External Mid-Term Evaluation
Professional Development System 2 (PDS 2 PROJECT)
in the Health Sector Reform in Albania

- Final Version

Phase II: 01.03.2011-28.02.2014

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Contents

1. Abbreviations

CE	Continuous Education
GP	General Practitioner
M & E	Monitoring and Evaluation
MoH	Ministry of Health
NCCE	National Center for Continuous Education
NGO	Non-Governmental Organisation
PDS2	Professional Development System 2 project
SCO-A	Swiss Cooperation Office- Albania
SDC	Swiss Agency for Development and Cooperation
ToR	Terms of Reference

2. Executive Summary

The Professional Development System 2 (PDS2) project has now been running for more than a year and a half, and just over one year remains.

Quoting from the Project Document, the main goal of PDS – Phase 2 is "**to support and contribute to the improvement of quality health care for all Albanians.**"

It is important to prioritise the strategies and mechanisms needed to implement the project with this main goal, and not to confuse this overall goal with the mechanisms of its implementation through (i) a nationwide system for accreditation of CE-programs/activities for all categories of health professionals and (ii) a re-certification system for health professionals (physicians, pharmacists and dentists)".

The main thematic findings of this evaluation relate to the **quantity** of accreditation activities being made available to the health professionals, and to the **quality** of these activities, and include the following:

- The **system of CE** (including the demand from the authorities for health professionals to achieve 150 credits within a 5 year timeframe and for providers to offer the minimum level of activities per year) appears to be well accepted by both the professionals and the Health Institutions who were met. This could not have happened without the support of the SDC-funded PDS2 project.
- Realistic **plans and timeframes** for the next steps forward are needed, acknowledging the current financial climate of the country. Ideas from the document on " Issues And Strategic Orientations" should be used to inform this planning process.
- According to most stakeholders and the independent findings of this mission, the NCCE currently has the capacity to manage the current **quantity of accreditation requests**, particularly for those happening in the Tirana region, albeit with a 3 month time lag which requires further analysis and incremental improvements.
- In order to better manage the accreditation and implementation of offered activities (especially monitoring) in the other regions, plans are in place to appoint, train and cooperate with staff within the Public Health Departments of each region to manage **CE coordination** to carry the functions perceived by the NCCE and the professionals to be most needed. **This should be considered a key priority of the remaining PDS2 project**
- The **role of the NCCE** in achieving the goal of the CE system needs to be clearly defined and emphasized. In this early phase of the system, optimal benefit from CE will be obtained when the providers of activities are clear about what they should offer and how they can provide it, and the NCCE together with the future regional CE coordinators have an important role to play in monitoring and guiding this process.
- The **content, availability and methods of activity provision** are key factors for improving the quality of the education of professionals, and serious consideration needs to be given to ensuring trainers are adequately prepared and supported to develop and teach their materials
- In the context of economic constraints, the establishment of a solid foundation for the development of **distance learning activities** could be an important activity to focus on in the final year of the current project, and could be the basis for future technical support of the CE system beyond the timeframe of the current intervention. **This should also be considered a key priority of the remaining PDS2 project**

In conclusion, it is the opinion of the consultants that the key priorities to enable future sustainability and effectiveness, among all the activities that are planned, is the development of the roles and responsibilities of the planned **CE coordinators** and the establishment of **distance learning** activities.

The PDS2 project has laid excellent foundations, and this next phase should focus particularly on the infrastructure that will maximise sustainability, not simply to produce short-term results that cannot be sustained when the project ends.

Table 1 below contains the list of Recommendations in the order in which they appear in the text. An attempt has been made to prioritise them in terms of their significance for the development of the CE system, to assign prime responsibility for their implementation between the NCCE and the PDS2 project (although both have roles to play in each of these activities), and to estimate their timeframe for implementation.

However, these "classifications" are not definitive and must be interpreted only as suggestions to the stakeholders.

Table 1: Summary of Detailed Recommendations

No.	Recommendation	Priority within PDS2 Project Timeframe	Prime Responsibility		Timeframe	
		1 = Urgent, 2 = Less Urgent 3 = Not Urgent	NCCE	PDS2	Mid-Term (within PDS2 project)	Long-Term (beyond PDS2 project)
1	Up-to-date list of those activity provider sites considered to be the weakest is developed, together with the reasons given and actions that could be planned to support them	2	X		X	
2	Conduct training and planning with the NCCE on sampling rationale and methods as part of the ongoing PDS2 work on Impact and Quality	2		X	X	
3	Carry out a transparent analysis on the causes of the time lag between the activity and its accreditation and any obvious solutions. HII to be involved if possible	1	X		X	
4	Establishing relationships and mutual understanding with the CE coordinators (who should be briefed, tasked, taught, and mentored) through workshops, conferences, and individual site visits with NCCE providing effective supportive supervision of the	1	X		X	X
5	Self-study materials to be made available to all the professionals to encourage easy uptake of proportion of credits available for this	2	X		X	
6	Assessment of whether 250 credits is realistic in the future. If the findings are negative, to lobby the MoH to keep the expectations at the current 150 level	2	X		X	
7	The NCCE, supported by the PDS2 project, should be at the forefront of encouraging a mentality of support towards the providers among the CE coordinators (monitoring, identifying areas for improvement, providing support through promoting training of teachers, and identifying relevant topics)	1	X		X	
8	NCCE to collate information obtained from accreditation assessments, using it to identify the areas for improvement of activities, and to work with the providers to ensure it does not get repeated	2	X		X	
9	Encourage other trained teachers to be involved in ongoing ToT trainings especially in the regions	1	X		X	

10	The number of ToT courses should be increased in this final year improving the quality of human resources in CE providers outside Tirana to further enhance the capabilities of the CE system	1	X		X	
11	Development of a number of usable Distance Learning modules for the Professionals	1		X	X	X
12	Establish a database of distance learning activities made freely available on the NCCE website and related resources	2	X		X	X
13	Identify an institution/organisation to employ 2 staff who would be trained in a Master's degree in distance techniques	2	X (MoH)			X
14	A workshop to discuss linking salary bonuses to difficult-to-achieve quarterly reporting of CE activities, (perhaps instead to link it to longer term 6-monthly or annual achievements) with input from affected professionals	2	X		X	
15	Minimal monitoring of self-study activities	1	X		X	
16	Pilot activities with Pharmaceutical companies be undertaken	3	X		X	X
17	Support Order of Pharmacists in developing Internet based distance learning modules	2		X	X	X
18	Exploration of CE inclusion in Journals could be done as a Workshop with input from Journal editors and publishers	2	X		X	
19	Film recordings (or PowerPoints accompanied by audio recordings) of high level speakers at conferences or workshops could be done and copied onto DVD discs or put online for access by professionals in the regions at their convenience	1		X	X	
20	Integration of CE activities with the (USAID-supported) Telemedicine infrastructure through the development and presentation of media library materials would help enhance the CE system	2		X	X	X
21	Further support the NCCE to build up a "library" of CE materials which could be further built upon by other interested donors or organizations	2		X	X	X
22	The regional CE coordinators should be supported to become aware of the legal/ financial situation of the facilities in their jurisdiction in order to advocate for CE funding to be made available locally	1	X		X	
23	PDS2 project to hold a joint workshop, initially only with the NCCE and start the process from the point of view of how the NCCE envisage the future based on a list of all the issues that must be addressed	1	X		X	
24	NCCE, working in cooperation with the PDS2 project, could draw up an exit strategy with a budget of projected costs for future discussions with the Steering Committee	1	X		X	

3. Methodology

This is based on an initial framework (Annex 3) which highlights the thematic areas and key questions asked for in the TOR in a way that is logical to the consultant. It was further adapted as the Evaluation progressed.

Having carried out an initial desk study of the documents made available by the SCO-A, a field trip was carried out over a period of 9 days from until 23rd November 2012. The national and international consultants followed the general schedule outlined in Annex 1. Due to the limited time available, the consultants spent most of their time interviewing and observing the situation in the capital, but also made one trip to Durres.

The methodology included qualitative analysis through interviews, observations and document reviews, triangulating information when necessary, and carrying out rudimentary focus groups with staff and stakeholders including doctors and leaders at the clinical training (CE) bases. Quantitative data was also assessed as available and appropriate, particularly at the NCCE.

Meetings with the stakeholders were carried out in a participative way to stimulate discussion on how the planned project outcomes are being achieved and to identify obstacles and possible solutions/ strategies that are feasible within (and even beyond) the project timeframe.

Two final feedback sessions were held. The first was with the staff of the NCCE and the local Coordinator of the PDS2 project in order to seek agreement and understanding of the findings, to make final clarifications, and to discuss future planning and strategies. The second meeting was with the SCO-A to feedback and discuss the main findings of the evaluation and to clarify the next steps in the reporting process.

4. Introduction

The consultants were originally asked to assess the PDS2 project based on a number of questions in the ToR (Annex 4).

However, having gone through a process that included answering all the questions, it was agreed with SCO-A in the final de-briefing meeting that the format of this report should principally focus on three main areas:

- The overall findings
- Longer term perspectives
- A critical reading of the main sections of the log-frame (what will be achievable within current timeframe and priorities)

5. Overall Findings

The system of CE (including the demand from the authorities for health professionals to achieve 150 credits within a 5 year timeframe and for providers to offer the minimum level of activities per year) appears to be well accepted by both the professionals and the Health Institutions who were met. Almost everyone spoken to acknowledged that this is a useful requirement and should, in the end, lead to better and more modern methods of care being offered to patients.

While the PDS2 project has 3 strategic objectives: namely the regulatory system, the demand for CE, and the supply of CE, the main issues were found to be related to the capacity to cope with the **quantity** of provision of activities and re-certification, and the capacity to ensure their **quality** in order that sustainability will be maximised through a smooth transition of the project achievements into the public domain.

These two major aspects of the CE system, Quantity and Quality, are explored in some detail below.

5.1 Quantity

Despite this being the second phase of the project, the CE system is still in the early stages as involved organisations and individual professionals come to terms with the new processes. This was evidenced by the contradictory responses received to a number of questions surrounding the administrative aspects of the system. These included, for example, how onerous (or not) it is to fill out the credit application form for self-study, how slow the NCCE website is to show whether activities are accredited, and the possibility for health institutions to allocate funds for CE activities from their budgets without fear of being punished.

This shows that there is work still to do to perfect the system, some of it improving through experience over time as the processes take hold and become a normal part of people's lives, and some of it the duty of the NCCE and all other stakeholders to take responsibility to meet the challenge that a full CE system brings.

