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Report on the

Regional consultation on accreditation of health professions education

Tunis, Tunisia
22–25 November 2011



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. BACKGROUND

The development of health professionals has been a vital area for WHO's Regional Office for the Eastern Mediterranean's collaborative work with Member States since its inception more than half a century ago. Human resources constitute a critical building block of any national health system and form the cornerstone for attaining national health goals in any country. While the commitment of the Regional Office to human resources development has remained steady, the focus of its collaborative development work in this field has been shifting over the years to match countries' growing capacities and stages of development of health systems including human resources in Member States. Despite the progress achieved in recent years in reforming and the improving performance of health care systems, health professional practice and health professions' education, key challenges continue to face efforts to bring about sufficient quantity, relevance, equity, quality and cost-effectiveness.

In the past three decades, strategies have begun to focus on improving the quality and performance of health professionals and relevance of their pre-service education and training to social and health needs of the population. The Region played a pioneering role in the international movement towards reforming of education and training curricula towards community-orientation and thus more relevance to people's needs with a role of health-related schools in solving national problems through attempts to adopt appropriate social accountability principles. Several institutions in the Region were supported to be among founding members of the international movement for community-based medical education and were among the first at global level including medical colleges of the universities of Gezira in Sudan, Suez Canal in Egypt, Arabian Gulf in Bahrain, Al-Ain in the United Arab Emirates, Tikrit in Iraq, Hadhramout in Yemen, Dow and others in Pakistan. The movement was propagated, and many schools in other countries followed, especially in the GCC countries.

The sharp rise in the number of health professions' education institutes was noticeable during the past three decades. Indeed, since 1950, the available data on medical schools, for example, show that the figure increased 17-fold from 18 in 1950 to over 300 in 2011 with a high ratio of private to public schools of medicine and other health professions. Despite such an increase, there was an essential need to systematically regulate such institutes in order to assure quality of outcomes to protect the public and be accountable to society. The Region witnessed series of events to guide and support countries to achieve such regulation. In 1995, a ministerial consultation in Cairo recommended and endorsed a call for partners like the WFME to jointly work towards formulating global standards for medical education. The first draft of the global standards was discussed thoroughly in a regional meeting in Jordan in 2000. In 2001, a technical paper was presented to the Fiftieth Session of the WHO Regional Committee for the Eastern Mediterranean in 2003, which issued a resolution (EM/RC50/R.9) urging countries to establish their national systems of accreditation during the coming five to ten years. Two months after that, a detailed project with a regional plan of action was developed during a regional consultation held in Bahrain in December 2003. Following that the Regional Office provided support to 16 out of the 22 countries to include and variably implement accreditation of health professions education projects in their biennial collaborative work plans with WHO.

At present, most countries of the Region are implementing a variable degree of accreditation. Some countries have established their national bodies and actually accredited some of their schools; others have started with ongoing activities at variable stages. During the present consultation, there will be a review of the progress of accreditation in countries and exchange of experience and best lessons and practice; review of a draft regional accreditation guide and regional standards; exploration of best modalities for effective coordination among regional and international partners; organization of capacity-building sessions on core accreditation; with guidance and plans the expected outcome being to ensure government commitment to regulating health professions education in order to ensure quality and safety of outcomes and the effect on people's health through observing principles of social accountability.

2. INTRODUCTION

A regional consultation on accreditation of health professions education was organized jointly by the WHO Regional Office for the Eastern Mediterranean and the World Federation of Medical Education, Association for Medical Education in the Eastern Mediterranean Region (WFME-AMEEMR) in Tunis, Tunisia, from 22 to 25 November 2011. Apart from Afghanistan, Djibouti and Somalia, all countries of the Region attended including South Sudan. There were 69 participants representing national accreditation bodies, deans and representatives of colleges of medicine, nursing, dentistry and pharmacy, regional and international experts and WHO staff.

The inauguration session was opened by Ibrahim Abdel Rahim, Coordinator, Human Resources for Health, WHO Regional Office for the Eastern Mediterranean, by welcoming the panelists: the Tunisian Minister of Public Health's representative Dr Mohamed Salah Ben Ammar, Director-General (Health); Dr Stephano Lazzari, WHO Representative to Tunisia; Dr Leif Christensen, representative of WFME headquarters; Dr Azmi Mahafza, President of the Scientific Society of Arab Medical Schools (SSAMS); and Dr Ibrahim Al Alwan, President, WFME Association of Medical Education in the Eastern Mediterranean Region (AMEEMR). Preliminary remarks were made by panellists emphasizing the importance of the consultation and reviewing the wide range of activities in accreditation across the Region. WFME is mandated to work not only with medical profession: others are not excluded although they have other bodies and organizations. The relocation (from Amman to Riyadh) and election of a new executive board for AMEEMR has opened the door wide for all countries of the Region to contribute to the many planned activities such as launching its journal and its website in 2012 and a wide range of plans to promote the cause of medical and health professional education in the Region. As part of the Union of Arab Universities, the SSAMS is committed to promoting medical schools and accreditation as an important project aiming at protecting the public and complementing the efficiency of the health care systems. Accreditation has been high on agenda and was addressed in many events the most recent being the Sana'a Declaration 2010, endorsed by regional partners and addressing accreditation in four resolutions: establishing a regional commission; urging Member States to complete the establishment of national systems; drawing up plans for institutional systems; and creating plans and resources for capacity-building in the field. The sharp increase in the

number of private institutes (for example 62 private nursing schools now operate in Tunisia with weak or no appropriate regulation or accreditation) renders the mission of this consultation an urgent need to come out with appropriate plans and actions to promote accreditation of health professions education in countries of the Region as a necessity.

A message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, was delivered by Dr Stephano Lazzari, WHO Representative to Tunisia. In his message, Dr Gezairy noted that accreditation was recognized today, worldwide, as a tool for maintaining and continuously improving the quality of education, institutions, their programmes and products and above all its impact on safe practice and people's health at large. It strengthened professional governance and the power for self-regulation. In the educational field, accreditation was vital to ensure that institutions were functioning at recognizable standards which would enable them to graduate capable, skilled, safe and caring health care professionals, and that institutions were complying with recognized global, regional and national quality improvement standards. The question for the meeting was: do institutions of higher health education in our Region produce graduates who are fit to practise in the 21st century? Studies and research suggested that the old approach to teaching was no longer appropriate or acceptable for the production of doctors, nurses and other health professionals who were capable of managing the increasingly rapid changes taking place every day in the domain of health practice. In addition to mastering core clinical competencies, graduates today were required to perform a range of non-clinical, and even non health-related competencies, in areas such as management and leadership, information technology and e-learning modalities. Moreover, and for health professions in particular, such concepts as cultural competencies and social accountability were also important to ensure graduates were in tune with the needs of populations and communities they served. Therefore, all available means and methods were needed to ensure that our graduates were capable of practising in the reality of a changing world. At the same time, accreditation was viewed as one of the best tools to keep our academic institutions both competitive and up to the globally recognized standards.

Since the 1988 Edinburgh Declaration on the reform of medical education, the WHO Regional Office for the Eastern Mediterranean had been working in close collaboration with the World Federation of Medical Education to promote reform of medical education in the Region. So far, 16 countries in the Region had started accreditation-related initiatives, including development of accreditation plans and national mechanisms. With the increasing demand to establish effective national accreditation schemes this meeting would, he hoped, produce plans for accreditation. The Regional Office, in close cooperation with the Association of Medical Education in the Eastern Mediterranean Region, would support and facilitate effective and sustainable regional coordination among national accreditation systems. A regional accreditation guide with valid standards had been prepared and would be presented for the meeting's review and improvement in this meeting which, he hoped, would represent a landmark and significant step for improved quality, relevance, equity and cost-effectiveness of health professions education in the Region.

The issue of using national languages as a medium in health professional education was vital, said Dr Gezairy, both for improving standards of learning as well as for cultivating and disseminating scientific knowledge within our culture. Accreditation systems would encourage use of local languages rather than foreign languages, which can be a barrier to communication with the communities where health professionals serve. This should be accompanied by effective courses in a foreign language that prepares students to be fluent in that language as a prerequisite before graduation to enable them to be part of the huge development in medical sciences around the world. This approach was essentially based on engaging the active participation of communities in their own health affairs. How could a community respond to such a call when addressed in a language that all its members did not understand?

At the end of the session, Dr Walid Abubaker, Acting Regional Adviser for Educational Development and Training at the Regional Office presented the meeting agenda and stated its theme as: “accreditation is a strategic priority in the Eastern Mediterranean Region”; its purpose: “facilitating development of functioning, cost-effective and sustainable national accreditation systems in all countries of the Eastern Mediterranean Region. Then he reminded participants of the meeting’s objectives and its expected outputs. Four participants were elected to act as reporting committee for the meeting: Drs Charles Boelen, Muntaha Ghariebah, Mohi Eldin Magzoub and Walid Abubaker. The programme and list of participants are attached as Annexes 1 and 2, respectively.

3. ACCREDITATION OF HEALTH PROFESSIONS EDUCATION: AN OVERVIEW

In this session, the regional status was overviewed. In addition, partners and invited experts made presentations to review the status of accreditation at variable levels, as related to global standards, to human resources development, to partnership and to experiences from the United Kingdom and Australia.

3.1 Global and country perspectives on health workforce development with reference to health professions education

Dr Manuel M. Dayrit, WHO headquarters

Does accreditation of health professional schools have an impact on the health of populations? It is expected that it should—because, as the logic goes, accreditation leads to better facilities, better curricula and better teaching methods which should result in better graduates: the products of the educational institution.

The pipeline for the production of the health workforce published in the World Health Report 2006 has accreditation front and centre in the process of educating and producing human resources for health. But as there are many intermediate stages between the accreditation of health education institutions and the graduation and actual practice of the graduates who have traversed this pipeline, drawing a link between accreditation and population-based health outcomes is difficult.

Nonetheless it is important to understand this link in order to better develop better standards and processes for accreditation. It is clear that a systems approach to accreditation is important—the educational system which produces graduates and the health system which uses them should be in constant conversation. In most countries, two different ministries and two different systems of governance, finance, policies and plans often do not converse at all. Beyond this, it is critical to understand the labour market, which is also where the two systems interact, is critical.

During the past century, the whole process of preparing and educating health professionals has gone through massive reform evolving from apprenticeship, science-based, community-orientation and integration around problems to the ultimate promising model of systems-based curriculum which is competency-driven (balanced global and local) and jointly governed by both education and health systems. Today, there is a pressing need to ensure that health professions education actually does affect population health outcomes in positive ways. In this light, the initiative to develop global recommendations on how to scale up and transform health professions education has been started by WHO. Driven by population health needs, transformative scale-up is a process of education and health systems reforms which is envisioned as addressing the quantity, quality and relevance of health care providers to contribute to population health outcomes.

A look at health professional schools in poor countries makes us realize how much has to be done in improving the quality of educational facilities. WHO is aiming to develop policy recommendations which countries might consider to scale up and transform health professions education so that it addresses the needs of populations. Different populations may have different needs but general lessons may be available which all, no matter the specific context, can benefit from.

It is important that the experiences and efforts at accreditation of health professional schools be documented and that appropriate research be published to improve its processes. To date, despite the large amount of literature on accreditation, direct evidence on its utility to improve the quantity, quality, and relevance of health professions education is lacking.

3.2 Human resources for health in the Eastern Mediterranean Region: issues for consideration

Dr Ibrahim Abdel Rahim, WHO Regional Office for the Eastern Mediterranean

Human resources for health (HRH) is looked at as one of the several components of the resources building-block of health system as shown in the conceptual framework presented in the *World health report 2000*. However, as a mediator of almost all functions of any health system, human resources for health can be looked as engine of any functioning health system. The issue of human resources for health has, for a long time, not been much cared for, but now this situation is changing. In particular the *World health report 2006* defined a benchmark of having 2.3 human resources for health per 1000 population as the minimum ratio needed to maintain any national health system; thus there is an estimated shortfall of four million workers globally. In this respect, 57 countries with a health workforce crisis

(eight within the Region) were identified across the globe. Workforce migration trends show compounding inequity and unfavourable demographic factors. There is a global effort to address critical shortages and maldistribution of the health workforce at various levels, leading to loss of health. WHO's global response has included the following World Health Assembly resolutions: WHO global code of practice on the international recruitment of health personnel (2010, WHA63.16); primary health care, including health system strengthening (2009, WHA62.12); strengthening nursing and midwifery (2006, WHA59.27); rapid scaling-up of health workforce production (2006, WHA59.23); international migration of health personnel: a challenge for health systems in developing countries (2004, WHA57.19). There has been immense response to the human resources for health crisis at global level in initiating relevant organizations, raising funds and producing documents and tools.

Health worker density comparisons by regions show clear inequity; while the ratio per 1000 population in the Region is 2, the ratio in North America reaches 10.9 and in sub-Saharan countries as low as only 0.98 per 1000 population. In addition, distribution of health workers hugely varies across regions when compared to level of burden of disease and expenditure. In the Region, with 9% of the global burden of disease, there are 9% global health workers working in countries; the Region of the Americas bears only 10% of the global burden but employs 47% of global health workers. In Africa, although there is 24% of the global burden of disease less than 3% of global health workers work in that region with the least expenditure in the world. In the Region, three country categories have been identified: those in human resources for health crisis, those with deployment challenges and those countries capable of employing sufficient health workers. Trends of density of health workers in the three categories during the past 15 years show flat linear growth (slight growth) in crisis countries; an up-and-down trend with overall noticeable growth in the second group (deployment challenges) and a steady increase in the third group (importing countries). Comparing doctor density in same groups shows a sharp and steady increase in group 2 as countries in this group tend to produce surplus doctors but have weak retention policies and failure of national systems to absorb graduates. In nursing, a similar comparison shows irregular growth in the three groups with up-and-downs, which shows poor planning. The trends for dentists and pharmacists show steady increases in all groups with slow increase in crisis countries. The maldistribution of different HRH categories is evident. Comparing ratio of doctors to nurses in the Region shows that there are as many as three doctors for every two nurses while in OECD countries the ratio is one doctor for nine nurses. Add to that maldistribution, there has been sharp mushrooming increase in number of private health professions education schools compared to public ones in the Region. The ratio of private to public of 0.25 in 1950 (mostly offshore schools) in 2010 went up to as high as having one public school for six private schools.

Major challenges facing HRH in the Region in the field of production of health workers includes: weak or absent linkage or coordination with a population's health needs and context; persistence of ineffective, traditional education curricula and pedagogic approaches; inconsistent standards; and weak regulations; the development of accreditation systems for educational institutions and their products is still in its infancy; the challenge posed by the sprouting of private-for-profit educational institutions and social accountability concerns is of

crucial magnitude; current response covers areas in growth in health professions education institutions and production capacity; growth in postgraduate programmes; scattered HRH policy development attempts and experiences; pioneering initiatives in medical education reform. The globally recognized experiences in producing and using *behvarz*, lady health workers and community health workers and volunteers has been well received; as has the amalgamation of health services and medical education in single ministry in Islamic Republic of Iran. Strategic directions for HRH in the Region at this stage include: reorientation of health professions educational programmes to be more relevant and responsive to health systems and population health needs with special focus on primary health care, family practice and long-term care models; reforming of educational programmes to adopt innovative strategies and transformative education modalities; addressing the problem of skill mix imbalance of the health workforce by adjusting production ratios for different HRH categories; assuring quality standards of institutions, programmes and products; and effecting regulation of health professions education and accreditation of institutions including private institutions.

Poor quality is unaffordable with scarcity; the need for effective measures is crucial. Accreditation is the most convenient quality improvement approach for educational systems that strengthens professional (self) governance and leadership through an effective approach to influence a system which is inherently fragmented and autonomous. Harmonization of HRH standards reflects positively on standards of care.

It is worth remembering Article II of the WHO Constitution mandating promotion of cooperation among scientific and professional groups, which contributes to the advancement of health; promoting and conducting research in the field of health; promoting improved standards of teaching and training in the health, medical and related professions. The most important input in health development and health care is the investment in human resource training and the undisputed or leadership role of academic institutions, particularly in lower and middle income settings. The WHO–WFME strategic partnership, which was signed in January 2004, calls on both organizations through their strategic partnership to improve medical education. The partnership has a clear relationship to the Millennium Development Goals of the United Nations and aims to foster a common commitment towards improvement of the quality of medical education. Human resources development has been for long time a priority in the Region within overall national health goals to achieve universal coverage.

3.3 Revising and updating the WFME global standards for basic medical education

Dr Leif Christensen, WHO Temporary Adviser

The WFME global standards for basic medical education were adopted by the WFME Executive Council in June 2001 and were endorsed at the WFME world conference in March 2003. Over the past decade, the standards have been extensively used in all parts of the world by medical schools as a basis for reform and were used as criteria in accreditation. Experience from the use of the standards has been mounting. The proposed procedure in revision of the WFME standards runs into four phases—phase 1: a small working group producing a draft; phase 2: comments and proposals to the draft will be sought from a broad

international panel of experts; phase 3: comments and proposals on the revised draft will be provided by the six regional medical education associations and main partners; and phase 4: debate on the final document will take place at the WFME world conference in November 2012.

The current stage of the revision process involves receiving comments and proposals from the international panel. This phase, which is almost finalized, involves so far only minor changes in formulation of standards. The need for changing the divide between the basic and the quality development standard is under consideration. In addition, there is a need to harmonize expressions and avoid unnecessary overlaps and improving the lay-out to allow clearer presentation of sub-standards or elements of standards and expansion of the annotations. As far as the standards statements are concerned, only minor changes in standards are expected to be needed and requested in order to avoid introducing unnecessary confusion among the community of medical education.

