

Report on the

**Regional consultation on the accreditation of
health professions education in the
Eastern Mediterranean Region**

Manama, Bahrain
20–22 December 2003



World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The WHO Regional Office for the Eastern Mediterranean held a regional consultation on the accreditation of health professions education in Manama, Bahrain on 20–22 December 2003. The objectives of the meeting were to enable countries of the Eastern Mediterranean Region to exchange experience in establishing national systems of accreditation, identifying strengths and constraints, and to formulate region- and country-specific plans of action for establishing accreditation of health professions education. The meeting was attended by national experts in health professions education from 11 countries of the Eastern Mediterranean Region, along with WHO staff and temporary advisers from the Regional Office.

The consultation was inaugurated by Dr Ghanim Alsheikh, Regional Adviser, Human Resources Development, WHO/EMRO, who delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy noted with approval that the meeting was taking place only two months after a resolution was endorsed by the Regional Committee in October 2003, calling upon countries to plan and prepare for the establishment of national systems of accreditation in collaboration with the Regional Office. As was well known, the global goal of WHO was to improve health. In this connection, the role of medical and other health professions education schools was not merely preparing an efficient health workforce. In addition, they were expected to play a leading and active role in improving health both locally and nationally. Global and regional sets of standards were used to design relevant national sets as a step towards establishing systems of accreditation. The Regional Office was implementing a regional project to reform education in the Region as part of its holistic efforts to improve the performance of national health systems. A group of experts had prepared a set of six regional guidelines to assist the schools to reform their programmes. One of the important guidelines included a regional set of standards and practical steps for establishing a national accreditation system. There was no doubt that accreditation represented one of the elements of any educational reform. It touched all interventions recommended in the reform package, and although it took some time to fulfil these elements, accreditation systems ensured the preparation and achievement of improvements in national accreditation systems.

Finally, Dr Gezairy stressed the importance of technical support to, and exchange of experience among countries and institutes adopting standards as part of a comprehensive regional reform project. There was no doubt that adoption of relevant standards represented the best strategy to improve the performance of schools and consequently improve the health of populations. He expressed his confidence that the discussions and exchange of experiences in the meeting would result in clear and feasible plans of actions to assist countries of the Region in establishing and sustaining national systems of accreditation of medical and other health professions education schools.

Dr Hossam Hamdy, Dean, College of Medicine and Medical Sciences, delivered a message from H.E. Dr Khaleel Ibrahim Hassan, Minister of Health of Bahrain. In his message, Dr Hassan emphasized the role that WHO was playing in promoting health professions and medical education in countries of the Region and specifically accreditation.

He noted the importance of accreditation topic both nationally and internationally. Quality health care was important to achieve, but could only be achieved through measures including the introduction of standards for medical education, including nursing. He closed by expressing the hope that the meeting would help to develop plans of action and propose strategies for the implementation of accreditation systems with the technical support of WHO.

Dr Alsheikh outlined the agenda and objectives of the meeting. During the meeting, participants would hear an overview of accreditation in developed countries; review the current status of accreditation in countries of the Region; share experiences from countries of the Region; identify and discuss issues related to the accreditation of health professions education and the challenges facing medical and health professions education in the Region; and propose actionable recommendations for implementation by countries and WHO.

Professor Nadia Badrawi (Egypt) was elected Chair of the meeting. Dr M. Gharaibeh (Jordan) and Professor Samim Aldabbagh (Iraq) were elected Rapporteurs. The agenda, programme and list of participants are included as Annex 1, 2 and 3 respectively. Annex 4 is a list of standards and indicators for a regional accreditation system. A list of core competencies is attached as Annex 5. A table showing the results of priority-setting by participants during group work is attached as Annex 6.

2. TECHNICAL PRESENTATIONS

2.1 An overview of accreditation of medical education in Australia and New Zealand

Dr Steve Trumble

Medical education in Australia can be divided into four distinct stages: undergraduate studies (MBBS) which may take from 4 to 6 years; prevocational training, for a minimum of 1 year to a maximum of 3 years; vocational training, which takes at least 3 and a half years but which can extend beyond that; and continuing professional development (see Table 1). Following undergraduate studies at universities, students attend hospitals for prevocational training. Vocational training is then provided by colleges, hospitals and government agencies. Private companies, universities and colleges undertake continuing professional development courses. Accreditation is necessary to recognize an institute as maintaining those standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice. Accreditation ensures community confidence in the institute. It ensures patient safety and the quality of clinical outcomes. The efficiency of processes and flexibility and diversity in the institute can also not be guaranteed unless accreditation takes place. It enables an institute to set high, yet achievable, standards for itself and then to work dedicatedly to attain those standards. From a consumer's point of view the process of accreditation must be transparently valid and reliable. Even though it is logistically difficult and consumes resources, accreditation encourages reflection, focus, motivation and team building; all of these factors make it an essential process, although there is still a lot of work to be done before all of these goals can be achieved.

Table 1. Stages of medical education in Australia

Level	Duration	Provider	Certification	Accrediting body
Undergraduate	4–6 years	University	MBBS	AMC
Prevocational	1–3 years	Hospitals	Medical registration	PMC and MRBs
Vocational training	3–5+ years	Hospitals/learned (Royal) colleges	Fellowship	AMC
Continuing professional development	Lifelong	Private organizations/colleges/universities	Maintained vocational recognition	AMC

AMC: Australian Medical Council

PMC: Postgraduate medical councils

MRBs: Medical registration boards

2.2 Accreditation of medical education and implications for health services in the United Kingdom

Dr Salman Rawaf

Before describing the system of accreditation of medical education in United Kingdom which is conducted by the General Medical Council (GMC), it was explained why accreditation was important. The education and training of doctors was needed to respond to a number of challenges and needs. Changing population needs is a big challenge to cope with. In any given population, 40% of people are healthy, 40% experience good health subject to risk factors, 10% have acute illness and 10% suffer from chronic illness and disability. This leads to the need for constant change in clinical practice. Research, for example, has shown high variation in practice. The percentage of coronary heart disease patients who are currently prescribed lipid lowering agents (150 000 patients) per practice varied between 18%–52%. Similarly, the rates for endoscopies per practice for patients who are under 45 years old showed variations of less than 2% up to 58% in 132 clinics. Other challenges for medical education include public accountability, professional accountability, and clinical governance. A doctor passes through a long series of stages within educational and training schemes which are GMC accredited and Royal College approved training sites. This represents the continuum of medical education and training which takes place throughout the professional life of doctors. The GMC Education Committee was established by Parliament to protect the public through:

- ? promoting high standards for medical education;
- ? coordinating all stages of medical education;
- ? determining the content and outcomes of the medical course;
- ? determining the standard of qualifying examinations;
- ? determining the content and outcomes of the pre-registration (internship) year;
- ? inspecting any aspect of the teaching and assessments of any body wishing to confer a primary medical qualification;
- ? holding the power to recommend that a body should no longer confer a primary medical qualification; or that new institutions be given the power to confer a primary medical qualification.

One of the major functions of the committee is to provide guidance. The committee does this using a number of documents including *Good medical practice* (2001), *Tomorrow's doctors* (1993; 2003), *The new doctor* (1997; 2004) and *Continuing professional development* (2003). These documents have been very effective in changing the whole system of medical education in the United Kingdom in the last decade. The publication *Tomorrow's doctors* deals with curricular outcomes, curricular content, assessing student performance and competence, student health and conduct and reflects contemporary society. The committee also deals with quality assurance of basic medical education in:

- ? standard quality assurance arrangements;
- ? collection of information using a template based on *Tomorrow's doctors*;
- ? confirmation of information by the visiting team;
- ? integrating information and making judgements;
- ? report to the education committee;
- ? publication of reports;
- ? visitors are recruited following public advertisement and a rigorous selection process;
- ? mix of medical/non-medical and student representation;
- ? formal training and appraisal;
- ? quality assurance of basic medical education: external evaluator to quality assure programme.

