Ministry of Higher Education and Scientific Research

A Guide for Accreditation of Medical Colleges, Iraq

By

NATIONAL COUNCIL FOR ACCREDITATION OF MEDICAL COLLEGES

NCAMC

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رقم الايداع في دار الكتب والوثائق ببغداد ١١٨٨ لسنة ٢٠١٦

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ADVISORY BOARD

PREFACE

Accreditation of medical colleges is normally carried out by national governments, or by national agencies receiving their authority from government. The National Council for Accreditation of Medical Colleges (NCAMC) was established in February - 2015 as an expansion of The National Committee for Accreditation of Medical Colleges in Iraq. It receives its authority from the Ministry of Higher Education and Scientific Research to become the formal reference to academic accreditation in Iraq based on the standards stated in the Iraqi National Guideline on Standards for Establishing and Accrediting Medical Colleges (INGSEAMC).

A Comprehensive guidance as to the purpose, structure and outcomes from the accreditation process are detailed in the document **"A Guide for Accreditation of Medical Colleges"**. It is anticipated that this guidance will be modified in the light of self-evaluations, accreditation visits and reports and further discussions with stakeholders. The document has been written by members of the NCAMC on the basis of their acknowledged expertise with input from the advisory board`s members namely; Prof. Nigel Bax, Prof. Ghanim Alsheikh, Prof. Mohammed AlUzri.

Accreditation is a step in the process of quality assurance that determines whether a program meets established standards for function, structure and performance. The accreditation process enhances institutional and program improvement and provides assurance to patients, employers, students and faculty that a program meets national and community needs, complies with relevant Iraqi Guidelines, and has comparability to international standards. It allows the identification of areas of good practice that may be shared and also areas that need to be modified in order to meet the required standards. The process of accreditation encourages and supports continuous quality improvement and will allow the development of a culture in medical colleges that will sustain this. It also determines where the quality of medical education meets the standards completely, partially, or does not.

Chapter 1 in this guide includes the INGSEAMC. The standards listed address all aspects of the program; including the: vision, mission & objectives, curriculum, student assessment, program evaluation, students, Staff, educational resources, governance and administration, research, continuous professional development.

The first step in the accreditation process is the self-assessment study (SAS) which is well discussed in chapter 5. During SAS a medical college undertakes a self-evaluation in relation to compliance with the required standards and gathers the supporting documentation. From this process. The college will identify its strengths and areas where more development needs to be carried out and produce an action plan for further work.

The college can request a peer review visit at any stage during the process of SAS which is well discussed in chapter 7. Peer review visit; is an optional advisory visit, to assist the college and also to collect centrally information that will be of assistance to other colleges as they undertake their own self-evaluations and prepare for an accreditation visit.

The last step is to conduct site visit for evaluation and, thereafter, the final decision for accreditation, which is discussed thoroughly in chapter 8, 9 and 10.

So, On behalf of the NCAMC, I dedicate this book to the Iraqi Medical Colleges, wishing for them all the success and prosperity.

Prof. Dr. Yusra AR. Mahmood
Chairman of NCAMC
MOHE – Iraq
April – 2016

HISTORY OF NCAMC ESTABLISHMENT

In Iraq there are 23 medical colleges distributed all over the country. These are all public colleges, funded by government through the Ministry of Higher Education and Scientific Research. The first college had been established in 1927 according to British model. The rest of the colleges that have been established later followed the same traditional model. National medical colleges worked jointly with international medical colleges at the start. Then with the development of national staff, the role of international staff became less. Political transitions in Iraq played a role in this change. Cooperation did not stop, and visitor professors kept teaching and examining Iraqi medical students until eighties of last century. Higher education and training of majority of Iraqi doctors used to be conducted in United Kingdom, United States, and other developed countries. In 1980s, Iraq established Iraqi Board for Medical Specializations and participated in Pan-Arab Board for Medical Specializations in order to qualify medical graduates in different specialties locally aiming at improving the health system and services. Cooperation between Iraqi medical colleges and International ones persisted in one way or another until sanctions have been imposed on Iraq in 1990 with UN sanctions.

Thereafter WHO represented the only source for international support to health service and to medical education. This cooperation with WHO led to the introduction of accreditation concept into medical education in Iraq in 2007 by WHO staff during a conference of the Association of Arab Deans of Medical Colleges that was held in Damascus, Syria and was attended by head of committee for deans of Iraqi medical colleges Professor Hikmat A. Hatem. National efforts were initiated thereafter to increase awareness of medical faculties the importance of accreditation and the need to accomplish by all colleges. A mile stone step in the journey was the official establishment of accreditation committee within the Ministry of Higher Education and Scientific Research which, was affiliated to Quality Assurance Division but the office was in Al-Nahrain College of Medicine in Baghdad. This committee named was as the National Accreditation Committee of Medical Colleges in Iraq (NACMCI) and included thirteen members, two of them from the Ministry of Health. Liaison committees also were established in each of the medical colleges in Iraq where all of them were affiliated to NACMCI. Many scientific activities have been conducted since in collaboration with WHO. These activities included workshops, conferences, and

panel discussions inside Iraq and in nearby Arab countries like Bahrain and Jordan. Members of NACMCI and liaison committees participated in these activities. The majority of these activities have been funded by WHO. The events covered variable aspects of accreditation theory and practice.

Another milestone in the accreditation process in Iraq is the formulation of Iraqi National Guideline on Standards for Establishing and Accrediting Medical Schools and its approval by Minister of Higher Education and Scientific Research, Minister of Health, WHO representative in Iraq, deans of medical colleges, members of NACMCI and members of liaisons committees endorsed and signed a copy of the guideline in 2009. This has led to a series of accreditation activities including peer visits carried by members of accreditation committee and liaison committees. Then the accreditation committee requested each medical college to conduct a self-assessment study, write a report, and submit the report to the accreditation committee. All colleges responded and submit self-assessment reports to the accreditation committee in 2010-2011. Those reports varied in their compliance with Iraqi National Guideline on Standards for Establishing and Accrediting Medical Schools. NACMCI on one hand and all medical colleges on the other hand were eager to carry on, but some constrains faced us all. At that time a question about who will accredit eligible colleges of medicine was raised. NACMCI needs to be approved by minister's board; this was requested by the Ministry of Higher Education and Scientific Research in April 2010 without reply. NACMCI wanted a more consistent accreditation decision through the participation of international experts and requested WHO for such international participation. As a result of the above constrains the NACMCI momentum regressed, until the establishment of Quality Assurance and Academic Accreditation Directorate within the Apparatus Supervision and Scientific Evaluation. Important developments have been achieved, including establishing Accreditation Council in 2015 as a development to NACMCI. This may be considered as an evolution for a more systematic work. The council through its periodic meetings prepared this comprehensive guideline book. The NCAMC will work on accrediting Iraqi Medical Colleges; meanwhile we will do our best toward international recognition by agency like WFME.

The ultimate results for all these efforts will be fulfilling community health needs through provision of safe and equitable health care services.

ACKNOWLEDGMENT

The National Council for Accreditation of Medical Colleges highly appreciates the unlimited encouragement of the Ministry of Higher Education and Scientific Research.

We like to acknowledge the big efforts of Prof. Dr. Nabil Alaaraji, the chairman of the Apparatus of Supervision and Scientific Evaluation for his continuous support in the establishment and achievements of the Council.

This book is dedicated to the memory of the late Prof. Hikmat Abdul Rasool Hatem, the Man who put the first steps on the road of accreditation and Chair the Iraqi Committee of Accreditation of Medical Colleges for many years.

The NCAMC is indebted to Dr. Ala Alwan, WHO Regional Director for the Eastern Mediterranean and Dr. Naeema Algasseer, the representative of WHO in Iraq who played a great role in the establishment of the Iraqi National Guideline on Standards for Establishing and Accrediting Medical Colleges along with the big efforts of the Deans of Colleges of medicine and the members of accreditation representative in all medical colleges, in addition to her great support in holding many workshops to develop the capabilities of the Iraqi academics.

The NCAMC are greatly indebted to many people who share in the development of the accreditation process among Iraqi Medical academics, namely WHO members: Dr. Sayed Jaafer, Prof. Ghanim Alsheikh, Dr. Waleed Abu Baker, and Dr. Aqeela Noori.

We like to express our thanks to Dr. Ali A. Abdulla the head of the quality assurance and accreditation department, MOHE and Amer A. Gazhi Muna the expert and consultant of TQM, Accreditation and Criteria building for their assistance, support and encouragement.

LIST OF CONTENTS

LIST OF ABBREVIATIONS

Abbr.	
ASSE	Apparatus of Supervision and Scientific Evaluation
CME	Continuous Medical Education
CPD	Continuous professional development
CV	Curriculum Vitae
FAIMER	Foundation for Advancement of International Medical Education and Research
DC	Data Collection
EC	Entrance Conference
HC	Head Committee
INSAMC	Iraqi National Standards for Accreditation of Medical Colleges
MOHESR	Ministry Of Higher Education and Scientific Research
NCAMC	National Council for Accreditation of Medical Colleges
NACMCI	National Accreditation Committee of Medical Colleges in Iraq
PHCC	Primary Health Care Center
POA	Plan Of Action
QA	Quality Assurance
Ques	Questionnaire
SAS	Self-Assessment Study
SC	Subcommittee
SSR	Self -Study Report
StC	Steering Committee
SWOT	Strengths , Weaknesses, Opportunities, Threats
RSC	Report Subcommittee
TFS	Task Force Subcommittee
VMO	Vision. Mission. Objectives
Verifi	Verification
WFME	World Federation for Medical Education
WHO	World Health Organization

CHAPTER 1

IRAQI NATIONAL STANDARDS FOR ACCREDITATION OF MEDICAL COLLEGES

Revised By

Ministry of Health, Deans of Colleges of Medicine,

National Council for Accreditation of Medical Colleges and Advisory Board

Endorsed by

National Council for Accreditation of Medical Colleges, Ministry of Higher Education and Scientific Research, World Health Organization, World Federation for Medical Education.

APRIL 2016

BACKGROUND

The purpose of accreditation and quality improvement in medical education is to reflect the changing conditions in the health care delivery system and prepare physicians for the needs and expectations of Iraqi society. Accreditation is both a statement of affirmation and empowerment for higher education institutions (Colleges) , used to obtain a distinguished character and identity, and gives a seal of approval that actions taken to improve quality are being successful. It is the gate way towards total quality assurance and it is also considered to be a motivation for colleges to promote a comprehensive educational process and quality systems to raise the level of confidence in the medical college and its graduates. Accreditation is a mandatory peer – review process designed to attest the educational quality of new and established educational programs to pre-defined standards. The Deans of Colleges of Medicine in Iraq have approved the need to develop basic minimum standards for the accreditation of medical Colleges to ensure they meet both the national and international quality standards, and also the interests of the public and students. It is imperative to have an established body at national level responsible for accreditation. The recommendations and guidelines in this document have been modified from Arabian Gulf Cooperation Council 'Recommendations & Guidelines on Minimum Standards for Establishing and Accrediting Medical Schools in The Arabian Gulf Countries' and also based on the joint World Health Organization and the World Federation for Medical Education (*WFME*) recent recommendations on Standards for Basic Medical Education.

The overall aim of the accreditation process is to evaluate the medical program in any particular college against its own goals and objectives in order for graduates to be competent professionals, provided these are concurrent with the general principles described below. It is the medical colleges' responsibility to develop and implement a curriculum that achieves these objectives. An appropriate internal appraisal mechanism must be in place to monitor the implementation of the curriculum and make appropriate changes in relation to varying requirements. This sets of standards for use in the regular accreditation of medical schools in Iraq. However, the value of accreditation is not just in the quality assurance of individual medical schools; it is in the creation of a general culture of quality improvement in medical education, to the ultimate benefit of the health of the population.

1. **Mission:**

1.1. The Medical College will have a documented mission statement, aims and educational objectives to produce competent graduates who are suitably prepared to meet the needs and demands of human rights and Iraqi values as physicians. The mission statements and objectives are being set in context of participation from key stakeholders, namely the college Dean, medical college faculty, medical students, health and education authorities, health professional associations and health societies, community and civil society.

1.2. The curriculum objectives should be governed by the quality and volume of material which should be learned by students in order to qualify them to deal with the common and prominent medical problems in the community with high level of competence and to aspire be lifelong learners.

2. **Curriculum:**

Annotation: Curriculum; in this document refers to the educational program and includes a statement of the intended educational outcomes, the content/syllabus, experiences and processes of the program, including a description of the structure of the planned instructional and learning methods and assessment methods. The curriculum should set out what knowledge, skills, and attitudes the student will achieve.

2.1. Goals:

Annotation: Goal is general principle that **guide decision making.**

2.1.1. The overall goal of undergraduate medical education program is to produce multidisciplinary educated medical graduates who are competent to practice both safely and effectively.

2.1.2. Graduates must have an appropriate foundation, not only to function upon graduation as a physician, but be prepared to pursue lifelong learning and readiness for further training.

Annotation: Lifelong learning: the curriculum need to provide opportunities for students to learn by practice, the abilities for self-

assessment, discover gaps and seek and learn further knowledge, skills, attitudes from different sources to bridge gaps. This can be achieved in active learning in small group learning which is structured around meaningful theme (e.g. case, problem) with formative assessment and reporting.

2.1.3. Emphasis must be placed on the professional behavior and values in the practice of medical science, rather than on the acquisition of a detailed compendium of current knowledge or a comprehensive list of clinical skills.

2.1.4. The program must be responsive to the health and developmental needs of the community, with continued community engagement.

2.2. Objectives of Undergraduate Medical Education: The outcome objectives must result in medical graduates who are competent and equipped to respond to the health needs of individuals and families based on a service that is compassionate, caring and taking into consideration human rights and gender equity. The competencies, which should be exhibited by the student at the point of graduation, must be defined. These must include the skills of continuing professional development.

Annotation: Objectives are specific, measurable steps that can be taken to meet the goal.

2.3. Program duration: The duration of the program in Iraq is not less than 200 weeks, this is based on the educational and experience required for addressing common health needs and problems.

2.4. Curriculum Design and Organization.

2.4.1. The curriculum must disseminate essential factual knowledge, impart requisite professional skills in communication and patient management, develop critical thinking, analytical ability and enhance the development of desirable professional behaviors and values founded in medical ethics relevant to Iraqi culture.