5.1.1 CE by Regulation

Unforeseen by the PDS2 project, the government has provided a strong catalyst to increase CE through **regulatory mechanisms** (the Law 'On Health Care", No 10 107, date 30.03.2009; MOH order no. 554, dated 22.10.2009 for the recertification of health professionals) for the Professionals (doctors, dentists and pharmacists) to acquire 150 credits by 2015, and the MoH Order in February 2012 for the Health Institutions to offer the minimum number of activities required by their staff per year).

This has succeeded in stimulating both **demand** for CE provision and accessibility, and the **supply** of such activities. This is shown in Table 2 below.

Table 2: Data on Accreditation Accomplishments [1]

Year	**A. Accredited Activities** (% of activities conducted outside Tirana/ Durres)	**B. Activities Carried Out**	**C. Awarded Credits**	**D. Accreditation Refused** (% total Accredited plus Refused: D/A+D))
2010	202 (17 %)	229	180425	7 (3.4%)
2011	161 (33 %)	269	127123	9 (5.3%)
2012	267[2] (35 %)	467	184360[3]	9 (3.3%)

[1] From the database of the NCCE

Total	**630** (27 %)	**965**	**491908**	**25 (3.8%)**

Out of the 267 applications submitted from January to November 2012, NCCE has been able to accredit only 147 or 55% of them by the end of September 2012. Therefore almost 45% of applications have not been accredited with 25% of the year remaining. It remains to be seen how the NCCE will cope with this increased workload at the end of the year (there are expectations that full completion of the accreditation data-entry will only be done by early March 2013- a 3 month time lag), but the NCCE have taken some steps to ensure that their capacity is better than previously (see Section On Capacity of NCCE below).

It is an encouraging sign that there is a steady increase in the proportion of accredited activities being conducted outside the Tirana/Durres regions (17% in 2010, increasing to 35% in 2012). This increasing proportion of activities taking place in regional hospitals and PHC centres are mostly not able to be monitored (not even by sampling) during implementation. This is an urgent problem, and the government are taking initial steps to deal with it through the assignment and empowering of regional CE coordinators (see section on Delegation of NCCE Functions below).

The number of activities that were applied for but were **refused accreditation** for failing to reach sufficiently high standards is an important figure to be understood, since it could well be that certain providers require more help than others in succeeding to have their activities accredited, and it may be that in a number (even a majority) of cases, failure to be accredited may have resulted from causes in the system such as ignorance of the standards, or misinterpretation.

These are issues to be resolved by support, not simply through punitive measures, and the NCCE needs to keep its eyes open and remain self-critical in understanding what the issues are and in seeking for ways to address them. It is therefore advisable that an up-to-date list of those activity provider sites considered to be the weakest be developed, together with the reasons given and actions that could be planned to support them (**RECOMMENDATION**)

5.1.2 Capacity of the NCCE

Prior to this mid-term review, concerns were raised about the **capacity of the NCCE** to cope with the anticipated increase in the quantity of activities requiring to be accredited. There are complaints about the functioning of the Accreditation and Re-Certification system, with accusations of slow notification of credits on the website (up to 3 months late was reported) and slow updating of upcoming activities on the website. While this feedback provides useful information for the NCCE to improve its efficiency, these do not appear to be major concerns to most of those interviewed.

This was assessed by the Review consultants from a number of angles and led to the following conclusions:

- Firstly, it is important to note that, while the number of newly accredited activities has risen modestly from 202 to 267 per year between 2010 to 2012 (an increase of 25%), the number of individual activities undertaken has increased substantially from 229-467 (an increase of 50%). This is because many activities for which an application has been made to the NCCE for accreditation are repeated for different groups of professionals **without the need to keep re-applying for accreditation**. Hence the workload of the NCCE has not risen in line with the number of activities carried out. Repetition of activities may also explain the fall in the number of new accreditations in 2011 compared to the previous year.

[2] 120 of these activities are still under accreditation process, therefore credits are not yet registered in the database

[3] This is the number of registered credits for activities that happened until October 2012 and does not include the activities that have not completed the accreditation procedure.

The number of credits awarded is also rising, and likely to be at least 25% higher in 2012 than it was in 2010, since the number shown in Table 2 does not include the credits for the last quarter of 2012. However, this raises two concerns:

Firstly, if NCCE certifies credits from activities that have not needed to be newly accredited, how well they can be monitored if only 7 days notice is needed before they are implemented (did they really happen?). Once again, this emphasizes the need to develop a nationwide system of CE coordination, and the need to develop appropriate sampling procedures.

Secondly, even if they are replicated, it could be that many activities are not sufficiently tailored to specific professional groups. Thus, while there are a few professional groups with a high number of members - such as GPs, pharmacists or dentists - that can benefit from replication of activities, the remainder are specialist physicians in small groups. Particularly for this latter group, it will be ineffective to indefinitely replicate activities, and this may exacerbate attendance by professionals who are “chasing credits" and not necessarily learning. This will remain a concern for some time to come as the institutions and other providers increase the variety and quantity of offered activities. While these are limited, and the targets so strict, there will be no choice but for Professionals to go "credit chasing" regardless of the relevance of the material.

- Secondly, the NCCE pushed the Health Institutions to develop a list of **planned activities for the year** early on and these allowed the NCCE to rapidly assess the plans and provide preliminary agreement for the activities to go ahead. NCCE agreement is based on the appropriate filling out of the official accreditation application forms which, among other items, detail the topic of the course, the goals and objectives, the anticipated participants, the proposed teacher (if known) and the teaching methods. Only on completion of each activity when final participant numbers, the identity of the actual teacher, and the exact course material is known and available for review, would fuller monitoring take place (which may or may not include a visit, since these are only conducted for a proportion of the trainings) and a final decision on accreditation be taken. This means that the NCCE workload is spread more evenly throughout the year, with quality control taking place during and after the events - at least for events centered around Tirana.

- Thirdly, there was a decision to allow unit **staff within the NCCE to be moved flexibly** to other units as needed, in particular with 3 staff from the M&E Unit being co-opted into the Accreditation Unit, doubling its capacity to 6 staff. As the workload decreased again, these staff could revert to their original tasks.

- Considering that there are about 50 public hospitals in Albania and more than 400 health centers, it is not logical for the NCCE personnel to monitor on-site all activities in order to be able to take a final decision on accreditation. Therefore visit-sampling of the trainings is carried out, particularly in the Tirana area where the NCCE is located. However, the manner of this sampling is not clear, and there is an emphasis on visiting the sites where training is considered to be the weakest according to the documentation received and previous experience. It would be advisable to conduct training and planning with the NCCE on sampling rationale and methods as part of the ongoing PDS2 work on Impact and Quality (**RECOMMENDATION**). Increasing the scope of such visits outside the Tirana area will require, as discussed in the next section, the support of regional CE coordinators

These factors have contributed to the conclusion of the Review team that the NCCE is currently able to cope with the accreditation workload and even if, as predicted by the NCCE leadership, the number of activities rises by up to 30% in the future, it should still be able to deal with the administrative aspects of accreditation.

However, according to the “Regulatory document on accreditation of CE activities” approved by MoH in 2009 and revised in September 2012, “NCCE shall carry out the process of external evaluation, and

shall make its decision known within 30 days following the application". The potential 3-month lag period in awarding the credits means that the NCCE is not completely able to respect the rules approved by MoH.

It may well be that this represents an unavoidable delay based on the constraints of the current system (probably due simply to administrative procedures related to a. the professionals: delays in submitting applications, b. the providers: delays in finalising course accreditation documents and submitting them, and c. the NCCE: collating this data and that of any monitoring visits). Clear documentation of the causes is needed, together with a consultative process involving the major stakeholders on how to address the issues. The PDS2 project should support the NCCE to carry out a transparent analysis on the causes of this (including sampling a number of the accreditation requests and documenting the time taken to be accredited) and any obvious solutions should be addressed (**RECOMMENDATION**). If possible, representatives from the HII should be involved in this since it may be wise to consider ensuring that the HII takes account of this in its awarding of quarterly bonuses.

At least one week before an agreed activity, all the final details of an activity to be carried out by a health institution including teaching materials have to be submitted to the NCCE (all other educational organizations such as universities, donors, NGOs must do so at least 45 days before carrying out their activities unless they have previously been accredited). But is the NCCE able to process such applications in such a short time? The danger is that the actual activities do not contain new information or good techniques and it is difficult for external reviewers to do any checks at these sites with just a week's notice. Hence the quality of provided education at the health facilities is likely to be lower than at the other sites, and this will be particularly so in the more rural areas where the NCCE are not regularly present. This can only be resolved through some form of delegation of the functions of the NCCE, and it should be a priority of the PDS2 project in the final phase to support this.

5.1.3 Delegation of NCCE Functions

As highlighted above, **monitoring the standard of the activities**, especially outside Tirana, is acknowledged to be a major issue by all stakeholders.

Therefore, at the request of the MoH as recorded in the Semi-Annual Report (decision of the MOH no.2106/1 on 19.06.2012), it has been decided to appoint the functions of **regional CE coordinators** to the Departments of Public Health.

The NCCE will cooperate with those who are designated from these departments in order to fulfil the requirements of managing the CE system. These functions could include providing advice and support for filling out accreditation/ credit applications, providing limited input on methods - and even perhaps content - for teaching activities, and answering questions that the professionals and health institutions might have.

By taking on these responsibilities - currently the daily work of the NCCE - a form of decentralisation (or delegation) of the current workload is envisaged. This will free up the resources of the NCCE to allow it to cope better with the more administrative aspects of carrying out the accreditation.

In addition, it is envisaged to allow certain facilities - such as the Medical Faculty where most activities are considered to be of a high standard- to accredit their own activities. This too, while in this case limited geographically to Tirana, would in effect be a form of decentralization, at least away from the NCCE. However, the consequences of this will have to be thought through, especially with regards to ensuring that high (and improving) standards continue to be adhered to. It is therefore preferable that the NCCE continues to monitor activities even here, albeit with less frequent need for site-monitoring visits.

In general, the **organizational setup/model** of the NCCE mirrors that of other countries in that an organisation is given the responsibility of accrediting educational programs/materials and certifying the Professionals. It could have been done through individual member organisations as it has been in the

UK, but this would require strongly organised and sufficiently funded entities. In the case of Albania, such an option may have been considered less viable, and a centralised body (NCCE) was created to carry on these functions.

Each option has its advantages and disadvantages. In the case of the current model in Albania, centralisation has advantages of neutrality for the accreditation process, and efficiency in terms of being able to develop a fully functional database and monitoring system. But linkage to other organisations to offer more educational materials, and to improve these materials and their delivery, will become more important over time.