The GMC expects medical schools to reflect the aspirations of contemporary society in patient-centred medicine, interprofessional and interdisciplinary medicine, promoting equality and valuing diversity and permanence of change. In framing the future, the GMC acts to evaluate, through research, the effectiveness of guidance on medical education and practice and setting future projects to identify trends that will shape medical practice in the future and to prepare doctors to meet these needs. In doing so, investigating alternative ideas to improve medical education creates debate on national assessment, on student registration with GMC, diversity and access and future themes for GMC guidance.

Discussion

The discussion centred around questions on the policy of selecting students in the United Kingdom. Selection is based on many factors and not merely on academic records. Participants discussed the need to strengthen social skills of practising doctors and curricular communication skills. Participants discussed how accreditation through self-governance and independent process can be implemented by GMC and other agencies. Speakers explained that accrediting bodies in both the United Kingdom and Australia operate independently from government, including self-financing funding through, for example, registration, licensing and re-licensing fees.

2.3 Accreditation of medical schools in Australia and New Zealand

Dr N. Suleiman

The aims of accreditation, the role of the Australian Medical Council (AMC), attributes of medical graduates and the accreditation process were outlined. The AMC aims to provide quality assurance of basic medical education in Australasia and New Zealand. While safeguarding the academic interests of universities, it brings standards into alignment with the World Federation for Medical Education (WFME) standards for basic medical education, adopted in 2001. The AMC process focuses on: achievement of the objectives, maintenance of academic standards, public safety requirements, and expected outputs and outcomes. They monitor implementation of recommended changes after approval of accreditation and ongoing cycle of review. The school completes the initial questionnaire, then supplies extensive documentation on the school, the medical curriculum and resources that support the curriculum. A team from the AMC reviews this material and conducts a one-week site visit to the school, its facilities and teaching hospitals and training sites. The team then prepares a draft report and circulates it to the school for comments before a final report with recommendations is prepared and sent to the AMC. A preliminary discussion takes place concerning the visit between 8 to 12 months before the assessment.

The team is constituted of 6-12 members. The school submits its documentation and visit arrangements for finalization six months prior to the assessment visit. A post-visit accreditation report is prepared in draft, which the school comments on, and then the team prepares its final report for the medical school accreditation. The accreditation committee at the AMC then develops draft recommendations on the school's accreditation, and sends them to universities for commenting. The report, recommendations and any comments by the university are then submitted to the AMC and the Medical Council of New Zealand (MCNZ), for their decision on accreditation.

AMC's accreditation options include: awarding accreditation for a maximum period of 10 years, usually available as accreditation for 6 years in the first instance, or grant a further 4 years' accreditation on the basis of a report submitted by the school in the fifth year of accreditation that demonstrates that the medical school has maintained its standards of education and of resources. The AMC may set conditions on the accreditation and/or may grant accreditation for a shorter period of time. The AMC may also refuse accreditation. A medical school with the maximum period of accreditation submits a report 2, 5 and 7 years after the school has been assessed by the AMC. More frequent reports are required of medical schools with conditions on their accreditation and of medical schools that have made major changes to their medical course. The AMC does not prescribe the detailed curricula, core subjects or topics, or educational methods required to deliver the curriculum. It supports diversity and encourages innovative approaches to education. Accordingly, each medical school should set in place a curriculum which is capable of achieving the school's objectives, a system of assessment, a system for evaluating and for monitoring the effectiveness of the curriculum.

Dr Suleiman proposed, for further discussions, options in the form of a national accreditation committee governed by the country's specific medical council; also, a regional

or sub-regional accreditation committees (RAC) at the Regional Office which recommend national councils in countries of the Region. Such systems can direct health and education systems towards community-oriented education and training, general or family practice, rather than university hospitals, population health (social rather than biomedical model) and continuous professional development.

2.4 Accreditation of vocational medical training in Australia

Dr Steve Trumble

Vocational training aims to take non-specialist doctors and turn them into specialists who are competent to practice unsupervised anywhere in Australia. It also has an obligation to ensure that these doctors are trained appropriately to meet the community's current needs. The AMC has recently begun a programme of accrediting the Royal Colleges in their longstanding role of setting the standards for selection, the curriculum and assessment. This was necessary because of growing concerns that health workforce were being unnecessarily restricted in the pursuit of ensuring standards. Most Royal Australian Colleges have embraced the CanMEDS framework set by the Royal Colleges of Physicians and Surgeons of Canada (RCPSC) that describes seven roles of the specialist practitioner:

- ? medical expert;
- ? communicator ;
- ? collaborator ;
- ? manager ;
- ? health advocate;
- ? scholar;
- ? professional

These specialist practitioners are provided with vocational training primarily by public hospitals. General practitioners are trained in community settings in private practices, after they have completed at least 2 years of general hospital training. The Royal Australian College of General Practitioners (RACGP) describes five areas in its curriculum:

1. communication skills and the patient/doctor relationship
2. applied professional knowledge and skills
3. population health and the context of general practice
4. professional and ethical roles
5. legal and organizational issues.

Colleges accredit training providers, their personnel, the programmes they deliver and the posts in which they deliver it. Key criteria are that the trainee:

- ? learns principally in the workplace ;
- ? learns principally from practising general practitioners;
- ? has sufficient one-on-one learning with direct observation;
- ? receives regular feedback;
- ? receives opportunities for peer reflection;

- ? receives pastoral support;
- ? has inspirational role models;
- ? sees a full range of patients and settings;
- ? learns all five domains;
- ? learns the non-clinical workings of practice.

Training posts are accredited separately to ensure that there is adequate supervision of the trainee, appropriate educational activities, sufficient facilities and resources and a balance between service and learning.

2.5 Standards for accreditation of undergraduate medical education in countries of the Gulf Cooperation Council

Dr Hossam Hamdy

In addition to accreditation, several projects have been initiated and implemented by the Gulf Cooperation Council (GCC) Medical Colleges Deans' Committee (GCCMCD) including a certified course in medical education in different countries, database of faculty in medical colleges in the GCC, including research. standards for accreditation of medical colleges in countries of the GCC project focuses on outcomes of undergraduate medical education in these countries, pilot study of standards of accreditation in medical colleges, medical education and medical students scientific conferences.

The factors stimulating the development of standards for accreditation in medical education comprise: a rapid increase in the number of public and private medical schools in the region; increased interest in medical education and curricular reforms; and the international movement to develop global standards in medical education. The problems encountered in developing the standards include: different procedures and criteria of student admission to medical college; variability of educational programmes i.e. traditional versus contemporary; resistance to the concept of programme evaluation (internal or external); variability in the administrative systems of medical education in different countries of the GCC; and variability in the relation between medical education institutions and health care delivery system of the countries. Suggestions for future development include: the further development and refinement of measurable variables for standards; dissemination of information, pilot studies to be conducted in different countries; the development of a subregional centre for accreditation of health professions institutions; the development of mechanisms of cooperation and support between the centres and national bodies in ministries of higher education and health. Standards for accreditation of undergraduate medical education in countries of the GCC aim to introduce the GCCMCD Committee as the driving force in the development of standards and in the presentation of the conceptual framework which guided the development of standards. A proposal is to be presented about what should be done for starting the accreditation process in these countries and the problems that were encountered during implementation. The committee was established in 1994 under the umbrella of the GCC. It includes 13 medical colleges in six countries. The aim of the committee is to create a spirit of cooperation between the medical colleges of the region and to initiate and support the provision of quality medical education in the countries of the GCC. The committee meets every six months. The secretariat is based at the Arabian Gulf

University in Bahrain. In the first GCC medical education conference in Kuwait in 1999, recommendations were made to develop criteria for the evaluation and accreditation of GCC colleges of medicine. In the meeting at Al-Ain in the United Arab Emirates in 2000 a task force was formed for the development of recommendations and guidelines on minimum standards for establishing and accrediting medical schools in the GCC countries. The main aim of these meetings and of the whole process of accreditation is to encourage improvement and ensure that acceptable standards of quality are developed and met. Various problems are encountered in developing the standards. One is that different medical colleges have different criteria for admission. The educational programme may vary between different colleges i.e. traditional versus innovative. Also, some colleges are more resistant to change in the programme. There are also differences in the administrative systems of colleges and in the relation between medical education institutes and national health care delivery systems.