2.4.2. The units into which the curriculum is divided must demonstrate adequacy of a core content to ensure that the required competencies of knowledge, skills and professional behavior for entry into medical practice are met.

2.4.3. The curriculum should provide opportunities for self-directed learning, for taking optional/elective units, and for gaining exposure to a wide range of institutional and community experiences.

2.4.4. Students must spend at least three academic years of their training in direct contact with individuals, families and the community with increasing clinical responsibility under supervision. The students should be exposed to patients and community as early as possible.

2.4.5. The curriculum must enable students to acquire appropriate knowledge, skills and professional behavior relating to disease prevention, health promotion and community health.

2.4.6. Medical ethics must be an integral part of the curriculum.

2.4.7. Basic science teaching must be relevant to the overall objectives of the medical college, and such relevance must be apparent to the faculty and students. Thus, basic science must illustrate the importance of principles being taught to the understanding of health and disease, both at the individual and community level.

2.4.8. Clinical medicine must be taught in such a way that reinforces underlying scientific principles and humanitarian values.

2.4.9. Staff from basic science departments should be involved in the teaching of clinical disciplines, as is the involvement of clinicians in the teaching of basic sciences.

2.4.10. An appropriate level of horizontal (concurrent) and vertical (sequential) integration (end point spiral integration) should be in place in order to achieve the educational objectives.

Annotation: Examples of horizontal (concurrent) integration would be integrating basic sciences such as anatomy, biochemistry and physiology or

integrating disciplines of medicine and surgery such as medical and surgical gastroenterology or nephrology and urology.

Examples of vertical (sequential) integration would be integrating metabolic disorders and biochemistry or cardiology and cardio-vascular physiology.

2.4.11. Explicit statements about the level of knowledge and understanding, skills, and professional behavior expected of the students at each phase of the curriculum will enhance its organization.

2.5. Curriculum Implementation: Schools must demonstrate that they have processes in place that allow the overall content and balance of the curriculum and its assessment to be defined in relation to the stated objectives of the medical school. A Curriculum Committee must exist and be given the authority for planning and overseeing the comprehensive curriculum and must have the ability to exhibit sufficient control over the curriculum to secure its objectives and development.

2.6. Teaching and Learning Methods and Educational Settings: These must be consistent with the schools educational objectives.

2.6.1. Teaching methods in different settings (lectures, tutorials, site visits, practical's) must use strategies which promote student-centered rather than teacher-centered learning, encourage active student interaction, stimulate analytical thinking and organization of knowledge, and foster life-long learning skills.

2.6.2. The school must ensure that students are made aware of the importance of information technology and medical informatics and opportunities are provided for the learning and practice of these skills.

2.6.3. Professional clinical skills must be introduced early in the curriculum and integrated with basic medical sciences. Skills laboratories must be developed and used in the preparation of students for their first day in practice.

2.6.4. Throughout the program, students must be exposed to a range of settings in which health care is delivered and health promotion is practiced. In addition to teaching hospitals and primary health care centers, students must also have the opportunity to work in the community, with families, in community health centers, in rural hospitals, in general practice, and in centers for those with chronic mental, physical disability and workplace to address occupational health.

2.6.5. Students must be exposed to common medical problems that are not seen in the hospital setting, and experience the effect of the family and community environment on symptom expression and therapeutic responses.

2.6.6. Mechanisms must be in place to ensure that all clinical placements are well organized and adequately supervised. The objectives and the assessment of all clinical placements, in hospitals and in the community must be clearly defined and made known to both the students and teachers.

2.6.7. It is desirable that students are given the opportunity to undertake a supervised elective study in areas such as social or environmental and community service with identified objectives, which are assessed by the Faculty.

2.6.8. The student should have at least one research project through the study period. Students must be exposed to issues and concerns that will violate medical research ethics and be guided in the development of research ethical professional behavior.

3. STUDENTS ASSESSMENT:

3.1. Student assessment:

3.1.1. Must match the objectives of the medical course. Methods of summative and formative assessment must be explicit and communicated to the students at the outset of the curriculum.

3.1.2. College should use “blueprints” in all student assessments to ensure systematic and objective assessment based on relevant learning objectives.

3.2. Continuous assessments must play an integral role in the education of medical students.

3.3. Methods of formative and summative assessment may comprise a variety of approaches, e.g. written assessments, oral assessments, projects, documentation of the performance of practical procedures (log book), checklists, clinical assessments and case examinations with real or simulated patients.

3.4. Clinical examinations must form a significant component of the overall process of assessment in the clinical disciplines.

3.5. Students must also be assessed on communication skills and professional behavior towards patients and other members of the health care team.

4. Program Evaluation:

4.1. Mechanisms for Monitoring and Evaluating the Curriculum: Each medical school must develop mechanisms for monitoring and evaluating the curriculum that are disseminated to faculty and students. Representative student as well as faculty opinions must be obtained regularly for each component of the curriculum and evaluated by the appropriate committee, in order to identify problematic areas and initiate corrective measures. Other pathways for student feedback on the curriculum must also exist, as High pass or failure rates need to be thoroughly investigated by the medical school.

Annotation: Program monitoring would imply the routine collection of data about key aspects of the curriculum to ensure that the educational process is on track and to identify any areas in need of intervention. Program evaluation: It would imply the use of reliable and valid methods of data collection and analysis for the purpose of demonstrating the qualities of the educational program or core aspects of the program in relation to the mission and the curriculum, including the intended based medicine and lifelong learning.

4.2. Quality of Graduates; Medical colleges must:

4.2.1. Have mechanisms for obtaining feedback about the performance of their graduates from the graduates themselves, from the involved faculty, from civil society and from the health institutions where their students work as interns and residents after graduation.

4.2.2. Respond to community and employer feedback about the performance of their graduates.

5. Students:

5.1. Selection of Students: Students selected for a medical school must have successfully completed their formal secondary education and admission interview. The Medical College may choose to apply a student admission policy or placement test.

Annotation: Admission policy would imply adherence to possible national regulation as well as adjustments to local circumstances.

5.2. Size of Student Intake: The recommended intake must be subjected to the available resources and fulfillment of requirements such as student: faculty ratios. Student ration is determined for theory; laboratory and clinical settings.

5.3. Student Support Services; Support services must include access to counseling services with trained staff, a student health service and student academic advisers. Students must be advised on the risks to themselves and to patients when dealing with infectious diseases. The medical school must have a policy on the immunization of students against infectious diseases, and a mechanism for monitoring its implementation.

5.4. Personal Development of Students: The curriculum must provide opportunities for students' extracurricular activities in pursuit of their personal and professional development.

6. Staff:

6.1. Faculty to Student Ratio: the academic staff cadre must be such that, overall, the medical school will have a 1:10 ratio of staff for clinical learning with ratio for laboratory 1:6, 1:5 for group work and 1:60 in lectures. It is imperative that at least 70 % of the faculties are full time. Each department must have at least one full-time Professor or Assistant Professor. Departments must also have adequate numbers of nonacademic support staff (secretaries, technicians).

6.2. Qualifications for Recruitment and Promotion of Academic staff:

6.2.1. Faculty recruitment and promotion must be guided by the University regulations. In the case of a private medical college, the University regulations in Iraq must guide the process of recruitment and promotion.

6.2.2. Non-medically qualified basic science teachers must be encouraged to teach their subjects in such a way that relevance to medicine is apparent to students.

6.2.3. Making joint appointments between basic science and clinical departments.

6.2.4. Making part-time appointments.

6.2.5. Making joint appointments between universities and hospitals.

6.2.6. Conferring academic designation for hospital or community practitioners involved in teaching and research.

6.2.7. Allowing promotion of part-time clinical faculty according to the University regulations.

6.2.8. Ensuring that faculty is publishing research according to set criteria.

6.3. Academic Staff Development and Career Review.

6.3.1. Medical education unit needs to be available with clear policy for the unit.

6.3.2. Medical schools must have in place a policy for staff development and career review. The process must be formative, and provide opportunities

for the mentoring of staff by their immediate superiors and feedback from students.

6.3.3. Staff must have access to staff development program appropriate to their developmental needs.

6.4. Teaching support and advice on Evidence-Based Medicine teaching and learning are available.

6.5. An established plan for human resources development.

Annotation: Training support and development would involve all teachers and staff, (not only new teachers), and also include teachers employed by hospitals and PHC.

7. Educational Resources:

7.1. Physical Facilities: The medical school must have adequate resource facilities for diverse learning settings such as lectures, tutorials and practical classes, including auditoriums, laboratories (multi-disciplinary, basic medical sciences and professional skills laboratories), dissection rooms and anatomy/pathology museums, tutorial rooms, audio-visual equipment, laboratory equipment and computers for satisfactory delivery of the curriculum. The physical resources must respond to the curriculum structure, organization and implementation.

7.2. Learning Resource Facilities.

7.2.1. Library Resources including virtual library: The school must have a collection of reference materials meeting the standards that are adequate to meet the curriculum and research needs of the students and faculty; support staff must be available to help the students. It is advisable that students have access to computer-based reference systems. A core of essential journals must be available in paper and /or electronic form, it should also be ensured that the most recent periodicals, and a number of referenced books are available.

7.2.2. Learning Resource Unit: this must be capable of providing support to learning and teaching including established skill laboratories plus the production of audiovisual aids and electronic networking facilities.

7.3.1. Clinical Learning environment / Teaching Primary Health Care and Hospitals: Sites for teaching and clinical environments, including primary health care centers and teaching hospitals, should meet the health institutions accreditation. In case there is a need to expand the clinical teaching of students or the unavailability of a University hospital, an official agreement must be reached between the medical school and affiliated teaching hospitals, indicating clearly the terms of cooperation and commitment. This agreement must be subject to regular review and there must be clear evidence that the relationship is functioning effectively.

7.3.2. Specialties and Teaching Beds; Affiliated health care institutions must be suitable for medical education and have teaching beds and outpatient clinics in the main specialties (surgery, medicine, pediatrics, obstetrics and gynecology, accident and emergency. ENT, Dermatology and other specialties) based on the health problems.

7.3.3. Student to Hospital Bed Ratio: With regard to the specialties of medicine, surgery, obstetrics and gynecology, and pediatrics, a medical college must have access to at least three occupied hospital beds per student in a clinical clerkship rotation at a given time. A medical college with an intake of 100 students per year must be affiliated to a teaching hospital(s) providing approximately 300-500 beds with high occupancy rate.

7.3.4. Ambulatory Care Services: Access to outpatient clinics and primary health care centers must be available. Learning and teaching in ambulatory care services are essential for the training of medical students.

7.3.5. Educational: library and on-call facilities must be available for students in the health care facilities.

7.4. Student Welfare Facilities must be provided for student study, sport and recreation.

8. Governance and Administration of the Medical College:

8.1. Administration and Structure within the University:

The College must have sufficient autonomy to be able to direct resources in an appropriate manner to achieve the overall objectives, in addition the college must have control over the curriculum, and a clear direct line of responsibility for the curriculum and its resources. **Annotation:** Management means the act and/or the structure concerned primarily with the implementation of the institutional and program policies including the economic and organizational implications i.e. the actual allocation and use of resources within the medical school. Implementation of the institutional and program policies would involve carrying into effect the policies and plans regarding mission, the curriculum, admission, staff recruitment and external relations.

8.2. Relationship with Affiliated Institutions and the Community

8.2.1. University academic staff working within teaching hospitals and other health care institutions must be integrated into the service and administrative activities of the affiliated institution.

8.2.2. Institutions associated or affiliated with university medical schools must share the educational and research objectives of the medical school and should work towards being accredited.

8.2.3. There must be effective methods for the medical school to communicate with, and receive the opinions of, medical practitioners, allied health professionals, community health workers and recipients of health care in the community.

8.3. Funding.

8.3.1. Schools must ensure that their financial resources are sufficient to allow the school's objectives to be achieved and to maintain high standards of medical education.

8.3.2. Sources of financial support must be transparent and fully disclosed.

8.4. Governance.

8.4.1. Providing an up-to-date and accurate organizational chart including the relation with the university.

8.4.2. All staff must be informed about their role and responsibility with effective coordination and leadership across the college.

8.4.3. A central registration of all policies and regulations is available to staff and students.

Annotation: Governance is primarily concerned with policy making, the processes of establishing general institutional and program policies and also with control of the implementation of the policies.

9. Research:

An active research environment within a medical college is necessary. Departments must strive to achieve an overall balance in which individuals may make differently weighted contributions in the areas of teaching, research and clinical service. Opportunities for students to be involved in research activities at any stage of their medical education must be provided. The College must have a time plan to develop and implement research.

Annotation: The balance of capacity between teaching, research and service functions would include provision of protected time for each function, taking into account the needs of the medical school and professional qualifications of the teachers.

10. Continuous Professional Development:

10.1. Medical colleges must recognize the need for continuing medical and health professional education.

10.2. The College has a written plan on CME and CPD that is known to faculty and staff.

10.3. The College ensures that faculty is participating actively in CPD. Regular symposiums, workshops and conferences should be organized to fulfill these needs.

Annotation: CPD includes all activities that doctors undertake, formally and informally, to maintain, update, develop and enhance their knowledge, skills

and attitudes in response to the needs of their patients. CPD is a broader concept than CME, which describes continuing education in the knowledge and skills of medical practice.

CHAPTER 2

NCAMC INTERNAL REGULATIONS

Introduction: National Council for Accreditation of Medical Colleges (NCAMC) was established in 02/26/2015 as development and expansion to the duties of the National Committee for accreditation of medical college in Iraq to be the formal reference to academic accreditation in Iraq based on the foundations and parameters stated in the Iraqi National Standards for Accreditation of Medical colleges**.** To facilitate the work of the Council, it has been determined to establish this internal regulation, according to the articles listed below:

Article (1):

The NCAMC has independent personality from the administrative, financial and legal issues. It works in accordance with laws, regulations and instructions of the Ministry of Higher Education and Scientific Research (MOHESR) guided by international standards and are supervised by the Apparatus of Supervision and Scientific Evaluation (ASSE).

Article (2):

Wherever they appear in this internal regulation, the meaning of the following words is shown below:

1. Council: the National Council for Accreditation of Medical Colleges (NCAMC).
2. Chairman: Chairman of the National Council for Accreditation of Medical Colleges.
3. Vice Chairman: Vice Chairman of the National Council for Accreditation of Medical Colleges.
4. Executive director; Executive director of the National Council for Accreditation of Medical colleges.
5. Member: The member of the National Council for Accreditation of Medical Colleges.
6. Internal Regulation: The internal regulation of the National Council for accreditation of medical colleges.
7. Quorum: half plus one of the members.

