WHO BENCHMARKS FOR
THE PRACTICE
OF UNANI MEDICINE
WHO benchmarks for the practice of Unani medicine

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Design by Inis Communication
The World Health Organization (WHO) is currently implementing its 13th General Programme of Work (GPW13) to support countries in reaching all health-related Sustainable Development Goals (SDGs). GPW13 is structured around three interconnected strategic priorities: achieving universal health coverage; addressing health emergencies; and promoting healthier populations. These strategic priorities are supported by three strategic shifts: stepping up leadership; driving public health impacts in every country; and focusing global public goods on impact.

Traditional medicine has always had a role in this collective endeavour. The Declaration of Astana, renewed from the Declaration of Alma-Ata towards universal health coverage and the SDGs, reaffirms the role of traditional medicine in strengthening primary health care, a cornerstone of health systems, in pursuit of health for all. This has also been reflected in the WHO global report on traditional and complementary medicine 2019, in which 88% of WHO Member States acknowledge the use of traditional and complementary medicine in health care.

Taking note of the growing importance of traditional medicine in the provision of health care nationally and globally, WHO and its Member States have strived to explore ways to integrate, as appropriate, safe and evidence-based traditional and complementary medicine services within national or subnational health systems, as committed to in the Political Declaration of the High-level Meeting on Universal Health Coverage.

WHO aims to provide policy and technical guidance to Member States; promote the safe and effective use of traditional and complementary medicine through appropriate regulation of products, practices and practitioners; and support Member States in harnessing the contribution of traditional and complementary medicine to people-centred health care in implementing the WHO Traditional Medicine Strategy 2014–2023.

Setting norms and standards is a unique function of WHO. The normative work is driven by needs and could be translated into real impact in relevant countries through appropriate policy options. This series of benchmarks, covering various systems and interventions of traditional, complementary and integrative medicine, aims to provide a reference point to which actual practice and practitioners can be evaluated.

I am very pleased to introduce this series to policy-makers, health workers and the general public, and I firmly believe it will serve its purpose.

Zsuzsanna Jakab
Deputy Director-General
World Health Organization
Preface

Integrated health services are essential for the World Health Organization (WHO) in the implementation of its 13th General Programme of Work, which aims to support countries in achieving universal health coverage and the health-related Sustainable Development Goals. The overarching mission for the Department of Integrated Health Services is to accelerate equitable access to good-quality health services that are integrated and people-centred, and that can be monitored and evaluated.

WHO is unique in its mandate to provide independent normative guidance. Its normative products encompass a wide range of global public health goods, including norms and standards. It is therefore the primary role of the Department of Integrated Health Services to generate and produce relevant global goods. Key to improving its work in this area is ensuring global public health goods are driven by country needs and can deliver tangible impacts at the country level.

As of 2018, when 88% of WHO Member States acknowledged the use of traditional and complementary medicine, WHO’s support in evaluating the safety, quality and effectiveness of traditional and complementary medicine has continuously ranked in the top areas of need, according to the WHO global report on traditional and complementary medicine 2019.

WHO prioritizes normative products based on an assessment of demands. To address increasing needs and to drive impact in countries, this series of benchmarks captures the main systems and interventions of traditional, complementary and integrative medicine by setting up required norms and standards on training and practice.

These benchmarks documents have been prepared following existing WHO methodology and processes. They consider consumer protection and patient safety as core to professional practice and reflect the consensus of what the community of practitioners of traditional medicine disciplines considers to be reasonable practice in the respective discipline. They provide a reference point to which the practice and practitioners of traditional medicine can be compared and evaluated. These documents will support countries to establish appropriate legal and regulatory frameworks for the practice of traditional medicine. WHO will not only assess the quality of these normative products but also streamline systems and plans for monitoring and evaluation.

I am pleased to present this series of benchmarks and invite you to join us in measuring and documenting their impact.

Rudi Eggers
Director
Department of Integrated Health Services
World Health Organization
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Glossary

ābzan  sitz bath
a’dá’ ra’isavital organs
af‘āl functions
akhlāt fāsida morbid humours
alam pain
‘amal-i-kayy cauterization
amrād-i-tafarruq-i-ittiṣāl diseases of breach of continuity
arkān elements
arwāḥ pneuma/subtle substances
asbāb sitta ḍarūriyya six essential factors
awrām inflammation
barāz stool
bawl urine
dalk massage therapy
fasd venesection
ḥammām Turkish bath
ḥifz mā taqaddum prevention
ḥijāma cupping therapy
ḥijāma bilā šarṭ dry cupping
ḥijāma bi’l šarṭ wet cupping
ḥuqna enema
ḥuqna-i-mughadhī nutritive enema
ḥuqna-i-muḥallila anti-inflammatory enema
ḥuqna-i-mushila purgative enema
ḥuqna qābiḍa astringent enema
idrār diuresis
‘ilāj bi’l ḍidd antagonistic therapy/hetero-therapy
‘ilāj bi’l tadābir regimenal therapy
īlām pain induction
imtilā plethora, congestion or fullness of the body with proper or improper humours or fluids
imtila-i-maqāmī local congestion
istirkhā flaccidity
istikā’ lahmī oedema
izāla-i-sabab removal of aetiology
kayfiyat  | condition, quality
maǎmda | mouthwashing or rinsing
mâlikiyya | melancholia
mantiq | logic
mawâlîd-i-thalâtha | three origins, resources or kingdoms of nature (herbs, animals, minerals)
medicatrix naturae | power endowed by nature to every individual for self-preservation and to regulate normal functions; administrator, protector and healer of the body
mizzâ | temperament
mujarrbât | empirical findings
mukhaddirât | anaesthetic
muqawwiyât | tonic
mutâ‘affin | with pus
mutâ‘affin qurûh-i-muzmina | infected chronic ulcer
nabd | pulse
naft al-dam | haemoptysis
nudj wa ishâl | concoction and purgation
nutül | irrigation or wet fomentation
pâshoya | footbath
qay | vomiting
quvâ | faculties
quwwat-i-ḥaywâniyya | vital faculty
quwwat-i-nafsâniyya | psychic faculty
quwwat-i-tabî‘iyya | physical faculty
quwwat-i-tanâsuliyya | reproductive faculty
rûḥ-i-nasîm | light gaseous substance in organs and fluids of the body that performs various important functions; obtained from the interaction of inspired air with pneuma
sû‘-i-mizzâ middi | derangement of temperament due to any matter or humour
sû‘-i-mizzâ sâda | simple derangement of temperament
tabiyat | healing power of nature
tadhîn | oiling
ta‘dîl-i-mizzâ | moderating and balancing the temperament	
tarahhul | laxity of the body
ta‘riq | sweating
tashannuj | spasm
Introduction

Why this benchmark?

In 2010 the World Health Organization (WHO) published *Benchmarks for training in Unani medicine*. This presented what professional experts and health regulators considered to be appropriate training programmes for Unani medicine practitioners.

A standardized protocol for Unani medicine, against which its actual practice can be compared and evaluated, has been lacking. With the increasing use of Unani medicine in clinical settings worldwide, there is an urgent need to develop benchmarks for the practice of Unani medicine to ensure its safety, quality and effectiveness.

Aligned to its objectives, this document serves as a reference to national authorities to establish or strengthen regulatory standards to ensure qualified practice of Unani medicine and to assure patient safety. It describes models of practice and the practice profile of providers, and provides consensus to practitioners, professional organizations, regulators, health system managers and patients on how the services should be organized.

This document will join WHO benchmarks for the training of Unani medicine to form an integral part of the serial benchmarks, targeting key modalities of traditional medicine intervention and contributing to the establishment of a reference toolkit for countries.

How was this benchmark prepared?

This document followed the established methodology of WHO to develop benchmarks in traditional, complementary and integrative medicine. A desk review of available information on formal licensure and established national standards and guidelines to assure good-quality health-care delivery of Unani medicine was undertaken.

Data from 26 Member States, including the 8 that regulate Unani practitioners, were reviewed. Information from Argentina, Australia, Bahrain, Bangladesh, Brazil, Colombia, Cuba, Germany, Hungary, India, Italy, Malaysia, Mauritius, Nepal, Netherlands, Oman, Pakistan, Qatar, Serbia, Singapore, South Africa, Sri Lanka, Switzerland, the United Arab Emirates, the United Kingdom of Great Britain and Northern Ireland and the United States of America were examined. The information was collected from relevant websites of ministries of the respective Member States, and from direct communication with officials and experts associated with these Member States. We examined the relevant information on existing benchmarks, legislation, national standards and guidelines available in these countries.

From the information we reviewed, we could not find evidence of an existing benchmark covering the objectives holistically. We found considerable diversity of the practice, its prevalence and acceptance among the Member States. It became clear that the WHO benchmarks document should take into account this diversity and suggest regulations for practice, products and training, keeping in mind the different levels of social acceptance, community awareness and uptake, and availability of resources for practice across the Member States.

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We further scoped the Google Scholar, PubMed and AYUSH research portals to identify information on existing publications for Unani medicine that would substantiate and support the development of the Unani medicine benchmark documents. Using a combination of “safety”, “quality” and “trial” along with “Unani” presented more than 71 300 references. Owing to the broad nature of the enquiry, we further refined the search into two categories.

One category identified the publications related to “benchmarks”, “regulations”, “quality”, “practice” and “training”. Filtering out duplicates and those not specifically relevant to Unani practice or training provided information on 469 publications. After studying the abstracts, we narrowed this down to 122 publications to be read in detail. Of these, 34 publications highlighted the need for a practice benchmark document for Unani medicine practice, and 53 a benchmark document for the training of Unani medicine. A total of 57 and 86 publications, respectively, provided insights into the content requirements of practice and training benchmark documents. Fifty-five publications identified regulatory gaps and requirements, and 64 provided inputs on quality requirements of Unani medicine practice or training.

The second category refined the information for “Unani and safety” and identified 2093 publications after exclusion of duplicates. The data were further cleaned using a combination of “medicine”, “drug” or “trial” as additional filters. This provided information on 809 publications. Another filtration added the terms “randomise/ze” or “safety” in the title or abstract of the publications. In this category, we identified and examined in detail 191 publications that were most relevant to the practice and training benchmarks of Unani medicine.

The first draft of the document was prepared based on the information gathered and directions identified through the desk review. As the basis for its development, the draft document used the existing regulatory frameworks in Member States; standard practices and processes adopted in Member States to guarantee safe, good-quality practice of traditional medicine; traditional textbooks of Unani; and relevant information from WHO and other publications.

