EXTERNAL EVALUATION

of the

Professional Development System
Project of the
Swiss Development Cooperation
in Albania

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Abbreviations

CCE	Centre for Continuous Education
CE	Continuous Education
CME	Continuous Medical Education
DHS	Demography and Health Survey
FM	Family Medicine
FoM	Faculty of Medicine
FoN	Faculty of Nurses
GoA	Government of Albania
GPs	General Practitioners
HC	Health Centre
HII	Health Insurance Institute
HIS	Health Information System
IHEID	Institut de Hautes Etudes Internationales et du Développement
IPH	Institute of Public Health
IUED	Institut Universitaire des Etudes du Développement
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCCE	National Centre of Continuous Education
NCD	Non Communicable Diseases
NCQSA-HI	National Centre of Quality, Safety and Accreditation of Health Institutions
NSDI	Albanian Strategy for Development and Integration
PDS	Professional Development System
PH	Public Health
PHC	Primary Health Care
PIU	Project Implementation Unit
ProDoc	Initial PDS Projec Document
RegDoc	Regulatory Document (on accreditation / on recertification)
SDC	Swiss Development Cooperation
SDC-A	SDC - Albania Office
UdeM	Université de Montréal
UNFPA	UN Agency for Family Planning
USAid	United States Agency for International Development

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A special thank goes to the Consortium members, first of all Prof. Rainhorn and Fino from the Graduate Institute in Geneva, the project implementer; and second and not least to Dr.Besim Nuri, from Albanian origin, now at the Faculté de Médicine/Unité de santé internationale of the University of Montréal. Meeting him ten years ago as WB-staff in Tirana and again during this mission stands for the guarantee to have a resource person at hand who knows all the insights of the Albanian health system and its ongoing reform processes.

I would like to acknowledge the contributions of and open discussions with my co-evaluator Manuela Murthy. We tried to get in a short laps of time as much as possible information about the Albanian health system and the PDS-project. It is obvious that some aspect might have been missed or have not been interpreted comprehensively enough. But it was our intent to assess the achievements as objective and neutral as possible and to contribute sincerely to a successful progress of the project.

M.Kerker, team leader, MD

A EXECUTIVE SUMMARY

A modern health workforce must continuously upgrade its knowledge and skills. To fulfil this requirement, standards exist (a) for accreditation of trainings and (b) for defining and registering credits earned through these trainings. The result is a system for periodic re-certification of professionals in all health disciplines. As the majority of European countries, Albania is creating such a Continuous Medical Education (CME) System, too. The Swiss Development Cooperation supports this effort since 2007 in form of the PDS, the Professional Development System project.

The first step of the Albanian PDS was the establishment of a national Centre as the hub for the development of the system, under the auspices of the MoH. Today, after little more than one year of commitment of all stakeholders, not only this centre, NCCE, is realized, with premises and staff, but regulatory documents have been drafted and officially approved. First training courses and seminars have got already their accreditation and first health professionals, mainly specialist doctors, started earning credits.

This success, recognized up to the Prime Ministers level, is surely due to the dedication and flexibility of many actors in the field of health, from Ministries of Health and Education to academic institutions and professional orders and associations. But the success is equally due to an adequate and thoughtful operational setup, with an international implementer for the expertise and a local coordination unit for the control and support of the project implementation.

The rapid availability of the basic prerequisites for the CME-system, i.e. centre, staff, regulatory framework, convinced the responsible authority to immediately launch the re-certification process for physicians country-wide. Doctors must get from this year onwards – staggered over the next five years - 150 credits to be re-certified. The evaluation team identified some risks as a result of this rapid paste: NCCE is not ready and fully equipped for the tasks (big number of CME-providers ask for accreditation and numerous doctors claim to be registered). And conceptual work for a nationwide extension of a comprehensive PDS is not done.

The 'Consortium' (IHEID and UdeM) stated from the beginning that *'while NCCE remains the central pillar of the approach and its first step, it is important to notice that developing a PDS is more comprehensive than building simply such a Centre'*. The evaluators have indeed observed that the 'system planning and implementing aspects' of the project is lagging behind with the risk, that the demand for CME, which is now compulsory, cannot be covered by the offer. And this especially in areas, where – in accordance with SDC's country strategy – the main focus for the PDS-extension should be: the remote, underserved areas, where many general practitioners and other health staff still work since years with very basic medical education and no up-grading training.

As an aggravating factor, substantive health training programs have been cancelled in the past years, reducing further the training opportunities. Multi- and bilateral donors should therefore be motivated to re-launch efforts in the field of CME.

But even if the autochthonous offer for CME, from academia and health institutions, should be able to cover the demands, the support for interested training providers must be strengthened, as foreseen already in the 2010 plan of operation: training of trainers, supporting CME-units, etc. And, in order to lower its workload, NCCE must stick to its core functions and put in practice the concept of decentralizing the accreditation work to district hospitals and other regional health institutions.

The main recommendation of the evaluation team is therefore, that the strategic and systemic planning must be reinforced, in view of the second phase of the PDS-project.

B INTRODUCTION

1) Albanian Strategies and Laws

The health system of Albania is facing enormous challenges related to accessibility and quality, particularly at the primary care level. The government's publicly announced objective is to provide quality health care to all. The strategic framework to reach this objective is laid down in the 'Albanian Strategy for Development and Integration NSDI 2007-13' as well as in a number of laws, as the Law on Health Care (March, 2009), the Law on Public Health (May, 2009), the MoH strategy 2007-13, and the draft Health Finance Law (which still is not finalized).

The three main reform areas and intervention lines addressed throughout these concept documents are:

- The governance of the health system;
- The management of services and facilities;
- The quality and safety of the services provided.

Among other priority issues mentioned in these strategies and laws, capacity strengthening - including the concept of continuous medical education of the health work force - as well as decentralizing responsibilities to lower service provider levels are omnipresent.

The problem of these strategies and laws seems to be the lack of provisions for their implementation and/or enforcement, i.e. realistic action plans to integrate the policies into health service operations at the regional and primary health care levels

The need for more rapid progress in health reforms is both a governance and civil society issue. And the lack of enforcement of existing laws and regulations is a rule of law issue.

The reform of the Albanian health system still needs many improvements at governance, management and care levels; standards are set, but implementation is weak, especially at the (rural) primary care level.

***To narrow these gaps, training is a key prerequisite**.*

*There is a consent among aid-agencies active in Albania, that – in order to close this (and other) gaps in a reasonable laps of time – continuous **independent international support** is crucial.*

2) SDC Cooperation Strategy for Albania 2010-13

This strategy encompasses a number of goals and objectives which are of relevance for the evaluated project and its performance and future development. In order to control for the coherence of PDS with SDCs cooperation strategy, the most important elements that should orient the next phase are reiterated below:

SDC in general pursues a 'pro poor', equity and justice oriented approach. While in Albania the disparity between rich and poor is increasing and the risk of poverty is real, especially in Albania's mountainous North, Switzerland is determined to have a strong focus in these regions which carry the highest burden of disease, in sectors that receive less support from the government as well as on marginalized and vulnerable groups of the population.

Another important goal of SDC in Albania is the support of this country in its steady evolvement towards the fulfilment of European integration requirements. The success of the reform process in the health sector is one of these requirements.

Decentralization is part of this process: the strategy states that 'effective decentralized structures are the backbone both of an efficient public administration and of the rule of law' and 'the decentralization reform needs further investment in order to improve the public administration's performance at local and regional level'. This is particularly true in the field of health.

SDC is especially attentive on that its contributions are in line with national strategic frameworks (e.g. the above mentioned NSDI). The long term aim is to develop with its governmental and non-governmental partners a 'strong and effective sense of ownership', which is an important base for sustainability.

> ***Decentralizing efforts towards underserved regions*** *and facilities, supporting the implementation of the reform process in order to* ***reach European standards*** *in health, developing accountable* ***multi-stakeholder partnerships****:*
>
> *These must be key criteria for the planning of the second phase of the Professional Development System project, in order to make it coherent with SDCs overarching strategy lines.*

3) The Albanian health system

3 a) Main characteristics:

The health system in Albania is mainly public with the state being the major provider of health services, health promotion/prevention and treatment. The private sector encompasses only some highly specialised clinics (most of them in Tirana) and is covering the majority of the pharmaceutical and dental services.

Albania counts with about 400 health centres (HC), 40 public hospitals (22 district, 11 regional, 4 university hospitals) and with a health workforce of over 21'000 people. Since the 2006/07 decentralization reform Primary Health Care must operate with increased financial responsibility and managerial autonomy: while decisions can (or could) be taken based on regional priority setting or planning efforts, a centrally approved 'minimal PHC package' must be made available to patients. All funds for PHC are pooled at the Health Insurance Institute (HII).

The health indicators presented in the 2008-09 Demographic and Health Survey (DHS[1]) are generally positive. The figures for Maternal and Child Health have improved: 95% full child immunization coverage; 99% of births attended (97% in a health facility); 97% post partum breastfeeding (declining to 60% after 12-15 months); and 68% to 70% seeking treatment for childhood ailments; an exception is the low prevalence of modern contraceptive methods, which, with the low Total Fertility Rate, suggests a heavy reliance on induced abortion.

In contrast, the burden from cardiovascular diseases is increasing (52% of NCD-deaths account for cardiovascular diseases), the same is true for breast and lung cancer, mental disorders, unintentional injuries (traffic accidents) and health problems caused by alcohol consumption and obesity.

Unfortunately, the DHS data are not disaggregated by income levels: the health status of small, underserved and poor population groups are masked under average figures and the published health indicators risk to obscure the failure of the health care system to meet health needs, especially those of the poor. The most serious barrier to access health services are under-the-table and other informal payments for treatment and pharmaceuticals (independent whether patients are insured or not!) ; this creates a heavy burden on the poor.

[1] the survey focused on a limited issues only (among them maternal and child health)

3 b) Financing health care[2]:

Total health expenditures are slightly over 6% of GDP or 358 $[3] per capita, of which only 142 $/capita (40%) are government money, corresponding to a 9% share of total government expenditures for health. The public health sector financing is provided through a combined mechanism of general taxes (90%), payroll taxes (7%) and donor contributions (3%). In terms of expenses, the MoH (with 70%) and the HII (with 25%) are the major players, whereby 52% of the money goes to hospitals and 42% to PHC.

MoH only controls financing for infrastructure and equipment for health centres and hospitals, while financial support for services is provided by HII. Annually, HII establishes new contracts with health centres and hospitals for payment of all operating costs (personnel, operations, consumables, pharmaceuticals). The Ministry of Finance decides on an allocation of funds based on the prior year's allotment, with adjustment as necessary based on fiscal realities; and the HII manages the allotment of these funds to individual health centres and hospitals. Article 33 of the Healthcare Law obliges the HII 'to allocate necessary funds for CME-activities to the contracted institutions and to determine and implement incentives for the promotion of such activities'.

Since the accuracy of data on actual costs, facility utilization, and human resources is very questionable, resource allocation is made in a 'virtual vacuum' and the system is still not able administratively and politically to implement a performance-based financing.