8. Absolute majority: more than half of the total numbers of the Council's members.
9. Simple majority: more than half of the members present after quorum.
10. Session: The formal meeting of the Council when a quorum is verified.

Article (3):

Vision, Mission and objectives of the Council:

Vision: upgrading to internationality in regard outcome quality of the Iraqi Medical Colleges.

Mission: upgrading medical education in Iraqi medical colleges to be accredited according to the Iraqi standards and in harmony with regional and international parameters through authorized council.

Objective: To accredit medical colleges in Iraq.

• Goals:

1. Assess the current situation of the colleges with a possibility to cooperate with international experts in this field.
2. Update the NCAMC members' capabilities on a regular basis with regard to developments in evaluation programs and medical accreditation
3. Identify and train members of the colleges committees for internal evaluation.
4. Supervise the application of the approved Iraqi standards for Accreditation of Medical colleges.
5. Supervise and monitor the implementation of self-assessment study in the colleges.
6. Review the self-assessment study reports of the colleges.
7. Supervise the peer review evaluation of the colleges' candidate for the Site-visit evaluation.
8. Site-visit evaluation of the colleges to award accreditation.
9. Continuing follow-up to these colleges even after being accredited.

Article (4):

First: Composition of the Council:

1. The Council is composed of fourteen members.
2. The followings are mandatory conditions to be a member at the council:
   - ❑ To hold the highest degree in the field of specialty and expert in medical education and accreditation.
   - ❑ To be a graduate of a college of medicine.
   - ❑ To be a professor or assistant professor in the medical field.
   - ❑ Have spent not less than fifteen years at his academic job.
   - ❑ Be of good manner and not convicted of a misdemeanor involving moral turpitude.
   - ❑ Not to be involved by the provisions and procedures of de-beatification, or any other law replaces it.
3. The nomination of the council members is from Iraqi medical colleges according to the conditions mentioned in paragraph (2) of this article.
4. Election of Chairman and Vice Chairman and the Executive Director of the Council from members of the council during the first meeting.
5. The chairman must be elected first by absolute majority.
6. Election of the Vice Chairman must be by absolute majority.
7. The chairman nominates three members, one of whom will be elected as Secretary of the Council, by a simple majority.
8. The Council can nominate one of their members by simple majority to represent him in the Committee of Deans of Medical Colleges.
9. The membership term of the council last for four years, this may be renewed once on request
10. The decision to award accreditation to colleges should be taken by a majority of 2/3 of the total number of the council.
11. The Council meetings hold regularly and decisions are taken by simple majority of a quorum taking in consideration some decisions that require special majority.

Second: The structure of the Council:

- **The Council members are:**

Chairman, Vice Chairman, the Secretary of the Council and members of the council who have high scientific titles and certified in different medical specialties. In addition, they should have a practice and experience in quality assurance and accreditation. In addition to members with other disciplines needed by the Council, among them a representative of the World Health Organization and a representative of the Iraqi Ministry of Health.

- **Administrators:**

Coordinator from the Apparatus of Supervision and Scientific Evaluation, and secretariat office members (not less than two) who are able to run the office and can manage computer and Internet works and are fluent in English language. In addition to other services staff

- **Advisory Board:**
  - External experts in quality assurance, accreditation and medical education.
  - Legal Advisor.
  - Financial Advisor.

Article (5)

- **Internal organization:**

1. Chairman, Vice Chairman and the Executive Director of the Council are elected by majority voting. This process is repeated every four years.
2. The Chairman and members of the Council have the right of part-time or full-time work to be able to do the tasks of the council.
3. The nomination for membership of the council should be from the faculty doctors of medical colleges, who have experience and interest in the field of medical education, evaluation and accreditation.
4. The membership of any of the members of the Council is reviewed according to periodic evaluation.
5. The Council is represented at the Committee of Deans of Medical Colleges by one of its dean members or a member who is chosen by a simple majority.
6. All members should have a continuous development process, by attending at least one workshop or conference per year in the field of academic accreditation.

7. The council membership continues after retirement (if not due to legal punishment) after submitting a request in this regard.
8. All members should be involved in the decision to award accreditation to the college that submits a request for accreditation.
9. The regular meetings of the council are held periodically and the decisions are made by a simple majority after the legal quorum (half plus one). Exceptional meetings may be held on need without the need to fulfill the quorum.
10. The council's member's discus the pre-prepared schedule. They should be informed about the schedule at least one week in advance.
11. The council's decisions and suggestions are submitted to the apparatus of supervision and scientific evaluation to inform it and to issue the related administrative orders.

Article (6):

❑ **The Council Tasks:**

❍ **The General Duties of the Council:**

1. To develop and implement a method of accreditation of medical colleges in Iraq which will involve visiting each medical college on a cyclical basis and to publish the results of Accreditation Visits.
2. To identify areas of good practice and to disseminate these across medical colleges.
3. To identify areas of educational practice that need further development.
4. The accredited college that does not keep with national standards, the NCAMC may withdraw accreditation.
5. The Council prepares plans, propose researches and work requirements.
6. The Council edits the mechanism for submitting a request for accreditation.
7. The Council edits the necessary instructions for the mechanisms of complaints, objections and appeals.
8. The Council edits proper mechanisms to assess the outcomes of medical colleges in Iraq.
9. Prepare a program for workshops and training courses (according to the needs of the faculty and colleges) and submit the appropriate recommendations in this regard.

10. The council continues its work by following the accredited colleges to keep with the standards.

❍ **The Duties of the Chairman:**

1. Leads the development, implementation and assessment of the performance of the accreditation process.
2. Chair the meetings of the council in accordance with the already prepared schedule.
3. Delegates the vice chairman or one of the members with his duties in case his absence.
4. Represents the Council in all events related to the Council work.
5. Follow up the achievements of the members with their assigned duties
6. Receive the requests of the colleges for accreditation, and submit them to the council.
7. Follow-up and coordinate the work of the nominated committees to visit colleges.

❍ **The Duties of the Vice Chairman:**

1. Assists the chairman of the Council in his duties.
2. Do all duties of chairman in the absence of Chairman after an official authorization.
3. Follow up the website of the Council.
4. Follow up the implementation of Council decisions.

❍ **The Duties of the Executive Director of the Council;**

1. Scheduling meetings.
2. Schedule the contents of meetings.
3. Invites council members to attend meetings.
4. Follow up the activities of the members.
5. Supervise the secretariat work of the council.
6. Prepare the report of meetings, edit them out in the final format and communicate to ministry for approval.

7. Support the site visit teams.

❍ **The Duties of the Council Members:**

1. Attend and actively participate in the periodic and exceptional meetings of the Council.
2. Carry out the duties assigned to them by the chairman of the Council (after their primary approval).
3. Participation in various committees of the Council (after their primary approval).
4. Commitment to the Council decisions that had been taken by voting, taking in consideration the confidentiality of some of them.
5. Follow up the scientific updates related to the council work and submit suggestions to develop Council's activities and the entire educational process.

Article (7):

❑ **Authorities of the Council:**

❍ **General Authorities:**

1. Revise the accreditation standards regularly with the possibility to update them, based on the country needs and the development in this context.
2. Revise any of the paragraphs in all the materials for the Council's regulation with the possibility of updating (when needed).
3. The council had the authority to grant accreditation, conditional accreditation or refuse to grant accreditation to Iraqi medical colleges (according to related mechanisms).
4. Follow up the outcomes' scientific level of the Iraqi medical colleges (according to related mechanisms).
5. The Council checks, with the colleges, the stages of accreditation and monitors their implementation on the ground (according to related mechanisms).
6. The council instructions to the medical colleges regarding accreditation are valid and mandatory.
7. Include external experts in the site visit team for colleges requesting accreditation.

8. Direct communication with all scientific, educational, medical and health organizations and bodies, such as WHO,WFME for cooperation and the development of members' experiences.
9. The Council has the right to request part-time or full-time job for any of its members, according to the requirements of the council work.
10. The consensus of at least half of the council members enables them to convene an emergency meeting of the Council.
11. Formulate thanks and praises documents to the colleges that show serious and executive steps towards accreditation and recommend ministerial thanking through the Apparatus of Supervision and Scientific Evaluation.

❍ **Authorities of the Chairman:**

1. Organize the work of the Council and prepare the schedule (taking into consideration the views of the rest of the members).
2. The claim for an emergency meeting of the Council.
3. Consideration of the requests and needs of the council members.
4. Granting thanks and appreciation.

Article (8):

❑ **The Financial System:**

1. The Council is linked to the Ministry of Higher Education and scientific research financially, at the present time.
2. The college should pay not less than twenty-five million Iraqi dinars on submitting the request to begin the accreditation process.
3. The college pays the expenses of the peer review visits and site visits.
4. The college pays the costs of the training courses done to the college.
5. The budget is managed through a financial member of the Council Secretariat. by the mechanism of "the consultations bureau".

CHAPTER 3

ACCREDITATION PROCESS FOR MEDICAL COLLEGES

❑ General Regulations:

1. Accreditation is a mandatory process.
2. NCAMC depends on the Iraqi National Standards for Accreditation of Medical Colleges (INSAMC), based on the World Federation for Medical Education Standards (WFME).
3. The process of accreditation begins by a request from the college to the NCAMC.
4. The college should provide the NCAMC with their final report of the SAS, curriculum, and other required documents.
5. Approved accreditation by NCAMC will be valid for six years. The accreditation process should be repeated after that.

❑ Accreditation Stages:

❍ First Stage:

❑ Self-Assessment Study (SAS):

1. Information gathering stage by the College according to the standards set by NCAMC, and based on the evidence of the INSAMC

2. SAS is carried out by the college accreditation committees, according to Council standards. During which, visits by committees formed by the NCAMC for follow-up and assistance may be conducted.

3. The College Council nominates the committees of SAS and Data Collection (DC).These committees should be consisting of:

1.1. Steering Committee (St. C):

1. Dean of the College ..... Head
2. Associate Dean for Academic Affairs ..... member
3. Associate Dean for Administrative Affairs ..... member
4. Director of the Teaching Hospital..... member
5. Member of the provincial council..... member
6. Director of the university QA dept. ..... member

7. Head of the Medical Association ..... member
8. Students representative ..... member
9. Other experienced according to college needed ..... member

❑ **Steering Committee Tasks:**

1. Leads the all accreditation process.
2. Formation of the Head Committees (HC) and subcommittees (SC), on the basis of the standards set by the NCAMC.
3. Provide support for the HC and SC when they face technical and administrative problems.
4. Increase awareness about accreditation and build the capacity and capabilities of the college staff in this regard. Awareness campaigns should cover accreditation standards, indicators, the mechanisms of action, and follow-up developments work with subcommittees.
5. Setting a schedule for the achievement of tasks, and monitoring the process of SAS.
6. Approval of the recommendations made by the SC and follow up their implementation
7. Approval of the final Self-Assessment report (SSR) supported by all required documents.

1.2. Head Committee for SAS:

1. Dean assistant for Academic Affairs ..... head
2. Head of the college Division of QA ..... member
3. Members of teaching module or QA member in scientific department. member
4. Employee representative ..... member
5. **S**tudents representative (different stages) ..... member
6. Member of medical education and quality assurance assessment committee ..... member
7. Other members according to the need ..... member

❑ **The Head Committee Tasks:**

1. Provide SAS forms, which were prepared by the NCAMC for distribution to SC.
2. Suggest the members of the SC proposed according to scientific disciplines and nominate each SC according to its domain and provide the proposal to the StC.
3. Set time schedule for the completion of the subcommittees' domain which should precedes the time schedule of StC.
4. Directing and follow-up SC to perform their tasks. Adoption of research methods to gather information (subjects included in the study, sampling method, and data collection tools as a distribution of questionnaires and interviews ...).
5. Support SC to resolve technical and administrative disputes, in coordination with the StC and the administration.
6. Hold regular meetings to discuss the drafts report and unify them into a single context.
7. Merge the reports and discuss them in successive meetings, statistically analyze them, SWOT analysis should be included to identify; strengths, weaknesses, threats, and opportunities. Reports should include presentation of data with appropriate tables and figures, and indicate the percentage of achievement of tasks.

Set recommendations to correct noncompliance, and propose a plan of action to overcome them. Supported by all documents and submit them to the StC for approval.

1.3. Sub-Committees:

1. Faculty member..... Head
2. Faculty members according to needs .....members
3. Employee according to needs.....members
4. Students Representative (different stages) ..... member

❑ **Subcommittees Tasks:**

1. Study and review their task standards and may enlist the opinion when needed
2. Adoption of research methods to gather information (subjects included in the study, sampling method, and data collection tools as a distribution of questionnaires and interviews).
3. Fill the forms for SAS domains.
4. Collect the required documents to achieve the standards

5. Prepare the report on that standard and submit it to the HC.

❑ **Second Stage: Peer Review Visit:**

1. Colleges may conduct a peer-review visit before submitting the request of accreditation. The purpose of this visit is to exchange experiences and points of view. This should be according to the mechanism prepared NCAMC.
2. Peer review detailed visit report about the college performance has to be submitted to the college and to the NCAMC.

❑ **Third Stage: Submission of the Application:**

1. Submission of the application to the NCAMC.
2. Provide all the required documents
3. The NCAMC will send a selected committee to conduct a field visit at the college, to advice and to help them address the challenges before the site-visit according to prepared process.

❑ **Fourth Stage: Site-Visit for Evaluation**

1. Carried out by a committee nominated by the NCAMC called the Site-Visit Team.
2. The committee consists of academic staff and experts (at least five members)preferably to add observational trainee faculty members
3. The college informed about the timing of the visit one month ahead.
4. The visit will continue for a period ranging between 3-5 working days.
5. The Committee checks and verify the information written in the final SSR submitted by the college, through:
    A. Collect documents and results of the statistics.
    B. Individual interviews (with Dean, heads of departments)
    C. Group interviews (the relevant committees, students, faculty
    D. Direct observations.
6. Writing the final report according to the NCAMC guidelines.
7. Submit the final report to the NCAMC during a period up to four weeks, from the end of the visit.