The first draft was reviewed and revised by the Working Group meeting in September 2018. The 39 experts (from 19 countries across the 6 WHO regions) of the working group reviewed the document for appropriateness in terms of its WHO-mandated objectives and its veracity with respect to the evidence considered. The experts also brought in new perspectives based on the current practice of the system in different Member States and evidence from publications. The second draft, which evolved through the discussions in the working group, was sent for extensive international peer review.

A total of 47 experts from 14 countries covering all 6 WHO regions contributed to the peer review. They represented the range of expertise deemed essential in the development of the benchmarks and provided more than 1207 concrete suggestions encompassing every aspect of the document, from overall structural arrangement to specialized technical issues. The peer review provided perspectives from Australia, Bangladesh, the Islamic Republic of Iran, Italy, Malaysia, Mauritius, Nepal, the Netherlands, New Zealand, Oman, Serbia, Singapore, South Africa, Sri Lanka, Switzerland, the United Arab Emirates and the United States of America based on respective national regulations and existing protocols. This valuable feedback supported the evolution of the second draft to the third draft, which was then readied for further review at the expert consultation meeting.

The expert consultation meeting conducted in November 2019 aimed to conclude the consulting process by inviting selected experts to finalize the document. A total of 49 experts from 22 countries across the 6 WHO regions joined the consultation and contributed to the development of the fourth draft. The resultant fourth draft became the last technical version of the benchmark before formatting and printing.
What does this benchmark cover?

This document is structured in five parts:

- Background: gives a briefing on the background and objectives of the document.
- Requirements for practice in Unani medicine: provides relevant requirements and considerations on practice of Unani medicine.
- Procedures of regimenal therapies: presents relevant requirements and considerations on the procedures.
- Safety in Unani medicine practice: emphasizes the key elements for the safe practice of Unani medicine.
- Health information management systems: describes guidance on management of the information system.

These five parts constitute a complete set of benchmarks for the practice of Unani medicine.

Who is this benchmark for?

By setting norms and standards, this document helps to address the gap between the increased demands and the uncertified delivery of Unani medicine services. It offers a useful reference point to evaluate Unani medicine service providers, which will benefit policy-makers, health workers, education providers and the public in general.

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Unani medicine uses clinical observations to maintain health and prevent and treat diseases safely, effectively and economically. It is strongly founded on its philosophical principles and long history of use. Hippocrates (460–377 BCE), the father of Unani medicine, put forward the concept of the four humours (akhlāṭ) in the human body – blood (dam), phlegm (balgham), yellow bile (ṣafrā’) and black bile (sawdā’). As long as these humours remain in perfect equilibrium in terms of quality and quantity, the body remains in health; in the absence of equilibrium, disease sets in (1).

Unani medicine provides dietary, lifestyle and pharmacological interventions to maintain health and prevent diseases. It treats diseases by modifying external and internal essential and non-essential factors (asbāb sitta ḏarrūriyya wa ghayr ḏarrūriyya) with various modes of diet therapy (‘ilāj bi’l ghidhā’), regimenal therapy (‘ilāj bi’l tadābir), pharmacotherapy (‘ilāj bi’l dawā’) and surgery (‘iāj bi’l yad) (2).

Unani medicine is practised widely in South and South-East Asia, the Middle East, some African countries and many other parts of the world. It is also known as Graeco-Arab medicine and Unani Tibb (1).

1.1 Historical background

Unani medicine amalgamated the knowledge of contemporary systems of traditional medicine from Egypt, India, Iraq, the Islamic Republic of Iran, Syria and other Asian countries. It originated in Greece in the fifth century BCE and then developed and flourished in the Islamic civilization (1).

Many authoritative texts on Unani medicine emerged from Central Asia, Egypt, India, Iraq, the Islamic Republic of Iran and Spain from the eighth to the twentieth centuries. In addition to the system’s standard texts, there are thousands of books describing empirical findings (mujarrbāt). Among these, Al-qānūn fi’l ṭibb (Canon of medicine, by Ibn-e-Sina (Avicenna)) remains the most comprehensive and rationally systematized standard text providing the basis for Unani practice. Unani medicine practitioners continue to learn Arabic, Persian, Urdu and other languages to maintain a lively rapport with these texts (1).

Education and training in Unani medicine are institutionalized and regulated by various government agencies. In 2010 the World Health Organization (WHO) published Benchmarks for training in Unani medicine to provide a uniform framework for Member States, while framing policies on training in Unani medicine (3). It is logical and essential to also provide benchmarks for establishing safe, effective and appropriate use of Unani medicine globally.

1.2 Purpose of this document

This document encompasses the broad frameworks regarding qualifications, knowledge, skills, competence, infrastructure, regulatory requirements and general safety requirements for Unani medicine practice. The document presents a set of generalized parameters and suggestions to maintain and streamline safety, efficacy and quality in health-care delivery and to create similarities in Unani medicine practice globally. These suggestions may be used as a reference by regulatory agencies while formulating regulations in their countries.

The document covers the following:

- minimum requirements for practice of Unani medicine:
• qualification of practitioners for basic- and advanced-level practice – see Section 2.1;
• general infrastructure requirements and processes to be followed in basic- and advanced-level practice – see Sections 2.2–2.4;
• safety requirements for practice of Unani medicine – see Section 4;
• reference for practitioners, regulatory bodies and authorities.

The document may support the regulation of safe, good-quality practice of Unani medicine, and help to streamline and formulate regulations on educational qualifications, knowledge of physicians, and accreditation of Unani clinics and hospitals.

Essential supporting details are included in the annexes.

Some general considerations for practitioners, regulatory bodies and authorities are given in WHO benchmarks for the training of Unani medicine (4).

1.3 Scope of Unani medicine practice

1.3.1 Areas and domains of practice

• preservation and promotion of health;
• prevention of diseases;
• treatment of diseases and management of systemic imbalances;
• improvement in quality of life.

1.3.2 Levels of practice

There are two levels of practice in Unani medicine – basic and advanced.

Basic-level practice may comprise the following:

• consultation only – requires minimal infrastructure;
• consultation with pharmacy services – requires infrastructure to provide consultations and pharmacy services; the practitioner may have their own dispensing unit with medicines provided by Unani pharmaceutical companies, or they may have their own dispensing unit and medicine manufacturing facility, according to the Member State’s regulatory provisions;
• consultation with basic-level facilities for regimenal therapy (‘ilaj bi’l tadābir);
• consultation with basic-level facilities for regimenal therapy (‘ilaj bi’l tadābir) and surgery (‘iāj bi’l yad).

For advanced-level practice, the following additional facilities should be available:

• diagnostic facilities or arrangements for all necessary and relevant laboratory investigations;
• facilities to admit patients for diagnosis, treatment, monitoring and other Unani medicine interventions and care.
In this document, Unani medicine practice is defined as the work undertaken by a Unani medicine practitioner that relates to the care of individual patients, including assessing health conditions, diagnosing diseases, giving advice, and treating patients using knowledge, skills and competence based on Unani medicine at a clinic or hospital.

A Unani medicine practitioner is defined as an individual who practises as a health-care provider, possesses essential Unani medicine qualifications, and is registered or licensed as a Unani medicine practitioner or health professional.

2.1 Qualification and training of Unani medicine practitioners and other human resources

2.1.1 Qualification and training of Unani medicine practitioners

The minimum requirement to practise as a Unani medicine practitioner at the basic level is a qualification acquired through type I (basic-level) or type II (advanced-level) training programmes for Unani medicine practitioners, as described in WHO benchmarks for the training of Unani medicine (4), or another equivalent qualification recognized by the Member State. The practitioner must be registered as a Unani medicine practitioner with the relevant appropriate regulatory bodies of the Member State.

The minimum requirement to practise as a specialist or super-specialist Unani medicine practitioner at the advanced level is a qualification acquired through type III (specialty) or type IV (super-specialty) training programmes, as described in WHO benchmarks for the training of Unani medicine (4), or another equivalent qualification in the relevant clinical branch of Unani medicine recognized by the Member State.

2.1.2 Qualification and training of allied health professionals, health workers and assistants

Allied health professionals such as therapists, pharmacists, paramedical staff, dispensers, masseurs and midwives employed to help the practitioner (e.g. assisting during procedures or dispensing medicines) should be properly trained according to the training programme for associated staff for Unani medicine practice, as described in WHO benchmarks for the training of Unani medicine (4).

Allied health professionals work under the supervision of qualified Unani practitioners.

2.2 Regulatory, legal and ethical requirements

In this document, regulation is defined as the rules or order having the force of law, prescribed by a competent authority, relating to actions of those under the authority’s control, in matters pertaining to the authority’s jurisdiction.

2.2.1 Qualification of practitioners

See Section 2.1.
2.2.2 Licensing and registration of practitioners
Licensing and registration of Unani medicine practitioners should be according to the regulatory provisions of the Member State.

2.2.3 Quality assurance of medicines
In this document, Unani medicines are defined as single or compound medicines of different origins (herbal, animal or mineral) that produce physiological effects when administered according to Unani description for the prevention of disease, promotion of health or treatment of disease.

The manufacturing processes for the medicines used in Unani medicine practice should follow standardized procedures:

- Preparation of Unani medicines should be according to Unani medicine principles.
- Unani medicines should be processed in facilities with good manufacturing practices and follow other regulations of manufacturing and sales of such medicines, as relevant to the Member State.

Unani medicines should comply with all existing regulatory requirements of licensing, registration and approval from responsible regulatory authorities in the Member State. To ensure safety, quality and efficacy of Unani medicines, Member States should follow the regulatory provisions they have established to assure quality of Unani medicines. If specific regulations for Unani medicines are not established in the Member State, they should adopt the corresponding regulations for traditional medicines or herbal medicines available within their regulatory framework or follow the various quality assurance guidelines for herbal medicines suggested below.

Adhering to the processes and guidelines discussed in the following WHO documents and other guidelines can ensure the quality of Unani medicines:

- WHO guidelines on good agricultural and collection practices (GACP) for medicinal plants (5);
- Quality control methods for herbal materials (6);
- WHO guidelines on good manufacturing practices (GMP) for herbal medicines (7);
- WHO guidelines on good herbal processing practices (GHPP) for herbal medicines (8);
- WHO guidelines for assessing quality of herbal medicines with reference to contaminants and residues (9);
- WHO guidelines for marker substances of herbal origin for quality control of herbal medicines (10);
- Guidelines for inspection of GMP compliance by Ayurveda, Siddha and Unani drug industry (11).

Unani medicines must be stored carefully to maintain their quality and shelf-life. The clinical establishment must maintain records pertaining to the quality and procurement of the Unani medicines and any other requirements and regulations of the Member State.

Quality control mechanisms should be robust enough to ensure proper storage and documentation of the medicines, appropriate shelf-life, identification and management of expired or near-expired medicines, and an infection-free environment.