Changing the divide between basic and development standards as required in the European specifications could be seen as a natural result of the development in medical education over the past decade. However, this tightening of the requirements is expected to be limited to a few standards. The improvement of the general lay-out will contribute to reach a presentation of the standards in a way that allows clear identification of elements of standards or sub-standards. The system for numbering will ease reference to a standard or part of it thereby facilitating effective communication. The proposed increase in the number of annotations will be used to clarify, amplify or exemplify terms or expressions in the standards. The purpose of this increase in annotations is to improve understanding of the standards as the annotations usually promote a shared understanding among users. The annotations guide in defining the data/information needed to assess attainment of a standard so the main change is expected to cover large expansion of annotations. Other standard related activities include pilot project on accrediting the accreditors and expanding and updating the FAIMER/WFME/Open University distance learning courses.

3.4 AMEEMR future strategies and plans for the region medical and health professions education

Dr Mohi Eldin Magzoub, Secretary General, WFME, Association of Medical Education in the Eastern Mediterranean Region, Riyadh, Saudi Arabia

Following the relocation of the Secretariat of the AMEEMR from Amman, Jordan, to Riyadh, Saudi Arabia, in March 2011, the Association held its first general assembly and elected a new president, secretary-general and executive committee (EC). The secretariat collaborated with number of experts, prepared draft constitution and plans which were thoroughly discussed and endorsed by the general assembly. The organization's vision states that AMEEMR will provide leadership for members and member institutions in order to attain excellence in medical education recognized regionally and internationally with a mission to promote medical education in the Eastern Mediterranean Region by all formal and informal means.

A meeting in Riyadh in March 2010 brought together 18 (out of the 22) countries in the Eastern Mediterranean Region; a new executive committee was elected including a president secretary-general, and the relocation of the association's headquarters to Riyadh approved. The formulation of the constitution was based on that of WFME and other sister regional organizations' experiences. The outline for the next three years covers: securing funds for the first two years; establishment of a furnished office with full-time secretary; production and distribution of two newsletters; participation of the president in the WFME executive committee meeting; production of a medical and health sciences journal; promotion of AMEEMR in the most recent AMEE meeting; co-organization of the present meeting; and running the first executive committee meeting, hosted by Sousse University, Tunisia, prior to this meeting. The future perspectives in publicity and promotion strategy aims at increasing membership; creation of a website; production of a bimonthly newsletter; organization of regular Medical education conferences; and participation in international meetings.

The association has established six working groups on: accreditation and social accountability; accreditation and quality assurance; faculty enhancement; student affairs and well-being; advanced technology of education; student assessment group; and research in medical education. The medical and health sciences journal is planned to be unique in addressing regional concerns. The next medical education conference is going to be organized in Riyadh, Saudi Arabia, in December 2012, and details will be announced shortly. The conference will bring together all educators in the health professions, health services providers and policy-makers. The main theme will be "towards more innovation in health professions education and response to community needs". In addition, to invited keynote speakers, the conference will have series of workshops, oral and poster presentations, seminars and social programmes.

3.5 Medical schools in the United Kingdom and regulations and accreditation: lessons and best practices

Dr Salman Rawaf, WHO Temporary Adviser

The experience of the United Kingdom General Medical Council (GMC) is presented to describe the documents regulating medical schools, the regulating laws, the medical graduate outcomes, the learning process, the learning players, innovative approaches, the teachers and learning through simulation. With production of *Tomorrow's doctors* document by the GMC in 1993 and its updated version in 2003, all the 32 medical schools in UK reformed their curriculums and defined their outcomes to conform with the detailed standards stated in the documents. The main goal of the GMC as an independent regulator is protecting, promoting and maintaining the health and safety of the public. In any given population, roughly 40% are healthy, 40% have risk factor(s), 10% acute illness and the remaining 10% live with disability. The majority of medical schools focus on the 10% of population with acute illness.

Regulating through laws and enforcements, the General Medical Council is responsible for undergraduate education, postgraduate training and medical practice. The medical learning continuum covers: medical school, two years of foundation training (F1 and F2),

specialist postgraduate training and continuing professional development (learning/skills). The five areas of GMC interventions are: regulations (standards: good medical practice), licensing, revalidation, professional values and lifelong learning. It is worth mentioning that graduation from medical school is an early threshold in doctors' careers. New graduates cannot be expected to have the clinical experience, specialist expertise or leadership skills of a consultant or of a family doctor. After the two years of foundation training (closely regulated by the GMC), it takes either three years training to become a general practitioner or up to five years to become eligible to be a specialist consultant. This period is called core specialty training and is closely regulated at individual and institutional levels by the GMC and the royal colleges of medicine through well described standards, procedure and frequent but periodic appraisal. The medical graduates outcomes (totalling to 107 well specified competences) are categorized into three main areas describing the role of the graduate as a scholar and scientist (33 in number), a practitioner (47) and a professional (27). The medical education is run collectively by the interaction of players, namely the regulator (GMC), the medical schools, the ministry of health (National Health Service), doctors, students and the public, who all have different and complementary roles in medical education with well described roles and responsibilities. The regulator (GMC) is responsible for protecting, promoting and maintaining the health and safety of the public through setting high standards of medical education; deciding on the knowledge, skills and behaviour required of graduates; setting the standard of expertise that students need to achieve at qualifying examinations or assessments; making sure that the teaching and learning opportunities are based on the highest standard of expertise; appointing inspectors of qualifying examinations and assessments and on the quality of teaching and learning; and appointing visitors to medical schools to report on the quality of teaching and learning. The regulator's procedures in regulating a medical schools involve the following: setting standards of medical education; specifying knowledge, skills and attitudes needed; setting the expertise required; assessment and exams; teaching and learning settings; inspections (appointing inspectors); and visiting and appointing visitors. In addition and throughout the procedure, the GMC makes sure that teachers and researchers attain higher levels of expertise.

The standards for the delivery of teaching, learning and assessment are grouped under nine "domains". For each domain there are one or more broad "standards". Under these are the core technical criteria by which are judged whether medical schools are meeting these standards and the evidence used for this. The detailed requirements and context expand upon these criteria and contain some important principles and requirements. Statements using "must" or "will" mean something is mandatory. Statements using "should" may be taken into account in the quality assurance process when the GMC considers whether the overall criteria have been met. The nine domains for the GMC and medical school standards are: patient safety; quality assurance, review and evaluation; equality, diversity and opportunity; student selection; design and delivery of curriculum (including assessment); support and development of students, teachers, and local faculty; management of teaching, learning and assessment, educational resources and capacity; and outcomes

Taking one example, on the design and delivery of the curriculum, including assessment shows the standard statement. The curriculum must be designed, delivered and

assessed to ensure that graduates demonstrate all the ‘outcomes for graduates’ specified in *Tomorrow’s doctors*. Criteria: basic knowledge and skills, while fundamentally important, will not be enough on their own. Medical students must be inspired to learn about medicine in all its aspects so as to serve patients and become the doctors of the future. Today’s undergraduates—tomorrow’s doctors—will see huge changes in medical practice. There will be continuing developments in biomedical sciences and clinical practice, new health priorities, rising expectations among patients and the public, and changing societal attitudes. There are two important dimensions in that teaching, learning and practices are sensitive to patient wishes, dignity and clinical needs and that basic knowledge and skills, while fundamentally important, will not be enough on their own.

Medical students must be inspired to learn about medicine in all its aspects so as to serve patients and become doctors of future learning: The players in the learning cycle throughout the curriculum aimed at building the person–doctor relationship and involve the following players: the learner (medical student), the teacher (the team), the person (the needs), the carer (the family), society (social values) and the organization (national health service, university). Person-centred learning brings together technical competencies, artistic abilities and caring attitude to move from sympathy to empathy. In the new world of innovation, medical education is enjoying a number of examples of innovative approaches such as: communication skills with actor-patients, video with feedback from patients, case-based learning (problem-based learning) often around patient experience, early patient contact courses (called first clinical attachment), the use of narrative in teaching, wide use of patient stories (health talk online), use of patients to teach clinical skills, history-taking and examination with feedback, patient projects (follow patient journey). Assessment includes patients giving an assessment score; clinical simulation teaching gives emphasis to skills and technical competencies and less to patient-centred training.

As we celebrated the 30th anniversary of the WHO Alma-Ata Declaration three years ago, the poorest countries of the world are still exposed to the most disease and therefore need commensurate access to properly trained doctors.

3.6 Accreditation of Australian medical schools by the Australian Medical Council

Dr Nabil Sulaiman, University of Melbourne, Australia

The Australian Medical Council (AMC) is the legal independent regulatory body which assesses and accredits basic medical education courses in Australia and New Zealand as well as postgraduate professional training. AMC’s accreditation of these medical courses allows their graduates to register in Australia. The main aim of recognition of medical courses is to ensure that graduates are competent to practise safely and effectively under supervision as interns in Australia and New Zealand, and with an appropriate foundation for lifelong learning and for further training in any branch of medicine. The AMC’s Medical School Accreditation Committee within the AMC is responsible for developing standards, policy, guidelines, and procedures for accreditation. Its main role is overseeing the accreditation process and encouraging improvements in medical education that respond to evolving health needs and practices, and educational and scientific developments.

The accreditation process is based on self-assessment and peer assessment. The medical school prepares an accreditation submission (self-study) on the school, curriculum, and policies, procedures and structures to support educational activities. This is coupled with self-reflection on and critical analysis of its performance and plans against the approved accreditation standards and the school's own objectives. The accreditation committee forms a team of experts to review the self-assessment report and conduct site visits to evaluate evidence of performance based on the college self-report and AMC standards. The team includes a mix of clinicians and scientists from other Australian and New Zealand medical schools, hospital and community-based teachers, experienced academic managers, allied health professionals, community members and health administrators. The accreditation team will visit the medical college to observe performance. This is conducted through several visits that usually take about a week. The committee interviews key academics, staff and students and visits resources, reviews reports related to curriculum and assessment and the quality improvement/evaluation process and documentation. This is based on AMC published accreditation standards as well as a college's self-study report. The self-study report should address the standards reflecting the requirements for delivery of high quality medical education and cover the following areas of requirements for delivery of high quality medical education and cover: context of the medical school; outcomes of the medical course; medical curriculum; teaching and learning; assessment of student learning; monitoring and evaluation; implementing the curriculum and implementing the curriculum.

The team prepares a preliminary report followed by a detailed report. The accreditation committee provides opportunities for the school to comment on the accuracy of the report, findings and conclusions. The team submits the report to the accreditation committee. Based on the detailed report the AMC may grant accreditation with or without conditions. The option exists for the AMC to refuse accreditation. The accreditation committee requests reports every two, five and seven years after the school has been assessed by the AMC. The AMC may grant accreditation if it is reasonably satisfied that a medical programme meets the approved accreditation standards. It may also grant accreditation if a programme substantially meets the approved accreditation standards and the imposition of conditions will ensure the programme meets the standards within a reasonable time.

Two AMC standards

3.1. Curriculum framework: accreditation standards statement as follows: "the medical school has a framework for the curriculum organised according to the overall outcomes which have, in turn, been broken down into more specific outcomes or objectives for each year or phase of the course". The statement has notes describing the standard which include: "the range of curriculum models which medical schools may employ is wide, including case based, system-based and discipline-based learning, and using organising principles such as domains and themes. Medical schools employ curriculum models that will enable them to achieve their desired outcomes and are capable of meeting the overall goal of medical education described earlier".

3.2.2. Scientific method: accreditation standard statement as follows: “the curriculum is based upon principles of scientific method and evidence-based practice, and inculcates analytical and critical thinking”. Descriptive notes: “scientific method and evaluation of evidence are fundamental to many aspects of modern medicine. The curriculum should include instruction in the principles of evidence-based practice and should foster critical thinking and analytical problem-solving by students”.

In summary, the AMC accreditation process is based on self-study and a peer review through site visits, interviews and document reviews to identify gaps, discrepancies, quality improvement processes and actions to close the loop. The accreditation team compares self-study and site visits findings with AMC standards, which are clearly listed with explanatory notes.

3.7 Accreditation of health professions education in the Eastern Mediterranean Region: an overview

Drs Ghanim Alsheikh, WHO Consultant, and Walid Abubaker, WHO Regional Office for the Eastern Mediterranean

As early as 1969, the World Health Assembly endorsed a resolution urging the setting of standards for doctor education in developing countries. Following the Alma-Ata Declaration on primary health care and the goal of attaining health for all (WHO 1978), WHO endorsed number of resolutions and interventions to address the quality of education of health professionals including its call for universities to reorient towards health for all by the end of the millennium (1982), the well known Edinburgh Declaration on reforming medical education (WHO and partners, 1988) and reorientation of medical education towards needs (WHA, 1993 and 1995). In 1995, a WHO ministerial consultation held in Cairo, WHO and partners (WFME, UNESCO and others) urged a setting out of global standards for medical education. The WFME and its six chapters in the six WHO regions worked with WHO to draft standards at global level through an extensive bottom-to-top workshops and meetings starting at country level followed by regional and global levels. The WFME global standards were the result of contributions from all countries and partners and were a real igniting kick-off for accreditation activities in the developing countries. Global standards for nursing education were made available by WHO in 2009. Work is ongoing to formulate standards for other health professions.

The Regional Office has actively contributed to the cause through number of decisions and activities during the last decade. In 2000, a regional consultation was held in Jordan at which draft WFME standards were released followed, in 2002, by a group-of-experts meeting in Cairo where preliminary draft regional standards and a guiding plan were produced that led to endorsement of a resolution by the Regional Committee for the Eastern Mediterranean (Cairo, 2003) urging and guiding countries to establish national accreditation systems. Two months after the resolution was adopted, a regional consultation on accreditation was held in Bahrain (2003) to come out with a regional plan to support initiate national systems. The consultation agreed on the Regional Office’s 10-step plan to support countries through the following steps.

- Countries contacted focal points to be participants in the Bahrain consultation.
- The Regional Office granted seed funds and made available technical support to countries to form national taskforces, which have usually comprised colleges or regulating bodies.
- Organization of awareness campaigns among college stakeholders.
- Establishment of a stakeholders' forum to review WFME and other existing sets of standards.
- Definition and agreement on a set of national standards and or criteria.
- Training of faculty on conducting self-assessment and produce such documents.
- Training of national experts on how to organize and conduct site reviews.
- Providing support and supervising peer reviews.
- Establishing (or assigning existing) regulatory bodies to be mandated by law as a national accreditation body.
- Implementing and sustaining national systems.

The plan ensures that the whole project and the process is nationally owned and regionally and globally supported and possibly recognized.

Accreditation becomes essential in all countries to ensure safe practice and attain health goals. However, in the Eastern Mediterranean Region it seems necessary due to number of specific reasons such as the growing numbers of new colleges without appropriate regulation or the need to define and attain education outcomes of graduates who are fit-for-purpose. In any case, regulation and accreditation are by themselves a continuing improvement of the input, process, output and hopefully impact of the college itself. Other reasons include the necessity to bring about all graduates whenever possible to the highest level of competence due to the growing trends of human resources for health, global mobility and demands of the licensing bodies in developed countries and among countries of the Region. In addition, the introduction of the Avicenna Directory of Medical Schools, replacing the WHO World Directory of Medical Schools, is still taken by licensing bodies as the reliable global source of information on status of recognition and accreditation of schools. It is now known that the US, through its Educational Commission for Foreign Medical Graduates, will recognize only medical graduates who have graduated from accredited colleges starting from 2023.

The current status in countries of the Region varies but accreditation is on the agenda in almost all of them. However, all colleges are usually licensed and or recognized by national authorities, usually ministries of higher education, according to sets of criteria. Many countries have started and some actually implemented appropriate accreditation systems. However, different stages of progress exist in different countries, and this will be reviewed during this meeting. The major problems and challenges facing countries of the Region include: weak government commitment; issues of legality and mandate; independent accreditation bodies vs. government-run bodies/committees (usually belonging to higher education authorities, which also run the colleges); using health-specific or -oriented set of standards vs. generic higher education standards used for different professions; and existing systems using different sets of standards adopted from other countries. At the end of the list

comes the very crucial and important issue of absence of or presence of inadequate standards on outcomes and accountability in most of the used sets of standards.

Much is expected from this meeting. A regional guide on accreditation establishing and sustaining national and institutional systems together with a set of updated regional standards will be reviewed and improved. A proposed partnership of regional partners aiming at advising, guiding, supporting and recognizing national systems will be discussed. Participants will have the opportunity to exchange experience and take home messages on how best accreditation can be improved towards making an impact on health and society.

4. SOCIAL ACCOUNTABILITY OF MEDICAL SCHOOLS

The main purpose of this session is to conduct a panel debate on how to strengthen social accountability in medical schools. Social accountability is now a hot issue, and we need to agree on strategies, activities and a future plan of action. We need to verify the purpose, and to improve it. The session included number of presentations and interventions followed by open discussion.