❑ Fifth Stage: The Final Decision of Accreditation:

- The NCAMC review and approve the decision of the site-visit team, within a month started from the end of the time period for submission of objection on the decision of the site-visit team.

  - **The Decision Will Be Either:**

1. **Accreditation**: When the college completes the accreditation requirements with a score of more than 40% for each domain with total score 312-395(80-100%).
2. **Conditional accreditation:** When the college scores less than 40% for two or less domain and total score 195-311(50-79%). The college must fulfill the requirement within two years to be accredited.
3. **Denied accreditation**: The College will not be accredited if in more than two domain score is less than 40% and the total score is 0-194 (0-49%). The College can reapply for accreditation one year later.
4. **The NCAMC** follow the accredited colleges annually through the submitted SSR.

❑ Sixth Stage: The Objection:

1. The College can object the Council decision within fourteen days from the date of issuance of the final decision. in the event of appeals or conflict of interest,
2. The Council accepts or rejects the appeal of the objection after reviewing the condition, within one month from the submission of the objection.

CHAPTER 4
DESIGNING TOOLS FOR EVIDENCE GENERATION

Conducting and implementing the SAS by Iraqi medical colleges will provide the opportunity to assess medical colleges' progress, to identify new goals, and establish indices of attainment of the future goals. The SAS also encourages a broad examination of the means for medical colleges to achieve future goals.

The starting point in initiating the accreditation is the evaluation of current status at level of college in relation to standards. Accordingly, the main task of the institutional SAS is to identify the gaps and shortcomings that exist in relation to each standard and to propose a plan for improvement. All sub-task forces/committees or teams assigned to areas of standards need to add material that can be elicited from reviewing of available laws, by-laws, regulations and other documentation in relation to their assigned area. However, more material is essential to add to show evidence on status that can only be elicited and generated through further studies. These studies need to be conducted through a wide participatory approach to cover wide representation of the college population and stakeholders who will add much about life in college. The major missing data and elements can be covered through conducting different kinds of research and studies using one or more of the following tools:

- Group brain-storming and SWOT analysis exercises involving wide scope of participants.
- Specifically designed questionnaire/s for each domain targeting faculty staff; administration; students; graduates; MOH staff; other health providers; student parents; community; etc.
- Specifically designed structured interviews with selected informants; ex-officers; partners; etc.
- Networking and exchange of inputs through websites, emails and list.
- Designed forms for feedback from desk reviews of available documents and searches.
- Any other appropriate tool.

In preparing for the SAS exercise, a number of tools need to be designed and reviewed in the hope to utilize the collected data in regard to each domain. In each domain the following areas are expected to be addressed through conducting the studies. The tools

should be designed, reviewed and then finalized so that their use can yield answers to the following concerns and questions stated in regard to each domain. The tools to be developed will include those to be used by the schools seeking accreditation such as questionnaires and interview guides for conducting their SAS besides the templates for writing the program and course specifications, the program and course reports and the annual report. In other parts of this guide, sample tools are presented for use by reviewers in the site-visits such as evaluation forms, interview guides, observation sheets and templates for writing the reviewers report. Also, all those developed tools can be used as a guide for accrediting national authorities to form their own set of tools. The College and authorities are given the option to adapt the tools with any relevant change but to observe the requirements of the agreed upon standards.

1. VMO:

1.1. Vision, Mission, and objectives statements:

1.1.1. The college must have documented vision statement.

1.1.2. The college must have documented mission statement.

1.1.3. The college must have documented educational objectives.

1.1.4. The objectives cover all domains.

1.1.5. The mission and objectives are routinely used in planning and monitoring and evaluation of educational program.

1.1.6. The objectives were reviewed and revised and approved formally by appropriate key committee of the medical college.

1.1.7. The objective should reflect the community needs and priority health problems.

1.1.8. The graduate's outcomes well described and detailed.

1.1.9. All stakeholders participate in setting VMO (Dean, college council, faculty, students, health authorities, medical associations, and community civil society)

1.1.10. The vision, mission and objectives have been made known to all stakeholders, faculty, and students and staff.

1.1.11. Faculty are made aware of proposed changes in the medical education program, its policies and procedures, and given an opportunity to provide input.

1.1.12. There is at least one general faculty meeting about VMO each year where faculty is notified of the agenda and outcomes of the meeting.

1.2. Curriculum:

1.2.1. The objectives are used to select curriculum content and determine its placements in learning experience.

1.2.2. The objectives are used to evaluate the effectiveness of the curriculum.

1.2.3. The linkage between learning and curriculum objectives is well defined.

Proposed tools for evidence generation; **VMO**

	Tool type	**Target**	**Components**	**Presentation**
1.1.1	Verif	Doc.	There is documented Vision	Description
1.1.2	Verif	Doc.	There is documented Mission	Description
1.1.3	Verif	Doc.	There is documented Objectives	Description
1.1.4	Verif	Doc	The objectives covers all domains	Description
1.1.5	Ques + interview	Curriculum committee faculty	Are M&O used for planning and monitoring?	Fact % , yes or no
1.1.6	Verif	Doc.	Committee for review and approval of objectives	Description
1.1.7	Interview	All college stakeholders	Do objectives represent community needs	Opinion yes or no
1.1.8.	Verif	Doc.	College graduate outcomes papers	Description
1.1.9.	Ques	Stakeholders	Do you participate in setting of VMO	% yes or no
1.1.10	Ques	All stakeholders	Have M&O been made known to you	Fact % yes or no
1.1.11	Ques	Faculty and students	Are they aware about change in program, polices, and procedures	Opinion % for each stakeholder
1.1.12	Verif	Documents	Time and place of the faculty meeting	Description
1.2.1	Ques + Verif	All stakeholders + documents	-Are M&O used to select curriculum content , for learning experience -Are M&O and curriculum content correlated	-Opinion % for each stakeholders -description
1.2.2	Ques	All stakeholders	Are the M&O used in evaluation of	Opinion % for each stakeholders

			effectiveness of curriculum	
1.2.3	Ques	All stakeholders	Are linkage of the learning and curriculum objective are well defined	Opinion % for each stakeholder

Document Requested:

1. An official document which includes the VMO, their updating, recognition by the college`s council and MOHE.
2. An official document of establishment of the curriculum committee.
3. An official Document approve that the college has assessed its outcome objectives and analyze it by:
    a. Annual revision of the objectives.
    b. Annual analysis of the students' achievement.
    c. Annual analysis of the graduates' achievement (self-satisfaction, employers' satisfaction, recruitment).
4. An official documents of the annual faculty's meeting'

Rating table (No.1); **VMO.**

	The Indicator	Indicators No.	Non Compliance	Compliance, need monitoring	Compliance
1	VMO statements	1.1.1			
2		1.1.2.			
3		1.1.3.			
4		1.1.4.			
5		1.1.5.			
6		1.1.6.			
7		1.1.7.			
8		1.1.8.			
9		1.1.9.			
10		1.1.10.			
11		1.1.11.			
12		1.1.12.			
13	Curriculum	1.2.1.			
14		1.2.2.			
15		1.2.3.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

2. CURRICULUM:

2.1. Goals:

2.1.1. The overall goal of undergraduate medical education program is to produce multidisciplinary educated medical graduates who are competent to practice both safely and effectively.

2.1.2. Graduates must have an appropriate foundation.

2.1.2.1. To function upon graduation as a physician.

2.1.2.2. To be prepared to pursue lifelong learning.

2.1.2.3. Ready for further training.

2.1.3. Emphasis must be placed on the professional behavior and values in the practice of medical science, rather than on the acquisition of a detailed compendium of current knowledge or a comprehensive list of clinical skills.

2.1.4. The program must be responsive to.

2.1.4.1. The health and developmental needs of the community.

2.1.4.2. Ensures continued community engagement.

2.2. Objectives of Medical Education:

2.2.1. The medical education objectives must result in medical graduates ;

2.2.1.1. Competent and equipped to respond to the health needs of the individuals.

2.2.1.2. Competent and equipped to respond to the health needs of the families.

2.2.1.3. Compassionate, caring and taking into consideration human rights and gender equity.

2.2.2. The competencies, which should be exhibited by the student at the point of graduation;

2.2.2.1. Must be defined.

2.2.2.2. Must include the skills of continuing professional development.

2.3. Program Duration:

2.3.1. The duration to implement the program in Iraq is not less than 200 weeks that is based on educational and experience required for addressing common health needs and problems.

2.4. Curriculum Design and Organization:

2.4.1. The curriculum must disseminate;

2.4.1.1.Essential factual knowledge.

2.4.1.2.Professional skills in communication, and patient management.

2.4.1.3.Skills in the development of critical thinking, and analytical ability.

2.4.1.4.Development of professional behavior and values relevant to the Iraqi culture.

2.4.2. The core content of each unit in the curriculum must demonstrate adequate competencies of knowledge, skills and professional behavior required for entry into medical practice

2.4.3. The curriculum should provide opportunities ;

2.4.3.1. For self-directed learning.

2.4.3.2.For taking optional/elective units.

2.4.3.3.For gaining exposure to a wide range of institutional and community experiences.

2.4.4. Students must spend at least three academic years of their training in;

2.4.4.2.Direct contact with individuals.

2.4.4.3.Direct contact with Families and community.

2.4.4.4.The students have increasing clinical responsibility under supervision.

2.4.5. The curriculum must enable students to acquire appropriate knowledge, skills and professional behavior relating to;

2.4.5.2.Disease prevention.

2.4.5.3.Health promotion.

2.4.5.4.Community health.

2.4.6. Medical ethics must be an integral part of the curriculum.

2.4.7. Basic science teaching:

2.4.7.2.It must be relevant to the overall objectives of the medical college

2.4.7.3.This relevance must be apparent to the faculty and students.

2.4.7.4.Basic science must illustrate the importance of principles being taught to the understanding of health and disease, both at the individual and community level.

2.4.8. Clinical sciences teaching:

2.4.8.2. Must be taught in such a way that reinforces underlying scientific principles and humanitarian values.

2.4.9.1. The involvement of staff from basic science departments in the teaching of clinical medicine is desirable.

2.4.9.2. The involvement of clinicians in the teaching of basic sciences.

2.4.10. An appropriate level of horizontal (concurrent) and vertical (sequential) integration (end point spiral integration) should be in place in order to achieve the educational objectives.

2.4.11. Explicit statements about the level of knowledge and understanding, skills and professional behavior expected of the students at each phase of the curriculum will enhance its organization.

2.4.11.1. The medical school must inform the students about the standards expected and required from them at the end of each year.

2.4.11.2. The medical school must inform the faculty about the standards expected and required from the student at the end of each year.

2.4.11.3. The medical school must inform the clinical sites about the standards expected and required from the student at the end of each year.

2.5. Curriculum Implementation:

2.5.1. Schools must demonstrate that:

2.5.1.1. They have processes that allow the overall content and balance of the curriculum is well defined in relation to the stated objectives.

2.5.1.2. The process of curriculum assessment is well defined in relation to the stated objectives.

2.5.2. A Curriculum Committee:

2.5.2.1. It must be exist

2.5.2.2. It must be given the authority for planning and overseeing the comprehensive curriculum.

2.5.2.3. It must have the ability to exhibit sufficient control over the curriculum to secure its objectives and development.

2.6. Teaching and Learning Methods and Educational Settings (lectures, tutorials, site visits, practical's); these must be consistent with the schools educational objectives.

2.6.1. Teaching methods in different settings must use strategies which ;

2.6.1.1. Promote student-centered rather than teacher-centered learning.

2.6.1.2. Encourage active student interaction.

2.6.1.3. Stimulate analytical thinking and organization of knowledge,

2.6.1.4. Foster lifelong learning skills.

2.6.2. The school must ensure that students are made aware of the importance of information technology and medical informatics and opportunities are provided for the learning and practice these skills.

2.6.3. Professional clinical skills;

2.6.3.1. Must be introduced early in the curriculum.

2.6.3.2. Must be Coordinated with basic medical sciences.

2.6.3.3. Skills-laboratories must be developed and used in the preparation of students for their first day in practice.

2.6.4. Throughout the program, students must be exposed to a range of settings in which health care is delivered and health promotion is practiced ;

2.6.4.1. Students must be exposed to teaching hospitals.

2.6.4.2. Students must be exposed to primary health care centers.

2.6.4.3. Students must have the opportunity to work in the community.

2.6.4.4. Students must have the opportunity to work with families.

2.6.4.5. Students must have the opportunity to work in community health centers.

2.6.4.6. Students must have the opportunity to work in rural hospitals.

2.6.4.7. Students must have the opportunity to work in general practice.

2.6.4.8. Students must have the opportunity to work in centers for those with chronic mental or physical disability.

2.6.4.9. Students must have the opportunity to work in workplace to address occupational health.

2.6.5. Students must be exposed to common medical problems that are not seen in the hospital setting, and experience the effect of the families and

community environment on symptom expression and therapeutic responses.

2.6.6. Mechanisms of clinical settings:

2.6.6.1. Must be in place to ensure that all clinical placements are well organized and adequately supervised.

2.6.6.2. The objectives and the assessment of all clinical placements, in hospitals and in the community must be clearly defined

2.6.6.3. The objectives and the assessment of all clinical placements, in hospitals and in the community must be made known to both the students and teachers.