Currently there are 50 standards that have been clustered under eight broad categories:

- ? mission and vision;
- ? undergraduate medical education programme;
- ? students;
- ? faculty;
- ? learning resources;
- ? teaching hospitals and training centres;
- ? management of the education process;
- ? scientific research

Medical education should follow a student-centred strategy that supports learning, stimulates logical and critical thinking and prepares the student for self-directed and life-long learning. Regarding the main specialties, the teaching hospital should provide a ratio of 25 occupied inpatient beds per student. A medical school which admits 100 students per academic year should provide 500 training beds. Horizontal and vertical integration in the curriculum should guide the curriculum structure and organization. Formative and summative students' assessments should comprise different assessment approaches with an acceptable degree of validity and reliability capable of measuring students' competency and progress.

Discussion

The Chairman allowed 15 minutes for the discussion of issues on accreditation and primary health care and the difficulties faced in the full implementation of this approach in Arab countries. Participants discussed the weak role of the community and the need for training of family physicians training in primary health care. Intercountry funds allocation on accreditation was also discussed.

2.6 Accreditation of health professions education schools in the Region: response to global challenges

Dr Ghanim Alsheikh

The accreditation of health professions education institutes in the Region is required for several reasons. Firstly, the national health systems are undergoing major reform which necessitates relevant reform in health professions education. Secondly, competent health professionals are needed to ensure an acceptable quality of health services at national and global levels. Relevant and good quality education is needed to train skilled professionals to participate in developing efficient health systems. Accredited education is an essential bottleneck tool that levers not only education, but the role of schools in meeting these goals. Accreditation guarantees quality and relevance of education and also protects institutions against unplanned pressures, such as increase of numbers of enrolment. Accreditation comprises institutional and educational parts. Institutional accreditation deals with the mission, aims, structure and organization of the institute. It also includes physical, human and educational resources of the institute and the facilities available to students such as clinical, laboratory, research, field training, services and recreation. Educational accreditation deals with the programmatic organization, process and evaluation of education including innovation. It looks at the programme of study and methods of learning and assessment. Accreditation can be operated at global, regional, subregional, national or provincial levels.

In the Region, undergraduate medical schools were usually recognized by the General Medical Council of the United Kingdom until the 1970s when listing in the WHO *World directory of medical schools* became the only recognized tool for graduates. Accreditation of postgraduate medical education is performed by the Arab Board of Medical Specialization. Several attempts for accreditation have been operating on a sporadic level in Iraq, Islamic Republic of Iran and Pakistan. A pilot testing of WFME global standards is being undertaken in several schools in the Region. The Regional Office is supporting several countries in establishing national systems of accreditation including Egypt, Sudan and Yemen. A set of regional standards has been worked out by a group of experts to guide countries in setting national sets of standards (Annexes 4 and 5). Regional guidelines have also been written to guide countries on how to establish national systems and how to conduct institutional self-study prior to external accreditation. They explain the rules, processes and procedures of accreditation and help in planning and conducting unified national examinations and as part of establishing the national accreditation system. The Regional Office is assisting countries through technical and financial support and through contracting national task forces in setting and adopting national standards, establishing or strengthening existing national bodies to be designated as accrediting bodies and in preparing a plan of action. Support has been extended to volunteer institutes to conduct institutional self-study, to develop and implement national examinations and to pilot implementation of national accreditation systems. It is planned that more than half of the countries in the Region will have taken steps towards establishing an accreditation process in their medical schools and in expanding into other health professions education schools, including nursing, pharmacy and dentistry.

2.7 Accreditation of nursing education in the Region: issues and challenges

Dr Fariba Al-Darazi

All countries in the Region have basic nursing schools under the governance of the Ministry of Health, Ministry of Education, universities, military services, private organizations and/or nongovernmental organizations. However, almost all countries still suffer from a shortage of qualified nursing and midwifery personnel. Also, there is a shortage of qualified teachers for nursing education. There are problems in clinical teachings of which some are shortage of clinical preceptors, absence of positive role models and clear standards of nursing care, unavailability of equipment and resources and lack of practice in community settings. The nursing curricula are founded on the medical model and comprise individual care and curative hospital care. There is inadequate teaching and learning material in the countries' national languages. Available texts are often not culturally relevant. To make the situation worse there is a lack of a systematic approach to the accreditation of nursing education programmes and there is no system for assessing the implementation of nursing education against identified standards. These problems have led to greater need for nurses who possess advanced knowledge and skills in different specialities. Various steps can be taken to improve the situation. The development of regulatory systems, educational reform and the adoption of regional nursing education standards is necessary. Technical assistance is also required. Guidelines for developing regulatory systems should be followed and national standards should be developed. Based on regional standards, sub-regional standards can also be developed. The aims of the Regional Office's reforms are the protection of society, and the potential to implement positive changes in nursing practice, in the nursing service delivery system and in nursing education.

In 1998, a regional publication was produced and adopted by the regional committee. The publication contained guidelines on future decisions in nursing education, the prototypical technical nursing curriculum and the prototype baccalaureate nursing curriculum. The target of WHO is to produce a cadre of professional nurses in the Region. It is hoped that this can be attained over the next 15 years, during which time two levels of professional nurses may exist. Professional nurses may enrol in a 4-year programme and technical nurses may enrol in a 2.5 year programme, with the requirement for admission to either programme being 12 years of general schooling education. The programmes follow current trends in nursing education. There is a need to guide institutions to improve existing programmes and to develop new programmes. Existing programmes should also be consolidated to advance the uniform development of nursing in the Region. To expand the horizon of students and graduates they should be allowed mobility among Member States and their activities should be guided. The profession should attract capable candidates and regional progress in the development of nursing education should be monitored. Nursing education in the Region faces many challenges. There is a lack of power and control by nurses over nursing in education and nursing is being deprived education resources in favour of medical schools. There is a lack of national standards and inadequate preparation for teaching. The variations in entrance requirements and curricular length also have negative implications. There is an isolation of nursing education from practice. It was concluded that there needs to be a shared responsibility towards society in developing educational programmes that respond to changing health care needs and changing health systems and which contribute to the

preparation of future nurses and allied health professionals. A system for accrediting health care facilities and health professions educational institutions needs to be developed

Discussion

The question of who should be responsible for accreditation was raised. Many participants highlighted the need for a role for the Regional Office and a regional system of accreditation. The future vision of accreditation in the Region was appreciated and both technical and financial support to countries was thought to be essential for further progress of reform in health profession education.

2.8 Accreditation of medical and dental education in Pakistan

Dr Mohammad Sohail Karim Hashmi

The accreditation body is conducted by the Pakistan Medical and Dental Council (PMDC). It is a corporate body constituted under Ordinance 1962 which was later amended through an act of Parliament in 1973. Its mission is to establish uniform minimum standards of basic and higher qualifications in medicine and dentistry. It aims at protecting the rights of the patient, providing guidance to doctors on medical ethics, maintaining a minimum standard of medical education throughout the country parallel with international standards and compiling and maintaining a register of medical and dental practitioners in Pakistan. The PMDC is composed of 55 members representing 1 member from the National Assembly; 4 members from provincial governments; 9 members from universities/examining bodies; 4 registered medical practitioner representatives; 4 members nominated by the Federal Government; 2 registered dental practitioners representatives; 29 teaching staff; 17 representatives from medical colleges; 8 representatives from postgraduate institutes; 4 representatives from dental colleges; member nominated by the Chief Justice of Pakistan; 1 Director-General of Health, Government of Pakistan. The Council produce regulations for the degrees of MBBS and BDS, the appointment of teachers and examiners, the registration of medical/dental practitioners, and for the National Equivalence Examination (NEB). It also produces guidelines for postgraduate medical institutions, inspectors of examinations and institutions, medical and dental journals, criteria for the establishment of medical and dental colleges, curriculum development, and code of ethics for medical and dental practitioners. The Council is a supreme body and takes all policy decisions. It meets one or two times a year or as and when there are sufficient items for the agenda which need policy decisions. It functions through seven committees namely:

1. executive committee;
2. standing recognition committee;
3. staffing committee ;
4. disciplinary committee ;
5. postgraduate medical and dental education committee ;
6. dental education committee and;
7. curriculum committee.