4.1 Making health educational institutions socially accountable

Dr Charles Boelen, WHO Temporary Adviser

To be socially accountable simply means serving society and being accountable to it. Meeting the health needs of society is challenged in attaining quality, equity, relevance and cost-benefit. The biggest challenge is bringing many players to act together to attain such health needs. These players include, in addition to health professionals, policy-makers, academic institutions, communities and health managers. The social accountability of medical schools goes back to WHO's call to reorient medical education calling for the "obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have the mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public" (WHO, 1995). The social obligation scale identifies three levels of obligation for five major areas of any medical school's role and functions. The scale passes through level 1 of responsibility (implicitly) to level 2 of responsiveness (explicitly) to the highest level 3 of accountability (anticipatively). Five areas can be identified to evaluate the medical school obligation to social accountability. These five areas and their levels of obligation are:

1. institutional objectives passing from being defined by faculty to being inspired from data to the highest level of being defined with society
2. educational programmes: from being community-oriented to being community-based to being contextualized
3. quality of graduates from being "good" practitioners to being able to meet criteria of professionalism to being health system change agents
4. focus of evaluation from process to outcome to impact
5. assessors from being internal to being external to being health partners.

The education of doctors covers three stages of conceptualization, production and usability, and obviously standards currently in use focus on production with less focus on the other two areas. Conceptualization domains will cover references, engagements and governance while production covers field operations, educational programme, students, teachers, research and services. In turn, usability covers employment and impact. A new set of standards for medical education needs to give the three areas equal and the same level of focus that runs across the four challenges of quality, equity, relevance and cost-benefit.

Is social accountability really a mark of excellence for medical school? There is now a global consensus for social accountability of medical schools (www.healthsocialaccountability.org). A socially accountable medical school should respond to current and future health needs and challenges in society, reorient its education, research and service priorities accordingly, strengthen governance and partnerships with other stakeholders and use evaluation and accreditation to assess performance and impact. In the next months, there will be dissemination of the global consensus translated into six languages, publication in international journals/posting on websites, as a theme of meetings at national and international levels, policy development, guidelines and resolutions, experimentation across an international sample of medical schools and design of standards, international recognition of excellence through the ASPIRE programme from the Association for Medical Education in Europe (AMEE), and there will be accreditation obtaining credit for official recognition of excellence or progress towards excellence. The credit will be obtained if standards are inspired by society's health needs, there are proper instruments to assess impact, efficient action is taken to meet needs, and there must be a reliable and competent national mechanism and reporting back to society.

4.2 Towards a charter of ethics for the faculties of medicine

Dr Mohamed Salah Ben Ammar, Ministry of Public Health, Tunisia

There is a need for faculties of medicine to ensure that graduates are high quality, able to perform their functions in the world of work and to have a role in national development. However, a number of challenges faces medical schools as they endeavour to produce such graduates which include: improving quality, equity, relevance and effectiveness in health care delivery, reducing the mismatch with societal priorities, redefining roles of health professionals and providing evidence of impact on people's health status. In order for a medical school to promote high standards of public service and ethical conduct there exists a need for charter to ensure that decisions, actions and stakeholder interactions conform to institutional moral and professional principles, laws and regulations. The legitimacy of the charter comes from the fact that there is a need to comply with the regulations while admitting that that alone is insufficient, to empower all teachers of the faculty and also to get the right balance of all the human, social, cultural and scientific-related needs together in the faculty and for responding appropriately to actual needs. But what are the strategic imperatives for our institutions? These include ethical practice in education; organization is to be a top priority; teacher and other staff members should serve as intentional or unintentional role models; and their exemplary behaviour is to reinforce our institutional commitment to teach ethical, responsible behaviour. Accordingly, themes for the institute should integrate

independence, accountability, equity, integrity, confidentiality, professional conduct, respect for person and respect for intellectual property.

According to the above themes, an institute needs to be independent in the sense of being free of personal, administrative or policy constraint; applying this value refers to conflicts of interest that must be identified and resolved. The choice of research topics conducted under the auspices of the faculty must be free, but they will be identified in order to optimize the beneficial impact, both individual and collective. It needs to be equitable in having recruitment and promotion of resource persons regardless of sex, age, socioeconomic, political or religious grouping, and the entry and selection of students should be based on equitable and non-discriminatory criteria and methods. On the other hand accountability for the institute means the responsibility of teachers to implement their conscience to work at the highest level for the students, and by extension, for the patients, and comply with procedures that ensure the dignity and the consent of patients participating in teaching. It also means teaching the moral, physical and psychological side of medical procedures and in particular everything about the suffering of others. Accountability also means that teachers must guide the students' relationship with commercial companies in the field of health, to avoid possible conflicts of interest and that the faculty is committed to develop a curriculum for medical education and docimology for practising teachers. Respect for the person makes the faculty, as well as each of its members, committed to promote a work environment in which people are treated with respect regardless of their hierarchical level. The medical training is required for all diagnostic or therapeutic action is to include reporting to the patient, obtaining explicit verbal consent, respecting patient confidentiality and addressing the patient's social, cultural and economic concerns.

Social accountability of medical education means a willingness and ability to adjust to the needs of patients and health care systems both nationally and globally. But it also implies a responsibility to contribute to the development of medicine and society through fostering competence for research and improvement. Accreditation is a process by which a statutory body evaluates and recognizes an educational institution and/or its programme with respect to meeting approved criteria. It is a means for quality assurance, but also a strong power to reinforce the need for improvement and reforms. It must be performed through internationally recognised and transparent standards and should foremost promote quality development. The social accountability of medical education must be included in all accreditation processes at all levels. The WFME global standards programme provides tools for national or regional accreditation but also guidance for reforms and quality improvement. The standards are used worldwide and have been adopted to local needs in most parts of the world. They are framed to specify attainment at two levels: basic standards or minimum requirements and standards for quality development. The concept of social accountability is embedded in all parts of the standards documents. Accountability has become a major issue in health care. Accountability entails the procedures and processes by which one party justifies and takes responsibility for its activities. The concept of accountability contains three essential components: health care consists of at least 11 different parties that can be held accountable or hold others accountable; parties can be held accountable for as many as six activities: professional competence, legal and ethical conduct, financial performance,

adequacy of access, public health promotion, and community benefit; and the procedures of accountability, including formal and informal procedures for evaluating compliance with domains and for disseminating the evaluation and responses by the accountable parties.

Last, there are different models of accountability which stress different domains, evaluative criteria, location and procedures. We characterize and compare three dominant models of accountability: the professional model, in which the individual physician and patient participate in shared decision-making and physicians are held accountable to professional colleagues and to patients; the economic model, in which the market is brought to bear in health care and accountability is mediated through consumer choice of providers; and the political model, in which physicians and patients interact as citizen-members within a community and in which physicians are accountable to a governing board elected from the members of the community, such as the board of a managed care plan.

4.3 Ethics in medical education

Dr Elsheikh Mahgoub, WHO Temporary Adviser

Dr Mahgoub made a short verbal contribution on professionalism with emphasis on delivering the best standards of care through patient respect, patient's rights, autonomy in decision making and consent to management plan. Importance of being a leader, commitment to best evidence based practice; professional development and health as a human right were also emphasized as being essential elements of professionalism.

4.4 Do accreditation standards promote the concept of social accountability?

Dr Mohamed El Hassan Abdalla, Jazan University, Saudi Arabia

Social accountability of medical schools is defined by WHO as the "obligation of the medical schools to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve, The priority health concerns are to be identified jointly by governments, health care organizations health professionals and the public". Social accountability of medical schools considers four values, as the accountability of the health system. These are relevance, quality, equity and cost-benefit (effectiveness). At the same time, accreditation is a system whereby an institution or programme is assessed for its compliance with predetermined standards of structure, process and achievement. Accreditation can be seen as an endeavour for development and improvements as defined by WFME. Now there is increased concern about social accountability of medical schools all over the world.

An assessment was conducted to determine the extent that current accreditation standards support the promotion of the social accountability concept. The standards in the main three existing accreditation systems by WFME, LCME (USA), and AMC (Australia) were seen to address social accountability when classified into process (preparation and execution 72%, 77% and 78 respectively), content (programme makeup 22%, 16% and 17 respectively) but not outcomes (programme results; only a few standards addressed social accountability in the three systems: 6%, 6% and 7% respectively). It was also reviewed in

terms of addressing social accountability using the social accountability grid already described. The results showed that the three systems scored on education (WFME: 19% on relevance, 8% on quality and none on equity and cost; AMC 11% on each of relevance and quality 6% on equity and again none on cost; LCME 5% on each of relevance and quality, 4% on equity and again none on cost.) and on research (WFME: 3% on relevance, 3% on quality and none on equity and cost; AMC 10% on relevance and none on quality, equity and cost while in LCME only 1% on quality but none on quality, equity or cost) but near to none on services (only LMCE scored a mere 1% on relevance and the three systems scored none on all other parameters).

It was concluded that social accountability was found not to be fully addressed in the current accreditation systems and not all the domains are also addressed. The concentration on the process standards on expense of the content and outcome standards may not lead to the expected role and impact of medical schools as agents of change.

4.5 Discussion

Following the interventions, an open discussion by participants raised the following points and received responses from the four panellists.

- The effects of the economic downturn and the freedom limitation immensely challenge institutes to open their boundaries to society. The big question is how to address this.
- Social obligation of bodies producing students and regulating institutes has no clear relations with institutes.
- Social obligation is missing in education to develop spiritual and other attitude-related dimensions to be a change agent. This needs a long-term evaluation.
- Governments and educational leaders are fond of high-cost spending in creating and boasting centres of excellence rather than social accountability.
- If a college is to be accountable there should be an input from all stakeholders who operate outside and use it. This is not the case in many countries.
- Professionalism is only limited to ethics with wrong instructional methods in most of the cases as such concepts are talked about in didactic courses.
- Questions to be answered include how social accountability of medical education to cover all health workforce; how to move from good ideas to action and how this can work in the private sector.
- There is a need for democracy and freedom; with limited resources, how to make it work at its best.
- Measuring the impact should start today collected material is available at later stages.
- The difficult task is a courageous bridging of gaps between sides, partnership also involves mixing with others' culture.

5. COUNTRY EXPERIENCE

The following session addresses important part of the consultation work to exchange experience in accreditation and map progress at four levels: national level, where national

mechanisms (bodies) are operational; regional and subregional levels; at the level of different health professions in different countries; and at the level of institutes.

5.1 Sudan: experience in accreditation of medical, dental and pharmacy schools

Dr Zein A Karrar, Sudan Medical Council

The presentation provides a brief history and background about the Sudan Medical Council (SMC), which was established in 1968; it was legally mandated in 2004 to accredit medical, dental and pharmacy schools in Sudan through its bylaws (1993; amended 2004). The issue was addressed by the council and after wide consultation with partners a national accreditation committee was formed with representation of all stakeholders and the community as the governing body mandated to set a national policy and plan of action for accreditation and supervise and monitor its implementation. The presentation describes the details of the process of advocacy, standards-setting, consensus-building, development of accreditation tools and guidelines, selection and training of assessors and evaluation teams as well as the steps of the accreditation including the internal evaluation and the SMC team visit and external evaluation. The process of decision making is also described.

The present outcome of accreditation so far comprises 31 medical, 13 pharmacy and 11 dental schools is presented. Efforts for capacity-building and ensuring sustainability are described including regional and international partnerships with WHO and WFME as main sources for technical support.

The summarized main lessons learnt show that well planned, implemented, monitored and evaluated legal mandate and framework are essential, partnership and coordination with the ministry of higher education and schools, with advocacy and consensus-building, is mandatory; capacity-building, funding and logistic support are essential for sustainability; regional and international partnership is needed; and last is to think of the whole project a continual and dynamic process.

Future plans include: strengthening partnerships, revising and further adaptation of standards with a focus on professionalism and social accountability issues, producing the first national report on accreditation of medical, dental and pharmacy schools in Sudan and conducting the second round of accreditation addressing advanced standards and quality issues as well as further efforts in capacity-building.

5.2 Accreditation of higher health education institutions in Egypt

Dr Magdy Kassem, National Authority for Quality Assurance and Accreditation of Egypt

The National Authority for Quality Assurance and Accreditation of Egypt (NAQAAE) is the national formal and sole accrediting authority of higher education institutes. Established in 2007 as an independent authority, it is responsible for setting standards and assessment mechanisms, evaluation of higher education institutions and programmes and dissemination of quality culture. The Authority is mandated by a law on accreditation and has

the authority to accredit institutes with five-year validity with follow-up. Failure to obtain accreditation can lead to one of the following actions: grace period granted to the institute to address defects or change of leadership as a recommendation to the minister of higher education or suspension of further student admissions. The accreditation process involves following steps: application of institute to the Authority, institute presents self-assessment study, review of the study, preliminary report sent to institute, feedback from institute, decision leading to one of three options: institute accredited or denied or institute needs to make certain reforms; a revisit will be scheduled. The accreditation standards used are based on two parts: institutional capacity, with eight domains: strategic planning, organizational structure, governance and leadership, credibility and ethics, administrative system, resources, community participation and environmental development and institution's self evaluation and quality management. The second part deals with educational effectiveness and covered by another eight domains: students and alumni, academic standards, programmes and courses, teaching and learning, academic staff, scientific research and other scholastic activities, postgraduate studies and continuous assessment of educational effectiveness. Currently the status of accreditation of the health professions education institutes show that a majority of institutes are still not engaged in the process. There is a conformity of accreditation system with the WHO/WFME guidelines in regard to fundamental requirements, legal framework, organizational structure, standards (standards used cover all global standards), process, decisions and public announcement of decisions

5.3 Accreditation and quality at Jordanian higher education medical schools

Drs Munir Dababneh, Jordan Higher Education Accreditation Commission, Muntaha Gharaybeh, Azmi Mahafzah and Sawsan Majali

The Jordan Higher Education Accreditation Commission (HEAC) was founded in 2007 as an independent body by royal decree to accredit higher education institutes in Jordan. The Commission includes following five sections: institutional accreditation, programme accreditation, quality assurance, ranking and national testing centre.

Programme quality assurance is designed to ensure the quality system for educational programmes offered by the universities and it is framed by a set of guiding principles which include a list of criteria against which programme quality is determined and a process for programme accreditation. The medical programme quality assurance is one of the programmes of the HEAC. The Commission developed quality assurance criteria for four health science programmes running at Jordanian universities, which include faculties of medicine, dentistry, nursing and pharmacy. However, the only one that has been implemented is accreditation and quality assurance of faculties of medicine. It is worth mention that all the four faculties of medicine operating in Jordan have by now been accredited by the Commission. The key issue in this was the formulation of a national set of standards for medicine in 2008 that opened the door to speed up the process.

Accreditation of medicine faculties is based on nine domains, based on the WFME global set of standards but addressing certain criteria specific to Jordan covering: first criterion: vision, mission and objectives; second criterion: educational programme; third

criterion: faculty members; fourth criterion: educational resources; fifth criterion: governance and administration; sixth criterion: students, accreditation and quality assurance criteria for faculty of medicine; seventh criterion: student evaluation; eighth criterion: programme evaluation; and ninth criterion: continuing innovation. The steps and pathways of achieving the accreditation is described. The decision-making involves the HEAC further scrutinizing the details of the committee's report along with the institution's report to make a final decision concerning the findings, HEAC publishes the decisions without details to safeguard the integrity of the institution. The decision may include: accreditation granting, postponement until corrective action is completed or accreditation denial. A percentage score is given based on the findings so that the score is used by HEAC to determine whether or not the institution is to receive recognition.

Future plans include implementation of accreditation and quality assurance on dentistry, nursing, pharmacy and medical/allied science faculties; application of programme ranking on the medical faculties and application of qualifying test exams to measure the learning outcomes of medical programmes.

5.4 Medical and dental council and accreditation of medical and dental graduate and postgraduate educational institutions in Pakistan

Dr Ahmed Nadeem Akbar, Pakistan Medical and Dental Council

The government of Pakistan through the Ministry of National Regulations and Services empowers the following accrediting institutions:

- the Pakistan Medical and Dental Council (PMDC) for accreditation of graduate and postgraduate medical and dental institutions on established criteria. The students and then graduates are registered by the Council.
- the Pakistan Nursing Council for accreditation of graduate and postgraduate nursing institutions. The students and then graduates are registered by the Council.
- the Pakistan Pharmacy Council for accreditation of pharmacy institutions.

The PMDC was established in 1962, under Pakistan Medical and Dental Council Ordinance 1962, as the national statutory accrediting and regulatory authority and in legal terms is a body corporate with its own seal. The Pakistan Medical and Dental Council is the oldest and most evolved accrediting body in the Eastern Mediterranean Region. Its processes and standards of accreditation have been declared by the United States government to be comparable with those of the United States. All the colleges accredited and recognized under the PMDC ordinance 1962 automatically get included in the Avicenna Directory of FAIMER and all other such directories. The graduates of colleges accredited by the PMDC are accepted by the General Medical Council, UK, and the graduates are eligible to sit the PLAB examination for the purpose of higher education in United Kingdom. PMDC is known and respected worldwide and is part of international community of medical regulatory authorities (IAMRA). Due to its well acknowledged, established and evolved accreditation standards, PMDC-registered practitioners are accepted and doing meritorious service all over the world. PMDC is a member of the AMEEMR.

The main functions of the PMDC are to accredit medical and dental colleges/universities in Pakistan, to act as a regulatory authority for universities having medical or dental programmes and to register medical students and faculty and practitioners. No medical institution can function without recognition of PMDC. No Pakistani doctor can practice in Pakistan or abroad without being registered or without being in good standing with PMDC. The statutory mission assigned to the Council by law is to establish a uniform minimum standard of basic and higher qualifications in medicine and dentistry and practice throughout Pakistan and maintain liaison with other regulatory authorities of the world to facilitate the Pakistani practitioners. The council is composed of members from the national assembly, provincial governments, registered medical practitioners, federal government, registered dental practitioners, teaching staff of affiliated colleges, nominee of Chief Justice of Pakistan and Director-general of Health.