2.2.4 Regulatory requirements for research
Unani medicine practitioners engaged in clinical research activities should be knowledgeable about methodologies, guidelines and ethics of research. Research in Unani medicine should adhere to the general principles of Unani medicine and follow internationally accepted modules and rules and regulations for medical research.

In addition to consulting with learned Unani researchers and scholars, Member States may refer to the following WHO documents and other relevant guidelines and prevalent laws pertaining to medical research in the Member State:
2.2.5 Principles of ethics relating to practice

Unani medicine practitioners should have knowledge of general principles of ethics to be followed in clinical practice. For more on ethics in clinical practice, see the documents referenced in Section 2.2.4 and the following:

- Code of conduct for registered health practitioners (17);
- “Putting ethical principles into clinical practice” (18);
- “Ethical aspects of clinical practice” (19).

Practitioners should also refer to relevant guidelines describing requirements for regulatory compliance with prevalent laws of the Member State pertaining to ethics in clinical practice.

2.2.6 The practitioner–patient relationship, rights and privacy, and information for patients

The regulatory aspects relevant to the practitioner–patient relationship should be governed according to the laws and regulations prevalent in the Member State.

The Unani medicine practitioner should (20):

- be aware of the rights of patients and respect the individual rights of all people who come to the clinical establishment for care;
- protect the rights of the patient and their family and inform them about their responsibilities during Unani medicine care;
- respect individual beliefs and values and involve the patient and their family in decision-making processes;
- be aware that the patient and their family have the right to be informed about their health-care needs, proposed treatment and intervention plans, and the related costs and time.

The clinical practice should establish a documented process for obtaining the informed consent of the patient or their family at appropriate times during treatment, as laid down by the prevalent laws of the Member State.

The practice should provide correct and appropriate information to patients. Unani practitioners and members of regulatory and accreditation organizations are encouraged to read the following WHO and other relevant documents while developing information for patients:

- Guidelines on developing consumer information on proper use of traditional, complementary and alternative medicines (21);
- Consumer guideline for proper use of traditional and complementary medicine in Malaysia (22);
- Patient rights and responsibility (23);
- Public notice to consumers and stakeholders for promoting safe use of ASU drugs (24).

See Annex 6 for more suggestions on processes to disseminate appropriate information to patients.
2.3 Other requirements

For proper functioning, Unani medicine clinical establishments may require staff such as dispensers, therapists, pharmacists, paramedical staff, masseurs and midwives. Staff may also be required for the maintenance and functioning of the establishment.

Basic-level practice requires sufficient space, essential instruments and equipment for general examination of the patient, and necessary furniture. Annex 2 details the infrastructure required for basic-level Unani medicine practice.

In addition to the basic-level requirements, advanced-level practice may require infrastructure and staff to carry out various clinical services, such as:

- regimen therapy (‘ilāj bi’l tadābīr) – specific requirements for different regimens (tadābīr) are listed in Annex 4;
- Unani surgery (‘iāj bi’l yad) requires instruments, dressing materials, dressing medicines and sterilization facilities;
- specialty Unani clinical services – for example, gynaecology and obstetrics (amrāḍ al-niswān wa ’ilm al-qabālāt) services require diagnostic and therapeutic equipment and instruments.

2.4 Responsibilities of practitioners

2.4.1 Referral and cross-referral

Unani practitioners should be able to identify critical and emergency conditions that may arise during practice. In such a case, when their clinical skills are not sufficient to manage clinical emergencies, they should be able to refer the patient in a timely manner to an appropriate higher-level medical establishment with facilities and expertise to manage such cases.

2.4.2 Reporting cases of notifiable diseases

Any notifiable disease encountered during Unani medicine practice should be notified to the appropriate authorities according to the prevalent regulations and health advisories in the Member State. The Unani practitioner should be aware of, and adhere to, the observations, instructions and guidelines issued by health authorities, state administration and professional bodies.

2.4.3 Reporting adverse effects of medicines (pharmacovigilance)

Appropriate precautions and measures must be taken to support the detection, evaluation, understanding and avoidance of adverse effects or any other medicine-related problem in Unani practice.

Adverse effects must be reported within the specified timeframe to local health authorities, pharmacovigilance centres and other relevant organizations in the Member State, according to the prevalent regulatory provisions. This may also include the data and analysis report of safety of commonly used Unani medicines in the practice and the dosages and duration of their use by individual patients.

Unani practitioners and members of regulatory and accreditation organizations are encouraged to read the following WHO publications for more information:

- The importance of pharmacovigilance: safety monitoring of medicinal products (25);
- Safety monitoring of medicinal products: reporting system for the general public (26);
- The safety of medicines in public health programmes: pharmacovigilance – an essential tool (27);
- WHO guidelines on safety monitoring of herbal medicines in pharmacovigilance systems (28);
- Key technical issues of herbal medicines with reference to interaction with other medicines (29);
- Medication errors: technical series on safer primary care (30).
2.5 Knowledge and skills of practitioners

Unani medicine practitioners should have the required knowledge and training in diverse applications of various philosophical concepts and basic principles of Unani medicine, and Unani principles of anatomy, physiology, pathology, clinical diagnosis and clinical practice, as described in WHO benchmarks for the training of Unani medicine (4).
Regimenal therapies (‘ilaj bi’l tadābir, shortened to tadābir) are one of the modes of treatment in Unani medicine. They include several different treatment regimens and procedures. Generally, these procedures are used not as standalone therapies but in conjunction with other modes of treatment (31).

3.1 General considerations

3.1.1 Categorization of procedures
Procedures in Unani medicine can be categorized into basic-level and advanced-level procedures, corresponding to the qualification to administer those procedures at the basic and advanced levels of practice.

All procedures permitted at the basic level can be administered at the advanced level. Advanced-level procedures should be administered only by advanced-level practitioners at advanced-level clinical establishments.

Annex 3 lists the basic- and advanced-level procedures.

3.1.2 General preparation and requirements
Procedures should be carried out according to Unani texts or accepted guidelines.

Every procedure requires a specific space with furniture, equipment, instruments and medicines related to the procedure. The furniture should be neat and clean, with sheets or bedlinen provided when necessary. There should be good illumination and proper ventilation.

Aseptic measures should be followed for all procedures. Special safety and aseptic measures must be ensured, particularly during invasive or bloodletting procedures and when dealing with patients with bloodborne or contagious diseases.

Before starting the procedure, aseptic measures should be ensured with proper cleaning and sterilizing. Equipment should be sterilized and ready for the procedure.

Pots, utensils, tubs and buckets should be cleaned, dried and ready to use.

All medicines necessary to carry out different procedures should be available in sufficient quantities. There should be facilities to prepare decoctions, infusions and pastes in proper hygienic conditions.

Dressing materials should be available, if required.

Unani medicine assistants should be available, if required.

3.1.3 General preparation of the practitioner
The practitioner should be fully trained to perform regimenal therapies and should maintain aseptic measures (e.g. clean or sterilized gown, cap, mask and gloves) before the procedure.

3.1.4 General preparation of the patient
The patient’s vital signs should be checked and recorded before, during and after the procedure.
The procedure must be explained to the patient and/or their attendant, and appropriate written informed consent obtained.

The patient should be assessed for indications and contraindications for the procedure.

The patient should be properly examined, including their vital signs, to confirm their eligibility to undergo the procedure safely.

Laboratory investigations should have been done and results noted by the practitioner to confirm the eligibility of the patient to undergo the procedure safely.

### 3.2 Special considerations

#### 3.2.1 Children and pregnant women

Invasive and vigorous procedures such as *ishāl* (purгation) and *qay’* (vomiting) are contraindicated in children and pregnant women.

#### 3.2.2 Elderly people

Invasive and vigorous procedures should be avoided in elderly people. If the procedure is considered absolutely essential, it should be carried out with the utmost care.

### 3.3 Procedure types

The major regimenal therapies (‘ilāj bi’l tadābir) are:

- baths (*hammām*);
- cauterization (*‘amal-i-kayy*);
- concoction and purgation (*nudj wa ishāl*);
- cupping therapy (*hijāma*);
- diuresis (*idrār*);
- enemas (*ḥuqna*);
- fomentation (*takmīd*);
- footbaths (*pāshoya*);
- gargles (*ghargharā*);
- insufflation (*nafūkh* and *nashūq*);
- irrigation (*nūtūl*);
- leech therapy (*irsāl-i-ʿalaq/ta’liq*);
- liniment with gauze (*ḥamūl*);
- lotions, ointments and pastes (*ṭila wa ḩimād*);
- massage therapy (*dalk*);
- mouthwashing (*maḍḍāma*);
- medicated oil massage (*masūḥ*);
- nasal drops (*saʿūṭ*);
- oiling (*tadhīn*);
- oil immersion (*tamrīk*);
- pain induction (*ilām*);
- sitz baths (*ābzān*);
- sweating (ta’rīq);
- syringing (zarūq);
- throat drops (wajūr);
- vaginal pessaries (farzajā);
- venesection (faṣd);
- vomiting (qay’).

Annex 4 explains the general methodologies for the regimenal therapies (ʾilāj biʾl tadābir).
Due care is required in the practice of Unani medicine to ensure the safety of patients and risk management.

4.1 Essential knowledge for practitioners

The Unani medicine practitioner and other support staff should be aware of personal hygiene and sanitation measures to ensure patient and personal safety.

The practitioner should be knowledgeable about the safe use of Unani medicines. The practitioner should be aware of the signs of potential adverse effects of Unani medicines, and be able to provide immediate relief to the patient and report such events to the relevant authorities following pharmacovigilance procedures.

The practitioner should have the skills to manage medical emergencies that might occur, whether during treatment or otherwise. The practitioner and other support staff at the establishment should undertake regular basic life support training.

The practitioner should be clinically competent to identify the need for timely referral of patients to other or higher centres of health care with appropriate medical expertise and facilities.

The practitioner should have the knowledge to manage various other safety and facility management requirements, including handling of potential hazards (e.g. biomedical waste) and emergency procedures (e.g. fire safety).

4.2 General considerations

Safety considerations in Unani medicine practice are similar to those in the practice of conventional medicine and other systems of medicine. In general, to ensure safety, the following aspects should be considered:

- appropriate training, qualification, skills and competencies of staff engaged in the functioning of the clinical establishment;
- safe and secure environment and infrastructure;
- adequate fire exits and fire management equipment, with enough staff trained in fire safety;
- safe drinking water;
- adequate ventilation;
- uninterrupted power supply;
- safety plan for fire and non-fire emergencies, including regular staff training in basic life support;
- staff with knowledge and skills to manage medical and non-medical emergencies;
- safe storage, management and use of medicines, devices and hazardous materials in the clinical establishment;
- staff trained in recognition and management of hazardous materials, and processes to clearly identify hazardous materials;
- special safety concerns for individual procedures (tadābīr);
- processes in place for appropriate maintenance of medical equipment, and staff qualified and trained to operate and maintain the equipment;
• infection prevention and control measures;
• waste management facilities, with staff trained to execute waste management work.

