Indonesian Accreditation Agency for Higher Education in Health (IAAHEH)

HANDBOOK FOR ASSESSORS

UNDERGRADUATE MEDICAL EDUCATION PROGRAM ACCREDITATION

FOREWORD

Thanks to God who has given the strength, so the writers finished writing a handbook for Assessor entitled: “Undergraduate Medical Education Program Accreditation - Handbook for Assessors”. The main reason for writing this handbook is to support the evaluator team in perceiving the real condition of medical programs that are willing to be accredited by Indonesian Accreditation Agency for Higher Education in Health (IAAHEH) located in Jakarta, Indonesia.

The handbook was arranged to be simple and easy to read, so every assessor who reviews a medical school will have the same perception as his/her colleague assessors in understanding and interpreting the education condition for each criterion and to what extent he/she perceives the level of compliance of medical school to each standard/criterion. It is believed that the handbook is not perfect yet, but at least it will provide the evaluator team with stronger self-confidence in describing his/her expert judgment. The same perception of the evaluator team will create the accreditation process to be more objective and accurate on how to treat the findings.

The World Federation for Medical Education (WFME) global standards for quality improvement in basic medical education are used as the main reference for this book to maintain its international standard for medical school as the IAAHEH has been recognised by WFME since 2018 and is allowed to accredit medical program outside its jurisdiction. It consists of steps of the accreditation process from registration to appeal.

This book is written by a team of medical education experts and practitioners who come from several big universities. I thank them for their hardworking in writing and finishing the book. I am pretty sure the expectation of the writers is that after understanding the handbook, the evaluator team will have high motivation to review the education process of medical school to facilitate a continuous quality improvement.

Jakarta, July 4th, 2023

Prof. Usman Chatib Warsa, MD., PhD
The Chairman of IAAHEH

Table of Content

FOREWORD ..... **i**
Table of Content ..... **ii**
List of Figures ..... **v**
List of Tables ..... **v**
List of Appendices ..... **v**
Chapter 1. Accreditation Criteria **1**
Criteria 1. Mission and Values 1
Criteria 2. Curriculum 3
Criteria 3. Assessment 10
Criteria 4. Students 15
Criteria 5. Academic Staff 18
Criteria 6. Educational Resources 22
Criteria 7. Quality Assurance 28
Criteria 8. Governance and Administration 31
Chapter 2. Accreditation Procedures **34**
Stage 2.1 Eligibility and Registration 34
2.1.1 Governance and Organization Structure 35
2.1.2 Educational Program 35
2.1.3 Students 35
2.1.4 Staff 36
2.1.5 Educational Resources 36
2.1.6 Accreditation Registration 38
2.1.7 Mechanism of Accreditation Payment 39
Stage 2.2 Nurturing and Preliminary Self-Evaluation Report 40
2.2.1 Nurturing 40
2.2.2 Preparation of Preliminary Self-Evaluation Report 40
2.2.3 Submission and Feedback of the Preliminary Self-Evaluation Report 40
Stage 2.3 Completing Self-Evaluation Report (SER) 40
2.3.1 Conducting Self-Evaluation 40
2.3.2 Writing the Self-Evaluation Report (SER) 40
2.3.3 Submission of the SER to IAAHEH 40
Stage 2.4 Desk Evaluation (DE) 41
2.4.1 Assessor Team 41

2.4.2 Implementation of Desk Evaluation 41
2.4.3 Consolidation of Desk Evaluation Results 41
Stage 2.5 Survey Visit 41
2.5.1 Preparation for the survey visit 41
2.5.2 Implementation of Survey Visit 41
2.5.3 Reporting of the survey visit 41
Stage 2.6 Decision of Accreditation Results (Online) 47
2.6.1 Review by Accreditation Council on Final Survey Visit Report 47
2.6.2 Assessment of Accreditation Council on Survey Visit Results 47
2.6.3 Accreditation Council Decision 47
2.6.4 Certificate of Accreditation and Internationally Published Directory 48
2.6.5 Post Accreditation Monitoring 48
2.6.6 Reporting of Accreditation Decision 48
Stage 2.7 Submission and Process of Appeal 49
Stage 2.8 Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments about Program Quality 49
Chapter 3. Guidance for Self-Evaluation Report 50
3.1 How to conduct Self-Evaluation Activities 50
3.2 Guidance of Writing a Self-Evaluation Report (Preliminary and Final) 50
3.2.1 Introduction 51
3.2.2 Conducting Self-Evaluation 53
3.3 Structure and Format of Self-Evaluation Report 55
Chapter 4. Guidance for Survey Visit 58
4.1 Survey Visit Guidance 58
4.2 Administrative Preparation for Survey Visit 58
4.3 The Survey Visit Procedure 59
4.4 Guidance for Introductory Meeting 61
4.5 Guidance for Interview 62
4.6 Guidance for Observation 63
4.7 Guidance for Document Checking 63
4.8 Guidance for Closing Meeting 64
4.9 Guidance for Survey Visit Report Preparation 65
4.10 Summary of the Accreditation Report 67
4.10.1 Summary of Findings from Self-Evaluation Reports 67
4.10.2 Summary of Findings from Survey Visit Reports 68
Chapter 5. Post Survey Visit 87

5.1 Accreditation Decision....87
5.1.1 Types of Accreditation Decision....87
5.1.2. Reporting of Accreditation Actions....87
5.2. Appeal and Complaint Guidance....88
5.2.1 Appeal....88
5.2.2 Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments about Program Quality....88

List of Figures

Figure 1. Accreditation Process Flowchart 34
Figure 2. Registration Flowchart 39
Figure 3. Plan-Do-Check-Act (PDCA) cycle of improvement 53
Figure 4. Example of a timetable to develop the SER 54

List of Tables

Table 1. Categories of Summary of the Overall Results 57
Table 2. Description of the Term Self-Evaluation Result 57
Table 3. The typical schedule for the survey visit 59
Table 4. Conclusion of the survey visit and recommendations 66
Table 5. Summary of Accreditation Report 68

List of Appendices

Appendix 1 Contract 89
Appendix 2 Statement letter 98
Appendix 3 Rundown Training on Accreditation Standards and Procedures 100
Appendix 4 The Assessors of IAAHEH 102
Appendix 5 Definitions of Findings 104
Appendix 6 Accreditation Council 105
Appendix 7 Monitoring Report 109
Appendix 8 The Procedure To Appeal Submission and Process 111
Appendix 9 The Procedure of Complaints 112

Chapter 1. Accreditation Criteria

Criteria 1. Mission and Values

1.1 Stating the mission: The school has a public statement that sets out its values, priorities, and goals.

Consider the role, audiences, and uses of the mission statement. Briefly and concisely describe the school's purpose, values, educational goals, research functions, and relationships with the healthcare service and communities. Indicate the extent to which the statement has been developed in consultation with stakeholders. Describe how the mission statement guides the curriculum and quality assurance.

Key questions:	Criteria for Compliance
1.1.1. How is the mission statement specially tailored to the school?	How did the school formulate its mission statement? How is the mission statement identified? How are health problems considered at the national and local level? What is the scientific approach in the mission statement formulation? What is the association of the mission of the university with the mission of the school?
1.1.2. Which interest groups were involved in its development and why?	What are the mechanisms to identify the internal and external interest groups in the mission formulation? What are the procedures for the engagement of these interest groups? How is each interest group determined? What is the judgment of their contribution and their reciprocal benefits?
1.1.3. How does the mission statement address the role of the medical school in the community?	How does the mission statement give a mandate to the school to be involved in improving the health status of the community? How does the medical school collaborate with the healthcare services, local governments, hospitals, and communities to execute the medical school's role?
1.1.4. How is it used for planning, quality assurance, and management in the school?	How is the mission statement translated into the school's program and activities during the planning process? How are the planned programs and activities implemented? How does the organisational structure conform with the managerial functions to achieve its vision and mission? How is the internal quality assurance system developed based on its vision and mission? How is monitoring and evaluation tracking the progress of achieving the mission? How to ensure the follow up action is completed? When was the last time the mission was evaluated and updated? Is it regularly evaluated and updated?

1.1.5. How does it fit with regulatory standards of the local accrediting agency and with relevant governmental requirements, if any?	How does the school translate the relevant national regulations and standards into its own regulations and standards concordantly? How does the school consider the local circumstances and uniqueness in implementing the national regulations and standards? Do the school's standards align with the mission of university?
1.1.6. How is it publicised?	How does the school use media for publication of its mission and programs? What are other programs or events that the school used to disseminate its mission and program? Who is involved in the programs?

Guidance for Assessor

The school has formulated its mission statement based on the identification of health problems in its catchment areas using a sound and scientific methodological approach. The school has also considered the vision and mission of the university.

The school has a mechanism for identifying its interest groups – both internally and externally – and has procedures on how to engage them – particularly in mission formulation. The determination of each interest group is based on an objective and fair judgment of their contribution and reciprocal benefits.

The mission statement gives a mandate to the school to be involved in improving the health status of the community. The medical school has a collaboration with the healthcare services, local governments, hospitals, and communities to execute the medical school's role.

The mission statement is consistently translated into the school's program and activities during the planning process. The planned program and activities are congruently implemented. An appropriate organisational structure is set up in line with the functions of its components. An internal quality assurance system is set up to monitor and evaluate the progress of achieving the mission, as well as to ensure the follow-up action is completed. The mission is regularly evaluated and updated.

The school translates the relevant national regulations and standards into school standards and regulations concordantly. The school considers the local circumstances and uniqueness in implementing the national regulations and standards. The school's standards are aligned with the mission of the school.

The school has selected media for the publication of its mission and programs based on available resources and capacity. The school has organised several events to disseminate its missions and program involving relevant stakeholders.

Supporting documents:

- Minutes of meeting when formulating the vision and mission of the school derived from the faculties and university's vision and mission. The vision and mission include the role of the school in improving the community's health status.

- List of attendance: students, faculty members, academic and administrative staff, alumni, stakeholders (employee) including documentation such as photograph/video recording during the meeting.
- Media use for publication of vision, mission, aims and strategies.

Criteria 2. Curriculum

2.1. Intended Curriculum Outcomes: The school has defined the graduate learning outcomes that students should have achieved by graduation, as well as the intended learning outcomes for each part of the course.

Outcomes can be set out in any manner that clearly describes what is intended in terms of values, behaviours, skills, knowledge, and preparedness for being a doctor. Consider whether the defined outcomes align with the medical school mission. Review how the defined outcomes map on to relevant national regulatory standards or government and employer requirements. Analyse whether the specified learning outcomes address the knowledge, skills, and behaviours that each part of the course intends its students to attain. These curriculum outcomes can be expressed in a variety of different ways that are amenable to judgment (assessment). Consider how the outcomes can be used as the basis for the design and the delivery of content, as well as the assessment of learning and evaluation of the course.

Key questions:	Criteria for Compliance
2.1.1 How were the intended outcomes for the course as a whole and for each part of the course designed and developed?	How does the school use its mission and priority health problems in the formulation of intended graduate outcomes? How are the course outcomes consistently derived from the intended graduate outcomes?
2.1.2 Which stakeholders were involved in their development?	Who are the internal and external stakeholders involved in the curriculum development? What are the procedures to involve internal and external stakeholders in developing the curriculum? How are the views of different stakeholders managed and considered?
2.1.3 How do they relate to the intended career roles of graduates in society?	What is the association of the intended graduate outcomes with the intended career roles of graduates in society. How does the school trace their graduates?
2.1.4 What makes the chosen outcomes appropriate to the social context of the school?	How do the intended graduate outcomes associate with the priority health problems in the school's catchment areas? How does the school select appropriate methods of needs analysis in line with available resources?

Guidance for Assessor

The school formulates intended graduate outcomes based on the school's mission and priority health problems. The course outcomes are consistently derived from the intended graduate outcomes. The school has proper procedures in curriculum development, consisting of planning and design, implementation, and evaluation guided by the school's mission. In all stages, there are clear procedures of how to involve internal and external stakeholders. Views of different stakeholders are properly managed and considered.

The intended graduate outcomes are concordant with the intended career roles of graduates in society which are derived from the vision and mission of the institutions, the education philosophy, and need analysis. The school develops proper tracer study to track its graduates. The intended graduate outcomes are formulated based on the priority health problems in the school's catchment areas and the results of consultation with external stakeholders and internal stakeholders. The school selects appropriate methods of needs analysis in line with available resources and support from the stakeholders. The graduate outcomes are aligned with the school's mission.

2.2. Curriculum Organisation and Structure: The school has documented the overall organisation of the curriculum, including the principles underlying the curriculum model employed and the relationships among the component disciplines.

This standard refers to the way in which content (knowledge and skills), disciplines, and experiences are organised within the curriculum. There are many options and variants, ranging from different models of integration to traditional pre-clinical and clinical phases, involving varying degrees of clinical experience and contextualisation. The choice of curriculum design is related to the mission, intended outcomes, resources, and context of the school.

Key questions:	Criteria for Compliance
2.2.1 What are the principles behind the school's curriculum design?	How does the school select the principles that are used for curriculum design (i.e., social reconstructionism, essentialism, existentialism, progressivism, etc.)? Do the principles appropriate to the school's mission, intended graduate outcomes, resources, and context of the school?
2.2.2 What is the relationship between the different disciplines of study that the curriculum encompasses?	What are the criteria identified by the school for the content of the curriculum to be relevant, important and prioritised? How does the school determine the scope of the content in terms of the breadth and depth of coverage and concentration? How does the school decide the sequence, i.e., hierarchy, and progression of complexity or difficulty?
2.2.3 How was the model of curriculum organisation chosen? To what extent was the model constrained by local regulatory requirements?	How does the school choose a particular model of curriculum based on sound and scientific judgment? Does the school take into consideration the local resources and the existing regulatory framework?
2.2.4 How does the curriculum design support the mission of the school?	What is the approach of the curriculum design? How does the curriculum design align with the school's mission?

<u>Guidance for Assessor</u>

The school has consciously selected principles that are used for curriculum design (i.e., social reconstructionism, essentialism, existentialism, progressivism, etc.) that are appropriate to the school's mission, intended graduate outcomes, resources, and context of the school.

The school identifies criteria consisting of relevance, importance, and priority of the content of the curriculum. The school determines the scope of the content consisting of the amount and depth of coverage and concentration. The school also decides the sequence, i.e., hierarchy and progression of complexity or difficulty. The criteria and sequence demonstrate the relationship between the disciplines of study.

The school consciously chooses a particular model of curriculum based on sound and scientific judgment. The school takes into consideration the local resources and the existing regulatory framework.

The curriculum design is carefully selected based on a sound and appropriate approach. The curriculum design is aligned to achieve the school's mission.

2.3. Curriculum Content: a) The school can justify inclusion in the curriculum of the content needed to prepare students for their role as competent junior doctors and for their subsequent further training. b) Content in at least three principal domains is described: basic biomedical sciences, clinical sciences and skills, and relevant behavioural and social sciences

Curriculum content in all domains should be sufficient to enable the student to achieve the intended outcomes of the curriculum and to progress safely to the next stage of training or practice after graduation. Curriculum content may vary according to school, country, and context, even where a national curriculum is specified. Content from at least three principal domains would be expected to be included: Basic biomedical sciences which are the disciplines fundamental to the understanding and application of clinical science; Clinical sciences and skills which include the knowledge and related professional skills required for the student to assume appropriate responsibility for patient care after graduation; Behavioural and social sciences which are relevant to the local context and culture, and include principles of professional practice including ethics. Content of other types may also be included: Health systems science which includes population health and local healthcare delivery systems; Humanities and arts which might include literature, drama, philosophy, history, art, and spiritual disciplines.

Key questions:	Criteria for Compliance
2.3.1 Who is responsible for determining the content of the curriculum?	How does the school establish a committee/ unit/ team responsible for determining the content of the curriculum? How are departments involved in formulating the curriculum content? How are internal and external stakeholders involved in formulating the curriculum content?
2.3.2 How is curriculum content determined?	What principles or methodologies are used to identify the curriculum content? What references at international, national, and local level are used to determine the curriculum content?
2.3.3 What elements of basic biomedical sciences are included in the curriculum? How are the choices made and time allocated for these elements?	How does the school identify the basic biomedical sciences that are relevant with the graduate learning outcomes?

	How does the school decide the content of the biomedical sciences and time allocation, and credit values?
2.3.4 What elements of clinical sciences and skills are included in the curriculum?	What content of clinical disciplines and skills are included in the curriculum that are in line with graduate learning outcomes? How do internal and external stakeholders are involved in determining the content of clinical discipline and skills? What references are used at international, national, and local level to determine the content of clinical sciences and skills?
2.3.4.1 In which clinical disciplines are all students required to gain practical experience?	Can you describe all clinical disciplines that are compulsory for students to gain practical experiences? Who decides clinical disciplines that are compulsory for students to gain practical experiences? What considerations are used?
2.3.4.2 How are students taught to make clinical judgements in line with the best available evidence?	What methods are used to teach students to make clinical judgments in line with the best available evidence?
2.3.4.3 How are the choices made and time allocated for these elements?	Who decides the clinical evidence selected for this purpose? How does the school decide the time allocated for teaching and learning in clinical judgements?
2.3.4.4 What is the basis for the school's allocation of student time to different clinical practice settings?	How does the school manage time allocated for different clinical practice settings?
2.3.5 What elements of behavioural and social sciences are included in the curriculum? How are the choices made and time allocated for these elements?	Can you describe the behavioural and social sciences that are included in the curriculum which are in line with the graduate learning outcome? How do you decide the choices and time allocation for the behavioural and social content?
2.3.6 What elements (if any) of health systems science are included in the curriculum? How are the choices made and time allocated for these elements?	Can you describe the content of the health system sciences that are included in the curriculum? How do you decide the choices and time allocation for the health system sciences?
2.3.7 What elements (if any) of humanities and arts are included in the	Can you describe the curriculum content related to humanities and arts?

curriculum? How are the choices made and time allocated for these elements?	How does the curriculum team allocate time for these contents?
2.3.8 How do students gain familiarity with fields receiving little or no coverage?	How does the school develop community-based programs and how do you ensure the students' health and safety during their placement in the field?
2.3.9 How does the school modify curriculum content related to advances in knowledge?	Can you describe how you evaluate your curriculum content? How do you involve internal and external stakeholders in curriculum evaluation? How do you use the result of the evaluation to modify your curriculum content in relation to the advancements in knowledge?
2.3.10 How are principles of scientific methods and medical research addressed in the curriculum?	How do you address the principle scientific methods and medical research in the curriculum? Who decides how these are addressed in the curriculum? Who delivers these contents?
2.3.11 Which fields (if any) are elective? How are elective fields decided?	Can you explain how you decide what fields or disciplines are included in the elective? Can you mention what fields and disciplines are elective?
2.3.12 How is student learning assured in disciplines in which they do not get specific experience (e.g. disaster management, emerging disease)?	Can you explain which disciplines that the students do not get specific experiences? How do you ensure the students can learn those disciplines?

Guidance for Assessor

The school establishes a structure responsible for curriculum development. This structure coordinates representatives of departments through various recognised means to formulate the curriculum content. The structure involves internal and external stakeholders that are relevant to the school.

Curriculum content is identified based on course learning outcome related to particular disciplines and multidiscipline. Standards of content that are formulated by professional associations or education associations at the national level should be used as the main reference. If there are no such standards, the school may develop their own standards of content using clear benchmarks. Standards of content at the international level formulated by the international professional association might be used.

The curriculum content might be determined using the following criteria:

1. Self-Sufficiency: This criterion means that students should be given a chance to experiment, observe, and do field study. This system allows them to learn independently.
2. Significance: The subject matter or content is significant if it is selected and organised to develop learning activities, skills, processes, and attitudes.
3. Validity: Validity refers to the authenticity of the subject matter or content selected. The contents are not easily obsolete.

4. Interest: Students learn best if the subject matter is interesting, thus making it meaningful to them.
5. Utility: This is the usefulness of the content or subject matter. This relates to what extent the contents are needed in the future job/career and life.
6. Learnability: The subject matter or content must be within the schema of the learners. Teachers should apply theories in the psychology of learning to know how subjects are presented, sequenced, and organised to maximise students' learning capacity.
7. Feasibility: Feasibility means the full implementation of the subject matter. Students must learn within the allowable time and the use of resources available.

The school identifies the basic biomedical sciences that are relevant with the graduate learning outcomes. For the sake of coherence and consistency, learning materials, such as textbooks, should be developed in line with the broader curriculum perspective that is usually defined in a curriculum framework. This is achieved by counting the 'hours of work' involved in studying for the various modules offered by a teaching establishment. To calculate the number of student hours which will be involved in successfully completing a new module is by being very precise, during its planning stage, in identifying and enumerating the Learning Outcomes and Competences.

The schools have identified clinical disciplines in line with the graduate learning outcomes. This process involves internal and external stakeholders, including data from health care delivery. There is a list of clinical disciplines during the clinical phase or clinical rotation where the students gain practical experiences. The school establishes a planning team for the clinical phase to decide choices of clinical placements based on the graduate learning outcomes, the availability of clinical resources and clinical supervisors. Various theories have been proposed relating to how a clinician reasons through a clinical consultation and how 'expert' clinicians' reason differently to novice learners. Novice learners, such as medical students, have limited clinical experience and therefore need to approach most consultations in a more analytical ('hypothetico-deductive') way. The clinical rotation planning team considers the importance and urgency of list of diseases and list of clinical skills of each clinical department, as well as the availability of mix cases in the relevant hospital. The school decides the allocation of student time in different clinical practice setting based on the availability of inpatient and outpatient in each teaching hospital, as well as the availability of clinical teachers, that are considered sufficient to achieve the learning outcome at clinical phase.

The school explains the behavioural and social sciences that are included in the curriculum which are in line with the graduate learning outcome, as well as the reasons for selection. The school establishes a curriculum team that will decide the time allotted for these contents and the arguments that are applied.
The school explains the content of health system science that is included in the curriculum based on the graduate leaning outcome, as well as the reason for selection. The school has demonstrated that consultations with relevant external stakeholders are conducted. The school provides arguments on how allocation of time for health system is conducted.

The school explains the curricular content related to humanities and arts. The curriculum team determines the time allocation for these content after conducting need analysis.

The school develops community-based programs in collaboration with local health offices to place students in remote areas. The school ensures that students' health and safety are insured during their placement in remote areas.

The school has an internal quality assurance system in place where regular review of curriculum is conducted based on certain procedures embracing input, process, output, outcome, and impact. Appropriate numbers and representativeness of internal and external stakeholders are involved in curriculum review.

The curriculum includes principles of scientific methods and medical research which are accommodated in modules or blocks or subjects. Time is allocated proportionally to address this content. A specific team or unit is assigned to be responsible for modules/blocks/subjects' development and implementation.

The school explains the elective modules included in the curriculum. The school could explain the reasons for deciding which topics are needed for elective.

The school appoints a Coordinating Team in each module/block/course who are responsible for planning, developing, and implementing the curriculum to achieve the graduate learning outcome. Where students are not exposed to specific experiences, the coordinators must produce alternative experiences to compensate.

2.4. Educational methods and experiences: The school employs a range of educational methods and experiences to ensure that students achieve the intended outcomes of the curriculum.

Educational methods and experiences include techniques for teaching and learning designed to deliver the stated learning outcomes, and to support students in their own learning. Those experiences might be formal or informal, group-based or individual, and may be located inside the medical school, in the community, or in secondary or tertiary care institutions. Choice of educational experiences will be determined by the curriculum and local cultural issues in education, and by available human and material resources. Skilfully designed, used and supported virtual learning methods (digital, distance, distributed, or e-learning) may be considered, presented, and defended as an alternative or complementary educational approach under appropriate circumstances, including societal emergencies.