In addition, there are nine sections in the Secretariat and five provincial offices. The Council is financially independent. It does not receive any grant in aid from the Government. The funds are generated through its own resources from registration fees from new doctors, renewal fees from registered doctors every 5 years, registration of postgraduate foreign qualification, issuance of different certificates and inspection fees from medical institutions. The Council's guideline for establishing colleges deals with comprehensive feasibility report, space and infrastructure, financial resources, legal requirement, organizational structure, faculty transport facilities, library, attached teaching hospitals and affiliation with a university.

Every institution intending to establish a medical/dental college must apply to the PMDC for an inspection prior to advertisement for application of admission in first year class. The advertisement for admission can only be issued after No Objection Certificate (NOC) is obtained from PMDC. The NOC is issued after going through the complete feasibility report and first inspection, there are eight inspections/visits in total before a college is recognized. The presentation pronounces that all the colleges recognized by the PMDC are also automatically recognized by the General Medical Council of the United Kingdom and by the National Committee on Foreign Medical Education and Accreditation (NCFMEA) of U.S. Department of Education. To ensure that the regulations of the Council are followed by the various colleges, the Council inspects the colleges periodically. The newly -opened institutions are inspected comprehensively after scrutinizing the application. The provisional recognition is granted for a specified period with certain condition for rectifying the deficiencies. Inspection is again carried out by the Council after that period to ascertain that the deficiencies of the previous inspection report have been rectified. The Council also inspects various professional examinations. After all deficiencies have been certified and following the final inspection, the institution is granted recognition. Seven visits are involved in the process. The first visit is conducted for comprehensive inspection prior to the first admission of students. The inspection team looks into the following:

- ? suitability of the venue for educational purposes;
- ? availability of all necessary infrastructure and physical facilities needed during the first professional examination;
- ? access to required educational resources;
- ? recruitment of an appropriate and adequate teaching faculty;
- ? availability of written curriculum;
- ? adequacy and source of funds and procedure for financial accountability.

The second visit is conducted at the time of first professional examination where the inspection team observes the conduct of examination, availability of appropriate and adequate numbers of examiners, relevance of assessment to the objectives of training for the year and report on the transparency and fairness of the examination. The third visit is paid at the beginning of the third year or second professional examination. The inspection team looks into the availability of all necessary infrastructure and facilities needed in the college, as well as in the affiliated teaching hospital, adequacy of clinical training opportunities including workload, case mix on the hospitals, availability of required clinical faculty, access to required educational resources, recruitment of appropriate and adequate teaching faculty and availability of written training programme with objectives, syllabus, teaching methods and

assessment programme. The fourth visit takes place at the time of second professional examination. The inspection team observes the conduct of the examination, availability of appropriate and adequate numbers of examiners, relevance of assessment to the objectives of training for the year and report on the transparency and fairness of the examination. The fifth visit represents the second comprehensive inspection at the beginning of the fourth year or third professional examination. The inspection team looks into the availability of all necessary infrastructure and facilities needed during the third professional in the medical college as well as the affiliated teaching hospital, adequacy of clinical training opportunities including workload, case mix, availability of required clinical faculty, presence of needed educational resources, recruitment of appropriate and adequate teaching faculty, availability of written training programme with objectives, syllabus, teaching methods and assessment programme. The sixth and seventh visits are conducted during third and fourth examinations respectively where team looks for appropriate conduction of the examinations.

Out of the 47 medical colleges that currently exist in Pakistan, the council has recognized 17 (16 public and one private); provisionally recognized 16 (one public and 15 private) and a still unrecognized further 14 colleges (six public and eight private).

2.9 Accreditation of Egyptian medical schools: a joint national project with WHO

Dr Wagdy Talaat

A presentation was given on a project to plan and prepare for the accreditation of Egyptian medical schools. The project is conducted by a national task force that has been contracted by WHO Regional Office for the purpose. Education and reach consensus concerning how to achieve better health care of populations. Internationally, the step taken for the accreditation of medical schools was the launching of a programme on International Standards in Medical Education in 1998 by the World Federation for Medical Education (WFME). This was to be used as a tool for accreditation in health professions education. WHO Regional Office has assigned a group of experts to prepare regional guidelines to help establish an accreditation system for health professions education in countries of the Region based on national sets of standards. At the national level, the Regional Office holds a number of projects of which the Accreditation of Egyptian Medical Schools (AEMS) is described here. The national task force is contracted to execute several phases starting with the following terms of reference:

- ? introduce Egyptian medical schools and allied sciences to the global standards developed by the WFME;
- ? train faculty from each health professions education institution on programme evaluation as a means for self-assessment (using the WFME standards as a tool);
- ? encourage peer and external evaluation of educational programmes among Egyptian health professions education institutes towards finding common groups for developing national standards;
- ? supervise organization of national workshops to adapt the WFME standards after testing such standards to formulate agreed upon national standards;

- ? supervise production of final document, including a work-plan to develop a national system for accreditation of health professions education institutes, based on agreed upon national standards.

To date, various activities have been carried out. Conduction of site visits to the schools to address the accreditation issue during their faculty board meetings and encouraging the schools to conduct self-assessment studies and peer assessment. Almost one-third of the Egyptian medical schools have finished their studies with technical help from the project team. A questionnaire was designed by the project team, derived from the WFME standards and regional guidelines. This questionnaire was also optionally provided to every medical school. A national workshop was conducted with the participation of deans and vice deans of 14 schools and representatives from the Egyptian Medical Syndicate, the Regional Office, Egyptian Health Professions Education schools, National Committee for Quality Control and Accreditation in Higher Education (NCQA), and the Higher Council of Universities. There has been full coordination between WHO efforts and national and governmental efforts to ensure synergy, applicability, sustainability and sharing in the process of proposing the required legislations submitted for approval from the National Assembly through the shared members of both the NCQA and WHO project team.

A major obstacle to accreditation has been the denial by most Egyptian medical schools that there is a problem. Although no schools have resisted the efforts for change lead by the Regional Office, few of the schools are still apprehensive about the aim and objectives of the process. The future plans include the convening of more than one national workshop with the objective of presenting self-studies and to come up with the national standards for accreditation in health professions education in Egypt. Also planned is the submission of the final report and dissemination of its results in Egypt and in the region. The outcomes expected to achieve by this project are awareness, self-studies, steps towards developing the national standards and collaboration with the governmental efforts for accreditation in higher education towards establishing a national system of accreditation.

2.10 Accreditation of medical schools in Egypt: national quality assurance and accreditation project

Dr Nadia Badrawi

The system of quality assurance, accreditation and internal review of the academic programmes and institutions has long been started in the developed countries and became an integral part of the assessment and development system of all elements of the educational process. In the past 20 years, higher education in Egypt has witnessed sharp increases in the number of universities and students. Between 1982 and 2002, number of public universities raised from 14 to 24 (1 to 7 private) and number of higher education institutes from zero to 51/80 (public/private). The number of enrolled students increased from 637 000 to 1 638 000. At present, there are 18 government and two private medical schools. For the academic year 2002–2003, the number of undergraduate students was 54 630; postgraduate students 21 877; number of graduates 7351; number of faculty members 14 384. In 2001, a conference on reform for higher education was held where 25 distinct projects were established in the diverse areas related to improving quality, efficiency and relevance of higher education.