While the NCCE cannot demand that outside agencies carry out such activities, those organisations that have a membership will feel pressure from within to provide suitable and relevant materials. In the case of cooperating with the regional CE coordinators based in the Departments of Public Health as is currently foreseen, there will be many challenges since they will not be directly accountable to the NCCE.

Therefore a significant effort has to be made to establishing relationships and mutual understanding through workshops, conferences, and individual site visits with NCCE providing effective supportive supervision of the regional CE coordinators. These are all activities that should form the priority of the focus of the NCCE in the final phase of the PDS2 project, so that on this strong foundation the opportunity to nurture the CE system on a national level will be made possible (**RECOMMENDATION**).

5.1.4 Interpreting the Numbers

The current CE regulation stipulates that the Professionals achieve 150 credits in 5 years. Failure of the professionals to achieve this can be due to:

- Either the professionals, the providers, the NCCE, or the project have failed in some way,
- Or the expectation of the MoH was too high in the context of the Albanian situation.

When CE credits were first developed in the UK, they built on the foundation of an already functioning system of case-study presentations, seminars, and conferences and were quickly supported by stakeholders. These included well-funded associations (eg the BMA) and medical publishing houses among others who quickly increased distance learning materials being made available in journals and online.

This was not the case in Albania when the regulation was passed, and it is more likely that failure of Professionals to achieve the necessary number of credits is due to over-expectations from the MoH and the pre-existing under-capacity of the CE system. There are two possible reactions to this outcome:

- The review team learned that the MoH have considered the possibility of reducing the expected number of statutory credits if it appears that a significant number of Professionals will not attain them in time. But reducing the expected number mid-way through the 5-year period could cause problems and ill feeling among those who have made considerable efforts to achieve all the credits.
- An alternative is to encourage a proportion of the credits to be gained as easily as possible by the professionals (as stated above, by simple registration of self-study activities) so that no-one is hindered from achieving the stipulated 150 target, and in later years the proposed target of 250. Perhaps self-study materials will need to be made available/promoted to all the professionals to encourage this (**RECOMMENDATION**).

Careful consideration and analysis should be given during this final part of the project to assessing whether 250 credits is realistic in the future and, if the findings are negative, to lobby the MoH to keep the expectations at the current 150 level (**RECOMMENDATION**).

Instead of expecting a higher number of credits, more time and effort could be spent on improving the quality and variety and support of CE activities, at least for the minimal number credits expected to be undertaken Quarterly.

It was suggested that activities that can be accessed outside normal working hours would be much appreciated, and suggestions focused on distance learning methods including the distribution of a journal containing CE accredited activities and internet based options.

5.2 Quality

5.2.1 Shortcomings of the Activities

As pointed out above, there are major concerns among all stakeholders, including the NCCE, about the quality of the accredited activities, particularly in the regions. This covers:

- Their **relevance** to the professionals undertaking them: many professionals are "credit chasing" without taking care to ensure that what they participate in is useful and appropriate their own specialty. Even if they are concerned about this, the activities on offer or the costs involved may not allow them to choose the most relevant to their needs.

  The best way to address this will be to offer more and varied activities in order to reduce the need for "credit chasing" for its own sake. Section 5.2.2 (c) below highlights strategies for this.

- The **method** of teaching: while a few teachers have now been trained in "how to teach" (a 2-week course managed by the NCCE with support from the PDS2 project), these are insufficient for the needs of the country. This has been aggravated by concerns about the criteria of selection of candidates, some of whom have shown very little enthusiasm for adopting new teaching techniques/philosophies.

  Increased awareness of good teaching methods will begin to help resolve this, with ideas provided in point Section 5.2.2 (b) below.

- The **content**: while the NCCE can evaluate the basic topic and objectives of the activities, it is difficult to assess the accuracy, level of being "up-to-date", teaching style, and potential bias (eg influenced by pharmaceutical companies) of the material taught.

  Efforts to improve this will require effective utilization of the data collected and analysed by the NCCE and the future CE coordinators- Section 5.2.2 (a), as well as increased awareness/availability of good teaching practices- Section 5.2.2 (b) and increased variety and access to good materials- Section 5.2.2 (c).

5.2.2 Addressing the Shortcomings

a. The Role of the CE Coordinators

All these aspects can be better addressed in the regions if the **planned regional CE coordinators are briefed, tasked, taught, and mentored** to address these issues, and this could be a major activity of the PDS2 project in the coming year (**RECOMMENDATION**).

The main goal of the project - "**to support and contribute to the improvement of quality health care for all Albanians"** should be borne in mind as the regional CE coordinators are trained and supported. If their task is simply to monitor and judge the suitability of the activities, cancelling those that are not considered of high enough standard, then the function of "Quality Control" will be achieved (if the activities are able to be stopped before they take place). However, the basis of accreditation systems in general - and Albania's in particular - is to seek to improve, and not simply to control.

In this case, the role of the regional CE coordinators should be to monitor/ measure the standard of the planned and completed activities, and to use this information to identify further areas for improvement. The NCCE, supported by the PDS2 project, should be at the forefront of encouraging this mentality and these skills (monitoring, identifying areas for improvement, providing support through promoting

training of teachers, and identifying relevant topics through the ongoing assessments and analysis) (**RECOMMENDATION**)

As an example, it was stated that one strategy by which the NCCE functions is to gather **feedback on the activities from the participants**, and to use this information to decide on whether to confirm accreditation of the activity, or not. However, the consequence of this "Quality Control" mentality to improvement soon becomes obvious. When the participants (Professionals) realise that their truthful but critical comments have led to the cancellation of the credits they were hoping for (and had travelled to and/or paid for) then it will soon be the case that they will no longer provide truthful critical feedback to the authorities, and the entire monitoring system will become meaningless and unnecessary.

Instead, the focus for the PDS2 project should be on encouraging NCCE and regional CE coordinators to collate such information, using it to **identify the areas for improvement** of the activity, and to work with the providers to ensure it does not get repeated (eg more training of the teachers may be needed, clarification on expectations, needs assessments of the participants, better information accessible to the providers etc). Ongoing work on this as part of the "Impact and Quality" component (Output 1.7) should help to address these issues in this manner.

In the end, if all else fails, some individual providers may have to be discouraged from providing activities, and alternative providers sought. But all this should be done in an atmosphere of learning together, and with a deep concern for the ultimate needs of the Professionals in a system that is, after all, still in the early stages of development.

b. Training the Teachers

One source of improvement of the CE system is the **training of trainers (ToTs) in modern teaching techniques** and approaches, an activity that has been made one of the responsibilities of the NCCE and has been supported by the PDS2 project from the start. Currently, it appears that the capacity of NCCE to carry out such courses is limited to one training of 20 participants per year. It consists of a **5-day curriculum** developed to establish a training course including development of a needs assessment, topic and agenda, teaching techniques, monitoring and evaluation, and logistics. It was first carried out in 2010, and repeated under PDS2 as shown below in Table 3.

Table 3: ToT Trainings Carried Out under PDS2

	Number of Participants (days of training)												
Year	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TOTAL**
2010	17 (5d)												**17**
2011				20 (4d)									**20**
2012					23 (3d)					20 (5d)			**63**
2013			X (details to be decided)						X (details to be decided)				
Total													**100**

However, instead of creating a formalised pool of experts, a loose group of experts now exists. Recently a ToT was organised by the NCCE for nurses so they could organize their own CE activities and a TOT trainer was located who was available to carry this out.

Although approximately 100 ToT trainers have undergone the ToT course, only a few of these are being called upon to use their skills to expand the courses. There are few individuals already involved and expected to be involved in the next courses: two staff of Faculty of Medicine, one professor of Ethics in Faculty of Social Science, and a nurse. This appears to be a small number of the total trained as teachers, and efforts should be made to encourage others to be involved in ongoing trainings, especially in the regions. The PDS2 project should definitely continue to support this, whether coordinated by the NCCE or by the newly appointed CE coordinators or other organizations/associations (**RECOMMENDATION**).

The effectiveness of the courses themselves may be limited by who the selected participants are, and experience is showing that those involved in teaching and who are younger in age and more open to new ideas will more likely adopt the modern ideas.

With the designation of regional CE coordinators comes the need to train them in good communication skills, and to oversee that those carrying out the bulk of training activities in their regions are aware of and, if possible, trained in such techniques. These CE coordinators could **select the most appropriate teachers** to attend such courses, and the number of ToT courses should be increased in this final year improving the quality of human resources in CE providers outside Tirana (where the needs are bigger), to further enhance the capabilities of the CE system (**RECOMMENDATION**)

Other individuals and institutions trained in conducting ToTs could be co-opted to help achieve more rapid spread of these ideas. Selection of participants should be done according to the best criteria possible, but always understanding that in some (unpredictable) cases there will be participants who never use their knowledge, at least perhaps not immediately. Managers who are trained and understand the techniques may never use them much themselves, but they could end up encouraging their staff to use them, an indirect benefit of having undergone the training. The NCCE should therefore see their role as disseminators of good teaching practices and theory and utilise the (time-limited) capacity of the PDS2 project to disseminate the ToT methodologies throughout the country.

Initiatives are under way to establish capacity to develop **distance learning** modules. Two NCCE staff will participate in an upcoming study tour to Canada to gain an oversight and vision for this. Other key stakeholders including representatives from membership bodies (eg Pharmacists) will also be involved. To augment and build on this, in the coming months a training activity has been scheduled for establishing/strengthening trainers skills on building distance learning programs. This training course will target 15 participants who represent NCCE and other CE providers who have a clear interest to introduce distance learning programs in their CE supply. As envisaged in the LogFrame Work Schedule, following through on this by ensuring the development of a number of usable modules for the Professionals would be an important first step in this process and is feasible within this final phase of the project (**RECOMMENDATION**).

NCCE cannot themselves develop course material for distance learning, since this would soon be a conflict of interest if they have to accredit their own courses, Instead, the NCCE needs to become the overseers, not the implementers, and could be supported to take on this role by the PDS2 project through partnering to lead the training workshops and establishing a database of distance learning activities made freely available on the NCCE website and related resources (**RECOMMENDATION**).

There has been a plan for 2 staff to do Master's degree in distance techniques, but it is sensible to wait until an institution/organisation is defined for them to be employed at to develop the materials if this is to bring the full benefit of such an investment (**RECOMMENDATION**).

c. Activity Accessibility and Content

In addition to improving the CE system by managing the process (eg with regional CE coordinators) and ensuring good delivery of the activities (eg through ToTs in teaching techniques), is the **accessibility** and **content** of the activities.