The PMDC has the mandate to inspect any or all medical and dental examinations and institutions in the country. The statutory functions and duties of PMDC are to:

- prescribe a uniform minimum standard of courses of training for obtaining graduate and postgraduate medical and dental qualifications. The National Curriculum Committee of the PMDC lays down the national medical and dental curriculum
- prescribe minimum requirements for the content and duration of graduate and postgraduate medical and dental courses of study
- prescribe the conditions for admission of courses of training as aforesaid
- prescribe minimum qualification and experience required of teachers for appointment in medical and dental institutions
- prescribe the standards of examinations and methods of conducting the examinations
- prescribe the qualifications, and experience required of examiners for professional examinations
- register faculty and students of medical and dental institutions
- maintain the register of medical and dental practitioners
- inspect and formulate recommendations regarding recognition of medical and dental institutions for training of undergraduates and postgraduates
- inspect undergraduate and postgraduate examinations for standardization
- act as a court of law to decide cases against registered practitioners for infamous conduct and professional malfeasance
- inspect and approve hospitals for house jobs
- recognition of medical and dental journals
- issue experience certificates to faculty
- set up schemes of reciprocity with other countries and medical regulatory authorities of the world.

The accreditation criteria/standards of PMDC are quantifiable, and the steps in the Process of Accreditation include the following.

- 1) A preliminary visit of a new applicant institution may be carried out at the request of a new institution by a team nominated by the President of the Council. This team shall

guide and explain the minimum requirements as are laid down in the criteria/standards of the Council for establishing a medical or dental college.

- 2) Visit one is the first comprehensive inspection for recognition of a new college, prior to any admission of students. In addition to ascertaining the fulfilment of the criterion, the inspectors are required to comment on:
 - suitability of the venue for educational purposes
 - availability of all necessary infrastructure and physical facilities needed during the first professional studies
 - presence of needed educational resources
 - recruitment of appropriate and adequate registered teaching faculty
 - availability of written curriculum
 - adequacy and source of funds
 - procedure for financial accountability
 - attached teaching functional hospital and its bed strength and
 - physical structure of the departments.
- 3) Visit two, second comprehensive inspection, is for third-year facilities. The inspection team may look into:
 - availability of all necessary infrastructure and physical facilities needed in the medical and dental college as well as affiliated teaching hospital
 - adequacy of clinical training opportunities including workload and case mix in the hospitals
 - availability of required full clinical faculty and beds
 - presence of needed educational resources
 - recruitment of appropriate and adequate teaching faculty
 - availability of a written training programme with objectives, syllabus, teaching methods and assessment programme.
- 4) Visit three, third comprehensive inspection, is before final professional (MBBS) examination. The inspection team may look into:
 - availability of all necessary infrastructure and physical facilities in the medical and dental college as well as affiliated teaching hospital
 - adequacy of clinical training opportunities including workload and case mix
 - availability of required clinical faculty
 - presence of needed educational resources
 - recruitment of appropriate and adequate teaching faculty
 - availability of a written training programme with objectives, syllabus, teaching methods and assessment programme.
- 5) Subsequent visits of an accredited institution. Mandatory subsequent comprehensive inspections may occur every five years and any or all examinations may be inspected.

The president or the executive committee can order a surprise comprehensive inspection of any institution any time. Visits to verify rectification of deficiencies pointed out earlier may be held, but not within two weeks of the previous inspection and preferably by the same team which visited earlier. Any reason for a change in the team including non-availability of inspector shall be recorded in writing and endorsed by the president of the Council.

The Council accredits postgraduate medical and dental programmes according to the Section 16 of the PMDC Ordinance which is the law governing accreditation of postgraduate medical and dental programmes. The process is elaborately defined in the postgraduate regulations and all regulations are binding on the postgraduate institutions and courses. Recent activities and achievements of PMDC have included promulgation of regulations, regulatory and registration software development, improvement of service delivery and office automation, strict monitoring of examination standards all over the country, strict enforcement of student and faculty registration, development of guidelines and registration of medical journals and start of the *Index Pakistan* of recognized journals as a step towards their inclusion in *Index medicus*, developing the national curriculum of MBBS and BDS and postgraduate studies in collaboration with HEC, development of national criteria for appointment of teachers in medical and dental institutions in collaboration with HEC, development of an international-level integrated and interactive PMDC website with the capacity to support information-sharing with other regulatory authorities of the world, continuing professional development and continuing medical education activities, protocols and memoranda of understanding with General Medical Council, recognition of PMDC accreditation standards as comparable to US standards by NCFMEA, USA, closure of illegal or substandard medical/dental colleges, inspection of colleges in neighbouring countries under Section 13 and 14 of the PMDC Ordinance 1962, conduct of transparent registration examination by National Examination Board of PMDC through public sector universities on rotation and defining and issuing experience certificates to doctors on clear, transparent and equitable rules in a predefined format to ensure uniformity.

5.5 Accreditation of health professions education in the Islamic Republic of Iran

Drs Ali Haeri and Amir Mohsen Ziaie, National Council of Medical Schools Education and Council of Medical Education, Islamic Republic of Iran

During the mid 1980s the Islamic Republic of Iran took a very serious and significant step towards health promotion by integrating medical education with the health services. This move resulted in the formation of the Ministry of Health and Medical Education. Accordingly in each province (31 provinces) there is today at least one university of medical sciences and health services; the rector of each university is an acting minister of health in the province. Ever since that, many types of councils within the ministry were established in order to supervise relevant schools and their programmes such as medicine, specialties in medicine, pharmacy, dentistry and nursing. The function of these national councils is to look into all educational aspects of the relevant discipline including accreditation.

International standards for accreditations amalgamated with locally based needs composed the tools for accreditation practice in Islamic Republic of Iran. Accreditation is performed at both institutional and programme levels, bearing the nature of internal (self) evaluation and external reviewing.

Future plan for the accreditation practice in the country is to divide the country universities into nine or ten educational poles. Each pole will be given the authority to act as a regional ministry of health that will supervise other universities in the same region or zone. Among the functions of such regional universities is the accreditation practice. All regional universities will at last be under the supervision of the Ministry of Health and Medical Education which in turn will perform accreditation on the regional universities.

5.6 Accreditation of medical schools in Iraq

Drs Thamer Kadum Yousif and Hikmat A. Rasoul, Ministry of Higher Education and Scientific Research, Iraq

There are currently 24 medical schools operating all over Iraq. The first medical college was founded in 1927 in Baghdad, and more colleges followed in 1959 (Mosul). In recent years, at least one college exists in each of the 18 governorates. In Iraq, the fertile Mesopotamian valley, medical standards existed since more than 4000 years ago when the Babylonian king Hammurabi in his famous legal statue devoted four articles to address medical practice. Article 215, for example, states that “If the Physician opens a mass over the eye with an operating knife and saves the eye, he shall receive ten shekels [the Babylonian currency]” and article 218) if “the physician makes a large incision with an operating knife, and kills the patient, or cuts out the eye, the physician’s hands shall be cut off”.

In 2007, Iraqi deans and faculty staff started to raise awareness on accreditation supported by the Regional Office and the Ministry of Higher Education founded the National Health Accreditation Committee (NHAC) to drive and coordinate efforts in this important field. Several events were organized and included workshops (inside and outside the country) and training at the Arabian Gulf University, Bahrain. The Iraqi National Guideline on Standards for Establishing and Accrediting Medical Schools was developed and demanded that deans of colleges of medicine in Iraq, as they have approved the need to develop basic minimum standards for accreditation of medical colleges, are to prepare their colleges meet both the national and international standards and ensuring meeting the interest of the public and students enrolled in medical programmes. The National Health Accreditation Committee (NHAC) tasks included:

- developing national standards that meet the Iraqi context and health characteristics based on acceptable regional and international standards
- assisting in developing a strategic plan of action
- increasing awareness about accreditation of medical and health institutions of Ministry of Higher Education and Ministry of Health staff
- assisting in selecting models
- selecting technical committees from members of NHAC

- monitoring activities/progress of provider and provincial accreditation teams
- assisting in self-assessment studies of medical and health professional colleges.

All the 24 medical colleges have prepared and produced their self-evaluation assessment study documents according to the following steps.

- The medical colleges started a process of self evaluation.
- More than 15 colleges finished their internal assessment and are waiting for the final process: external evaluation.
- Almost all colleges were visited by NHAC representatives.
- Iraqi National Guideline on Standards for Establishing and Accrediting Medical Schools was used.
- Objectives of future workshops:
 - continuing the evolution of accreditation
 - developing and revising quality indicators.
 - supervising self evaluation report of medical schools
 - assisting in the process of external evaluation.

The NHAC faces major challenges: the need to tailor the plan to match the changed situation on the ground, to extend membership of the NHAC in order to be more representative, a national regulating council is needed to be established to take full legal authority on accreditation, programmatic vs. institutional assessment is still to be sorted out, an accreditation plan of action with a time frame is needed by all stakeholders, the mandatory nature of accreditation must be activated and to improve the national capacity-building in accreditation towards mechanism for external evaluation.

5.7 United Arab Emirates accrediting authority, Ministry of Higher Education and Scientific Affairs

Dr Mohammed Yousef Baniyas, United Arab Emirates University

The United Arab Emirates realizes that all institutions inside the country should offer high quality academic programmes which are recognized both within the country and internationally for their excellence. Therefore the Commission for Academic Accreditation (CAA) at the Ministry of Higher Education and Scientific Research (MHESR) was established to conduct licensure of institutions of higher education and accreditation of each of their academic programmes. The major goal of the CAA is ensuring quality and academic standards by maintaining and implementing frameworks which assure that institutions of higher education in the UAE operate at international standards of quality. These standards cover institutional licensure and programme accreditation as well as standards for licensure and accreditation of technical and vocational education and training and e-learning programmes.

The CAA is an autonomous body that is linked to and supervised by the Ministry of Higher Education and Scientific Research with full legal backup and support. The CAA itself is accredited by the International Network of Quality Assurance in Higher Education

(INQAHE). All private and semi-government universities, colleges and institutions within the country go through the licensing and accreditation process (semi-government refers to universities established by local government decree and not by federal government decree). There are over 70 private and semi-government universities many of which are branches of international universities.

There are only three government universities (Emirates University, Zayed University and the Higher Colleges of Technology) that were established by federal decree and currently there are special arrangements for accrediting federal government universities and institutions. The process for accrediting federal government universities follows quality standards higher than just obtaining minimum standards for programme accreditation and institutional accreditation and the process is managed by the Ministry of Higher Education and Scientific Research but not directly through the CAA. The CAA works on accrediting all levels of academic programmes and degrees (diploma, higher diploma, BSc, MSc and PhD) as well accreditation of vocational programmes and e-learning programmes. There is no special independent medical council, and accreditation of medical and health institutions and programmes (at the undergraduate level) is conducted by CAA.

Accreditation of residency and postgraduate clinical training is performed by the Arab Board and coordinated by Ministry of Health. Recently a transitional committee for establishing an Emirates Board of Medical Specialties was formed for the purpose of accrediting postgraduate clinical training. The CAA works closely with another department within Ministry of Higher Education and Scientific Affairs which is the Department of Equalization of Certificates. However equalization of postgraduate clinical certificates (boards and fellowships) is conducted by the Ministry of Health (federal) and local health authorities such as Health Authority Abu Dhabi (HAAD) and Dubai Health Authority (DHA). These bodies are responsible for licensing of health care professions within the country, and there are new initiatives to unify licensing standards. Programme and college accreditation for all institutions, government, semi-government and private, includes self-study, sending programmes for external evaluation and external site visits at the beginning and every four to six years. These site visitors are mainly from the US (sometimes with a local representative), and the institution themselves are responsible for covering the accreditation cost.

5.8 Accreditation of medical and health professions education in the Bahrain

Dr Alya Al-Sindi, College of Health Sciences, Bahrain

Education is identified as one of the national priorities for reform in Bahrain in line with Vision 2030, which focuses on strengthening Bahrain's human capital through undertaking education reform, economic reform and labour market reform, hence the establishment of a national system for accreditation. The Higher Education Council (HEC) was founded in 2006, and by 2007 the Quality Assurance Authority for Education and Training (QAAET) and Higher Education Review Unit (HERU) were established.

The QAAET and HERU aim at ensuring the quality of education and training across all fields including the health field. The mandate for QAAET is to ensure that all educational

institutions meet the international standards and best practice; they conduct institutional and programme reviews. The first review cycle started in May 2008 and was completed in 2011. In this cycle 25 review indicators, grouped under the following eight themes, were used to assess the quality assurance practices and outcomes of Bahrain's higher educational institutions:

- mission, planning and governance (5 indicators)
- academic standards (6 indicators)
- quality of teaching and learning (3 indicators)
- student support (1 indicator)
- human resources (3 indicators)
- research and community engagement (3 indicators)
- infrastructure, physical and other resources (3 indicators)
- quality assurance and enhancement (1 indicator).

The review process starts with a self-evaluation review in which the university assesses its performance using 25 review indicators (developed by HERU) and submits a self-evaluation report (SER). An external review panel is then identified for each institution and the SER is sent to panel members for review and comments. This is then followed by a site visit to the institution by HERU and the panel. Finally HERU prepares the final review report which is then communicated to the institution for further comments before it gets finalized and published. Following the review the university prepares an action plan to address the panel recommendations and also produce a progress report.

The results of the two-year institutional review cycle (2008–10) are published on HERU's website. Though the findings and recommendations were institute-specific the review revealed several issues of a general nature. For example; under the mission, planning and governance, there was a disjuncture between the institution's vision and mission and its ethos and education provision. The governance and management structures were generally not clearly delineated, and some institutions did not have functioning boards of trustees. Research and community engagement are two core functions that were found to be underdeveloped in some universities.

In addition to the institutional review, HERU conducts programme reviews. Evaluation of academic programmes focuses on four important areas:

- curriculum
- efficiency of the programme
- academic standards of the graduates
- effectiveness of quality management and assurance

The relationship between the HEC and the QAAET is well established: the HEC is responsible for the licensing of private higher education institutions and the QAAET assists the HEC to determine whether its licensing regulations, including academic standards for higher education institutions, are met.

Another development in Bahrain was the establishment of the Bahrain Qualification Framework Project (BQF) in 2010. The aim of BQF is to facilitate the recognition, transparency and transfer of qualifications by developing a national qualification framework that can be linked to major international frameworks. This will serve to reduce the barrier to learning and employment and bridge the gap between vocational and academic qualifications and allow more learning pathways and translation for certifications and mobility. On the other hand, the professional medical accreditation continues to adopt WFME standards for basic medical education. Postgraduate specialization in medical education has been organized by the Arab Board for Medical Specialization since 1978.

Constraints and challenges currently facing accreditation of health profession education in Bahrain can be summarized under the following areas:

- variability of administrative systems of accreditation of higher education
- lack of consistency/compatibility of accreditation systems applied in health education institutions and those applied in the health care delivery system
- absence of professional accreditation body for health professions.

Bahrain welcomes the WHO initiative to develop regional accreditation guidelines as a way forward to standardize the accreditation system across countries of the Region, and reduce confusion caused by multiple accreditation bodies. Bahrain will support WHO initiatives to establish a regional higher education fund for financing the development and reform of an independent accreditation system.

5.9 Accreditation of higher education programmes in health in Palestine

Dr Najah Musmar, An-Najah National University, Palestine

Although education programmes in medicine, dentistry, and pharmacy are relatively new, a good number of programmes for nursing and allied health professions started much earlier and during Israeli occupation. Early on and before universities were launched, two-year and three-year diplomas of nursing and allied health sciences were operating. Most of these programmes started in the 1970s either in hospitals or community colleges and a good number of them are still functioning. In the 1980s several universities in West Bank and Gaza started BSc programmes in nursing and allied health sciences. However it was only after the Oslo Agreement and the recognition of the Palestinian National Authority (PNA) that health education programmes receive the attention of most higher education institutions in Palestine.

Since the launch of the first medical school in 1994 at Al-Quds University, a United Kingdom charity established a quality agency, FQMS, to provide strong technical and financial support to the administration, faculty members and the students. Currently there are three recognized MD (medical doctor) programmes in Palestine, three dental programmes (the first was launched in 2000), four pharmacy schools (the first was launched in 1993) and six schools for allied health profession programmes. Because Palestine was under occupation, most of universities are classified as national (non-governmental but not for profit); there is only one governmental college (Ibn Sina) and one private university (American University at

Jenin). Consequently, most health education programmes in Palestine are provided through national higher institutions/universities. Because of the difficult political situation and non-recognition of Palestine as a state, the financial support of all of higher education institutions regardless of their type is very poor or non-existent, and therefore all higher education institutions are charging tuition fees for their programmes.

Until 2002, there was no formal system for accreditation of any programme or institution in Palestine. However, the rapid growth of health professions education institutes and programmes after the PNA called for regulation of higher education. The Accreditation and Quality Assurance Commission (AQAC) was established in 2002 as the sole semiautonomous governmental body responsible for accreditation and quality assurance of higher education in Palestine. The aim of AQAC is to reinforce a culture of quality education based on accountability, control, guidance and improvement. Seeking accreditation by AQAC from all institutions is compulsory, and AQAC reports directly to the Minister of Education and Higher Education. Two important committees advise AQAC's head on policy and technical decisions about accreditation process and standards; the Accreditation Council, which is chaired by the head of AQAC and is composed of 12 commissioners: six representatives from institutes and six from various fields of professional practice including health; and the Advisory Council, which comprises seven committees, one of which is a health committee.