3 c) Main problems ahead:

The evaluation team had neither the mandate nor the capacity to judge the progress of the reform process of the Albanian health system. For a broad appreciation of the challenges ahead, a summary from a recent USAid assessment[4] might be helpful. USAid concludes that *'there is an evident gap between the legal, political and regulatory mandates and the administrative capacity, financial resources, and implementation plans to achieve them'.*

As reasons for inaction towards implementing the reforms, USAid identifies the following problems:

1. *Inconsistent commitment to the health sector;*
2. *Health reform ambitions exceed resource availability and implementation capacity;*
3. *Roles and responsibilities between MoH and HII are unclear and overlapping;*
4. *Weak management capacities, exacerbated by frequent staff turnovers;*
5. *The absence of a substantive national-regional dialogue to define implementation priorities and parameters for health care reform.*

> *As a result, the health sector reform process seems to be fragmented and moving slowly. While the government health system has changed in positive ways during the country's economic and democratic transition, issues like equity, access to and efficiency or quality of service delivery have deteriorated. Education[5] and capacity building for all actors in the system, at all levels and in a continuous manner, is a prerequisite for closing these gaps and implementing the reforms.*

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[2] 2006 WHO-data and 2008-9 DHS data, respectively

[3] International dollar rate is a common currency unit that takes into account differences in relative purchasing power annual average

[4] from the 2010 USAid health sector assessment which is part of a new USAid project proposal under the title 'Enabling Equitable Health Reform EEHR', published recently for an open bidding process

[5] The 'flagship' health project of USAid in the recent years (2003 – 2009) was 'Pro Shëndetit', contributing to the development of the Basic Package of Medical Services for PHC-centres and **training of** roughly one third of **GPs and nurses** in order to upgrade their skills

C THE PDS-PROJECT

1) The concept

From the year 2004 onwards, the issue of systematically improving the professional capacities of the health workforce was raised, from government side as well as by various donor agencies. SDC launched a first in-depth study 2005 (Dominighetti/Fäh) which was succeeded by a concrete project proposal (ProDoc), finalized after exposure to all the stakeholders, on May 2007 (IUED/UdeM). It defines impact and goal as follows:

Expected long term Impact: competence and skills of health providers are strengthened; motivation of health personnel reinforced; quality of care and responsiveness of health system improved and patient satisfaction increased.

Goal: The professional competence of the Albanian health workforce will be reinforced.

2) The first phase and the Agreement with the MoH

Purpose for Phase 1: A professional development system (PDS) for the Albanian health workforce is designed and begins functioning.

The initial project contractor (IUED) and his implementing consortium (IUED/UdeM) respectively postulated – for the first phase - a **'three-pillar Professional Development System (PDS)'** with

- the provision of continuing education through a **Centre** for Continuing Education (CCE),
- the **accreditation** of training programs,
- the **re-certification** of health professionals.

According to the April 2008 Agreement between SDC-A and MoH, beneficiaries of the project were staff of MoH and the Centre, of academia and professional associations and specific groups of health workers, with a strong emphasis on three categories of **main beneficiaries**:

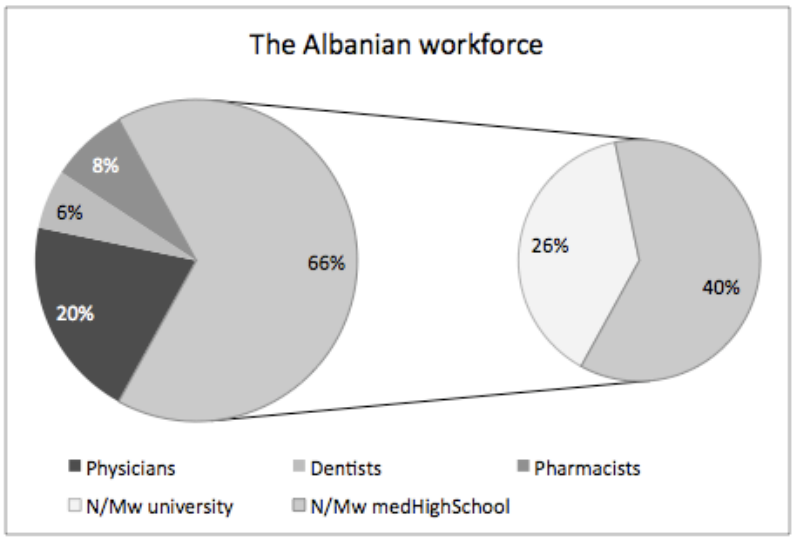
- the GPs, Family doctors and nurses or midwifes working at PHC-level,
- public health workers and managers at districts level,
- health professionals who were already enrolled in earlier SDC training programs (HC/hospital managers, nurses from the secondary level) who might be trained as trainers.

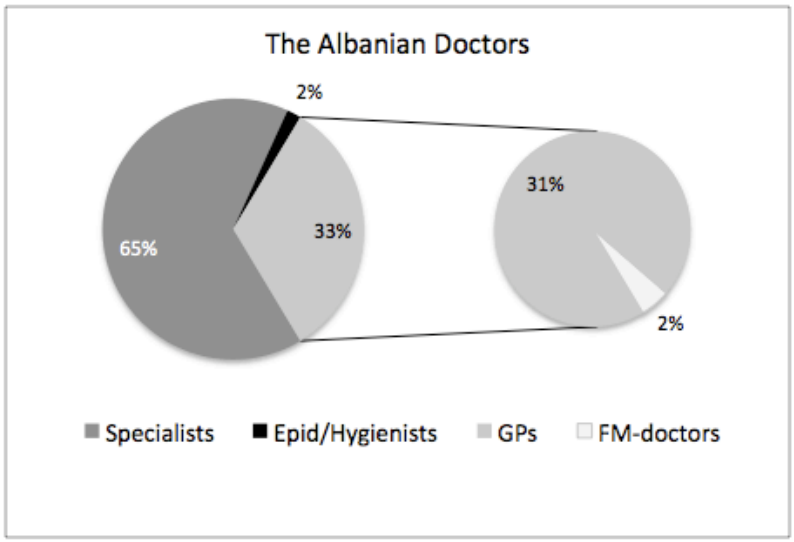
The agreement refers to an action plan with **four outcomes** (called objectives), namely the 'platform for CE' (the NCCE), 'accreditation', 're-certification' and 'equitable participation of women in the process and decision making'. The agreement specifies under 're-certification', that this outcome should be reached 'on a pilot basis' only.

3) The Albanian health workforce: target population of the project

The approximate number of professionals working in the health sector is estimated at about 20'000. There are discrepancies in the figures depending on the source, be they published by the MoH or coming from the various organizations and associations dealing with each specialty. It is expected that, at least for the physicians, the mandatory registration and re-licensing process will bring some clarity into this data.

The ambition of the PDS project being the establishment of a modern and sustainable continuous training system for this health workforce required – as the basis for the evaluation - a closer look at the various groups of professionals involved, in terms of their number, training status or training gaps:





All staff ≈ 20'000 people

≈ 6'100 doctors (≈1'800 GPs)
≈ 1'200 dentists
≈ 1'600 pharmacists
≈ 13'500 nurses/midwifes
+ HC-managers
+ health system 'governors'

For more details on the evaluators brief health workforce overview, see annexe 1.

A comprehensive PDS for the health workforce should – ideally - involve all these actors in an upgrading or CME process adjusted to their needs, because all contribute essentially to the envisaged impact of the project.

The size of the workforce and the heterogeneity in training level claims for a step-by-step approach based on well defined priority criteria. Rapid accreditation is planned for all CME-activities (including doctors and nurses), while re-certification starts with doctors (including dentists and pharmacists) first.

D PDS - THE FIRST PHASE

1) Facts and findings

1 a) The process

According to the consortium's 2009 annual report, 'the policy-making process established and developed in this first project phase has been very transparent, consensual and productive. Most important stakeholders maintain excellent relations with the project. MoH has been very committed and has demonstrated a strong leadership: the Minister of Health and his close collaborators have attended and contributed to project activities in the second half of 2009. The NCCE team has shown motivation and enthusiasm and has been very active in implementing the planned activities.'

The consortium also remarks that the Plan of Operation for the year 2010 was developed in close cooperation with representatives of the most important Albanian stakeholders such as Faculty of Medicine, Faculty of Nursing, University hospitals (maternity), Order of Nurses, Order of Physicians, representatives of PHC clinics, association of pediatricians, association of obstetricians etc.'

The evaluation team got indeed the impression through the numerous interviews with members of the MoH as well as with all the above mentioned stakeholders that the project and the necessary reform processes have a widespread support and the progress is unanimously welcomed. Inclusiveness, independence, transparency and sensitivity to expectations of all partners involved were key ingredients for the progress that – starting slow in 2008 – showed an astonishing acceleration through 2009 and early 2010.

1 b) Achievements by outcome and outputs

Outcome 1:

CE platform developed, starts performing during phase 1

(i)	NCCE legally created, personnel appointed	
(ii)	Review of existing training programs completed	
(iii)	Training needs assessments conducted, priorities identified	
(iv)	A national training plan is designed and approved by MoH	
(v)	NCCE organizes/coordinates CE programmes/courses	
(vi)	Pilot CE-units organised in different health settings	
(vii)	Capacity of trainers in andragogy reinforced	

accomplishment scale: from black=fully achieved to white=not yet achieved

The summary shows that this outcome has been accomplished only partially. The ambition to realize all planned outputs has been too high, some outputs didn't succeed, other outputs have not been addressed at all:

Ad (i): the most essential prerequisite of the PDS-project, the establishment of a National Centre for Continuous Education, has been fully achieved, with assigned premises and appointed professional staff, on the payroll of MoH.

Ad (ii): It exists, at present, no comprehensive review or inventory of available training opportunities for the various health professionals[6]. And the recently started accreditation of CME activities is generating a course database with a strong bias towards trainings for specialist doctors in Tirana. A new, proactive identification of CME-providers for main beneficiaries of PDS, as the GPs, has not yet started by NCCE. It might therefore be difficult for PHC-staff to get their credits on time, especially because important trainings for PHC doctors and nurses have ceased to exist (e.g. Pro Shëndetit by USAid).

Ad (iii): This output has seen a partial accomplishment. Over the past 2 years, three broad training needs assessments have been carried out: the first on nurses/midwifes (2007/08), assisted by the 'haute école de santé de Genève'; the second on public health professionals (2008), carried out by the IPH; and the third on managers of HCs of the PHC-system (2009). All needs assessments were supported and assisted by the PDS-project, only the last one was carried out mainly by NCCE-staff. These assessments are indeed a valuable basis for decision making and priority setting in the planning process of CME for these priority groups of professionals.

Ad (iv): Till now, PDS could not produce a useful result under this output line. Despite the fact that such a national training plan is the essence and one of the key mandates for the NCCE. This shortcoming must be qualified by the fact that a training plan has been submitted to MoH in two versions, first in a comprehensive and second in a slim form, but – unfortunately – MoH had no funds for CE activities at that time (due to change of priorities at government level according to Besim Nuri). But the evaluation team got still the impression that the proposals might not have been elaborated enough conceptually and strategically: the evidence, why to do what and where, was not clear enough. This output must become one of the major tasks of the next months or – rather a periodic outcomes during the next phase.

