desirable?
16. Lessons for future policy actions and administrative measures in the country which have emerged in regard to international recognition of health professionals' qualifications and experiences.
17. Any proposals put forward by the Government for international action or study, possibly through the auspices of WHO, on the issues under discussion in this inquiry.
18. Indicate the number of nationals and non-nationals coming into and leaving the country during the past five years for purposes of training and/or practice in the various health professions. If possible, the major directions (countries) of these movements, need to be indicated.
20. Any available data, laws, regulations, publications or other materials likely to be relevant to this inquiry should be attached.

The study must be written in a precise and detailed form - over 10-15 pages.