The Higher Education Enhancement Project Fund which dealt with reforming the higher education system is comprised of six subprojects of which Quality Assurance and Accreditation Project (QAAP) dealt with accreditation of higher education colleges including health professions education. Establishing the National Quality Assurance and Accreditation Agency (NQAAA) included political approval, concept paper, feasibility studies, legislative steps, and to delegate the responsibility to the agency. The NQAAA project deals with setting-up academic standards and benchmarks through different sector committees to set up all degree qualifications for the diverse professions, looking into the equivalency of degrees, and establishing academic standards on institutional and programme levels. The project objectives and activities include establishing the National Quality Assurance and Accreditation Agency, setting up standards for institutional self-study, awareness raising campaigns, setting up academic standards and benchmarks, capacity-building for universities and international cooperation with different organizations such as WHO, UNESCO, WFME, AAMC, World Bank and others. It also includes collaboration among Arab countries through Arab Ministers Agreements (Cairo 2001) which recommended establishing a performance evaluation and quality assurance centre in each university within 2 years and establishing a national quality assurance and accreditation body in each Arab country within 4 years.

The Regional Office initiative seeks to establish a regional body to look into coordination activities, quality assurance, accreditation of medical schools and the equivalency and recognition of degrees among countries.

The NQAAA prerequisites for success include :

- ? The NQAAA must be independent and directly affiliated with the head of state at all declared levels.
- ? The establishment of the National Higher Education Enhancement Fund (HEEF) as a mechanism for financing development/reform programmes should be completed.
- ? The legislation for establishing the NQAAA must be finalized so that a Board of Trustees can be formed.
- ? Partnership and collaboration agreements must be concluded during the early stages (first 5 years) with counterpart quality assurance agencies to benefit from their previous experiences.
- ? Government commitment to allocate the necessary funds is required to establish the NQAAA to ensure its sustainability and support its recommendations to develop the performance of educational institutions, including the implementation of planned pilot projects to gain the utmost benefit.
- ? Awareness campaigns and training for relevant institutions should be initiated on an immediate basis, and missions sent to quality assurance and accreditation authorities renowned internationally.

Discussion

Dr Rawaf commented on the outcomes and products of medical education in Egypt and Pakistan and how they related to the quality assurance efforts described in the presentations. Quality assurance is a key challenge for all medical schools and that is why they are participating in the NQAAA project. Dr Hashimi identified gaps that need to be addressed and the systems that need to be strengthened. Dr Diab from the Syrian Arab Republic suggested multicountry workshops on accreditation to reduce resistance to this issue.

2.11 New evaluation and accreditation system for graduate medical education in the Islamic Republic of Iran

Dr Masud Naseripour

An historic outline of the Secretariat of the Iranian Council for Graduate Medical Education (GME) was presented. The council was founded in 1974 by a special act of the national parliament and has since had a pivotal role in directing graduate medical education in the Islamic Republic of Iran. The council's mission is a stated improvement in health care in the country through improving the quality of graduate medical education. It is responsible for evaluation and approval of residency training units, conducting assessment of trainees related to graduate medical education and planning in different clinical specialties. It works under the aegis of the Ministry of Health and Medical Education, and is chaired by the Minister of Health and Medical Education. The members of the Council include the Deputy Minister for Education and University Affairs, chancellors of universities of medical sciences (46 in number), and representatives of faculty members of major universities, seven high-ranked academics who are assigned by the Minister of Health and Medical Education. There are 24 specialties, 21 sub-specialties and nearly 570 residency training units in 26 universities training more than 5500 residents. There was a rapid growth of graduate medical education residency training units from 1986–1996. This growth has been attributed to the lack of a well-developed and approved curriculum in nearly all specialties at national and institutional level, and as a result of the changing needs of society and the health care system.

The short-term goal is the reactivation of the traditional residency programme evaluation and approval system, and the long-term goal is the establishment of a well-structured accreditation system. Problems in traditional approval system include the lack of well-defined standards in each specialty, lack of defined and approved policies and procedures for programme evaluation and judgment, the absence of representatives of all principal stakeholders in evaluation process, overemphasis on facilities and resources versus process and outcomes in evaluation process. An outline of what has been done to address these problems include the following steps: assignment of an ad hoc committee (1998); conduction of preliminary studies (1999); development of initial draft of action plan (1999); receiving input and finalizing the action plan (1999); and approval by the council (2000). The proposed action plan entails designing and approval of the system structure and function, establishment of required infrastructure, developing residency programme standards in each specialty, dissemination of approved residency programme standards, internal evaluation in residency programmes, formative evaluation of residency programmes, summative evaluation of residency programmes, designing and approval of the system structure and function.

Each speciality review committee is responsible for the development of residency programme standards in related specialities and periodic reviewing of residency programmes and proposing accreditation status to the accreditation commission. Each speciality review committee comprises representatives of: national speciality board, professional society and academic departments of universities. The Secretariat of the Accreditation Commission consults the Council about the submitted standards of each speciality for decision-making about the accreditation status. The Accreditation Commission is composed of representatives of universities of medical sciences, specialty review committees and the Minister of Health and Medical Education. The action plan consists of designing and approval of the system structure and function, establishment of required infrastructure and developing standards in each speciality. The publication of approved standards can be found on the commission's website (www.cgme.hbi.or.ir).

Next steps include the establishment of other speciality review committees, approval of university of medical sciences standards in the Council, approval of RPSs of other specialities in the Council, internal evaluation of residency programmes (in remaining specialities), formative external programme evaluation (in all specialities) and summative external programme evaluation (in all specialities).

The accreditation process will include distribution of RPS and PIF, completion of PIF by related staff of the programme, site visit, review and submission of notification letter by SC to programme, response of programme, final review and recommendation of an accreditation status to the accreditation council by the SC and determination of the accreditation status of programme by the accreditation council. Other activities included the establishment of accreditation systems in other fields of health professions education, and the convening of a second national conference on evaluation and accreditation, Tehran, 2005.

Discussion

Several participants made queries on the accreditation of postgraduate medical education. These included questions on how the council and the accreditation commission are financed, was the council funded by the government? What was the influence of the Ministry of Health on the council? Were hospitals accredited under the Commission? What kind of feedback existed from medical schools and was the system mandatory or through application of medical schools? Also, there were queries on the role of universities in the council and the standards of graduates as compared with other graduates from other countries. Dr Naseripour responded to all questions and clarified the role of integrating medical education and health services in the Ministry of Health and Medical Education.

2.12 Accreditation system in Iraqi medical schools

Dr Samim Ahmad Al-Dabbagh

In 1959, there was only one medical college in Baghdad. Now there are 17 colleges, many of which are recently established. The national system of accreditation was implemented in 1993 and comprises three components:

- ? The systematic questionnaire component is conducted centrally by the Unit of Performance Evaluation in the Ministry of Higher Education and Scientific Research.
- ? The Central Students Examination (CSE) conducted by the Ministry
- ? The annual performance evaluation of faculty staff conducted by the department, college or university.

The first part comprised a comprehensive and detailed checklist organized around seven domains which are devoted to evaluation departments, in addition to the overall evaluation of the college and its programmes. These domains cover mission, aims and objectives, structure, resources (human, financial and physical), professional and social services, students, teaching staff, curriculum and methodologies, scientific activities, research, cultural exchange and external cooperation. The system is designed to fulfil agreed standards and criteria with a feedback mechanism on inputs, processes and outcomes. Almost all indicators are quantitative in that the analysis by the Unit of Performance Evaluation eventually leads to evaluation and provides feedback on quantity and quality alike. The first pivot is the departmental structure. This includes data on departments in the college, scientific units connected with the college, the numbers qualifications and experience of available human resources including administrators, technicians, workers and faculty staff members and information concerning their academic qualifications and titles. The second pivot deals with services and equipments made available to students and staff. This includes transport and library and information technology services. The third pivot focuses on students and includes the numbers of Iraqi and non-Iraqi students enrolled on various degree courses, success and attrition rates, students' research and dissertations. The fourth pivot focuses on the teaching staff and includes ratios of different academic ranks, qualifications and teaching experience and load. The fifth pivot deals with teaching and learning strategies and approaches. It also deals with educational training opportunities, resources available for teaching e.g. classrooms, televisions, multimedia halls and programme evaluation studies. It also includes data on grants and awards excellent performance. The sixth pivot deals with scientific research and external exchange. All published research and books are evaluated according to impact and usability by services. Also scientific events such as conferences and symposiums are held, and cultural exchanges with other departments are included. The seventh pivot deals with societal services and activities provided to the community beyond the academic arena.