AQAC uses three main steps to make sure that all higher education institutions are continuously going through accreditation process:

- initial accreditation and initial licensing for the opening of new educational programmes and institutions respectively, leading to the status of a publicly recognized entity
- ongoing monitoring and evaluating the established institutions and programmes (commonly relating to minimum standards).
- accreditation (after first graduation)
- professional certification of graduates in chosen professional fields (medicine, engineering, etc.); for medicine and dentistry it is the Palestinian Medical Council's responsibility.

The AQAC follows the following procedures in accreditation:

- self-assessment: evaluation process conducted by faculty, administrators, higher education institutions' programme staff and students, adhering to AQAC standards
- peer review (site visit) conducted by team of experts selected by AQAC and guided by the academic reference standards
- decision-making: AQAC board, based on evidence and recommendations on the bases of AQAC criteria concerning quality.

Achievements of AQAC in health education accreditation.

- AQAC started with the health education programmes as pilot programmes of (2003–04).
- AQAC has finished evaluation of all health education programmes by external experts except medicine and dentistry (2010–11).
- All accredited programmes are reviewed every five years.

Because AQAC started after health education institutes were established, it needed a timetable and flexibility in dealing with the process until the accreditation and quality culture became established. The peer review process requires a large number of qualified experienced reviewers which is sometimes difficult to find; we depend on Palestinians in the diaspora and experts from neighbouring Arab countries. However this process is costly and AQAC is working hard to overcome this financial burden. Finally the unstable political situation is another important challenge. We look forward to training a larger number of local experts to strengthen our system and to develop further regional and international relations. The website contains all needed information, files, brochures, etc., about AQAC's function and the accreditation process. All accredited programmes are also displayed on the AQAC homepage at <http://www.aqac.mohe.gov.ps/>

5.10 Accreditation of health professional programmes in Oman

Drs Alya Al Rawahi and Hamood Al-Kharusi, Ministry of Health, Oman

Oman is one of the developing countries in the Region, and since 1970 the government has emphasized the importance of developing human resources to drive Oman's developments. Health profession human resources were one of the priorities of the government from that time. The Ministry of Health began training nurses and medical laboratory technicians in 1973 at Al-Rahma School of Nursing. In 1982 the Institute of Health Sciences was established by the ministry, and these programmes were relocated there. At present the institute has four programmes: medical laboratory sciences, medical imaging, physiotherapy and dental surgery assistant programme. The nursing programme is now offered at nine nursing institutes across the country. The ministry also has assistant pharmacy and health information management programmes that are offered in institutes in Muscat. Other providers of health professions programmes in the country including the following: Sultan Qaboos University (medicine, nursing and medical laboratory sciences), Higher College of Technology (Ministry of Manpower) and pharmacy. Private institutes include Oman Medical College (medicine and pharmacy), University of Nizwa (pharmacy and nursing), Oman Dental College.

By 2000, there were many public and private colleges and universities and there was a need to regulate the institutions and the programmes. For these reasons, the Oman Accreditation Council was established by Royal Decree No. 74/2001 and is now legally responsible for the external quality assurance and enhancement of the higher education institutions in Oman and accredits all public and private higher education institutions. The Council now is known as Oman Academic Accreditation Authority (OAAA) and has developed a plan of action to accredit all higher education institutions. The plan includes an extensive training programme to promote and develop a culture of quality assurance in higher

education. The details of the plan can be found in the website of OAAA at www.oac.gov.om. The OAAA is now in the process of implementing the first stage of a two-stage institutional accreditation process (stage one: quality audit; stage two: standard assessment). The OAAA is not ready to accredit programmes at present due to staffing and other logistic issues but has already put together process of programme accreditation.

Private higher education institutions require a licence from the Ministry of Higher Education to be established and to run specific programme. Also the ministry requires each private institution to have a collaborative agreement with an internationally accredited institution. Furthermore, the Ministry of Higher Education and the Ministry of Health have jointly established a committee in 2007 consisting of deans and experts in medicine, dental, pharmacy and nursing education from public institutions to review, advise and support private institutions in maintaining quality education both in providing appropriate educational environment and professional education. In preparation for national programme accreditation from OAAA, many health professions programmes are seeking international programme accreditation. For example, in Sultan Qaboos University, nursing programme—National League for Nursing Accrediting Commission (NLNAC), medical laboratory science programme—National Accrediting Authority for Clinical Laboratory Sciences (NACCLS), medical imaging programme—Joint Review Committee on Education in Radiologic Technology (JRCERT), physiotherapy programme—Commission on Accreditation in Physical Therapy Education (CAPTE), dental surgery assistant programme—Commission on Dental Accreditation of America (CODA), pharmacy programme—Accreditation Council for Pharmacy Education (ACPE), health information management programme—Commission on accreditation for Health Informatics and Information Management (CAHIIM). The ONMC has already established national standards for nursing education which are benchmarked with international standards. These standards have been discussed with OAAA and other stakeholders and it is hoped that they will be finalized soon.

Generally, the challenges are in relation to OAAA's lack of human resources, insufficient knowledge and experience in quality experience, collaboration between OAAA and professional bodies—there is a fear with some professional bodies that their role in setting standards and accreditation of such programmes may be diminished..

5.11 Status of accreditation of higher health professions education institutions in the Syrian Arab Republic

Dr Mayssoon Dashash, Ministry of Higher Education, Syrian Arab Republic

In 2005, the Council of Higher Education of the Syrian Ministry of Higher Education led an initiative and invited all public universities to self-evaluate their academic programmes. The purpose was to assess the performance of academic and administrative processes and to highlight points of weaknesses in order to draft future strategies for improvement. A wave of development and an increased pace of change have occurred as part of the Government's reforms in higher education. These included a strategic implementation plan at the ministry based on the 10th five-year plan, new initiatives from the ministry, and

outcomes of the universities' self-evaluations coming on stream with implications for national policy.

In 2005, the Council of Higher Education adopted a framework for performing evaluation, quality assurance and accreditation in Syrian universities. A permanent committee in the Ministry of Higher Education was formed called the Higher Committee for Quality and Accreditation, and its tasks are adoption of a mechanism for continuous self-evaluation in universities, develop standards for quality and academic excellence, establish a system for quality assurance in public and private institutions in order to conduct external auditing and standards of quality and academic excellence and to set rules for recognition and accreditation, propose appropriate organizational structure to establish a national body for quality and accreditation and accreditation rules for public and private universities.

Accreditation rules were developed for public and private universities in order to ensure the quality of the output of these universities. These include rule 31 issued by the Council of Higher Education, dated 29 November 2007, which described the following components.

- 1) Administrative and financial management at the university (the board of trustees—board of the university—faculty council—council of the department) and the organizational structure and management of the university board of trustees in addition to the roles of the head of each council.
- 2) Rules for general accreditation, which include the accreditation of university buildings, structures, equipments, facilities and teaching methods, qualifications of the teaching, technical, administrative staff, public and private facilities in the university according to the form provided for this purpose.
- 3) The rules for special accreditation, which include the accreditation of the academic programmes in private universities. They also include key areas of the standards of accreditation related to the mission, aims, content and structure of the programme, teaching and learning atmosphere, infrastructure, academic staff, student admission, assessment and output, external collaboration and information exchange, internal evaluation and quality assurance system.
- 4) Qualifications to be met in the academic and technical members.
- 5) Monitoring and implementation mechanisms that determine the roles of accreditation committees and mechanisms for action.
- 6) Conditions for increasing the general capacity of the programme/faculty/university as well as to increase the number of students.
- 7) Competency test and its rules and conditions applied to private and public universities.

Students of public and private universities should set a competency examination in each discipline at a national level to reflect the efficiency of graduate programmes and universities. The competency test is a standardized evaluation of the scientific ability of Syrian graduates from public and private universities in order to measure the impact of the processes taking place in institutions of higher education. This test is for the ratification of the certificate obtained by the graduates, but is not a requirement for graduation. The competency test has been applied for testing graduates from dental, pharmacy and architecture faculties in the

country. All of this creates competition among national universities to achieve better levels through the development of curricula and teaching methods, increase the qualifications of the faculty members and provide the requirements of the learning process.

In 2010, the Council of Higher Education began to adopt a series of decisions that paved the way for the establishment of national medical examinations with high quality. For assessing all Syrian medical students, national academic reference standards, which define the minimum knowledge and skills essentials for medical students before graduation, have been considered a reference point for the assessment and for designing questions. Consequently, success in the examination has been considered an indicator of competency and is essential for graduation and for applying for postgraduate studies and specialization. Decision 274, dated 10 April 2010, approved setting a national medical written examination for all sixth-year medical students from Syrian universities (government and private) under the supervision of a committee designated by the Minister of Higher Education. A proposal to set a national examination for dental and pharmacy graduates have been suggested. In July 2012, the national examination for dentistry and pharmacy will be set, for the first time, under the supervision of the ministry. It is hoped that this will reflect the efficiency of graduate programmes and universities and will help to achieve quality in higher education outputs and the standards of accreditation.

The Council of Higher Education in its meeting held on 21 October 2009, approved Decision 68, which includes a national plan for the development of programmes and curricula of higher education. This plan aims to: develop national academic reference standards (NARS) of the system of higher education according to the methodology approved by the Higher Committee for Quality Assurance and Accreditation, develop programmes and curricula currently available, in order to ensure the quality of educational attainment of the graduates of these programmes, harmonize the output to the requirements of national development and the needs of local and regional communities and to develop new programmes in response to global developments and the needs of society.

The current and future plan covers several phases. The first phase, which included the development and adoption of the NARS, has been completed for each academic sector including the health sector. The ministry is preparing for launching the second phase, which includes reforming the curricula for all programmes in accordance with the following mechanism. This will be performed through the evaluation of the current programmes in light of the NARS, the labour market, population needs and international trends. It will be followed by drafting programme specifications and course descriptions for the future programmes (the development of the capabilities of the teaching staff) in order to formulate the academic reference standards after defining the requirements of future programmes. New curricula for all courses (curriculum mapping, credit hours, teaching methods, learning and assessment), will be developed. It is hoped that the implementation of programmes will take place at the beginning of 2013. It will be followed by guiding institutions towards the external evaluation of programmes and preparing for programmes accreditation from international bodies.

In conclusion, the national plan for the development of programmes and curricula, which was adopted in early 2009 in higher education, has offered a unique opportunity for involving all teaching staff to actively participate in improving their academic working environment. Development of a suitable curriculum model will be accompanied by capacity-building programmes for all faculty members in order to introduce the concept of developing intended learning outcomes at the course level. It is quite clear that future tasks cannot be accomplished without the full participation of all faculty members. The national plan in its first stage and the design of NARS, have opened the door for introducing issues in medical education which no one would raise in the past. The vertical/ and horizontal integration, SPICES model, OSCEs, student centred teaching and learning, problem based learning, community-based education, are all new concepts that have been introduced to the academic staff in medical faculties. It is hoped that these concepts and tasks will be adopted by 2013. The road to accreditation is long, but a trip of thousand miles starts with the first mile.

5.12 Status of higher health professions education in South Sudan

Dr Thomas Madit Timothy, Bahr el Ghazal University

South Sudan is only four months old as a state. No functional system is in place for accreditation. However, the country has inherited a useful experience from the formerly united Sudan, which has been very helpful and, we trust, will continue to assist us in this field whenever we call on them. The Southern Sudan branch of the Sudan Medical Council was approved in 2009. It could not start work because of many constraints. However, it started the registration of health professionals in March 2011 using the Sudan Medical Council conditions of eligibility and procedures. New procedures for the registration of training institutions and teaching hospitals are still not yet formulated. However, there are a number of already accredited institutions including four nursing schools, four medical institutes and three medical schools.

In Juba there is a meeting going on between the Ministry of Higher Education and the universities, colleges and institutes concerning accreditation. We do not know whether accreditation will be under the Ministry of Education or Medical Council. Whichever way we will seek your help and assistance to put us on the right track. Currently the committee includes representatives of all the medical institutions—Dean of College of Medicine, University of Bahr el Ghazal, Registrar of the South Sudan Medical Council and the Principal of the Health Sciences Training Institute Juba. The Dean of the University of Juba College of Medicine was unable to attend for logistic reasons. In South Sudan, everything is a priority, but there are priorities of priorities that we need to sort out. We hope there will be government commitment and funding otherwise we may not start the process of accreditation of training institutions soon. Certainly we need your technical expertise and funding and attending this consultation opened doors for us to look forward and work towards this.

In South Sudan there are five high education universities with three colleges of medicine and proposed four universities, medical institutions four in number and awarding diploma certificates and four nursing schools awarding certificates.

5.13 Accreditation of Libyan medical schools

Dr Mohammed S. Ambarek, Libya International Medical University

Accreditation in higher education is to ensure that education provided by institutions meets acceptable levels of quality and to promote institutional self-evaluation and improvement. The Libyan Centre of Quality Assurance for Accreditation (CQAA) was established in 2006, with responsibility for determining standards and criteria for academic accreditation and assessment and for accrediting post-secondary institutions and the programmes they offer. The CQAA has defined the standards that will apply in two documents, *Standards for quality assurance and accreditation in higher education institutions* and *Standards for quality assurance and accreditation in higher education programmes*. The Centre is an independent authority reporting directly to the Higher Council of Education. Its role is separate from that of the ministries and other government agencies to which institutions are administratively accountable and which may establish regulations and reporting requirements for the institutions for which they are responsible. The Centre became a full member of the International Network for Quality Assurance Agencies in Higher Education (INQAAHE) in April 2009. The Centre is committed to a strategy of encouraging, supporting and evaluating the quality assurance processes of post-secondary institutions to ensure that quality of learning and management of institutions are equivalent to the highest international standards.

The Centre provides the following forms and guidelines in quality assurance and accreditation: guidance of quality assurance and accreditation of higher education institutions, which includes:

- procedures for licensing and accreditation
- a plan to license mechanism, auditing and accreditation of higher education institutions
- accreditation standards of higher education institutions
- guide to self-audit procedures and external reporting
- application forms for institutional and academic programme accreditation
- general requirements for accreditation, including the following:
 - form 1: standards for quality assurance and accreditation in higher education institutions
 - form 2: standards for quality assurance and accreditation in higher education programmes
 - form 3: standards for quality assurance and accreditation in higher studies programmes
 - course specifications template
 - programme specifications template.

The Centre provides many awareness courses and workshops to educational institutions, such as:

- stages of quality assurance and accreditation educational institutions
- self-study, mechanism of assessment, and reporting in higher studies

- criteria for programme accreditation in higher education
- criteria for programme accreditation in higher studies
- preparation of quality assurance auditors.

Accreditation of higher education institutions is going through several stages and processes are interrelated and integrated since its inception and until the accreditation is final, The stages and processes are summarized in the following:

- obtaining license
- request for provisional accreditation (given by the Centre)
- internal and external audit (under the supervision of the quality assurance)
- request for final approval (granted final certification or a conditional accreditation, or deny accreditation)
- complaint (committee neutral).

Libyan International Medical University (LIMU) is the first national medical sciences university in the private sector and was established in 2007. It obtained provisional accreditation in 2008 from CQAA. The university has six medical colleges (medicine, dentistry, pharmacy, basic medical sciences, health sciences, health information technology). It has adopted a new strategy of active learning (problem-based learning) and community-based education. The quality assurance office at LIMU is seeking to develop a comprehensive strategic plan with specific goals to improve the academic and administrative performance in the field of teaching and learning, research and community service. In this regard, the quality assurance office plans for improvement through:

- performing a periodic institutional self-study
- monitoring customer satisfaction through questionnaires
- performing annual programme evaluation as per template of programme report
- performing course evaluation the following are recommended:
- establishing a network of accredited universities and the ones trying to qualify to promote cooperation
- encourage hospital administration to give priority of recruitment to accredited graduates.
- establish a regional registry and annual ranking list.
- allocate funds and grants for quality assurance and raising standards for accreditation fulfilment.
- promote new modalities of teaching methods like problem-based learning and community-based.

LIMU is the only health professions education institution subjected to the accreditation process and awarded provisional accreditation in 2008. Institutional independent review by the CQAA of six public universities and eight private institution showed a bad assessment score of the public universities; LIMU scored the best among universities. Only private institutions are subject to accreditation process for the time being. Numbers of private students are negligible compared to public students. Accreditation process does not

differentiate between traditional system of education and modern strategies like problem-based learning and community-based education.

5.14 Accreditation of health professions education in Lebanon

Dr Antoine Romanos, Ministry of Public Health, Lebanon

The establishment of a hospital accreditation system in Lebanon paved the way for the provision of good quality of health care. As the accreditation system matures the standards will further develop, and quality assurance and quality improvement will lead on to the more precise measurement of health outcomes. It is vital that the concepts of quality assurance and quality improvement be seen as critical and not as an adjunct to hospital services, and quality and accommodation standards are not viewed in isolation. The development of quality hospital services is linked quite clearly to quality generally, whether it is in the building/infrastructure component, the refurbishing component, equipment or the patient care services. Quality assurance principles and hospital accreditation address quality of care deficiencies and harmful and/or wasteful practices, and can stimulate debate between public and private providers, policy-makers and consumers on what practices conform to the latest reliable evidence. This promotes a wider dissemination of knowledge. Increased knowledge and awareness by the public ensures that hospitals achieve greater throughputs because of the public's faith that the hospital is able to meet the wide range of quality standards. The image of what constitutes a good hospital is generally supported by the current hospital classification system, and it is this image that is required to be changed through the implementation of quality assurance/improvement to support the marketing of Lebanon's hospital services to other countries. A public education campaign is therefore a concomitant exercise to be carried out in parallel with the development of the quality approach.