2.6.7. Elective study:

2.6.7.1. It is desirable that students are given the opportunity to undertake a supervised elective study.

2.6.7.2. The elective study should include areas such as social or environmental and community service.

2.6.7.3. The elective study should have identified objectives.

2.6.7.4. The elective study should be assessed by the Faculty.

2.6.8. The student should have

2.6.8.1. At least one research project through the study period.

2.6.8.2. Exposed to issues and concerns that will violate medical ethics.

2.6.8.3. Be guided in the development of research ethical professional behavior.

Proposed tools for evidence generation; **curriculum.**

Indicator	Tool type	Target	Components	presentation
2.1.1	Ques interviews	Students and graduates	Does curriculum provide you with learning opportunities in all disciplines to practice safely	% satisfaction
2.1.2	Ques	graduates	Does the curriculum prepare you for critical thinking and lifelong learning	% yes or no

2.1.3	Verif	document	Goals of curriculum ensure principles and values in practice.	Curric. description
2.1.4	Verifi	Documents	Documents on changes in curriculum in response to certain community problems	Description of doc
2.2.1	Ques	stakeholders	Satisfaction with Curriculum objectives content	% satisfied
2.2.2	Verif	Documents	Documents on graduate outcomes	descripti
2.3.1	Verif	Documents	Documents showing educational program duration	descript
2.4.1	Ques interviews	Stakeholders	the curriculum must contain all items	Opinion, regarding Design and organization
2.4.2	Verif	Documents	The curriculum contains knowledge, skills, professional behavior.	description
2.4.3.	Verifi	Documents	Presence ,in curriculum ,units for elective studies and self-directed learning	description
2.4.4	Verifi	Documents	Presence of documents to show the duration for student contact	description
2.4.5	Ques	Faculty Students and graduates	Do students acquire knowledge, skills, attitude in health promotion and other disciplines	Opinion %
2.4.6	Verifi	Documents	Medical ethics present in curriculum	description
2.4.7	Ques	Faculty, students, graduates	Relevance of content of basic science to objectives	Opinion %
2.4.8	Ques	Faculty, students, graduates	Humanitarian values are taught in clinical science	Opinion %
2.4.9	Verif	Documents	What educational system college follows (concurrent or sequential integration)	description
2.4.10	Ques	Faculty, students, graduates	Level of knowledge and understanding .skills and attitudes expected of the students at each phase of the curriculum must be	% yes and No

			known to Faculty ,students, graduates	
2.5.1	Verif	Documents	Presence of a written mechanism for content ,balance and assessment	Description
2.5.2	Verif	Documents	Presence of committee and to see if committee reviews its responsibilities and authorities	description
2.6.1	Ques	Faculty, students , graduates	Presence of new teaching methods foster students-center teaching, analytic thinking and life-long learning	% yes ,and No
2.6.2	Ques	Students	Does they have adequate knowledge about new technologies	% yes ,and No
2.6.3	Ques	Students and graduates	Determine how early is the exposure of student to clinical setting	Fact / opinion
2.6.4	Ques	Faculty and student	Presence of training in different setting as rural hospitals, community clinics...etc.	% yes ,and No
2.6.5	Ques	Faculty and student	Training in PHCC, community clinics, on common transient conditions	% yes ,and No
2.6.6.	Verif Ques	Documents Student	Organization of hospital and primary health center. Is the objectives and assessment of hospital and PHC clear for them	Description Yes or no %
2.6.7	Verification	Documents	Presence of elective subjects in curriculum	Description
2.6.8	Ques	Students	Does have a research project	% yes ,and no
2.6.8.1	Ques	Students and graduates	Do you have training on issue violate research medical ethics	% yes , and no

Document Requested:

1. Guideline describe the curriculum in details ,for example: degree granted by the college, duration of the study and graduation`s requirements, the type of the educational system, general information about the faculties ,teaching methods, knowledge, attitude and practice gained by student in each phase of the curriculum, elective study, humanitarian values, medical ethics, mechanism of assessment etc.

2. The tools and policy which are used to evaluate the effectiveness of the curriculum, updating and renewal in response to community needs.

3. Guideline for each department describes, the objectives, outcome objectives, syllabus (theory, practical, clinical) in details, and general information about the members.

4. Summary of the study analysis about students` and faculties` feedback about the curriculum.

Rating table (No. 2): **Curriculum**

	The indicator	**Indicators No.**	**Non Compliance**	**Compliance, need monitoring**	**Compliance**
1	Goals	2.1.1.			
2		2.1.2.1.			
3		2.1.2.2.			
4		2.1.2.3.			
5		2.1.3.			
6		2.1.4.1			
7		2.1.4.2			
8	Objectives of medical education	2.2.1.1.			
9		2.2.1.2.			
10		2.2.1.3.			
11		2.2.2.1			
12		2.2.2.2.			
13	Program duration	2.3.1.			
14	Curriculum design and organization	2.4.1.1.			
15		2.4.1.2.			
16		2.4.1.3.			
17		2.4.1.4.			
18		2.4.2.			
19		2.4.3.1.			
20		2.4.3.2			
21		2.4.3.3			
22		2.4.4.1.			
23		2.4.4.2.			
24		2.4.4.3.			
25		2.4.5.1.			
26		2.4.5.2.			
27		2.4.5.3			
28		2.4.6.			
29		2.4.7.1.			
30		2.4.7.2.			
31		2.4.7.3.			
32		2.4.8.1.			
33		2.4.9.1.			

34		2.4.9.2.
35		2.4.10.
36		2.4.11.1
37		2.4.11.2.
38		2.4.11.3.
39	Curriculum implementation	2.5.1.1
40		2.5.1.2.
41		2.5.2.1.
42		2.5.2.2.
43		2.5.2.3.
44	Teaching and learning methods	2.6.1.1.
45		2.6.1.2.
46		2.6.1.3.
47		2.6.1.4.
48		2.6.2.
49		2.6.3.1.
50		2.6.3.2.
51		2.6.3.3.
52		2.6.4.1
53		2.6.4.2.
54		2.6.4.3.
55		2.6.4.4.
56		2.6.4.5.
57		2.6.4.6.
58		2.6.4.7.
59		2.6.4.8.
60		2.6.4.9.
61		2.6.5.
62		2.6.6.1
63		2.6.6.2.
64		2.6.6.3.
65		2.6.7.1.
66		2.6.7.2.
67		2.6.7.3.
68		2.6.7.4
69		2.6.8.1
70		2.6.8.2.
71		2.6.8.3.

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

3. STUDENT ASSESSMENT:

3.1. Student assessment must;

3.1.1. Match the objectives of the medical courses.

3.1.2. Methods of summative and formative assessment must be explicit.

3.1.3. The methods of summative exam must be made known to the students at the outset of the curriculum.

3.2. Continuous assessments must play an integral role in the education of medical students.

3.3. Methods of formative and summative assessment may comprise a variety of approaches, e.g. written assessments, oral assessments, projects, documentation of the performance of practical procedures (log books), checklists, clinical assessments and case examinations with real or simulated patients.

3.4. Clinical examinations must form a significant component of the overall process of assessment in the clinical disciplines.

3.5. Students must also be assessed on;

3.5.1. Communication skills and professional behavior towards patients.

3.5.2. Communication skills and professional behavior towards health care team.

Proposed tools for evidence generation; **Student Assessment**

Indi	Tools	Target	Components	presentation
3.1.1	verifi	documents	How much there is matching between the assessment methods and the objectives.	Description
3.1.2	Ques	students	Are assessment method made known to students	% opinion
3.2.	Ques	Faculty &students	Presence of continuous assessment (formative exam)	% of present and absent
3.3.	Verifi	Document	The approaches of formative and summative exam.	Description
3.4.	Ques	Faculty, students &graduates	To examine the percentage of clinical in clinical disciplines	% opinion
3.5.1.	Ques	Students &graduates	Presence of training on communication skills and professional behavior toward patient	% of Yes and No

3.5.2	Ques.	Students & graduates	Presence of training on communication skills and professional behavior toward health care team	% of Yes and No

Document requested:

1. The general frame work of the examination and scoring system used, and for each discipline.
2. Enrollment of the staff in training courses about different assessment methods.
3. Sample questions used in the examination and other assessment papers.
4. Studies used to assess the methods of students` assessment.

Rating table (No. 3); **Students Assessment**

	indicators	**Indi No.**	**Not Compliant**	**Partially Compliant**	**Compliant**
1	Methods of students assessment	3.1.1.			
2		3.1.2.			
3		3.1.3.			
4		3.2.			
5		3.3.			
6		3.4.			
7		3.5.1.			
8		3.5.2.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

4. PROGRAM EVALUATION:

4.1. Mechanisms for Monitoring and Evaluating the Curriculum

4.1.1 Each medical school must.

4.1.1.1. Develop mechanisms for monitoring and evaluating the curriculum

4.1.1.2. The monitoring mechanism is disseminated to faculty and students.

4.1.2 Feedback:

4.1.2.1. Representative students as well as faculty opinions must be obtained regularly for each component of the curriculum.

4.1.2.2. Representative students as well as faculty opinions must be evaluated by appropriate committee.

4.1.2.3. The appropriate committee (i.e. curriculum) should identify problematic areas and initiate corrective measures.

4.1.2.4. Other pathways for student feedback on the curriculum must also exist.

4.1.3 High pass or failure rates need to be thoroughly investigated by the medical school.

4.2 Quality of graduates;

4.2.1 Medical Schools must have mechanisms for obtaining feedback about the performance of their graduates

4.2.1.1. From the graduates themselves,

4.2.1.2. From the involved faculty,

4.2.1.3. From civil society.

4.2.1.4. From the health institutions where their graduate work as interns and residents after graduation.

4.2.2 Medical schools must respond to community and employer perceptions about the performance of their graduates.

Proposed tools for evidence generation for; program evaluation.

Indi	Tools	Target	Components	presentation
4.1.1.	Verifi	Documents	Mechanisms for program evaluation	Description
4.1.2.	Ques+interview	Faculty, students	There is an appropriate role for student and faculty in the feedback mechanism	% opinion
4.1.3	Verif	Documents	Mechanism to investigate exam. results	% opinion
4..2.1	Ques	Document	feedback mechanism is important element in program evaluation	% opinion
4.2.2.	Ques	Curric. committee faculty	Does the college has a mechanism to respond to community	%opinion

Document Requested:

1. Tools and policies used to assess the effectiveness of the curriculum.
2. Study analysis of students' as well as faculties' opinions about each component in the curriculum.
3. The measures taken to correct the identified problems.
4. Study analysis of the outcomes, for example, Satisfaction of the graduates, involved faculties, civil society, or health institution.
5. The mechanism by which the college responds to community needs and employers perception.
6. Study analysis of the examination results.

Rating table (No. 4); Program Evaluation.

	indicators	Indi No.	Noncompliance	Compliance, need monitoring	Compliance
1	Mechanism of monitoring	4.1.1.1			
2		4.1.1.2.			
3		4.1.2.1.			
4		4.1.2.2.			
5		4.1.2.3.			
6		4.1.2.4.			
7		4.1.3			
8	Quality of graduates	4.2..1.1.			
9		4.2.1.2.			
10		4.2.1.3.			
11		4.2.1.4.			
12		4.2.2.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

5. STUDENTS:

5.1. Selection of Students.

5.1.1. Students selected to a medical school must have successfully completed their formal secondary education, and admission interview.

5.1.2. The medical school may choose to apply a student admission policy or placement test.

5.2. Size of Student Intake

5.2.1. The recommended intake must

5.2.1.1. Be subject to the available resources.

5.2.1.2. Fulfillment of requirements such as student: faculty ratios to student ration is determined for theory; laboratory and clinical settings.

5.3. Student Support Services

5.3.1. Support services must include;

5.3.1.1. Access to counseling services with trained staff.

5.3.1.2. A student health service.

5.3.1.3. Student academic advisers.

5.3.1.4. Students must be advised on the risks to themselves and to patients when dealing with infectious diseases.

5.3.2. The medical school must have;

5.3.2.1. A policy on the immunization of students against infectious diseases.

5.3.2.2. A mechanism for monitoring the implementation of immunization policy.

5.4 Personal Development of Students; the curriculum must provide opportunities for students' extracurricular activities in pursuit of their personal and professional development.

Proposed tools for evidence generation; S**tudents.**

Indi	**Tools**	**Target**	**Components**	**presentation**
5.1.1.	Verif	Document	To show high school certificate	Description
5.1.2.	Verif	Document	To show students admission policy or placement test.	Description
5.2.	Verif	Document	Presence of policy to determine number of students per year ,student ration	Description
5.3.1.	Ques + intervie	Students	Presence of Academic advisor	% opinion
5.3.2.	Ques	students	Availability of immunization program	% yes , no
5.4.	Ques	Faculty, students	Presence of elective activities	% yes , no

Document Requested:

1. Admission policy: number of students admitted each year.
2. Samples of students` documents on admission.
3. Copy of admission examination.
4. Copy of advisory committee.
5. Students` guideline which should include:
    a. Policies about students` behavior, responsibilities, their rights, pitfalls.
    b. List of students` services provided by the college, e.g. elective activities (social, educational etc), health care (immunization).

Rating table (No. 5); **the students.**

	The indicators	Indic No.	Noncompliance	Compliant, need monitoring	Compliance
1	Selection of students	5.1.1.			
2		5.1.2.			
3	Students intake	5.2.1.1.			
4		5.2.1.2.			
5	Students support services	5.3.1.1			
6		5.3.1.2.			
7		5.3.1.3.			
8		5.3.1.4.			
9		5.3.2.1			
10		5.3.2.2.			
11		5.4			

Use the rate of; noncompliance 1, compliance need monitoring 2, compliance 3

6. STAFF:

6.1 Faculty to Student ratio:

6.1.1. The medical school must have a faculty to student ratio of:

6.1.1.1 1:10 for clinical learning

6.1.1.2 1:6 for laboratory

6.1.1.3 1:15 for group work.

6.1.1.4 1:60 for Lectures

6.1.2 It is imperative that;

6.1.2.1. At least 70 % of the faculty must be full time.

6.1.2.2. Each department must have at least one full-time Professor or Assistant Professor.

6.1.2.3. Departments must also have adequate numbers of nonacademic support staff (secretaries, technicians).

6.2. Qualifications for Recruitment and Promotion of Academic staff.

6.2.1. Faculty recruitment and promotion must.

6.2.1.1. be guided by the University regulations

6.2.1.2. Non-medically qualified basic science teachers must be encouraged to teach their subjects in such a way that relevance to medicine is apparent to students.

6.2.1.3. Making joint appointments between basic science and clinical departments.

6.2.1.4. Making part-time appointments.

6.2.1.5. Making joint appointments between university and hospitals.

6.2.1.6. Conferring academic designation for hospital or community practitioners involved in teaching and research.

6.2.1.7. Allowing promotion of part-time clinical faculty according to the University regulations.

6.2.1.8. Ensuring that faculty is publishing research according to set criteria.

6.3. Academic Staff Development and Career Review.

6.3.1. Medical education unit need to be available with clear policy for the unit.

6.3.2. Medical schools must have in place a policy for staff development and career review.

6.3.3. The process must be formative, and provide opportunities for the mentoring of staff by their immediate superiors and feedback from students.