Ad (v): Again, this output line could not be achieved. NCCE staff was not ready to launch concrete initiatives for the proactive identification, organization and coordination of training activities for priority beneficiaries. There might be some small exceptions, e.g. a training course for public health professionals (on hygiene, etc.) at the IPH; but the 'contracting' of the course implementer (i.e. the governmental IPH) has been a 'nightmare', as stated in the consortium's annual report: '*The completion of contracting and financing procedures of this training activity from NCCE resulted to be hard and complex due to the legal barriers (law of public procurement and budget) and lack of experience for this type of activity*'.

Ad (vi): The plan to establish in five pilot institutions a proper CME-unit has been launched shortly before the arrival of the evaluation team. The staff assigned to each of these units (Faculty of Medicine, Order of Nurses, Institute of Public Health, Maternity hospital "Koço Gliozheni" and Tirana PHC clinic number 8) have been interviewed. They all are in the process of learning about the preconditions of a CME-unit (according to the accreditation regulations), to identify their obligations and to think about training options of their corresponding staff. Ideas are developed, but concrete action did not really take place up till now.

Ad (vii): Some foreign input has been given during 2009 to improve andragigic capacity to NCCE staff. The evaluation team got the impression that NCCE wasn't clear about its role in this field, i.e. the right balance between some own expertise at the centre

[6] An inventory of CE activities for the period 2005-2007 has been compiled and a report published. The objective of the project was in fact to carry out a retroactive action for the 2-3 years prior to the beginning of the project; PDS wanted to show that many CE activities existed and were provided in the past but they were not accredited or registered somewhere (Besim Nuri)

and the organization of capacity outside. According to Besim Nuri, the original purpose of the project in relation to andragogy was *(1) to create some expertise in andragogy at the centre but mostly (2) to create a pool of experts in andragogy out of the centre that the centre could mobilize later for supporting all the individuals and organizations who are involved in CE'*. At the moment, both aims of this output haven't been reached (ToT-curriculum on andragogy not ready, ToTs not trained).

Outcome 2:

A mechanism for accreditation of CE-programmes developed and functional by end of phase 1

(i)	Mechanism designed, standards formulated/approved	
(ii)	CE-programmes begin to be accredited	

accomplishment scale: from black=fully achieved to white=not yet achieved

The summary shows that this outcome has been fully achieved:

Ad (i): The 'regulatory document on accreditation of CME-activities' is established and officially approved;

Ad (ii) Since January 2010, NCCE started accrediting educational activities for different categories of health professionals. Up to April 30, 60 applications for training activities have been submitted to NCCE for accreditation; 38 of them did already get it, 1 has been refused, the others are under scrutiny:

- Applications by CE-categories:

Trainings	24
Conferences	20
Seminars/Workshops	16

- Applications by CE-providers:

Professional Associations	25
NGOs	14
Health Institutions (HCs, Hospitals, etc)	9
MoH or institutions depending on it (IPH, etc)	8
Private Academic Institutions	4
Public Academic Institutions	0

- Applications by groups of health professionals:

Medical specialists	25
Multidisciplinary teams	10
Dentists	8
General Practitioners	6
Medical specialists + Nurses	4
General Practitioners + Nurses	4
HC-Managers / HC-Directors / Economists	2
General Practitioners + Medical specialists	1
Pharmacists	0
Nurses	0

The workload resulting from the accreditation of CE-activities is increasing steadily, showing that institutions and organizations are aware of the possibility to get their training offers accredited – in order to enable participants to earn credits.

The criteria for accreditation are well defined in the regulatory framework and the work is 'outsorced' to contracted experts, university professors, etc. The quality of the experts' work, an issue which might not get too much of attention at this early stage, could not be verified by the evaluators.

Outcome 3:

A system of re-certification designed and implemented on a pilot basis end of phase 1

(i)	A policy doc produced in coop with authorities/stakeholders	
(ii)	Broad consensus reached, legal acts approved	
(iii)	Re-certification applied on a pilot basis for specific groups	

accomplishment scale: from black=fully achieved to white=not yet achieved
over'-achieved

The outputs for outcome 3 have been achieved or – referring to output (iii), 'over'-achieved; and this under political pressure from authorities: MoH ordered the 'full-fletched' launch of registry of health professionals and their corresponding earned credits; the 're-certification outcome' can therefore not anymore be considered as a step-by step or pilot approach, as foreseen in the agreement with the government.

Ad (I and ii): The 'Regulatory Document on the Re-certification of Health Professionals' has been established and officially approved, the dissemination to those professionals included at this stage is under way (i.e. to all physicians, dentists and pharmacists; inclusion of nurses and other professionals is planned in the future).

Ad (iii): Based on an order of the Minister (of 12/17/2009) most public institutions must submit a staff list to the NCCE, in order to establish the 'national register of re-certification'. Since than, the re-certification process is focusing mainly on collecting and recording (in a provisional Excel database) the information of all doctors, pharmacists and dentists employed in the public and private sector in Albania. The Order of Doctors and Pharmacists has contributed to the collection of information of health professionals, including those from the private sector, a sector where there has been (and still continues to exist) a big lack of information. In addition, first credits earned are introduced into this Excel-database.

Outcome 4:

Ensure equitable participation of women in decision-making process as well as in training program activities

(i)	Strong and permanent participation ensured	
(ii)	High women participatory rate in CE-activites ensured	*
(iii)	High participatory rate of female technical consultants ensured	

accomplishment scale: from black=fully achieved to white=not yet achieved

* In the near future, NCCE will be able to provide gender aggregated data, i.e. proportion of women among participant of CE-courses/-seminars etc. from their credits database

The summary shows moderate achievements related to the gender objective. But this is mainly due to the fact that few CE-activities took place, so output (ii) could not unfold; and hard data on output (iii) were not available. In contrast, the most important output (i) – really relevant for the developments up till now - is 'fully achieved':

Ad (i, ii): From the very first CME-system development efforts onwards, the participation of women in decision making and action has been important. According to Besim Nuri from the consortium, until June 2009, the policy dialogue and decision-making processes and the establishment of the NCCE were led by Albanian women:

- ✓ By Dr Anila Godo, the than minister of Health, Dr. Zamira Sinoimeri, deputy minister and a wise leader of the process, and by Dr Entela Shehu, the today's director of the centre.

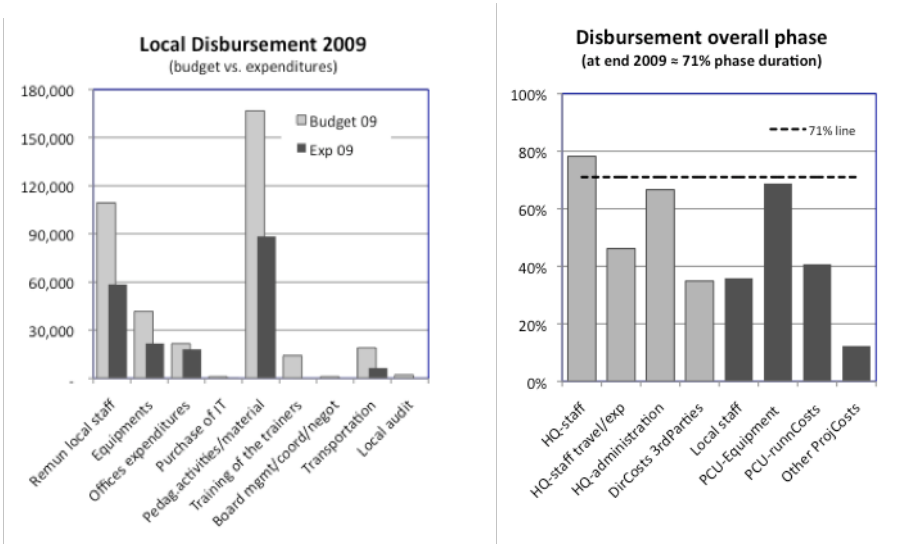
In addition, the following facts have been verified:

- ✓ NCCE professional staff: 70% women;
- ✓ CPU staff: 75% women;
- ✓ In courses recently accredited at NCCE: > 50% registered participants female;
- ✓ Among the 57 interviewees during the mission: 55% women;
- ✓ According to the Dean (still male!) of the Faculty of Medicine: 80% of students in recent years are female (a fact which he sees as a problem, because *'female doctors work part-time, take maternity leaves, and are not 'strong enough' for disciplines like surgery'*).

Ad (iii): the evaluation team didn't control whether the female rate among 'technical consultants' was high, but according to the PCU, more than 50 % of local or international experts involved till now were female.

1 c) Disbursement analysis of phase I

Disbursement of the available funds is behind the budget plan, mainly at local level (left side graph, absolute figures of year 2009; right side graph disbursement rates since inception of phase 1: dark columns = local, clear columns = IHEID):



The expenditures are not linked to outcome and output budgets, but are organized according to fiduciary accounting categories. Disbursement cannot be related to the corresponding output expenditures and – as a proxy – to progress of work. A different accountability software might boost the capacities for program monitoring.

1 d) Observations related to the extension of phase 1:

According to the PDS-consortium, the 2010 Yearly Plan of Operation was developed in Tirana on December 14-15, 2009, in cooperation with the personnel of NCCE and representatives of the main Albanian stakeholders. Because of delays in progress of the 2009 work plan, a no-cost extension was proposed and approved by SDC (July-December 2010). Under the same outcome (objective) headings, some outputs were adjusted according to progress level and new time schedule.

As described above, outcomes 2 and 3 (accreditation, registration/re-certification) had to be put on the main focus of NCCE's activities during the past months, and the centre staff is still mainly occupied with work related to them. As a result, **activities under outcome 1 are lagging behind**, as the following table shows:

Planned and realized activities of objective 1:
A CME-platform will be developed and will start performing during phase 1

Month		1	2	3	4	5	6	7	8	9	10	11	12
Building capacities of NCCE to perform its new roles and functions													
1.1	office space												
1.2	IT/equipment												
1.3	Website support												
1.4	establish CE doc-centre												
1.5	communication training												
1.6	studies abroad												
1.7	national CME conference												
1.8	plan scaling-up strategy												
National CME plan 2011 formulated, approved by health authorities													
4.1	developed												
4.2	approved												
NCCE implements 2010 National CME-plan: organizes, finances, contracts courses													
5.1	TOR for contracting												
5.2	NCCE contracts providers												
Strengthens H-Organizations and ProfAssociations to plan/organize CME													
6.1	5 pilot units organized												
6.2	equipment to units												
6.3	training of 30 unit staff												
6.4	training for accreditation												
6.5	networking/study tours												
6.6	support CME impl.												
6.7	support OofN conference												
6.8	support OofN website dev.												
Train trainers for andragogy techniques (courses)													
7.1	develop ToT curriculum												
7.2	30 trainers trained												
Training of priority categories of health professionals is completed													
8.1	curriculum for PHC-mgmt												
8.2	first courses												
8.3	trainings PH-professionals												
8.4	andragogy for FM-ToTs												
8.5	trainings for GPs												
8.6	ToTs in academia												

grey = planned outputs; black = activities realized

This presentation of achievements might not be fully accurate, but it shows that some outputs are difficult to achieve during the foreseen time-span – for various reasons:

- Outputs 5.1 and 5.2, referring to a 'national CME-plan' and to 'contracting of providers', i.e. the concrete implementation of CME-activities, will hardly be achieved because (i) no such 2010 National CME-Plan has been approved by the MoH (4.1, 4.2) and (ii) no MoH-budget is available (despite promises).
- Outputs 8.1-8.6 (referring to the real CME-implementation stuff) will be difficult to achieve, too, considering that training for trainers for the various beneficiary groups didn't take place until now and more than 1/3 of the plan period has past.