Key questions:	Criteria for Compliance
2.4.1 What principles inform the selection of educational methods and experiences employed in the school's curriculum? How were these principles derived?	Can you explain principles that are used in selecting educational methods and experiences? How are these principles formulated? How do internal and external stakeholders are involved, including experts in medical education?
2.4.2 According to what principles are the chosen educational methods and experiences distributed throughout the curriculum?	How do you distribute the chosen educational methods and experiences distributed throughout the curriculum? What principles are adopted for these purposes?

2.4.3 In what ways are the educational methods and experiences provided for students appropriate to the local context, resources, and culture?	Can you explain how the educational methods and experiences provided for students are appropriate to the local context, resources, and culture?

Guidance for Assessor

The school has decided on principles that are used in selecting educational methods and experiences based on the educational philosophy. The principles are formulated in consultation with internal and external stakeholders, as well as experts in educational psychology.

The school explains the sound and scientific principles that are applied in deciding the educational methods and experiences throughout the curriculum.

The school demonstrates thorough analysis regarding the local context, resources, and culture in deciding which educational methods and experiences are most appropriate.

Supporting documents:

- Minutes of curriculum committee's meeting on formulating the intended graduate's outcomes of each course (including knowledge, skills, and behaviours) based on school's vision and missions, and the priority health problems. The outcomes can be measured using appropriate assessment.
- Curriculum book (curriculum organisation: principle, content, sequence), learning outcomes, educational methods, assessment.
- List of clinical departments for student's placement
- List of teaching hospitals
- Minutes of curriculum committee's meeting on educational methods

Criteria 3. Assessment

The school has a policy that describes its assessment practices. b) It has a centralised system for ensuring that the policy is realised through multiple, coordinated assessments that are aligned with its curriculum outcomes. c) The policy is shared with all stakeholders.

3.1. Assessment Policy and System

An assessment policy with a centralised system that guides and supports its implementation will entail the use of multiple summative and formative methods that lead to acquisition of the knowledge, clinical skills, and behaviours needed to be a doctor. The policy and the system should be responsive to the mission of the school, its specified educational outcomes, the resources available, and the context.

Key questions:	Criteria for Compliance
3.1.1 Which assessments does the school use for each of the specified educational outcomes?	Can you explain which assessment method you apply for each of the specified educational outcomes? How do you ensure that these assessment methods meet the validity, reliability, and educational impact criteria?

3.1.2 How are decisions made about the number of assessments and their timing?	How do you decide the number of assessments and the timing to ensure the achievement of graduate educational outcomes as well as the course learning outcomes? How do you decide which assessments are formative or summative? Who takes the decision about the number of assessments and their timing? How do you ensure that staff and students are well informed?
3.1.3 How are assessments integrated and coordinated across the range of educational outcomes and the curriculum?	How are the integration and coordination of assessments across the educational outcomes and the curriculum? How do you develop an assessment blueprint at program level and how do you evaluate it? How do you develop assessment blueprints at across levels and how do you evaluate them?

Guidance for Assessor

The school uses appropriate assessment methods for each of the specified educational outcomes. The assessment methods that are used meet the validity, reliability, and educational impact criteria. The following are examples of assessment methods: The school uses various assessment types, multiple summative and formative assessments on the knowledge, skills, and behaviour for each of the educational outcomes. The school anticipates any limitation that may occur related to the suitable assessment of students' clinical skills. Policy and system should be centralised and related to the school mission, resources available, and the context.

The decisions about the number and type of assessments are based on the graduate educational outcomes as well as the course learning outcomes. Both formative and summative assessment are planned in line with the stages of achievement of the learning outcomes. The timing of formative and summative assessment is decided based on the progress of learning outcome achievements. The decisions are made by the Assessment Committee and approved by the School's Authority. The policies should be shared with all students and other stakeholders.

The assessment committee develops an assessment blueprint at program level to demonstrate the integration and coordination across the range of educational outcomes and curriculum content. The Assessment blueprint at program level is evaluated regularly. The module team develops an assessment blueprint for each module to integrate and coordinate learning outcomes and content for each module.

3.2. Assessment in Support of Learning:

a) The school has in place a system of assessment that regularly offers students actionable feedback that identifies their strengths and weaknesses and helps them to consolidate their learning. b) These formative assessments are tied to educational interventions that ensure that all students have the opportunity to achieve their potential

Feedback is one of the biggest drivers of educational achievement. Students need to be assessed early and regularly in courses and clinical placements for the purposes of providing feedback

that guides their learning. This includes early identification of underperforming students and the offer of remediation.

Key questions:	Criteria for Compliance
3.2.1 How are students assessed to support their learning?	How do you give feedback for students based on the result of the assessments across the curriculum?
3.2.2 How are students assessed to determine those who need additional help?	How do you decide which students need additional help based on their assessment across the curriculum?
3.2.3 What systems of support are offered to those students with identified needs?	How do you support the students with the identified needs?

Guidance for Assessor

The school provides feedback for summative and formative assessments. A narrative assessment such as a portfolio or logbook could be included where there is direct feedback from the teacher to student in a timely manner. During the clinical rotation, the school designs a system to guarantee that all medical students have the opportunities to obtain learning experiences and direct feedback from the clinical supervisor.

Every student has an academic counsellor who evaluates and monitors students' learning progress using a centralised system (learning management system) such as students' achievement on each module, GPA, a portfolio and progresses test result. Data across all levels of education is used to identify students who need support. School provides a student support system that is assigned to fulfil students' needs in academic issues.

3.3. Assessment in Support of Decision-Making: a) The school has in place a system of assessment that informs decisions on progression and graduation. b) These summative assessments are appropriate to measuring course outcomes. c) Assessments are well-designed, producing reliable and valid scores

Assessment for decision-making is essential to institutional accountability. It is also critical to the protection of patients. These assessments must be fair to students and, as a group, they must attest to all aspects of competence. To accomplish these ends, they must meet standards of quality.

Key questions:	Criteria for Compliance
3.3.1 How are blueprints (plans for content) developed for examinations?	Can you explain how you develop blueprint examination? Who develops blueprint examination?
3.3.2 How are standards (pass marks) set on summative assessments?	How do you apply the standard setting procedures to establish passing mark summative assessments? Can you explain how you make decisions on progression and graduation in all educational levels across all expected learning outcomes? Who makes decisions on progression and graduation in all educational levels across all expected learning outcomes?

3.3.3 What appeal mechanisms regarding assessment results are in place for students?	How is the policy/system regarding appeal mechanism for the assessment results? How do you ensure that the students are well informed about the appeal mechanisms? Who is involved in implementing these appeal mechanisms? What happens if there are disputes between the students and the school?
3.3.4 What information is provided to students and other stakeholders, concerning the content, style, and quality of assessments?	How do you ensure the validity and reliability of the assessment program? How do you communicate your content, style, and quality of assessments to your student and other stakeholders?
3.3.5 How are assessments used to guide and determine student progression between successive stages of the course?	How do you decide student progression between successive stages of the course? How do you use assessment results to guide and determine student progression across the program? How do you provide feedback to students regarding their progression across the program?

Guidance for Assessor

Assessment blueprints are developed by making a cross-tabulation of test content, educational outcomes, and the appropriate type of assessment. The assessment blueprint is included in the curriculum and set by the Assessment Committee.

The assessment committee applies standards setting procedures to establish passing marks on summative assessment. The school ensures that every student who passes the summative examination meets the expected standard. The assessment system should include decisions on progression and graduation in all educational levels across all expected learning outcomes. The standards and procedures of assessment should be clearly stated, shared with students, and applied consistently.

The school has developed a policy/system regarding assessment appeal, which is clear, distributed to all students, and implemented continuously. The system includes the course organiser and faculty members who are responsible for reviewing and solving these issues. If an agreement is not reached among all the parties involved, it will be reported to a higher authority.
The school provides a system to ensure the validity and reliability of the assessment program. The school has procedures to develop and review items for each assessment program. This information is shared with the students and other stakeholders.

The course coordinators regularly evaluate and monitor students' learning progress after the formative and summative examination. The student's progress is then informed to the students via a system that can also be monitored by their academic counsellors. Feedback should be provided by staff to improve students' achievement.

3.4. Quality control: a) The school has mechanisms in place to ensure the quality of its assessments. b) Assessment data are used to improve the performance of academic staff, courses, and the institution

It is important for the school to review its individual assessments regularly, as well as the whole assessment system. It is also important to use data from the assessments, as well as feedback from stakeholders, for continuous quality improvement of the assessments, the assessment system, the course, and the institution.

Key questions:	Criteria for Compliance
3.4.1 Who is responsible for planning and implementing a quality assurance system for assessment?	How do you plan and implement the quality assurance system for your assessments system? Who is involved in the planning and implementation of the quality assurance system for your assessments?
3.4.2 What quality assurance steps are planned and implemented?	Can you explain how the quality assurance steps are planned and implemented?
3.4.3 How are comments and experiences about the assessments gathered from students, teachers, and other stakeholders?	How do you collect comments and experiences about the assessment system from students, teachers, and other stakeholders? How do you ensure that those comments and experiences are trustworthy?
3.4.4 How are individual assessments analysed to ensure their quality?	Can you explain the procedure for the analysis of individual assessment to ensure their quality? Who is involved in developing and implementing these procedures?
3.4.5 How is data from assessments used to evaluate teaching and the curriculum in practice?	How do you use assessment results to evaluate the teaching and the curriculum in practice? Who is involved in this process?
3.4.6 How is the assessment system and individual assessments regularly reviewed and revised?	Can you explain the procedure for regularly reviewing and revising your assessment system in individual assessment?

Guidance for Assessor

The school assigns a quality assurance and quality team who is responsible for assuring the quality of individual as well as the program assessment. The team includes experts in assessment who plan and implement quality assurance consistently.

The quality assurance steps are planned and implemented regularly (e.g., at the end of each semester). Data obtained is then distributed to improve the performance of staff, course organisers, and institutions.

The school develops a system to collect information regarding assessment from the students, teachers, and other stakeholders (e.g., distributing a questionnaire or google form, focus group discussion).

The quality assurance team collects, reviews and analysis data from course organisers for each

assessment regularly. Data collected included the assessment instruments, item analysis (discrimination index, difficulty index), standard setting, portfolio or logbook based on predetermined standards of competencies, alignment on writing assignment, essay questions and discussions process with rubrics.

Data from assessments are shared with staff and other stakeholders to be considered as a basis to improve the teaching and learning process as well as curriculum reform.
The school designates a quality assurance team, medical education unit, or assessment centre to review and revise the assessment system and individual assessments regularly.

Supporting document:

- Standard operational procedure on assessment
- Student's logbook, document of revision on teaching strategies: assessment as student's (evaluation and monitoring student's progress) and teacher's feedback (teacher's teaching strategies)
- Procedures for remediation and counselling
- Support system algorithm
- Assessment blueprint
- Procedure of appeal mechanism
- Document of Quality Assurance system: planning and implementation
- Policy and procedure for workplace based assessment

Criteria 4. Students

4.1. Selection and Admission Policy: The medical school has a publicly available policy that sets out the aims, principles, criteria, and processes for the selection and admission of students.

Where selection and admissions procedures are governed by national policy, it is helpful to indicate how these rules are applied locally. Where the school sets aspects of its own selection and admission policy and process, clarify the relationship of these to the mission statement, relevant regulatory requirements, and the local context. The following admissions issues are important in developing the policy: the relationship between the size of student intake (including any international student intake) and the resources, capacity, and infrastructure available to educate them adequately; equality and diversity issues; policies for re-application, deferred entry, and transfer from other schools or courses.

Consider the following issues for the selection process: requirements for selection, stages in the process of selection; mechanisms for making offers; mechanisms for making and accepting complaints.

Key questions:	Criteria for Compliance
4.1.1 How is alignment determined between the selection and admission policy, and the mission of the school?	How do you align your selection and admission policy to the mission of your school? Who is involved in developing the selection and admission policy? How do you ensure that the implementation of selection and admission policy are free from direct intervention from unauthorised parties?

4.1.2 How does the selection and admission policy fit with regulatory (accreditation) or government requirements?	How do you ensure that selection and admission policy is in line with regulatory body or government requirements? What happens if they do not fit the regulatory or government requirements?
4.1.3 How is the selection and admission policy tailored to the school?	Can you explain how selection and admission policy are tailored to the school?
4.1.4 How is the selection and admission policy tailored to local and national workforce requirements?	How are the selection and admission policy tailored to local and national workforce requirements? Who is involved in this process?
4.1.5 How is the selection and admission policy designed to be fair and equitable, within the local context?	What are the procedures to design the selection and admission policy to be fair and equitable, within the local context? How are students from economically and socially disadvantaged backgrounds selected?
4.1.6 How is the selection and admission policy publicised?	How do you disseminate selection and admission policy to internal and external stakeholders?
4.1.7 How is the selection and admission system regularly reviewed and revised?	How are the procedures for regularly reviewing and revising the selection and admission system? Who is involved in these procedures?

Guidance for Assessor

The school develops student admission and selection policies in accordance with its vision and mission. An admission and selection team/committee are established to develop guidelines for implementing/ determining student admissions and selection. The committee has autonomous authority and is free from intervention.

The school considers government regulations, national accreditation standards, and university policies in developing admission policies. Based on this admission policy, the school establishes criteria for student selection and develops procedures, such as decisions making on admission, selection, student applications, compliance with national regulations.

The operationalisation of government/ university policies is adjusted to the school, based on; capacity, number of teaching staff, infrastructure, school's vision and mission, and equality of student background.

The school develops and publishes technical standards for the admission, retention, and graduation of applicants for medical students in accordance with the requirements. Central and local government policies regarding the need for a healthy workforce. Selection and acceptance policies are tailored to the needs of health workers.

Fair and equitable selection and admissions policies according to the local context are developed based on acceptable principles. Affirmative policies are accommodated to recruit students from economically and socially disadvantaged communities.

Admission information should be publicised through information technologies with adequate capacity, such as widely accessible websites, sufficient IT support, and social media engagement. There is a clear procedure to review and improve the selection and admission system on a regular basis.

4.2. Student Counselling and Support: The medical school provides students with accessible and confidential academic, social, psychological, and financial support services, as well as career guidance

Students might require support in developing academic skills, in managing disabilities, in physical and mental health and personal welfare, in managing finances, and in career planning. Consider what emergency support services are available in the event of personal trauma or crisis. Specify a process to identify students in need of academic or personal counselling and support. Consider how such services will be published, offered, and accessed in a confidential manner. Consider how to develop support services in consultation with students' representatives.

Key Questions:	Criteria for Compliance
4.2.1 In what ways are the academic and personal support and counselling services consistent with the needs of students?	Does the school provide an appropriate package of support that meets the academic and pastoral needs of students, such as academic and career advisor, financial assistance/education financial management counselling, health and disability insurance, counselling/personal welfare program, student access to health care services, a student interest, and talent development, etc?
4.2.2 How are these services recommended and communicated to students and staff?	How is information on services made available to staff and students? How do you ensure that students and staff are aware of the availability of these student support services?
4.2.3 How do student organisations collaborate with the medical school management to develop and implement these services?	How do you ensure that students and management of student organisations are involved in developing and implementing these services?
4.2.4 How appropriate are these services both procedurally and culturally?	How do you ensure that student services meet the needs of the diversity of the student population, as well as meeting the needs of the local/national culture? Who is involved in the provision of student services that are culturally sensitive?
4.2.5 How is the feasibility of the services judged, in terms of human, financial, and physical resources?	How do you ensure that these services are feasible in terms of human, financial, and physical resources?
4.2.6 How are the services regularly reviewed with student representatives to ensure relevance, accessibility, and confidentiality?	What are the procedures to evaluate the effectiveness of these services through a range of methods, e/g surveys, complaints, representative groups? How are changes accommodated where appropriate?

Guidance for Assessor

The school provides effective student services to all medical students to assist them in achieving program learning outcomes. All medical students have equal rights and receive comparable services, such as academic and career advisor, financial assistance/education financial management counselling, health and disability insurance, counselling/personal welfare program, student access to health care services, a student interest, and talent development, etc.
The school has student service guidelines which are disseminated to students and staff which can be accessed easily.
The school has clear implementation procedures for the involvement of student organisations to carry out these services.
There are a variety of complete and appropriate service instructions/guidelines for students and staff to use according to local culture. Counselling procedures are in accordance with counselling principles (mechanism of handling) and tailored to the local cultures.
The school regularly conducts a user satisfaction survey to evaluate the student services in terms of human, financial and physical resources. The feasibility of the services is judged based on the results of the survey and complaints.
The school conducted regular reviews together with student representatives to ensure the relevance, access, and confidentiality of counselling services. Procedures for these are available.

Supporting documents

- Regulation on selection and admission policy schools: alignment with mission and accreditation/requirements, publicity, review, and revise.
- Policy, regulation, and procedures on student support.
- Policy, regulation, and procedures on student counselling.
- Supporting human resources, facilities and financial for student supports system.
- Monitoring and evaluation of student support system implementation.

Criteria 5. Academic Staff

5.1. Academic Staff Establishment Policy: The school has the number and range of qualified academic staff required to put the school's curriculum into practice, given the number of students and style of teaching and learning.

Determining academic staff establishment policy involves considering: the number, level, and qualifications of academic staff required to deliver the planned curriculum to the intended number of students; the distribution of academic staff by grade and experience.

Key questions:	Criteria for Compliance
5.1.1 How did the school arrive at the required number and characteristics of their academic staff?	How do you calculate the required number and characteristics of your academic staff? What are your considerations in deciding the number and characteristics of your academic staff? How do you monitor and review the workload of your academic staff?
5.1.2 How do the number and characteristics of the academic staff align with the design,	How do you ensure there is an alignment between the number and characteristics of your academic

delivery, and quality assurance of the curriculum?	staff with the design, delivery and quality assurance of the curriculum? How do you do human resource planning to ensure the staffing adequacy with the development of your school?

Guidance for Assessor

The school has procedures on how to analyse the required number and qualification of the academic staff based on the number of the student body, the designed curriculum, the burden of research activities, community services, training programs, alignment of discipline mix as well as managerial responsibilities. The school analyses and decides the optimal academic staff to student ratio and evaluates it regularly. The workload of the academic staff is monitored and reviewed systematically. The methods to monitor and review the workload are known to all academic staff. The school has a manpower plan for academic staff and supporting staff based on those analyses, implementing the plan, evaluating the progress, and reviewing it regularly.

The school has a human resources policy covering the characteristics of the academic staff to be aligned with the design, delivery, and quality assurance of the curriculum. The manpower plan is adequate to implement the curriculum, including its development of education programs and the missions of the school, staff development, and continuing education and regeneration plan of the existing academic staff.

5.2. Academic Staff Performance and Conduct: The school has specified and communicated its expectations for the performance and conduct of academic staff.

Develop a clear statement describing the responsibilities of academic staff for teaching, research, and service. Develop a code of academic conduct in relation to these responsibilities.

Key questions:	Criteria for Compliance
5.2.1 What information does the school provide for new and existing academic staff and how is this provided?	How do you disseminate information on responsibilities of academic staff for teaching, research, and services for the new and exciting academic staff? How do you disseminate the expectations of performance and codes of conduct to the new and existing academic staff?
5.2.2 What induction training does the school provide for academic staff?	How do you conduct the induction training for your new academic staff? How does the school arrange induction programs for academic staff? What are the contents of the induction programs? Does the training and development plan reflect the university and study program's mission and objectives? How does the school evaluate and review its training programs?

5.2.3 How does the school prepare academic staff, teachers, and supervisors in clinical settings to enact the proposed curriculum?	How do you prepare your academic staff, teachers, and supervisors in the clinical setting to deliver the proposed curriculum? How do you ensure the academic staff, teachers, and supervisors are ready to implement the proposed curriculum?
5.2.4 Who is responsible for academic staff performance and conduct? How are these responsibilities carried out?	What are the procedures for academic staff performance appraisal? Who is responsible for carrying out these procedures? What are the policy and procedures for monitoring and reviewing the academic staff performance and conduct? What are the policies and procedures for retention, promotion, granting rewards, retraction, demotion and dismissal for the staff? Are the policies and procedures clearly understood? How could the staff get regular and sufficient information related to their responsibilities, benefits and remuneration? What are the policies and procedures for feedback provision to the academic staff performance and progress toward retaining, promotion, granting rewards and tenure?

Guidance for Assessor

The school provides information on the school's policies regarding human resource policy and other related policies. For the existing academic staff, the school provides (for example) scholarships, travel grants, research grants, and publication grants as required.

The school organises induction programs on a regular basis. The contents of the induction program are government policies in teaching, research, and community services. The training and development plan reflects the university and study program's mission and objectives. The training programs are evaluated and reviewed regularly.

The school organises faculty development programs, which is operated by the medical education unit. Academic staff, teachers and supervisors who are responsible for delivering curriculum in the clinical phase are obliged to attend the training in the clinical curriculum. The medical education unit designs the training in accordance with the needs and the roles.

The school has procedures for staff performance appraisal. The school has authority and structure to carry out these procedures. The roles and relationships of academic staff members are well defined and clearly understood by all academic staff. The policy and procedure are clearly understood by all the relevant parties. A system for the responsible unit (e.g., Head of Department towards the members of the department) to carry out the evaluation is set and well known by all the staff. Each staff must prepare an annual plan including the key performance indicators which are monitored, evaluated, and reviewed systematically.

The school also has clear policies and procedures for retention, promotion, granting rewards, retraction, demotion, and dismissal. The policies and procedures are clearly understood by all academic staff. The school ensures that all the staff will get regular and sufficient information related to their responsibilities, benefits, and remuneration. The school has policies and procedures for feedback provision to the academic staff performance and progress toward retaining, promotion, granting rewards, and tenure.

5.3. Continuing Professional Development for Academic Staff: The school implements a stated policy on the continuing professional development of its academic staff

Develop and publicise a clear description of how the school supports and manages the academic and professional development of each member of staff.

Key questions:	Criteria for Compliance
5.3.1 What information does the school give to new and existing academic staff members on its facilitation or provision of continuing professional development?	What is the school plan for a professional development program and career pathway for the academic staff? How is the plan socialised to the academic staff? What are the considerations for the development program and career pathway? What is the development program for the tenure academic staff? Who is involved in the development program of the junior/new academic staff? How does the school review and evaluate the program? What are the aspects that are considered in the development program? How does the school support and accommodate the professional development of the academic staff?
5.3.2 How does the school take administrative responsibility for the implementation of the staff's continuing professional development policy?	How does the school monitor, evaluate and review the continuing professional development program of the academic staff? How could the school appraise and reward the academic staff related to their continuing professional development?
5.3.3 What protected funds and time does the school provide to support its academic staff in their continuing professional development?	How could the school support its academic staff in their continuing professional development? What are the policies for this? How could the academic staff understand the policy and procedure clearly?

Guidance for Assessor

The school has a professional development program and career pathway for the academic staff. The program and pathway are socialised with the newly recruited and the existing academic staff. The development program and career pathway are based on the merit system and performance evaluation. Each tenure academic staff has a developed program and career pathway. The development program involves senior academic staff in mentoring and/or training the junior/new academic staff. The program is regularly evaluated and reviewed. The development program is designed by taking the curriculum development and its institutional roadmap, research, and community services into account.

The school accommodates and supports the continuing professional development of the academic staff, including pursuing additional or higher academic degrees deemed suitable.
The school monitors, evaluates and reviews the continuing professional development program of the academic staff. The school has a system of appraisal and rewards for academic staff related to their continuing professional development.

The school has policies to support its academic staff in their continuing professional development. The school provides funds and permits for continuing professional development. The policy and procedure of the support are clearly understood by the academic staff.