4.3 Crucial elements in patient safety and risk mitigation

Due care is required in Unani medicine practice to ensure the safety of patients and risk management. Risk implications resulting from any compromise to a patient’s safety must be managed effectively. Safety concerns may be related to:

• the structure of the health-care facility;
• clinical errors;
• the use of equipment and tools;
• the nature and dose of medicines;
• drug–drug or drug–herb interactions;
• drug–food interactions;
• food–food incompatibilities;
• medicinal or therapeutic incompatibility;
• improper administration of therapeutic procedures;
• morbidity of the patient;
• falls and associated injury.

All possible risk factors in the clinical establishment should be assessed for preventive, remedial or mitigative measures. Important considerations include:

• procedures to avoid injuries to staff and patients caused by, for example, heating devices, hot substances, sharp instruments or falls;
• minimizing use of hazardous materials, technologies and situations;
• preventing injuries to patients due to medical interventions and clinical errors, and accidents such as falls;
• steps to prevent faulty administration of clinical interventions;
• training and educating staff in management and prevention strategies against all identified risks.

4.4 Safety related to Unani medicines

Ensuring the safety of patients taking medicines and undergoing interventions is of the utmost importance. While framing the clinical establishment’s patient safety policies, the nine WHO Patient Safety Solutions may be considered (32), with suitable and appropriate modifications, to include special requirements for Unani medicine practice:

• lookalike and soundalike medicine names;
• patient identification;
• communication during patient handovers and referral;
• performance of the correct procedure at the correct body site;
• control of concentrated electrolyte solutions;
• control of toxic and hazardous medicines, substances and materials used in the clinical establishment;
• accuracy of medicines during care transitions;
• avoiding catheter and tubing misconnections;
• single use of injection or invasive devices;
• improved hand hygiene to prevent health care-associated infection;
• measures to prevent falls and associated injury.
Unani medicines may cause adverse events and harm through contamination, adulteration, misidentification, inappropriate use of herbal species, or prescribing above accepted dosages.

The quality and safety of Unani medicines must be ensured by using manufacturing processes that adhere to traditional Unani texts or according to approved industrial processes. Improperly prepared medicines can be unsafe for patients.

Unani medicine practitioners and pharmacists should be able to recognize adverse effects of Unani medicines and know the procedures to deal with them. The Unani medicine practitioner or pharmacist should inform the patient of the expected effects of the administered medicines, caution about any possible adverse effects, advise on how to timely identify such effects, and recommend emergency or appropriate responses, including ways to report any incident to the practitioner.

Medicines that are toxic, poisonous, narcotic or potentially harmful should be labelled, stored, used and disposed of under the guidance and responsibility of a Unani medicine practitioner or a staff member specifically assigned and recorded as responsible for such medicines.

The clinical establishment should have appropriate provision for recording and managing adverse events, according to the level of its practice.

### 4.5 Safety related to Unani interventions

Knowledge of contraindications of Unani therapies (tadābīr) is just as important as that for Unani medicines. Generally, if Unani therapies are performed according to the Unani texts, incidences of adverse events and emergencies are likely to be reduced. Nevertheless, the following measures are suggested.

Potentially harmful Unani interventions should be administered under the guidance and responsibility of the Unani practitioner or staff member specifically assigned and recorded as being responsible for administering such interventions.

The clinical establishment should have a plan to address adverse events, communicated to all staff. Staff should be periodically trained in preparedness for, and mitigation of, adverse events. Unani practitioners and paramedical staff should have a basic knowledge of cardiopulmonary resuscitation, basic life support and primary management of burns.

The facility should have a well-defined policy on when to refer patients. Unani practitioners and other health service providers should have adequate knowledge of the conditions that require urgent treatment or referral to another hospital.

#### 4.5.1 General precautions when administering Unani interventions (tadābīr)

- Informed consent of the patient must be obtained before administering the intervention.
- Assure proper functioning and safety standards of specific medical devices to conduct the planned therapeutic intervention.
- Medical devices must be periodically calibrated and monitored for quality.
- Availability and accessibility of appropriate Unani medicines must be ensured.
- The patient must be assessed before the procedure to confirm their necessary fitness to undergo the procedure:
  - the patient’s history of other ailments, concomitant medicines, and known allergies and intolerances should be recorded clearly;
  - the patient’s vital signs and general condition must be monitored before, during and after each procedure.
Establish processes to identify the patient, the type of procedure and the site of the procedure (intervention) before administering the procedure.

Establish safe surgical and intervention processes for invasive interventions and ensure appropriate training of practitioners and support staff to undertake and document such processes, in a timely manner (34).

Use disposable instruments such as surgical blades and needles for invasive procedures to avoid the possibility of infections, and put in place necessary operating procedures to assure safe disposal of such instruments.

Put in place operating processes to ensure reusable invasive instruments and equipment are cleaned and sterilized following appropriate procedures.

4.5.2 Precautions when treating people with special requirements

Special precautions should be taken when administering Unani interventions to people with special requirements, such as pregnant and postnatal women, elderly people, children, people with mental disorders, and people with special needs.

4.5.3 Safety criteria for regulating Unani medicine interventions

Unani medicine interventions may be regulated and monitored on the basis of prescribed standards and quality control parameters with regard to:

- training and professional competence of Unani medicine practitioners;
- infrastructure facilities, hygienic and sanitary conditions, and safety measures adopted in clinical settings;
- locations where therapeutic procedures are administered;
- safety, efficacy and quality of products used;
- knowledge and skills of assistants and therapists;
- compliance with professional codes of conduct, etiquette and medical ethics by staff.

4.6 Safety related to health-care facilities and workplaces

Safety at health facilities and workplaces should have appropriate infrastructure, equipment, furniture, storage facilities and medicine dispensing areas to support the services offered. Signage should be used effectively to reduce the chances of error and unnecessary delays for patients, staff and others.

Proper safety at health-care facilities and workplaces may be ensured by:

- using standard-quality structural elements, including building design and construction materials;
- periodically checking non-structural components, such as equipment, furniture, storage facilities and dispensing areas;
- proper use of signage to reduce the chances of error and unnecessary delays for patients and staff;
- adhering to standard operating procedures in all operations of the clinical establishment;
- adhering to the rational prescription of medicines, therapies and precautions;
- training all health workers in the clinical establishment in aspects of safety and adverse events.

Establishing and adhering to standard operating procedures is very supportive for maintaining high standards of patient safety. It is important that Unani practitioners follow rational prescription of medicines, therapies and precautions to support patient safety.

All health workers should have orientation training on safety and adverse events. A safety culture should be promoted to eliminate risks to patients during the care process and to ensure the safety of other patients, staff and family members.

Challenges and constraints in prevention and control of infection in the Unani clinical establishment should be known and addressed appropriately.
**4.7 Cleaning and sterilization**

The best possible measures and methods should be applied for regular cleaning of the clinical facility to keep it free from contamination, infection and hazardous material. Air flow, floors, walls and water resources must be kept clean and disinfected.

Equipment, instruments and tools used in diagnostic procedures and therapeutic interventions should be appropriately sterilized with autoclaving, antiseptic reagents, disinfectants, fumigation and other approved conventional techniques and procedures.

Disposable gloves, clothing, syringes, surgical blades, gauze, cotton pieces and single-use sets for enemas should be used.

Appropriate contemporary relevant methods and agents should be used for cleaning and disinfecting the patient’s body and body parts where any therapeutic procedure is to be applied.

**4.8 Waste management**

In this document, medical waste is defined as any discarded biological (e.g. blood, body fluids, body tissues) or non-biological (e.g. laboratory disposables, bandages, plaster of Paris casts, syringes) products that have been used and are no longer required.

Waste management is the process of collecting waste material, including proper collection and segregation of different types of waste in colour-coded containers, storage, and transportation to the site of treatment or disposal within stipulated time limits, in an appropriate manner.

Waste management should follow the regulations, guidelines and provisions prevailing in the Member State.

A robust waste management system should be in place according to standard processes and protocols. Degradable and non-degradable wastes must be separately disposed. Waste classified as biohazards must be handled according to protocols of the Member State.

Workers handling waste must be properly trained, and their skills and work performance monitored at regular intervals.

**4.9 Infection prevention and control**

Appropriate hand hygiene procedures and relevant guidelines should be implemented in the Unani medicine facility. All staff should be educated and trained in these procedures. Detailed guidelines are available in the WHO information note on hand hygiene (35).

The risk of infection should be reduced or eliminated by adopting appropriate antiseptic and disinfectant measures and careful handling of infected patients. Potential infection risks should be identified and addressed promptly.

A safety culture should be promoted to eliminate risks to patients during treatment and to ensure the safety of other patients, staff and family members.

Challenges and constraints in prevention and control of infection in the facility should be known and addressed appropriately.

Annex 5 provides additional information on staff health programmes and other basic infection control methods.
Health data are an important resource providing comprehensive information on the health of an individual or population and enabling effective and efficient health-care delivery, while supporting its continued improvement.

Unani practice includes data on:

- health conditions and status of health, including well-being and mental and spiritual health;
- health-related habits and activities of daily life;
- morbidity, births and mortality, including reproductive health and causes of death;
- health interventions, including interventions for health promotion, interventions for general and specific prevention, interventions tailored to specific health conditions and stages of life, and related outcomes observed on an individual or population.

Multiple data streams are generated when individuals interact with health-care systems, and these streams need to be captured. Health system data should include records of health-care services rendered, clinical conditions encountered, health interventions undertaken, and information about the outcomes of the interventions.

Health systems may also record information on socioeconomic and environmental factors that might influence health and wellness outcomes in the community and for individuals.

The goal of health data management in Unani practice is to ensure the required information is provided in an authenticated, secure and accurate manner at the right time, in the right place and to the right person. The system should be able to collect, store, analyse, use, transmit and retrieve health data, and generate specific reports, as and when required to improve clinical outcomes, individual health, and overall health system performance.

Health information management systems in Unani practice are similar to those used in conventional and other systems of medicine. In an Unani clinical establishment, relevant data of every patient attending the facility should be recorded and stored and should include:

- demographic data;
- unique identification and contact details connecting the dataset to the specific patient;
- data on clinical conditions;
- diagnostic data;
- data on interventions and outcomes at different stages of interaction of the patient with the clinic throughout the timeline of the entire treatment process;
- referral data, post-treatment advice and follow-up.