The accreditation of hospitals in Lebanon was the first step of this concept and was defined in the law of hospitals in 1983. The quality of hospital care in Lebanon has witnessed a paradigm shift since May 2000, from a traditional focus on physical structure and equipment to a broader multidimensional approach, emphasizing managerial processes, performance and output indicators. In the absence of an effective consumer voice, the impetus for change has come from the Ministry of Public Health, which has supported the development of an accreditation programme for hospitals. The accreditation process seems to be as vital for health sector as it is for the education system.

External quality assessments show evidence of improved services quality. In several cases, accreditation processes have also had a positive effect on the use of health facilities. In addition, accreditation processes have proven to increase organizational efficiency by reducing waste and making better use of staff time and have helped to streamline management and regularize supervision, allowing for more timely and accurate identification of performance gaps. As early as 1969, the World Health Assembly (WHA) endorsed a resolution requesting the WHO secretariat to work with partners to define and formulate standards for the education and production of physicians. International standards take account of the variations among countries in medical education due to differences in teaching,

tradition, culture, socioeconomic conditions, health and disease spectrum and different forms of health care delivery systems. Such differences can also occur within each single country.

A proposed law reforming the higher education system in Lebanon specifies and focuses on assessment and accreditation for higher education institutes and their programmes (curriculum), evaluation of the performance and compliance (administrative and academic) with international standards, ensuring student rights and continuous improvement and quality of the whole academic process. Accreditation is mandatory for universities and higher institutes (institutional and programme assessment), comprising self-audit and external audit, certification for both institutional and programme assessment and funding by the budget of the institution itself.

5.15 GCC countries as subregional experience: medical college self-study

Drs Hossam Hamdy and Nabil Sulaiman, University of Sharjah

The Gulf Cooperation Council (GCC) Deans of Medicine Committee was founded to coordinate several aspects of medical education in the GCC countries. Accreditation was mandated to the committee and operated until recently when national bodies were gradually established and took over. The committee formulated standards, guides and procedures and actually accredited number of colleges. The Regional Office requested the committee to accredit number of private colleges in GCC countries which was accomplished.

The essence of accreditation is to find answers to the following three questions about educational outcomes, process used to achieve outcomes and evidence of performance against standards.

- Has the programme clearly established its mission, goals and institutional learning objectives (outcomes)?
- Are the curriculum and resources organized to meet its mission, goals and objectives (process)?
- What is the evidence that the programme is currently achieving its mission, goals and objectives and is it likely to continue and meet them in the future (evidence)?

The mission, goals, graduate profile and institutional learning objectives should differentiate the institution and describe how they were developed and who participated in developing them. The different stakeholders involved in generating the mission statement and programme outcomes should be described. Ideally graduate outcomes should be developed in consultation with internal and external stakeholders. A curriculum blueprint should be developed.

The process should describe how the education programme was designed to achieve the educational outcomes; the assessment of effectiveness against goals/objectives/outcomes. How are the results of the programme evaluation process used to improve the institutional effectiveness? Input, process, output and outcome models could be used with specific indicators for each category. The Miller pyramid describes different methods used to assess

what graduates “know”, “know-how”, “show” and “do” at different phases of the programme, especially at exit points.

The self-study report should show evidence that the written curriculum matches the curriculum in action. Kirkpatrick’s (1994) and Freeth’s (2003) models of programme evaluation is a useful guide to providing evidence for changes in satisfaction, knowledge, attitude, skills and behaviour as well as the impact of the education programme.

Lastly, the following are key issues identified through accreditation; it is advisable to be aware of them and address them during the preparation of the self-study report.

- Lack of clear statement of outcomes and curriculum objectives.
- Poor linkage between outcomes, curriculum contents, delivery and assessment.
- Inadequate programme evaluations, feedback and curriculum renewal.
- Inadequate educational resources.
- Lack of expertise in curriculum development, student assessment and programme evaluations

5.16 Regional experience: accreditation of training hospitals by Arab Board of medical specialization for purpose of postgraduate clinical studies

Dr Mohammed Hisham Al Sebai, Arab Board of Medical Specialization, Syrian Arab Republic

The Arab Board of Medical Specialization Board was founded in 1978 by a resolution taken by the Council of Arab Ministers of Health, and its basic constitution and regulations were endorsed during the first meeting of its supreme Council in January 1979. The Board aims at preparing specialist doctors with high professional and scientific competences according to global standards and to work towards improving health care services in the Arab world through developing and improving the level of competence of working doctors in different specialities and in coordination with relevant educational institutes. The Board is also responsible in setting standards of recognized training for developing specialists in different medical disciplines. It also, defined the basics of assessing professional, scientific and technical levels of the doctors who are going to practise these specialities after finishing their Board training period in accordance with global standards through effective and efficient integrated and coordinated training with national boards of medical specialities in different countries.

The Board is composed of different scientific councils and committees for all medical specialities. These bodies put the details of required training and endorse assessment approaches. They use a database of trainers that includes their qualification and abilities to dedicate efforts to training and their record of continuing professional development in coordination with another database for training centres in the Arab world, which includes bed capacity and training and resource opportunities of different departments. The bodies also endorse procedures for award of certificates and continuing professional development programme for graduates.

The accreditation of hospitals for board training in each speciality is based on a number of standards including that a hospital needs show the following characteristics:

- a general hospital with at least four main specialities, i.e. internal medicine, general surgery, paediatrics and gynaecology and obstetrics
- bed capacity needs to be at least 200
- other subspecialities must be taken into consideration
- availability of well developed departments of laboratory (with branches of clinical biochemistry, haematology, immunology, bacteriology, blood bank, morbid anatomy) and radiology
- system of statistics and record-keeping, a library (with updated references and periodicals) and appropriate lecture halls.
- a functioning intensive care unit
- at least two equivalent full-time specialists for every 30-bed unit; of these two need to be qualified equivalent to university faculty with previous experience in education and research
- a well qualified nursing and management staff
- functioning scientific seminars (three a week in every department) and cover clinical meeting, journal club, clinical grand rounds, laboratory seminars, specialities lectures, and daily rounds
- number of trainees should not exceed four for every ten beds throughout the whole period of training; i.e. enrolling one trainee per ten beds per year.

Teaching hospitals are accredited for training after a strict assessment procedure following application, which is submitted for a committee study which may then form a local (national) taskforce to visit the hospital to ensure that detailed information is submitted. Upon recommendation of the local team, a further visit by members of bodies of the Board is organized to prepare a report that will be submitted to the Board to decide on level of accreditation and gaps to fill (if any). Usually centres are accredited for six years after which the Board will conduct a new assessment for extension of the period. The accredited centre need to submit application after the six-year period otherwise the accreditation will be automatically cancelled.

5.17 Accreditation of nursing education: reflecting on the Jordanian experience

Dr Muntaha Gharaybeh, Higher Education Accreditation Commission, Jordan

Nursing education in Jordan has been university-based since the 1970s after a long period of hospital-based education, and accreditation of nursing education programmes started in the 1990s. Regulation of the nursing profession in Jordan presents a model for the nursing professions in the Region where accreditation is part of a large regulatory system. The profession is regulated by the Jordanian Nursing Council (JNC) while the nursing education is regulated by the Ministry of Higher Education (MOHE) and the Higher Education Accreditation Commission (HEAC). The three institutions work in strong collaboration with each other and are represented in each other's councils and committees. MOHE and the accreditation commission are responsible for academic standards,

accreditation and quality assurance while professional bodies like JNC are responsible for professional regulation issues like certification and registration.

Currently, accreditation of nursing education programmes is mandatory for all government and private programmes. The accreditation standards were developed by experts in nursing education, nurse practitioners, JNC and in guidance with HEAC. Currently, there are 15 nursing programmes which are all accredited by HEAC and are looking forward to achieve the quality assurance standards recently established by HEAC.

The current accreditation standards follow the same guidelines set by HEAC for all programmes. These standards set the minimum requirements for the bachelors degree in nursing which are as follows:

- a minimum of 132 credit hours in four years
- must cover the main domains of nursing education (adult health nursing [medical/surgical], maternal and child health nursing, mental health nursing, community health nursing) in addition to ethics, communication and professional conduct in addition to core courses (basic and medical sciences)
- the minimum requirements for training in each course per semester are to be 168 contact hours
- 50% of training should be in teaching/referral hospitals (criteria for teaching and training hospitals were developed by JNC)
- 20% of student training is done using simulation
- the standards acknowledge the use of expert practitioners from clinical settings in the clinical teaching process.

The process of accreditation is set by HEAC according to the existing standards and starts with the self-assessment report, external review panel and a final decision by the HEAC board. HEAC formulates a review committee of external evaluators that consists of three members who are always nurses from other institutions who have no conflict of interest with the institution under accreditation. The expert evaluation committee visits the institutions and measures achievements against the existing criteria, validates what is in the self-assessment report and forwards a recommendation to HEAC for a decision by the board.

After accreditation of all nursing programme, it was decided by HEAC, nursing experts, and JNC to raise the bar on the quality of nursing education by moving into quality indicators since the current standards reflect the minimum safe level of academic requirements. It does not include criteria for achieving the required programme competencies with criteria on the teaching learning processes. The new accreditation standards and quality assurance standards for nursing education programmes were developed by a selected group of experts representing all nursing sectors including JNC and JNMC under the direction of the HEAC.

The accreditation standards and quality assurance standards for nursing education programmes are based on the global standards for the initial education of professional nurses

and midwives developed by WHO in 2009. The 10 standards are qualitative in nature to allow for innovation and excellence. They cover 28 domains and measurement criteria including vision, mission, philosophy, governance and administration, curriculum, curriculum development and revision, the students, the faculty members, resources, partnership with the community, continuous quality improvement, programme effectiveness, research and development.

The challenges facing the accreditation systems are the shortage of faculty members to meet the standards of student–faculty ratio, the shortage of well trained external reviewers/evaluators in addition to financial constraints to recruiting international evaluators. In addition, there is the belief of the value added of accreditation by academic institution in both private and government institutions.

The lessons learned from Jordan’s experience of accreditation can be summarized as follows.

- Regardless of what educational model you have, accreditation is a very important beginning to maintain good outcomes of nursing education. Therefore, countries in the region need to start accreditation.
- WHO standards and guidelines for nursing education are direct and provide bases for a good accreditation system.
- Collaboration with health and academic institutions is essential in setting up a strong national accreditation system.
- Nurses have the capabilities and potentials to develop and implement a good accreditation system in collaboration with all institutions.

5.18 Dentistry accreditation: experience of the Faculty of Dentistry in Morocco

Dr A. El Ouazzani, Mohammed V University, Morocco

The Faculty of Dentistry at Mohamed V University, Casablanca, Morocco, has 620 students and 52 teachers. It has graduated 1874 students and 62 specialists. The vision and objectives include: developing pedagogical programmes and teaching methods based primarily on self-learning and self-evaluation; bridging the gap between the needs of competencies of Moroccan society and profiles of majors of the institution; and improving the quality of all activities of the institution. Its mission is to: organize training programmes, research and service delivery in line with population needs and strengthen the ethical approach (in the fields of public health, clinical and research); ensure its social responsibility by contributing to the quality, equity, relevance and effectiveness of services of oral health. It encourages an open environment by providing in-service training programmes and working with other health professionals. The accreditation process was supported by WHO and the strategy adopted was based on self-evaluation through: constitution of the self-evaluation local committee, constitution of data banks, SWOT analysis, action plan and corrective measures

The accreditation committee is composed of project chair, coordinators, steering committee members, and group of self-evaluation: 9 teams (1 coordinator, 2 teachers, 2 students (from the third and second cycles), 1 administrative, team of the treatment and data analysis and editorial and communication team. Components of self-evaluation through WHO support covered:

- International standards for accreditation of basic medical studies
- Developed by the WFME in 2000 and revised in 2003
- Adapted to local requirements
- Nine major areas and 36 standards (WFME).

Self-evaluation stage following the WHO accreditation guide covered drafting of self-evaluation questionnaires, distribution of questionnaires to students, teachers and administrative staff, identification and consultation of all paperwork related to the standards, establishment focus groups to check some results of questionnaires. This was followed by self-evaluation covering: data analysis covering 66% of students, 76% of teachers and 67% of administrative staff. SWOT analysis was also undertaken, Results showed that for the educational programme:

- Curriculum structure well defined and documented
- Curriculum management by the Committee of Academic Affairs
- Semester organization of teaching
- Integration of basic medical sciences in the curriculum
- Offering training in the internship and residency.

Weaknesses in curriculum showed redundancy of some courses, deficiency of education on the management of dental surgeries, deficiency of education on communication with the patient, deficiency of education on modern languages (English, French). The opportunities included: reform of dental education, plan for pedagogy training for teachers, internship project of solidarity medicine, agreement with foreign dental schools (student exchange, etc.) and threats: slow implementation of the reform.

A team of national and international experts (including WHO and WFME) visited the college in November 2008 for the purpose of bringing an outside perspective on the reality of training and research in the Faculty of Dentistry and the experiences of students, teachers and university and hospital staff.

Corrective measures taken by the follow-up committee on accreditation included the following measures: introduction of teaching methods allowing students to participate in their own training, introducing students to the population's needs of oral health through the establishment of an internship of community medicine, implementation of a management module in the fifth year, implementation of a language and communication module in the first year and strengthening the competence of teachers.

In conclusion, accreditation created evaluation culture and resulted in improving all the services of the institution.

5.19 Accreditation of pharmacy schools: a global and regional perspective

Dr Mohamed Bin Shahna, WHO Regional Office for the Eastern Mediterranean

The Accreditation Council for Pharmacy Education (ACPE) is the only agency that has formally established an international operation. ACPE's international division is called the International Services Programme (ISP) and is not yet fully operational but international quality criteria to evaluate the professional degree programmes in pharmacy are under development and they will be adopted in June 2012. ISP will not be offering "accreditation," as we will restrict that term to the accreditation of PharmD programmes using ACPE's PharmD standards (the same standards that are applied in the United States). Instead, ACPE ISP will be offering "ACPE certification" to professional degree programmes that comply with the international quality criteria. These degree programmes could be bachelors, masters, or doctorate programmes. Currently, ACPE has only one non-USA-based PharmD degree programme that is accredited; that programme is at the Lebanese American University in Byblos, Lebanon. The Canadian Council for Accreditation of Pharmacy Programmes (CCAPP) has offered accreditation to programmes in Qatar and Saudi Arabia.

In our Region and according to the presentations of the different national systems for accreditation of higher education have accredited pharmacy programmes in the countries such as Egypt, Islamic Republic of Iran and Palestine. The General Pharmaceutical Council (GPhC) in the United Kingdom (formerly a part of RPSGB) accredits pharmacy programmes in other countries such as five MPharm programmes in Malaysia, but the degrees are awarded by British universities, some of which have collaborative arrangements with institutions/educational providers in Malaysia.

In 2008, at the Forum for Human Resources for Health in Kampala, Uganda, 2008, the global tripartite FIP UNESCO and WHO Pharmacy Education Taskforce and the Education Action Plan 2008–2010 have been launched. The advisory group works on quality assurance of pharmacy education (details will come later). WHO has organized meetings in 1988 and 1993, and there are WHO resolutions on the role of pharmacists. The Regional Office in turn has organized a meeting in Lebanon meeting on pharmacy education and agreed upon a generic curriculum for pharmacy education in 1997.

The Taskforce Action Plan identified four core domains for action in pharmacy education: academic and institutional capacity, vision and competency, quality assurance and pharmacy support workforce. As the practice of pharmacy has become more complex and more accessible and as medical therapies have been used in more and more diverse patients, patient safety and accountability for outcomes of therapy have become a greater focus of attention. Consumers and governments are demanding higher standards and seeking assurances of quality. Likewise, greater attention is being paid to the quantity and quality of pharmacist and pharmaceutical human resources, including the systems in place to assure the quality of education and training and the ongoing competence of practitioners. Consequently,

many countries are introducing, expanding or undertaking major reform of pharmacy education. Such developments must be accompanied by robust systems to assure the quality of the educational structures, processes and outcomes; the latter primarily being graduates who are competent and capable of performing safely and effectively in their practice setting and contributing to the delivery of health care.

To promote and facilitate international dialogue and collaboration in the area of quality assurance of pharmacy education, the International Forum for Quality Assurance of Pharmacy Education was established in 2001. It operates under the auspices of the Academic Section of the International Pharmaceutical Federation (FIP), primarily as an informal network of individuals interested in the quality assurance and quality advancement of pharmacy education. The Forum has identified that countries seeking to establish or improve their quality system would benefit from an internationally developed and adopted quality assurance framework. The quality assurance project team of the Pharmacy Education Taskforce has been convened to continue the development of this “global framework”. The framework incorporates core principles and elements considered essential for an effective approach to quality assurance.

The objectives of the quality assurance project are to:

- validate and further develop the global framework for quality assurance of pharmacy education
- examine accreditation and quality assurance models and systems in country case studies
- provide guidance for quality assurance system development.

In 2009, the global framework underwent a validation exercise and an updated version is under development.