Supporting documents

- Manpower plan according to the needs of each discipline and scientific development
- Policy and procedures for staff's development
- Minutes of meetings and list of attendance during development of manpower plan
- Mapping of discipline of the curriculum
- Form for monitoring and evaluation of academic staff performance, sampled a filled in form from several academic staffs, result of performance appraisal each semester
- Induction training program report
- Reports of the training programs for new and existing academic staff members.
- Summary of the professional development of the academic staff

Criteria 6. Educational Resources

6.1. Physical Facilities for Education and Training: The school has sufficient physical facilities to ensure that the curriculum is delivered adequately.

Physical facilities include the physical spaces and equipment available to implement the planned curriculum for the given number of students and academic staff.

Key Questions	Criteria for Compliance
6.1.1 How does the school determine the adequacy of the physical infrastructure (space and equipment) provided for the theoretical and practical learning specified in the curriculum?	How do you ensure that the physical infrastructure (space and equipment) provided for the theoretical and practical learning specified in the curriculum are adequate – including for people with special needs? How do you ensure that the laboratory and equipment are up to date, in good condition, readily available, and effectively deployed? How do you ensure that digital and physical libraries resources are sufficient, up to date, well-maintained and readily accessible? How do you ensure that the student safety and security systems are in place at all locations?
6.1.2 Is it appropriate or necessary to supplement or replace classroom teaching by distance or distributed learning methods? If so, how does the school ensure that these offer a	How do you decide whether distance or distributed learning methods are necessary to replace or supplement classroom teaching?

commensurate level of education and training?	How do you ensure that once you decide to employ distance learning for classroom teaching you are able to offer a commensurate level of education and training?

Guidance for Assessor

The classroom is shown to be sufficient, in good condition and up to date in terms of all types of classrooms and meeting space. The number of faculty offices is sufficient, in good condition and up to date. The number of laboratories and equipment are adequate and shown to be up to date, in good condition, readily available, and effectively deployed. The school provides digital and physical libraries resources that are sufficient, up to date, well-maintained and readily accessible. Library services are supervised by professional staff. There is a policy and facility for access for people with special needs. The physical, social, and psychological environment supports the education, research, and community involvement programs. The number and competencies of the support staff are shown to be sufficient. There are excellent quality facilities (library, laboratory, IT, and student services).

When students are required to participate in late-night or overnight learning experiences, they have good access to a call room. There are adequate facilities used for teaching and assessment of students' clinical and procedural skills with an adequate scheduling program. There are significant changes in facilities for education and/or research anticipated by the medical school over the next three years, especially if there will be an increase in class size soon. There are adequate security systems in place at all locations to ensure student safety and address emergency and disaster preparedness. Student support services are subjected to monitoring, evaluation, and enhancement. The budget is sufficiently provided for facilities and infrastructure development, maintenance, and enhancement.

Distance or distributed learning methods to replace or supplement classroom teaching are limited to lectures and implemented during certain conditions only (pandemic, disaster, etc.). Lectures are delivered by members of the faculty, on average lectures last two hours. PowerPoint presentations and lecture materials are available to all students participating in distance learning teaching. When needed, lectures are followed by an online discussion group. Lectures are recorded and uploaded into the system to be available as podcasts. IT support is available via the online IT help desk. Examination and assessment of distance or distributed learning process is part of the student development assessment. The online platform is designed to be user-friendly, enjoyable to use, very accessible, and includes all the familiar online functions and capabilities including tutorials and seminars, study forums, libraries, journals, course content, videos, etc.

6.2. Clinical Training Resources: The school has appropriate and sufficient resources to ensure that students receive the required clinical training.

Consider the facilities that are required to provide adequate training in clinical skills, and an appropriate range of experience in clinical practice settings, to fulfil the clinical training requirements of the curriculum.

Key Questions	Criteria for Compliance
6.2.1 What range of opportunities are required and provided for students to learn clinical skills?	What opportunities are provided for students to learn clinical skills? How do you ensure that all students have equal access to learning opportunities for clinical skills on campus, in teaching hospitals, in affiliated and satellite hospitals, and outside campus? How do you ensure that the facilities and infrastructure for learning clinical skills are well maintained and up-to-date?
6.2.2 What use is made of skills laboratories and simulated patients, and of actual patients in this regard?	How do you utilise skills laboratories, simulated patients and actual patients for learning clinical skills? How do you ensure that the skills laboratories, simulated patients and actual patients support the acquisition of students' clinical skills? What clinical skills are learnt using skills laboratories, simulated patients and actual patients?
6.2.3 What is the basis of the policy on the use of simulated and actual patients?	What policies are used as the basis for the use of simulated and actual patients? How have these policies been developed? Who is involved in the development of these policies?
6.2.4 How does the school ensure that students have adequate access to clinical facilities?	What clinical facilities can be utilised by students for clinical clerkships? How do you ensure that your School has guaranteed and sustained access for these clinical facilities? How do you organise the students' access to the clinical facilities to support the achievement of intended learning outcomes? How do you monitor and evaluate these clinical facilities?
6.2.5 What is the basis for the school's mix of community-based and hospital-based training placements?	How do you decide the mix of community-based and hospital-based training placements in the school's clinical phase? Who is involved in making this decision?
6.2.6 How does the school engage clinical teachers and supervisors in the required range of generalist and specialist practice settings?	How do you recruit clinical teachers and supervisors in the required range of generalist and specialist practice settings? How do you ensure that clinical teachers and supervisors understand their roles and responsibilities in relation to students learning in practice settings? How do you maintain engagement with clinical teachers and supervisors?

6.2.7 How does the school ensure consistency of curriculum delivery in clinical settings?	How do you ensure that all clinical teachers and supervisors understand the school's curriculum? How do you organise your curriculum delivery in clinical settings to achieve consistency? How do you ensure that the curriculum delivery in clinical settings is effective?

Guidance for Assessor

The school's affiliated clinical teaching facilities and information resources are of sufficient size, quality, and accessibility to serve the needs of the school to fulfil its mission. The clinical affiliation agreement at least should describe responsibility of the institution, responsibility of the facility, application of the rules and procedures of the facility, student and faculty status, student removal, term and termination, non-discrimination and anti-harassment, liability, and governing law. The medical school and clinical teaching facilities affiliates ensure that all medical students have access to needed facilities such as classrooms, study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late-night or overnight clinical learning experiences. All clinical teaching sites (both inpatient and ambulatory) that will be used for core clinical clerkships for the first cohort of medical students have been identified. The medical school will ensure that the volume and mix of inpatient and ambulatory settings used for required clinical clerkships provides adequate numbers and types of patients in each discipline.

The school has adequate numbers and types of clinical skill laboratories dedicated to the teaching of clinical skills. These skills laboratories should help to ensure that all students acquire the necessary techniques and are properly assessed before practicing on real patients. The school has a monitoring and evaluation program which shows that the skill laboratories support the acquisition, maintenance, and enhancement of the clinical skills of students. The term 'clinical skills' involves history-taking, physical examination, clinical investigations, using diagnostic reasoning, procedural perfection, effective communication, teamwork, and professionalism.

The basis of the policy on the use of simulated patients is patient safety and enhancement of student self-learning. Simulation is an important component of the clinical and communication skill centres and clinical skills laboratories and encourages self-learning. Clinical skills laboratories have been designed to support the intended learning outcome and to form an integral part of the overall curriculum. The school has developed various types of simulators which include part-time trainers, simulated patients and environments, computer-based systems (multimedia programs, interactive systems, virtual reality) and integrated simulators. The use of clinical skill laboratories does not replace, but rather complements bedside teaching in health care facilities. Prioritise patient's safety in appointing simulated patient in the clinical skills training.

The school has identified all clinical teaching sites (both inpatient and ambulatory) that will be used for clinical clerkships. There is a written agreement between the institution and all clinical affiliates that are used regularly for required clinical clerkship. The school has a comprehensive plan of clerkship program for students in all clinical teaching sites which support the intended learning outcome. The clerkship program has been designed and developed in cooperation with

teaching hospitals and other clinical teaching sites which cover both general and specialist services. If there are any students from other health professions programs or residents that also use these facilities the medical school has a policy as to how scheduling conflicts are resolved. The medical school has mandatory requirements and documents to access hospital wards for students participating in clinical clerkship. The school has information for inpatient and outpatient services used for all required clinical clerkships at each hospital. Only provide information for services used for required clinical clerkships at each hospital. Schools with regional campuses should include the campus name for each facility. The medical school has data and information of the mix of inpatient and ambulatory settings used for required clinical clerkships shown to be adequate in the numbers and types of patients in each discipline. The school has a policy and implements monitoring and evaluation program for clerkship program, students, faculty, hospitals, and other clinical teaching site staff feedback is available.

The medical school has a community - based education and services program to expose medical students early in their training and throughout their education to the public health and primary health care needs of communities. The program has been designed and developed to support the intended learning outcome in public health and community health. The program also aims to create awareness among students of the importance of developing community partnerships to implement sustainable healthcare initiatives. The school considered community-based training placements are important to provide situated or contextual learning. The faculty shows a strong commitment to community- based training by providing sufficient resources for the program.

The school has a policy that helps improve high quality staff recruitment, retaining and performance by providing clear mission, feedback and career development support and well-defined staff role and expectation. The school encourages staff participation in decision-making related to medical education programs including but not limited to policy making discussion. All medical school faculty members work closely together in teaching, research, and health care delivery. The medical school is part of a university offering other graduate and professional degree programs that contribute to the academic environment of the medical school. The medical school has an effective curriculum committee that oversees the planning, implementation, monitoring, and evaluation of educational programs. The academic staff is responsible for the planning and implementation of the components of the curriculum. There is evidence of effective curriculum management. The educational program for all medical students remains under the control of the medical school's faculty. Written affiliation agreements provide assurance of medical student and faculty access to appropriate resources for medical student education.

6.3. Information Resources: The school provides adequate access to virtual and physical information resources to support the school's mission and curriculum.

Consider the school's provision of access to information resources for students and academic staff, including online and physical library resources. Evaluate these facilities in relation to the school's mission and curriculum in learning, teaching, and research.

Key Questions	Criteria for Compliance
6.3.1 What information sources and resources are required by students, academics, and researchers?	How do you identify the needs of information sources and resources for students, academics and researchers? How do you ensure that the information sources and resources are up to date and well maintained?
6.3.2 How are these provided?	How do you provide information sources and resources required by students, academics and researchers?
6.3.3 How is their adequacy evaluated?	How do you monitor and evaluate information sources and resources that serve the needs of the students, academics, and researchers? How do you improve, update, and renew the information sources and resources?
6.3.4 How does the school ensure that all students and academic staff have access to the needed information?	What are the procedures for students and academic staff to get access to the needed information?

Guidance for Assessor

Students, academics, and researchers require paper-based and electronic-based or computer-based information resources. The information technology systems are up to date and well maintained to meet the needs of staff and students.

A digital library is shown to be set up, in keeping with progress in information and communication technology. The school provides ready access to well-maintained library resources sufficient in the numbers and variety of textbooks, journals and other sources and technology to support its educational and other missions. The university is shown to provide a highly accessible computer and network infrastructure. Students, faculty, and administration have access to sufficient information technology resources, including access to Wi-Fi, to support learning outcomes and the achievement of the school's goals.

The institution implements a program of regular monitoring, evaluation, and feedback regarding information resources from students, academic staff, and administration. The library and information centres have built up collection, management, and dissemination of information resources to meet the needs of the academic, research and administrative users. A policy and plan are in place for continuous improvement, updating and renewal of adaptive information resources.

The quality of the facilities shown to be subjected to evaluation and enhancement. Library services are supervised by a professional staff that is responsive to the needs of the medical students, faculty members, and others associated with the institution. The library has sufficient number and quality of textbooks and journals. It has opening hours sufficient for students to have ready access to its resources. Information technology staff with appropriate expertise are available to assist students, academic staff, and administration. Off-campus access to electronic resources should be seamless from any medical school networked computer. It is eligible for all students, faculty, and staff members with valid IDs.

Supporting documents

- List of physical infrastructure
- List of other learning supporting systems. Learning Management System, Internet speed
- List of academic hospital network and teaching clinics
- List of facilities in the academic hospitals and Teaching Clinics (discussion rooms, room for night shift, library, etc.)
- List of mannequins available for clinical skill training of the students
- List of standardised patients, report of the training of the standardised patients
- List of training and its reports of the clinical teachers and preceptors
- List of databases of available journals
- Forms for evaluation and feedback from students and academic staff and administration for available information resources
- Facilities to access information resources
- Data on the results of satisfaction surveys for the services provided by the management to all stakeholders (students, faculty, staff, associates, and employer of the alumni).
- Data on the results of satisfaction surveys for adequateness, quality and access to physical facilities and equipment and information resources for education and clinical training.

Criteria 7. Quality Assurance

7.1. The Quality Assurance System: The school has implemented a quality assurance system that addresses the educational, administrative, and research components of the school's work

Consider the purposes, role, design, and management of the school's quality assurance system, including what the school regards as appropriate quality in its planning and implementation practices. Design and apply a decision-making and change management structure and process, as part of quality assurance. Prepare a written document that sets out the quality assurance system.

Key questions:	Criteria for Compliance
7.1.1 How are the purposes and methods of quality assurance and subsequent action in the school defined and described, and made publicly available?	How has the internal quality assurance system been established, implemented, maintained, and continuously improved? What are the processes required for the quality management system and their application throughout the organisation and how are they determined? How does the school determine and apply the criteria and methods (including monitoring, measurement, and related performance indicators) necessary to ensure the effective operation and control of these processes? How does the school determine the resources required for this process and ensure their availability? How does the school assign responsibilities and authorities for these processes? How does the school address risk and opportunities?

	How does the school evaluate these processes and implement any necessary changes to ensure that these processes achieve the desired result? How does the school provide and disseminate information to the public?
7.1.2 How is responsibility for implementation of the quality assurance system clearly allocated between the administration, academic staff, and educational support staff?	How does the school assign responsibility and authority to ensure that the quality management system complies with the requirements of standards that are used? How does the school ensure that reporting on the performance of the quality management system and opportunities for improvement has been established? How does the school ensure that the integrity of the quality management system is maintained? What changes occur when the quality management system is planned and implemented? How does the school provide the people needed for the effective implementation of its quality management system and for the operation and control of its processes?
7.1.3 How are resources allocated to quality assurance?	How does the school identify resources needed for the implementation, maintenance and continuous improvement of the quality assurance system? How does the school justify that the allocated resources are sufficient?
7.1.4 How has the school involved external stakeholders?	How does the school identify the relevant external stakeholders for the quality management system?
7.1.5 How is the quality assurance system used to update the school's educational design and activities and hence ensure continuous renewal?	How does the school utilise the results of the quality assurance system to identify, review and control changes made during, or after, the design and development of educational programs? How does the school evaluate the performance and effectiveness of the education program? How does the school identify and select opportunities for improvement and implement any necessary actions to meet stakeholder needs and to increase stakeholder satisfaction?

Guidance for Assessor

It is advisable for the institution to explain the method used which includes the PDCA cycle:

a. the organisation explains whether it understands the needs and expectations of interested parties.

b. the organisation should explain the scope of the quality management system.

c. the organisation should explain that it has established, implemented, maintains, and continuously improves a quality management system, including the necessary processes and their interactions, in accordance with the requirements of the Standard.
d. the organisation should describe the processes required for the quality management system and their application throughout the organisation,
    - determine the required inputs and expected outputs from the process;
    - determine the sequence and interaction of these processes;
    - determine and apply the criteria and methods (including monitoring, measurement, and related performance indicators) necessary to ensure the effective operation and control of these processes;
    - determine the resources required for this process and ensure their availability;
    - assign responsibilities and authorities for this process;
    - address risks and opportunities evaluate this process and implement any necessary changes to ensure that this process achieves the desired result.

Top management should assign responsibility and authority to ensure that the quality management system complies with the requirements of international standards. Top management should ensure that reporting on the performance of the quality management system and opportunities for improvement for top management have been established. Top management should ensure that the integrity of the quality management system is maintained. When changes occur to the quality management system is planned and implemented. Top management should explain how to determine and provide the people needed for the effective implementation of its quality management system and for the operation and control of its processes

The school explains how the implementation, maintenance and continuous improvement of resources is carried out. The school determines the external stakeholders relevant to the quality management system.

The school identifies, review and control of changes made during, or after, the design and development of educational programs. The school evaluates the performance and effectiveness of the quality management system. The school retains appropriate documented information as evidence of results. The school identifies and selects opportunities for improvement and implements any necessary actions to meet customer needs and increase customer satisfaction.

Supporting Documents

- Organisation chart of the internal quality assurance system
- Policy and procedures of quality assurance of the medical school and quality standard
- Reports on the internal quality audit
- Resources allocated to quality assurance
- Minutes of meeting and report of the involvement of the external stakeholders in the quality management system.
- Follow-up documents on the quality assurance feedback for continuous quality improvement.

Criteria 8. Governance and Administration

8.1. Governance: The school has a defined governance structure in relation to teaching, learning, research, and resource allocation, which is transparent and accessible to all stakeholders, aligns with the school's mission and functions, and ensures stability of the institution

Describe the leadership and decision-making model of the institution, and its committee structure, including membership, responsibilities, and reporting lines. Ensure that the school has a risk management procedure.

Key questions:	Criteria for Compliance
8.1.1 How and by which bodies are decisions made about the functioning of the institution?	Which bodies are responsible for decisions made related to the functioning of the school? How do the school bodies make decisions on the functioning of the school?
8.1.2 By what processes and committee structures are teaching, learning, and research governed in the institution?	How are the teaching-learning and research activities governed by the school? Which structures are responsible for managing teaching-learning and research activities?
8.1.3 How is the budget aligned with the mission of the school?	Can you explain the alignment between budget allocation with the mission of the school?
8.1.4 What governance arrangements are there to review the performance of the school?	Which body is responsible for reviewing the performance of the school?
8.1.5 How are risks identified and mitigated?	By what mechanisms does the school identify and mitigate all risks which may occur during teaching-learning, research and budget allocation?

Guidance for Assessor

The school has an appropriate organisational structure of governing board, school administrator and faculty members that describes their function related to teaching, learning, research, and resource allocation. This structure is transparent and can be accessed by all stakeholders and aligns with the university vision and mission. The school governance also aligns with the teaching hospitals function as a resource for clinical teaching. The school provides policies, procedures, and regulations to prevent conflict of interest at the level of governing administration and faculty members.

Teaching, learning, and research are governed by a body and its committee structures. All members of the committee have responsibilities for planning, implementing, monitoring-evaluating, and reporting all activities regarding teaching, learning, and research from team members-committee chairman-the Dean.

The budget allocation is developed based on the mission of the school related to teaching, learning, and research activities; accessible and transparent.

There is a body (under the university) that is assigned to review the performance of the school periodically e.g., Internal Quality Assurance Body.

The school develops a risk management system including risks in clinical settings outside the school to identify and mitigate all risks which may occur regarding the activities of teaching, learning, research, and resource allocation.

8.2. Student and academic staff representation: The school has policies and procedures for involving or consulting students and academic staff in key aspects of the school's management and educational activities and processes.

Consider how students and academic staff might participate in the school's planning, implementation, student assessment, and quality evaluation activities, or provide comment on them. Define mechanisms for arranging student and academic staff involvement in governance and administration, as appropriate.

Key questions:	Criteria for Compliance
8.2.1 To what extent and in what ways are students and academic staff involved in the school decision-making and functioning?	How far are the students and academic staff involved in school decision-making and functioning?
8.2.2 What, if any, social or cultural limitations are there on student involvement in school governance?	What are the limitations regarding socio-cultural aspects of student involvement in school governance?

Guidance for Assessor

The school involves students and staff in medical education programs (e.g., curriculum revision, student assessment) and institution management (governance: school decision-making and functioning) to improve the quality of the school.

There is no obstacle to socio-cultural aspects of student involvement in school governance. Students are given the opportunity to freely sound their thinking and argumentation.

8.3. Administration: The school has appropriate and sufficient administrative support to achieve its goals in teaching, learning, and research

Develop a policy and review process to ensure adequate and efficient administrative, staff, and budgetary support for all school activities and operations.

Key questions:	Criteria for Compliance
8.3.1 How does the administrative structure support the functioning of the institution?	How does the school design the administrative structure? What are the roles of the administrative structure in supporting the functioning of the school?
8.3.2 How does the decision-making process support the functioning of the institution?	What are the roles of the decision-making process regarding the functioning of the school?
8.3.3 What is the reporting structure for administration in relation to teaching, learning, and research?	How does the school design the administrative reporting structure on teaching-learning and research programs/activities.

Guidance for Assessor

The administrative structure is designed by the institution based on its need and function in supporting the school. Schools provide appropriate administration staffing to be able to plan and develop programs including developing policy and review processes to warrant adequate and efficient administrative matters.

The school conducts regular meetings involving all governing boards, academic staff, students, and other stakeholders to plan, implement, evaluate, and take any action regarding school activities and operations so that the institution can function appropriately.

The reporting structure for administration in relation to teaching, learning, and research includes administrative, staff, budget, outcomes, and obstacles (plan and realisation).

The administrative structure is designed by the institution based on its need and function in supporting the school. The school provides appropriate administrative staffing to be able to plan and develop programs.

The school conducts regular meetings to plan, implement, evaluate, and take any action regarding school activities and operations so that the institution is able to function appropriately.

Supporting Documents

- Organisation chart of the management and administrative of the school
- Standard operating procedure for budget allocation
- Report on the school performance review
- Document on risk identification and mitigation
- Reports on students and academic staff in decision making and functioning. Minutes of meeting of the discussion
- Standard operating procedure for decision making process
- Standard operating procedure for reporting of teaching, learning and research

Chapter 2. Accreditation Procedures

Accreditation procedures will be conducted within eight stages starting form eligibility and registration up to certificate issuance as depicted in figure 1.

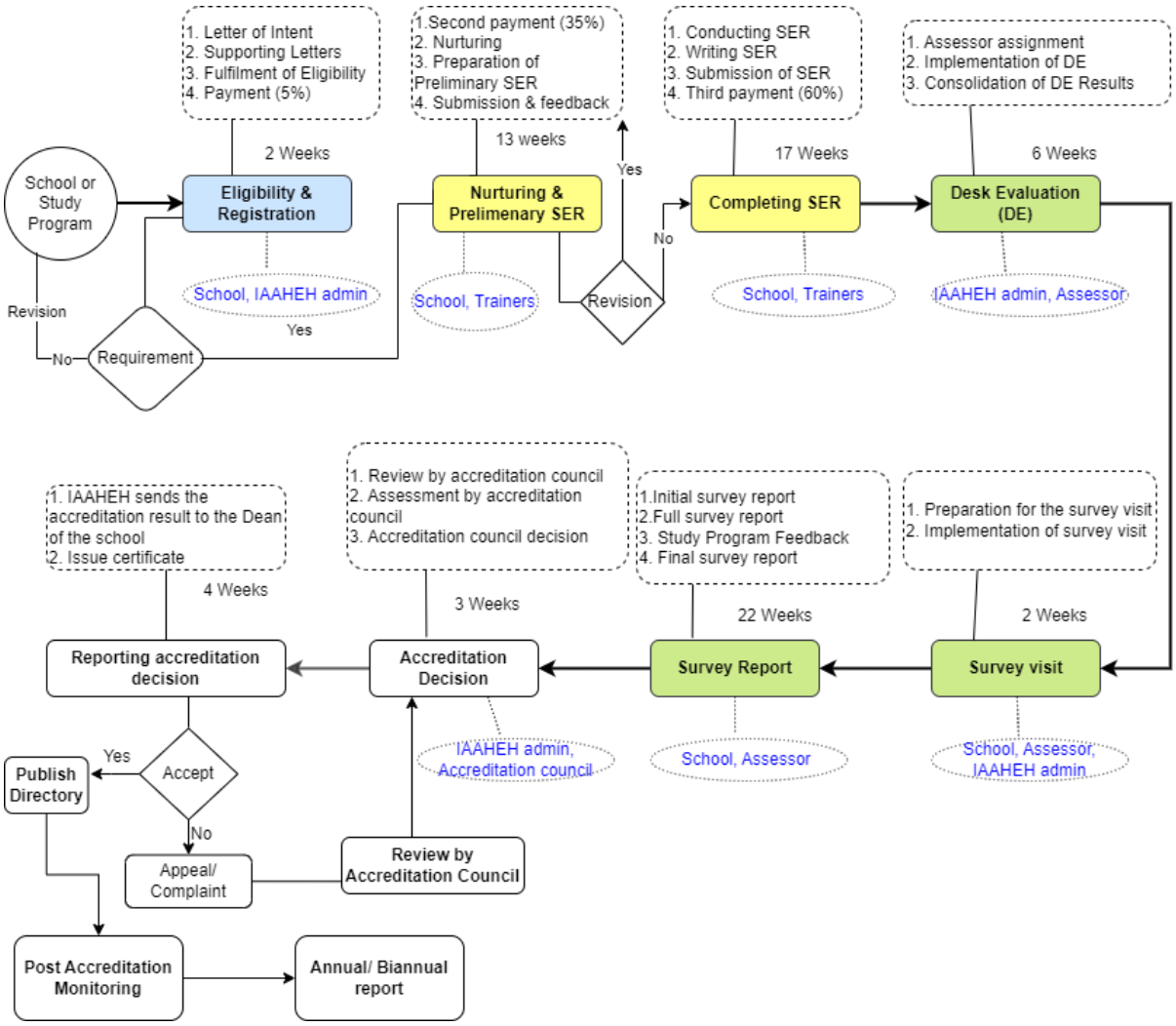

Figure 1. Accreditation Process Flowchart

Stage 2.1 Eligibility and Registration

Any new medical education program seeking IAAHEH accreditation registration must follow a series of steps outlined in the IAAHEH Handbook for medical school. Clearly, IAAHEH expects some elements of institutional organization, operation, and resources to be in place before IAAHEH do consider the programs for accreditation registration. These eligibility criteria are described below.