Health professionals who were interviewed explained how, although they feel under pressure to go "credit chasing" and therefore attend activities that are irrelevant for them, they would prefer to have

the **possibility to participate in appropriate activities** if the opportunities were readily accessible and affordable.

The review team understood that considerable time was needed for professional workers to leave work - particularly to attend workshops or conferences lasting full, and sometimes multiple, days. Family doctors are under pressure from the Health Insurance Institute (HII) to monitor certain indicators related to the care of their patients. Failure to achieve 100% means they lose a proportion of the 20% of their potential salary now linked to achievement of these pre-set standards. Ideally HII should manage this process in a more flexible and less punitive way and, instead of strictly linking the bonus to difficult-to-achieve quarterly reporting of CE activities, to link it to longer term 6-monthly or annual achievements. A workshop to discuss the issues with input from affected professionals and the HII would be one step forward (**RECOMMENDATION**).

However if this is not possible, the NCCE should be encouraged to do all it can to **help the professionals to achieve the HII goals**. The "Regulatory document on Recertification of Health professionals" approved by MoH in 2009, indicates clearly that: "Credits earned from self-reported activities could constitute up to 20% of the total number of credits reported from the professional for each calendar year and/or for each 5-year cycle » (page 11 of Recertification document). This allows professionals to **obtain a proportion (not the majority) of their activities in a very easy and regular manner** for example by reading Journal articles and other self study activities. The NCCE should encourage this in every way possible, training the regional CE coordinators to make this known and to support the Professionals to apply for these credits. At this point in time, minimal monitoring of these self-study activities would nurture trust in the NCCE and demonstrate its role as their "helper", not their judge or enemy (**RECOMMENDATION**). In future years, monitoring could begin to probe to confirm the activities were carried out

Although there seems to be a real fear among stakeholders that allowing **drug companies** to be involved in offering and supporting activities, they are a strong resource who are "omni-present". Could ways be explored to harness their resources in ways that allow highly productive material to be made available in a low key manner with minimal "posturing/promotion" by the companies? This will require strict and clear adherence to criteria already in place (eg company name and giveaways/ refreshments only to be marketed with no lectures/teaching by those with a conflict of interest), with good supervision and monitoring. If these could be further encouraged and implemented they could prove to be a valuable support for the CE process. Could more specific pilot activities with drug companies be undertaken with NCCE participation and oversight leading to a publication on lessons learned (**RECOMMENDATION**)?

It was already mentioned above that professionals suggested to the review team that **distance learning methods would be very helpful** to them. A consultancy has been carried out and a report is available that outlines the possibilities and options, and a study tour to Canada for 6 participants including 2 from the NCCE is planned for December 2012.

Following this, discussions will take place to develop a plan for distance learning and to begin to agree roles and responsibilities. While it would be ideal to formalise an agreed strategy, this may not be easy in the current economic climate. In this case, at least basic next steps should be followed up to allow progress in this area, supported by the PDS2 project.

Distance learning cannot pretend to be a replacement for high quality hands-on skills training activities, nor even for participative workshops/discussions with experts. However, in the current climate and with the need for professionals to increase - at least - their knowledge base, distance learning activities are in demand and have an important role to play.

During this review, distance learning options specifically discussed included (a) the distribution of a **journal containing CE accredited activities** (especially for older or rural-based doctors for whom internet access is more problematic) and (b) **internet based solutions**, both of which would allow easier access particularly for non-health institution based professionals such as family doctors, pharmacists

and dentists. The Order of Pharmacists expressed a keen interest in developing internet options for their own members and they should be supported by the Project in this.

Inclusion of accredited CE activities in journals could easily be done in the existing journals, and this may even increase membership levels. Whether a new journal purely focused on CE, or targeted at GPs, could be produced is questionable, and the logistics of payment and distribution of physical copies is a task that requires a high degree of logistical capacity and skills. Exploration of CE inclusion in journals could be done as a Workshop with input from Journal editors and publishers (**RECOMMENDATION**).

The Review team suggest also to consider utilising the quality of training activities available in Tirana. For example, **film recordings** (or PowerPoints accompanied by **audio recordings**) of high level speakers at conferences or workshops could be done and copied onto DVD discs and/or put online for access by professionals in the regions at their convenience (**RECOMMENDATION**).

Until now, the establishment of the **Telemedicine system** has been focused mainly on "live" presentations between facilities, but this same infrastructure could easily cater for the presentation of such a growing library of video or audio material, perhaps divided up into hour/credit-length sections with suggested discussion questions to promote more participation among the watching/ listening participants. USAID, who have been supporting the Telemedicine initiative, are concerned about the sustainability and use of this infrastructure when the current project ends in March 2014. Integration of CE activities with this Telemedicine infrastructure through the development and presentation of media library materials would help address the USAID concerns and simultaneously enhance the CE system: a win-win situation! (**RECOMMENDATION**)

Ideally, **targeted funds from the MoH** to help support such CE activities should be sought, and these could be used to fund the more effective forms of hands-on training programs, hand-outs for professionals, and the development of distance learning initiatives.

However, if such funding is not readily available, or is causing problems by diverting funds from other important health activities, at least the PDS2 project could help further support the NCCE build up a "library" of materials which could be further built upon by other interested donors or organizations (**RECOMMENDATION**). While enhancing the sustainability of the CE process, it would at the same time increase the quality of available materials to professionals, aided by the regional CE coordinators, with little extra burden placed on the NCCE who would be accrediting such activities only on the first production.

6. Overarching Achievements/Concerns

6.1 Ownership

While it had been hoped that there would be more tangible commitment of resources from the government for the CE programme at this stage, incorporated into a national strategy paper, there are other factors that should be taken into account.

Firstly, the government has committed itself through the issuing of the CE regulation to this system of improvement, and has recently augmented that with the order to the Health Institutions to provide the minimal number of activities to the professionals in their employment.

Secondly, increased staff have been allocated to the NCCE, and more are promised, paid for from the government budget.

Thirdly, while not expanding the NCCE to the regions with additional staff, staff will be assigned to coordinate CME activities and monitoring in each regional Department of Public Health.

And finally, the failure to move forward with the development of a national strategy paper should not simply be taken as a sign that the authorities are not committed to, nor "owning", the CE initiative. This can also be taken to show their concern for their CE system, highlighted by their hesitancy to set out plans that they consider may not be realistic, and which are highly sensitive in the current political and financial climate. The PDS2 project must remain sensitive to these "ownership" issues.

6.2 Long Term CE Funding and Developing a Future Strategy

There is little CE funding by the government other than for NCCE salaries and basic office costs. One way to free up some funds for this is through the allocation of a part of the budget of each health institution for this purpose. The regional CE coordinators should be supported to become aware of the legal/ financial situation of the facilities in their jurisdiction in order to advocate for CE funding to be made available locally (**RECOMMENDATION**).

While there is an expectation that the government should allocate funds for the management of the CE system, this must be balanced against the danger of diverting funds from other aspects of the health system causing damage elsewhere.

Table 4 below highlights the financial costs incurred by PDS2 to support the NCCE and the CE system, and many of these activities (some smaller in scale after the initial start up period) will need to be funded long-term after the end of the project if the CE system is to be sustained.

Thus, the need for **future strategic planning and budgeting** is clear, and collaborative work is needed to develop plans that are both feasible and acceptable. Support to be given to the NCCE to develop realistic plans and timeframes for the next steps forward, acknowledging the current financial climate of the country. Ideas from the document on " Issues And Strategic Orientations" should be used to inform this planning process, at the least using it to form a list of the major issues that should be considered in the future planning process.

One way to move forward would be for the PDS2 project to hold a joint workshop, initially only with the NCCE and start the process from the point of view of how the NCCE envisage the future based on a list of all the issues that must be addressed (**RECOMMENDATION**). Later workshops with other stakeholders could build on what has been developed.

It may be that this will develop simply into a mid-term strategy plan, perhaps little more than the Yearly Plan of Operations, but by looking deeper into the future, some of the longer term sustainability issues will be highlighted and thought will have to be given to addressing them, even if policy direction cannot be clearly set at this stage.

As part of this work on planning, NCCE, working in cooperation with the PDS2 project, could draw up an exit strategy with a budget of projected costs for future discussions with the Steering Committee (**RECOMMENDATION**). This will help raise awareness of the MoH to support a small but essential flow of funds that could ensure a smooth functioning of essential NCCE tasks as the project nears its end

Table 4: NCCE Capacitating Activities Supported From PDS2

#	Grouped activities *(example of activities included in each group)*	Albanian Lek (ALL)	
		2011 (12 months[4])	**2012** (9 months[5])
1	Maintenance and improvement of NCCE website and improvement of (including accreditation) database	424,000	4,820,400
2	Capacity building of NCCE staff *(participation in international activities focused on CME & subscription in international journals on CME)*	2,106,840	1,822,296
3	Technology supplies *(PCs, hardware & software, AC devices, printers, routers etc)*	1,006,600	264,874
4	Public Relation activities *(newspaper advertisements, leaflet production, informational campaign through logistic support and SMS etc)*	743,569	676,804
5	NCCE development activities *(strategic planning, workshops on communication, gender equity etc, networking with national/local partners and CME actors etc)*	1,156,828	338,820
6	ToT Training courses (trainers fees and logistics)		2,225,391
Total (Approximate)		**5,437,864**	**10,148,585**

6.3 Gender

Based on documentary reports and related information, it appears that significant steps have been taken to bring gender issues to the forefront of CE activities.

A consultancy on gender analysis was completed in 2011 and led to the designation of a gender focal point person, training and activities focused on gender being incorporated into the Yearly Plan of Operations for 2012.

In terms of decision makers, observations by the Review team showed that while many healthcare leaders are male, a number of influential personnel interviewed (Medical Faculty, NCCE, Doctors) were female. In fact, it is reported that the co-chairing of the Steering Committee was, on a couple of occasions, left to the director (female) of the NCCE. Also, four women represent different stakeholder agencies and organizations in the Steering Committee.

During Year 1 of the project four women professionals from NCCE participated in different training activities, a number were also planned to attend the distance learning study tour in Canada in December 2012, and five female consultants were hired to provide their expertise in support of project activities. A high proportion of participants in training programs organised by the project (pedagogy, NCCE strategic planning and communication workshops and the yearly planning workshop) were women.

In 2011, it was estimated that 60% of health professionals who participated in CE activities across Albania were women.