The second component evaluates the outcome of the learning process in the form of the Central Students Examination (CSE). The written Multiple Choice Question (MCQ) examination is conducted by central national boards in randomly selected 1-2 papers in each year. The score of the CSE accounts for 50% of the total mark in the selected topic. Continuing course assessment accounts for the other 50%. There are some problems in the

examination system such as the focus on knowledge and not on practical skills and biases involved in constructing objective questions.

The third component includes an annual performance evaluation of teaching staff under several domains and scoring system. The evaluation is directly linked to promotion and increments of faculty staff. Direct and face-to-face feedback is conducted with those who achieve the highest marks and with those who fail to achieve the minimum marks.

Feedback from accreditation encouraged colleges to initiate specific activities to fulfill the standards which included, for example, evaluation of undergraduate students by external examiners, comprehensive evaluation of newly-graduated doctors, adoption of community-based training, introduction of new subjects such as family practice, ethics, research and communication skills. As a result, a national board was established in the Ministry of Health to integrate and develop both health professions education and health services.

Discussion

Participants commented on the need for distinction between appraisal, evaluation and accreditation. They expressed the belief that unified examinations could not substitute the role of the evaluation of the colleges. Also, they questioned accreditation although addressing field training, research and other services, not directly addressing health.

2.13 Yemen vision and plan for accreditation of medical education in Yemen

Dr Mohamed M. Motahar and Dr Najeeb A Jalil

Higher education started in Yemen in 1970 with the founding of the universities of Sanaa and Aden. Now, there are seven public and eight private universities affiliated to five public and four private medical schools. Since the foundation of the Ministry of Higher Education and Scientific Research (MOHESR) in 2001, efforts have been focused towards ensuring the quality of these universities. In addition to other measures, the project to develop higher education is based on establishing a national system of academic accreditation in different colleges. At present, there is a joint project being undertaken with the Regional Office to establish a national system of accreditation of medical and other related schools. A national workshop was jointly organized in October 2003, and was attended by all stakeholders from MOHESR, various colleges and the Ministry of Public Health and Population. The workshop was facilitated by a WHO consultant and ways of adapting global and regional standards were discussed, and it was agreed that a national committee for the accreditation of medical education would be formed. The committee which was headed by the Deputy Minister of MOHESR and the deans of colleges was extended to include representatives of the Ministry of Health, the Yemen Medical Council, the Yemen Board of Medical Specialization, professional syndicates, the community, students, two experts and WHO. The participants agreed on adopting the following in addressing the domains as appropriate to Yemen in upgrading medical education based on WFME and regional standards:

- ? Mission, aims and objectives: responsive graduates to health care and services in a health team and community settings; support Arabization in medical education; address ethical issues; play a role in periodic programme evaluation, continuing professional development system and skills improvement of staff.
- ? Educational programme: enable students to acquire skills to solve Yemen community health problems observing acceptable ethics and attitudes; focusing on self-learning and research abilities.
- ? Student assessment: continuing assessment of students' active participation, using different and appropriate methodologies, concentrating on analytical and clinical skills and legalizing the assessment approaches.
- ? Students: agreeing on a more effective admission policy, controlling enrolment size to match national health systems needs, providing non-curricular services during the course of study including counselling and better utilization of students' feedback.
- ? Academic staff: adoption of standardized scientific policy for staff recruitment, providing continuing professional, especially educational and research skills development, reciprocal utilization of human resources in both MOHESR and the Ministry of Health in teaching, services and research adopting staff active role in developing strategies in developing medical education and health systems.
- ? Educational resources: to provide and develop resources for infrastructure, clinical and field training, information technology, research, medical education development and collaboration with partners including the Ministry of Health.
- ? Programme evaluation: periodic evaluation of education through feedback from students, college administration and staff to improve and develop the performance of the colleges.
- ? Governance and administration: legalizing the structure and authority of the college through decentralization and through active relations with partners including the health sector and care sectors.
- ? Continuous renewal: adoption of innovative educational methods and collaboration with international, regional and local bodies.

The next steps towards establishing a national system of accreditation of medical education included the following:

- ? establish a national task force to plan and prepare for the system;
- ? organize awareness workshops in colleges on standards and accreditation;
- ? endorse national standards from councils of departments, colleges and universities;
- ? establish a team of experts to prepare guidelines for self-study;
- ? establish a database for medical education and performance indicators;

- ? produce self-study documents by different colleges;
- ? discuss produced self-study documents;
- ? correct weaknesses shown in documents;
- ? establish a team of experts to prepare guidelines for unified medical examinations;
- ? formulate a document on the project of the national system of accreditation, discussed by academic departments and colleges for endorsement by the national accreditation committee;
- ? agree on a plan of action to implement the project of accreditation at national level.

2.14 Medical education in the Syrian Arab Republic

Dr Musbah Dhiab

A short account of medical education in the Syrian Arab Republic was presented. There are four medical schools and a number of health-related professions colleges. All colleges are licensed by the Ministry of Higher Education. Features of programme evaluation and educational development are executed in these colleges. These measures include periodic training opportunities in educational development, an evaluative system of the performance of faculty staff and programme implementation, and introduction of a national system of accreditation with support from WHO.

Conclusions from the country presentations

Countries in the Eastern Mediterranean Region appear to be grouped into three types of quality systems of medical education. In the first group, there are established accreditation systems that in some countries need upgrading according to global and regional standards. The second group includes countries where accreditation systems have been introduced but they are still in the process of implementation. The third group of countries include those which still need to introduce standards and accreditation systems.

3. GROUP WORK

3.1 Session One

Participants were divided into three groups to analyse the different situations in countries of the Region using the SWOT analysis tool. Each group was assigned a different subtask. The main task was to identify country-specific strengths, weaknesses, opportunities and threats in planning (Group A), implementing (Group B) and in sustaining (Group C) a national accreditation system. The following represents the feedback from the group work

Group A: Planning of a national system

Strengths	<ul style="list-style-type: none"> ? experiences of WHO Regional Office, GCC, Association of Arab Board used in setting the stage for planning the accreditation systems; ? experiences of self-study in countries of the Region; ? long-standing formal medical education; ? Integration and cooperation between medical education and health services, such as in the Islamic Republic of Iran; ? existence of financial support and other resources; ? qualified staff and health professionals in health profession education; ? standardized systems and subsystems of educational programmes; ? positive acceptance and approach for accreditation system at high government level ? the adoption and implementation, in many countries, of innovative medical education models, such as PBL and evidence based.
Weaknesses	<ul style="list-style-type: none"> ? weak systems of measurement; ? inadequate medical education research; ? lack of formal programme evaluation; ? lack of identified outcomes and graduate follow ups; ? inadequate resources for example in virtual medical libraries ; ? resistance and difficulty in the legislation process and outcomes; ? lack of unified definition and understanding of accreditation; ? limited use of educational technology; ? limited financial resources; ? lack of experienced peer reviewers and accreditation committees.
Opportunities	<ul style="list-style-type: none"> ? presence of national potential expertise in the countries; ? positive directions of health authorities towards accreditation; ? support of international and regional organizations; ? presence of postgraduate and doctorate programme in countries; ? exchange of regional and international experiences (best evidence medical education); ? global and regional environment [Political circumstances and support; ? great value added Medical Education to the nationals and population (society).
Threats	<ul style="list-style-type: none"> ? poor planning leading to the establishment of a government-dependent and involuntary accrediting body; ? bureaucracy could lead to unpredictable outcomes.