Medical schools/Medical colleges are encouraged to consult with IAAHEH secretariat to ensure that they meet the eligibility criteria prior to proceed to the second stage, i.e registration.

2.1.1 Governance and Organization Structure

A medical school should have fulfilled at least the following regarding governance structure and institutional setting of the medical education programs:

a. For medical schools operating as part of a university, formal delineation of the relationshipbetween the medical school and the parent university is provided.
b. For medical schools operating as a stand-alone education institution, a decree from the relevant authorities of a country should be provided. This decree should mention that the medical school or medical college is granted a degree – granting power of medical degree for their medical graduates.
c. Definition of the governance structure of the medical school, including the composition and terms of membership of any governing board, should be provided.
d. Appointment letter for the governance structure (such as board, deaneries, any relevant committees/units/departments as required for the operation of medical school/colleges.
e. Appointment letter for the senior leadership within the dean's staff, particularly in the areas of academicaffairs, student affairs, hospital relationships, and administration & finance.
f. Appointment letter for administrative leadership (e.g., department chairs or their equivalent) for academic units that will have major responsibilities for medical student education, especially inthose disciplines to be taught during the two years of the curriculum.
g. Appointment letter of the major standing committees of the medical school, particularly those dealingwith the curriculum, student advancement, admissions, and faculty promotion & tenure.

2.1.2 Educational Program

The educational program is essential for IAAHEH accreditation process and standards. Prior to admitting its first class of students, a school is expected to have accomplished at least the following for its educational program:

a. Graduate profiles and competencies.
b. Creation of a working plan for the curriculum as a whole, consistent with the learning outcomes.
c. Detailed layout of the first year of study, including required courses and content, and identification of the resources needed for the delivery of required courses.
d. Specification of the types of teaching and student evaluation methods best suited for the achievement of educational objectives.
e. Design of a system for curriculum management.

Learning objectives should include general objectives for the educational program as a whole and specific learning outcome at the level of required courses and clerkships, and so need to be specified at the earliest stages of program planning. The structure of curriculum should be integrated horizontally and vertically to enhance early clinical exposure.

2.1.3 Students

A school has to fulfill the following requirement before requesting consideration for accreditation registration:

a. Clearly defined admissions policies and selection criteria.
b. Sufficient student services at least in the areas of academic counselling, financial aid, health services, and personal counselling.
c. Written standards and procedures for the evaluation, advancement, and graduation of students and for disciplinary action, including appeal mechanisms to assure due process.

2.1.4 Staff

A school should be able to provide the following requirements regarding faculty when a school applies for accreditation registration:

a. Specific written policies and procedures for faculty appointment, promotion, and tenure.
b. Availability and sufficient number of faculty in biomedical and clinical sciences. Sufficient number of other staff as needed for the implementation of institutional plans regarding medical student selection, and curriculum development and management.

2.1.5 Educational Resources

A school should be able to provide the following requirements regarding budgets, financial resources, and physical facilities when applying for accreditation registration:

a. Supporting financial resources for the first five years of educational programs.
b. Physical facilities for face-to-face education program which include classroom space, discussion room, student lounge, and supporting educational infrastructure for the whole program.
c. Facilities for distributed and distance learning which include IT infrastructure, learning management system, and electronic learning resources.
d. Availability of other resources including library, information technology, student and staff security services.
e. Availability of academic hospital and other health care facilities as clinical teaching sites, demonstrated by ownership or having access (MOU).

Criteria	Criteria for Eligibility
a. Governance and Organization Structure	
For medical schools operating as part of a university, formal delineation of the relationship between the medical school and the parent university is provided.	1. Medical school is attached to/part of university. 2. Documentation of the organization structure of the university and the medical school. 3. Address of main campus office 4. Website
For medical schools operating as a stand-alone education institution, a decree from the relevant authorities of a country should be provided. This decree should mention that the medical school or medical college is granted a degree – granting power of medical degree for their medical graduates.	1. Formal or legal documentation of the organization structure of the medical school. 2. Legal documentation of medical degree granting power. 3. Address of main campus office 4. Website
Definition of the governance structure of the medical school, including the composition and terms of membership of any governing board, should be provided.	1. Formal or legal documentation of the organization structure of the medical school. 2. Composition, term of membership, and function of the governing board.
Appointment letter for the governance structure (such as board, deaneries, any relevant committees/units/departments as required for the operation of medical school/colleges.	1. Availability of formal documentation and organization structure of medical school. 2. Function of governing board, deaneries, and other relevant units/committee/department
Appointment letter for the senior leadership within the dean's staff, particularly in the areas	Availability of appointment letter for those positions (dean's staff, particularly in the areas of

of academic affairs, student affairs, hospital relationships, and administration & finance.	academic affairs, student affairs, hospital relationships, and administration & finance)
Appointment letter for administrative leadership (e.g., department chairs or their equivalent) for academic units that will have major responsibilities for medical student education, especially in those disciplines to be taught during the two years of the curriculum.	Availability of appointment letter for those positions (department chairs or their equivalent)
Appointment letter of the major standing committees of the medical school, particularly those dealing with the curriculum, student advancement, admissions, and faculty promotion & tenure.	Availability of appointment letter for those positions (the curriculum committee, student advancement and admissions committee, and faculty promotion & tenure committee)
b. Educational Program	
Graduate profiles and competencies.	Availability of curriculum documents
Creation of a working plan for the curriculum as a whole, consistent with the learning outcomes.	Availability of curriculum plan
Detailed layout of the of the whole program, including required courses and content, and identification of the resources needed for the delivery of required courses.	Availability of instructional design book
Specification of the types of teaching and student evaluation methods best suited for the achievement of educational objectives.	Availability of curriculum document
Design of a system for curriculum management	Availability of instructional design book
c. Students	
Clearly defined admissions policies and selection criteria.	Availability of policy of student's selection and admission
Sufficient student services at least in the areas of academic counselling, financial aid, health services, and personal counselling.	Availability of student support service unit
Written standards and procedures for the evaluation, advancement, and graduation of students and for disciplinary action, including appeal mechanisms to assure due process.	Availability of standard operational procedures on evaluation, advancement, and graduation of students and for disciplinary action, including appeal mechanisms to assure due process
d. Staff	
Specific written policies and procedures for faculty appointment, promotion, and tenure.	Availability of policies and procedures for faculty appointment, promotion, and tenure
Sufficient number of faculty in biomedical and clinical sciences. Sufficient number of other staff as needed for the implementation of institutional	Availability of sufficient number of faculty in biomedical and clinical sciences

plans regarding medical student selection, and curriculum development and management.	
e. Educational Resources	
Supporting financial resources for the first five years of educational programs.	1. Availability of bank guarantee 2. Budget planning
Physical facilities for face-to-face education program which include classroom space, discussion room, student lounge, and supporting educational infrastructure for the whole program.	3. Availability of teaching and learning and clinical practice learning facilities 4. Availability of student support facilities
Facilities for distributed and distance learning which include IT infrastructure, learning management system, and electronic learning resources.	1. Availability of distributed and distance learning facilities, IT infrastructure, learning management system, and electronic learning resources 2. Availability of sufficient faculty/staff to support distributed and distance learning
Other resources including library, information technology, student and staff security services.	1. Availability of library and information technology 2. Availability of student and staff security services
Academic hospital and other health care facilities as clinical teaching sites, demonstrated by ownership or having access (MOU).	1. Availability of academic hospital and other health care facilities as clinical teaching sites 2. Availability of ownership or having access (active MOUs)

2.1.6 Accreditation Registration

Accreditation registration is done after fulfilment of eligibility criteria by the medical school/colleges.

The school needs to submit a request for Accreditation, with the following requirements:

a. Related documents to section 2.1.1;
b. The accreditation team of the school apply the accreditation online through the website: https://accreditation.iaaheh.org.
c. Then, the school representative creates an account by entering the name of responsible person of accreditation team, develops a username, an email address of the school and a password.
d. Further, please ensure the accreditation team agrees to the privacy policy & terms of conditions.
e. Finally, click the "register" and a verified email will be sent to the school email address (registered email).
f. Accreditation process will be initiated after signing the contract (Appendix 1)

After the verification process is completed, please open or re-visit the website (https://accreditation.iaaheh.org.) and enter the email address or username and its password then click sign in. Then, complete the required data and documents into the system. The potential documents need to be ready in PDF, such as:

a. Letter of Intent,

b. Supporting letters from relevant local authorities or government,
c. Expression of interest, includes a brief description of the study program,
d. The decree of school establishment from relevant authorities,
e. A statement letter,
f. A signed agreement (appendix 1)
g. A bank transferred proof of payment (5%)

All documents are uploaded through the system, then wait for the checking process from the admin. The information of acceptance or refusal will be notified on the SIMAk-Int system and by email.

The process of registration is demonstrated as follows:

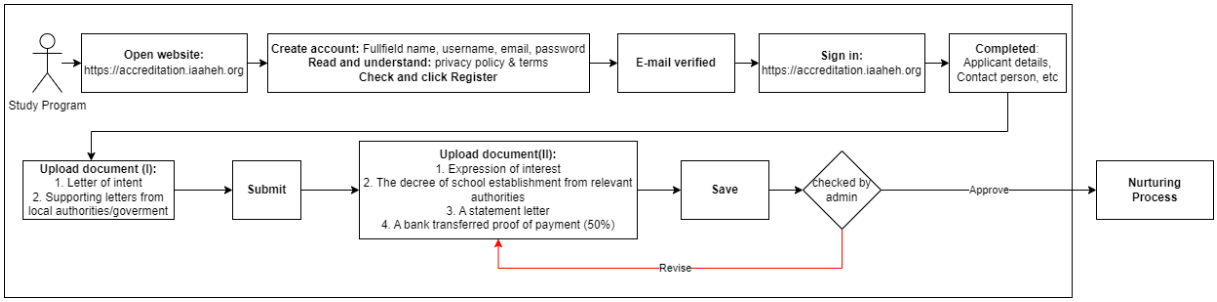

Figure 2. Registration Flowchart

A letter requesting IAAHEH international accreditation is submitted with the following attachments:

a. The Legal Document on the establishment of the school
b. A statement letter, according to the attached format (Appendix 2)
c. A copy of National Accreditation Certificate
d. Appointment from the head of institution to the accreditation committee of the study program
e. Supporting documents regarding eligibility as described above.

2.1.7 Mechanism of Accreditation Payment

Study Program Accreditation Fees

The fees that must be paid to the IAAHEH for the accreditation of one study program which cover:

a. Nurturing
b. Desk evaluation
c. Survey visit
d. Daily expenses for the assessors
e. Review of the monitoring report

The Cost will not cover:

a. Appeal process
b. Cancellation of survey visit schedule by the school.
c. Local transports
d. Round trip tickets (Business class is applied for trips more than 7 hours)
e. Accommodation
f. Travel insurance

g. Travel Document (visa, etc)

Stage 2.2 Nurturing and Preliminary Self-Evaluation Report

2.2.1 Nurturing

The school should understand the IAAHEH accreditation standards, instruments, and procedures before submitting the preliminary self-evaluation report. For this purpose, IAAHEH provides training for the members which is carried out in the study program for **three days** (training agenda and content see appendix 3). IAAHEH will assign two trainers. The content of the training will cover how to prepare the SER and other required documents. The trainers will take the opportunity to get acquainted with the study program.

2.2.2 Preparation of Preliminary Self-Evaluation Report

After the training is completed, the institution will prepare a preliminary self-evaluation report according to the provided guidance to be submitted maximum **eight weeks** after the completion of the training. The preliminary SER should be sent online to the IAAHEH. The trainers will review the preliminary SER and provide online feedback within **two weeks**. The school is then given **four weeks** to revise the SER based on the feedback received. The final revision of the preliminary SER is then submitted online to the IAAHEH.

2.2.3 Submission and Feedback of the Preliminary Self-Evaluation Report

The preliminary SER should be sent online to the IAAHEH Secretariat through SIMAk-Int. The assessors will review the preliminary SER and provide online feedback within **two weeks**. The school is then given **four weeks** to revise the SER based on the feedback received. The final revision of the preliminary SER is then submitted online to the IAAHEH Secretariat.

Stage 2.3 Completing Self-Evaluation Report (SER)

2.3.1 Conducting Self-Evaluation

Upon receiving an approval for the preliminary SER, the institution then conducts a full self-evaluation in accordance with the guidelines for self-evaluation. The school is given a duration of **ten weeks** to complete the self-evaluation.

2.3.2 Writing the Self-Evaluation Report (SER)

After conducting the self-evaluation procedures, the institution writes an SER in line with the directions provided in Chapter 3. During the preparation of the SER, the IAAHEH trainers may provide online consultation as needed. The institution is given the duration of **six weeks** to complete the report.

2.3.3 Submission of the SER to IAAHEH

The institution submits the SER online to the IAAHEH along with its supporting documents after obtaining an approval from the trainers. The institution uploads the SER on the SIMAK-Int (Accreditation management information system) website: https://accreditation.iaaheh.org

Requirements for the submission of the Self-Evaluation Report are:

a. SER must be submitted and made available in softcopy to the IAAHEH, maximum **seventeen weeks** after obtaining the preliminary SER approval.
b. The submitted SER will be treated as the “final and official” document and no further changes to the documents are allowed.

Stage 2.4 Desk Evaluation (DE)

2.4.1 Assessor Team

IAAHEH will assign a 5-person Assessor Team consisting of a chair, concurrently a member, a secretary, also concurrently a member, and 3 members, one of them being an international assessor within **two weeks**. The team comprises 1 member from basic medical science, 1 member from public health, 1 member from medical education, 1 member from clinical sciences, and 1 member who has experience in managing a medical school (Appendix 4).

2.4.2 Implementation of Desk Evaluation

Each assessor conducts a desk evaluation independently for **two weeks** (online).

2.4.3 Consolidation of Desk Evaluation Results

The Assessor Team holds an online meeting to consolidate the results of the desk evaluation within **two weeks**.

Stage 2.5 Survey Visit

The survey visit includes two steps which are preparation of visit and survey visit. Preparation of visit is done for **one week**, starting from IAAHEH sending notification letters to the school and the name of the assessors, as well as the date of the survey visit. The survey visit will last for **four working days excluding round-trip travel to the school**. For the preparation of the survey visit, the school may refer to the guidance in Chapter 4.

The survey visit should focus on self-evaluation and management of the study program. Qualitative and quantitative data and information should be provided to prove the effectiveness of the internal quality assurance system.

2.5.1 Preparation for the survey visit

Prior to the survey visit, the assessor team must review the material that has been submitted by the institution. Based on the SER, the assessor team devises a survey visit plan which includes notes of items needing verification/ validation during the survey visit. Upon completing and approving the SER, the secretary of the assessor team and faculty accreditation team will organise the survey visit.

The institution should issue an invitation letter for the visa application of the international assessor. IAAHEH sends notification letters to the institutions and assessors regarding the date of the survey visit in the schedule agenda.

2.5.2 Implementation of Survey Visit

The survey visits last for 4 days excluding the round-trip travel to the school (typically takes 1-2 days).

2.5.3 Reporting of the survey visit

2.5.3.1 Initial Survey Visit Report

During the visit, assessors develop a list of findings related to specific elements. Thereafter, the secretary of the team prepares a narrative report for the Dean based on the findings of all the team members. The early findings are compiled in the form of an initial report subject to additional detail during the writing of the final survey visit report. This report is confidential and should only be accessed by the Dean.

The Assessor Team meets online to prepare a draft site report. The purpose of the initial report is for the assessor team to provide their findings to the medical school management. The assessor team conducts the visit to gather sufficient information and evidence of each sub-criteria to justify each finding. The visit is guided by the survey visit plan previously developed by the assessors during the preparation of the visit. These findings will be presented to the management of the medical school during the closing meeting and are written in accordance with the survey visit report. The findings should be delivered in a concise, sufficiently clear, and detailed manner. Relevant descriptions and data should also be included in the finding. Although the survey is conducted as a team, each member of the team is responsible for specific aspects of the visit and the report writing process. The survey visit reports by each member of the team are submitted to the chief of the team. The chief and the secretary of the team will compose the initial survey visit report and initiate discussions in the team. Although each member of the team has his/her own task, all members are welcome to contribute to the findings of the standard assigned to other members of the team. A copy of the initial report is provided to the management of the medical school in the closing meeting. The report should not be discussed or disseminated by the school to other parties.

2.5.3.2 Full Survey Visit Report

Two weeks after the survey visit, the report and its appendices should be written in the provided IAAHEH format by the assessor team. The report will be finalised in **one week**. The report includes information based on the SER and information gathered during the survey visit. Documents of findings during survey visit related to elements that can be considered as strengths, areas of concern, or areas that need further evidence are separately reported. The survey visit report should not include or mention compliance with the standard, the accreditation status, or actions that should be taken by the institution. These decisions will be made exclusively by IAAHEH accreditation council.

The full survey visit report is necessary for the council of IAAHEH to come to a decision on the accreditation status of the study program under review. The assessor is responsible for his specific section of the final report. The final report is written in accordance with the template. Any additional information or evidence to support the written findings in the report should be provided in the attachment to the report. Aside from the narrative report, the final report should include a list of findings that are presented into categories of 'Strength', 'Areas of Concern', and 'Areas that Need Further Evidence' as described in Chapter 4. Each assessor should submit a draft of their written section report to the secretary of the team three days before the assessor meeting commences. The secretary of the team is responsible for compiling the report draft. The chief of the assessor team is responsible for writing the summary of the survey visit's findings.

The report contains a list of findings during the visitation, organised by standards and sub-criteria of the standards. The sub-criteria of the standards should be included specifically in the report if there is a finding that needs to be monitored or followed up by the medical school. The members of the team should ensure that the findings are written in detail and fully explained and documented in the reports. The information provided in the sub-criteria of the standards should be sufficient to ensure the report is fully understood by the reader. If necessary, the final report could also include relevant attachments in its appendices. The attachments are arranged sequentially, and the appendices are listed on the page following the last page of the report narrative.

The secretary of the team will provide the draft to the other members of the team via e-mail or share it through the official cloud repository of IAAHEH. All members of the team should read the draft prior to the meeting and make notes of insufficient narrative or necessary

changes to be discussed during the meeting. The main agenda of the meeting is to discuss and finalise the final report. The full report will be sent through SIMAk-Int to medical school for input and feedback.

2.5.3.3 Feedback on the Report from the Study Program

The finalised draft of the final report is sent to the secretariat of IAAHEH which will proceed to send the draft to the study program for review. The Dean is responsible for ensuring that the narrative report and the supporting data are reviewed thoroughly since the final report will serve as a formal record of visitation. The response of the Dean of the draft report to the team secretary is only related to the information available in SER or provided during the survey visit. The Dean may only provide feedback regarding the findings where there is an error due to incorrect evidence which significantly impacts the findings. The feedback should be submitted within **two weeks**. If the Dean does not provide any feedback on the draft within two weeks, the draft is considered correct and accepted as it is by the study program. Writing of final survey visit report uploading the final survey visit report within **four weeks** after the feedback submission.

2.5.3.4 Final Survey Visit Report

The final report and the list of findings would then be submitted to the accreditation council of IAAHEH to decide the status of the accreditation of the study program **(four weeks)**.

Survey Report Format

Executive Summary
Glossary

Criteria 1. Missions and Values

Narrative response:

- The use of vision and mission for planning, quality assurance, and management in the school.
- Alignment with regulatory standards of the local agency and with the relevant governmental requirements
- Alignment of vision, mission, aim and strategy; developed during schools' activities and program planning process.

Criteria 2. Curriculum

Narrative response:

- The graduate's outcomes in line with teacher's teaching and learning planning strategy
- Narrative of curriculum development process (planning, implementation, evaluation): note's meeting, list of attendance, other supporting documents
- Alignment of intended graduate outcome with graduate career role in society derived from institution vision and missions, the education philosophy and need analysis.

Criteria 3. Assessment

Narrative response:

Brief description on assessment policy (centralised system), alignment with its curriculum outcomes, management (frequencies, timing), Standard assessment, criteria, and decision

Criteria 4. Students

Narrative response:

- Description of the student support system (relevance, accessibility, confidentiality)

- Students support systems: academic and non-academic, communication with students

Criteria 5. Academic Staff

Narrative response:

- Description on academic staff planning (manpower plan) including the number, discipline mix, academic and professional development plan of the academic staff.
- Initial training for academic staff should there is any.
- Performance evaluation and reports of the academic staff.
- Feedbacks provided to the academic staff.

Criteria 6. Resources

Narrative response:

- Judgement for the school to provide certain physical infrastructures (buildings, classrooms, etc.) based on the curriculum designed and the national or university standard (e.g., room per students in class, in laboratory, internet bandwidth per students, academic staffs, etc.).
- policies for students to learn clinical skills, in a simulated setting, but also in the real setting, with mannequins, simulated patients or real patients.
- Policies on student's clinical education, either in the hospital, clinic, or community-based setting
- Policies on study resources provision, library (incl. Books, journals, electronic or hard copies), internet bandwidth, etc.

Criteria 7. Quality Assurance

Narrative response:

- Policies on quality assurance, its purposes and methods and subsequent action.
- Quality assurance system is embedded in the structure of the organisation, with its allocated resources.
- Involvement of external stakeholders in quality assurance

Criteria 8. Governance and Administration

Narrative response:

- The organisation chart of the institution and its function and responsibilities
- Budget decision making in the organisation
- Involvement of students and academic staff in decision making and functioning
- Reporting structure for administration in relation to teaching.

Preparation of Survey Visit Reports

- **Assessor Team Online Meeting**

  The Assessor Team meets online to prepare a draft survey report in **one week**. Each assessor prepares a report according to their assigned criteria which will be compiled by the secretary of the team and to be sent to the school through https://accreditation.iaaheh.org for input and feedback in **four weeks** after the assessor meeting.