5.20 Preparation for accreditation at Hadhramout University College of Medicine, Yemen

Dr Ali Batarfi, Hadhramout University College of Medicine, Yemen

Preparatory steps for accreditation included training activities for staff, students and administrators, organizing awareness campaigns using media, posters, boards, wall charts, and a website. Activities towards accreditation included: formation of a central accreditation committee headed by the dean; nomination of nine taskforces, the head of each is a member of central accreditation committee based on the nine WFME domains; and establishment of the accreditation unit. The nine taskforces were then trained by the accreditation unit consultant on producing a self-assessment-study document,

The accreditation unit team arranged several meetings with groups of students from each year to enlist volunteers to assist in data collection for the self-assessment study representing balanced years and sex per standards domains. A SWOT analysis exercise was conducted and followed up with related questionnaires among staff. Data were collected, analysed; evidence-based points of strength and weakness, gaps and shortcomings in the college life were identified and corrective measures and possible actions were suggested to

meet standards criteria. The accreditation unit and the nine taskforces held several meetings (focused group discussions) for clarifications on issues pertaining to their reports especially on sources other than the SWOT and self-assessment study results such as reference documents. Coordination with stakeholders included the rector of the university, the national accreditation authority and members of the higher council of education.

Through a productive workshop, corrective measures were identified and actions and measures were immediately initiated and implemented. These covered measures on raising awareness about the mission, vision and objectives of Hadhramout University College of Medicine through posters, boards, charts and a website, a new office for student counselling was established, a new skills laboratory for clerkship students on the west campus was established, internet services were introduced free of charge, 15 small rooms for small group discussion were added to established facilities, electronic library established in west and east campuses, new place for the cafeteria established, major auditorium hall reconstructed and furnished, toilets were repaired and staff appointed to maintain them, marking machine provided to the student assessment committee, data show sets were provided to all lecture rooms and labs in both east and west campuses, and a memorandum of understanding was officially signed between the university and the teaching hospitals where students are trained.

The final draft of the self-assessment study is ready for approval and a site visit requested but the national accreditation body is still not ready to conduct the site visit.

5.21 Faculty of Medicine, Suez Canal University: experience as the first accredited school in Egypt

Dr Somaya Hosny, Faculty of Medicine, Suez Canal University

The Faculty of Medicine, Suez Canal University was established in 1978. Its curriculum responded to community needs; namely the primary health care approach, bio-psychosocial paradigm, explosion of information and principles of learning. The school's strategies are founded on community-based education, problem-based learning, student-centred education and interdisciplinary integration. To sustain the leadership for innovation, FOM/SCU established the centre of medical education in 1986, which was designated as the only WHO collaborating centre in Egypt in the field of medical education for four consecutive rounds; the most recent one from 2010 to 2014. It also established the medical education department in 2001 to offer graduate programmes in medical education.

In 2004, the school submitted a proposal to the Higher Education Enhancement Project (HEEP) for establishment of an internal quality assurance system. Its achievements were: establishing and updating a schools database, conducting self-study (according to WFME global standards) and establishing a management and monitoring system for an ongoing quality assurance. An action plan was prepared based on SWOT analysis. Follow-up visits were done by HEEP and WHO. After the establishment of the National Authority for Quality Assurance and Accreditation of Egypt (NAQAAE) in 2006, the Faculty of Medicine at Suez Canal University was one of the first six institutes to get funding from the Ministry of Higher

Education to prepare for accreditation. The school upgraded its infrastructure and began fulfilling the 16 standards of accreditation, set by NAQAAE.

Three senior faculty members were nominated to lead the process. They assigned 16 ad hoc committees to review the requirements of related standards, documenting the achievements of the school and proposing any required actions to satisfy standards. The 16 committees worked under close supervision of the leading board and university administration.

In March 2010, a team of six reviewers, including one professor from United Kingdom, visited the Faculty of Medicine for four days. They reviewed all the documents, held meetings, made observations and interviewed over 400 faculty members, medical students, graduate students, administrators and community representatives.

In May, 2010, the Faculty of Medicine became the first higher education institute in Egypt to get national accreditation from NAQAAE. This was the outcome of the efforts of the innovative medical education strategies adopted by the Faculty since its establishment.

6. GROUP WORK

Three sessions of group work were conducted through four groups of mixed members of participants. In session A, groups were requested to revise the set of regional standards. Each of the four groups was assigned one or two domains. In session B, each of the four groups was assigned to one or more domains to revise the appropriate part of regional guide and derive tools needed to generate evidence for a self evaluation study. In session C, the four groups were assigned to revise and improve sections of the regional guide describing planning for accreditation at four different levels namely: Group 1: support countries needs, Group 2: national taskforce functions, Group 3: national plan and Group 4: college plan and activities. During each session, participants were assigned randomly to groups, lists of participants and facilitators were announced and displayed. Instructional handouts were distributed on general guides for group dynamics, specific tasks and feedback forms. The facilitators of the four groups were: Drs Walid Abubaker, Charles Boelen, Wagdy Talaat and Samim Aldabbagh.

6.1 Session A: regional standards

A set of regional accreditation standards was formulated and endorsed by a WHO group of experts in 2002, and a draft was updated recently specifically for the purpose of this consultation in order to address recent developments in the field during the past decade. The session aims at sharing participants' experience in order to improve the draft of the regional standards to reflect the need to improve the status in our Region's colleges of health professions education through fulfilling these accreditation standards. The set of regional standards is to address the regional concerns and specificities and to be used in parallel with both national and global sets of standards.

The groups' task was to revise the standards in the domains allocated to each group (two or three in number) and provide bullet notes and suggestions to improve the document. As groups were dealing with certain assigned domains, participants were requested not to discuss or make notes on other domains that other groups were working on as all participants would have a chance to do so during feedback panel session from other groups. In addition to group report, participants were asked to submit individual written notes to facilitators or organizers if any further notes were felt useful. Groups were instructed not to spend time debating causes and circumstances in their own countries or colleges as the main aim was to set the range of standards that all colleges in all countries in the Region looked to in order to achieve through variable short- to long-term planning a continual improvement accreditation process.

Participants were divided into four groups to ensure distributed representation of countries and status of accreditation in each group. The groups were assigned domains to cover in two sessions as follows: group 1: domains 1, 2 and 6; group 2: domains 3 and 7; group 3: domains 4 and 8; group 4: domains 5, 9 and 10.

6.2 Group feedback

Group 1: domains 1, 2 and 6

- The group explained that there is no need for three levels of standards and suggested one highest level standard that encompasses all best description needed for quality improvement.
- In domain 1; to replace title "Vision, mission and objectives" with: "Vision, mission and outcomes".
- In domain 2, to replace title "Governance and management" with "Governance and administration".
- The group worked on each of the assigned standards and proposed one amended best text. These texts would be amalgamated with other groups' input in rewriting the regional standards.

Group 2: domains 3 and 7

- The group suggested adding sub-domains to the already two namely: selection and enrolment to include other three namely: student support and counselling; student representation; student life and proposed texts for these sub-domains would be considered during the rewriting process in accordance with other groups' input and panel discussion consensus and recommendations.
- Proposed amalgamating sub-domains 7.5 (validation) and 7.6 (standardization) in one sub-domain under validation.
- Proposed changing title of sub-domain 7.7 to read: appraisal and feedback instead of appraisal only.

Group 3: domains 4 and 8

- General: The group proposed that the term “substandard” be replaced by “Not acceptable standard” as this will add more clarity to the standard, and as the word substandard is being used to denote subparts of a standard.

Domain 4: Faculty staff and human resources

- In standard 4.1: add written and disseminated at regional level.
- In standard 4.2: definition of term (staff) needs to be clarified as faculty or academic staff. Faculties are full-timers but the part-timers are not considered faculty; it will be clarified in the definition of terminology. Add to ratio: “as specified by the relevant national accreditation authority”.
- In standard 4.3: Add: “with continuous appraisal and regularly updated”.
- In standard 4.4 replace hi-tech hospitals with teaching hospitals and health facilities (affiliated and recognized) and approved centres and the number of part timers to be determined by the national accreditation authority”.
- In standard 4.5 delete opportunistic and not regular to make it a positive statement. Remove comprehensive word; Clear definitions of capacity-building in the glossary. Optional standard for professions that use clinical trainers as well as field trainers. Add a statement to emphasize the use of local staff in the clinical facilities as preceptors for the students, if the teaching strategy so demands.

Domain 8: Educational continuum

- The group agreed on the importance of addressing the postgraduate and continuing education programmes; however, the group had a strong debate regarding including the standards for those programmes within the standards for basic (undergraduate) health education. The postgraduate component of educational continuum is not part of the basic standards of the undergraduate programmes.
- There is a need to have separate standards for postgraduate studies. The regulators in the medical schools do not regulate postgraduate studies.
- It is the responsibility of the government to regulate research-based programmes.
- Regarding the continuing education courses they are not part of the academic programmes within educational institutions.
- The title also needs to be changed to undergraduate continuum.
- The issue of funding for private schools will be a challenge because government will not fund private schools.
- The standards are guiding the accreditation of health and medical schools.
- The standards need to be clear if it covers the BS level health programmes or all levels of educational programmes.
- The Regional Office needs to develop special guidelines for each level of health programmes.

*Group 4: domains 5, 9 and 10***Domain 5: Physical resources: teaching and learning technical facilities**

- Essential standard: facilities are available, accessible and sufficient for the curriculum implementation in regard to teaching and learning and assessment; research activities according to the mission of the college.
- Quality standard: the college contains advanced facilities like audiovisual equipment, interactive and multimedia information and communications technology, skills laboratory, simulation facilities, and specific areas for small group discussion for students.

Domain 5: Physical resources: clinical training facilities

- Essential standard: the college has access to teaching hospital and primary health care centres.
- Quality standard: the college has advanced technology facilities for clinical teaching. Regional and international students exchange. Optimum use of primary health care centres.

Domain 9: Research: the group decided to deal with research as a block

- Essential standard: The college is committed by its vision, mission and objectives to play a role in research related to health needs of the population; research should be interdisciplinary; students should participate in research activities. Research is partially supported from governmental and external agents in addition to use of fiscal budget.
- Quality standard: research is to be published in refereed and indexed journals; Research projects are basically depending on fund raising through grants to specific projects in addition to fiscal budget.

Domain 10: programme evaluation and reform

- Essential standard: the college has a documented system and policies for programme evaluation. The college incorporates results of evaluation to reform programme.
- Quality standard: the programme review system incorporates all stakeholders and complies with national professional standards where available. College is committed to using evaluation, results for decision making and continuous renewal.

6.3 Regional accreditation guide

A draft regional guide for accreditation has been compiled from three sources: a draft on regional activities with a focus on works in Egypt (by Wagdy Talaat and Ghanim Alsheikh, 2006); a draft analysis and description of methods and tools used by the Regional Office to support countries and colleges in accreditation (Ghanim Alsheikh, Fariba Aldarazi, Walid Abubaker, Ali Hassanabadi and Ibrahim Abdel Rahim, 2009) and draft tools for

accreditation (Somaya Hosny). The final draft presented in this consultation has been compiled from these sources and recently endorsed by a WHO group of experts specifically for this consultation in order to address recent development in the field during the past decade. The group work sessions aim at sharing participants' experience to improve the draft of the regional guide to respond to the needs, concerns and specificities and the status in our Region's countries and colleges of health professions education. In addition to notes from participants to improve the draft, the group feedback and notes during panel discussions will be used to produce the final draft which will go to WHO editing and printing for wide circulation inside and outside the Region.

Participants were divided into four groups to ensure distributed representation of countries and status of accreditation in each group. The groups were assigned domains to cover in two sessions as follows: group 1: domains 1, 2 and 6; group 2: domains 3 and 7; group 3: domains 4 and 8; group 4: domains 5, 9 and 10.

- In session B, each of the four groups was assigned to one or more domains of standards to revise the appropriate part of regional guide and derive tools needed to generate evidence for a self-evaluation study.
- In session C, the four groups were assigned to revise and improve sections of the regional guide describing planning for accreditation at four different levels namely:
 - session C1: group 1: support countries needs
 - session C2: group 2: national taskforce functions
 - session C3: group 3: national plan
 - session C4: group 4: college plan and activities.

6.4 Session B: design of tools for evidence generation for self-evaluation

Based on the group experience and deliberations exerted during the previous two sessions of group work on regional standards, the participants were asked in this session to refer to the regional guide describing what questions need to be answered by self-evaluation study to respond to the standards and try to derive tools to generate evidence on the regional standards allocated to each group and providing feedback by filling the provided forms. The samples stated in the guide are designed to measure the WFME global standards so they certainly guide participants to come out with modified feedback/tools that respond to regional standards. Participants were asked to fill all columns shown in the feedback form and need to look for relevant areas in the guide that help to respond specifically to concerned standards. In addition to group report, participants were encouraged to submit individual written notes and suggestions to facilitators or organizers. Also, participants were advised to consider all possibilities and not to confine their feedback to their own college circumstances.

6.5 Group feedback

Group 1: domains 1, 2 and 6

Domain 1: Mission, vision, and objectives: include mission, vision and objectives in all statements. Add to item 7: are the mission, vision and objectives regularly reviewed and updated? Add to item 4 after community needs “expectations”. Sources include: documents, web-sites, strategic plan, college perspectives, study guides, SWOT and other analytical methods.

Domain 2: Governance: remove statements 10–12 and add to item 1: terms of reference of committees and management staff. Sources include: organizational structure and specific functions, terms of reference of committees, rules and regulations of the college, policies and procedures, ethical code document, minutes of meetings, document follow-up on resolutions, budget, financial plan, strategic plan, decision-making process, memorandum of understanding, agreements, methods of communication with students and faculty, fund raising documentation, funds that do not cause conflict of interest.

Domain 6: Educational programmes: Sources include: curriculum, curriculum and assessment committee members and minutes of meetings, course syllabi, students, faculty members, employers, health service providers, clinical supervisors and clients.

Group 2: Domains 3 and 7

Domain 3: Students: general principles followed by the group included reading the list supplied under the domain on students and proposed two areas to add to the namely student mistreatment policy and student code of conduct. The group proposed different rewriting of the content used classified and organized according to categories. Students admission criteria covered: policy document, periodical criteria review, matching of numbers with facilities and resources and evaluation of numbers involved. Academic support and counselling covered: Career and residency counselling, Information and dissemination and Academic Advising and remedial activities. Student life covered: representation in various committees, financial assistance, health services and extracurricular activities.

Domain 7: Assessment to cover balance between formative and summative evaluation; Confidentiality of exams is maintained (inspection of records and reports and no report of breaking confidentiality).

Group 3: Domains 4 and 8

General notes:

- There was a concern about the statement of addressing the tools in the form of open-ended questions.
- Suggestion to add “providing evidence for each concern statement”.

- Make sure the policies are communicated to staff clearly.
- Choose some of the concerns that need evidence and state them in a way that can be identified as indicators.
- Essential standard need a document as evidence

4.1 Selection: essential standard: provide a document of employment policy; improvement standard; improvement standard is to have transparent well-advertised announcements.

4.2 Staff/student ration: essential standard: look for student-to-teacher ratio in the school policy documents. Each health profession needs to provide the programme policies for student to teacher ratio. Taking into consideration differences in the teaching setting (class, laboratory, clinical site) and the phase of study. improvement standard. How this is linked to the mission of the school and how it is related to labour market, admission and the available resources?

4.3 Job description: essential standard: look for evidence related to job description; improvement standard: look for evidence related to staff performance assessment and portfolios

4.4 Employment: essential standard: look for policy of appointment of part-time staff; improvement standard: determine the ratio of part-time to full-time staff and link it to mission of the school and the teaching methodologies used.

4.5 Capacity-building: essential standard: evidence related to school policy on professional competencies necessary for each faculty member; improvement standard: look for continuing professional development activities for each staff member and how the continuing professional development is linked to promotion.

4.6 Field trainers: essential standard: look for evidence related to the school trainers and their qualifications; improvement standard: look for evidence related to the systematic and legal arrangement for staff and field trainers.

Group 4: Domains 5, 9 and 10

General notes:

- Research and reform to be included
- No tools for research
- Rephrase questions to statement
- Design multi-purpose questionnaires taking into consideration domains and target groups

Educational facilities concerns include:

- Student exchange
- Age, size, appearance, etc.
- Library's databases
- Intranet access
- Number of inpatients, outpatients attending in the last year
- Specific tools should be provided to schools as well as to reviewers.
- Verification of budget and financial documents
- Questionnaire to staff and students
- Current system in the last three years
- General facilities
- Available spaces
- Student satisfaction with staff
- Verification of plan
- Verification of available facilities
- Verification of adequacy and questionnaire for students and staff
- Verification of library and contents and service plus questionnaire for staff and students
- Technologies+ questionnaires

Programme evaluation concerns include:

- Social and cultural background
- Feedback mechanism is essential
- Change questions to statement
- Was graduate performance pattern evaluation done
- Repeated with 5
- Verification of efforts, activities, SWOT analysis
- Verification of available facilities
- Verification of questionnaire/reviews for students and staff related to programme
- Verification of staff, students, graduate, administration, feedback.

6.6 Session C: preparation for accreditation

Planning for accreditation

Notes on plans shown in the regional guide:

- Suggested: the step of establishment of the national accreditation body comes first.
- The sequence of steps is not according to priorities; each country uses the steps according to its own set-up.
- The steps on page 18 should be bulleted and not numbered.
- Sustaining the national system can be done through legalization.
- Change in point 4 "regional landmarks" to "regional and national standards".

Preparation by national task force

The group debated the sequence of the 10 steps to initiate accreditation in a country, noting that there are differences between countries in regard to stage of development of accreditation. The proposed steps can be applied in a country starting to introduce accreditation for first time. Therefore, different countries can pick up the step that is appropriate to its status of accreditation development.