There is no surprise that disbursement linked to these planned outputs is again behind schedule.

2) Conclusions from the findings

2 a) On outcomes

CO1 *- Conclusion Outcome 1:*
A platform for CME will be developed and will start performing its functions during phase 1

The full fledged establishment of the NCCE in a short laps of time must be considered – and is considered by all of the interviewees – as a success story under Albanian realities; and it has even become a 'show-case' at Prime-Minister's level. The compulsory nature of accreditation and re-certification has created a great dynamics. It can be interpreted as a strong sign that a sustainable development and cultural change in the field of CME has been launched.

The drawback of this success and dynamics is the overload of a new structure which is not ready to fulfill the tasks properly (IT, communication) and to loose out of focus crucial strategic and conceptual aspects for the system implementation. Therefore, the steps from need assessment to priority setting and realistic planning is not done, the lack of plan makes the identification of training providers and potential sponsors difficult, and decentralization efforts to delegate tasks and lower the centre's workload are inexistent.

Concerning the 'needs assessments': To transfer the relatively vast list of identified skill and knowledge gaps into concrete CME-plans requires more thinking.

Concerning NCCE's job as 'subcontractor': The 'law on public procurement' is a major concern in view of NCCE's future role as financier of seminars and courses using the budget allocated for this purpose by the MoH. The evaluation team didn't hear of any solution of this problem, neither from government nor from multi- or bi-lateral donor side (WHO representatives, among others, were helpless).

Concerning the 'pilot CME-units approach': The concept of such pilots seems reasonable in order to make first experiences; scaling-up and outreach to more remote institutions or organizations in order to really offer trainings to the target beneficiaries is still a big challenge.

CO2 *- Conclusion Outcome 2:*
A mechanism for accreditation of CE-programs will be developed and will be functional by the end of phase 1

The launch of practical and concrete accreditation work is obviously part of the project's success story.

But, as seen in the statistics of accredited courses until now, the groups of professionals, to whom the training is addressed, is biased towards specialist doctors (probably most of them in Tirana): only 1/6 of accredited trainings focus on GPs – i.e. on those who need CME most and should be the main beneficiaries.

The fact that – at the moment – all accreditation work is done at NCCE and no concept of delegating this task to a decentralized structure, holds the risk to deviate NCCE's capacity and focus from other more conceptual and strategic work necessary for the development of a nationwide functioning system for CME.

CO3 *- Conclusion Outcome 3:*
A system of re-certification of health professionals will be designed and begin to be implemented on a pilot basis by the end of phase 1

The evaluation team confirms what the PDS-consortium has stated in its 2009 technical report, referring to the achievements of this outcome:

'It is probably another success of a prudent, inclusive and transparent guidance (by consortium, PCU, SDC-A office) of this policy process, that this delicate issue of re-certification - considered the most difficult objective of the project - reached a consensus so rapidly. The participation of all stakeholders and an explicit will and leadership of the MoH amplifies this success with the necessary dose of Albanian ownership.'

But this acceleration and the pressure by the authorities leads – again - to an overload of the centre, a still not fully operational structure, which must now absorb and secure data with inadequate tools. This contributes to a deviation of staff from other important tasks. A step by step introduction of outcome 3 might have been preferable; now, the project must deal with it in a rushed manner.

On the other side, from a tactical point of view, MoH's pressure might have been legitimate. Course-accreditation and credit-earning are obviously interlinked, and doing the first without allowing the second would have hampered the rising dynamics for a 'cultural change in Albanians' CME': the offer (of accredited courses) did ignite the corresponding demand. So, NCCE has no choice than just muddle through.

***CO4** - Conclusion Outcome 4:*
Ensure equitable participation of women in the decision-making process as well as in the program training activities

Up till now, the project development could count with a strong participation of women. The now established CE-structures operate with over two third of female staff. First indications seem to confirm equally a high female participation in accredited courses. In a project focusing - in the future - on a workforce with a large majority of nurses, it shouldn't be too difficult to get 'high women participation' in CE-activities.

But it is clear – and has been obvious during the evaluation mission – that 'the highest decision making level' is still in the hands of male: Minister of health, Director of Cabinet, all Presidents of health professionals associations (including order of nurses), etc. This reality probably holds true especially in rural areas (members of local governments, prefectural Public Health departments, regional HII directories, boards of health centers, medical directors of HCs are rarely women). At these important levels, the project's influence will be limited and the project's ambitions for this 'cultural change' should not be pushed too far…

2 b) On Concept and Strategy

***CConc** - Conclusion Underlying Concept:*

The project's hypothesis is self-evident, namly that health staff with up-to-date competences and skills will lead to the proclaimed impact, i.e. *'an improved quality of care and responsiveness of the health system and an increased patient satisfaction'*. But it is evident as well, that CME is only one – while crucial – component for a modern and efficient health system and that other elements must show improvements in parallel (infrastructure, equipment, financing, etc.). Good staff can only make a difference if there is progress in the overall health reform agenda[7].

[7] A similar conclusion is found in the new USAid project proposal under the title 'Enabling Equitable Health Reform EEHR', published recently for an open bidding process: 'although our project will support progress with the primary health care agenda, exclusive focus on PHC … would be inherently undermined by the lack of progress in health reform; the current imperative is to transform the laws, policies and regulations into operational measures ….'

As mentioned in chapter C1, the concept of a 'Centre of professional development' was developed after a thorough inception period, where the government's own endeavor to improve the health workforce as well as the international (European) standards in this field were considered. The IUED/UdeM consortium finally proposed *'a more advanced concept'*, called a *'Professional Development System PDS'*, stating from the beginning that *'while a CCE remains the central pillar of this approach and its first step, it is important to notice that developing a PDS is more comprehensive than building simply such a centre'*.

The evaluators have noted, that in the past various training programs for health professionals did exist (e.g. the 'flagship' project of USAid 'Pro Shëndetit', that trained in the years 2003 – 2009 *'roughly one third of GPs and nurses, upgrading their skills'*). In the context of 'Pro Shëndetit', a concept was elaborated with MoH and other stakeholders, presenting an analysis of the big deficiencies of Primary Health Care and designing a framework for 'bridging' specifically the competency gap of GPs (more on this concept see annexe 1). The principle of PDS is a focus on CME, i.e. on a system obligeing the physicians to 'earn 150 credits in the next 5 years'. The hypothesis, that a CME alone will lead - over time - to a real upgrading of GPs to the level of family doctors, is questionnable. Or the question is, whether PDS, with its high ambition on impact on quality of care at PHC-level, should engage, in one or the other way, with a transition country's need for a broader 'bridging concept', at least at the level of concept and policy dialogue.

***CStrat** - Conclusion PDS-Strategy:*

The strategy of the consortium was divided in three phases, whereby the first had its focus on the creation of a physical centre with staff and equipment, the establishment and approval of the legal framework for course accreditation and health professional re-certification. The second phase should see the consolidation of the achievements, an extension of the CME-activities over the whole country, including decentralization of specific tasks from the Centre to the periphery. The third phase, finally, would see the phasing out of the external support and the autonomous and continuous functioning of CME. At this stage of PDS, this time schedule seems reasonable.

While major principles stipulated in the ProDoc, like working closely with the Albanian authorities, networking with the relevant stakeholders and observing a gender-balanced approach were satisfied and the main outcomes of the first phase were reached, other principles and prerequisites for a smooth transition into the second phase have not been met in the same satisfactory manner. This refers mainly to the lack of systemic preparation of the project roll-out (strategic planning, decentralization) and the fact, that the principle of a 'step-by-step' approach has been overthrown, leading to a fait accompli, which imposes many operational tasks to the just created NCCE, tasks it was not ready or conceived for. It is said that 'the project became the victim of its own success'…

One risk of this development is that the project lost – or couldn't envisage and develop – a specific focus on the 'key beneficiaries' and 'underserved areas'. The famous 'national CME-plan' should have been an instrument for priority setting in this sense. While the government authorities were not very keen to see emerge such a plan (the priority for financing of CME has been down-graded), SDC and other donors[8] would have strongly appreciated it: SCO-A to see that the project alignes with their country strategy, UNFPA and USAid to join the CME-efforts by including certain components in their future health sector aid portfolio.

[8] another PDS principle was the 'synergies with other donors': synergies will be established and exploited in order to cross-fertilize, amplify and complement the PDS inputs and outputs…

2 c) On the operational Set-up:

***CSet** - Consortium, PCU, NCCE, MoH:*

CME-Systems exist in most industrialized countries, in various forms, established longer or shorter ago. The project obviously had to draw on these foreign experiences, foreign experts had to be identified and involved in the design of an Albanian model. IUED and UdeM, **the Consortium**, got this mandate to bring in their own experience, to give strategic advise and to establish the links to the technical experts. An important asset for the consortium was the participation – from UdeM side – of Dr.Besim Nuri[9], a well known public health specialist with Albanian origin. The rapid development of the backbone of an Albanian PDS, the NCCE and the regulatory frameworks, can clearly be attributed to the renowned professional competence, commitment and cultural sensitivity of the consortium members who have guided this process.

The original operational design encompassed an Albania based 'coordination or implementation unit', **the PCU**, to act between the external support partners, MoH and other stakeholders. This set-up corresponds to the opinion of other donors, that Albania is not ready yet for direct collaboration with the government and that therefore an independent intermediary entity should facilitate project implementation.

During the mission, the evaluation team got a good insight into the mandate of the PCU, as outlined in the ProDoc: ensure relations with authority and stakeholders, prepare meetings, facilitate work of experts, participate in planning activities, monitor progress and ensure financial management of local funds. In the opinion of the evaluators, Dr.Fabian Cenko and his team fulfilled the tasks of this mandate well and gave the impression that such an interface is still necessary: neither SCO-A staff nor consortium members can keep the important and close contacts to the many actors involved in the project.

Nevertheless, the real workload of this mandate was difficult to assess. The PCU could act more proactively, e.g., as mentioned above, by a strong involvement in the development of implementation plans (in order to make them more realistic), by advocating stronger the goals of SDC's country strategy in the project (decentralization, beneficiaries) or by an explicit commitment for the identification and motivation of potential partners (training providers, donors).

The most visible product of PDS, **the NCCE**, is located within the premises of the Institute of Public Health IPH. The office space for the director, Dr Entela Shehu, and her staff (10 professionals) is rather narrow, but well equipped. The staff made a committed impression during a half day workshop where they presented their respective tasks. NCCE's activities are basically defined in the YPO, developed with the relevant stakeholders and approved by the Steering Committee, chaired by the Minister of Health. For operational guidance and monitoring of progress, Consortium and PCU are regularly involved. So, theoretically, NCCE isn't subject to direct MoH-interference.

In practice, for tactical and political reasons, **MoH** intervened with (a) the claim to immediately launch re-certification or (b) by not complying with its budget commitments for CE-courses. These interventions led to a distortion of the agreed upon plan with the problems and risks mentioned above (overload, not operational for certain outputs).There is a certain ambiguity, whether NCCE is now simply an institution under the guidance of MoH or – still – part of a project guided by an approved YPO.