Group B: Implementing a national system

Strengths	<ul style="list-style-type: none"> ? political will makes legislative decision more feasible; ? willingness of staff; ? pressure to improve quality from students and public; ? availability of existing system/initiatives in the Region that can be shared and further developed; ? affiliation with external bodies/organization; ? financial support ; ? well-prepared human resources.
Weaknesses	<ul style="list-style-type: none"> ? resistance to change; ? lack of independent regulatory bodies which have the power to implement systems of accreditation; ? lack or uncertainty of necessary power and support;

	<ul style="list-style-type: none"> ? lack of a reward system; ? lack of necessary resources; ? absence of environment for implementation; ? accreditation bodies not working toward international recognition.
Opportunities	<ul style="list-style-type: none"> ? availability of regional/national bodies /Arab Board, GCC that need to be strengthened and empowered; ? the strong move toward accreditation at global, regional and national levels (perfect time) ; ? opportunities to work together with international technical support (Australia/Canada/UK); ? changing international political climate is forcing schools in the Region to improve quality and adopt accreditation to compensate for the reduced opportunities; ? access and mobility; ? multidisciplinary implementation .
Threats	<ul style="list-style-type: none"> ? implementation with pitfalls in the system; ? some schools might not properly implement due to resistance.

Group C: Sustaining a national system

Strengths	<ul style="list-style-type: none"> ? legislative support ; ? political commitment; ? involvement of all stakeholders; ? securing enough funds; ? change process could be an early successful impact; ? cooperation is necessary through a Memo of Understanding between countries of the Region; ? establishment of a regional body or council for accreditation could facilitate the sustainability of national systems; ? freedom of movement and transfer of students and doctors exchange within the Region; ? international/global recognition of graduates and programmes.
Weaknesses	<ul style="list-style-type: none"> ? insufficient funds or restriction to single source; ? resistance to change mostly due to misunderstanding ? poor planning leads instability; ? insufficient staff development ; ? variations of available accreditation criteria.
Opportunities	<ul style="list-style-type: none"> ? Regional Officer support should be sustained; ? WFME global standards need to be continuously developed and improved; ? accreditation by international bodies; ? faculty development will be linked with accreditation; ? accreditation is linked with momentum of change in general.
Threats	<ul style="list-style-type: none"> ? inability to institutionalize the newly implemented systems; ? lack of follow up and continuous evaluation and development; ? high turnover of high rank officials leads to lack of interest.

3.2 Session Two

The aim of this group work was to set the priorities for further actions using the Nominal Group Technique. The groups reviewed, discussed and ranked the following a list of 12 pre-actions according to priority for planning national accreditation systems in countries of

the Region (Annex 6). The final list of suggested actions for planning national accreditation systems in countries of the Region was prioritized as follows.

Priority	Action
1	Nominate a national task force
2	Ensure legislation/political commitment
3	Design organizational structure
4	Engage professionals, etc
5	Define role of WHO Regional Office
6	Draft TOR for accrediting body
7	Raise awareness
8	Define and obtain financial resources
9	Set national standards
10	Plan workshops/seminars
11	Agree on timelines
12	Plan monitoring and evaluation

3.3 Session Three

The task of the working group was to draft recommendations and country-specific plans of action to establish and sustain a national/subregional system of accreditation. Each of the three groups was assigned to discuss and accomplish the task in regard to the following aspects of accreditation:

- ? Group A: accreditation of medical schools;
- ? Group B: accreditation of other schools of health professions;
- ? Group C: medical schools' learning outcomes in the form of unified examinations.

4. RECOMMENDATIONS

Member States

1. All countries in the Region should plan and prepare for the establishment of a national system of accreditation of medical and other health professions educational programmes.
2. Participants should report to their governments and act as focal points in initiating action towards accreditation of health professions education and in exchange of information with colleagues in other countries.
3. Each country should nominate a national team to act as a task force to prepare for establishing a national system of accreditation. Activities should include holding

meetings and discussion groups to identify appropriate measures and actions, which will include the following steps:

- ? Identify outcomes description (graduates) based on adopted model.
 - ? Estimate costs and secure financing from various sources.
 - ? Identify and establish terms of reference for the national accreditation body.
 - ? Design the organizational structure and write by-laws.
 - ? Organize awareness campaigns.
 - ? Plan training workshops and disseminate information.
4. A national set of standards, based on regional and global sets, should be defined, agreed upon and adopted.
 5. A monitoring and evaluation component should be planned
 6. Legislative support for an accreditation body should be ensured, and periodic review of the system should take place every 1–5 years.
 7. A system of incentives, appreciation, awards, research grants and development funds should be created. Faculty development needs to include teaching and training technique workshops and continuing professional development. There should be a link between the accreditation body and licensing body, and regular review of the system should be conducted for improvements to be implemented.

WHO

8. The Regional Office should consider the establishment of a regional advisory mechanism to lead countries towards building sustainable national systems of accreditation of health professions education.
9. The Regional Office should continue and extend its technical support to countries to plan the establishment of accreditation systems in all health professions education colleges.

Annex 1

AGENDA

1. Inaugural session
2. Objectives of the meeting
3. An overview of the accreditation of medical education
4. Accreditation of medical education in Australia and New Zealand
5. Accreditation and implications for health services in the United Kingdom
6. WHO's response to global challenges in accreditation of health professions education
7. Country case studies on accreditation
8. Country specific plans of action to establish national systems of accreditation including Unified Medical Examinations
9. Conclusions and recommendations

Annex 2

PROGRAMME

20 December 2003

- 08.30–9.00 Registration
- 09.00–10.00 Inaugural session
Regional Director's message
Speech by the Minister of Health
Introduction to the workshop objectives, Ghanim Alsheikh
Nomination of Chair and Rapporteur
- 10.00–10.30 Overview of accreditation of medical education in Australia and New Zealand, Steve Trumble
- 10.30–11.00 Accreditation of medical education and implications for health services in the United Kingdom, Salman Rawaf
- 11.00–11.15 Discussion
- 11.45–12.15 Accreditation of medical schools in Australia and New Zealand, Nabil Suleiman
- 12.15–12.45 Accreditation of vocational medical training in Australia, Steve Trumble
- 12.45–13.15 Standards for Accreditation of Undergraduate Medical Education in Gulf Cooperation Council countries, Hossam Hamdy
- 13.15–13.30 Discussion
- 14.30–15.00 Accreditation of health professions education schools in the Region: response to global challenges, Ghanim Alsheikh
- 15.00–15.30 Accreditation of nursing education in the Region: Issues and challenges, Fariba AlDarazi
- 15.30–15.45 Discussion
- 16.00–16.30 Accreditation of medical and dental education in Pakistan, Mohammad Sohail Karim Hashmi
- 16.30–17.00 Accreditation of Egyptian medical schools : A WHO/EMRO Joint National Project, Wagdy Talaat

17.00–17.30 Accreditation of medical schools in Egypt: National quality assurance and accreditation project, Nadia Badrawi

17.30–18.00 Discussion

21 December 2003

09.00–09.45 New evaluation and accreditation system for graduate medical education in the Islamic Republic of Iran, Masud Naseripour

09.45–10.30 Accreditation system in Iraqi Medical Schools, Samim Al-Dabbagh

10.30–11.45 Yemen vision and plan for accreditation of medical education, Mohamed M. Motahar and Najeeb A. Jalil

11.45–12.30 Medical education in the Syrian Arab Republic, Musbah Dhiab

13.30–15.00 Group work session 1, Ghanim Alsheikh and Fariba alDarazi

15.15–16.45 Group work session 2, Nabil Suleiman

16.45–17.30 Discussion and conclusions on group work outcomes

22 December 2003

09.00–10.00 Group work session 3, Salman Rawaf

10.00–10.15 Group work presentation

10.15–10.30 Discussion and conclusion on group work outcomes

10.30–11.30 Drafting set of recommendations

11.30–12.30 Drafting plan of action

12.30 Closing session

Annex 3

LIST OF PARTICIPANTS

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Mrs Hanan Hamdy, Senior Secretary, WHO/EMRO
Mrs Iman Atteya, Secretary, WHO/EMRO

Annex 4

REGIONAL ACCREDITATION SYSTEM STANDARDS AND INDICATORS

Table 3. Eastern Mediterranean regional accreditation system standards and indicators