National plan

- Workshop to communicate the results at the end of item 1.
- Prepare forms and tools for site visits including self-study in item 2.
- Select a qualified and certified reviewers in item 3.
- Draft the report and communicate it to the dean to facilitate communication and feedback in item 8.
- Include publicize the results in item 10.
- Add item 11 to include follow-up at the end of the plan.

Accreditation site visit team composition:

- There was a concern about the number of the team: at least three to five members
- The importance of ensuring that there is no conflict of interest
- Activities to include meeting the university president and some of the administrative staff.

College plan and activities

The order for the stages of the process for accreditation will be left to countries according to their national guidelines. Stages can be performed in parallel.

7. REGIONAL COORDINATION: PARTNER PROPOSALS, RESPONSIBILITY AND ACCOUNTABILITY AND META-ACCREDITATION MECHANISM

This panel/seminar session was devoted to input on how partners can work together in the Eastern Mediterranean Region to support countries to achieve accreditation of the health professions education colleges. A number of regional and global partners and stakeholders contributed to the session which was chaired by Mohamed Ambarek, Libyan International Medical University, Benghazi.

7.1 Scientific Society of Arab Medical Colleges

Dr Azmi Mahafzah

Accreditation so far is dealt with at national level without regional coordination. Such coordination is a necessity as countries are unable to coordinate with others for capacity building in accreditation for example. This meeting represents an excellent opportunity to

plan for coordination between health professions education. One of the themes of the AMEEMR is accreditation. However, the issue of having a regional accreditation body has not been discussed and not raised before. In addition, the issue has not been taken seriously at WHO.

7.2 WFME

Dr Leif Christensen

The regional accreditation of medical education is nonexistent and national systems are the operating mechanism across the world. However, in some of the regions of the world there are sub-regional accreditation bodies, operating for example in the United States and Canada, Australia and New Zealand, Caribbean countries and in Eastern Europe. These mechanisms are created by governments organizing joint accreditation bodies with joint responsibilities. All sub-regional bodies are different in structure and procedures. But have similarities in covering countries of similar socioeconomic background with usually some of the countries are small and contain limited number of colleges. In the WHO South East Asian Region, small countries could not accomplish accreditation alone and hence they mandated the Association of Medical Education in South-east Asia to take care of accreditation in these countries. If governments cannot agree between them, then they can mandate bodies to do so on their behalf.

7.3 AMEEMR

Dr Ibrahim Al Alwan

The regional standards will be benchmarks towards achieving accreditation in the Region. It seems necessary at this stage to document the different experiences on accreditation in the Region. As it is known, WFME is not an accrediting body by itself and accordingly same can be understood on its regional chapters like AMEEMR. However, regional coordination is done by AMEEMR in co-accrediting and selecting of assessors for example. It is necessary that some mechanism needs to be operating to ensure that national systems abide to standards and accordingly are recognized. Bilateral recognition of systems needs to be encouraged.

7.4 WHO

WHO is not an accrediting body. Any regional mechanism needs to start with structure and then function. Is that going to be a bottom-top process or not? There is a need to build regional mechanisms bottom-top and not the other way. Building structures which are not functioning is not needed. National systems need to be encouraged, different incentives to be created to allow smooth work. National bodies can come together gradually once such bodies are legally mandated to accomplish the accreditation goals independently. If AMEEMR is looked at to coordinate between national bodies then this process needs to be from the bottom up, and not through a top-bottom floating body.

7.5 Nursing Council

Dr Sawsan Almajali

The council made in 1995 a landmark for the profession in establishing regional standards for accreditation and trying to bring to minimum of nursing profession education to be at least 4 years. Standards were completely adopted in many countries like GCC with high mobility of human resources for health.

7.6 GCC Committee of Deans of Medicine

Dr Mohammed Y. Baniyas

There is need for national mandate if any regional or sub-regional body is to accredit on behalf of the national government. The GCC Committee initiated accreditation in the 6 GCC countries, agreed and produced set of standards and guidelines. However, national bodies were also created and took over.

7.7 Discussion

The following points and concerns were raised.

- It is worth mentioning that a resolution was endorsed by ministers of health of the Region in 2003 (EM/RC50/Tech.Disc.1) which requested the Regional Director to establish a regional mechanism of accreditation. Such a mechanism would mainly achieve three goals: first, providing support (including capacity-building) to establish and sustain autonomous, impartial national systems that can have an impact on population health; second, ensuring that national systems are on the right track and use minimum standards and third, coordinating between national systems.
- There is a need to focus on regional standards. Involve partners like keen and professional associations through revision of standards. Insist on national aspect to accredit the national system.
- It is dangerous creating over-accreditation.
- National systems need to work to improve health.
- There is a need to support national systems to get legal mandate.
- National systems to accredit practice and an outside body still needed to recognize that.
- It is noticed that some terms overlap.
- The International Pharmaceutical Federation is working on developing standards for pharmacy education.
- Reflecting on last four days' work, need to congratulate countries. The Regional Office needs to work on advocacy through ministries of health to support national bodies and development of accreditation activities jointly by ministries of health and that of higher education.
- Meeting need to focus on national accreditation as standards are accepted at that level; a regional body is not favoured.
- Internal recognition: the idea is accountability to people.

- It is worth observing the global scene in accreditation; there are no international standards. A regional mechanism is not to be on top of national systems but to support them. One example is the case of small countries where there is conflict of interest where you cannot have a national system. There is a lot to be done at national systems level and the regional body is to help them.

8. PARALLEL CAPACITY-BUILDING WORKSHOPS

During the last day of the meeting, three parallel capacity-building workshops were organized. The subjects were selection and training of assessors (facilitated by Leif Christensen), institutional accreditation (Ibrahim Al Alwan, Somaya Hosny and Mohi Eldin Magzoub) and clinical presentation curriculum (Ali Batarfi, and Ali Haeri).

8.1 Selection and training of assessors

The workshop objectives were to obtain a shared understanding of the importance of selection and training of assessors and jointly identify and specify avenues for national and regional action. It is necessary to clarify: role/tasks of assessors in accreditation and working conditions of assessors in accreditation. The role of assessors includes: preparing for the job (reading background information on conditions, actual rules and regulations regarding the educational and health care system, about medical education and accreditation in the country); reading and assessing the self-evaluation/self-study report; participate in planning the site visit; participate in the site visit; participate in writing the report. Working as an assessor covers the following: characteristics of the working conditions of assessors in accreditation; working in a team; both common and specific assignments for the individual assessor during site visit and writing the report. The size of the review or site visit team should be at least three members, with at least one from the basic biomedical sciences and one from the clinical disciplines. At least one should be from the Region and preferably there should be at least one international expert (WHO/WFME guidelines for accreditation, 2005).

Required general qualifications are primarily recognized high academic/professional standing and good communication skills. Required specific qualifications include some knowledge on the country, its educational and health care system and rules and regulations regarding medical education.

8.2 Institutional accreditation

The objectives of the workshop were to enable participants to: recognize the experiences of some selected medical schools in accreditation; identify the practical and real challenges that face the process of accreditation in their own institutions; suggest some practical solutions that can help solve some of the identified challenges and identify the expected impact of accreditation on the institution. The topics covered: accreditation process, challenges, impact and country experiences. The format of the workshop covered: small group tasks, small group discussions, large group discussions and presentations. Input of the groups: challenges facing the accreditation in different institutes covered: lack of experience

about accreditation process, lack of awareness about the importance of accreditation, resistance of the faculty members, lack of funding, work load, lack of documentation, no mandating in some countries and fear of failure. Suggested solutions for the challenges faced included: exchange of experience with other experienced institutions and countries, training workshops, dissemination of information among different institutes using different channels, raising funds—sharing in projects—seeking government funds, assigning task groups for the accreditation process and allocating time and incentives for those who work in this mission, assigning groups to collect documents, conduction research projects in accreditation and communication with the ministry of higher education or other responsible authorities to establish accrediting bodies in the countries not having them yet. The impact of the accreditation on the institutions covered: public recognition, more community confidence, more demands on graduates, encouraging cooperation with other agencies, continuous self-assessment, enhancing quality assurance culture and social accountability, improving the documentation process, improving the resources and attracting more students.

8.3 Clinical presentation curriculum

The aim of the workshop was matching the teaching and learning with clinical practice and reason beyond its conduct. The participants were asked to respond to list steps they follow during clinical practice to reach diagnosis. All agreed that the chief complaint of the patient is starting point in taking the history and doing the physical examination followed by the investigations. So that means the presentation of the patient to the doctor in the practice is key issue in solving the problem of the patient. The clinical presentation curriculum (CPC) is being implemented in the undergraduate phase in Hadhramout University College of Medicine. In the Islamic Republic of Iran, this approach is being implemented in the postgraduate phase. Both emphasize the schemata induction and forward thinking as a road map for the student to reach to a diagnosis. Participants were asked to describe as teachers, how they structure a lecture on peptic ulcer? The participants structured their lecture usually on theoretical and practical subtitles. After discussion, they agreed that giving the lecture in the form of CPC is more relevant to what happens in real clinical practice. The workshop was designed to introduce CPC as the newly evolved version of medical curriculum which looks into the mental design and schema of the learner in medicine and how to turn the medical teaching/learning issue as a clinical presentation being a real encounter with the patient rather than having the process as a disease centred programme. Yet it is advised that medical schools should practice organ/system based curriculum in which they experiment the vertical and horizontal integration of the medical sciences and clinical approaches before they introduce CPC since the clinical presentation curriculum requires a lot of work and experience to develop.

9. CONCLUSIONS

Dr Manuel Dayrit, WHO headquarters, wrapped up the consultation, emphasizing that it had been a breakthrough meeting. The wrap-up covered four areas: synthesis of discussions on the importance and imperatives of accreditation; a summary of the “burning issues”;

where are we now in the work of organizing and implementing accreditation systems in countries, regionally and globally; and final observations and take-home messages.

Regarding the importance and imperatives of accreditation: does accreditation contribute to the overall efforts to produce the type of graduates for the 21st century, i.e. to respond to the needs of populations? It was pointed out that poor quality worsens scarcity, and accreditation is a convenient way to assure quality. Accreditation is one approach to assessing whether a health professional school strives towards social accountability. Accreditation of health professional schools is only a part of the bigger process to ensure that the health professional is ethical, competent and does what the health system has trained him/her to do. Dr Dayrit then asked whether accreditation is an effective tool to ensure the quantity, quality, relevance of health professionals. There is no direct evidence in the literature but obviously a lot of work is being done in the Region on this.

What are the burning issues?

- National accreditation systems have primacy in accreditation. Accreditation must be mandatory. These national bodies must have a legal mandate. (Consensus)
 - How well do national accreditation systems function in respective countries? Countries are in different stages in this respect.
 - How are the concepts of social accountability to be operationalized in the accreditation processes? (See recommendations)
 - Are minimum standards a right way to go? (No consensus)
 - How do we build capacity in countries?
- The role of global and regional bodies was discussed.
 - WHO's role is to provide a platform so countries can come together; it can help build capacity
 - WFME: recommendations are simply a template which can be adopted by countries and other stakeholders
 - Roles of AMEEMR and other regional bodies are established to help but their role is still unclear
- The role of national accreditation in a globalizing world.
 - Do students who work overseas need accreditation from an international body?
 - Does the global community accreditors of accrediting bodies? In the absence of international agreements, where would the "accreditors of accreditors" derive its legal and political mandate.

In terms of where we are now in work on accreditation, countries are of three categories: those countries with mature accreditation systems, countries with recently established accreditation systems (8–10 years) and countries with systems in infancy. Globally, WFME standards are being used; regionally, revising the regional standards and the guide for implementation (see recommendations).

Final observations and take home messages:

- National accreditation systems have primacy. These are mandatory.
- Accreditation systems and processes have technical, political, legal processes.
- Strengthening capacity or national accrediting bodies is an ongoing process. Regional and global entities must have clear roles in order to effectively assist.
- We should provide evidence that accreditation improve the quantity, quality, relevance of health professions education. We must include all health professions in this process.

10. RECOMMENDATIONS

The recommendations were formulated by a committee formed of representatives from the participants and included Zein A-Karrar (coordinator), Muntaha Gharaibeh (reporter) Ali Haeri, Somaya Hosni, Mohamed Saad Ambark and Hamood Bin Mohamed. The team presented its set of recommendation; participants discussed and proposed suggestions to improve. A revised and updated set of recommendations included following.

To WHO

1. Strategize and plan the future of accreditation of health professions education accreditation.
2. Produce a blueprint on the future of accreditation by 2020 in the form of a “Tunis call for action”.
3. Finalize the regional standards and guidelines on accreditation for health professions education within the perspectives of social accountability and professionalism and within a time-frame.
4. Provide advisory and technical support, training and capacity building on accreditation (i.e. preparing of assessors and institutions).
5. Develop regional database on accreditation and establish inventory of resource people on accreditation
2. Update the experiences at levels of national bodies and regional and global development.
3. Sustain and improve partnerships with WFME, AMEEMR, Association of Arab Schools of Medicine, professional societies and other institutions/organizations.
4. Assist research on accreditation and include it in the priority list for WHO support, to provide evidence to the impact of accreditation on quality of graduates and services.
5. Support establishing a network in Eastern Mediterranean Region on accreditation to facilitate exchange of experiences, collaboration and access to best practices.

Annex 1**PROGRAMME****Day 1. Tuesday, 22 November 2011**

8:30–9:00 Registration

Session 1: Welcome and opening remarks

9:00–10:30	<p>Message from Dr Hussein A Gezairy, Regional Director for the Eastern Mediterranean Region</p> <p>Statement by Professor Azmi Mahafza, Chairman, Scientific Society of Arab Deans of Medical Schools of The Arab Universities union.</p> <p>Statement by Dr Leif Christensen, Representing the President of the World Federation of Medical Education (WFME)</p> <p>Statement by Dr Ibrahim Alwan, President of WFME Chapter in the Region (Association for Medical Education in Eastern Mediterranean Region)</p> <p>Welcome remarks and official opening by H.E. the Minister of Public Health, Tunisia</p>	I. Abdel Rahim
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Session 2: Accreditation overview

10:30–12:30 (Chair: M. Ben Ammar)	<p>Introduction: Meeting theme, objectives and expected outputs</p> <p>WHO Global initiative on transformative scale-up of health professional education.(15 min)</p> <p>Regional health workforce challenges and accreditation</p> <p>Global Overview: WFME global standards on basic medical education (15 min)</p> <p>AMEEMR: Future strategies and plans for the Region's medical and health professions education (15 min)</p> <p>Discussion</p>	<p>W. Abubaker</p> <p>M. Dayrit</p> <p>I. Abdel Rahim</p> <p>L. Christensen</p> <p>M. Magzoub</p>
13:30–15:00 (Chair: C. Boelen)	<p>UK experience on accreditation, lessons and best practices</p> <p>Australian system of accreditation (15 min)</p> <p>Regional overview: status and support to countries (15 min).</p> <p>Discussion</p>	<p>S. Rawaf</p> <p>N. Sulaiman</p> <p>G. Alsheikh/W. Abubaker</p>

Session 3: Country experiences in establishing, implementing and sustaining accreditation

15:30–17:00 (Chair: E. Mahgoub)	Panel: Country experiences with established and operational national accreditation systems and with already accredited schools Sudan (15 min) Egypt (15 min) Jordan (15 min) Discussion Pakistan (15 min) GCC (15 min) Iran (15 min) Discussion	Z. Karrar M. Kassem M. Dababneh N. Akbar N. Sulaiman A. Haeri
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Day 2. Wednesday, 23 November 2011*Session 4: Introductory remarks on social accountability of medical schools (20 min)*

8:30–9:30	Panel discussion: making medical schools socially accountable – a regional perspective	Panelists: C. Boelen, M. Ben Ammar, E. Mahgoub, B. Hamad
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Session 5: Regional accreditation standards

0930–1730	Regional standards for health professions education accreditation: introduction and group work	G. Alsheikh and W. Talaat
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Day3. Thursday, 24 November 2011*Session 6: Institutional country experience*

08:00–10:30 (Chair: S. Rawaf)	Steps at national level: Iraq (15 min) Steps at institutional level: Yemen: (15 min) Application in Pharmacy United Arab Emirates (15 min) Application in Nursing: Jordan (15 min) Application in Dentistry: Morocco (15 min) Discussion	T. Al Hilfi A. Batarfi O. Atef M. Garaibeh A. Elouazzani
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Session 7: Regional accreditation guide

11:00–11:15	Regional guide and group work task to revise parts of the guide and provide improvement notes	G. Alsheikh
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11:15–12:30	<p>Session 1: Revision of planning to establish systems Task: use the guide samples to develop your appropriate plans</p> <p>Session 2: Revision of design of tools to measure standards Task: Use the guiding samples to design appropriate tools for your college</p>	Group work
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Day 4. Friday, 25 November 2011

Session 8: Regional coordination and capacity-building workshops

08:30–09:30	<p>Regional partners' joint proposal Accreditation responsibility and accountability and proposed regional meta-accreditation mechanism</p>	WHO/WFME/AME ERM/Assoc. Deans of Med Sch/Nursing (TBC)
09:30–12:00	<p>Parallel capacity building workshops Workshop A: Selection and training of assessors Workshop B: Institutional accreditation Workshop C: Clinical presentation curriculum (CPC)</p>	WFME AMEEMR (I. Al Alwan, S. Hosny, M. Magzoub HUCOM
12:00–12:30	<p>The way forward and recommendations Close</p>	Chair: M Dayrit

Annex 2

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