  The school submitted input and feedback for the draft survey visit report through https://accreditation.iaaheh.org to IAAHEH within **two weeks** after receiving the draft survey visit report.

Comments and additional information from the study program will be forwarded to the assessors to be discussed in the second round of the assessor meeting. Adjustments will be made to the draft of the final report if the additional information is considered substantial and significant enough to be included. The Assessor Team of IAAHEH will revise the draft survey visit report based on input and feedback from the medical school within a maximum of **four weeks** after receiving the report. The Assessor Team will meet online to consolidate the final survey visit report. Assessors should decide whether each sub-criteria and criteria is full compliance, partial compliance, or noncompliance. The definition is provided in Appendix 5.

The Secretary uploads the final survey visit report to the https://accreditation.iaaheh.org. The final survey visit report and the list of findings would then be submitted to the accreditation council of IAAHEH for the decision of the study program accreditation status.

- **Submitting the Draft Survey Visit Report to the Medical School**
  IAAHEH sends a draft of the survey visit report to the medical school for input and feedback.

- **Preparation of Final Survey Visit Report**
  The Assessors revise the report based on input from the institution within a maximum of two weeks. The assessors then upload the survey visit report to the SIMAk-Int of IAAHEH.

- **Consolidated Summary of Compliance with Standard**
  Assessors complete the following table based on the conclusion from the Self-Evaluation Report and the Survey Visit Report.

Standard	Summary of Self Evaluation Report Conclusion	Summary of Survey Visit Report Conclusion
1. MISSION AND VALUES		
1.1 Stating the mission		
2. CURRICULUM		
2.1 Intended curriculum outcomes		
2.2 Curriculum organisation and structure		
2.3 Curriculum content		
2.4 Educational methods and experiences		
3. ASSESSMENT		

3.1 Assessment Policy and System		
3.2 Assessment in support of learning		
3.3 Assessment in support of decision-making		
3.4 Quality control		
4. STUDENTS		
4.1 Selection and admission policy		
4.2 Student counselling and support		
5. ACADEMIC STAFF		
5.1 Academic staff establishment policy		
5.2 Academic staff performance and conduct		
5.3 Continuing professional development for academic staff		
6. EDUCATIONAL RESOURCES		
6.1 Physical facilities for teaching and learning		
6.2 Clinical training resources		
6.3 Information resources		
7. QUALITY ASSURANCE		
7.1 The quality assurance system		
8. GOVERNANCE AND ADMINISTRATION		

8.1 Governance		
8.2 Student and academic staff representation		
8.3 Administration		

Stage 2.6 Decision of Accreditation Results (Online)

2.6.1 Review by Accreditation Council on Final Survey Visit Report

Each member of the Accreditation Council reviews the final survey visit report online individually within **two weeks**. The accreditation decision will be made during a plenary meeting of five council members **one week**. Types of accreditation decision will be discussed in Chapter 5.1.

2.6.2 Assessment of Accreditation Council on Survey Visit Results

The final report of the result is submitted to the accreditation council to determine the decision of accreditation (Appendix 6).

2.6.3 Accreditation Council Decision

The survey visit report will be reviewed by five accreditation council members. The final decision will be one of the following options:

a. Fully Accredited (granted for 8 years), a written report is required to be submitted biannually.
b. Accredited with monitoring (granted for 5 years), a written report is required to be submitted annually.
c. Not Accredited (Re-accreditation is granted after improvements are made with a minimum waiting period of one year)

2.6.3.1 Evaluation and Approval of Survey Visit Report

a. The assessors submitted the survey visit report to the IAAHEH.
b. The Accreditation Council performs an evaluation of all submitted documents to determine the accreditation status during the scheduled Council Meeting.
c. The Chairman of IAAHEH publishes the accreditation certificate.
d. IAAHEH reports the accreditation result to the institution.

2.6.3.2 Accreditation Status Decision Making Process

a. The Assessors' Report is submitted by IAAHEH to the Accreditation Council within two weeks before the Council Meeting.
b. The status is determined by the Accreditation Council during the meeting scheduled.
c. The Council Meeting is attended by all members.
d. Each member of the Accreditation Council conducts a review.
e. Each member of the Accreditation Council should provide their comments and insight into the presented case by each criterion taken into consideration.
f. The Accreditation Council may invite the assessors if there are any significant changes relating to the accreditation results.
g. The accreditation council declares the decision in a consensus.

2.6.3.3 Categories of the Accreditation Status by the Accreditation Council

There are three possible results of the accreditation process:

a. Fully accredited (8 years)

The medical school will be considered fully accredited for 8 years if it has met all the elements of eight criteria as written in Chapter 1.

b. Accredited with monitoring (5 years)

The medical school will be considered accredited with monitoring for 5 years if most of the elements of criteria curriculum, assessment, academic staff, resources, and governance have been met.

If within 3 years of monitoring, the medical school has resolved all the substantial issues and concerns related to the majority element of criteria vision and mission, student, and quality assurance, the medical school will be granted full accredited status for the remaining of 8 years.

If within 3 years of monitoring, the medical school is unable to resolve substantial issues related to the majority element of criteria vision and mission, student, and quality assurance, a monitoring visit will be conducted after 3 years and the medical school ought to be responsible for the expenditure of the monitoring visit.

c. Not accredited

IAAHEH determines that there are substantial issues related to the criteria curriculum, assessment, academic staff, resources, and governance that cannot be resolved within a relatively limited period or that a program whose accreditation has failed to remedy the problems that have been identified during monitoring. The medical school may submit a progress report after one year. Based on this report IAAHEH will recommend that the medical school can re-submit the application in the following year or within 2 years the medical school may directly re-submit the application for accreditation.

2.6.4 Certificate of Accreditation and Internationally Published Directory

IAAHEH sends the accreditation result to the Dean of the medical school. The accreditation result includes accreditation certificate with the IAAHEH decision on the accreditation status, areas of strengths, recommendations for improvement in relevant criteria, areas of concern if any. Once the Certificate of accreditation is accepted by the Dean, the medical school's profile will be included in the International Published Directory of IAAHEH Recognised Medical Schools.

2.6.5 Post Accreditation Monitoring

All accredited study programs must submit a monitoring report (Appendix 7).

2.6.6 Reporting of Accreditation Decision

Within 30 calendar days of any final council decision on survey visit reports, IAAHEH sends a notification letter to the president or equivalent chief executive of the institution informing that the accreditation certificate can be downloaded in SIMAk-Int. IAAHEH will also send an accreditation report to the medical school, including medical school's performance in accreditation elements, its decision regarding the medical school's compliance with accreditation standards, and a description of any required follow-up.

If a medical school makes public disclosure of its accreditation status, the medical school must disclose that status accurately. Any incorrect or misleading statements made by a program about IAAHEH accreditation actions or the program's accreditation status must immediately be corrected or clarified by an official notification announcement. Failure to make timely corrections and clarifications may result in reconsideration of the medical school's accreditation status. The information to the public must also include contact information for the IAAHEH so that the information can be verified. Such contact information could include the URL of the IAAHEH website or the names, email or surface mail addresses, and telephone numbers of the IAAHEH.

Stage 2.7 Submission and Process of Appeal

Medical school may appeal the accreditation decision within one month after receiving the accreditation result. The medical school must fill in the form requesting for an appeal in the https://accreditation.iaaheh.org as detailed in (Appendix 8).

a) Institutions may appeal the accreditation decision within 1 month after receiving the initial decision online. The institution must fill in the form requesting for appeal as detailed in the guidelines, attached with supporting evidence or relevant documents. The form and supporting documents are submitted to the IAAHEH.
b) IAAHEH will send the appeal request form and document to the assessor team for re-evaluation within 2 weeks of receiving the appeal request.
c) The Accreditation Council will hold a meeting and decide upon the results of the re-evaluation conducted by the assessor team, for a maximum of 1 week. The decision of the Accreditation Council will be sent to the Chairman of IAAHEH through SIMAk-Int.

IAAHEH will adjust the final certificate of accreditation.

The procedure to appeal submission and process can be seen Appendix 8.

Stage 2.8 Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments about Program Quality

If a written complaints is submitted by student, alumni, user, or public which is related to the result of accreditation findings on program quality, IAAHEH will conduct review and related action if needed (Appendix 9).

Chapter 3. Guidance for Self-Evaluation Report

This chapter describes how to conduct self-evaluation, writing a self-evaluation report, and identifying supporting documents. The medical school needs to read them thoroughly to produce a readable Self-Evaluation report and a well-prepared survey visit.

3.1 How to conduct Self-Evaluation Activities

The purpose of an external quality evaluation is to determine the status of the medical school in complying with the IAAHEH standard on quality of education of a medical school. The process of evaluation includes studying a written self-evaluation report of the medical school.

To conduct an objective and accurate self-evaluation, a series of activities need to be carried out by the medical school and coordinated by the accreditation team. The medical school will obtain data and information that will be used as tools to evaluate themself. All findings will be written as a self-evaluation report.

A self-evaluation report needs to represent the real condition of the medical school, specifically in the education process and to what extent the medical school may maintain compliance with the IAHEH standards. Therefore, a series of steps need to be conducted by the medical school and lead by the accreditation team of the medical school.

The following steps are carried out by the team, as follows:

- To identify the people whom, they need to communicate with in exploring the information.
- To collect all relevant documents such as vision and mission, strategic plan, management system, curriculum implementation, data on students (including recent tables), faculty members and their academic performance and the future expectation related to the vision achievement.
- To study the vision and mission and the efforts of achieving the vision and mission, the strengths, and weaknesses of the medical school in managing the education process which could be compared with the strategic plans of the medical school. A series of interventions to manage the issues is identified as well.
- To schedule several meetings with internal and external stakeholders to gain accurate information by exploring their perception of how far they perceive on the quality of education offered by the medical school.
- To identify and analyse the strengths, weaknesses, opportunity, and threats and how the team uses these data in developing a plan toward a better perceived quality of education. A process of planning/determining, implementation, evaluation, controlling and improvement of the education program needs to be reflected in the process of self-evaluation activities and be presented as a Self-Evaluation Report.

3.2 Guidance of Writing a Self-Evaluation Report (Preliminary and Final)

Following the activities of self-evaluation, a written report needs to be designed by the accreditation team of the medical school. There are two steps of writing a Self-Evaluation Report (SER), namely: Writing a preliminary self-evaluation report and a final Self-Evaluation Report. The preliminary SER is a FIRST DRAFT of SER which is like the final SER. The report is liable to change based on the feedback of the trainers. The structure and content are the same as the final SER (*refer to information below as follows*).

3.2.1 Introduction

Self-evaluation is the process of an organisation collecting comprehensive data about its own activities and achievements without any external assistance or pressure. Self-evaluation is undertaken within the given time-limits and for a specific purpose. Self-evaluation in a higher education medical school is a thoughtful analysis of all components of the study program, compared against agreed and accepted standards. The analysis should draw on the expertise of the medical school and its local environment. It represents the opportunity to appreciate the strengths of the medical school and to identify areas for improvement. This needs to be a formal part of quality assurance that provides the opportunity to record and document changes and improvements in a medical school.

The purpose of self-evaluation is to elicit the medical school's description and analysis of itself, and its program in relation to the predetermined standards and criteria. Besides being the basis for the accreditation process, the self-evaluation should be recognised as an important planning instrument to enable the medical school to achieve insight into its strengths and weaknesses and to identify areas for quality improvement of its program.

An effective self-evaluation is time-consuming as it requires effort and time. However, the gains from a good self-evaluation are invaluable. It gives information and facts about the quality assurance system and provides a platform for stakeholders to discuss issues on the quality of education.

There are many reasons for undertaking a self-evaluation as follows (Banda, et al., 2016):

a. For improvement:
   - Identifies and specifies problems.
   - Identifies and specifies possible causes and means to change.
   - Identifies avenues for change and improvement.
   - Providing information that may not normally be evident (such as localised innovative practices in teaching and learning)

b. For accountability:
   - If there are external standards set by accreditation bodies, you may want to know how well you are achieving them.
   - Or a self-evaluation might be part of the entire review process and required by the external body. In this case, though, you should aim to understand, evaluate, and improve, not simply to describe and defend.
   - To find solutions to a known problem:
     - Where problems have been highlighted or indicated, a self-evaluation can address these and help you to understand the context – for example, students might not be achieving their course objectives as well as expected, or teachers might have raised concerns about their programs.
   - Verifying those processes are in place, and whether these are operating effectively.
   - Providing evidence of quality processes in place
   - Enabling self-identification of improvement gaps and development of associated strategies to address these prior to external audit.

c. As part of the medical school's managerial process:
   - Self-evaluation allows you to look at your educational program and services.
     - You should pay particular attention to the student's experience, particularly to their learning and performance. You will be able to assess how well you

are meeting your educational goals and any external standards which apply to your medical school.

- Self-evaluation allows evidence-based educational planning and management.
  - You will experience the greatest benefit if the self-evaluation process becomes part of the medical school's regular planning cycle.
- Determining whether existing policies and procedures are effective in meeting schoolable goals and identifying any gaps.
- Enhancing understanding (across staff, student and/or other stakeholders) of organisational processes and outcomes
- Disclosing weaknesses and forcing confrontation
- Promoting honest communication
- Encouraging benchmarking, internally and/or externally
- Identifying activities that are misaligned with organisational goals/objectives.
- Promoting an evidence-based culture

Two principles that relate to the assessment process are:

- Independence as the basis for the impartiality and objectivity of the assessment conclusions.
- Evidence as the rational basis for reaching reliable and reproducible assessment conclusions in a systematic assessment process. Evidence is based on records and statements of fact or information which are relevant to the assessment criteria and are verifiable.

Adherence to these fundamental principles is a prerequisite for providing a reliable and relevant assessment process and outcome. The following considerations should be made before carrying out a self-assessment:

- Management must fully support the self-assessment and provide access to relevant information that is needed for an effective quality assurance system. The self-assessment serves to acquire structural insight into the operation and performance of the medical school.
- Gaining management support to carry out a self- assessment is not enough. The whole organisation must prepare itself for the self-assessment. Assessing quality is more than evaluating the performance of a program; it is also about developing and shaping the medical school. Staff members should be made responsible for the quality and all staff should be involved in the self-assessment.
- Writing a critical self-evaluation of the quality assurance system demands good organisation and coordination. Primarily, someone must lead and coordinate the self-assessment process. The chosen leader should have good contacts within the medical school including key management staff, faculty, and support staff; have access to obtain the required information at all levels; and have the authority to make appointments with stakeholders.
- It is desirable to install a working group in charge of the self-assessment. It is important that the group is structured in such a way that the involvement of all sections is assured. The working group should oversee the self-assessment, gathering and analysing data and drawing conclusions.
- As it is assumed that the self-assessment is supported by the medical school, it is important that all staff members should be acquainted with the contents of the SAR. The working group might organise a workshop or seminar to discuss or communicate the SAR.

3.2.2 Conducting Self-Evaluation

The period to write a draft is four weeks. The accreditation team of the medical school needs to revise the draft of SER according to the input and feedback from the trainers.

Figure 3 Illustrates the approach for preparing a self-assessment which encompasses the Plan-Do-Check-Act (PDCA) cycle of improvement.

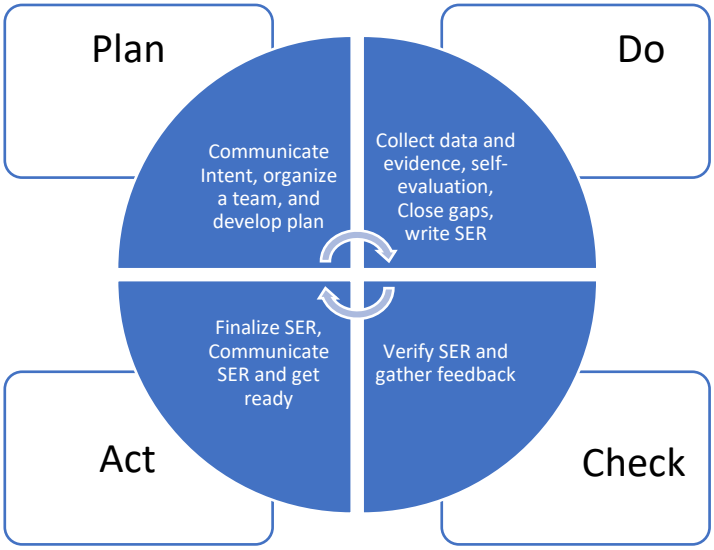

Figure 3. Plan-Do-Check-Act (PDCA) cycle of improvement

Details of each step are explained in the following paragraphs:

a. Plan

The "Plan" phase starts with the communication of intent for quality assessment. Appoint a group responsible for writing the SER. The group should consist of key people representing various departments and led by someone appointed by the faculty or university. This group should have financial, and staff support from the medical school management. The group could then be divided into subgroups in which each subgroup is assigned to address one or several standards. As part of the change management process, early engagement with stakeholders is crucial to get their buy-in and commitment before the start of the project. A clear timetable should be set up to develop the SER. Each member in the group should be made responsible for collecting and analysing data and information, and writing the SER. Each member must have a good understanding of the accreditation criteria before proceeding to the next phase. Figure 4 is an example of a timetable that could be developed.

	Activity/Month	1	2	3	4	5	6	7	8	9	10	11	12	Deadline	Assigned to	Status
P L A N	Communicate Intent															
	Organizing Team															
	Development Plan															
	Understanding WFME Criteria and Process															
	Self-assessment															

D O	Collect Data & Evidence														
	Close Gaps														
	Write SER														
	Review SER														
C H E C K	Verify SER														
	Gather Feedback														
A C T	Improve QA														
	Finalise SER														
	Communicate SER														
	Get Ready														
Change Management															

Figure 4. Example of a timetable to develop the SER

In summary, the following are steps that need to be taken during the planning stage, namely (1) to appoint a group/committee with representation of relevant stakeholders, (2) to ensure sufficient financial support, (3) to ensure staffing support, (4) to clarify the task, including the standards to be addressed, (5) to plan timetable (Banda, 2016).

IAAHEH provides training and assistance in conducting self-evaluation reports during the application phase.

b. Do

The "Do" phase involves identifying the gaps in meeting the accreditation criteria. Data collection is a critical step in this phase as it helps to quantify the existing quality assurance practices as well as to identify what the institution needs to do to meet the accreditation criteria. Solutions to close the gaps should be implemented before proceeding to write and review the SER. In the process of conducting its self-study, a medical school brings together representatives of the administration, faculty, student body, and other constituencies to:

1. collect and review data about the medical school and its educational program,
2. identify evidence that supports the achievement of accreditation standards
3. identify gaps between the existing conditions and the accreditation standards
4. define strategies to ensure that the gaps are closed, and any problems are addressed effectively.
5. write the draft according to the determined structure.
6. complete the draft with an executive summary and glossary (if required)
7. send the draft to the trainers to whom have trained the school staff in writing the preliminary SER.

As data collection is an important step, it is crucial that data collection is done according to sound methodology. Wherever possible, it is suggested to use the existing data. The same set of data could be used for more than one standard. In case new data is required, data collection methods should be designed that can demonstrate achievement of the accreditation standards.

There might be some barriers during the data collection, such as lack of access to the required documentation, low response rates, scattered information, missing information, or limited access to data. These barriers need to be overcome. All data that has been collected needs to be analysed and presented in simple and understandable formats to answer each key question. Table, charts, graphs, narratives might be used.

Once the data collection is completed, the writing of the SER could be started. Each key question in the Accreditation Standards needs to be answered according to the existing conditions and supported with evidence.

c. Check

To prepare a creditable and objective report, the assessment team must verify the evidence gathered. The "Check" phase involves verifying the SER as well as the quality assurance practices and giving feedback to improve them. An independent team should be appointed to assess the SER and the existing quality assurance practices against the accreditation criteria. Recommendations to improve the SER and close the gaps in the existing quality assurance practices should be made.

d. Act

The "Act" phase involves implementing the recommendations raised in the "Check" phase. The SER is finalised before communicating it to relevant stakeholders and getting ready for the external assessment.

3.3 Structure and Format of Self-Evaluation Report

An executive summary is required to provide an overall picture of the program, follows with a glossary to clarify the specific terminologies. A brief description of the study program is written at the beginning of a Self-Evaluation Report. Further, the self-evaluation report is developed through a specific design consisting of structure of the SER, the used format, the dissemination of SER to stakeholders and content, as described below.

a. Structure

In writing the Self-Evaluation Report (SER), each key question in the Accreditation Standards needs to be addressed. The evidence that supports the achievement of each substandard needs to be referred, attached, and linked in the designated google drive.

The structure of Self-Evaluation Report:

Executive Summary
Glossary

Chapter I Medical school Context

Chapter II Self-Evaluation

1.1. The Need for Self-Evaluation
1.2. The Team
1.3. The Process of Self-Evaluation (who is involved and how)
1.4. Methods (sample, data collection and analysis)

Chapter III Accreditation Standards

1. MISSION AND VALUES
1.1 Starting the mission
1.2. Recommendation

2. CURRICULUM
2.1 Intended curriculum outcomes
2.2 Curriculum organisation and structure
2.3 Curriculum content
2.4 Educational methods and experiences
2.5. Recommendation

3. ASSESSMENT
3.1 Assessment Policy and System
3.2 Assessment in support of learning
3.3 Assessment in support of decision-making
3.4 Quality control
3.5. Recommendation

4. STUDENTS
4.1 Selection and admission policy
4.2 Student counselling and support
4.3. Recommendation

5. ACADEMIC STAFF
5.1 Academic staff establishment policy
5.2 Academic staff performance and conduct
5.3 Continuing professional development for academic staff
5.4. Recommendation

6. EDUCATIONAL RESOURCES
6.1 Physical facilities for teaching and learning
6.2 Clinical training resources
6.3 Information resources
6.4. Recommendation

7. QUALITY ASSURANCE
7.1 The quality assurance system
7.2. Recommendation

8. GOVERNANCE AND ADMINISTRATION
8.1 Governance
8.2 Student and academic staff representation
8.3. Administration
8.4. Recommendation

Chapter IV Summary of the Overall Results

Chapter V Appendices

In Chapter IV, the study program summarises the overall results for each sub criteria and determines whether it is compliance, partially compliance and non-compliance, as shown in the table below:

Table 1. Categories of Summary of the Overall Results

Accreditation Standards	Compliance	Partial Compliance	Non-Compliance
1.1. Stating the mission			
2.1. Intended curriculum outcomes			
2.2. Curriculum organisation and structure			
2.3. Curriculum content			
…etc.			

b. Format

The SER should be written in size 12 Times New Roman font in A4 paper with single space. The maximum page is 80 pages excluding Executive Summary, Glossary and Appendices.

c. Dissemination

The medical school needs to identify who will receive the full reports and the executive summary, for both internal and external stakeholders. Many have been involved in completing the Self-Evaluation and would need to be informed of the results. A communication strategy needs to be planned. The main point of this entire process should be to facilitate change where change is required. Therefore, the last element that must be addressed is the issue of securing the commitment to act on the findings of the SER.

Table 2. Description of the Term Self-Evaluation Result

Compliance	Almost all components in each sub criterion can be fulfilled
Partial Compliance	Some components in each sub criterion can be fulfilled. But there are components in some sub criteria which cannot be fulfilled. These unfilled components of sub criteria are not systemic and will not affect the education process, will not disrupt the achievement of vision, mission, objectives, and targets of the institutions, and will not hinder the achievement of learning outcomes and competencies.
Non-Compliance	All components in each sub criterion cannot be fulfilled

d. Content

IAAHEH has developed 8 (eight) criteria consisting of mission and values, curriculum, assessment, student, academic staff, resources, quality assurance, governance and administration as described in Chapter 1.