[4] March 2011 – February 2012
[5] March 2012 – November 2012

6.4 Relevance

All stakeholders agree that the CE system is appropriate and necessary as Albania seeks to develop towards international standards of health care. The PDS2 project has supported this process in ways that appear to be highly useful and appropriate, including especially the enhancement of the database software and the ongoing developmental and training support.

6.5 Impact

The establishment of the CE system and the clarity and efficiency of its management by the NCCE have caused the professionals to adopt the new concept without much trouble: CE is now an accepted part of all professionals lives.

However, the impact in terms of patient care will only be felt over the longer term, and the real challenge now is to build on the solid foundation that now exists to provide high quality and relevant materials to all the professionals concerned

7. Long-Term Perspectives

In the course of just a few years Albania has been able to develop and regulate for a functioning system of CE which is appreciated by all stakeholders. However, the main task for the future is to move from the quantity of accreditation and certification activities to the quality of them. Failure to enhance this through sustainable mechanisms could potentially lead to a loss of all the momentum gained so far.

While ongoing monitoring of the efficiency of the NCCE should be continued and supported to make incremental improvements, efforts should now focus much more on improving the delivery, content, availability and accessibility of the materials being offered by the providers.

Great opportunities exist, many of them not requiring huge investment. Taking into account the fact that budgetary funding levels are currently limited, these include the following:

7.1 Human Resources:

- Supporting the NCCE as they continue to assist the regional CE coordination to carry out their responsibilities, perhaps even handing over more responsibilities as time continues. Unless the current political/financial climate changes, outside support will be needed over the longer term to ensure smooth communication including regular trips by all NCCE staff to the regions and to plan suitable workshops and other training/coordination activities.

- Mentoring of the NCCE, Orders, Associations and Medical Faculty teachers to be able to develop relevant and appropriate distance learning modules for all 3 types of professionals, commencing also with nurses.

7.2 Development and Delivery of (Activity) Materials:

- Building up a sustainable and disseminated library of materials, including through the filming/recording of conferences/courses in Tirana, and through development of appropriate distance learning materials

- Developing the Teleconference Facilities being made available mainly through US funding to every region of the country, to deliver content not just live but also previously recorded on eg DVD.

- Exploring further the possibility of (carefully) aligning CE activities with Pharmaceutical Company funding and initiatives.

8. Log-Frame Analysis and Priorities

Outputs (per outcome)	Output indicators	Potential for Completion	Recommendations
Outcome 1. NCCE is able to fulfill the range of functions stipulated in the regulatory documents in close collaboration with other stakeholders active in the field			
Output 1.1 - The organizational performance of NCCE is improved through decentralization of its structures and establishment of functional processes of strategic planning and management	- Extended network of NCCE structures is in place (2-3 peripheral branches or antennas) and functioning and 60% of their personnel are women	An alternative strategy has been proposed: to designate regional staff in the Public Health Depts to manage CME coordination.	PDS2 should enable NCCE and MoH to support this as a priority. Devolvement of some specific functions of the NCCE onto the regional CE coordinators to free up the NCCE to improve their administrative functions (eg responding to Accreditation and Certification demands) and further develop NCCE support functions (eg Andragogy, Monitoring and Evaluation, Feedback to the Providers). Support for the NCCE to develop the regional CE coordination function (so that there will be an emphasis on evaluating and highlighting areas of weakness and addressing the issues in a positive and effective way) Training on sampling procedures and analyzing/interpreting the results could be helpful for the NCCE as they seek to monitor and evaluate the all ongoing activities across the country with limited resources.
	- Strategic plan of NCCE is developed, approved and starts to be implemented	Ongoing and satisfactory (also see Output 2.1)	Ongoing support by PDS2 is warranted
	- Operational plans of NCCE developed and implemented	Ongoing	Ongoing support by PDS2 is warranted
	- At least three CE programs delivered by 2013 through contracts between NCCE and CE providers with an emphasis on reproductive health issues and/or other	Due to the requirement by MoH for providers to arrange CE activities, this output has been far surpassed and contracts are no longer needed.	Emphasis on reproductive health issues and/or other women health priorities can be promoted through ToT Andragogy training, by the CME coordinators, and through distance learning course development

	women health priorities - Gender principles permeate strategic and other plans of NCCE	 There is no gender bias obvious	 Ongoing support by PDS2 is warranted
Output 1.2 - The number and type of accredited CE-activities has increased nation-wide, with an emphasis on decentralized activities and distance-learning approaches	- NCCE elaborates in time 95% of all accreditation requests; - 20% of CE programs are accredited in the decentralized structures, following their establishment; - Distance-learning activities are accredited, starting from Year 2; - Accreditation criteria for new CE[6] activities developed and implemented	Due to adaptations in the Accreditation process and NCCE system, this is being accomplished. This is no longer needed This will likely commence in Year 3 This will need to happen, especially for new distance learning mechanisms.	Devolvement of some specific functions of the NCCE onto the regional CE coordinators to free up the NCCE to improve their administrative functions (eg responding to Accreditation and Certification demands) and further develop NCCE support functions (eg Andragogy, Monitoring and Evaluation, Feedback to the Providers). Support for the NCCE to develop the regional CE coordination for evaluating and highlighting areas of weakness and addressing the issues in a positive and effective way Training on sampling procedures and analyzing/interpreting the results could be helpful for the NCCE as they seek to monitor and evaluate the all ongoing activities across the country with limited resources. Initially, criteria for acceptance of Accreditation should not be too strict in order to encourage development and improvement.

[6] "New activities" means activities for which accreditation criteria have not yet been elaborated

Output 1.3 - A safe and accurate electronic database on re-certification of health professionals and accreditation of CE programs is established and maintained correctly	- Re-certification database fully developed and functional	Fully achieved and current NCCE technical staff able to utilize the capacity and potential of the database system	Incremental improvements are now needed, and these will be aided by regular analysis of the speed at which applicants receive their credits. The database system would be the ideal mechanisms to use to monitor this, but if such information is not available, then limited sampling of cases could be carried out.
	- Accreditation database developed and fully functional	Fully achieved	Regular feedback from the Professionals is also needed, utilizing the opportunity afforded by CE trainings and the newly assigned regional CE coordinators
	- Health professionals are able to access online their personal information	Achieved	Ideas for improvement of the database system should be collated from both NCCE and the Professionals to inform the planning for future CE system financing.
	- The Board of re-certification and HCOs are able to check the status of credits for every individual professional through NCCE reports;	Achieved	Discussions should be set up with the HII in order to understand the problems faced by Professionals in attaining sufficient quarterly credits in order to obtain their bonuses. Perhaps a lag time could be permitted, but this will require discussions/decisions that go higher even than the HII, to the Council of Ministers.
Output 1.4 - NCCE is able to organize and contribute to pedagogy/andragogy and distance-learning courses with the support of its' network of Albanian education experts	- NCCE network of education experts in place and functional, with 60% of them being women;	A number have been trained, but no network is yet in place.	Clarifications should be made with the NCCE as to how these trained staff can be best utilsed. Consider linking them to their own Orders/ professional associations. How could the regional CME coordinators cooperate with them? (This should be a topic for the upcoming training of the CME coordinators)
	- 7 ToT courses in andragogy organized by NCCE and 3 distance-learning courses developed with the	Feasible	ToTs (short courses) will be needed to bring those tasked with regional CE coordination up to date on teaching techniques offered by the Health Institutions. More ToTs (full courses) to be carried out for teachers especially in the regions in order both to improve the quality of activities carried out, and to increase their familiarity with the Accreditation application

	participation and contribution of NCCE ; - NCCE pedagogy documentation center created and functional	 Not yet fully functional as a center	procedures. Other trainers outside the NCCE already trained in ToTs could be mobilized to provide such an increased number of ToTs this coming year. Development of distance learning modules, focused around those returning from the study tour to Canada, should be prioritized to set the stage for a future rapid increase in provision of such modules throughout the country, perhaps led by the well organized and motivated Order of Pharmacists. Further development of a library of CE activities could be enhanced though direct filming (or simple audio-recording) of high level conference speakers and recording it to DVD for playback at times and in places convenient to the Professionals. Use of live Teleconference equipment at the regional sites could also be considered. Regional CE coordinators should be provided with materials to enable them to communicate the achievements to-date and to highlight best practices and guide the Professionals to the appropriate sources of information Ongoing support through teaching or providing materials for any publications/ journals describing or offering CE materials
Output 1.5 - An IC-culture with public and private stakeholders and health professionals is established by promoting best experiences and practices	- Listing of CE activities developed and updated periodically and disseminated on-line; - Periodic newsletter of NCCE published quarterly starting from Year 2; - A series of documents (toolkits and guidelines) on CE techniques and practices published by NCCE; - At least 3 national events on	Partially achieved Feasible Feasible Feasible	Regional providers may need more support to enable them to send in information regularly (CE coordination function could be used to support this) This could be done at least for the regional CME coordinators and (through them) to the providers in order to update them on news, remind about key issues and to highlight areas for improvement This could be an output of those undertaking ToT courses, and could be outsourced to those already trained, perhaps in coordination with the Orders/Asscociations But may not be needed in view of new regulations. May be better to focus