Data on referral should contain information about the reasons for referral and the name of the hospital or centre to which the patient is being referred.

Member States may use Unani-specific terminology to describe and record diagnostic criteria, diagnostic terms, Unani health interventions, prognosis and outcomes of health conditions while collecting and managing health data involving Unani practice in clinical establishments and health systems.

Member States may use *International statistical classification of diseases and related health problems (ICD)* (36) or other nationally endorsed and accepted standard terminologies and codes. It is advisable that such records use a dual coding system in which codes from other sections of ICD and *International
Classification of health interventions (37) or other national terminology or coding documents are used concurrently with Ayurvedic terms to bring clarity to health data, especially in pluralistic health system environments.

Confidentiality of clinical data should be maintained at all levels with due ethical considerations. Privacy, confidentiality and safety of medical records must be maintained in accordance with national law and directives of the Member State. In general, patient information may be shared in medicolegal cases only when asked for officially and specifically.

Dedicated space to secure and store data for the time period specified by the regulations of the Member State, and with due measures to protect data from damage or corruption or theft, may be provided by the clinical establishment. After the stipulated period required by the laws of the Member State, the data may be destroyed following due processes to maintain its confidential nature.

Although digitizing and storing improves efficiency in health data management, and is preferred, the basic principles of a good information management system apply equally to a manual or paper-based system. Member States are encouraged to use electronic health records where appropriate and plausible, but there should always be sound processes in place to protect the privacy and confidentiality of patients.
References


Gewali MB, Awale S. Aspects of traditional medicine in Nepal. Japan: Institute of Natural Medicine, University of Toyama; 2008.


Annex 1. Domain of practice in Unani medicine

A1.1 Preservation and promotion of health and prevention of diseases

The holistic approach of Unani medicine promotes health by potentiating the power of self-preservation or adjusting the healing power of nature (tabi‘at-medicatrix naturae) through:

- moderation of the six essential factors (asbāb sitta darūriyya) to maintain good health and prevention of diseases;
- adoption at regular intervals of certain regimens conducive to the maintenance and promotion of health and the prevention and cure of many diseases;
- use of single-ingredient and compound medicines and dietary regimens.

A1.2 Treatment of diseases and management of systemic imbalances

Unani medicine treats both the general imbalance underlying a disease and the disease itself. The treatment relies on three major pillars – an holistic approach, temperament (mizāj)-based prescription and regimen therapy (‘ilāj bi‘l tadābīr) – to maintain and restore health.

Diseases are categorized into three groups:

- diseases due to temperament (sū‘-i-mizāj) imbalances:
  - abnormal qualitative temperament (sū‘-i-mizāj sāda);
  - abnormal quantitative temperament (sū‘-i-mizāj māddī);
- structural diseases (sū‘-i-tarkīb);
- diseases of discontinuity (tafarruq-i-ittiṣāl).

Principles of treatment are based on different pathologies:

- removal of the causative factor (izāla-i-sabab);
- hetero-therapy or antagonistic therapy (‘ilāj bi‘l didd) – treatment with a medicine that has the opposite temperament to the disease;
- normalization of the abnormal temperament (ta‘dil-i-mizāj);
- evacuation of morbid matter (mawād-i-fāsida) by various modes of therapy and through different routes (tanqiya-i-mawād).

Unani medicine also treats specific diseases with medicines discovered by empirical means without reference to the above principles. These medicines are said to act by their specific or special characteristics (ṣūrat al-naw‘iyya).

The methods of treatment are:

- diet therapy (‘ilāj bi‘l ghidhā’) – modification and specification of the person’s diet;
- regimen therapy (‘ilāj bi‘l tadābīr), including lifestyle modifications;
• pharmacotherapy (‘ilāj bi’l dawā’);
• surgery (‘iāj bi’l yad).

A1.3 Improvement in quality of life

Unani medicine interventions for quality of life are include:

• toning and strengthening of organs and resistance against diseases by use of tonics (muqawwiyyāt);
• regimenal therapy (‘ilāj bi’l tadābir) at regular intervals to moderate humours (akhlāṭ) and eliminate morbid material;
• adjuvant therapy to enhance efficacy or to minimize the adverse effects of conventional therapies, hence improving overall quality of life;
• as a rehabilitation measure after certain ailments.
Annex 2. General requirements for a Unani clinic offering outpatient services

A2.1 Clinical equipment and furniture

The following equipment is essential for the Unani medicine clinic:
- facility for the Unani medicine practitioner to work comfortably;
- appropriate seating for the patient and their attendant;
- examination couch with clean linen, and with adequate facilities to ensure the patient’s privacy;
- appropriate stepladder to assist the patient on to the examination couch;
- stethoscope;
- sphygmomanometer;
- thermometer;
- clock;
- weighing scale;
- measuring tape;
- tongue depressor;
- torch;
- percussion hammer;
- disposable gloves;
- handwashing facilities;
- adequate washroom facilities, with access for disabled people;
- emergency trolley with equipment for use in emergencies;
- necessary medicines;
- necessary consumables;
- equipment for waste collection and disposal;
- fire extinguisher;
- other essential equipment depending on the specialty of the practice, such as:
  - instruments for minor surgery;
  - instruments for gynaecological examinations, normal delivery and simple gynaecological procedures;
  - ear, nose and throat examination set;
  - proctoscope.

A2.2 Infrastructure

The clinical establishment should:
- have adequate space and facilities for waiting patients and for clinical consultations;
- be adequately ventilated or air-conditioned and well illuminated;
- have proper facilities for easy access and exit for all patients;
- be maintained with proper hygienic measures and regular cleaning with disinfectants;
- have easily accessible drinking water facilities;
• have adequate, accessible and clean washroom facilities;
• have appropriate safety and security facilities, equipment and expertise according to regulations of the Member State;
• have necessary additional provisions of infrastructure, equipment, furniture and expertise if it is an advanced-level practice;
• have any other facilities according to the prevalent requirements and regulations of the Member State.
Annex 3. Procedures at the basic and advanced levels of practice in regimenal therapies

A3.1 Basic-level procedures (non-invasive)

- aromatic inhalation (shamūm);
- baths (ḥammām);
- dry cupping/cupping without scarification (ḥijāma bilā shart);
- fomentation (takmīd);
- footbath (pāshoya);
- fumigation (bakhūr);
- gargling and rinsing (mazmaza);
- inhalation (lakhkaha);
- insufflation (nafūkh and nashūq);
- irrigation (nutool);
- lotion and paste application (ṭila wa ḍimād);
- massage (dalk);
- medicated oil massage (masūḥ);
- nasal drops (sa’ūt);
- oil immersion (tamrīkh);
- oiling (tadhīn);
- sitz bath (ābzān);
- steam bath (inkibāb);
- sweating (ta’rīq);
- throat drops (waṣūr).

A3.2 Advanced-level procedures (invasive or need special precautions)

- cauterization (‘amal-i-kayy);
- diuresis (idrār);
- enemas (ḥuqna);
- leech application (ta’liq);
- liniment with gauze (ḥamūl);
- pain induction (ilām);
- pessary (farzajā);
- purgation (ishāl);
- syringing (zarūq);
- venesction (faṣd);
- vomiting (qay’);
- wet cupping therapy/cupping with scarification (ḥijāma bi’l shart).
Annex 4. Procedures in Unani medicine

A4.1 Cauterization (‘amal-i-kayy)

In cauterization (‘amal-i-kayy), part of the body is cauterized with a hot metallic rod, needle or sheet or with specific chemicals.

Requirements of cauterization (‘amal-i-kayy) include:

- proper room for the procedure;
- cautery (mikwā) made of gold, silver, copper or iron;
- facility for heating;
- dressing material;
- chemicals for chemical cauter, such as lime, oxalic acid or strong vinegar.

Contraindications to cauterization (‘amal-i-kayy) are:

- children;
- elderly;
- severe illness;
- pregnancy or lactation;
- acute disease;
- extra sensitive;
- severe anaemia;
- excessively hot and cold seasons.

A4.2 Concoction (nuḍj) and purgation (ishāl)

Concoction (nuḍj) is the process by which morbid material is made suitable for evacuation. Purgation (ishāl) is the process to remove morbid material or humours from the body through the intestines.

Contraindications to concoction (nuḍj) and purgation (ishāl) are:

- food poisoning (tukhma);
- intestinal inflammation or obstruction;
- children;
- elderly or debilitated;
- pregnancy;
- extremely hot or cold weather conditions.

A4.3 Cupping therapy (ḥijāma)

Cupping (ḥijāma) is one of the most important procedures in Unani practice. A cup is applied over the surface of the skin and a vacuum created by fire or suction. As per Unani practice, this is used to eliminate or deviate morbid material and enhance the blood supply and rectify the temperament of a particular organ.

Wet cupping (ḥijāma bi’l sharṭ) and dry cupping (ḥijāma bilā sharṭ) are the main techniques. Fire cupping (ḥijāma nāriyā), cupping without fire (ḥijāma ghayr nāriyā), and cupping with decoction of herbal medicines (ḥijāma mā’ī) are also practised in Unani medicine.
Common sites for cupping therapy are:

- vertex/middle of the head (ḥāma);
- occiput (qamaḥduwa);
- nape of the neck (nuqrā);
- lateral side of the neck (akhdaiyn);
- chin (dhuqūn/dhaqan);
- superior border of the scapula right side (nahiz);
- superior border of the scapula left side (nahiz);
- between the shoulders (bayn al-mankibayn);
- both shoulders (mankibayn);
- between the breasts (bayn al-thadyayn);
- wrist joints (rusgh al-yadayn);
- lumbar region (qaṭan);
- coccyx (ʿusʿus);
- buttocks and hips (warikayn);
- thighs (fakhizayn);
- knee (rukbā);
- calf muscles (sāqayn).

Requirements for wet cupping (ḥijāma biʾl sharṭ) include:

- cupping therapy table and chair;
- cupping set with sterilized suction pump and cups;
- surgical blades;
- dressing material;
- check the patient’s haemogram, bleeding time and clotting time before treatment;
- test the patient for hepatitis B, hepatitis C and HIV before treatment.

Contraindications to cupping (ḥijāma) are:

- age under 12 years;
- pregnancy;
- bleeding disorder;
- taking anticoagulants;
- malignant or severe hypertension;
- immediately after bathing (ḥammām);
- postcoitus;
- grossly anaemic;
- elderly or debilitated;
- mental instability.

**A4.4 Diuresis (idrār-i-bawl)**

Diuresis (idrār-i-bawl) is the process of increasing urination by procedures or medicines to evacuate morbid matter from the body.