DOMAIN/ Indicator	LEVEL 0 (Sub-standard)	LEVEL 1 (Basic standard)	LEVEL 2 (Essential standard)
SPONSORSHIP/*Funding	Depends on temporary and/or foreign source	Depends on permanent and/or national source	Self dependent (regular revenues/fund-raising) with or without national support
LEADERSHIP/Vision/mission	No vision/unstated mission	Personal vision, unreflected in the mission	Shared vision among all stakeholders, well translated into a stated mission
Involvement in improving health systems and service	Not involved	Involved only in routine services	Full involvement in improving health systems services
STUDENT ADMISSION POLICY/ Selection	Tuition-oriented selection	High school final marks-oriented selection	Personality/skills-oriented selection
HUMAN RESOURCES/Selection	No clear criteria for selection	Quantitative-based criteria	Quantitative/qualitative-based criteria
Staff–student ratio	Under or overstaffing	Adjusted, demand-based, s–s ratio	Adjusted, need-based, s–s. ratio
Job descriptions	No job descriptions	Written job descriptions	Regularly updated job descriptions
Faculty	All part -timers	Mixture of full/part-timers	All full-timers
Capacity-building	No capacity-building programmes	Irregular, on request, capacity-building programmes	Regular, pre-planned, comprehensive capacity-building training programmes
Health professionals (MOH)	Do not contribute to training	Partial contribution in teaching only	Full contribution in teaching, research and programmes
PHYSICAL AND TECHNICAL RESOURCES/ Teaching/learning facilities	Deficient teaching/learning facilities (buildings, classes, laboratories, lecturing rooms, etc.)	Enough teaching/learning facilities	Multi-purpose teaching/learning facilities and specialized technical units (like audiovisual, computer and multimedia, etc.)
Technical resources	Deficient technical resources	Essential technical resources	Highly advanced technical resources

DOMAIN/ Indicator	LEVEL 0 (Sub-standard)	LEVEL 1 (Basic standard)	LEVEL 2 (Essential standard)
*Teaching hospital/primary care and community outreach	No teaching hospital and/or no primary care or community outreach	MOH teaching hospital and MOH primary health care teaching units with/without community outreach	University teaching hospital with primary health care units belonging either to MOH or university or both with community outreach
*Curriculum/documented?	No written curriculum	Written, non-detailed	Written, detailed
*Language of instruction	Foreign language	Foreign-national mixture	National language
*Textbooks	Foreign	Translated	Adapted
*Teaching/learning strategies	Discipline-oriented, teacher-centred, and based entirely on teaching	Discipline-oriented, supplemented with innovative teaching learning methods, but based mainly on teaching versus learning	Objective-oriented, community-oriented, student-centred, integrated and based mainly on learning versus teaching
*Instructional methods	Lecture-based	Mainly lecture-based, using innovative approaches like problem solving	Innovative approaches are adopted like: problem-based learning, community-based education, and evidence-based medicine. Tutorials, seminars and fieldwork are more used than didactic lectures
*Content	Knowledge-based with minimum skills emphasis	Knowledge-based, but giving some attention to the skills component	Competency-based, with balanced content of knowledge, skills, and attitude. Even content of basic, clinical and socio-behavioural sciences
*Curriculum committee	Not present	Present but not central	Central committee with delegation
STUDENT ASSESSMENT/			
*Rationale, concepts, approaches and modalities	To test mainly recall of knowledge (knowledge-based), using only summative formats	To test both knowledge and skills	To certify competence (competence-based), provide feedback to both faculty and students
*Frequency	Annually	After each semester	After each learning activity as a form of “formative evaluation” and after each block, year and phase as a “summative evaluation”
*Methods	Mainly oral, long essays, practical,	Mainly short essays, multiple choice	Mainly structured oral exams (e.g. triple jump), structured

DOMAIN/ Indicator	LEVEL 0 (Sub-standard)	LEVEL 1 (Basic standard)	LEVEL 2 (Essential standard)
*Confidentiality *Testing *Standardization	and clinical exams No security measures No testing procedures Local	questions, practical and clinical exams Safe Moderate validity and reliability Graduates are subjected to a national qualifying exam	clinical exams (OSCE), structured clinical exams (OSPE), and modified essay questions Highly secure and confidential Highly valid and reliable Graduates are subjected to a qualifying national exam and trained to pass international qualifying exams
POSTGRADUATE STUDIES AND CONTINUING MEDICAL EDUCATION/ *Policy	No policy	Adapted to the national health needs	Adapted to the national health needs with a social accountability perspective
RESEARCH COMPONENT/ *Purpose *Productivity	Staff promotion Confined to promotion purposes	In addition, teaching research methodologies to students Individual research studies	In addition, attempting at solving community health problems Multidisciplinary group research work and multiprofessional community projects with student involvement
PROGRAMME EVALUATION/*Practice *Conduction REFORM TENDENCY/*Readiness	Not practised No present Resisting	Irregularly practised Only internal Accepting	Built-in strategic component Both internal and external Cooperating

Annex 5

**PROTOTYPE CORE CURRICULUM FOR MEDICAL SCHOOLS IN THE REGION:
LIST OF ESSENTIAL COMPETENCIES IN FORMULATING STANDARDS FOR
ACCREDITATION OF EDUCATIONAL PROGRAMMES**

1.	Clinical methods practical skills and clinical behaviours	With a shift to community health and family health
2.	Communication skills	Listen Written as important as spoken
3.	Human biology	Structure and function of body Molecular, cellular, organ and body levels
4.	Human disease	Abnormal structure and function Natural pattern of disease
5.	Man in society	Human development aspects: psychology, sociology and anthropology (throughout the 5-year programme)
6.	Public health medicine	Should figure prominently the impact of changing needs in society, prevention, early detection of diseases and promotion of health and health systems.
7.	Management of diseases and rehabilitation	Responses to illness and help towards recovery. Management of diseases and disabilities
8.	Crisis management	Medicine in wars/emergencies
9.	Self learning	Should start from first year and continue throughout the programme
10.	Special study modules	Should start from first year and spread over 5 years.

Annex 6**PRIORITY-SETTING FOR ACTIONS TOWARDS IMPLEMENTING NATIONAL SYSTEMS OF ACCREDITATION**

Participants in the group work were given a specially designed form and were asked to give each of the following 12 actions a priority number from 1 to 12.

- A. nominate and contract a national task force;
- B. ensure legislation and political commitment;
- C. engage professional leaders and consumers;
- D. design the organizational structure, procedures and bylaws;
- E. define the role of WHO Regional Office;
- F. define and obtain financial resources;
- G. draft terms of reference for the accrediting body;
- H. agree on and adapt national standards guided by regional and global sets;
- I. plan training workshops/seminars;
- J. raise awareness;
- K. plan for the monitoring and evaluation component of the system;
- L. agree on timelines.

After discussions and group presentations, priority setting was worked out and presented during a panel session in a summarized table as follows.

Action	Rank assigned by each participant (n=18)																Score		
A	4	11	4	12	12	11	11	11	11	10	10	10	12	11	11	12	12	12	187
B	12	12	11	10	11	9	5	12	7	12	12	12	2	12	9	10	10	10	178
C	7	7	10	9	6	10	6	10	11	3	8	9	10	6	5	9	9	11	146
D	8	10	7	8	10	6	10	9	8	11	11	6	7	5	7	11	8	6	148
E	11	8	1	7	2	8	8	8	1	9	7	11	9	9	12	8	2	9	130
F	10	9	6	6	8	7	9	6	2	8	1	3	7	10	6	2	6	8	114
G	4	6	8	5	9	3	12	7	9	7	9	4	1	7	10	5	7	4	117
H	5	5	5	4	7	5	3	3	6	6	6	7	4	2	8	4	5	5	90
I	3	2	3	2	5	2	7	5	5	5	7	7	6	3	4	7	3	7	83
J	6	3	12	11	4	12	4	4	10	4	4	8	11	8	3	6	4	2	116
K	1	1	2	1	3	1	1	1	4	2	3	2	3	1	2	1	1	3	33
L	2	4	4	3	1	4	2	2	3	1	2	1	8	4	3	3	11	1	59