	CE themes and issues organized by 2013;		efforts on regionalization of activities with emphasis on distance learning
Output 1.6 - NCCE is able to identify needs, gaps and priorities in order to build the evidence base for incentives to CE-providers	- At least two reports on CE needs, gaps and priorities of two professional groups (GPs and midwifes of primary and secondary health care) produced and disseminated to CE providers	In process	
Output 1.7 - NCCE is able to assess quality of training and impact on performance of health care providers according to European standards	- NCCE designated personnel and other Albanian professionals trained in assessment of CE impact on health care services and performance; - Report of performance assessment work produced and disseminated	Not assessed	Still early for any impact to be measurable, and ambitious to be able to expect to assess this with any degree of accuracy
Outputs (per outcome)	**Output indicators**	**Potential for Completion**	**Recommendations**
Outcome 2. The stakeholders are able to assume their respective responsibilities and to fulfill their distinct roles in the continuing education system; a smooth transition of project achievements into public hands is guaranteed			
Output 2.1 - A national strategy for further development of CES, including a CE financing mechanism, is in place and supported by	- Document of national strategy adopted and published (including regulatory framework); - New financing mechanism identified and included in the	Medium term strategic/ operational plan is feasible in the current climate	Support to be given to the NCCE to develop realistic plans and timeframes for the next steps forward, acknowledging the current financial climate of the country. Ideas from the document on " ISSUES AND STRATEGIC ORIENTATIONS" should be used to inform this planning process. the designated regional Public Health departments who are being assigned

corresponding regulatory documents	national strategy of CE, with a strong emphasis on gender-related equity - Guideline and regulations related to financing mechanism approved and disseminated;		the role of CE coordination in their areas • Development of clear ToRs for the regional CE coordinator role • Identifying training needs • Providing training eg via initial update workshop, followed by other workshops etc • Education on Andragogy • Regular supportive supervision
Output 2.2 - Capacities of CE-provider institutions for developing training programs are strengthened (from needs-assessment to delivery of CE activities) and number of qualified CE-trainers has increased	- Minimally 5 selected CE provider organizations will able to develop and deliver quality training courses to priority professional groups (from needs assessment to teaching materials); - More than 50% of trainers in these organizations are women professionals - At least 5 selected CE provider organizations develop management and fund-raising capacities through training and twinning arrangements	Dozens of organizations are now providing activities, but the quality is the main concern now, especially outside Tirana. Not assessed in detail, but impression was that this is feasible In process, with many organizations charging fees for attending accredited events.	Output 2.2 is one of the priorities of the final year of the PDS2 project. Inputs from studies on needs (eg of GPs) should be fed back clearly to the providers who should be supported to develop or adapt materials to make available to the staff. The leading institutions of Tirana and other leading organizations should be supported to appropriately survey the needs of their staff and members in order to improve the relevance of the offered materials and make these findings available to other providers. Since the current climate makes it unlikely that funds will be allocated directly for CE activities, short term goals should be developed to allow budgets to be allocated for CE activities by Health Institutions, and to educate them in cooperation with the relevant authorities on their rights with regard to allocating budgets for this. A pilot with a Pharmaceutical Company could be carried out (using the developed guidelines) to see how their financial support could be harnessed

			without degrading the quality or independence of the CE activities.
Output 2.3 - Capacities of CE providers in adult pedagogy/andragogy and distance-learning techniques are strengthened leading to improvement of quality and accessibility of CE programs	- 85 trainers develop expertise in andragogy through participation in ToT courses organized by NCCE and its' network of education experts (more than 50% of the participants in these courses are women); - 20 trainers from different CE provider organizations develop distance-learning expertise through a learning-by-doing approach (more than 50% of these trainers are women);	Achieved, but proportion of women not assessed. Recent training was for a group of nurses. In process: this is both achievable and highly desirable	More support is needed for the providers of activities, especially in the regions, through: • increased number of Andragogy ToTs supported by PDS2 and managed both by NCCE and other interested organizations/Orders • monitoring of activities by the regional CE coordinators with feedback to the providers on areas for improvement • increased availability of good quality CE materials though development of distance learning See Output 2.4 below
Outcome 2.4 - Volume of CE-activities increased and accessibility improved, especially for priority professional categories (GPs, nurses) in remote areas		The MoH Order for Institutions to provide a proportion of the necessary activities for their staff has increased the number of activities now taking place, and the providers should be supported in their task now in every way possible.	Development of regional CE coordination functions will begin to help to address the needs of rural GPs, as will development and dissemination of good quality and relevant distance learning materials based on needs assessments and open feedback and ideas. Regional CE coordinators should be helped to support the providers by passing on available (eg NCCE library, documented) materials for teaching purposes The regional CE coordinators should also teach Professionals about their rights to do self-study or small group activities and supporting them to apply for credits for these

	- Training infrastructure and capacities improved (3-5 clinical skills reference centers)	While the development of clinical skills reference centers in the Primary Care Sector is a project activity currently under implementation through collaboration with the University of Geneva and an MoH working group , this may be beyond the scope of the project in terms of both the current timeframe and the overall goals.	Over the longer term, this is really the realm of the Medical Training Institutes
	- At least 5 CE programs targeting personnel of remote areas are developed and delivered during year 2 and 3, based on priorities recommended by NCCE and using the new financing mechanisms; (more than 50% of the trained personnel are women professionals)	The quantity of CE programs available to staff in remote areas has increased far beyond five. However, how accessible these programs are and the relevance and quality are questionable.	Again, there is an important role to be played here by the regional CE coordinators, who should be supported in every way to analyse the situation in their areas and report back for further mentoring. This could be achieved by funding some workshops in Tirana, or in a number of regional areas, to prime them in what to do, and then to follow up with them in how to actually improve the access and quality of offered activities to remote staff.
	- At least 3 distance learning programs targeting priority professional groups are developed and provided (more than 50% of trainers and of participants in this	Achievable: development of distance learning materials and access to it is a priority for the coming year	The study tour to Canada should be carried out as planned, and full use be made of those returning to begin development of at least these 3 distance learning programs with continuing supportive supervision offered to those who return, eventually with them leading a national workshop to introduce the distance learning concepts to others. Including Pharmacists in the Distance Learning initiative and also supporting

	programs are women)		them to develop materials will help address their needs and could see them (through what appears to be highly organized and motivated Order) become leaders in this field.
Outcome 2.5 – Policy and regulatory framework for nurses CE established and implemented on a pilot basis	- New policy and regulatory framework documents published and disseminated; - Nurses included in the pilot intervention start collecting credits for their re-certification program; - 80% of beneficiaries of this program are women	Ongoing regulatory framework discussions and documents can be prepared	Must take into account lessons learned from the implementation of the CE activities by the other professionals: aim for fewer credits in early stages. But the NCCE does not have the capacity to manage this process in addition to its current activities. This needs careful consideration before commencement even of any pilot activities.
Outcome 3. Health care providers (Individuals and institutions) increase the demand for CE through planning and creation of supportive environments for participation in and implementation of CE activities			
Outcome 3.1 - Individual health professionals (especially MDs) are aware of their obligation and responsibility to engage in CE and are able to self-assess their corresponding needs	- 95% of medical health professionals (physicians, dentists and pharmacists) are aware and informed about the rules of re-certification and their obligations related to CE; - 75% of medical personnel are able to identify individual priority needs for CE;	All are now aware of their needs thanks to the new regulations Achievable, but currently too much emphasis is still on "credit chasing".	More activities need to be made available so that, as activities are offered, professionals will have the chance to become more interested in choosing what best suits them. Ongoing education and training of staff in identifying their needs can come through newsletters and email/SMS messages supported by providers and regional CE coordinators. Andragogy ToTs are also an opportunity which could be used to pass on lessons in developing

	- 60% of family physicians, dentist and pharmacists operating in poor remote rural areas are able to identify their personal priority needs for CE;	Should be attempted using all resources currently available.	these skills Regional CE coordinators should be tasked with supporting remote staff to identify their needs. Provider activities could be provided with simple training material to increase awareness and possibilities to develop these personal plans. The plans should be evaluated and used to inform all providers of the needs of these remote staff (Ideally, Orders/ Associations could be used to help with this in cooperation with the NCCE)
Outcome 3.2 - Health care organizations are able to promote and support CE activities for their personnel	- 6-8 regional hospitals have elaborated regulations regarding CE activities based on orientations circulated by MoH - 6-8 regional hospitals have set-up CE units and their respective personnel is trained in planning of CE activities; - New regulation on CE activities at the level of PHC elaborated and adapted in the contracts with HII		Improvements in longer term (>1 year) planning of CE activities are needed by the Institutions, and this can be aided using the regional CE coordination functions supported by the NCCE. In turn the Institutions can be encouraged and aided to provide support to the Professionals as they develop longer term CE plans and present ideas and feedback to the Providers.

Annex 1: Schedule of Consultants

Mid-term Review of PDS2 - Albania:

Peter Campbell& Valdete Bizhga, Albania-Tirana

15 November 2012 – 23 November 2012

Date:	Time:	What	Meeting place	Who
15.11.12 Thursday Tirana	**23:45**	**Peter Campbell: Arrival at Tirana Airport – Transfer to Hotel**		Peter Campbell
	09:30	Briefing with SCO-A –	SCO Tirana Premises	SAV/HAXSO /MtR Team
	10:30	Meeting between experts – review of the agenda	SCO Tirana Premises	MtR team
	11 :00	Meeting with PDS PIU staff- Fabian Cenko	PIU office	MtR Team
	13:00	Lunch		
	15:00	Updating information on PDS2 with Besim Nuri	Via Skype	MtR Team
	09.30	Meeting with president of Professional Associations of pharmacists Arjan Jaupllari	PIU office	MtR Team
	11:00	Continuation of meeting with Fabian Cenko	PIU office	MtR Team
	09: 30	Continuation of meeting with Fabian Cenko	PIU office	IC
	9:00	Meeting with Entela Shehu – NCCE Director	NCCE premises	MtR Team
	10:00	Group meeting with head of units: Ilir Shamata – Accreditation Unit Adriana Ristani – Recertification Unit Laura Kolaneci - Planning and Monitoring Unit Sonila Mecaj- Pedagogic Techniques Unit Armand Qipo – Information Technology Unit	NCCE premises	MtR Team
	13:00	Lunch		

	14:00	Group meeting with head of units & other NCCE experts (continued)	NCCE premises	MtR Team
	18:00	Dinner		IC/SAV & HAXSO
	9:00	Ministry of Health - Meeting with • Pellumb Pipero, Director of Policies at Ministry of Health (head of CE task force)	MoH	MtR Team
	11:00	Meeting with Prof. Isuf Kalo, Director of the Center of Quality, Safety and Accreditation of Health Institutions	CQSAH - premises	MtR Team
	12:00	Meeting with Suela Kellici- Deputy Dean of Faculty of Medicine in charge of CE	University premises	MtR Team
	13:00	Lunch		
	15:00	Meeting with NGO-s rep and other structures related to CE: • Dr. Ervin Kallfa – CE Coordinator at Maternity Hospital "Koco Gliozheni" • Dr. Adrian Hoxha – Head of Association of Public Health • Dr. Llukan Rrumbullaku – Head of Family physicians Association • Association • Dr. Ilir Tasha – Head of Gynaecologists Association (active NGOs on CE) • Dr. Fabian Cenko –PIU	Rogner 'premises	MtR Team
	16:00	Skype conference with implementing partner (Dr. Besim Nuri)	SCO-A	MtR team

	9:00	Travel to Durres- Regional Hospital: Dr. Lida Boshku –Deputy Director of Regional Hospital in charge of CE Regional Directory of Public Health Dr. Vasil Ziu – Director Dr. Shpetim Leka – Deputy Director Dr. Evelina Balliu – Head of Family Physician Department	Durres	MtR Team