Requirements of diuresis (idrār-i-bawl) include:

- room with a low temperature;
- water;
- diuretics (mudir adwiya).
Contraindications to diuresis (idrār-i-bawl) are:

- hypotension;
- severe renal parenchymal disease;
- dehydration.

Idrār ūmtth is the process of inducing or increasing menstrual flow by procedures or medicines to remove morbid matter from the body.

### A4.5 Enema (ḥuqna)

Enema therapy (huqna) is a method of evacuation of waste products from the intestines by the administration of liquid medicine through the anal canal. Enemas are also used to provide nutrition or medicine where the patient is unable to take these orally. The procedure is usually done in the late evening or early morning.

Requirements for enema therapy (ḥuqna) include:

- lavatory facilities;
- enema bed;
- stand to hold the liquid medicine at a height;
- enema set comprising a small bucket connected with a tube in the bottom, and the lower end of the tube fitted with a long disposable nozzle or readymade enema set;
- facilities to prepare the enema;
- medicines, oils, soap and glycerine;
- pots, utensils and heating facilities;
- sterilized surgical gloves;
- lubricant;
- waste disposal facilities;
- fumigation of enema room with appropriate herbs.

Precautions for enema therapy (ḥuqna) include:

- avoid use of repeated enemas;
- the patient’s vital signs should be monitored for hypotension and bradycardia.

Contraindications to enema therapy (ḥuqna) are:

- diverticulitis;
- ulcerative colitis;
- Crohn’s disease;
- tumours of the rectum or colon.

### A4.6 Fomentation (takmīd)

In fomentation (takmīd) the body or a part of the body is exposed to different temperatures by different means.

Requirements for hot fomentation (takmīd-i-ḥarr) include:

- heating facility;
- pieces of cloth;
- wheat and paddy husks;
• sand and salt;
• water and oils (e.g. sesame, olive);
• longwave or shortwave diathermy;
• infrared lamp;
• heating pad and wax bath.

Requirements of cold fomentation (takmīd-i-bārid) include metal sheets, stones or ice.

Contraindications to takmīd hārr are:
• injury in the past 72 hours;
• acute inflammation.

Contraindications to takmīd bārid are:
• chronic inflammation;
• chronic pain, such as cervical or lumbar spondylosis.

A4.7 Footbath (pāshoya)

In pāshoya, the feet and legs are put in a decoction of certain medicines. Sometimes the legs are massaged gently downwards for different therapeutic benefits.

Requirements of footbath (pāshoya) include:
• space for footbath (pāshoya);
• footbath (pāshoya) chair;
• different-sized containers;
• facilities to prepare decoctions;
• medicines.

A4.8 Gargling (gharghara) and rinsing (maḍmaḍā)

In maḍmaḍā, the patient keeps a solution or decoction of medicines in the mouth for a few seconds. In gharghara (gargling), the patient keeps the solution in the throat for a few seconds.

A4.9 Insufflation (nafūkh and nashūq)

In nafūkh, a finely powdered drug is blown with the help of a tube into the nose, throat or any other opening of the body. In nashūq, liquid medicinal preparations are used.

Contraindications to insufflation (nafūkh and nashūq) are:
• children;
• very elderly.

A4.10 Irrigation (nutūl)

Irrigation (nutūl) involves irrigating water, oil, infusions or decoctions at different temperatures on specific body parts to derive therapeutic benefits. Hot irrigation (nutūl-i-ḥārr) and cold irrigation (nutūl-i-bārid) are used.
Requirements for irrigation (nutūl) include:

- irrigation table and chair;
- small bucket or pot fitted with a nozzle at the bottom;
- stand to hang the bucket or pot;
- large bucket to collect and reuse the solution or medicine preparation;
- facilities to prepare decoctions;
- medicines and oils.

**A4.11 Leech therapy (irsāl-i-‘alaq)**

Leech therapy (irsāl-i-‘alaq) is one of the important procedures for local evacuation (tanqiya muqāmi) of morbid humours (akhlāṭ fāsida) and for the treatment of various disorders. Medicinal leeches must be used. Utmost care must be taken when applying a leech near an orifice due to the migratory nature of leeches.

Requirements for leech therapy (irsāl-i-‘alaq) include:

- table for leech application;
- aquarium, fish tank or glass jar to keep leeches;
- fresh cultivated medicinal leeches;
- needle;
- dressing materials.

Contraindications to leech therapy (irsāl-i-‘alaq) are:

- bleeding disorder;
- taking anticoagulants;
- immunocompromise;
- taking systemic immunosuppressants;
- severe or malignant hypertension.

Leeches should not be applied to the hypochondriac regions in the upper third of the abdomen, located on the lateral sides of the abdominal wall, and inferior to the thoracic cage.

**A4.12 Liniment with gauze (ḥamūl)**

In ḥamūl, a piece of cloth is soaked or dipped in a mixture of medicines such as honey, oil or fat and used as a vaginal or rectal suppository.

**A4.13 Local application of pastes (ṭila wa ḍimād)**

Medicinal pastes made with oil or water are used for local applications for medicinal benefits. Thin pastes (ṭila) and thick pastes (ḍimād) are used.

Requirements for application of paste (ṭila wa ḍimād) include:

- grinder (mortar and pestle of different sizes);
- strainer of different size;
- bedlinen;
• spatulas of different sizes;
• utensils;
• containers.

A4.14 Massage (dalk)

Massage (dalk) is used in the management of diseases of the muscles, joints and nerves.

Requirements for massage (dalk) include:
• massage room;
• massage table;
• bedlinen and towels;
• massage oils.

Contraindications to massage (dalk) are:
• fever;
• acute swelling or inflammation;
• skin wound, ulcer or abscess;
• severe osteoporosis;
• phlebitis;
• deep vein thrombosis.

A4.15 Nasal drops (saʿūṭ)

In saʿūṭ, liquid medicine is dropped in the nasal cavity.

A4.16 Oil immersion (tamrīkh)

In tamrīkh, an oil or oily medicine is applied to the body.

A4.17 Oiling (tadhīn)

In oiling (tadhīn), specific medicinal oil is applied over the body or parts of the body. There should be a separate room for oiling the patient equipped with an oiling table.

A4.18 Pain induction (īlām)

īlām, is a painful stimulus.

In strenuous massage (dalk qawi), massage is done forcefully with strong hands. In strenuous exercise (riyādat qawi), the practitioner vigorously exercises a part of the body.

Use of localized pressure (bandish) is done to induce pain.

In scratching (taqarruḥ), the skin is scratched with a corrosive substance.
Contraindications to pain induction (īlām) are:

- localized acute inflammatory conditions;
- children;
- very elderly.

**A4.19 Pessary (farzajā)**

In farzajā, herbal pastes are made into suitable shapes and sizes for application via the vagina.

**A4.20 Sitz bath (ābzan)**

In ābzan, the patient sits in a tub filled with a decoction or infusion of medicines for different therapeutic benefits.

Requirements of sitz bath (ābzan) include:

- bathroom with proper space for a sitz bath (ābzan);
- different sized containers;
- facilities to prepare decoctions;
- strainer to sieve decoctions;
- utensils and pots;
- medicines for decoctions.

**A4.21 Sweating (ta’rīq)**

Ta’rīq is a procedure to induce sweating to remove morbid matter from the body or to help control raised body temperature. The main types are sweating in a hot, dry atmosphere (ta’rīq yābīs) and sweating in a hot, moist atmosphere (ta’rīq raṭb).

Requirements for sweating therapy (ta’rīq) include:

- warm or heated room;
- woollen cloths;
- quilt;
- lukewarm milk or tea (qahwā).

Contraindications to sweating therapy (ta’rīq) are:

- weak, thin patient;
- dehydration.

**A4.22 Syringing (zarūq)**

In zarūq, liquid medicines are pushed by a syringe or syringe-like device inside a normal or abnormal opening.
A4.23 Therapeutic bath (ḥammām)

Ḥammām is generally advised to resolve inflammation (taḥlīl-i-waram) and to induce heat and wetness (taskhīn and tarṭīb).

Requirements for ḥammām include:
- the air of the first room should be cold and wet (bārid raṭb);
- the air of the second room should be hot and wet (ḥārr raṭb);
- the air of the third room should be hot and dry (ḥārr yābis).

The patient should enter the ḥammām rooms one after another. They should stay for just long enough in each room to keep comfortable.

The patient should not eat or drink very cold or very hot things immediately after ḥammām.

Contraindications to ḥammām are:
- very weak or thin;
- dehydration;
- hot and dry (ḥārr yābis) season or atmosphere.

A4.24 Throat drops (wajūr)

In wajūr, liquid medicine is applied to the throat as drops.

A4.25 Venesection (faṣd)

Bloodletting from the veins (faṣd) is one of the important procedures for evacuation of morbid humours from the body to detoxify the blood and tissue fluids, reduce blood volume, and divert morbid matter from one site to another.

Requirements for venesection (faṣd) include:
- venesection table or chair;
- surgical blades;
- tourniquet;
- blood pressure instrument;
- dressing material;
- haemostatic medicines.

Specific considerations for venesection (faṣd) include:
- basic investigations as per the requirements of the procedure;
- evaluation for hypertension;
- the patient’s vital signs should be monitored throughout the procedure.

Contraindications to venesection (faṣd) are:
- history of bleeding disorders;
- use of anticoagulants;
- any type of colic;
- menstruation;
- pregnancy;
A4.26 Vomiting (qay’)

Vomiting (qay’) is one of the important methods of evacuation of morbid matter from the body in general and from the stomach in particular.

Requirements for vomiting therapy (qay’) include:
- a prepared space such as a bed and a basin for vomiting;
- medicines or materials used to induce vomiting;
- proper arrangement for the preparation of different medicines required for vomiting and to manage complications;
- medicines.

Contraindications to vomiting therapy (qay’) are:
- haemorrhoids;
- rectal prolapse;
- debilitating condition or thoraco-abdominal structural deformity that limits vomiting;
- prone to haemoptysis;
- disease of the throat;
- peptic ulcer;
- difficulty in vomiting;
- stressful condition of the eyes in which intraocular pressure is increased, such as glaucoma or acute conjunctivitis.

- anaemia;
- debilitating disease;
- fever due to severe inflammation;
- severe pain;
- full stomach;
- children;
- elderly;
- thin veins.
Annex 5. Staff health programmes and other basic infection control methods

General precautionary actions related to staff engagement:
- Pre-employment medical check-ups should be undertaken for all staff, including contractual staff.
- Annual medical check-ups should be undertaken for all staff.
- Vaccination for hepatitis B should be advised for all staff members.
- Records of medical fitness of staff and any proactive steps taken should be maintained by the facility’s administrative office.