6.3.4. The process must provide opportunities for feedback from students.

6.3.5. Staff must have access to staff development program appropriate to their developmental needs.

6.3.6. The development program must be appropriate to the staff`s developmental needs.

6.4. Teaching support and advice on Evidence Based Medicine teaching and learning are available

6.5. An established plan for human resources development is available.

Proposed tools for evidence generation; **Staff.**

Ind	Tools	Target	Components	presentation
6.1.1.	Verif	Document	Total No. of full time staff, and students	Description
6.1.2.	Verifi	Document	NO. of faculty per department, and No. of non –faculty employee	Description
			Teacher: student ratio In lecture room In the laboratory In the clinical session…etc.	
6.2.1.	Verifi	Document	Presence of recruitment policy	Description
6.2.2.1	ques	Faculty ,students	Presence of recruitment and promotion university regulations	% present or not
6.2.2.3	ques	Faculty	Presence of appointments between basic and clinical science	% present or not
6.2.2.4	ques	Faculty	Presence of part time appointments	%present or not
6.2.2.5.	Ques	Faculty	Presence of appointments between college and hospital	%present ,not
6.2.2.6	Verifi	Documents	There is academic designation for community practitioners involved in teaching and research.	Description
6.2.2.7	Verifi	documents	Presence of promotion policy	description
6.2.2.8.	Verif	documents	There is a written criteria For research publication	description
6.3.1.	Verif	Documents	Presence of bylaws of medical education unit	Description
6.3.2.	Verifi	Documents	Promotion policy based on teaching , research and service component	Description

6.3.3.	ques	Faculty	Staff have access to development program	% yes or not
6.4.	Ques intervi	Faculty	Presence of evidence based Teaching facilities	% yes or not
6.5.	Verifi	Documents	Presence of a well-planned human resources development	Description

Document Requested:

1. List of staff working in each department their CVs , scientific degrees, number of full time or part time , academic or nonacademic members
2. Teacher to student ratio, in the: lecture halls, practical lessons, clinical sessions or other activities.
3. The recruitment policy.
4. The promotion policy.
5. Summery about the staff recruitment, promotion, and retirement during the last 5 years.
6. Policies which govern non full time staff `s recruitment, promotion.
7. The plan for development programs to the staff through CME, conferences, meetings etc.).
8. The bylaws of CME units.
9. The written criteria for research plan; for the college in general and for each department and the publication policies.
10. Summary of the most significant scientific products performed by the staff, during the last 3 years.
11. Examples of the community services provided by the staff.
12. Policies and measures used for staff assessment, with sample for each one. e.g.:
    - *a.* The standards used for assessment.
    - *b.* Students` assessment tools to the staff with summery results for the last 3 years.
    - *c.* The Mentors assessment to other staff members.

Rating table (No. 6); **Staff.**

	indicators	Indi No.	Noncompliance	Compliance, need monitoring	Compliance
1	Faculty /student ratio	6.1.1.1			
2		6.1.1.2.			
3		6.1.1.3.			
4		6.1.1.4.			
5		6.1.2.1.			
6		6.1.2.2.			
7		6.1.2.3.			
8	Qualification &promotion	6.2.1.			
9		6.2.2.1			
10		6.2.2.2.			
11		6.2.2.3.			
12		6.2.2.4			
13		6.2.2.5.			
14		6.2.2.6			
15		6.2.2.7.			
16		6.2.2.8.			
17	Academic staff development	6.3.1.			
18		6.3.2.			
19		6.3.3.			
20		6.3.2.			
21		6.3.4.			
22		6.3.4.			
23		6.3.5.			
24		6.3.6.			
25		6.4.			
26		6.5.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

7. Educational Resources:

7.1. Physical Facilities

7.1.1. The medical school must have adequate resource facilities for diverse learning settings such as:

7.1.1.1. Lectures, tutorials and practical classes, including auditoriums,

7.1.1.2. Laboratories: multi-disciplinary, basic medical sciences.

7.1.1.3. Skills laboratories.

7.1.1.4. Dissection rooms.

7.1.1.5. Anatomy and pathology museums.

7.1.1.6. Tutorial rooms.

7.1.1.7. Audio-visual equipment.

7.1.1.8. Laboratory equipment and computers for satisfactory delivery of the curriculum.

7.1.2. The physical resources must respond to the curriculum structure, organization and implementation.

7.2. Learning Resource Facilities

7.2.1. Library Resources including virtual library.

7.2.1.1. The school must have a collection of reference materials meeting the standards that are adequate to meet the curriculum and research needs of the students and faculty.

7.2.1.2. Support staff must be available to help the students.

7.2.1.3. It is advisable that students have access to computer-based reference systems.

7.2.1.4. A core of essential journals must be available in paper and /or electronic form.

7.2.1.5. Ensuring that the most recent periodicals are available and the number of referenced books.

7.2.2. Learning Resource Unit

7.2.2.1 This must be capable of providing support to learning and teaching including established skill laboratories.

7.2.2.2 It is capable of Production of audiovisual aids.

7.2.2.3 It has Electronic networking facilities.

7.3. Clinical Learning environment; Teaching Hospitals and Primary Health Care

7.3.1. Teaching hospitals and primary health care centers should meet the health institution's accreditation.

7.3.1.1. An official agreement must be reached between the medical school and affiliated teaching hospitals

7.3.1.1.1. Indicating clearly the terms of cooperation and commitment.

7.3.1.1.2. This agreement must be subjected to regular review

7.3.1.1.3. There must be clear evidence that the relationship is functioning effectively.

7.3.2. A specialties and Teaching Beds, Affiliated health care institutions must be.

7.3.2.1. Suitable for medical education

7.3.2.2. Have teaching beds and outpatient clinics in main specialties (surgery, medicine, pediatrics, obstetrics & gynecology), accident & emergency. ENT, Dermatology and other specialties) based on the health problems.

7.3.3. Student to Hospital Bed Ratio;

7.3.3.1. A medical college must have access to at least three occupied hospital beds per student in a clinical clerkship rotation at a given time.

7.3.3.2. A medical college with an intake of 100 students per year must be affiliated to a teaching hospital(s) providing of approximately 300-500 beds with high occupancy rate.

7.3.4. Ambulatory Care Services;

7.3.4.1. Access to outpatient clinics must be available.

7.3.4.2. Access to primary health care centers must be available.

7.3.5. Educational, library and on-call facilities must be available for Students in the health care centers.

7.4. Student Welfare Facilities must be provided

7.4.1. For student study

7.4.2. Sport and recreation.

Proposed tools for evidence generation; **Educational Resources**

Ind	Tools	Target	Components	presentation
7.1.1.	Verif	Documents	To show presence of sufficient resources	Description
7.1.2.	Ques	Faculty and curriculum committee	is the physical resources responds to curriculum changes	% opinion
7.2.1.	Verif	Documents	Adequacy of library resources ,services, holdings	Description
7.2.2.	Verif	Documents	Presence of facilitated learning center	description
7.3.1.	Ques	Hospital administrators	Are affiliated health institutions are accredited	% yes or no
7.3.2.	Verif	Documents	Presence of written agreement with affiliated hospitals	Description
7.3.3.	Ques	Faculty, students	All specialties are present at affiliated hospitals	% opinion
7.3.4.	Verif	Document	Student number and hospital bed number	description
7.3.5.	Ques	Faculty , students	Presence of ambulatory care services	%opinion
7.3.6.	Ques	Faculty , students	Availability of educational facilities in hospitals	%present , not
7.4.	Ques interview	Students, graduates	Availability of welfare facilities	% yes and not
7.5.	Ques	Students, graduates	Spaces for sport and elective activities	% yes or no

Document Requested:

1. Booklet about the teaching facilities in the campus .Future plan for their development, e.g. renewal of the equipment.

2. Booklet about the Clinical Learning environment / Teaching Hospitals and Primary Health Care.
3. A copy of the official agreement between the medical school and affiliated teaching hospitals, PHCCs directorate.
4. Written document demonstrates the policy and results of ER(educational resources)
5. Booklet about the Learning resources center.
5. Documents about the Students` welfare activities.

Rating table (No. 7); **Educational Resources.**

	The indicators	**Indicators No.**	**Noncompliance**	**Compliance, need monitoring**	**Compliance**
1	physical facilities	7.1.1.1.			
2		7.1.1.2.			
3		7.1.1.3.			
4		7.1.1.4.			
5		7.1.1.5.			
6		7.1.1.6.			
7		7.1.1.7.			
8		7.1.1.8.			
9		7.1.2.			
10	Learning resource	7.2.1.1.			
11		7.2.1.2			
12		7.2.1.3.			
13		7.3.1.4.			
14		7.3.1.5.			
15		7.2.2.1.			
16		7.2.2.2.			
17		7.2.2.3.			

18	Clinical learning	7.3.1.1.
19		7.3.1.2.1
20		7.3.1.2.2.
21		7.3.1.2.3.
22		7.3.2.1
23		7.3.2.2
24		7.3.3.1.
25		7.3.3.2.
26		7.3.4.1.
27		7.3.4.2.
28		7.3.5.
29		7.4.1.
30		7.4.2.

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

8. Governance and Administration of the Medical College.

8.1. Administration and Structure within the University

8.1.1. The college must have control over its curriculum to allow its objectives to be achieved.

8.1.2. The college must have sufficient autonomy to be able to direct resources in an appropriate manner to achieve the overall objectives of the college.

8.1.3. There must be a clear and direct line of responsibility for the curriculum and its resources.

8.2. Relationship with Affiliated Institutions and the Community.

8.2.1. University academic staff working within teaching hospitals and other health care institutions must be integrated into the service and administrative activities of the affiliated institution.

8.2.1.1. Institutions affiliated with university medical schools must share the educational and research objectives of the medical school.

8.2.1.2. Both affiliated institutions and medical schools must work towards being accredited.

8.2.2. There must be effective methods for the medical school to communicate with, and receive the opinions of,

8.2.3.1 Medical practitioners.

8.2.3.2. Allied health professionals.

8.2.3.3. Community health workers and

8.2.3.4. Recipients of health care in the community.

8.3. Funding.

8.3.1. Schools must ensure that their financial resources are sufficient to allow the school's objectives to be achieved and to maintain high standards of medical education.

8.3.2. Sources of financial support must be transparent and fully disclosed.

8.4. Governance

8.4.1. Providing an up-to-date and accurate organizational chart including the relation with the university.

8.4.2. All staff to be informed about their role and responsibility with effective coordination and leadership across the college.

8.4.3. A central registration of all policies and regulations and is available to staff and students.

Proposed tools for evidence generation; **Governance and Administration of Medical College**

Indi	Tools	Target	Components	presentation
8.1.1.	Verif	Documents	Curriculum committee have control over curriculum	Description
8.1.2.	Verif	Documents	Bylaws shows college autonomy in taking decisions	Description
8.1.3.	Ques	Curriculum committee	Obvious line for control over curriculum	% opinion
8.2.1.	Verif	documents	Bylaws that regulate faculty responsibilities at hospital	description
8.2.2.	Ques	Faculty and senior hospital administration	The affiliated hosp. share the college objectives	% opinion

8.2.3.	Verif	Documents	Presence of feedback mechanism from GP, health professionals , community	Description
8.3.1.	Verif	Documents. financial administrators and experts reports	Sufficiency of financial resources	Description
8.3.2.	Verif	documents	College bylaws on financial affairs	Description
8.4.1	Verif	documents	Relationships between college and university(organizational chart)	Description
8.4.2	Ques	Staff	Are they informed about responsibilities	Opinion %
8.4.3	Ques	Staff and students	Presence of a site for all policies and regulations	Yes or No %

Documents Requested:

1. Narrative document about the managing system and the structure of the medical school.
2. Booklet about the responsibilities and authorities of each employer in the college.
3. Official bylaws clarify the relations between the college, Hospital/s, and PHCCs.
4. The financial policy, its raising and the supportive financial resources.
5. The official order of the curriculum committee formation, its authorities and responsibilities.
6. The official order of establishing the Medical Education Unit. , its authorities and responsibilities.
7. Documents for policies and regulations.
8. Updated organizational chart clarifies the relation with the university.

9. Documents of roles and responsibilities of the managers , directors and heads of departments

Rating table (No. 8); **Governance and Administration of Medical College**

	The indicators	Indicators No.	Noncompliance	Compliance need monitoring	Compliance
1	Administration and structure	8.1.1.			
2		8.1.2.			
3		8.1.3.			
4	Relation to affiliated institute	8.2.1.1.			
5		8.2.2.1.			
6		8.2.2.2.			
7		8.2.3.1.			
8		8.2.3.2.			
9		8.2.3.3.			
10		8.2.3.4.			
11	Funding	8.3.1.			
12		8.3.2.			
13	Governance	8.4.1.			
14		8.4.2.			
15		8.4.3.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

9. Research:

9.1. An active research environment within a medical college is necessary.

9.2. The academic staff must make differently weighted contributions in the areas of teaching, research and clinical services.

9.3. Opportunities for students to be involved in research activities at some stage of their medical education must be provided.

9.4. The College must have a time-plan to develop and implement research.

Proposed tools for evidence generation for; **Research.**

Indic	Tools	Target	Components	presentation
9.1.	Ques interview	Stakeholders	Presence of research environment	% opinion
9.2.	Ques	Faculty	Presence of balance in areas for researches	% opinion
9..3.	Ques	students	Availability of opportunities for research's during study	% opinion
9.4.	Verifi	documents	Availability of time- plan for researches	description

Documents Requested:

1. The policy of performing and implementing researches.
2. Active records including number of researches completed and/or published.
3. The policy of research funding.

Rating table (No. 9); **Research.**

	The indicators	Indicators No.	Non Compliance	Compliance need monitoring	Compliance
1		9.1.			
2		9.2.			
3		9.3.			
4		9.4.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

10. Continuous Professional Development:

10.1. The College has a written plan on CME and CPD.

10.2. The CPD plan is known to faculty and staff.

10.3. Regular symposiums, workshops and conferences should be organized to fulfill the CME and CPD plan.

Proposed tools for evidence generation; **Continuous Professional Development**

Indica	Tools	Target	Components	presentation
10..1	Verifi	Document	Procedure for regular reviewing and updating medical and health education	Description
10.2.	VerifiQues	Documents Faculty	Written plan for CME and CPD ,known by staff Are you participating in CME or CPD	Description % yes ,no
10.3.	Verifi	Documents	Presence of plan for workshops and conferences	Description

Documents Requested:

1. The policy for CME and CPD.
2. The written plan for CPD, it's reviewing and updating.

Rating table (No. 10); **Continuing Medical Education.**

	The indicators	Indicators No.	Non compliance	Compliance need monitoring	Compliance
1		10.1.			
2		10.2.			
3		10.3.			