		PHC no 6 in Durres: Dr. Fahri Merollari –head of HC		
	15:30	Lunch		
	17:00	Metting with Dr. Agim Kociraj - USAID	West –Café	MtR Team
	19:30	Meeting over dinner with the team from University of Geneva	Restaurant	

	10:30	Focus group with beneficiaries of the PDS2: • Dr. Donjeta Bali –General Secretary of Paediatrics Association • Sabri Skenderi – President of Nurse Order • Dr. Mimoza Dollenga - Health Centre no6 in Tirana, in charge of CE, • Dr. Ramiz Kernaja –Director of Health Center No 6 in Tirana • Dr. Alban Ylli – IPH	SCO-A premises	MtR Team
	13:00	Lunch		
	14:00	Meeting with PIU, NCCE to discuss project' issues in more depth etc)	NCCE premises	MtR Team
	17 30	Skype conference with implementing partner (Besim Nuri)	PIU office	MtR Team

	09:00 **11:00** **12: 30**	Debriefing with SCO-A Leave for airport **Peter Campbell: Departure from Tirana Airport**	SCO-A premises	MtR Team/ SAV/ HAXSO Driver

Annex 2: Reference Literature

1. CHUM/USI; January 2011; Albania Human Resources Development in The Health Sector Professional Development System – Phase 2 (Final Document)

2. C Blanchette; 16-21 October 2011; Albanian National Continuing Medical Education And Distance Learning Ecosystem

3. E Kakarriqi, A Ylli, E Toçi; September 2008; Study Report on Training Needs Assessment of Public Health Professionals in Albania

4. Graduate Institute of Geneva; May 2008; Training needs assessment for nurses/midwives in primary health care sector, Albania (study report- draft)

5. Graduate Institute of Geneva, SDC, CHUM, University of Montreal; February 2009; Human Resource Development in the Health Sector Professional Development System (Report of Technical Mission - Albania)

6. Graduate Institute of Geneva, SDC, USI; 1 April 2010; Albania Human Resource Development in the Health Sector Professional Development System Technical Mission Tirana, Albania

7. Institut Universitaire D'études du Développement and Université De Montréal/Chum; May 2007; Albania Human Resources Development in the Health Sector: Professional Development System (Project Document)

8. M Benigeri; March 2012; NCCE Accreditation and Recertification System Improvements to the System (Mission Report)

9. M Kerker, M Murthi; May 2010; External Evaluation of the Professional Development System Project of the Swiss Development Cooperation in Albania

10. M Kerker, V Bizhga; October 2012; Albania-Health Sector Assessment: For an evidence based decision making in light of the new Country Strategy 2014-2017 of the Swiss Cooperation with Albania; SDC/SECO - SCO-A (Draft Report)

11. QKEV; 2011; Plani i Punes per strategjine e komunikimit te QKEV-se

12. PDS; 4 July 2008; Minutes of Steering Committee Meeting; Tirana

13. PDS; 12 February 2009; Minutes of Steering Committee Meeting; Tirana

14. PDS; 6 May 2009; Minutes of Steering Committee Meeting; Tirana

15. PDS; 2 March 2010; Minutes of Steering Committee Meeting; Tirana

16. PDS; 10 December 2010; Minutes of Steering Committee Meeting on December; Tirana

17. PDS II; 1 April 2011; Minutes of Steering Committee Meeting; Tirana

18. PDS II; 9 Dec 2011; Minutes of Steering Committee Meeting; Tirana

19. PDS II; 4 April 2012; Minutes of Steering Committee Meeting; Tirana

20. PDS II; 11 July 2012; Minutes of Steering Committee Meeting; Tirana

21. SDC; 14 May 2007; Albania - Human Resources Development in the Health Sector - System of Continuing Education (Mandate with TFM)

22. SDC; June 2010; Albania- Human Resource Development in The Health Sector. Professional Development System - Phase 2

23. SDC; 2011; Fact sheet credit proposal for projects / programs- CP PDS final

24. SDC, SCO_A; 2011; Professional Development System (PDS 2) in the Health Sector Reform

25. USI; 2008; Inventory of Continuous Medical Education Courses in Albania, January 2005 – December 2007; (Final Report)

26. USI; December 2009; Explanatory note on yearly plan of operations 2010

27. USI; 2012; Mapping of CME Activities for GP-s, 2012 *(trend analysis observed during 2011 and geographic mapping for CE activities planned for 2012)*

28. USI/B Nuri; July 2012; Strengthening and Consolidation of Professional Continuing Education System in the Health Sector of Albania (*Issues and Strategic Orientations)*

29. USI/CHUM (Besim Nuri); June 2011; Albania – Human Resources in the Health Sector Professional Development System Project – Phase 2; (Mission Report)

30. USI/CHUM; Nov, 2011; Albania - Human Resources Development in the Health Sector Professional Development System – Phase 2, Semi-Annual Operational Report of the Project, March 1st – August 31, 2011

31. USI/CHUM; April 30th, 2012; Human Resources Development in the Health Sector Professional Development System – Phase 2; Annual Operational Report; March 1st, 2011 – February 29, 2012

32. USI/CHUM; October 2012; Albania -Human Resources Development in The Health Sector

33. USI/PIU; 2010; Albania - Human Resources Development in the Health Sector Professional Development System – Phase 2; Yearly Plan of Operations 2011(Draft)

34. USI/PIU;2012; Albania - Human Resources Development in the Health Sector Professional Development System – Phase 2; Yearly Plan of Operations; March 1st 2012 – February 28, 2013 (Draft)

35. USI/PIU; 2012; Albania- Human Resources Development in The Health Sector Professional Development System – Phase 2 Yearly Plan Of Operations March 1st 2012 – February 28, 2013

36. USI/ PIU/ SCO; June 2012; Budget 2012 final- Revised June 2012

Annex 3: Terms of Reference

Terms of Reference for an External Evaluation

Professional Development System 2 in the Health Sector Reform in Albania

"PDS 2 PROJECT"

Phase II: 01.03.2011-28.02.2014

1. Introduction

The health system of Albania is facing enormous challenges related to accessibility and quality of health care. There are neither standards for quality nor standard treatment protocols, while health care providers do not have a system or incentives for quality improvement. Patients often by-pass primary care facilities in order to seek services at secondary or even tertiary level and this is costly and time consuming. Due to all these factors, the health system has a poor response to reasonable expectations of the population in terms of quality of care. Moreover, it can not cope with inherited as well as emergent health problems related to changes in economy, society and life-style of Albanians.

The health workforce skills and competence presents specific features in Albania and this is related to a) a lack of standardization in basic education systems for different professional categories and 2) to the lack of a system of permanent training and learning. Faculties of nursing were created only in the mid '90s and consequently, nurses have a very heterogeneous basic education with only a tiny minority possessing a university diploma. The vast majority of general practitioners have completed relatively well structured under-graduate studies, while post-graduate training in Family medicine started only in the mid of '90s. Specialist physicians are theoretically the better trained professionals that have attended well structured undergraduate and post-graduate studies provided in universities. Most of these health workers have never attended any retraining activity during their professional life and this affects their competence and consequently the quality of care, responsiveness and performance of the health system.

There has been some progress in the area of public health and mental health. The Law on Compulsory Health Insurance has been adopted, with the aim of improving standards of health financing. However, this has not prevented a very widespread corruption practices in the health sector. And partly this is the reason why charges for the health care services have risen in 2012 by 3.2 by creating more problems of accessibility for vulnerable groups. Primary health care in general has not been accessible for all groups, especially marginalised and young people. Moreover, administrative capacity in the field of public health remains weak.

The need for more rapid progress in health reform is both a governance and civil society issue, as it entails strengthening the institutional, governmental as well as strengthening non-governmental performance such as professional associations, interest groups, etc. And the lack of enforcement of existing laws and regulations is a rule of law issue. Education and capacity building for all actors in the health system, at all levels and in a continuous manner, is a prerequisite for successful implementation of the reforms. In order to reduce these shortcomings in a reasonable time period international support is still crucial.

Against this background, the health system in Albania is considered a good entry point for Switzerland to ensure equal access and qualitative services for all, as well as to support the country to improve its effective governance and enforcement of rule of law, contributing so towards the fulfilment of EU integration requirements.

1.1. Project Background

Switzerland is a longstanding partner for Albania and since 1993 the Swiss Government has supported the Albanian health sector through several programs including rehabilitation of hospitals and health centers, training of nurses, midwives and senior health managers. Health in Albania remains an important area for Switzerland and it is considered as a good entry point to ensure equal access and qualitative services for all.

The Swiss Government is funding *Professional Development System in the Health Sector Project* (from 01/07/2007 to 31/12/2010) with over CHF 1.7 mln for its first phase and from 01.03.2011-28.02.2014 with over CHF 1.8 mln for its second phase. Its *overall goal* is to strengthen the continuing education of the Albanian health workforce, consequently contributing to the improvement of the quality of care delivered from the health services and facilities, as well as to the overall responsiveness of the health system. The specific objectives of the second phase of intervention are the followings: *i) The National Center for Continuing Education (**NCCE) is able to fulfill the range of functions** stipulated in the regulatory documents in close collaboration with other stakeholders active in the field; ii) The **stakeholders are able to assume their respective responsibilities** and to fulfill their distinct roles in the continuing education system; a smooth transition of project achievements into public hands is guaranteed; iii) Health care providers (individuals and institutions) **increase the demand for CME** through planning and creation of supportive environments for participation in and implementation of CME activities.*

This intervention is part of the Swiss Cooperation Strategy with Albania 2010-2013 with a special focus on decentralisation process and reform of public services in order to reinforce democratisation and rule of law. The Professional Development System project is aligned with Albania's national legal framework, national strategies and policies. It is supposed to contribute to the implementation of the National Strategy for Development and Integration 2007-2013 (NSDI). Moreover, it is said to be harmonized with projects of other

donors, through participation of SCO-A in Sector Working Group[7] on Health under the Department of Strategy and Donor Coordination at the Prime Minister's Office.

The first project phase was externally evaluated in April 2010. The evaluation report gave an overall positive assessment of the project. In the first phase of PDS, two out of four project outcomes could be fully achieved. This mainly due to the strong support from the government of Albania and the transparent and participatory approach from the project implementers' side, as well as the right choice of the operational set up: The National Center for Continuing Education (NCCE) was established, with premises, infrastructure and staff on Ministry of Health (MoH) pay roll. The compulsory nature of accreditation and re-certification has created a great dynamics which might indeed lead to a sustainable change in attitudes toward Continuing Medical Education (CME) in professional health force. Regulatory Documents on 'Accreditation of CME-trainings' as well as on 'Re-certification of Health Professionals' have been established and officially approved, the dissemination to professionals is under way. Since January 2010, NCCE started accrediting educational activities for different categories of health professionals.