Handwashing:
- Frequent and appropriate handwashing is very important.
- Staff should be periodically trained in appropriate handwashing techniques.
- Checks should be in place to ensure compliance of staff with the clinical establishment’s hand hygiene measures.

Personal protective equipment (PPE):  
- Gloves, aprons, caps, masks and other appropriate PPE should be provided to staff, according to requirements, and monitored for correct and diligent use as and when needed.

Cleaning of equipment and articles:  
- Contaminated disposable articles should be collected appropriately in leak-proof bags and disposed of properly.
- Reusable medical equipment must be disinfected or sterilized after use.

Laundry:
- Soiled linen should be handled with care and adequate precautions taken to prevent cross-contamination of the surroundings and of people handling it.
- All soiled linen should be collected in designated bags or stored separately. It should not be sorted or pre-rinsed in patient care areas.
- Linen soiled with blood or body fluids should be transported in leak-proof bags.

Periodic cleaning of the clinical establishment:
- Periodic general cleaning of the premises, including walls, blinds, curtains and the surrounding area, should be carried out.
- Housekeeping methods should be followed according to the requirement of services provided at the clinical establishment and the volume of people it cares for.

Housekeeping in the Unani therapy room:
- The Unani therapy room should be kept clean.
- Floors and other surfaces should be cleaned with soap solution.
- Procedure rooms should be cleaned daily, or after every procedure, depending on the level of possible contamination and level of sterility expected for the services offered in the room. If multiple rooms are connected, it is good practice to clean the entire complex thoroughly once a week.
- All instruments, equipment, furniture, pañakarma tables (droni) and slabs should be wiped with soap solution.

Food handling:
- Standard guidelines should be followed to ensure food served to patients, visitors and staff is processed in a manner that avoids contamination.
Annex 6. Principles and processes for dissemination of information

- A written document on the type of services provided at the clinical establishment should be available to patients in booklet form in the local language and in other languages according to requirements.
- The available services should be displayed in the local language at a prominent place in the clinical establishment and should be available on the clinical establishment’s website.
- Any change or increase or decrease in the services offered should be updated.
- A booklet in the local language covering basic information on Unani medicine, Unani health interventions, Unani therapies, “do’s and don’ts”, code of conduct, dietetic guidelines to be followed during Unani health interventions, and time, duration and schedule for different Unani therapies should be available to patients.
- Information on the safety of Unani health interventions, including health advisories and other communications administered as part of public health programmes, should be developed with the utmost care and be disseminated in the most appropriate manner to reach the target population. There should be established checks to monitor and assess the benefits and risks of such public information instruments and their immediate and long-term impact on the target population, while also comparing them with possible unintentional outcomes in other sections of the population.
Annex 7. Formal licensure and established national standards and guidelines available in Member States that supported the development of this document

Our enquiry on formal licensure and established national standards and guidelines available in Member States that can assure good-quality health-care delivery of Ayurveda and Unani systems of medicine provided the following information, which has supported the development of the content of this document. The information was collected from relevant websites of ministries of the respective Member States, and from direct communication with officials and experts associated with these Member States.

A12.1 Argentina

Argentina has Ayurveda medical training programmes that educate conventional doctors. Since 2000, postgraduate courses in Ayurveda have been held for physicians and other health professionals at various universities in Argentina. Since 2014, the Argentine Medical Association has conducted similar courses. Some insurance companies provide medical malpractice insurance to physicians covering the Ayurvedic medical care provided by these health-care professionals.

A12.2 Australia

The Australian Government officially recognized two training programmes in Ayurveda in 2015 – the Diploma in Ayurvedic Lifestyle Consultation, and the Advanced Diploma in Ayurveda. Each qualification has a clearly defined scope of practice for its graduates. This official recognition of Ayurveda allows qualified and certified Ayurveda doctors to practise in Australia without further qualification.


A12.3 Bahrain

The Ministry of Health started to approve alternative medicine licences in 2003, including for Ayurveda and Unani. Since 2012, the licensing authority for regulating practice in Ayurveda and Unani has been the National Health Regulatory Authority.
**A12.4 Bangladesh**

The Unani and Ayurveda Practitioners Ordinance of 1983 provided for the regulation of qualifications and registration of Ayurvedic and Unani practitioners, formally acknowledging the Ayurvedic and Unani systems of medicine.


**A12.5 Brazil**

Ayurveda has been recognized within the framework of the National Policy of Integrative and Complementary Practices since 2017.


**A12.6 Colombia**

There is no specific policy or law document for Ayurveda or Unani, but there is a regulatory framework that covers traditional and complementary medicine practice by health-care professionals; the inclusion of services in the health system; the provision of services, phytotherapeutic products; and health food stores. Ayurveda and Unani medicine are classified under complementary medicine in Colombia. Decree 2753 of 1997 (Article 4) limits complementary medicine practice to physicians.

Resolution 2927 of 1998 defines and regulates different types of complementary medicine practices. Law 1164 of 2007 dictates provisions on the practice of traditional and complementary medicine, and Resolution 2003 of 2014 regulates all health-care services, including traditional and complementary medicine. It defines the minimum requirements for physical spaces where services are to be provided, equipment and training of professionals, and the standards for health professionals. The regulations on traditional and complementary medicine providers, enforced at the national level, are for acupuncture (2006), Ayurvedic medicine (2006), herbal medicines (2006) and homeopathic medicine (1962, 2006). Traditional and complementary medicine providers practise in private and public clinics. A traditional and complementary medicine licence or certificate issued by a relevant academic institution is required to practise. As a result of participatory work with the expert committees for traditional and complementary medicine, there is a proposal to define the profile and professional competencies of health professionals, to guide the formation and performance in each of the recognized systems.

A12.7 Cuba

Cuba regulates traditional medicine under the umbrella of the Natural and Traditional Medicine Program. In 2019, Cuba initiated the process of regulating Ayurveda and a pañcakarma department opened at a health centre operating within the national health system.

A12.8 Germany

There is no statutory recognition for Ayurveda or Unani, but there are increasing numbers of practitioners and their associations. Several courses have been conducted by private institutions, often under the aegis of medical associations, providing different levels of Ayurveda training.

A12.9 Hungary

Hungary officially recognized the Ayurveda medical system as a natural medicine through the 40/1997 Government Decree and the 11/1997 NM Order in 1997. According to the Decree, Hungarian medical doctors who have undertaken training of Ayurveda can practise it.


A12.10 India

India recognizes and regulates Ayurveda and Unani medicine as medical systems and has specific laws and frameworks in place to regulate training and practise of the systems. Ayurveda and Unani medicine are part of health system establishments. The services are delivered through government and private establishments. India has the world’s largest number of registered Ayurveda and Unani practitioners who have completed the graduate medical training of the respective systems, which are of more than 5000 hours duration.

Apex manual: biomedical waste management policy. New Delhi: All India Institute of Ayurveda; 2017.
Apex manual: patients right and education policy. New Delhi: All India Institute of Ayurveda; 2017.

Central Register of Indian Medicine (Amendment) Regulation 2016 (https://www.ccimindia.org/pdf/CCIM%20(Central%20Register%20of%20Indian%20Medicine)%20(Amendment)%20Regulation%202016.pdf).


National AYUSH morbidity and standardized terminologies portal (http://namstp.ayush.gov.in/#/index).


Ayurveda was recognized as a medical act in 2002 by the National Federation of Medical and Dental Orders, supervised by the Ministry of Health. This position, expressed by the highest body of the medical profession in the field of ethics, reiterates that doctors, surgeons and dentists, after appropriate certified training, are the only people qualified to practise clinical Ayurveda. In 2018, the first elective course of Introduction to Ayurveda was activated for fifth- and sixth-year medical students of the Faculty of Medicine of the State University of Milan.

In 2019, the Italian National Organization for Standardization issued the normative UNI 11756:2019 for the profession of technician (therapist) in Ayurveda, which has become an officially acknowledged and protected profession by the Italian Government under Law 4/2013. The recognition is subject to verification of the education, examination and certification by the Federazione delle Associazioni per la Certificazione, a body recognized by Accredia, the sole national accreditation body appointed by the Italian Government under the vigilance of the Ministry of Economic Development. The qualifying education programmes in Ayurveda for medical doctors and technicians (therapists) are private and preferably certified by third parties such as ISO 9001 certification for teaching quality.


Malaysia recognizes and regulates Ayurveda and Unani medicine as medical systems and has laws and frameworks in place to regulate them. In Malaysia, the Programme Standards: Traditional and Complementary Medicine, composed of the recognized standard Ayurveda Curriculum Design and Delivery, was established in 2009 and revised in 2021. In 2016, legislation for traditional and complementary medicine was established to regulate traditional and complementary medicine practitioners and services.


A12.13 Mauritius

The Ayurveda and other Traditional Medicine Act came into effect in 1989. In 1992, Ayurvedic clinics were started in the Government hospitals and clinics in Mauritius. Ayurveda is now integrated within the Mauritian health system.


A12.14 Nepal

Nepal recognizes and regulates Ayurveda and Unani medicine as medical systems.


A12.15 Netherlands

Ayurveda and Unani medicine are classified as complementary and alternative medicine. There is no Government regulation for complementary and alternative medicine, and provision of alternative care is legal. Both medically and non-medically qualified professionals are allowed to practise complementary and alternative medicine.

By passing amendments to the Individual Health Care Professions Act on 1 December 1997 (Beroepen in de Individuele Gezondheidszorg), practice of medicine is open to all, with some limitations; some procedures may be carried out only by categories of professional practitioners authorized to do so by law.

According to the Individual Health Care Professions Act, the performance of certain medical procedures is limited to categories of professional practitioners authorized to do so by law. The eight health professions regulated by Section 3 of the Individual Health Care Professions Act are dentist, doctor, health-care psychologist, midwife, nurse, pharmacist, physiotherapist and psychotherapist. The new registration and title protection of these professions started on 1 December 1997. Performance of such a procedure by an unauthorized practitioner is a criminal offence. The procedures specified are artificial insemination (including vasti), cardioversion, catheterizations and endoscopies, defibrillation, electroconvulsive therapy, general anaesthetics, lithotripsy, obstetric procedures, procedures involving the use of radioactive substances and ionising radiation, punctures and injections, and surgical procedures.