Use the rate of; noncompliance 0, compliance need monitoring 1, compliance 2

CHAPTER 5

GUIDELINES TO SELF-ASSESSMENT STUDY (SAS)

The SAS exercise and procedure is a diagnostic, participatory and planning project for the continuous quality improvement of all aspects of the college input, process, output and outcome. The preparation at the college level forms the cornerstone of the process of the national accreditation in any country.

The following stages are recommended to be taken at the level of the college:

- ❑ Establishment of committees and their detailed tasks.
- ❑ Planning with feasible time schedules.
- ❑ Awareness campaigns (posters; mission displays; workshops; meetings...etc.).
- ❑ Establish data base with continuous quality improvement.
- ❑ SAS conduction.
- ❑ Planning for research component of SAS to generate evidence.
- ❑ Preparing self-assessment study report (SSR).
- ❑ If possible, conduct a peer review visit (mock-accreditation review visit).
- ❑ Submission of the SSR to the NCAMC and request a site visit.

First: Foundation Structure for Accreditation Process:

This includes all the official\administrative orders and paper-work required through-out the process of accreditation. On top, there should be a coordinator to provide overall leadership and coordination of the SAS process. He should have a good administrative sense, a broad perspective of the college and he should be given some authorities to manage and facilitate a complex tasks.

Second: Awareness campaigns (posters; workshops; meetings etc.)

Introduce the concepts of accreditation, quality assurance and self-assessment and review to the stakeholders. One of the most important methods to accomplish this is by conducting large or small meetings to various disciplines of stakeholders. Also, hands-on workshops are so helpful in this regard with involvement of people who are, directly, in the process of accreditation; explaining the risks, challenges, opportunities … etc. that the college might face or/and achieve. These measures can be done along with a reasonable distribution of posters, booklets etc. for the publicity of the process, college's achievements, challenges and shortcomings presentation etc.

Third: Committees (description, personnel, authorities, duties etc.)

Establish a suitable and sustainable organizational structure to deal with all accreditation matters. Such structure should be well empowered (headed by the Dean and linked to College Council) with clear authority, infra-structure, resources and duties.

Usually this structure will be in the form of accreditation committees (StC, HC, Task Force subcommittees (TFS), etc.).

The membership of each committee should reflect college environment including different stakeholders as faculty staff, administrative staff, students and others as required. The number, titles and administrative positions of the members should be determined by the tasks and authorities of the committee.

The Steering Committee (StC): (refer to CH 3)

It is formulated by the Dean and is better to be headed by him (the Dean) with the participation of the coordinator, Vice Dean in addition to representatives from the main stakeholder disciplines as university administration, health institutions, Medical syndicate, governorate council, students and others (as needed).

The duties of this committee are to:

- Guide the whole accreditation process at the college.
- Formulate a feasible time schedule to be followed.
- Establish other committees as head committee and task force committees.
- Support task force subcommittees.
- Participate in awareness campaigns.
- Develop of the capabilities of the faculty members in the regard to accreditation.
- Approve recommendations from the head committee and.
- Approve the final SSR and submit it to the Dean or to the college`s council.

The Head Committee (HC): (refer to CH 3)

It is responsible for all SAS process and linked to the steering committee and report to it. It should be headed by the vice dean and includes members like the manager of the quality assurance division , departments` representative of accreditation, head of faculties and staff members, students and other members as needed.

The duties of this committee are to:

- Prepare the questionnaire in different domains (getting use of the lists prepared by the NCAMC),
- Nominate members of the task force committees,
- Set a time schedule for the tasks in concordance with the schedule of the steering committee.
- Support subcommittees.
- Direct support and follow up the work of the subcommittees,
- Collect and discuss reports of the subcommittees and amend them to be in a uniformed structure and style.

Task Force subcommittees (SC) (refer to CH 3)

Each TFS should be assigned to a major domain stated at the INSAMC. The members of such SC might vary in number and specialties (faculty or staff members, students etc.) according to the tasks and nature of that SC. They are linked to the head committee each standard should be addressed by SC; however one SC may be given responsibility for multiple standards. College may wish to create additional SC to review specific topics, either to undertake a more detailed review or to accommodate distinctive institutional needs. For example, a College with distributed campuses may want to create a separate SC to review each campus, or a College with a particularly strong research mission may want to create a distinct SC to review the relationship of that mission to the medical education program.

Their duties are to:

- Conduct the SAS of the specified standard for each SC.
- Select and perform the proper statistical method to be used for the analysis of collected data and results.
- Collect the required documents and
- Write a report about its related standard(s).

One of the measures that the college could conduct to collect data is to prepare and use of the questionnaires (get use of those prepared by the NCAMC) (refer to CH4). These should be directed to different disciplines of the stakeholders (faculty staff, students, graduates, training and supervising physicians, administrative staff of the university, and administrative staff of the health institutions, health syndicate, and representative

of the community etc.).

These should conduct several SWOT analysis exercises (internal strengths and weaknesses; external opportunities and threats).

Their work should be in a transparent atmosphere to reach to realistic conclusions. Avoiding the plan to address the basic category of standards only and ignoring quality improvement ones is important. Many aspects and achievement which exist in the college could qualify the college for a higher degree of fulfillment when adopted as part of a quality improvement type of standard in addition to the basic category.

The SC reports should not simply summarize or repeat the information in the DC. They should be thoughtful analyses of each area, based on the combined perceptions and expertise of the subcommittee members in the context of accreditation standards. The analyses should lead to conclusions about programmatic strengths and challenges (including potential or suspected areas where elements might be unsatisfactory) and to recommendations for actions to resolve any identified problems. In the event that a consensus cannot be reached, a minority report may be included.

Task force subcommittee for writing final report (RSC):

It is headed by member of a high scientific degree and composed of members from the accreditation committees or faculties. It is helpful to have one or more members of the TFS serve in RSC in order to provide continuity and to facilitate communication. Furthermore, it should include at least one member with known skills in English writing and typing, other members as needed. The responsibilities:

- It designs for the task forces` reports and formulates a template to unify their structure.
- It collects the reports from the SC.
- It is responsible, along with the HC, in discussing the reports with the SC.
- It synthesizes the individual SC reports into a final self-study report that includes a statement of institutional strengths and issues that require attention to ensure ongoing or future compliance with accreditation standards and to improve programmatic quality.
- Present a summary report (appendix template).
- Present the final draft of SAS report, with all required documents, to the HC, using the template prepared by the NCAMC.

Fourth: Data Base:

Establish a data base within the college. This is beneficial for the outgrowing college activities in regard to accreditation (SAS, SSR, peer review visit, site visit, follow up after accreditation etc.). These data may be about different aspects of all faculty programs and its monitoring, governance and regulatory issues of the college, staff-student issues, facilities and events … etc. Hence, proper archiving and indexing with appropriate paper and computer work are so important to collect and preserve related documents and evidences especially those mentioned in the SAR. To fulfill this task, it is better for the college to formulate related administrative orders, provide necessary resources, locate a given space and assign one or more staff member/s for this task. Documents and evidences collected by taskforces should be handled here and followed-up and updated continuously by these taskforces and related personnel.

Fifth: Self-Assessment Study Conduction:

1. **Data collection:** Using the well-designed tools for evidence generation (refer to CH 4). The evidence of each component can be generated through different tools like for example verification, questionnaires, structured group discussion while the results are presented in a narrative descriptive manner or as percent opinion or any other suitable form.

   The SC are responsible for conducting the SAS. Each SC should review the relevant accreditation standard(s) and elements; information from the DC, and other sources related to its specific area of responsibility and should develop a report. Each SC should be appointed to prepare a report on the specific areas.

   Collection and review of data and documents about every aspect of all faculty programs and their monitoring, governance and regulatory by-laws organized according to the standards.

2. **Data management:** Field and office quality check are to be done to ensure completeness of the collected forms. Answers of open questions are to be organized, grouped and coded for data entry using spread sheets.

   Performance of the research component: Furthermore data has to be collected on research basis in order to complete the required analysis of the standards. Data collectors are to be well acquainted with the tools and the whole process.

Planning for research component of the SAS to generate evidences:

a. Setting the research objectives
b. Designing the methodology used including:
    1. Sample of students, academic staff, non-academic staff and other stakeholders.
    2. Sample size estimation to detect the prevalence of any problem or opinion. The equation for single proportion, with finite population might be used.
    3. Sampling method; to assure random sampling and appropriate representation of target population.
    4. Data collection tools; Questionnaires, structured interviews and focus group discussion. The layout is to be adjusted for computer analysis of collected data.
    5. Following statistical analysis, using different methods as SWOT analysis, results are presented in tabular or graphical forms.
3. **Interpretation:** The results obtained are to be studied by the faculty administration and other stakeholders, and campus-wide discussions of the results and their indications are to be held.
4. **Plan of action:** Define strategies to ensure that the strengths are maintained and any challenges to be resolved making use of the available opportunities.

Sixth: Preparation of Self Study Report (SSR):

The planning, preparation and conduction of the SAS is regarded as the foundation stone of the accreditation process and should end with writing SSR. It is of particular importance that the college should pay attention to the awareness of all stakeholders about the accreditation and its value as a continuous improvement process rather than writing the SSR by limited number of concerned college staff.

The SSR is to be as comprehensive as necessary. At the same time, it should be as brief as possible and it is advisable for this report not to exceed 50 pages.

The SSR should explore different aspects and activities within the college. Improving these aspects is as important as writing the report itself. Furthermore, the SSR should be evidence-based with documents collection and this cannot be achieved unless so many of stakeholders are involved in this process. The accountability of this SSR is important as it will be verified by the visiting teams from the peer colleges (peer review visit) and from the NCAMC (site visit). Hence, it is reasonable for the college to

mention (in its SSR) both achievements and shortcomings in regard of accreditation rather than magnify the first and ignore the last. Of course, this should be written along with suitable measures necessary to improve\maintain these achievements and improve\overcome shortcomings.

The details of what to include, how to arrange and present and who should do that, will be explained in following chapter.

Seventh: Processing of the SSR:

The SSR should be handled from the RSC to the HC who in turn handle it to the StC. The StC will discuss it thoroughly and, eventually, approve it. The SSR will be presented to the Dean and College council for approval.

The College is then able to send a request to the NCAMC (along with this SSR) asking for a site visit for accreditation.

Suggested Templates for College Plan of Action (POA)

Template 1

Action	1	2	3	4	5	6	7	8	9	10	11	12
Formulation of accreditation and taskforce committees												
Formulation of administrative orders												
Awareness campaigns and actions												
Performing tasks for each domain (according to INSAMC												
Announce duties of committees and												

taskforce teams
Taskforce actions (questionnaire, meetings, photo…etc.)
Stastical analysis (and other) as needed
Workshops to discuss and consolidate feedback
Write reports about each domain by the subcommittees
Discuss and uniform reports of the subcommittees
Prepare the SSR along with all required documents
Management suggestions and overcome shortcomings
Approve the SSR by the dean and college council
Conduct peer review visit
Submission of SSR to NCAMC
Send a request to

NCAMC and request site visit				

Template 2

When	**Who**	**How**	**Action**	**Objectives**
D1	College council, MOH training sites administrators, physicians in contact with students and graduates, university authorities, graduate and community representative.		1-Formulation of (Steering committee (StC) and head committee (HC).	To nominate the members of StC.
1st W.	Academic staff Expertise Nonacademic staff	Nomination from the departments and administrative units.	2-Nomination, endorsement of subcommittees	Organization of work
4 M	Members of StC and HC	Weekly meeting using well organized schedule. Awareness during lectures, or using posters,	3-Awareness campaign.	To prepare staff and students for the accreditation process. To enhance the accreditation knowledge to academic staff ،Nonacademic staff

		media.		and Students.
1 W	Members of HC and other members.	Weekly meeting Small groups meeting for each subcommittee to revised its area and subareas.	4-distribute the duties among the subcommittees	To perform the task one for each area of the 11 areas (standards)
2 M	Subcommittee members	Direct interview with the departments and units.	5-Document collection, for each area, using the available data base and other documents.	Fulfill the compliance of the standards.
1 M	Members of the subcommittees	Design research methodology	6-Preparation of the analytic tools (questionnaires).	To get feedback studies from Academic and Nonacademic staff ,students, graduates , community
2 mo.	subcommittees	Direct interview, using the proposed tools for evidence generation.	7-Conducting self-study	Clarify the real situation of the college on the ground.
1 mo.	Members of StC and HC , Subcommittees	Periodic meetings	8-groups workshops	Announce the findings and discuss the shortcomings

	And others			and challenges.
1 M	Experts in statistical analysis	Tabulating and analyzing the results	9-Data management	Identify strong and weak points for each area, opportunities and threats.
2 W	Report subcommittee	According to a template	10-Reporting each area.	Discuss the finding in a systematize narrative way
2 W	Report committee.	According to template	11-Unifying the reports	To be submitted to the steering committee for discussion.
4M.	St.C and HC	Corrective action	12-Plan of action	To fill gaps and overcome shortcomings
2 W	The StC		13-Approval of the report	Official documentation
2 W	Dean and StC	According to the guideline	14-Thereafter, either ask for peer review	To incorporate the external auditing, exchanging opinions.
2 W	Dean and StC	According to the guideline	15-Submission to NCAMC	For approval
	Dean and StC	According to the guideline	16-Request to the NCAMC for site visit.	To get the accreditation

CHAPTER 6

GUIDELINES FOR WRITING SELF STUDY REPORT (SSR)

The purpose of SAS: When the medical college starts its preparation to get accredited, it should run a SAS process. This process aims to realize the current situation of the college relating the different domains stated in the INSAMC. This participates clearly in improving the college outcomes ensuring better health services. To fulfill these aims, the results of this process should show clearly the points of strength and weakness in each of these domains.

The SAS is designed to report these aims and results in a documented and organized way. Furthermore, it should include an explicit explanation about the strength point present and define the college actions to maintain them. At the same time, the SAS should discusses the weakness points and explain the college actions to correct them by reasonable plan of action and suitable time schedules.

Steps for writing SSR: To facilitate this process, the college is advised to follow the next steps ending with writing the required report in an informative and realistic way.