But in general, the actual arrangement seems to be a formula for rapid success, at least in most aspects of the project.

[9] B.Nuri worked for several years for the WB in Albania, he published in 2002, on behalf of the European Observatory on Health Care Systems, a comprehensive study on the Albanian health care system

2 d) Synthesis of conclusions and lessons learnt

***CO1a**: A big step towards a professional development system for health professionals in Albania has been made by establishing a national center and the corresponding legal framework for continuous medical education.*
The demand for accreditation of institutions and training activities has raised rapidly and doctors start earning and registering credits – a dynamics due to the menace of sanctions and due to the fact that PDS brings already existing CE activates in surface and adds value to these activities.
This gives hope that a sustainable cultural change has been initiated related to CME of health professional .

***CO1b**: The other side of the coin of this success is the 'side-effects' of the rapid paste of this developments: it puts a heavy work-load on NCCE, which is not fully ready and equipped for all tasks. And it deviates the focus of work away from the main objective, i.e. to develop a really nationwide System of CME.*

***CO1c**: Once a training provider identified and his course accredited, NCCE faces big obstacles to 'subcontract' this provider and finance the training[10], as it is foreseen in the PDS: no government funds are available, the 'law on public procurement' makes public financing cumbersome.*

***CO1d**: Delegating certain functions to decentralized 'CME-antennas', like accreditation of courses etc., has not been addressed yet, and the development of 'CME-units' in peripheral health institutions (hospitals, health canters) has only started recently, in Tirana only.*

***CO2/CO3**: For the majority of 'CME-clients', especially the GPs, is it not evident to know where and how they can get their required credits: NCCE is not able, at the moment, to provide to them an up-to-date inventory of training opportunities; this problem might be of less relevance for specialist doctors (in Tirana).*

***CO4**: PDS has seen a strong participation of women from its inception, at policy level as well in first training events. Sustainability of this fact is guaranteed within PDS.*

***CConc**: The basic concept of PDS is sound and needs no change. But the aspect 'decentralization and system development' has not yet got the attention needed for a smooth transition into the next phase. A broader conceptual issues is the question whether CME alone will really be enough to reach the ambitious impact of the project: some claim for a broader 'bridging concept' to reach this goal.*

***CStrat**: The strategy was right to start a CME-system with a central institution carrying forward the responsibility for developing and planning a nationwide system, accessible to the envisaged health workforce. This first step has been successful, but the project has now reached a critical turning point where the extension and 'roll-out' must be envisaged and thoroughly planned – the overload of NCCE with tasks which should be transferred to decentralized 'CME-antennas' (CME-units) hinders this duty.*

***CSet**: The rapid progress and success of the first steps of the project is clearly attributable to the right choice of the operational set-up. In contrast, the guidance and control of the Consortium/PCU could have been stronger during 2010, in order to counter-balance the MoH-influence and avoid the 'success-trap'.*

[10] obviously, only the more substantial CME-opportunities will be eligible for public financial contributions

3) Recommendations for the end of phase 1 (R1 1…7)

R1-1: For the remaining 6 months of phase 1, an adjustment and priority setting exercise should be undertaken, with a realistic allocation of the available professional staff to the most important tasks.

R1-2: The development of a 'Strategic Plan for CME-extension…' (output 1.1.8) and the 'formulation of a National Training plan 2011' (output 1.4.1/1.4.2) should be given high priority. For these outputs, high consultative input from Consortium/PCU must be foreseen. The same is obviously true for the planning exercise of phase two.

R1-3: In view of the obligation for physicians in the whole country to take CME-credits already this year, NCCE should proactively identify countrywide CME-providers (at hospitals and other health care institutions), motivate them to go through the accreditation process, establish a 'new, updated CME-inventory' for the use by physicians and disseminate it (e.g. by internet). This is an adjustment of the output 1.6 YPO10 'strengthening the capacities of Organizations to organize CME-activities', that had a focus only on '5 CE-units'. The focus of this 'proactive mobilisation' should be on identifying CME-opportunities for the main beneficiaries (the PHC-personnel). The rational for this adjustment is the unexpected acceleration of the process, i.e. the instauration of the countrywide re-certification already 2010.

R1-4: Rapidly formulate concrete requests for CME-support to those donors who are involved in the health field and who might still be able to allocate funds to CME in their coming budget period (UNFPA, UNAids, WHO, ..); SCO-A and PCU should engage in this collaboration endeavor. SCO-A should equally intervene at MoH level to insist on the availability of government funds for CME, as promised in the Agreement (article 4, obligation of parties, 4.3).
In this context, the option could be studied whether SDC itself might engage - from phase 2 onwards - in the direct financing of certain CME-activities, e.g. a specific CME-program for PHC-staff in some northern districts (similar to a successful SDC-program in Bosnia-Herzegovina by the team of HUG/Geneva[11]), or re-engage into a management training (similar to the former Montreal courses) for health decision-makers in the newly created Regional Health Directories.

R1-5: Get hold of potential trainers, in academia and other Albanian organizations, including participants of former training courses (Pro Shëndetit, Montreal management courses, nurses/midwife courses, etc.). These already trained health professionals are spread in various public institutions all over the country, can be involved in CME-activities and can boost the quality of trainings and become part of first efforts to decentralize PDS.

R1-6: Upgrade rapidly the NCCE-Website, including a Web-based health professional registry which guarantees security and easy data management and which offers easy access to all relevant information, e.g. to the above mentioned course inventory.

R1-7: If there is evidence that the workload for this adjusted YPO10 is too heavy for the existing staff, at NCCE as well as PCU, the project could use part of its local budget to hire temporarily additional staff (e.g. for administrative work at NCCE); in the past, disbursement for local staff was largely under the allocated budget.

[11] SMIH/HUG: service de médecine internationale et humanitaire

E RECOMMENDATIONS FOR THE SECOND PHASE

1) ProDoc and phase 2

The program to be implemented in a second PDS phase has already been outlined in the ProDoc, encompassing the following main outcomes and activities:

> 1) **Consolidation** of CE expertise and functioning at central (i.e. NCCE) level
>
> 1a) NCCE staff will be more autonomous but still needs expert support and supervision
>
> 2) **Extension** of CE functions at the periphery (districts, hospitals)
>
> 2a) Mechanisms of accreditation and re-certification will become fully functional
>
> 2b) Most CE-programs will be accredited
>
> 2c) Health professional re-certification will be implemented in a larger scale
>
> 2d) Albanian agencies/organizations will be supported to build competence
>
> ProDoc May 2007, p 11

In general terms, this frame is still valid for the planning of the second PDS-phase, the main objectives of the second phase being indeed the consolidation of the achievements at NCCE-level, and then the extension of PDS countrywide. Obviously, the developments during phase one, especially the rapid paste of the process towards nationwide re-certification in the last months, call for a refinement of this outline.

2) Specific expectations for phase 2

In the new SDC-A cooperation strategy 2010-13, PDS-project runs now under the domain 'Democratization and Rule of Law' or the sub-domain 'Decentralization'. This indicates, that SDC expects a strong focus – as described already above - on the strengthening of 'capacities of local government units' and the improvement of 'quality of public services'; both with a clear focus on 'underserved regions' and with a 'high impact on the poor' section of the population. These strategic targets must be kept in mind in the planning of the continuing phase of PDS. Besides consolidation and refinement of the processes, phase 2 is expected to give the systemic development aspect a strong importance.

3) Recommendations (R2 1…8)

In this sense, the evaluation team makes the following recommendations (in parenthesis the conclusions they relate to, from page 17).

R2-1: With the formulation and approval of the regulatory documents on accreditation and recertification and with the physical establishment of a center and the staff, NCCE is now in position and has the mandate and necessary guidance to create the CME-system as planned. The consortium/PCU's role will therefore shift even more towards an advising, supporting and supervising function, contributing to the timely and correct implementation of a pre-defined concept.

> **OWNERSHIP, SHIFT OF ROLES**: PDS-phase 2 must assure that the role of the players in the project are clearly defined and the right balance is found between NCCE's legitimous autonomy and its ongoing need for external guidance and advise. (CStrat, CSet)

R2-2: While the regulatory base for accreditation and re-certification is close to international/European standards, NCCE is not yet able to fulfill all the functions it is mandated to (as defined in RegDoc-accreditation pp.28/29 and RegDoc-recertification p.23), and there is clearly a need for fine-tuning of its work. A support and supervision is necessary to assure that NCCE keeps to its defined role and functions. In addition, quality control is crucial, not only by the designated national entities (NBRA, NCQSA-HI), but externally by the project implementer, too.

> **CONSOLIDATION AND CONTROL**: PDS-phase 2 must offer a strong external support to NCCE in order to make sure that – at the end of phase two – **the complete range of functions as stipulated in the regulatory documents are fulfilled**; this requires still a close supervision by the project implementer. (CO1b/d, CStrat)

R2-3: The main challenge of NCCE's functions is the extension of activities, in size and in geographical terms. To realize a countrywide CE-system, professional strategic and operational planning is required.

> **SYSTEMATIC ANNUAL PLANNING PROCESS**: PDS-phase 2 must envisage the annual execution of a comprehensive CME-plan (as foreseen in the RegDoc-accreditation p.26); this plan must be established based on evidence criteria (available human resources, priority health problems, most urgent training needs, underserved areas, discriminated populations, etc.) and requires sound scientific preparatory work; the needs assessments realized during phase 1 are elements of this work. The plan defines priorities in terms of training topics, personnel and regions to be targeted, institutional level, etc. as well as implementation strategies (decentralization, phasing, steps). NCCE is not yet ready to succeed in this task on its own and needs external expert advice. (CO1b/d, CStrat)

R2-4: Theoretically, a big number of CME-activities can and will be offered (or are already offered) and the providers will seek accreditation of their CME-activities. These offers come mainly from government side (PHI, HII, MoH), from academia (FoM, FoN, various orders of professionals, etc.) or from bigger medical facilities (e.g. regional hospitals). 'Publishing and updating the list of accredited CME-activities' is one of the mandates of NCCE (RegDoc-recertification p.23). This inventory allows NCCE to identify gaps in CME-offers and to take corrective action and initiatives.

> **CME-INVENTORY**: PDS-phase 2 must assure that NCCE monitors proactively available CME-opportunities and makes this inventory available to health care professionals (e.g. on its Website); gaps, especially concerning CME for main beneficiaries, must by identified and solutions found. (CO2/3)

R2-5: The problem with subcontracting providers of CME-activities, utilizing the (hopefully) available MoH-funds, must be addressed with the authorities and a solution must be found; this problem is a big obstacle to the extension of PDS; without at least some seed money, many potential providers will not engage in conferences, seminars etc.

> **SUBCONTRACTING CME-PROVIDERS**: PDS-phase 2 must resolve the problem with public procurement in order to facilitate the disbursement of CME-funds by NCCE. (CO1c)

R2-6: After the shut down of a number of training-providing projects (PRO Shëndetit and others have bee cited), the evaluation team has some doubts whether the CME-activities, which in theory should be available (see para above), can – in reality - cover the CME-demand from health professionals in the whole country, especially from those in remote areas and/or from GPs and family doctors. As the evaluation team didn't come across new projects in this field, PDS should address agencies and donors active in the health field and motivate them for an engagement in CME-activities: USAid and UNFPA might consider entering this field, but await concrete proposals from PDS.