The PDS II was meant to support Albania in its CME reform gradually during 2 phases of intervention, through a step by step approach. The **first phase** of the project (2007-2010) concentrated on CME creation and functioning, as well as on the development and implementation of a mechanism for accreditation, while certification was mostly in its phase of policy-making and design. **Phase 2** (2011-2014) aims at the **consolidation of the NCCE** expertise and functioning at the central level, as well as at the extension of CE functions at the periphery (main districts and hospitals), in order to **increase CME outreach** and **accreditation capacities** in the regions. According to the plans and agreement met in 2010, the **mechanism of accreditation and certification** should become fully functional by 2014 and the PDS II support could see the consolidation of the system and the progressive handing over to Albanian authorities.

A mid-term review was planned in the framework of the PDS II in order to assess early enough the developments towards the exit and formulate recommendations (incl. possible changes) for the remaining of the phase, accordingly.

The Western Balkan Concept has a political objective to **support the stabilization and reform** processes as well as puts a thematic focus on **Rule of Law and Democracy** and especially on the topic of "**Promotion of decentralization and local governance**". The SDC Health Policy pursues a "pro poor", equity and justice oriented approach.

2. Objectives of the External Evaluation

The external evaluation has the below main tasks:

- To assess the **achievements so far** of the second phase of PDS project at output and outcome level;
- To assess the **chosen approach and strategy, incl. gender** mainstreaming;

[7] The Sector Working Group, lead by the Ministry of Health (MoH) and facilitated by WHO, has not been particularly active over the last years.

- To assess and analyze **where is the ownership** of the reform process and especially whether the **financial sustainability of CME system** has been achieved/is on good track to be achieved from the government's side.
- To assess the extent to which the **decentralization of NCCE's role/functions** are in the process and if not the consequences toward the project and the entire CME system in the country.
- To analyze the project's **implementing set-up** in terms of effectiveness and costs efficiency;
- To identify the **lessons learnt** as well as **good practices to be scaled up** and/or promoted by the end of the phase;
- Based on the findings of above and taking into account the dynamic context in Albania, to **formulate recommendations**, possible readjustments – as need be – (incl. revised outcome, outputs) for the remaining part of the project phase.

3. Specific Questions

a) PDS2 Project

1. How far has the project **achieved its mid-term objectives** against those set in the log frame, notably regarding the **strengthening of the professional competence** of Albanian health force?

To what degree is the **professional competence** of the Albanian health workforce strengthened, contributing consequently to the improvement of the **quality of care** delivered in health services and facilities, as well as to the overall responsiveness of the health system (reported and perceived impact)?

Which objectives of the project have been fully reached, partially reached or not reached at all? What are the efficiency and effectiveness of the project so far? What have been the most important changes for the target groups? What lessons have been learnt and what good practices have been identified so far?

Has the **decentralization component** of the project being realized? If not, what are the problems/bottlenecks, accordingly the realistic solutions and options to expand CME outreach and accreditation capacities?

What are the drivers and restrainers of change regarding the successful **implementation of CME reform** in the country and specifically for the PDS2 project? What are the main risks towards the CME reform in a mid- to longer-term perspective? To which extent is the CME system currently operationally and **financially sustainable**? To what extent CE functions related to the offer of training activities are being **established at the periphery** (main districts and hospitals?

2. To what extent is **the project approach** – on organizational, institutional, and technical levels – appropriate? Which approach has proven successful in reaching the objectives? Which have not?

3. How well the PDS2 project activities **fit into Albanian health system** and the Albanian context in general? To what extent does the actual intervention **respond to national policies**, developments and structural changes of Albania? To what extent PDS2 succeeded in enriching the topic of continuing education in the **national policy** level? Does the project involve permanently the **Albanian expertise** in every step of its implementation? Does the project **promote NCCE** and its role? Is the organizational set-up of the NCCE optimal for achieving the goals?

4. What is the **relation with other donors** and organisations operating in the health field of activities? To what degree the development of contacts with other similar institutions in the region is explored? Where are possible links and synergies with other Swiss funded projects?

What is the current and **planned support (institutional and financial) by the Albanian health authorities**? To what extent the Swiss investments are promoted and guaranteed by the competent Albanian authorities? To what level is guaranteed **the ownership and sustainability** of the reform?

5. To what extent does the **use of the budget** contribute to the expected outcomes?

b) Gender equality mainstreaming

6. To what degree an **equitable participation of women and men** in decision making process as well as in the program training activities is ensured?

c) Implementing Partners' (UdeM, PCU) Performance

7. How efficient and effective are the PDS2 **Project Implementation Unit** (PIU), **Coordination Unit** partner (UdeM), the **steering committee** and **national task force** for CME?

How effective are the **TA missions** and support? Are the **tools**, procedures, instruments, monitoring mechanisms, financial controlling, working plans appropriate and well used? How effective is the **collaboration with SDC**, is its support appropriate? What should be improved in view of the planned exit/ to further foster the exit (hand-over to public hands)?

4. Tasks

The consultants will be commissioned to:

- analyze the project documentation, including annual and semi-annual reports as well as additional information (relevant to the MTR subject);
- have briefing and debriefing with SCO-Tirana and possibly with SDC HQ Bern;
- have an exchange in Switzerland with representatives of the initial PDS evaluation and recently conducted health sector evaluation;
- meet/exchange with representatives of implementing partner;
- visit project site (PIU, NCCE, pilot CE units, etc);
- interview a range of stakeholders involved in the project (medical associations, technical consultants dealing with accreditation and certification, direct beneficiaries of the project, etc);
- meet with the institutional partners of the project (Ministry of Health, HII, Ministry of Education and Sciences, DSDC, Director of NCCE, SC members, etc.,) and other donors who are active in reformation of health system in Albania (World Bank, USAID, WHO, etc), as well as PCU staff;
- organize a debriefing in Tirana with SCO-Albania and, as needed, in Bern with SDC; a 3-page aide-memoire will be provided by the evaluation team;
- send a draft evaluation report with specific recommendations, 7 days after the debriefing to SDC and SCO - Tirana; and based on the comments given by SDC Bern and SCO-Tirana on the draft report, finalize it.

To be noted here is the fact that such mid-term review will be conducted in very close cooperation between the team of experts and the PDS2 Project. The role of the review team will be – in dialogue with the stakeholders – to challenge them along the initially planned outcomes and to trigger discussions on the identified restrains/bottlenecks and

realistic solutions/steps that can still be realistically undertaken by the end of the project so as to ensure sustainability.

5. Methodology

The mid-term review methodology should aim at bringing a participatory and forward looking approach. It should be proposed/designed by the international consultant.

In addition to interviews with stakeholders, the following could be envisaged (not exclusive):

- organize a first "study" (as a preparatory activity to set the ground for the international expert' mission in Albania) with different stakeholders involved in CE (This be something like a one day workshop with 5-7 participants, probably best during the first days of the experts field mission);
- organize a focus group discussion with the implementers of training needs assessment for primary health care and public health personnel on reviewing the achievements on CE;
- organize a focus group with the direct beneficiaries of the program to assess how/if the program is meeting their needs and what are their visions for the future;
- have an insight on the work, capacities and dynamics of the NCCE; and have a concrete idea how the project reaches out to areas outside Tirana.

6. Time schedule

The mission is planned to take place in November 2012. The contractual assignment will encompass:

Description	**International Consultant (Time Frame)**	**Local Consultant (Time Frame)**
Preparation, documentation, briefing in Berne international consultant; desk study (local consultant)	3	4
Mission to Albania, including the travel time and debriefing in SCO-Tirana **(14 November-22 November 2012)**	7	7
Preliminary report **(30 November 2012)**	3	2
Debriefing Berne (possibly)/Consultation with SCO-A (part. On proposed scenario)	1	0
Final Report **(14 December 2012)**	3	2
Total	**17 Days**	**15 Days**

7. Consultant team and logistic

The External Evaluation team will be composed by a team of one international consultant and one national consultant. The overall responsibility is with the international consultant who is the team leader. Both consultants have their own contract with SDC. Also, if needed an interpreter (English-Albanian-English) will be hired to facilitate the communication during this mission. PDS2 Project Implementation Unit will offer to the mission all logistics support required (reservations, transportation) and provide all documentation. The SCO Tirana is responsible for the overall organisation.

The consultants should possess the following qualifications:

- Good knowledge and proven expertise on health system reforms, incl. the establishment of a medical continuing education system in Europe and transition contexts (Western Balkan/Albania will be an asset);
- Working experience in continuing education for health forces approaches;
- Excellent knowledge and experience of sustainable development and transition cooperation, in particular as regards project management, capitalization of experiences and advocacy activities;
- Excellent oral and written knowledge of English.
- Good communication skills.

8. Documentation to be provided by SCO-A

The consultants shall receive the following documents in electronic form:

- PDS1 & 2 Project Document and budget, evaluations and fact finding mission;
- The annual and semi annual reports of the PDS 2 Management and its planning documents;
- NCCE Strategy;
- Document (s) prepared from CME National Task Force;
- Steering Committees Minutes;
- NSDI 2007-2013 (with esp. chapter on health); Sectorial strategies: Health System Strategy (2007-2013); National Education Strategy (2004-2015).
- Other relevant reports.

9. Documentation to be provided to SCO-A

The consultants will provide a final report with findings and recommendations to the review. The report will be not more than 15 pages (ideally 10 pages), plus annexes and an executive summary. A draft report will be provided not later than three weeks after the mission in Albania. The final report will be delivered to SDC not later than two weeks after the feed-back of SDC.

The consultants shall not disclose to third parties the information made known to him/her under this project without an explicit authorisation to the SDC HQ. It is not in the responsibility of the consultants to promise any kind of future activities with financial consequences for SDC.

10. The following documents are requested for application:

1) Technical proposal (max. 3-5 pages excluding Annexes), which shall include:
   - Understanding of the consultancy:
   - Description of the relevant context
   - Proposed approach and methodology to complete the task
   - Proposed timeframe/availability
   - Curricula vitae of the proposed consultant
   - Relevant reference projects from previous mandates:

2) Financial proposal: the financial proposal shall be submitted using the standard form provided by SDC.

The completed application shall be sent electronically with the title "MTR PDS application" at sokol.haxhiu@sdc.net, not later than 8th of November 2012.

SCO-A

Tirana-Albania