Chapter 4. Guidance for Survey Visit

4.1 Survey Visit Guidance

One important step of the accreditation process is the survey visit. The survey visit aims to obtain evidence through interview and observation of all criteria in WFME standards based on the result of Self-Evaluation Report (SER) Review. The targeted sites of the survey visit include building, infrastructure, and facilities to deliver the study program. This guidance aims to provide key points for the study program in preparing the survey visit. It consists of an explanation of the assessors, survey visit, and survey visit report.

Principles of the survey visit

The survey visit should focus on:

- The continuous quality improvement, such as PDCA (*plan, do, check,* and *action*).
- Achievements in education, research, and public services, competition, and internationalisation.
- Compliance with WFME Standards.
- Academic and non-academic achievement, including assessment of input, process, and output.
- Availability of evidence and traceability.
- Management of the study program.
- Effectiveness of internal quality assurance system

4.2 Administrative Preparation for Survey Visit

The team and the study program achieve an agreement on the schedule during the survey visit, especially schedule for interview with faculty, students, and alumni; progress report session, the closing session, and other activities such as post accreditation meeting with dean or administrator, including confirmation of the schedule on observing student learning activities, and assessing facilities.

- The date of survey visit is organised by the secretariat of IAAHEH.
- Invitation letter for the Assessor
- Booking accommodation for the Assessor
- Dietary requirements such as vegetarian, halal food, etc.
- Health protocol
- The interviewee cannot be replaced.
- The medical school provides local transport, airport transfer.
- The medical school invites medical school board, senate, academic staff, students, alumni, user, supporting staff, and translator.
- The medical school prepares facilities infrastructure (management office, classroom, laboratory, clinical practice setting, community practice setting, student facilities, student counsellor office, academic staff room, etc)
- The medical school prepares documents related to curriculum (curriculum map, module, syllabus, samples of student work, sample of examinations, practical guidance, clinical rotation/clerkship guidance.
- The medical school prepares documents related to internal quality assurance system (medical school academic policy, academic regulations, other manual and procedures as required).
- The medical school prepares information resources system (library, internet connection, IT, application, Learning Management System-LMS, etc).

- The medical school provides translator if English is not native language and documents are primarily not in English.
- The medical school provides working room for the assessor (LCD and screen, flipchart, internet connection, printer, paper, whiteboard marker, etc).

4.3 The Survey Visit Procedure

The activities of the survey visit would include:

- An introductory meeting with the management of the study program and the faculty
- Interview sessions with:
  - Management of the study program
  - Internal quality assurance team
  - Faculty members from various departments (10-12 faculty members)
  - Students represented from each academic year (10-12 students)
  - Supporting staff (8-10 staff, including laboratory technicians/analysts, IT, administration, librarians, etc.)
  - Alumni who graduated in the last 3 years. (8-10 alumni)
  - Employers of the graduates (6-8 employers preferably non-alumni)
  - Management of the teaching hospitals and teaching clinics
- Observation and assessment of the teaching and learning processes (in the classroom, practical/ skill laboratory, and the teaching hospitals)
- Visitation and assessment of physical facilities: library, laboratories, simulation centre, teaching hospitals, teaching clinics, student services, and other facilities for students
- Clarification and validation of documents
- Closing meeting with the medical school management

If needed, an interpreter from a non-related party should be provided to bridge communication between the assessor team and the local staff.

Table 3. The typical schedule for the survey visit

Day -1		
08.30-09.00	:	Introductory meeting of the management of the study program and assessors
09.00-10.00	:	Presentation of the profile of the study program by the management of the study program (and Q&A session)
10.00-11.30	:	Interview and discussion with the faculty members
11.30-12.30	:	Interview with the supporting staff
12.30-13.30	:	Lunch break
13.30-15.00	:	Visitation and assessment of the library, laboratories, classroom, simulation centre, and other facilities in the study program.
15.00-16.00	:	Interview and discussion with the Internal Quality Assurance team of the study program

16.00-17.00	:	Internal discussion of the assessors
Day-2		
08.30-09.00	:	Introductory meeting with the management of academic hospitals.
09.00-11.00	:	Visitation of the academic hospitals: outpatient clinics, in-patient wards, emergency room, and other facilities for students in the hospitals.
11.00-12.00	:	Interview and discussion with the clinical preceptors of the academic hospitals
12.00-13.00	:	Lunch break
13.00-14.30	:	Interview and discussion with the students
14.30-16.00	:	Document verification
16.00-17.00	:	Internal discussion of the assessors
Day-3		
08.30-09.00	:	Introductory meeting with the management of teaching clinics or teaching facilities in the community
09.00-11.00	:	Visitation to the teaching clinics or teaching facilities in the community.
11.00-12.00	:	Interview and discussion with the clinical preceptors and stakeholders
12.00-13.00	:	Lunch break
13.00-14.30	:	Discussion with the alumni of the study program
14.30-16.00	:	Discussion with the employers of the graduates and other stakeholders
16.00-17.00	:	Internal discussion of the assessors
Day-4		
08.30-09.30	:	Observation of the teaching and learning process
09.30-10.30	:	Additional Documents verification
10.30-12.00	:	Clarification and verification with the management of the study program
12.00-13.00	:	Lunch break

13.00-16.00	:	Internal discussion of the assessors to draft the initial report to be presented in exit meeting
16.00-17.00	:	Closing meeting and discussion

The typical schedule above could be rearranged to suit the situation. However, all the agenda should be conducted.

4.4 Guidance for Introductory Meeting

The introductory meeting is aimed to inform both the assessors and the study program during the four-day visit concerning each responsibility.

- The leader collaborates with the medical school in determining the fixed schedule of introductory meeting.
- Assessors introduce themselves as well as their roles on the survey visit.
- The leader gives a summary of the whole survey visit activities including the deliverables that should be completed by the assessors. He or she informs the study program that the team will end up with the recommendation based on the survey visit results and deliver the recommendation to the council.
- The leader informs the study program that the aim of the accreditation is mainly to improve the quality of the study program.
- The assessors and the study program should work collaboratively and support each other according to their responsibilities.
- The leader reminds the team and the study program to encourage open and honest discussions.
- Assessors should report their initial findings based on the self-survey visit report according to his/her responsibility.
- The team and the study program achieve an agreement on the schedule during the survey visit, especially schedule for interview with faculty, students, and alumni; progress report session, the closing session, and other activities such as post accreditation meeting with dean or administrator, including confirmation of the schedule on observing student learning activities, and assessing facilities.
- The leader reminds the secretariat of IAAHEH to provide form to be fulfilled by the team.
- The leader reminds the procedure of the survey visit, including each member's assignment.
- The leader reminds assessors to take notes during the survey visit and report it by the end of the visit.
- Leader reminds on the prohibition of using laptop or mobile phones during the meeting, interview and observation, or doing other unrelated activities with the study program except activities required for accreditation process.
- The leader reminds the team to always consider private data information and the confidential matters of the accreditation process.

a. Preparation for the Venue

The medical school must provide the venue with equipment (LCD, Screen, microphone) that can accommodate all the invitees.

b. Preparation for the Invitee

The following are the person or the parties to be invited:

- The Dean
- Vice Dean
- Head of Study Program
- Accreditation Team
- Head of Quality Assurance Unit
- Directors of Teaching Hospitals
- Education Unit
- Research Unit
- Community Service Unit
- Heads of Departments
- Heads of Administrations
- etc.

c. Medical School Preparation for the Presentation

The profile of the medical school will be presented during the first session of the visit.

- The Dean/ Vice Dean will prepare a presentation on the highlight of the school's profile and the school's strategic planning and management, resources available to run the medical program, human resources and other physical and non-physical resources required for the medical program, counselling, and student supports.
- The head of the study program will prepare a presentation on the graduate profiles, graduate competencies, curriculum, and assessment system.
- Head of the quality assurance unit to prepare a presentation on internal quality assurance system.

It is advised that the presentations will stress the important points and updated information. It is strongly suggested that the presentations will not repeat all the information that is already in the SER. In total the presentation lasts 30 minutes and Q&A session should last about 30 minutes.

4.5 Guidance for Interview

This guidance is intended for assessors and the medical school during the visit. The interview session will be held without the presence of school management and accreditation team. The interview will be :

- Interview with the management of the medical school about governance, quality assurance, human resource management, curriculum management, finance and asset management, program development, collaboration program, academic environment, description of how research is disseminated and utilised, research rewards and incentives, ethics review board composition and functions.
- The school appoints academic staff that will be interviewed, the academic staff represent the clinical and non-clinical departments/units (basic medical sciences, public health, bioethical and medical education), as well as representing different academic ranks. The interview with academic staff will cover leadership, faculty development program, working atmosphere, relationship with management and colleague, workloads (teaching, research, and community services), learning, teaching and research facilities, job security and satisfaction, relevant academic issues, academic and non-academic support system, ranking and

promotion system, faculty orientation program, salary scale, faculty performance evaluation, academic advising and referral system, description of how research is disseminated and utilised, research rewards and incentives

- The school invites support staff representing different function, such as technician (Mechanical and Electrical (ME) and laboratories), librarian, administrative, IT support, finance.
- The interview will cover leadership, supporting staff, development program, working atmosphere, relationship with management and colleague, workloads, staff qualification relevant to the assignment, job security and satisfaction, relevant issues, information technology support system, library acquisition and collection development plan and profile of library staff.
- The school invites students that will be interviewed, which represent different academic years and achievement, student organisation.
- The interview will cover academic atmosphere, learning, teaching and research facilities, student learning and teaching satisfaction, student support system, academic advising and referral system, non-academic development program, job and career information.
- The school invites alumni that graduated in the last five years. The interview will cover learning experiences, job preparedness, relevance of the acquired competencies with the current job, alumni feedback and contribution, time to get the first job, involvement in the academic, research, community services of the school, and internship program.
- The school invites employer of the alumni, representing various kind of workplaces (or such as hospitals, health offices, universities, clinics, other health services, companies). Preferably the employer is not alumni. Otherwise, a maximum of 30% of the interviewees are alumni. The interview will cover hard skills and soft skills of the alumni employed, employer feedback to the school.

4.6 Guidance for Observation

Observation is a way of gathering data by watching behavior, events, process, activities, and physical setting.

- The school prepares physical facilities of the university, hospital, and health center to be visited by assessors.
- The physical facilities of the university observed include equipment and instrument. The observation may include office, bio-medical laboratories, classroom, clinical skill labs, library (library acquisition and collection development plan and profile of library staff), IT, small room for discussion, student lounge, student lockers.
- The visit to the hospital may include the emergency department, OPD, IPD, ICU, CCU, surgery theatre, student room for the night shift, and some medical departments.
- Physical facilities for student support, such as clinics, sport facilities, dormitory, classroom size.
- Observation of some activities, such as teaching and learning, small group discussion, laboratory activities. The observations are focused to check consistencies between descriptions in the SER with the curriculum implementation.

4.7 Guidance for Document Checking

If there are any new information/data/documents which had not been included in SER, the school may display during the visit of assessors, otherwise the assessors will not require any additional document. The purposes of the document checking are:

- To verify that the evidence is genuine, valid, and current

- Sample syllabi, sample examination question, sample of theses, dissertations, capstone projects, sample of academic advising and referral system, schedule of current term, list of thesis advisers and number of advisees per adviser, performance in the licensure examinations. List of co-curricular activities, and sample of minutes of curricular review and evaluation
- Research agenda, research manual, faculty research journal/s, graduate research journal, list of faculty and student research and publications, research budget and performance report, research contracts with government and private agency and institutions, ethics review board composition and functions
- Tuition fee schedule, admission and retention policies, enrolment figures per program and year level, statistical data on dropouts, graduation/completion rates, scholarships and grants, support and auxiliary services student satisfaction survey visit results, health clearance certificate of canteen personnel, safety and sanitation inspection reports/documents of the canteen/cafeteria, Memorandum of Agreement (MoA) with accredited dormitories, sample minutes of meetings of student services offices, list of graduate student organisations, tracer and employer satisfaction surveys and exit interviews, list of student activities and collaborations.
- Faculty profile, samples of accomplished evaluation forms, list of visiting and/or exchange professors, list of in-services an off-campus, monitoring of online campus, sample of minutes of faculty meetings.
- Library staff development program, library fees, library budget and performance reports, instructional/Orientation program for users, list of print, non-print, electronic resources, utilisation report.
- Organisational chart, profile of Board of Trustees and key institutional and program administrators, latest institutional and program strategic plans and program operational plan, contingency plan or emergency and business continuity plan, audited financial statements for the last three years, graduate school budget, data privacy policy, MOA/MOUs with local and/or international academic, professional, research, private and/or government institutions/organisations, list of chairs, grants, and donations from foundations, minutes of consultation meetings with stakeholders.
- Description of outreach activities/service-learning program, classroom utilisation statistics, list of classrooms and/or special rooms dedicated for graduate school activities, facilities and laboratory maintenance, sanitation and/or inspection schedule and report, documentation of the following (videos and/or photos): faculty room, consultation rooms including those used for counselling, student lounges and student organisation rooms, classrooms and laboratories used by the graduate school, co-curricular, extra-curricular, and community service activities.

4.8 Guidance for Closing Meeting

A closing meeting needs to be prepared by the Study Program to allow the assessor team to present their finding in front of the Study Program. The study program needs to invite relevant invitees specifically their accreditation team. It is usually attended by the management of the Study Program. The Study program also prepares all the needs for the presentation.

The following is the procedure for the Closing Meeting:

- The draft of summary findings will be given to a study program to be read thoroughly.
- The accreditation team of the study program discusses each sub-criterion.

- The accreditation team will write comments or criticise the findings if there is any irrelevant description with the real condition.
- In the following morning, the study program prepares a representative room for discussion with the assessors, required equipment such as audio-visual, LCD, white screen, a printer with sufficient ink, etc.
- The study program invites all relevant invitees from the study program especially the accreditation team.
- The representative of the Study program will open the meeting and ask the team of assessor to lead the meeting.
- The head of the assessor team assigns one of the team members to present the summary of findings.
- Each sub criteria will be read and discussed.
- All invitees will listen carefully and respond to a relevant sub-criterion.
- The Study program will show related evidence/s to support their assumption on related sub-criteria.
- Each sub-criteria will have a new description based on an agreed statement from the study program.
- The study program representatives will listen to the recommendation for each sub-criteria after been adjusted with the recent changes.
- After discussing all sub criteria, and both sides agree with the findings, the accreditation team of Study program will listen to the summary findings, re-describe the commendation and the recommendation.
- The head of the team concludes the summary findings, re-describe the commendation and the recommendation, then allow the assessor team to print.
- While the assessor team prints the documentation, the study program will wait for the next session.
- The head of assessor returns the session to the Study Program.
- The responsible person of the Study Program will receive the session and then deliver his/her closing remarks.
- The meeting is dismissed.

4.9 Guidance for Survey Visit Report Preparation

a. Written in A4 format, with 1 inch for left and right margin, 1.2 inch for top and bottom margin. Using Times New Roman black font, 12 pt. 1.15 space between each line. The heading and subheading could use a different font size.
b. The report should be written in British English.
c. The report consists of:
    - Cover of the report
    - List of pages
    - Identification of the school under survey visit
    - The date of received of the self-evaluation report, desk evaluation of the SER, date of survey visit
    - The assessors' member
d. Summary of the findings
    - Brief profile of the school
    - Strength of the school
    - Area of concern

- Area that needs further evidence

e. Findings of each standard and its sub criteria. This should be written in the following sequence:
   - Findings of sub criteria of the standard
   - Area of strength of the school in the described standard and its sub criteria
   - Area of concern
   - Area that needs further evidence
   - Recommendation for the standards and their sub criteria

f. Conclusion of the survey visit and recommendations.

Table 4. Conclusion of the survey visit and recommendations

Criteria 1: Mission and Values
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 2: Curriculum
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 3: Assessment
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 4: Students
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria

Criteria 5: Academic Staff
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 6: Educational Resources
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 7: Quality Assurance
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria
Criteria 8: Governance and Administration
Narrations findings from the survey visit and judgment assessor: … ● Findings of sub criteria of the standard ● Area of strength of the school in the described standard and its sub criteria ● Area of concern ● Area that needs further evidence ● Recommendation for the standards and their sub criteria

g. List of appendices
Appendices arranged in sequential order as its appearance in the narrative.

4.10 Summary of the Accreditation Report

4.10.1 Summary of Findings from Self-Evaluation Reports

Upon receiving the Self Evaluation Report as explained in Chapter 3, the assessors review the SER and prepare the following reports. The assessors make the summary of findings from the Self Evaluation Report by extracting important data and information. Based on the summary of findings, the assessors decide whether each element of the sub criteria is full compliance, partial compliance, and non-compliance

4.10.2 Summary of Findings from Survey Visit Reports

Table 5. Summary of Accreditation Report

Criteria 1. Mission and Values

Key Questions	Summary of Findings from Self Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
1.1.1. How is the mission statement specially tailored to the school?				
1.1.2. Which interest groups were involved in its development and why?				
1.1.3. How does the mission statement address the role of the medical school in the community?				
1.1.4. How is it used for planning, quality assurance, and management in the school?				
1.1.5. How does it fit with regulatory standards of the local accrediting agency and with relevant governmental requirements, if any?				
1.1.6. How is it publicised?				

Criteria 2. Curriculum

2.1 Intended Curriculum Outcomes

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
2.1.1 How were the intended outcomes for the course as a whole and for each part of the course designed and developed?				
2.1.2 Which stakeholders were involved in their development?				
2.1.3 How do they relate to the intended career roles of graduates in society?				
2.1.4 What makes the chosen outcomes appropriate to the social context of the school?				

2.2 Curriculum organisation and structure

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
2.2.1 What are the principles behind the school's curriculum design?				
2.2.2 What is the relationship between the different disciplines of study which the curriculum encompasses?				

2.2.3 How were the model of curriculum organisation chosen? To what extent was the model constrained by local regulatory requirements?				
2.2.4 How does the curriculum design support the mission of the school?				

2.3 Curriculum Content

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
2.3.1 Who is responsible for determining the content of the curriculum?				
2.3.2 How is curriculum content determined?				
2.3.3 What elements of basic biomedical sciences are included in the curriculum? How are the choices made and time allocated for these elements				

2.3.4 What elements of clinical sciences and skills are included in the curriculum? 2.3.4.1. In which clinical disciplines are all students required to gain practical experience? 2.3.4.2. How are students taught to make clinical judgements in line with the best available evidence? 2.3.4.3. How are the choices made and time allocated for these elements? 2.3.4.4. What is the basis for the school's allocation of student time to different clinical practice settings?				
2.3.5 What elements of behavioural and social sciences are included in the curriculum? How are the choices made and time allocated for these elements?				

2.3.6 What elements (if any) of health systems science are included in the curriculum? How are the choices made and time allocated for these elements?				
2.3.7 What elements (if any) of humanities and arts are included in the curriculum? How are the choices made and time allocated for these elements?				
2.3.8 How do students gain familiarity with fields receiving little or no coverage?				
2.3.9 How does the school modify curriculum content related to advances in knowledge?				
2.3.10 How are principles of scientific methods and medical research addressed in the curriculum?				
2.3.11 Which fields (if any) are elective? How are elective fields decided?				
2.3.12 How is student learning assured in disciplines in				

which they do not get specific experience?				

2.4 Educational methods and experiences

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
2.4.1 What principles inform the selection of educational methods and experiences employed in the school's curriculum? How were these principles derived?				
2.4.2 According to what principles are the chosen educational methods and experiences distributed throughout the curriculum?				
2.4.3 In what ways are the educational methods and experiences provided for students appropriate to the local context, resources, and culture?				

Criteria 3. Assessment
3.1. Assessment Policy and System

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
3.1.1 Which assessments does the school use for each of the specified educational outcomes?				
3.1.2 How are decisions made about the number of assessments and their timing?				
3.1.3 How are assessments integrated and coordinated across the range of educational outcomes and the curriculum?				

3.2. Assessment in Support of Learning

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
3.2.1 How are students assessed to support their learning?				
3.2.2 How are students assessed to determine those who need additional help?				

3.2.3 What systems of support are offered to those students with identified needs?				

3.3. Assessment in support of decision-making

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
3.3.1 How are blueprints (plans for content) developed for examinations?				
3.3.2 How are standards (pass marks) set on summative assessments?				
3.3.3 What appeal mechanisms regarding assessment results are in place for students?				
3.3.4 What information is provided to students and other stakeholders, concerning the content, style, and quality of assessments?				
3.3.5 How are assessments used to guide and determine student progression between successive stages of the course?				

3.4. Quality Control

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
3.4.1 Who is responsible for planning and implementing a quality assurance system for assessment?				
3.4.2 What quality assurance steps are planned and implemented?				
3.4.3 How are comments and experiences about the assessments gathered from students, teachers, and other stakeholders?				
3.4.4 How are individual assessments analysed to ensure their quality?				
3.4.5 How are data from assessments used to evaluate teaching and the curriculum in practice?				
3.4.6 How are the assessment system and individual assessments regularly reviewed and revised?				

Criteria 4. Students

4.1 Selection and Admission Policy

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
4.1.1 How is alignment determined between the selection and admission policy and the mission of the school?				
4.1.2 How does the selection and admission policy fit with regulatory (accreditation) or government requirements?				
4.1.3 How is the selection and admission policy tailored to the school?				
4.1.4 How is the selection and admission policy tailored to local and national workforce requirements?				
4.1.5 How is the selection and admission policy designed to be fair and equitable, within the local context?				
4.1.6 How is the selection and admission policy publicised?				

4.1.7 How is the selection and admission system regularly reviewed and revised?				

4.2 Student Counselling and Support

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
4.2.1 In what ways are academic and personal support and counselling services consistent with the needs of students?				
4.2.2 How are these services recommended and communicated to students and staff?				
4.2.3 How do student organisations collaborate with the medical school management to develop and implement these services?				
4.2.4 How appropriate are these services procedurally and culturally?				
4.2.5 How is the feasibility of the services judged, in terms of human, financial, and physical resources?				

4.2.6 How are the services regularly reviewed with student representatives to ensure relevance, accessibility, and confidentiality?				

Criteria 5. Academic Staff

5.1 Academic Staff Establishment Policy

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
5.1.1 How did the school arrive at the required number and characteristics of their academic staff?				
5.1.2 How do the number and characteristics of the academic staff align with the design, delivery, and quality assurance of the curriculum?				

5.2 Academic Staff Performance and Conduct

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
5.2.1 What information does the school provide for new and existing academic staff and how is this provided?				

5.2.2 What induction training does the school provide for academic staff?				
5.2.3 How does the school prepare academic staff, teachers, and supervisors in clinical settings to enact the proposed curriculum?				
5.2.4 Who is responsible for academic staff performance and conduct? How are these responsibilities carried out?				

5.3 Continuing Professional Development for Academic Staff

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
5.3.1 What information does the school give to new and existing academic staff members on its facilitation or provision of continuing professional development?				
5.3.2 How does the school take administrative responsibility for the implementation of the staff continuing professional development policy?				

5.3.3 What protected funds and time does the school provide to support its academic staff in their continuing professional development?				

Criteria 6. Educational Resources
6.1. Physical Facilities for Teaching and Learning

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
6.1.1 How does the school determine the adequacy of the physical infrastructure (space and equipment) provided for the theoretical and practical learning specified in the curriculum?				
6.1.2 Is it appropriate or necessary to supplement or replace classroom teaching by distance or distributed learning methods? If so, how does the school ensure that these offer a commensurate level of education and training?				

6.2. Clinical training resources

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
6.2.1 What range of opportunities is required and provided for students to learn clinical skills?				
6.2.2 What use is made of skills laboratories and simulated patients, and of actual patients in this regard?				
6.2.3 What is the basis of the policy on the use of simulated and actual patients?				
6.2.4 How does the school ensure that students have adequate access to clinical facilities?				
6.2.5 What is the basis for the school's mix of community-based and hospital-based training placements?				
6.2.6 How does the school engage clinical teachers and supervisors in the required range of generalist and specialist practice settings?				