> **LOBYING FOR CME, COORDINATION**: PDS-phase 2 must support NCCE in its endeavor to identify and motivate donors to fund CME-activities. One of the functions of NCCE is to 'coordinate CME-activities funded by different donors and other local and international agencies'. With the risk that promised public funds for CME will not be allocated, NCCE must seek alternative options, motivating multi- and other bi-lateral agencies for a commitment in CME. (CO1c, CConc)

> **AN SDC CME-ACTIVITY**: In this same context, SDC might consider funding a specific CME-activity, e.g. for PHC-personal in its focus districts in the North. In order not to jeopardize sustainability, this could be planned as a 'start-up' project with the aim to transfer it rapidly under government responsibility once public funds become available. (see R1-4 above)

R2-7: PDS is considered by Albanian stakeholders a success story; the evaluation team has been able to confirm this fact, at least in most aspects. It stands now at a crucial turning-point for further smooth progress towards the next steps, i.e. extension towards a full-fletched CME-system. In the opinion of the evaluators, a change of the operational set-up at this moment seems not a good idea ('never change a winning horse'). The advantage of the actual arrangement is that implementer and experts have a profound knowledge of the project environment and obtained the confidence of the Albanian stakeholders, resulting from their broadly appreciated attitude and long experience in the country.

> **Continuum**: PDS-phase 2 should try to maintain the actual operational set-up; some adjustments will be necessary, but a foreign implementer and an on site PCU should be maintained (rational see CSet and ch.E4 below)

R2-8: During the mission, the evaluation team has been exposed to the question, whether the CME-concept will suffice to upgrade the competency gaps between the 'old' and the 'new' generation of health professionals (especially the GPs and nurses); and whether the CME-approach alone will have the expected impact on the quality of care (especially at PHC-level). Proposals (called 'bridging' or 'ratrappage' concepts), how to overcome this specific problem of a 'transition country' like Albania, have already been suggested to the MoH[12].

> **PDS and 'bridging concept'**: PDS-phase 2 should have a close look at the competency gap between the 'old' GPs (N≈1'800) and the 'new' family physicians (N≈250) in order to identify the consequences of this gap (or the lack of a specific response to it) on the envisaged impact of PDS. (CConc)

[12] In the context of the USAid sponsored 'PRO Shëndetit' project, see annexe 1 for more details

4) Options for the operational Setup

The actual implementer and contract holder (=IHEID, merger between IUED and HEI) cannot continue for statutory reasons: the need for a change has been announced. This transition might imply a number of administrative steps; if not well thought and prepared, this change risk to endanger – in a crucial moment – a well established and successful relationship between external experts, the local coordination unit staff and the many people involved in the project, government, academia, professional associations, etc..

For the evaluators, the following change options are conceivable, preferred is option 2a:

Setup 1a: Same setting as first phase (continuity, no tendering):

IHEID can be convinced to accept a second phase as implementer, despite their legal obligation to withdraw.

Cons: for statutory reasons, IHEID cannot keep operational mandates, small chance for favourable decision; project director (Rainhorn) will soon retire from IHEID (might continue as an independent consultant)

Pros: Consortium and PCU know project and developments up till now, excellent relations with all stakeholders, contributed essentially to progress and success

EE-opinion: the evaluators would stick to this (straight-forward) set-up, but little chance for attainment

Setup 2a: Very similar setting as first phase (continuity, no tendering):

SDC accepts to transfer - without tendering - the contract to UdeM, which would act the same way as IHEID (i.e. hire experts, supervise PCU, etc.)

Cons: administrative problems (SDC internal rules)

Pros: UdeM has been strongly involved in PDS from its inception, a continuation would be a strong advantage in the crucial phase of project-extension; Besim Nuri, staff of UdeM and member since the beginning of the Consortium, is an extremely qualified expert and of big value for the project

EE-opinion: **this option is preferred by the evaluators and has been recommended under R2-7**

Setup 2b: Similar setting as today, but new actors (tendering, no continuity):

Implementer is a new, suitable international institution, contracted by SDC, with responsibility for the local arrangement (PIU); implementer hires experts according to project needs.

Cons: new institution must start from scratch, might not have the necessary contacts and easy access to the many stakeholders, a prerequisite for this project; might equally select an other PIU-arrangement/staff; this option would probably require another extension of phase 1 to allow for the tendering procedures

Pros: 'new blood' might bring new emphasis to the project; but with the risk to become operational with much delay

EE-opinion: the evaluators would not recommend taking these risks at a moment of big dynamics in the project, where a close support and supervision of the main actor, NCCE, is paramount

Setup 3a: Mixed Albanian-International setting (tendering, partial continuity?):

SDC/SCO-A contracts an Albanian implementer (NGO, Institute), which establishes its PIU. In addition, SCO-A gives a backstopping mandate to an international institution or agency; this latter could again be one of the institutions already involved in the project, e.g. UdeM.

Cons: the problem is to find an Albanian institution able to carry out this support and supervisory mandate for PDS; SCO-A might get involved in the management of this contract (controlling, etc.) more then desired; despite a backstopping by an already involved institution, the new Albanian contractor would only be operational with a certain delay – in addition to the tendering delay;

Pros: this formula would be in line with SDC's goal to 'allow for more ownership' within its projects; depending on the backstopping agency, expertise would be maintained and a certain continuum guaranteed (if e.g. UdeM would be mandated); a certain financial advantage (local salaries)

EE-opinion: per se, a valid option, but the evaluators were not able to identify a potential Albanian institution for such a contract – which does not mean it would not exist;
the evaluators heard some words of caution that – at this stage in the country's development – *'still an objective, neutral third party is needed to facilitate, inform and guide projects and processes….'* and that this *'enabling party must be open, transparent, and non-aligned in order to break down political barriers, facilitate identification of constraints, and develop realistic operational and implementation plans supported by all parties…'*. It's up to SCO-A to judge, whether this remarks are relevant for PDS or not. And, if true, a backstopper will be able to compensate such concerns.

Setup 3b: Pure Albanian civil society setting (tendering, partial continuity?):

Same setup as 3a, without backstopping mandate: an Albanian implementer (NGO, Institute) is contracted by SDC/SCO-A, establishes a PIU, is responsible for hiring local/international experts according to needs.

Cons: the big autonomy of a purely Albanian setting carries a high risk; high competency and broad international contacts in the field of health would be a prerequisite, which might be difficult to meet; tendering delay

Pros: again, the 'ownership argument' counts; to lower the risk of too large autonomy, the PIU could be located (on the payroll of PDS) in SCO-A premises, for a closer supervision and coordination; financially convenient (main salaries local)

EE-opinion: same as 3a; the evaluators consider such a fundamental change of setup as too risky at this stage of the PDS

5) Potential partners/donors

The following organizations, which have been contacted during the mission, have manifested interest to join forces in Albania's PDS/CME-efforts:

- **UNFPA**: might have and/or make available in the future some grants for CME.
- **WB**: actually, MoH profits from a loan (still under IDA conditions = low interest rate) that will run for the next 18 months; for after that period, a new loan for health is under preparation (but this will be under IBRD-conditions = higher interest rate).
- **WHO**: has supported quality, integration, capacity building, and improved monitoring, through numerous technical advisory missions.
- **USAid**: has withdrawn from prior CME-projects, but is preparing a big new health commitment under the title 'Enabling Equitable Health Reform EEHR', published recently for an open bidding process (see below).

No other potential sponsoring agency has been identified or contacted.

All these multi- and bi-lateral agencies have explicitly stated that training of health professionals and CE is a priority issue for them and that they see PDS as a very successful project. They see opportunities to contribute financially or take up certain CME-activities in their health portfolio. But all have expressed the need to be addressed for support and to be contacted in advance in order to comply with their budget planning requirements. They all would welcome a detailed CME-plan, with arguments and evidence allowing a rational selection of potential commitment options. For some agencies, closing deadlines for their 2011 (and beyond) planning exercises are approaching rapidly, so NCCE should move quickly to get a chance to palliate potential GoA/MoH budgetary restrictions with alternative funds.

The following excerpts from the new USAID's health project for Albania might give some concrete hints how to invite and involve other donors in the CME-development process:

> The EEHR Project aims to **strengthen the Albanian health sector's capability** through the implementation of equitable health reforms, moving from strategies into implementation action plans, by providing instruments and tools and testing those in selected districts.
>
> The purpose of this project is to **provide access to health services for the poor** by a) helping remove the existing barriers and constraints to the reforms at the national level and b) field testing approaches and tools that define a feasible set of implementable reforms in Albania.
>
> The primary objective of this activity project is to **Improve and Expand Access to Essential Health Services by the Poor** of Albania.
>
> The following statements can be found in the proposal:
>
> - Institutional **capacity building** is the key to implement sustainable reforms
> - This initiative is expected to utilize technical assistance to **promote inter-agency cooperation** in strategic and operational planning in order to advance the reform agenda
> - **Collaboration and consensus building** are important parameters of the implementation strategy
> - Participation in various NGOs and other donor fora provides an excellent vehicle to determine comparative advantages, **collaborate on activities**, and develop relationships.

The impression of the evaluators is that – by seeking and maintaining good relations with other donors active in the health field – niches for contributions to PDS can be identified. The new USAid project shows that synergies are evident. Main actor in this endeavor to develop ideas and make concrete proposals is now NCCE, but the conceptual support of SCO-A and the Consortium/PCU is pivotal, too.

F ANNEXES

1. Overview of the Albanian health workforce

2. List of people met during evaluation

3. ToR of the EE-mission

1) Overview of the Albanian health workforce

The approximate minimal number of professionals working in the health sector is estimated at about 20'000, of which ≈13'500 are nurses and midwifes, ≈7'000 physicians (medical doctors and dentists) and about ≈1'500 pharmacists. There are discrepancies in these figures depending on the source, be they published by the MoH or coming from the various organizations/associations dealing with each specialty. It is expected that, at least for the physicians, the mandatory registration and re-licensing process will bring some clarity into this data.

Specialist physicians:

Their number is about 4'000, they cover a big number of specialties, were licensed after a postgraduate training and are mostly organized in specialist associations. No stringent data on accuracy of their professional capacity is available, but some CME has been available in the past, organized through their associations or by travelling abroad for conferences etc. This fact increases the probability for a rapid establishment of a modern re-licensing system. The big number of members and associations and the demand for course-accreditation and registering has already lead to a high workload of the NCCE and its experts (e.g. university professors hired through NCCE) for the corresponding training activity accreditation.

Among these group of specialists are the so called 'public health professionals', i.e. the epidemiologists (N≈38) and hygienists/sanitary inspectors (N≈70) with their assistants (N≈330). They act under the authority of the MoH and the Public Health Directory of the 36 districts respectively. Since 1996, a postgraduate specialization is available at the Faculty of Medicine in Tirana. A recent study of the IPH (see PDS-financed 'needs assessments 2008', chapter C1b), showed not only an uneven distribution of PH-staff among the districts but big gaps in knowledge and performance, resulting probably from the difference between the 'younger' (graduated) and the 'older' PH-professionals as well as the non-existence of a CME-program. In that sense, the situation is similar to the one with the GPs/family medicine doctors (see below).