A new health insurance system was introduced in 2006. Complementary and alternative medicine treatments are not covered by basic health insurance, but health insurers cover alternative treatment as either additional “free” benefits or covered by complementary voluntary health insurance. Ayurveda treatments and fees for consultation are partially covered by private insurance companies. The prerequisite for such reimbursement is that the Ayurveda practitioner needs to be a registered member of a professional body. If Ayurveda treatment is offered by a Bachelor of Ayurvedic Medicine and Surgery or an Ayurveda practitioner educated on accredited institutes in the Netherlands and in accordance with WHO guidelines for Ayurveda education, most health insurers will reimburse all or part of the treatment or consultation under the supplementary package. Most insurers do not require referral from a doctor for Ayurvedic treatment.


A12.16 Oman

Ayurveda practice is regulated by the National Office for Traditional and Complementary Medicine, under the Ministry of Health.


**A12.17 Pakistan**

Pakistan recognizes and regulates Ayurveda and Unani medicine as medical systems and has specific laws and frameworks in place to regulate these systems.


**A12.18 Qatar**

The Qatar Council for Healthcare Practitioners has approved the practice of Ayurveda since 2016.

**A12.19 Serbia**

The Ministry of Health of published and adopted the *Rule book on detailed conditions and ways of implementation of complementary medicine* in 2007, which allows doctors of medicine or dentistry, with appropriate training, to use Ayurvedic knowledge within the practice of illness prevention, diagnosis, treatment and rehabilitation. The updated version was adopted in December 2019.


**A12.20 Singapore**

Ayurveda practice runs within a self-regulatory framework supported by an operation manual, practice guidelines and code of ethics. All products, including Ayurvedic medicines, are used in clinical practice with a consent by the Health Sciences Authority issued for each batch of manufactured medicines. Therapy practices are not currently regulated by the Ministry of Health.


**A12.21 South Africa**

South Africa recognizes and regulates Ayurveda and Unani medicine as allied health professions.


**A7.22 Sri Lanka**

Ayurveda and Unani medicine are recognized and regulated as medical systems and has specific laws and frameworks in place to regulate training and practice of these systems. Both Ayurveda and Unani medicine are part of health system establishments. The services are delivered through government and private establishments.


Ayurveda Act No. 31 of 1961 (http://www.commonlii.org/lk/legis/num_act/aa31o1961156/).

Ayurveda (Amendment) Law (No. 7 of 1977) (http://www.commonlii.org/lk/legis/num_act/a17o1977248/).


**A12.23 Switzerland**

In 2009, further to the federal popular initiative Yes for Complementary Medicine, accepted by more than 67% of Swiss voters, the Swiss constitution was amended to better recognize and support complementary medicine. This opened new avenues for complementary and alternative medicine, including for Ayurveda.
Since 2012, introductory courses on complementary and alternative medicine have been given to undergraduate medical students at Swiss medical faculties. In that at the medical faculty of Lausanne, a course on Ayurveda is included.

In 2015, two federal Ayurvedic diplomas were created under the authority of the State Secretariat for Education, Research and Innovation: Naturopath in Ayurvedic Medicine, and Complementary Therapist in Ayurveda. These diplomas should favour recognition and integration of Ayurveda. Furthermore, more supplementary health insurers will reimburse Ayurvedic care in 2022.


Méthodes de la thérapie complémentaire reconnues par l’OrTra TC. Solothurn: Organisation der Arbeitswelt KomplementärTherapie OdA KT (https://www.oda-kt.ch/fr/methodes/).


**A12.24 United Arab Emirates**

The Traditional Complementary and Alternative Medicine Unit was established in 2002 under the Ministry of Health, and the Department of Traditional Complementary and Alternative Medicine started licensing Ayurveda and Unani medicine practice.


A12.25 United Kingdom of Great Britain and Northern Ireland

There is no statutory recognition for Ayurveda or Unani, but there are increasing numbers of practitioners and their associations. Several courses have been conducted by private institutions, often under the aegis of medical associations, providing different levels of Ayurveda and Unani training.

Code of ethics including code of conduct and disciplinary procedures of British Ayurvedic Medical Council incorporating the British Association of Accredited Ayurvedic Practitioners. Harrow: British Association of Accredited Ayurvedic Practitioners (http://www.britayurpractitioners.com/download/d774c6dc-6856-11e6-a3a0-153011a6e257/).

A12.26 United States of America

Standalone Ayurveda or Unani practice is permissible in the Health Freedom States, where Ayurvedic clinical services are provided by Ayurvedic health counsellors, Ayurvedic practitioners and Ayurveda doctor graduates. Ayurvedic panchakarma services are provided by trained massage therapists or other licensed health-care practitioners if the services are allowed within their licence’s scope of practice. For example, doctors of medicine and licensed acupuncturists and naturopathic doctors are allowed to practise Ayurveda under their licences in some states.

University-based Ayurveda practitioner training programmes started in 2008. These are designed to impart training to all, including people with no previous medical education. There are currently courses for training Ayurvedic health counsellors, Ayurvedic practitioners and Ayurveda doctors, among others. There are also other types of Ayurveda training, including a programme that trains conventional practitioners as part of their integrative medicine training module, and a programme that trains conventional medicine students in relevant aspects of Ayurveda as part of their university-based undergraduate medical training.


Annex 8. WHO working group meeting

The following were participants at the WHO working group meeting for developing the documents *Benchmark for the practice of Ayurveda*, *Benchmark for the practice of Unani medicine*, and *Benchmarks for the practice of Panchakarma* held in Jaipur, India, 17–19 September 2018:

S Ajit, Chief Executive Officer, Planet Ayurveda, New Zealand

Alireza Abbassian, Assistant Professor, Department of Traditional Medicine, Tehran University of Medical Sciences, Islamic Republic of Iran

Madhaw Singh Baghel, former Director, Institute for Post Graduate Teaching and Research in Ayurveda, India

Jorge Luis Berra, Director, Fundacion de Salud Ayurveda Prema, Argentina (Rapporteur: Ayurveda subgroup)

Santosh Kumar Bhatted, Associate Professor, Department of Panchakarma, All India Institute of Ayurveda, India

Swapan Kumar Datta, Ayurvedic Expert, Directorate General of Drug Administration, Bangladesh

Sohrab Dehghan, Shahid Beheshti University of Medical Sciences, Islamic Republic of Iran

Kartar Singh Dhiman, Director General, Central Council for Research in Ayurvedic Sciences, India

Stephen Yao Gbedema, Associate Professor and Head, Department of Pharmaceutics, Kwame Nkrumah University of Science and Technology, Ghana (Rapporteur: Unani subgroup)

Mujeeb Hoosen, Coordinator – Unani Tibb, School of Natural Medicine, Faculty of Community and Health Sciences, University of the Western Cape, South Africa (Rapporteur: Unani subgroup)

Simone Hunziker, Swiss Ayurvedic Medical Academy, Switzerland (Rapporteur: Ayurveda subgroup)

Mohammad Idris, Principal and Medical Superintendent, Ayurvedic and Unani Tibbia College and Hospital, India

Raveendra Nathan Pillai Indusekhar, President, Ayurveda Practitioners Association of Singapore, Singapore

Syed Shakir Jamil, Department of Moalajat, School of Unani Medical Education and Research, India (Co-Chair: Unani subgroup)

Ghazala Javed, Research Officer, Central Council for Research in Unani Medicine, India

Dinesh Katoch, Advisor, Ministry of AYUSH, India (Co-Chair: Ayurveda subgroup)

Asim Ali Khan, Director General, Central Council for Research in Unani Medicine, India

AK Azad Khan, Dean, Faculty of Unani Medicine, Hamdard University; and President, Diabetic Association of Bangladesh, Bangladesh

Manoj Kumar, Professor and Head, Department of Panchakarma, Ayurveda College, India

Prakash Mangalasseri, Associate Professor, Department of Kayachikitsa, Ayurveda College, India

Abdul Mannan, Vice Chancellor, Hamdard University Bangladesh, Bangladesh (Co-Chair: Unani subgroup)

Antonio Morandi, Ayurvedic Point, Italy (Co-Chair: Ayurveda subgroup)
Paulo Peter Mhame, Assistant Director Responsible for Traditional Medicine, Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania

Kalanther Lebbe Mohamed Nakfer, Director, Ayurvedic Research Hospital, Sri Lanka

Manoj Nesari, Adviser (Ayurveda), Ministry of AYUSH, India (Co-Chair: Panchakarma subgroup)

Valdis Pirags, Director, International Institute for Indic Studies and Professor of Medicine, University of Latvia, Latvia

Buduru Sreenivasa Prasad, Principal, KLE University’s Shri BM Kankanawadi Ayurveda Mahavidyalaya, India

Mukhtar Ahmad Qasmi, Joint Advisor, Unani Ministry of AYUSH, AYUSH Bhawan, India

Revana Siddappa Sarashetti, Professor and AYUSH Chair, Peoples’ Friendship University of Russia, Russian Federation

Anusha Sehgal, Chair, National Ayurveda Medical Association Certification Board, United States of America

Sanjeev Kumar Sharma, Director, National Institute of Ayurveda, India

Mansoor Ahmed Siddiqui, National Institute of Unani Medicine Bengaluru, India

Goh Cheng Soon, Director, Traditional and Complementary Medicine, Malaysia (Co-Chair: Ayurveda subgroup)

Anup Kumar Thakar, Director, Institute for Post Graduate Teaching and Research in Ayurveda, India

Siddhartha Kumar Thakur, Executive Director, National Ayurveda Research and Training Center, Nepal (Rapporteur: Panchakarma subgroup)

Sivarama Prasad Vinjamury, Professor, Research, Southern California University of Health Sciences, United States of America

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Tilakasiri Weerarathna, Deputy Director (Technical-Medical), Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka (Co-Chair: Panchakarma subgroup)

Asmita Ashish Wele, Ayurveda Chair, University of Debrecen, Hungary (Rapporteur: Panchakarma subgroup)

**WHO Secretariat**

Aditi Bana, Technical Officer, Traditional, Complementary and Integrative Medicine Unit, WHO, Switzerland

Sungchol Kim, Regional Adviser, Traditional Medicine, WHO South-East Asia Regional Office, India

Geetha Krishnan Gopalakrishna Pillai, Technical Officer, Traditional, Complementary and Integrative Medicine Unit, WHO Switzerland

**Local secretariat**

Staff of the National Institute of Ayurveda, India, under guidance of its Director Sanjeev Kumar Sharma

Staff of the International Cooperation Section of the Ministry of AYUSH, India
Annex 9. WHO expert consultation meeting

The following were participants at the WHO expert consultation meeting for developing the documents *Benchmarks for the practice of Ayurveda*, *Benchmarks for the practice of Unani medicine*, and *Benchmarks for the practice of Panchakarma* and updating the documents *Benchmarks for the training of Ayurveda* and *Benchmarks for the training of Unani medicine* held in Jamnagar, India, 26–29 November 2019:

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