6.2.7 How does the school ensure consistency of curriculum delivery in clinical settings?				

6.3 Information Resources

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
6.3.1 What information sources and resources are required by students, academics, and researchers?				
6.3.2 How are these provided?				
6.3.3 How is their adequacy evaluated?				
6.3.4 How does the school ensure that all students and academic staff have access to the needed information?				

Criteria 7. Quality Assurance

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
7.1.1 How are the purposes and methods of quality assurance and subsequent action in the				

school defined and described, and made publicly available?				
7.1.2 How is responsibility for the implementation of the quality assurance system clearly allocated between the administration, academic staff, and educational support staff?				
7.1.3 How are resources allocated to quality assurance?				
7.1.4 How has the school involved external stakeholders?				

Criteria 8. Governance And Administration
8.1. Governance

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
8.1.1 How and by which bodies are decisions made about the functioning of the institution?				
8.1.2 By what processes and committee structures are teaching, learning, and research governed in the institution?				

8.1.3 How is the budget aligned with the mission of the school?				
8.1.4 What governance arrangements are there to review the performance of the school?				
8.1.5 How are risks identified and mitigated?				

8.2 Student and academic staff representation

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
8.2.1 To what extent and in what ways are students and academic staff involved in the school decision-making and functioning?				
8.2.2 What, if any, social or cultural limitations are there on student involvement in school governance?				

8.3. Administration

Key questions	Summary of Findings from Self-Evaluation Reports	Performance in Accreditation Element	Summary of Findings from Survey Visit Reports	Performance in Accreditation Element
8.3.1 How does the administrative structure support the functioning of the institution?				
8.3.2 How does the decision-making process support the functioning of the institution?				
8.3.3 What is the reporting structure for administration in relation to teaching, learning, and research?				

Chapter 5. Post Survey Visit

5.1 Accreditation Decision

5.1.1 Types of Accreditation Decision

There are three possible results of the accreditation process:

a. Fully accredited (8 years)

The school will be considered fully accredited for 8 years if it has met all the elements of the eight criteria as written in Chapter 2.

b. Accredited with monitoring (5 years)

The school will be considered accredited with monitoring for 5 years if the majority of the elements of criteria curriculum, assessment, academic staff, resources, and governance have been met. If within 3 years of monitoring, the school has resolved all the substantial issues and concerns related to the majority element of criteria vision and mission, student, and quality assurance, the school will be granted full accredited status for the remaining of 8 years.

If within 3 years of monitoring, the school is unable to resolve substantial issues related to the majority element of criteria vision and mission, student, and quality assurance, a monitoring visit will be conducted after 3 years, and the school will be responsible for the expenditure of the monitoring visit.

c. Not accredited

IAAHEH determines that there are substantial issues related to the criteria curriculum, assessment, academic staff, resources, and governance that cannot be resolved within a relatively limited period or that a program whose accreditation has failed to remedy the problems that have been identified during monitoring. Within 2 years the school may re-submit the application for accreditation.

5.1.2. Reporting of Accreditation Actions

Within 30 calendar days of any final council decision on survey visit reports, IAAHEH sends a notification letter to the president or equivalent chief executive of the institution informing that the accreditation certificate can be downloaded in SIMAk-Int. IAAHEH will also send an accreditation report to the school, including school's performance in accreditation elements, its decision regarding the school's compliance with accreditation standards, and a description of any required follow-up.

If a school makes public disclosure of its accreditation status, the school must disclose that status accurately. Any incorrect or misleading statements made by a program about IAAHEH accreditation actions or the program's accreditation status must immediately be corrected or clarified by an official notification announcement. Failure to make timely corrections and clarifications may result in reconsideration of the school's accreditation status. The information to the public must also include contact information for the IAAHEH so that the information can be verified. Such contact information could include the URL of the IAAHEH website or the names, email or surface mail addresses, and telephone numbers of the IAAHEH.

5.2. Appeal and Complaint Guidance

5.2.1 Appeal

a. Institutions may appeal the accreditation decision within 1 month after receiving the initial decision online. The institution must fill in the form requesting for appeal as detailed in the guidelines, attached with supporting evidence or relevant documents. The form and supporting documents are submitted to the IAAHEH. IAAHEH will adjust the final certificate of accreditation.
b. IAAHEH will send the appeal request form and document to the assessor team for re-evaluation within 2 weeks of receiving the appeal request.
c. The Accreditation Council will hold a meeting and decide upon the results of the re-evaluation conducted by the assessor team, for a maximum of 1 week. The decision of the Accreditation Council will be sent to the Chairman of IAAHEH through SIMAk-Int.

IAAHEH will adjust the final certificate of accreditation.

The procedure to appeal submission and process can be seen Appendix 8.

5.2.2 Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments about Program Quality

A complaint is an opinion expressing unsatisfaction perceived by a student, alumni, user, or public which is related to the result of accreditation findings on program quality. All complaints must be submitted in writing to the IAAHEH, and complainants must sign a form allowing the complaint to be disclosed to the medical education program. Anonymous complaints and duplicate complaints by one individual that address the same circumstances will not be considered.

IAAHEH will conduct an initial review of any complaint about program quality to determine whether it represents potential non-compliance with accreditation standards or unsatisfactory performance in accreditation elements. If the review result shows that the complaint potentially presents such evidence, IAAHEH will send a copy of the complaint to the dean of the school and will be given an opportunity to respond.

The points of issue in the complaint and the response from the dean will be reviewed by the Accreditation Council. The Accreditation Council will decide whether the related program will be re-visited or ineligible to be reviewed. In the case that the program is ineligible for re-visitation, then the result of the accreditation will not be changed. If the Accreditation Council decide that the study program is eligible for re-visitation, the status of the re-visited program will be decided after the revisitation is conducted.

The procedure of complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments can be read in Appendix 9.

INTERNATIONAL ACCREDITATION AGENCY FOR HIGHER EDUCATION IN HEALTH (IAAHEH) CONTRACT AGREEMENT

This IAAHEH Contract Agreement ("Agreement") is made and entered into by and between the following Parties: IAAHEH and the entity described in the signature section of this Agreement ("Medical School or Medical Education Program"). IAAHEH and the Medical School or the Medical Education Program are referred to herein as a "Party" or "the Parties".

In consideration of the mutual rights and obligations of the Parties set forth below, the Parties agree as follows:

1. **Scope of Agreement**
   1.1 This Agreement, which is to be executed once, is made for one medical school that submits for Accreditation of the medical school or medical education program.
   1.2 Each medical school or medical education program to be accredited shall be as identified in a fully executed accreditation schedule incorporated into this Agreement. This Agreement and the accreditation schedule embody the entire agreement between the Parties relating to the accreditation schedule.
   1.3 This Agreement and its Schedules incorporate the applicable Accreditation Procedures, which could be found on the IAAHEH website.

2. **Definitions**

Accreditation	Accreditation of some aspect of a Medical School or Medical Education Program means that the Medical School or Medical Education Program has been independently assessed as meeting a set of criteria, which usually include criteria for the applicable quality assurance system. For example, an institution of learning may be termed "Accredited" after an assessment by an official review board states that the institution has met specific requirements.
Accreditation Agreement	The agreement between the IAAHEH and the medical school or the medical education program defines the accreditation service to be provided and contains the legal commitment by the medical school or the medical education program, to the conditions of the Accreditation Standards and Procedures.
Accreditation Logo	The trademarks and tag lines as designated from time to time by The IAAHEH for use in association with Accredited Medical Schools or Medical Education Programs.
Accreditation Policy	The IAAHEH Accreditation Policy document relating to the medical school or medical study program, as amended from time

	to time by The IAAHEH and made available on the IAAHEH website.
International Accreditation Published Directory	The official list of all Accredited Medical Schools or Medical Education Programs, is maintained by the IAAHEH and made publicly available on the IAAHEH website.
Accreditation Requirements	The criteria that the Medical Schools or Medical Education Programs must meet to be considered conformant. These criteria are documented in IAAHEH Handbook for Medical Schools and made available on the IAAHEH website.
Accreditation Trademark License Agreement (Accreditation TMLA)	The agreement between IAAHEH and The Medical School or Medical Education Program that contains the legal commitment by the Medical School or Medical Education Program to the terms and conditions for use of the Accreditation Logo relating to the IAAHEH's Accredited Medical School or Medical Education Program.
Accredited Medical School	A medical school or medical education program, that has successfully completed the accreditation procedures, and which is listed in the Accreditation Directory.
Assessment	A systematic collection, review, and use of information about educational programs undertaken to determine the degree to which the medical school or medical education program provider is operating per the accreditation requirements.
Assessor	The individual or individuals who have fulfilled the requirement and are appointed by the IAAHEH to perform assessments.
Dean of School	The specific individual(s) identified within a medical school or medical education provider as having the overall responsibility for managing the Accredited medical education program on a day-to-day basis and ensuring that it is carried out in accordance with its documented processes and procedures.
Medical Education Program Provider	A provider of medical education programs that offers at least one Accredited Medical Education Program.
Candidate Medical Education Program	A medical school or medical education program that has not yet been accredited.
Certificate of Accreditation	A document issued to a medical school or medical education program provider by IAAHEH certifying that a medical school or medical education program has successfully met the requirements for accreditation and thus is considered an accredited medical school or medical education program.
Certification Policy	The applicable Certification Policy document is identified in the Program Configuration document.
Medical School	A medical education provider and Party to this Agreement that is applying for a medical education program to be accredited. While the medical school is in the process of having a course accredited, the medical school may be referred to as an applicant.
Medical Education Program	an educational program from an institution that provides a complete or full program of instruction leading to a basic medical qualification;

	that is, a qualification that permits the holder to obtain a license to practice as a medical doctor or physician.
Registration Form	A web form is completed by the medical school or medical education program provider to register for accreditation by IAAHEH.
Schedule	The document contains supplemental details that are mutually executed and incorporated into this Agreement. Together with this Agreement, it embodies the entire agreement between the Parties relating to its subject matter.
Medical Education Program Academic Calendar	The academic calendar containing that identifies the medical education program that the Medical School would like to accredit in the specified Program.

3. The Medical School or Medical Education Program Provider's Obligations

The Medical School or Medical Education Program Provider will perform all the actions required by the IAAHEH in the Accreditation Policy and will promptly communicate all information required by the IAAHEH as defined in the Accreditation Policy. In particular, the Medical School or Medical Education Program Provider will be responsible for ensuring that the names and contact information for all contacts specified in the web-based accreditation system are up to date. Changes to such information may either be made in the web-based accreditation system itself or by notifying the IAAHEH.

3.1 Registration and Payment of Accreditation Fees

3.1.1 The medical school or medical education program must complete a Registration Form, thoroughly defining the medical school or medical education program to be accredited.

3.1.2 The medical school or medical education program must formally accept the terms of this Agreement by having an authorized person sign below, if not previously executed, and execute a Training Course Schedule corresponding to the Candidate Training Course.

3.1.3 The medical school or medical education program must sign the agreement with IAAHEH and authorize payment of the applicable accreditation fees when due. Unless the IAAHEH has agreed on alternative arrangements for payment in advance, payment must be made by transfer or by corporate credit card, at the time of registration. The IAAHEH will not initiate the accreditation process until payment has been received.

3.2 Documentation Assessment

3.2.1 The medical school or the medical education program undertakes to coordinate with and support the assessor in performing the assessment. The medical school or medical education program agrees to provide the assessors with access to the medical education program manager and other relevant staff for the purpose of assessing the medical school or medical education program's fulfilment of the accreditation requirements.

3.2.2 In addition to the accreditation-related information provided as part of the accreditation and assessment process, the medical school or medical education program undertakes to answer all additional questions reasonably related to accreditation that the IAAHEH or the assessor may raise and to make available for inspection all documentation and other information reasonably related to the medical school's or medical education program's fulfilment with the accreditation requirements.

3.2.3 The medical school or medical education program agrees to provide all required supporting evidence to the IAAHEH and the assessors.

3.2.4 The medical school and medical education program agree to comply with the IAAHEH's and the Assessor's reasonable requests for clarification or rework regarding the completeness, correctness or consistency of the provided information and documentation.

3.3 Survey Visit Assessment

3.3.1 The medical school or medical education program will provide the IAAHEH's designated assessors with attendance at a medical school or medical education program at a time and place to be mutually agreed upon no later than three months after the submission of the Self-Evaluation Report (SER) and thereafter when requested by the IAAHEH.

3.3.2 The medical school or medical education program will provide accommodation, international and local transport, and other expenses related to the survey visit to the assessor to IAAHEH, otherwise, no other fees are required.

3.4 Warranty of Compliance

3.4.1 By signing this Agreement below, the medical school or medical education program hereby warrants and represents that the medical school or medical education program identified in the registration form will provide data and information which is valid, accurate, and relevant.

3.4.2 The medical school or medical education program hereby warrants and represents that the medical school or medical education program identified in the registration form and meets the accreditation requirements at the time of accreditation and, after achieving accreditation result, the medical school or medical education program will continue to meet the accreditation requirements throughout the duration of accreditation validity, in accordance with the accreditation policy.

3.4.3 If the medical school or medical education program forfeited data and documents or fails to ensure continued fulfilment with the accreditation requirements, the IAAHEH may revoke the accreditation status for the medical school or medical education program, in accordance with the accreditation policy. For the avoidance of doubt, any demonstrable shortfall with respect to the accreditation requirements is grounds for withdrawal of accreditation status, whether that shortfall is apparent from the supporting evidence supplied or the accreditation process itself.

3.5 Duration of Accreditation, Renewal of Accreditation, and Re-Accreditation

3.5.1 Depending on the accreditation result, accreditation status may be valid for periods of 96 months if it is fully accredited or 60 months if it is accredited with monitoring from the date at which the IAAHEH provides written notice to the medical school or medical education program that accreditation has been achieved unless removed in accordance with the accreditation policy. During the Accreditation Period, the medical school or medical education program shall submit an annual report by the anniversary of the accreditation date.

3.5.2 The last day of each Accreditation Period is referred to as the re-accreditation date, after which time Accreditation ceases to be valid unless extended in accordance with the re-accreditation process defined in the Accreditation Policy.

3.5.3 To extend Accreditation for another period, the medical school or medical education program shall abide by the terms of the re-accreditation process defined in the accreditation policy. For the avoidance of doubt, failure to respond within thirty (30) calendar days to the IAAHEH prior to the expired date of the accreditation certificate, medical school or medical education program will be deemed a withdrawal, and the accreditation will expire on the re-accreditation date, resulting in removal from the accreditation directory. Likewise, failure to complete the re-accreditation process within the applicable period prescribed by the accreditation policy will result in the removal of the medical school or medical education program from the accreditation directory.

4. IAAHEH Obligations

4.1 IAAHEH will perform all the actions required in the accreditation policy as described in the Accreditation Handbook.

4.2 IAAHEH will list the medical school or medical education program which has been accredited in the IAAHEH directory of the accredited study program.

4.3 IAAHEH will issue an accreditation certificate to medical schools or medical education programs valid for the accreditation period.

4.4 IAAHEH will provide feedback on the annual report submitted to the medical school or medical education program.

4.5 IAAHEH will send a notification for re-accreditation six months and three months before the accreditation certificate expires respectively.

5. Confidentiality

5.1 IAAHEH shall, except where a provision of this Agreement provides otherwise, maintain in confidence all information the medical school or medical education program discloses in relation to this Accreditation. No license, express or implied, under any trademark or copyright is granted by the medical school or medical education program by virtue of such disclosure and IAAHEH shall not use any such information except for the purposes of this Agreement. The IAAHEH's obligations under this sub-clause shall be limited to taking such steps as it ordinarily takes to preserve the most important of its own confidential information. The obligations of non-disclosure and non-use set out in this Agreement shall not apply to any item of information which:

a) Is in the public domain at any time (but without prejudice to any Person's rights of action against another person who wrongfully causes or permits such information to be in the public domain),
b) Was rightfully in the receiving Person's possession without obligation of confidence prior to its disclosure pursuant to this Agreement, or is subsequently independently developed by the receiving Person's employees having no access to the information disclosed hereunder,
c) Is subsequently rightfully obtained without obligation of confidence by the receiving Person from a source other than the medical school or medical education program as evidenced by written records,
d) Is required to be disclosed by order of any court of competent jurisdiction,

PROVIDED that no right or interest under any license, patent, or otherwise shall be acquired by the recipient of any information by virtue of the application of this clause.

5.2 Information regarding an assessment report shall not be disclosed in any publicly available document or to any third party by the IAAHEH, the medical school or medical education program, or any party acting on the medical school or medical education program's behalf.

5.3 The IAAHEH may disclose the medical school or medical education program's confidential information to those of its staff and assessors who reasonably require access to such information. The IAAHEH may also disclose the medical school or medical education program's confidential information to any third party acting on behalf of the respective Government who reasonably requires access to such information.

5.4 The medical school or medical education program agrees to keep confidential information that comes into its possession during and after the accreditation process, particularly information related to the implementation of accreditation.

6. Liability and Indemnity

6.1 Liability

The Medical School or Medical Education Program acknowledges that because of the special nature of the certification authority, it is reasonable for the certification authority to exclude liability as set out below and for the organization to take measures, including insurance where appropriate, to mitigate or prevent any potential losses that may arise (provided that such measures are not in breach of this agreement).

The certification authority on its own behalf and on behalf of its officers, employees and agents hereby excludes all liability, whether in contract, tort or otherwise, arising out of or relating to this agreement or the use or non-use by any person of any information provided by the certification authority to the maximum extent permitted under Applicable law. In no event shall the certification authority be liable for Any indirect or consequential losses (including, without limitation, any loss of profits, contracts, production or use)

6.2 Indemnity

If a third party asserts a claim against IAAHEH, the Medical School or Medical Education Program hereby agrees, at its expense, to defend, indemnify and hold IAAHEH and its respective officers, agents and employees (the "Indemnitees") harmless from such claim (whether criminal or civil, in contract, tort, or otherwise) by defending Indemnitees at the Medical School or Medical Education Program's expense and paying all direct damages (including attorney's fees, court costs and expert's fees) that a court finally awards against Indemnitees or that are included in a settlement approved in advance by the Medical School or Medical Education Program, provided that the claim arises out of:

a) Allegations that the Medical School or Medical Education Program's training courses bearing the Trademark do not meet the Accreditation Requirements (but only to the extent IAAHEH has performed its obligations set forth in the Accreditation Agreement); and/or
b) The misuse of the Trademarks by the Medical School or Medical Education Program or its Affiliate; and/or

c) The Medical School or Medical Education Program's or its Affiliate's failure to discontinue its use of the Trademark pursuant to IAAHEH's right to withdraw permission to use the Trademark pursuant to this Agreement.

PROVIDED that:

a) This Indemnity shall not apply in respect of any act done by the Medical School or Medical Education Program on the express instructions of IAAHEH, and
b) The Medical School or Medical Education Program (together with any other ATC Provider and/or Affiliate under the Trademarks affected by such claims) shall have the conduct of such claims but shall consult fully with IAAHEH before taking any action or making any admission or settlement, which may adversely affect IAAHEH's interests.

6.2.1 Interpretation

Any provision of Sub-clause 6.1 above shall not apply in any circumstances or in respect of any liability or class of liability to the extent that it may not apply in accordance with applicable law. In the event of such a provision being held to be inapplicable or invalid, the parties will make such amendments to this Agreement by the addition or deletion of wording, or otherwise, as to remove the inapplicable or invalid part of the provision but otherwise retain the provision to the benefit of IAAHEH to the maximum extent permissible under applicable law.

6.2.2 Damages

In no event shall IAAHEH be liable for any damages, including without limitation, loss of profits, arising from or related to the Medical School or Medical Education Program's use of the Trademarks or the Termination of this Agreement, even if IAAHEH has notice of the possibility of such damages.

7. Payment of Fees

7.1 The fees are listed on the IAAHEH's website and are quoted gross of all applicable taxes and duties that, where appropriate, will be payable under the Indonesian tax authorities. The fees are not included applicable taxes and duties outside Indonesia's jurisdiction.

7.2 The accreditation fee covers expenditures as mentioned in the IAAHEH accreditation handbook. A further fee that has not yet been included in the accreditation handbook may apply for unexpected expenses related to force majeure.

7.3 First payment of 5% should be made during the registration process (nonrefundable if the medical school or medical education program is considered not eligible for accreditation by IAAHEH).

7.4 Second payment of 35% should be made before nurturing program (refundable 60% if the medical school is considered not eligible for accreditation by IAAHEH).

7.5 Third payment of 60% should be made after the medical school is considered eligible for accreditation by IAAHEH (non-refundable, except the medical school or medical education program cannot continue the accreditation process due to force majeure causes). The secretariat will consider the amount to be refunded based on the condition of each case.

7.6 The IAAHEH will charge the applicable Accreditation fee upon receipt of a completed registration.

7.7 Fees are payable in U.S. dollars.

7.8 Unless the IAAHEH has agreed with alternative arrangements for payment, fees must be paid by transfer or by corporate credit card in advance.

8. General

8.1 Entire Agreement

This Agreement including any documents referred to therein (as amended from time to time) together with all other forms relating to this Agreement submitted and accepted by both Parties constitutes the entire agreement and supersedes all prior oral or written agreements, understandings, or arrangements between the Parties relating to such subject matter. Neither Party shall be entitled to rely on any agreement, understanding, arrangement, or representation relating to the subject matter of this Agreement which is not expressly contained in this Agreement and no change may be made to this Agreement except in writing and signed by duly authorized representatives of both Parties.

Notwithstanding the above, IAAHEH may introduce changes to this Agreement as may be required by the Program. In such cases, changes shall immediately take effect either by a mutually written or electronically signed amendment.

8.2 Waiver of Rights under this Agreement

No failure or delay on the part of either of the Parties to exercise any right or remedy under this Agreement shall be construed or operate as a waiver thereof nor shall any single or partial exercise of any right or remedy preclude the further exercise of such right or remedy as the case may be.

8.3 Notices

Any notice or other document to be given under this Agreement shall be in writing in the English language and sent by email to the addresses set out in this Agreement, in the case of the medical school or medical education program, the address currently on record in the web-based Accreditation System for the Authorized Signatory or such other address as either party shall notify to the other in writing for this purpose. Notices shall be deemed to be effective upon receipt by the party to which notice is given or within the 5th day following the transmission of email.

8.4 Interpretation

The headings in this Agreement are inserted only for convenience and shall not affect its construction. Where appropriate, words denoting the singular only shall include the plural and vice versa.

8.5 Term and Termination

This Agreement comes into effect upon the date of the last signature of the parties hereto and will expire only if explicitly terminated:

a) At any time upon six (6) months' written notice by either Party to the other; or
b) If a period of thirty (30) days has elapsed from one Party notifying the other Party of a breach of this Agreement or of the terms of the Accreditation Policy or Accreditation Requirements, and such a breach has not been rectified to the satisfaction of the other Party; or

c) Immediately upon the Certification Authority's discovery of a breach of Sub-clause 5.6. Notwithstanding the termination of this Agreement for any reason, the obligations of non-disclosure in respect of any confidential information disclosed prior to such termination shall survive for a period of five (5) years following such termination.

8.6 Governing Law

This Agreement shall be governed by the laws of the Commonwealth of Massachusetts and the Parties hereby submit to the non-exclusive jurisdiction of the Massachusetts courts.

9. Execution

By signing below, the Medical School or Medical Education Program agrees to be bound by this Agreement, the Accreditation Policy, and the Accreditation Requirements.