Physicians providing Primary Health Care, i.e. GPs and FM-doctors:

Most of these doctors are assigned to one of the over 400 health centres or polyclinics in the country; the size of these HCs varies, encompassing between only one up to over 30 doctors. As with PH-specialists, there are two categories among these doctors: a small number (N≈100) of licensed Family Medicine specialists (with a two years postgraduate training, offered since 1995 at the Faculty of Medicine) and a big number of doctors with only a basic six years training, licensed before 1995. The number of these GPs vary from 1200 (according to the order of physicians) and close to 2000 (according to the recent DHS-study of the MoH).

The lack of postgraduate as well as continuous training of this big number of GPs is a well known concern. In the context of the USAid sponsored 'PRO Shëndetit' project a technical proposal for the improvement of Family Medicine in Albania was elaborated together with various stakeholders (MoH, Faculty of Medicine, HII, Order of Physicians, etc.), analysing the big deficiencies of Primary Health Care and designing a framework for 'bridging' the competency gap of these GPs. The document refers to some piloting activities in this sense under the 'PRO Shëndetit' project during 2006-08:

> *A pilot program in Family Medicine Professional Development has been implemented by the PRO Shëndetit project over the last two years **in 6 different prefectures**, resulting in the training of approximately 50 trainers and subsequently an additional*

*630 general physicians, of whom **575 completed almost all of the twenty eight initial Family Medicine modules**. The training modules and all training were done by the Department of Family Medicine of the Faculty of Medicine. Interviews of the original faculty, trainers, and general physicians trained indicated that this has improved some health care practices and resulted in improved learning attitudes and a desire for more learning on the part of the participants. **An additional twenty Family Medicine modules have now been completed by the Department of Family Medicine and are ready to be presented to the physicians who have completed the original twenty eight modules**.*

This 'bridging-concept' is meant, if implementation is continued, to upgrade all primary health care doctors to a similar and up-to-date standard. But the proposal identified equally the need for a CME-policy to maintain this standard in future – and sees the NCCE as the leading actor to make this happen. At this very moment, 'PRO Shëndetit' project doesn't exist any more and the 'upgrading' of hundreds of GPs is, if ever, progressing very slowly. And the USAid-proposal itself – encompassing some additional important policy adjustments related to the work of Primary Health care doctors – seems to have ended up in a drawer at the MoH.

The dentists:

According to the legal advisor of the Order of Physicians of Albania (with a mandate equally for dentists), there are at least 1200 dentists in Albania, their basic training at the Faculty is 5 years. 2/3 of them are established in private practice. According to the advisor, this fact makes a coordinated CME-effort difficult.

The pharmacists:

To this group of professionals, the differential in basic training applies, too: the 'before 95s' (N≈370, called 'health pharmacists') only had a 2 year basic training, the 'after 95s' (N≈1200) went through a graduate education at the newly established Department of Pharmacy within the Faculty of Medicine in Tirana. According to the order of pharmacists, there is a willingness to engage in CME, there is even a plan for CME activities, but a lack of financial support is jeopardizing this effort: according to them, and in contrast to the specialized physicians, donors (e.g. pharmaceutical companies) are not interested in sponsoring their CME ('those who prescribe drugs are the doctors…'). The order expects NCCE to assist in their endeavour.

For this group of professionals, besides the non existence of CME, the issue of 'bridging' training is equally present.

Nurses and midwifes:

As with doctors in Primary Health Care, nurses and midwifes have different levels of education. According to HII statistics (year 2008), 6636 nurses/midwifes are employed in PHC of the public sector; their education can be categorized in the following different levels: nurses with university diploma, those with basic education at a medical high school, those with a 1-2 years nursing school education after non-medical high school or 8y mandatory school respectively, and the assistant nurses with short nursing courses of various length.

In contrast to the HII figures, the president of the order of nurses (created 1 ½ years ago) counts with an overall number of 13'600 nurses/midwifes (included physiotherapists and medical/lab technicians), 40% of them holding a university diploma and close to 60% at least a medical high school license, while only 2% would belong to the other categories.

The discrepancy in numbers might partly be explained by the fact that in PHC-institutions, the proportion of less educated nurses/midwifes is higher, because the

university trained nurses tend to go to the (urban) private sector or even abroad (problem of brain drain).

Switzerland was among the first, from 1993 onwards, to engage in basic nurses training, and contributed to the establishment of Nurses High Schools. in 1994, the first Faculty of Nurses was established, and today 20 private and public faculties exist, 3 of them in Tirana and 17 in all regions. The president of the Order is therefore convinced that the proportion of nurses with university diploma will grow over 60% in the next 4 years.

Because of the varying level of basic training, a real CME concept did never exist. Until recently, two USAid sponsored Projects, 'PRO Shëndetit' and 'Albanian Child Survival Project' (implemented by Albanian Red Cross), supported some 'upgrading' or 'ratrappage' training for nurses in a limited number of districts, including the training of nurses trainers. Participants of these courses were nurses with university diploma as well as those without. Whether these trainings shall be considered as CME or 'upgrading' seems rather hypothetical; the performance gap in PHC-institutions seems to be so important and thus the quality of services so low that any kind of continuous professional development is useful (see Training Needs Assessment of PHC-Nurses).

The managers of health centres in the PHC-system

As a result of health system reform processes over the past years, managerial tasks at the PHC-level have gained importance. This is mainly due to one of the components of this reforms, i.e. the increased fiscal and managerial autonomy of health centres. The responsibility for these tasks lies on three staff categories: the HC-director or -manager HCM (in most cases a person with medical background), the HC-economist manager HCEM and/or the HC-economist. General planning, daily work management, financial/quality/human resources management and organizing/analyzing the HIS in his catchment area are new obligations of many GPs in the HCs. Fulfilment of standard performance criteria are now linked to payments from HII. Despite this big responsibility, till now no official basic training exists; a small proportion of HCMs and HCEMs had the opportunity to follow management training courses in the past (UdeM, MoH/HII, PRO Shëndetit).

For this part of the health workforce (N≈400-800) there is a need (as expressed in the HCM-needs assessment) not only for a CME, but – even more importantly – for a basic educational program in order to achieve *'full and complete knowledge on health management'*. And, again, the question of a differentiation between basic (upgrading) and continuous education is raised.

The 'governors' of the health system

This component of the health workforce is as crucial as those acting 'at the front'. It encompasses the decision makers from the ministerial to the regional and district level, and finally the members of the HC-boards. These people normally take crucial decisions in the field of resource allocation, procurement (drugs, material), human resources etc. and are responsible for the implementation of reform processes. Most of them haven't any medical background, are politically appointed. Despite the fact that this health workforce plays a key role for the efficient functioning of the whole system, regular basic or continuous training is not institutionalized[§].

[§] The University of Montreal developed a 6-months basic training course in health planning and management and 180 high-level MoH, regional and district decision-makers and managers were trained from 2001 to 2008. The course was financed from SDC in the last period 2005-2008 and thereafter SDC decided to discontinue funding of this activity.

2) List of people met during evaluation

Date	Contact	Function
24-Mrz	Mrs. Anne Moulin	SDC-Western Balkans Division
15-Apr	Mrs. Nathalie Barbancho	SDC-Western Balkans Division
26-Apr	Prof.Dr.med. Jean-Daniel Rainhorn	Director, Graduate Institute IHEID
26-Apr	Prof. Daniel Fino	Senior lecturer, Directeur du Programme International MAS, IHEID
27-Apr	Mrs. Diana Linka	Assistant Administrator / SCO-A
27-Apr	Dr.med. Fabian Cenko	PDS, Coordinator PCU
27-Apr	Mr. Daniel Züst	Country Director SDC / SCO-A
27-Apr	Mrs. Rahel Boesch	Deputy Country Director SDC / SCO_A
28-Apr	Dr. Besim Nuri	Consortium member, Faculté de Médecine, Unité de santé internationale, UdeM
28-Apr	Dr. Erjeta Ashiku	PDS, PCU-Assistant
28-Apr	Mrs. Sabiela Nallbani	PDS, PCU-Office manager
28-Apr	Mrs. Manuela Murthi	Consultant for PDS
28-Apr	Mrs. Entela Shehu	Director National Center for Continuous Education NCCE
28-Apr	Dr. Fedor Kallajxhi	Maternity Hospital
28-Apr	Dr. Rudina Gumashi	Institute of Public Health
28-Apr	Dr. Rovena Daja	Institute of Public Health
28-Apr	Dr. Llukan Rrumbullaku	Faculty of Medicine
28-Apr	Mrs. Eralda Turkeshi	Faculty of Medicine
28-Apr	Dr. Zhaneta Shatri	USAID - Health program manager
29-Apr	Dr. Zamira Sinoimeri	WHO, NP representative
29-Apr	Dr. Ledia Lazeri	WHO Mental Health Officer, Officer in charge
29-Apr	Dr. Vasil Mino	WHO, climate change project, NPO
29-Apr	Dr. Angeles Lazcoz	WHO Project Officer
29-Apr	Mrs. Karin Peltier	WHO UNV
29-Apr	Dr. Ervin Toçi	Institute of Public Health IPH
29-Apr	Dr. Agim Kociraj	Institute of Public Health IPH
29-Apr	Dr. Majlinda Hunda	Health Insurance Institute HII
29-Apr	Mrs. Tatjana Trajko	Chief Nurse Health Center HC
30-Apr	Dr. Alban Ylli	Director Institute of Public Health IPH
30-Apr	Dr. Sabri Skenderi	President of Order of Nurses
30-Apr	Dr. Ramirez Kernaza	Director Health Center 6, Family Doctor
30-Apr	Dr. Mimoza Dollenga	Director Health Center 6, Family Doctor, Staff of CE-Unit in HC
30-Apr	Dr. Eralda Turkeshi	Faculty of Medicine, Family Doctor, Staff of CE-Unit in FoM
1-Mai	Dr. Tauland Baku	Durres Hospital, General Manager
1-Mai	Dr. Neritan Myderizi	Durres Hospital, chief surgery service, former director
1-Mai	Dr. Eno Qerimi	Durres Hospital, specialist Ophthalmology
1-Mai	Dr. Florian Bullaca	Durres Hospital, specialist Maxillo-facial surgery
3-Mai	Dr. Gazmend Bejtja	Head Department of Public Health, Ministry of Health
3-Mai	Mrs. Vjollca Mulliqi	Head Nurse Maternity Hospital, Pilot CE Unit
3-Mai	Prof.Dr.med. Alfred Priftanji	Dean Faculty of Medicine, Tirana University
4-Mai	Mrs. Entela Shehu	Director National Center for Continuous Education NCCE
4-Mai	Dr. Ilir Shamatu	NCCE, Chief evaluation, planning, coordination
4-Mai	Mrs. Adriana Ristani	NCCE, Economist, chief finance and administration
4-Mai	Mrs. Mimoza Ismaili	NCCE, specialist admin/finance, Master of accounting
4-Mai	Mrs. Kristina Voko	NCCE, Chief accreditation and training programs
4-Mai	Mrs. Sonila Mecai	NCCE, Chief pedagogic sector, psychologist
4-Mai	Mrs. Blerina	NCCE, Media-communication specialist
4-Mai	Mrs. Laura Kolaneci	NCCE, Specialist accreditation sector
4-Mai	Mrs. Anduela Pinguli	NCCE, Specialist implementation sector
4-Mai	Mr. Geront Shemu	NCCE, Technician administration finance sector
4-Mai	Dr. Klodian Rjepaj	Director of Cabinet, Ministry of Health
4-Mai	Mrs. Flora Ismaili	UNFPA, programme analyst P&D strategies
4-Mai	Dr. Manuela Bello	UNFPA, assistant representative
5-Mai	Mrs. Konzilia Rapo	Order of Physicians, vice general secretary, legal advisor
5-Mai	Dr. Adrian Jaupllari	Order of Pharmacists, president
5-Mai	Dr. Admir Malaj	Order of Pharmacists, secretary general
5-Mai	Mrs. Lorena Kostallari	OThe World Bank, operations officer health
5-Mai	Mr. Klodjan Seferaj	Consultant Council of Ministers, Department of Strategy and Donor Coordination
6-Mai	SCO-A and EE-team	SDC Country Office Albania, Debriefing

3) ToR of the EE-mission

Terms of Reference for an External Evaluation

Professional Development System in the Health Sector Reform in Albania

"PDS PROJECT"

Phase I: 01.07.2007-31.12.2010

1. Introduction

The health system of Albania is facing enormous challenges related to accessibility and quality of health care[13]. 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[14].