AGREED by the Parties through their authorized signatories:

FOR AND ON BEHALF OF	FOR AND ON BEHALF OF
Medical School or Medical Education Program	**Indonesian Accreditation Agency for Higher Education in Health (IAAHEH)**
Signed	Signed
Name	Name
Title	Title
Date	Date
Email	Email : sekretariat@lamptkes.org
Address	Jalan Sekolah Duta 1 No. 62, RT 003, RW 014, Kelurahan Pondok Pinang, Kecamatan Kebayoran Lama, Jakarta Selatan 12310 +62 21 769 0913; +62 21 2765 3495/96

Appendix 2 Statement letter

MEDICAL SCHOOL

LETTERHEAD

On behalf of the (Medical Study Program) (the "School"), I hereby apply to the International Accreditation Agency for Higher Education in Health ("IAAHEH") for International Accreditation using WFME global standard for Basic Medical Education of the Medical Schools (a "Accredited Medical School") in accordance with and subject to the procedures and regulations of WFME.

I understand and agree that the Medical School will be subjected to denial of accreditation status; to withdrawal of accreditation status and forfeiture of any accreditation credential granted by IAAHEH as an extended hand of WFME; and to denial of future eligibility for recognition in the event that any of the statements or answers made in this application are false or in the event that the Medical School violates any of the rules or regulations governing Accredited Medical School, as described by IAAHEH/WFME.

I authorize IAAHEH to make whatever inquiries and investigations it deems necessary to verify the contents of this application. I understand that this application and any information or material received or generated by IAAHEH in connection with the accreditation process will be kept confidential and will not be released unless the Medical School has authorized such release or such release is required by law. However, the fact that the Medical School is or is not, or has or has not been, accredited is a matter of public record and may be disclosed. Finally, IAAHEH may use information from this application for the purpose of statistical analysis, provided that the School's identification with that information is not disclosed.

I hereby agree to hold IAAHEH, its officers, commissioners, employees, and agents harmless from any and all actions, suits, obligations, complaints, claims, or damages, including, but not limited to, reasonable attorneys' fees arising out of any action or omission by any of them in connection with this application, the application process, or the denial or withdrawal of the Medical School's recognition or eligibility for recognition.

Notwithstanding the above, should the Medical school file suit against IAAHEH, the undersigned agrees that any such action shall be governed by and construed under the Laws of Republic of Indonesia without regard to conflicts of law. The undersigned further agrees that any such action shall be brought in the applicable court of the High Court of Justice of Republic of Indonesia, or such subordinate Court as shall be applicable; as a court of first instance; consents to the jurisdiction of such courts; and agrees that the venue of such courts is proper.

The undersigned further agrees that, should the Medical School not prevail in any such action, IAAHEH shall be entitled to all costs, including reasonable attorneys' fees, incurred in connection with the litigation.

I UNDERSTAND THAT THE DECISION AS TO WHETHER THE MEDICAL SCHOOL QUALIFIES FOR ACCREDITATION STATUS RESTS SOLELY AND EXCLUSIVELY WITH IAAHEH AND THAT THE DECISION OF IAAHEH IS FINAL.

I HAVE THE AUTHORITY TO ENTER INTO THIS AGREEMENT ON BEHALF OF THE MEDICAL SCHOOL.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND I CERTIFY THAT THEY ARE TRUE AND THAT I INTEND FOR THE MEDICAL SCHOOL TO BE LEGALLY BOUND BY THEM.

MEDICAL SCHOOL EXECUTIVE OFFICER

_____
Print Name

_____
Title

_____
Signature

_____
Date

Rundown Nurturing on Accreditation Standards and Procedures

Day 1

Time	Activities	Presenter/PiC	Resources
08.00 – 08.30	Registration		
08.30 – 09.00	Pretest		
09.00 – 09.15	Opening Session		
09.15 – 09.45	Ice Breaker		
09.45 – 10.00	Learning Outcomes of the Training		
10.00 – 10.30	Break		
10.30 – 12.00	The Concepts of Accreditation Standards and WFME Global Standards for Basic Medical Education (Criteria 1-4)		
12.00 – 12.30	Individual Assignment and Presentation		
12.30 – 13.30	Lunch Break		
13.30 – 15.00	WFME Global Standards for Basic Medical Education (Criteria 5-8)		
15.00 – 15.30	Individual Assignments and Presentation		
15.30 – 16.00	Break		
16.00 – 17.00	Question and Answer		
17.00	Reflection		

Day 2

Time	Activities	Presenter/PiC	Resources
08.00 – 08.30	Lessons Learnt from Day 1		
08.30 – 09.30	IAAHEH Accreditation Procedures		
09.30 – 10.00	Question and Answer		
10.00 – 10.30	Break		
10.30 – 12.00	Implementation of the WFME Global Standards (1-4)		
12.00 – 12.30	Individual Assignment and Presentation		
12.30 – 13.30	Lunch Break		
13.30 – 15.00	Implementation of the WFME Global Standards (5-8)		
15.00 – 15.30	Individual Assignment and Presentation		
15.30 – 16.00	Break		
16.00 – 17.00	Question and Answer		
17.00	Reflection		

Day 3

Time	Activities	Presenter	Resources
08.30 – 10.30	How to do Self-Evaluation How to prepare a Preliminary Self-Evaluation Report and a Self-Evaluation Report		
10.30 – 12.30	Group Assignment		
12.30 – 13.30	Lunch Break		
13.30 – 14.30	Group Presentations		
14.30 – 15.30	How to Prepare for the survey Visit		
15.30 – 16.30	Discussion for Accreditation Preparation		
16.30 – 17.00	Closing		

The Assessors of IAAHEH

Characteristics

Assessors are individuals who are a member of profession organisation or association of higher education institution and assigned by IAAHEH to perform tasks related to the accreditation of medical programs after having completed the training for assessors.

Functions

An assessor will function in a team as an external evaluator to review, assess, and evaluate the Self-Evaluation Report of a medical school; and also, to conduct a survey visit to a medical school. They will work as a team, and an assessor may serve as a responsible person or member. An assessor may serves as a responsible person after having manifested the capability to lead a survey team, and, have sufficient knowledge and experience as an external evaluator to assess the quality of medical education. The members of a survey team must be individuals who have the capability to make judgment, have great experience, and integrity.

Recruitment

The information on the assessors needed will be put on the IAAHEH website. Assessors are recruited through two ways. First, they are recruited based on their proposal to be an assessor of IAAHEH. Secondly, IAAHEH communicates and coordinates with Profession Organisation and Association of Higher Institution to get candidates. Both types of candidates have experiences as administrators, or head of the medical program; are recommended through psycho-test and fulfil the criteria to be assessors of IAAHEH. Then, the assessor will be employed in IAAHEH; and they will continue to serve as assessors even after they are retired from their respective institutions.

Training

A basic training will be provided by IAAHEH for all would be assessors; and afterwards, a refreshing training will be conducted periodically. The training for the candidates to be assessors consists of three stages; that are: (1) an online supervised learning, to study 10 modules for ten weeks. (2) offline learning for four days, to study and exercise an online accreditation system using program sample, exercise in an interview and obtain other data using a simulation or roleplay, (3) three times internship as a newly assessor and act to become an assessor team member. All processes will be done based on a elimination system.

The training modules for assessors include important information on the policy of accreditation, the accreditation process, SIMAk system, effective communication and conflict management, internal and external quality assurance system, as well as a simulation of an actual survey visit. After completed the training, each new assessor will receive an assessor certificate and an accreditation kit.

The training for international assessors were conducted for four days in collaboration with General Medical Council, United Kingdom included reviewing handbooks of international quality standard based on World Federation for Medical Education Standard (WFME).

Responsibilities of assessors

The assessors are expected to:

1. Obtain a big picture of the medical program. Some efforts need to be exerted to evaluate the details to figure out the larger context. Each assessor needs to always keep in mind that the final goal of a survey visit is to assist and support the program to achieve its mission by providing conclusion and expert judgment based on a thorough evaluation of the presented evidence of a program.
2. Be objective in assessing the evidence presented and has no conflict of interest with the school being assessed.
3. Provide objective and realistic recommendations to the study programs
4. Communicate humbly as a colleague not as an inspector.
5. Optimise the time allotted during the Survey Visit so all tasks can be completed. All interviews and meetings must begin and end on time. An assessor needs to be an active recipient of information that the program staff would like to provide the survey team. Do not spend time on unclear objectives. All activities must be purposeful.
6. Need to self-controlled from making remarks about the personnel, or programs, whether positive or negative, anytime during a Survey Visit.
7. Must refrain from providing friendly advice or making comparisons to their own or other institutions/programs. This will be misconstrued as requirements for accreditation.
8. Need to behave professionally at all times.
9. Handle all information about a program properly and confidentially.

Code of Conduct

The Assessors should always refer to the code of conduct which has been set by IAAHEH during all their assignments.

a. The Assessors must produce a written statement that they are free from any conflict of interests which might be related to their duties as part of the Accreditation Team.
b. The Assessors must maintain honesty and integrity.
c. The Assessors must classify all information/documents related and the results of the accreditation process by respecting the sensitivity of the information received and not reveal them to any party except the IAAHEH.
d. The Assessors must be objective and fair. The assessors must be impartial in their decisions and not influenced by their own or any other person's interests.
e. The Assessors must be competent in applying their knowledge, skills, and experience.
f. The Assessors must work independently and professionally.
g. The Assessors must maintain their dignity and are prohibited from receiving any form of gifts which may be related to their duties as part of the Accreditation Team.
h. The Assessors are prohibited from taking personal advantage through their position.
i. The Assessors must maintain a supportive and conducive atmosphere when participating in the accreditation process.
j. The Assessors must obey all rules and regulations which apply in the IAAHEH.
k. The Assessors must comply with the local rule and regulation during the accreditation process.

Definitions of Findings

Non-compliance: Non-fulfilment of a requirement or standard.

Partial compliance:

Major noncompliance: noncompliance that affects the capability of the school to achieve the intended results in terms of student learning outcomes as stated in the curriculum.

Noncompliance could be classified as major in the following circumstances:

- If there is a significant doubt that effective process control is in place, or that student learning outcomes will meet specified requirements;
- A number of minor noncompliance associated with the same requirement or issue could demonstrate a systemic failure and thus constitute a major noncompliance.

Minor noncompliance: Noncompliance that does not affect the capability of the school to achieve the intended results.

Fully Compliance: The study program fulfils all the requirements of standards.

Areas for improvement: It is a statement of fact made by an assessor during an assessment, and substantiated by objective evidence, referring to a weakness or potential deficiency in a management system, educational programs, curriculum or educational resources which if not improved may lead to noncompliance in the future. Generic information will be provided about educational process best practices but no specific solution shall be provided as a part of an opportunity for improvement.

Accreditation Council

1. The Accreditation Council

The Accreditation Council is the sole authority to determine accreditation status and action. Members of the Council consists of five persons that have been appointed by IAAHEH based on certain strict requirements for council membership (as stated in IAAHEH Regulation No. 04 02 2021) as follows:

a. Indonesian nationality, except for the invited international council member.
b. Has high integrity.
c. Has never been convicted/or served a sentence due to committing criminal offenses.
d. Does not hold a structural position/ leading position in another institution/ association at the time of appointment and throughout their council membership.
e. Not in a position that could cause a conflict of interests with the duties as a member of the Board of Supervisor
f. An expert and has experience in managing organisations of higher education institutions.
g. Has the knowledge and commitment in quality assurance of higher education
h. Has completed the Assessor/Accreditation Team Training using both the online and offline modules.
i. At least 5 years' experience as an assessor
j. Obtained written permission from his/her employer (if needed)

2. Composition and Appointment

a. The Accreditation Council consists of 5 members (4 from Indonesia and 1 from Asia-Pacific Region)
b. Members of the Accreditation Council consist of 1 (one) person for each field of study. The BoD appoints members of the Accreditation Council as nominated by the relevant Profession organisation and Associations of Higher Education in Health. In addition, 1 (one) person is appointed as a member representing civil society, and 1 (one) person is appointed as a member representing other fields in Health.
c. Members of the Accreditation Council are appointed by the Chairman of IAAHEH

3. Qualification

a. Background in medical science
b. At least 5 years' experience as an assessor in their respected home country
c. Experience in managing a medical school.
d. Never convicted of any crime or violating any law or regulation of IAAHEH
e. The person has moral integrity and upholds the value of IAAHEH.

4. Role and Responsibility

a. Reviewer
   To review the summary of findings of the self-evaluation report and survey visit report including other relevant documents.
b. Decision maker
   To make accreditation decision.

5. Code of Conduct

The Council Members should always refer to the code of conduct which has been set by IAAHEH during all their assignments.

l. The Accreditation Council must produce a written statement that they are free from any conflict of interests which might be related to their duties as part of the Accreditation Council.
m. Accreditation Council must maintain honesty and integrity.
n. The Accreditation Council must classify all information/documents related and the results of the accreditation process by respecting the sensitivity of the information received and not reveal them to any party except the IAAHEH;
o. The Accreditation Council must be objective and fair. The Council must be equal in their decisions and not influenced by their own or any other persons' interests.
p. The Accreditation Council must be competent in applying their knowledge, skills, and experience.
q. The Accreditation Council must work independently and professionally.
r. The Accreditation Council must maintain their dignity and is prohibited from receiving any form of gifts which may be related to their duties as part of the Accreditation Council.
s. The Accreditation Council is prohibited from taking personal advantages through their position.
t. The Accreditation Council must maintain a supportive and conducive atmosphere when participating in the Council Meeting.
u. The Accreditation Council must obey all rules and regulations which apply in the IAAHEH.

6. Term of Office

a. Each council member shall be appointed to a term of five years and shall serve for not more than two consecutive terms.
b. In the event of the resignation of a council member for any valid reasons (death, unable to carry out, violation of contract) a replacement shall be appointed immediately to serve the unexpired term. The Board of Directors shall appoint the replacement upon the recommendation of the Board of Founders.

7. Conduct of Council Meetings

The conduct of all council meetings is guided by the current edition of the Standard Code of Council Procedure. The accreditation decision is based on eight WFME standards, while methods of evaluation of all standards and elements are developed by IAAHEH.

The procedure of the accreditation decision is as follows. The Chairman of IAAHEH informs the Chairman of the Accreditation Council that all accreditation reports have been received. The Chairman of the Accreditation Council will then call a council meeting in a special in-person or virtual meeting. The meeting is scheduled at least 2 weeks after all council members received the assessor's reports and all relevant documentation. Participation in virtual meetings must comply with the following rules:

- All discussions related to the review of survey visit reports are strictly confidential.
- Quorum
- The accreditation decision meeting must be attended by all members of accreditation council.

- All council meetings are guided by the current edition of the Standard Code of council procedure.
- Attendance and Recusals

8. Conduct of Council Members

Council members are expected to attend all meetings and remain for the duration of the meeting unless exceptional circumstances preclude them from doing so. The Secretariat office maintains a record of member attendance. The minutes of each meeting must include the list of attendees.

Members shall not vote on and shall absent themselves from the discussion during consideration of any school with which there could be a real or perceived conflict of interest as described later in this document.

Members who have participated in the survey visit of a school being reviewed will not be assigned as a primary or secondary reviewers of the assessors' report, both during consideration of the report and at all other times during council meetings, survey visit participants will not offer comments or be asked questions by any member of the council and will not discuss their personal impressions of the program being reviewed. Should the members reviewing a survey visit report require clarification of a specific aspect related to report content prior to the meeting, the Secretariat will arrange a conference call between the reviewers and the assessor secretary. A member of the Secretariat will participate in the call if the team secretary is not a member of the Secretariat. Council members who have participated in the visit of a school being reviewed may give comments on any related accreditation action but shall not initiate or second any motions relating to an accreditation action for such schools.

9. Conduct for Observers at Council Meetings

National and international medical educators and individuals from other disciplines involved in higher education or the accreditation process may request to attend a council meeting. Requests must be made in writing to the Secretariat and require prior approval by the voting members of the council. Observers must agree in writing to hold all meeting materials and results of council discussions in strict confidentiality.

10. Evaluation of Standards and Elements

During the meeting, the council will discuss and decide the compliance of the school with the accreditation standards and the performance of each accreditation element.

The council uses the following definitions for compliance with accreditation standards:

- Compliance: Taken as a whole, the expectations of the standard are being met.
- Partial Compliance: While there are concerns based on the performance in individual elements, those concerns do not seriously compromise meeting the expectations of the standard.
- Non-compliance: Taken as a whole, the performance of the elements does not permit the expectations of the standard to be met.

The council uses the following definitions for performance in accreditation elements:

- Strength: The policy, process, resource, or system required by the element is in place and, if required, there is sufficient evidence that it is effective.
- Areas of Concern:

a) The policy, process, resource, or system required by the element exists but there is insufficient evidence of sustainability and/or effectiveness, OR
b) The requirements of the element are met but anticipated circumstances could negatively impact future performance.

- Need for further Evidence: One or more requirements of the element is/are not met. The required policy, process, resource, or system is not in place or is ineffective. Formal evidence of effectiveness/sustainability is absent.

11. Review of the Final Assessors Report and Any Other Relevant Documentation

The council will review the final assessors' report and any other relevant documentation and draw conclusions about the program's performance regarding the accreditation elements, compliance with accreditation standards, the accreditation status of the program, and any required follow-up. Depending on the extent of the program's compliance with accreditation standards, the council will take an accreditation action as specified in the section on "Types of Accreditation Decision." The accreditation decision will be effective as of the date of the IAAHEH decision and a change in status will never be applied retroactively.

Monitoring Report

The school is required to submit a monitoring report biannually for those who received full accreditation status and annually for those that have been granted accreditation with monitoring.

The purpose of this monitoring report is for the school to provide information to IAAHEH to demonstrate that they are meeting the standards and resolving issues and concerns timely.

To maintain accreditation status, all accredited members should complete and submit the IAAHEH Monitoring Report between October 1 and December 31 of each year, beginning the calendar year following a provision of initial IAAHEH accreditation. The report needs to be uploaded to SIMAk-Int system. Once this report is received, IAAHEH will send a notification.

An instruction page is included in the SIMAk-Int.

The Monitoring Report template consists of two parts. Part I requires data on program performance and student achievement; this information is posted publicly by the accredited program no later than January 15 of the year following submission. A link to that information is posted on the IAAHEH website as well. Part II consists of strategic planning information and other programmatic updates communicated to IAAHEH annually.

If evidence shows the program is at risk of no longer meeting one or more of IAAHEH standards, the Accreditation Council/Secretariat requests the program to send a supplemental self-study report on specific required aspects of the standards within 60 days; IAAHEH will review that report within 30 days of its receipt and may:

a. reaffirm accreditation,
b. specify a condition that must be addressed within a specified timeframe with evidence provided in a focused report, or,
c. revoke accreditation

Monitoring Report Form

A substantive change is one that may significantly affect an institution's quality, mission, and operations including methods of delivering curriculum, or control. Substantive changes are reviewed to ensure that changes in student enrolment, educational process, teaching and learning resources, locations, the scope of the curriculum, and control of the institution are or will be made in compliance with IAAHEH accreditation standards.

They include:

1. Issues, concerns, or areas for improvement
2. Change in school vision and mission.
3. Change in organisational structure and functions.
4. Change in student enrolment.
5. Student achievement
6. Faculty developments
7. Curriculum delivery
8. Teaching and learning resources.

Follow Up Action of the Monitoring Report

If an Accreditation Action Report includes a notation of a concern or a condition, the Medical School reviews the information presented relative to the identified issue. That medical school liaison works with the provider and the Accreditation Council/ assessor/ IAAHEH to ensure that the timeline is honoured, and the issue is resolved.

Assessors may also contact the Medical School in the event of other marked changes in programs. Indicators that would trigger contact may include sudden increases in enrolment, changes in levels of reported performance, changes in curriculum delivery or changes in teaching and learning resources. Such indicators would serve only as triggers for further review and data collection by staff.

Programs whose Monitoring Reports do not have any concerns or conditions or include indications of program weakness will be notified that their report has been received and reviewed.

IAAHEH secretariat staff will remain the medical schools if they have not completed the Monitoring Report by the December 31. If a Medical School Monitoring Report is not submitted by October 31 of the year following submission deadline, the Medical School is considered to violate the accreditation policy. In this situation IAAHEH may initiate a sanction.

The Procedure for Appeal Request Submission

An appeal request is the procedure to re-consider the result of accreditation finding from medical school as follows:

a) An appeal request must be submitted in writing within 30 days upon receiving the accreditation result.
b) An appeal request must be accompanied by a signed consent form in which the medical school corroborates materials to the members of accreditation council and/or secretariat of the IAAHEH.
c) The written appeal should contain information and details on the circumstances that form the basis of the appeal. The medical school should cite the relevant accreditation standards or elements relating to the appeal. If the appeal indicates areas of non-compliance with accreditation standards/unsatisfactory performance in accreditation elements, the Secretariat of IAAHEH will contact the medical school to obtain additional evidence and related documents which should be uploaded in the SIMAk-Int. If the medical school is unable to comply with the request for additional information or does not provide a signed consent form, the appeal request will be rejected, and no further action will be taken.
d) The appeal request and its related document/evidence will be kept confidential.
e) The accreditation council will review all the receiving additional evidence and documents and inform the result to the Chairman of the IAAHEH.
f) IAAHEH will communicate with the school's representative to fully investigate the appeal request to obtain additional evidence required by IAAHEH within 14 days of receiving the appeal request and all accompanying evidence and documents.
g) Hearing will be conducted virtually between the accreditation council and the school's representative after 30 days of receiving additional evidence and relevant documents. The hearing consists of oral presentations by the school's representative, inquiries by the accreditation council, private discussions of the accreditation council, additional inquiries by the school's representative, and closing. During the closing, the accreditation council will inform the decision.
h) If an additional visit is necessary for further verification of the evidence, IAAHEH will appoint at least two of the members of the original assessor team to carry out the survey visit. The school will be charged an additional fee.
i) The assessor team will submit an additional visit report to the accreditation council for consideration. The accreditation council will decide the final accreditation result based on the additional visit report.

The Procedure of Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments

The Process to consider Complaints, Information from Credible and Verifiable Public Sources, and Third-Party Comments about Program Quality:

a) IAAHEH will submit the document of complaint to the Accreditation Council to determine whether the complaint contains issues related to the school's compliance with accreditation standards and/or performance in accreditation components.
b) The Accreditation Council will ask IAAHEH to draft a letter to the dean or related authority of the school or to the individual (if the case of a conflict of interest) describing specific information needed to be provided in response.
c) The Accreditation Council will review the complaint, assess, and explore the relationship between the complaint and the non-compliant to the IAAHEH quality standard.
d) The Accreditation Council will write a report provided with evidence of non-compliance with the standard and the recommendation to be discussed further.
e) The IAAHEH will make a final decision including any change in the school's performance in elements, compliance with standards, and accreditation status and specify the nature and timing of any required follow-up.
f) The decision will be directed also by IAAHEH to the dean of the school or the related individual (in case of conflict of interest).
g) The complainant will be notified whether further investigation will be undertaken or not. The complainant will not be informed of the result of any such investigation.
h) The IAAHEH will take formal action based on the recommendation by Accreditation Council, including setting up a new team of assessors, if required.
i) The complaints that represent non-compliance with accreditation standards and/or unsatisfactory performance in accreditation elements, will require follow-up by the medical school on how the identified problems were addressed.
j) The complaints with such findings will be retained in SIMA-Int records as part of the accreditation history of the medical school.
k) The assessors who will conduct a full survey visit will receive documentation of complaints, which have been found after investigation to relate to areas of non-compliance with accreditation standards and/or unsatisfactory performance in accreditation components.
l) The assessors will also receive information on the final IAAHEH action related to these complaints.

Any further response from the dean or individual that requires legal action will be prepared following specific procedures which are determined on a case-by-case basis.