Recently, there has been some progress on public health policy. Parliament adopted the Law on Public Health Care in May 2009. However, the relevant implementing regulations are pending and the national health sector strategy has not been adopted. There has been limited progress in the field of mental health, but much is needed. Moreover, administrative capacity in the field of public health remains weak. *Overall, situation of health system*

[13] Albania Health Sector Note. The World Bank, Report nr. 32612 – Al, February 2006.
[14] *Création et développement d'un centre de formation continue*, Albanie. Rapport d'évaluation et de faisabilité préparé par Prof. Dr. Gianfranco Domenighetti et Barbara Fäh. Novembre 2005

remains weak; corruption remains high al almost all levels of the health sector and quality of service delivered low[15].

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. 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 this intervention includes: *i)* A *platform of Continuing Education for health professionals of Albania is developed and has started performing its functions; ii) A mechanism for accreditation of continuing education programs is developed and is functioning; iii) A system for certification/revalidation of health professionals is designed and begins to be implemented on a pilot basis;* and *iv) An equitable participation of women and men in the decision-making process as well as in the program training activities is ensured.*

The project preparation has started in June 2004 with *an external evaluation* mission mandated by SDC to analyse the status of the health system in Albania, to review relevant development activities and to formulate recommendations[16] for a future strategic orientation of SDC in the health sector. The mission identified a range of problems, challenges as well as the following potential fields to support: *(i) Human resource development*; *(ii) Surveillance and Control of Sexually Transmitted Infections (STI*);(iii) Health promotion – enhancing health promotion capacities in Albania. In consultation with Albanian health authorities and taking into consideration its previous activities and experiences in the health sector in Albania, SDC decided to pursue the option *"Human Resource Development",* which is also one of the Albanian government objectives for the health system reform.

In August 2005, *a workshop* organised in Ascona with a number of experts prepared the basis for an assessment of health human resources and the feasibility study, which were conducted in Albania, in October 2005[17]. The recommendations[18] of this mission laid the ground to start up the project formulation aiming at building up *a Centre for Continuing Education (CCE)* and an international bidding process to chose the implementing agency.

In August 2006, SDC has identified a consortium to implement this programme, composed by *Institute universitaire d'études du développement* (IUED), *l'Université de Montréal* (UdeM) and other experts, which is under the lead of IUED. Later on, IUED was merged with HEI

[15] Commission of the European Communities, Albania 2009 Progress Report
[16] *Health Sector Assessment*. Problems, priorities and recommendations for the SDC, Besim Nuri and Dana Farcasanu, Albanie, June 2004.
[17] The feasibility study was conducted in Albania, in October 2005 and the mission team was composed by Gianfranco Domenighetti and Barbara Fäh.
[18] *Création et développement d'un centre de formation continue*. Rapport d'évaluation et de faisabilité préparé par Prof. Dr. Gianfranco Domenighetti et Barbara Fäh, Albanie, Novembre 2005

creating *Graduate Institute of International and Development Studies* (IHEID). This team of experts has elaborated a first draft of a programme document, which has been discussed with several key stakeholders during its inception mission[19] in Albania in November 2006. *A planning workshop* organized in Tirana in February 2007, was an important step in the process of understanding, supporting and contributing to drafting the *action plan* for building up the PDS system.

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[20] 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 on Health under the Department of Strategy and Donor Coordination at the Prime Minister's Office.

The PDS reform in Albania is meant to be introduced gradually during three phases of intervention, through a step by step approach. This means that each phase will prepare the ground for a series of interventions that are going to take place in the subsequent phase. Thus, the first phase of the project (2007-2010) concentrates on CCE creation and functioning, as well as on development and implementation of a mechanism for accreditation, while certification is mostly in the phase of policy-making and design. Phase 2 (2011-2014) will aim 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). Mechanism of accreditation and certification will become fully functional. Phase 3 will be mostly a phase of consolidation and handing over to Albanian authorities.

The project implementation has been delayed right from its outset and especially during the year 2009. The reason of this delay is mainly due to the fact that the signature of bilateral agreement took place only in April 2008. This postponed the decree about the establishment and functioning of the National Centre for Continuing Education (NCCE) and was transmitted to all subsequent steps such as appointment of NCCE director and recruitment of other NCCE technical staff. During the year 2009 the progress of work dedicated to the three pillars of the project (training, certification and accreditation) has accelerated and the project has caught up. In March 2010, the project was granted a six more month's extension time without any additional cost (June-December 2010) in order to have the necessary time and opportunities to carry out the planned activities, produce the forecasted outputs and achieve the objectives of the phase 1. In addition, the PDS Yearly Plan of Operation for 2010 allows for a wider spectrum of activities across health system than foreseen in the logframe[21].

2. Objectives of the External Evaluation

The external evaluation has the below main tasks:

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

[19] The inception mission took place in November 2006 and the team was composed by the following experts: Jean-Daniel Rainhorn (IUED), Pierre Fournier (IUED) and Besim Nuri (UdeM)
[20] Draft Health System Strategy 2007-2013, National Education Strategy 2004-2015, Cross-Cutting Strategy on Gender Equality and Eradication of Domestic Violence 2007-2010.
[21] PDS YPO 2010: Output 1.1 and 1.2 are newly formulated reflecting the current progress of the project ongoing.

- To analyze the project's implementing set up in terms of effectiveness and costs efficiency;
- To identify the lessons learnt to be taken up in the second phase as well as good practices to be scaled up;
- Based on the findings ~~of~~ above and taking into account the highly dynamic context in Albania, including opportunities and challenges to formulate draft outcome, outputs for the second phase as well as draft overall strategic approach;
- To draft three scenarios for the organisational set up for implementation of the project.

3. Specific Questions

a) PDS Project

1. How far has the project achieved its objectives against those set in the logframe, 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? 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?
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 PDS 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 PDS 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 support (institutional and financial) by the Albanian health authorities? To what extent the Swiss investments are promoted and guaranteed by the competent Albanian authorities?
5. To what extent does the use of the budget contribute to the expected outcomes?
6. What are realistic overall outcomes and outputs for the 2 phase? What are the appropriate strategic approaches to be chosen in phase 2?
7. What would be the appropriate and realistic organisational/implementation set up? Please provide 3 scenarios for the second phase.

b) Gender equality mainstreaming

8. To what degree an equitable participation of women and men in decision making process as well as in the program training activities is ensured? What is the further potential for GEM for phase 2 and what are the recommendations accordingly?

c) Implementing Partners' (IHEID, UdeM, PCU) Performance

9. How efficient and effective are the PDS Project Coordination Unit (PCU), Consortium (IHEID/UdeM) and the steering committee? How effective are the consortium missions and supports? Are the tools, procedures, instruments, monitoring mechanisms, financial controlling, working plans appropriate and well used? What is the role and responsibility of the national project coordinator? How effective is the collaboration with SDC, is its support appropriate?

4. Tasks

The consultants will be commissioned to:

- analyze the project documentation, including annual and semi-annual reports as well as additional information (when important to the subject);
- have briefing and debriefing with SCO-Tirana and SDC HQ Bern;
- have an exchange in Switzerland with representatives of the initial assessment, the feasibility study, IHEID and the Ascona workshop;
- meet with representatives of implementing partner (consortium);
- visit project site (PIU, NCCE, pilot CE units, etc);
- interview different stakeholders involved in the project (medical associations, technical consultants dealing with accreditation and certification, direct beneficiaries of the project, etc);
- meet with institutional partners of the project (Ministry of Health, Ministry of Education and Sciences, DSDC, Director of NCCE, SC members, ect) and other donors who are active in reformation of health system in Albania (World Bank, USAID, WHO, ect), as well as PCU staff;
- organize a debriefing in Tirana with SCO-Albania and an other in Bern with SDC; a 3-page aide-memoir 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.

5. Methodology

The external evaluation methodology should aim at bringing in a participatory and forward looking approach as far as possible. In addition to interviews with stakeholders the following can be envisaged:

- organize a desk 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 3-4 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 on if the program is meeting their needs and what are their visions for the future;
- have a look at the work of the NCCE, its work, training courses; and have a concrete idea how the project reaches out to areas outside the capital

6. Time schedule

The mission is planned to take place in spring 2010. The contractual assignment will encompass:

Description	International Consultant (Time Frame)	Local Consultant (Time Frame)
Preparation, documentation, briefing in Berne int consultant; desk study (local consultant)	3	4
Mission to Albania, including the travel time and debriefing in SCO-Tirana **(26 April-6 May 2010)**	10	10
Preliminary report **(13 May 2010)**	3	2
Debriefing Berne/Consultation with TIA (part. On proposed scenario)	1	
Final Report **(7 June 2010)**	3	1
Total	**20 Days**	**17 Days**
Reserve days (possible support to planning process)	8	7
Total	**8 Days**	**7 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 head of the team. Both consultants have their own contract with SDC. Also an interpreter (English-Albanian-English) will be hired to facilitate the communication during this mission. PDS Project Implementation Unit will offer to the mission all logistics support required (reservations, transportation) and provide all documentation, and might accompany the team on site if needed. The SCO Tirana is responsible for the overall organisation.

The consultants should possess the following qualifications:

- Working experience in continuing education for health forces approaches;
- Excellent knowledge of sustainable development and transition cooperation, in particular as regards project management, capitalization of experiences and advocacy activities;
- Good knowledge and proven expertise on establishment on medical continuing education system and democratisation process in Europe and in Western Balkans;
- Excellent oral and written knowledge of English.

8. Documentation to be provided

The consultants shall receive the following documents in electronic form:

- PDS Project Document and budget, evaluations and fact finding mission;
- The annual and semi annual reports of the PDS Management and its planning documents;
- Steering Committees Minutes.
- NSDI 2007-2013 (with esp. chapter on health); Sectorial strategies: Health System Strategy (2007-2013); National Education Strategy (2004-2015); Strategy on Gender Equality and Eradication of Domestic Violence (2007-2010).

9. Report

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 one week after the mission in Albania. The final report will be delivered to SDC not later than one week 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.

SDC, Western Balkans Division

Bern, Switzerland

SCO-A

Tirana-Albania