The first thing is the formulization of a committee responsible for this task with a clear tasks and authorities. This Report Subcommittee RSC (task force subcommittee for writing final report) should include a group of faculty members, staff members and students who were oriented and have a good experience in different disciplines, as the process of accreditation and its importance, the INSMAC requirements and the college background and infrastructures in relation to these requirements. Furthermore, they should have the ability to write the report in a well-structured way and in readable English. The RSC should be composed of an odd number of members with a head, deputy head and not less than three other members form the faculty staff. The head of this committee should be faculty member who spent not less than 10 years in that college and have a title of Assistant Professor / Professor. The members of this committee could be members of the accreditation committee of the college. Furthermore, this committee should include at least one member with known skills in English writing and typing and it should be equipped with the required secretariat personnel, offices and computers. This RSC has a reasonable fund (from the college) and the authority to consult outsider experts, if needed.

A committee with such specifications should be formulated by the StC of the college for such purpose and its members should be aware and committed for this task. The job of this committee is writing the SSR of the college depending on the prior efforts of the accreditation committee at that college. Before starting the writing process, this committee should put an applicable time schedule to be followed. It is better to take in consideration the available manpower, facilities, challenges etc.

A. Generic structure of SSR: One of the most important objectives of the SSR is the recognition of the college status in the light of the standards showed in the INSAMC. Through this process, points of strengths should be enlightened and measures to maintain and improve them should be mentioned and documented. On the other hand, weaknesses, shortcomings and appeals should be well addressed, and measures to improve and overcome them, should be well planned and followed up regularly.

Hence, it is clear that the benefit of the SSR is not just to describe the status but to draw a tailored plan to fulfill accreditation requirements by maintaining of good achievements and managing gaps. The process of writing the SSR should be included in the general plan of the college to meet accreditation requirements and a suitable and a feasible time schedule should be there and followed strictly. As the general idea of the SSR is of diagnostic type, analytical tools should be used to target the wide scope of participants aiming to collect the required information and data.

In general, the report is expected to provide a readable and useful description of the institution, the SAS, the evaluation of the College in terms of the accrediting standards. Conclusions and recommendations emerging from SAS should focus on acquiring and maintaining of accreditation and quality improvement. Information included should be edited and crosschecked for consistency. Generally, the report should be constructed to be comprehensive to non-faculty stakeholders as well as its benefit for involved faculty members and accreditation committees and communities for maintenance and follow up.

Accordingly, the following steps and criteria might make a suitable combination that each college could choose, adopt or adapt:

1. The measures and analysis taken through the SAS should be written in the SSR

and they should be comprehensive with adequate depth. The results of the surveys/researches need to be discussed (preferably in a narrative way) and should be evidence-based.

2. Although the SSR usually portrays prevailing and constraining circumstances, it should neither expect nor express great and unrealistic optimism about conditions that may modify (improve or worsen) the short-term outcomes. Instead, a feasible plan of action (in measurable scales) should be showed taking in consideration the time schedule, human resources, cost, technical limitations etc.
3. Always prepare a well written and conclusive executive Summary for the SSR. Particularly this, along with writing the whole SSR usually requires expert personnel in English language and writing skills.
4. The RSC should collect reports of the SC and uniform them is one texture that (preferably) follows a given headings. This report should finalize the whole accreditation process done at the college.

B. Points to be remembered while writing the SSR:

The SSR generally, should be:

1. Simple, so it can be clearly conducted without complicated Jargons or sophisticated statistical and analytical methods and data that can be easily conceived.
2. Affordable, so it does not involve using complicated and expensive tools for institutional self-assessment which can cause a burden on the institution budget.
3. Comprehensive in aspect of participation, so it can address a wide range of spectrum of contributions from students, staff, administration, physical facilities, community etc.
4. Measurable, measuring each domain should include the related college benchmarks, achievements, results and SWOT analysis
5. Flexible, so each step can be adapted according to each college circumstances and it can also be upgraded according to future development.
6. Making use of the most available advance in the technology of information and communication and the available data base within and outside the college.

7. Steps need to be incorporated and be built in the mechanisms of external and internal auditing of university and college so it can measure the impact of the college on the community and medical profession etc.

C. Backbone (Heading) of SSR:

The essential content of the SSR should cover the following elements:

1. The title page
2. Dean's statement about the college accreditation.
3. The Historical background of the college.
4. Acknowledgment.
5. Summary report (Abstract).
6. The purpose of evaluation.
7. Evaluation methodology and methods.
8. Discussion of different domains (domain description) along with the evaluation results and SWOT analysis.
9. Conclusion and recommendation
10. Citation and Appendices.

D. Details, permits and limits of the SSR:

The title Page: one page including title of the study, institution name and mailing address, names and affiliations of report authors and the date of submission.

Dean's statement: not more than one page stating the vision of the college about accreditation and the achievement of that college in this regard. It might include a photo of the dean or the college.

The Historical background of the college: one or two pages stating the historical background of the college as the date of initiation, number of graduates, awards acquired etc. It might include a historical photo of the college or related events.

Acknowledgment: not more than one page to show the efforts of the participating personnel, society groups, agencies and others who participate in one way or another in the process of accreditation and SSR writing.

Summary (Abstract): one or two pages including the summary of main chapters of the report with the results concluded. It should show the methodology used.

The purpose of evaluation: not more than one page stating the college`s point of view, the college`s needs for accreditation and how this report is beneficial in this regard.

Evaluation Methodology: one to two pages showing the study model and design (quantitative, qualitative or mixed) and reason for choosing such design. Data collection (instruments, sources, procedures, sample size and sampling techniques, and limitations) should be described. Furthermore, this section should show how data will be analyzed, i.e. content analysis of qualitative data, descriptive statistics and/or statistical tests of significance of quantitative data).

Discussion of different domains (domain description) along with evaluation of the results and SWOT analysis: it is preferable to write a chapter for each domain. Each chapter includes a background and rationale context of that domain along with the related INSAMC requirements. It should also take in consideration the lists and other documents supplied by the NCAMC. Within the stem of each chapter there should be a clear referral of events and results to their documents (cited in the appendices). Discussing each domain should include the related college benchmarks, achievements, results and SWOT analysis. Furthermore, it is important to report how progress will be measured along with a time schedule.

The benchmarks should be shown clearly with a reasonable details (when needed) making the related college achievements obvious. The results should be so clear with a logical and narrative summary (quantitative and qualitative). The use of tables and figures are preferable when appropriate (clearly labeled). The results should highlight the relevant negative as well as positive findings preparing them for analysis. The SWOT analysis is so vital to emphasis and enlightens the points of strength, weakness, opportunities and threats along with the appropriate measures and actions taken by the college in this regard (maintain the strength and correct the weakness).

Conclusions and Recommendations: One or two pages. The conclusions should enumerate the summary of the SWOT analysis appropriately. Recommendations aims to facilitate the future work to overcome shortcomings and maintain strength points. The recommendations should be focused and have a significant impact on the process explaining how their implementation will participate in improvement.

Citations and Appendices: list sources for any references made in the stem of the report to relevant theories, research or data from other sources. Include tables, figures, graphs, charts, questionnaires, photos etc. that is relevant and explanatory.

The appendices could be the last chapter of the SAS report or in isolated booklet with proper referral to the report stem.

This step requires an enthusiastic collaboration between this committee and different departments, sections, personnel and committees of the college especially the accreditation committee.

CHAPTER 7
PEER REVIEW VISIT

Overview: The medical college can ask for a peer review visit during the process of self-assessment and before requesting for site visit. This is an optional step, determined by the college at any stage of the SAS process.

The aim of the peer review visit is exclusively advisory. It aims to exchange knowledge and experience, and to reevaluate the actual situation of the college and its readiness to site visit. Sharing opinion with the peers, definitely, will improve the college`s performance toward satisfactory compliance of the accreditation standards.

Team members: The NCAMC must designate a core team of, preferably, members from different accreditation committees from different colleges. The NCAMC should have a list of experts from different colleges to nominate the team members for peer review, taking into consideration the geographical area of the college in selection of team members. These experts should have interest in evaluation and accreditation; preferably they had previous practice in accreditation.

Team members should be knowledgeable enough in the field of medical education in general and in program evaluation in particular. Each peer review team should include three members, the review visit time should be reasonable

Procedure: The College should send its SSR to the peer visitors, at least one month before the peer review visit for reviewing.

The team should hold a preliminary meeting to outline their duties and responsibilities. All/some areas, as requested by the college, are examined in details. Peer visit team adopts the NCAMC guideline.

At least three working days required to finish the peer review visit. The college should nominate a coordinator who is preferably an expert senior staff member who can manage the logistics and other administrative issues.

The reviewers can evaluate any of the areas related to INSAMC, as requested by the college. Feedback should be given to the college confidentially. This feedback may include areas of strength and areas of weakness. The college can benefit from reviewers feedback to maintain strengths and improve weaknesses. Peer visitors may also advise visited college about writing the self-assessment report.

Peer review visit process should include the following activities:

1. Meetings with the Dean and key persons in order to collect necessary data and explore any significant issue.
2. Reviewing important documents for SAS as indicated by INSAMC.
3. Team members are allowed to interview faculty members, representatives of students, graduates, others as indicated, each interview must not last more than 30 minutes.
4. Inspecting the physical resources in the college as well as the teaching hospital and the related affiliating centers.
5. Any type of qualitative and/or quantitative research like for example surveys or focus group may be used if necessary to obtain further documentation.
6. NCAMC guideline should be used as peer evaluation form to give quantitative evaluations to each area and sub areas accordingly.
7. The college has the right to add any other activity accordingly.
8. It is important to report the visit and send copy to the NCAMC.

CHAPTER 8

GUIDELINE FOR ACCREDITATION SITE-VISIT

Overview: The accreditation reviews of compliance with each accreditation standard, culminating in site-visit, typically occur on a 6-year cycle and consist of the following steps:

A self-analysis of compliance with accreditation standards (college Self-Assessment study SAS) by the medical education program, On-site review by a team of peer evaluators (the peer review-visit), and review of the site-visit team's written report.

Pre visit procedure: Pre-site-visit documents, including the Data Collection (DC) and instructions for the college SAS. College personnel work, over a period of several months, to provide the information requested in the DC The DC will then be used to inform the college SAS. The college should submit its completed DC, SAS report, and other materials to the NCAMC Secretariat offices three months before the site-visit.

Site-Visit Procedure:

1. A written notification to the college, *(at least)* within two months before visit.
2. Team Size and Composition. The NCAMC is responsible for appointing the members of site-visit teams. It typically, consists of five to seven members selected from a pool of experienced medical educators and practitioners, including professional members of the NCAMC, to ensure consistency in the assessment process. Each site visit team will have a team chair and a team secretary.
3. The team chair is NCAMC member who had previous or current managerial experience. The team secretary is an experienced NCAMC member with responsibility for visit organization and report preparation.
4. The duration of the site visits typically are 3-5 working days depending on size of the college.
5. The institution seeking accreditation has the right to review the composition of the visit team in case of presence of conflict of interest.
6. Persons invited to serve as members of site-visit teams (assessors) are expected to disqualify themselves if they are aware of any situation or circumstance that might be a conflict of interest.

7. NCAMC maintains a pool of potential assessors with different specialty.
8. The site visit coordinator; is Contact person at school nominated who should be an experienced senior staff member who will manage the logistics of the site-visit and other administrative functions.
9. Each team member receives a copy of the council's site-visit procedures, which explain the team's activities and responsibilities in details.
10. The assessment team holds a preliminary team meeting normally one month before the on-site visit and after assessing the self-study. At this meeting, the team identifies key issues and develops an outline of the assessment plan.
11. Visit Structure. The visit begins with a team meeting, followed by a meeting with the dean. During the visit, the team will meet with those persons or groups who can provide or verify information, including faculty, students, administrators, and representatives of clinical affiliates. While meetings with faculty members and students typically take place without the presence of institutional leaders, the dean's participation is appropriate during the team's meetings with program administrators, especially regarding finances and relationships with clinical affiliates.
12. The members of the team divide the assessment task into specific responsibilities, depending on their experiences and interests. These responsibilities are directly linked to the contents of the final accreditation report.
13. From its examination of the SAS report before the visit, the team will develop questions about the unit to explore during the site-visit. The report is the basis of the team's initial understanding of the unit, its mission, the range of its programs and activities, its evaluation of itself, and its plans for the future. Thus, a report that merely describes the unit is not a satisfactory base on which to build a useful site visit.
14. Teams also determine whether colleges meet any major claims they have made of outstanding performance in areas other than the standards normally examined by a team.
15. The visit includes appointment with the dean to whom the unit administrator reports. Team members attend classes and interview faculty members. The team conducts group interviews with students, and staff, on separate days of the visit. Each interview should be with 20 or more students, if possible.

16. All interviews are conducted with the knowledge of the academic head of the medical program although not necessarily in their presence. This ensures that dissenting views can be expressed freely without being attributed to individuals.
17. The team inspects the physical resources, including teaching resources available in research laboratories, libraries, community clinics, general practice settings and hospitals. Maximum opportunities are provided for interactive discussion with the medical education providers' senior staff and students during the visit.
18. A reassessment procedure of site-visit steps to cover new challenges may arise during evaluation process.
19. The team needs a workroom (must be provided by the college), preferably equipped with computers, printing equipment and Internet access.
20. The team will successively develop and refine his list of summary findings.

Team Caucus: The site visit team should assemble before meeting the dean on the first evening before the visit to make any adjustments in the schedule, confirm responsibilities and review ground rules and timelines, and prioritize areas needing particular attention over the course of the visit (e.g., potential areas of noncompliance with accreditation standards or common questions to be asked for all required clerkships). At this initial caucus, the team should review the preliminary findings developed by team members based on the review of pre site-visit materials.

Entrance Conference (EC): Generally, the site-visit team met privately the dean at the entrance conferences. All team members should attend the (EC), the chair clarifies the purpose and the schedule of the site-visit, gets the dean`s permission to interview staff members or students or to explore any documents. The Dean can clarify the accomplishment, goals and challenges, and other major current issues; like principal findings of college SAS, organizational relationships of college with university and teaching hospital(s); organization of dean's staff; financial status, research programs, faculty development.

Exit Conference: Visits typically conclude exit conferences with the dean and the university chief executive (or his or her designee), although the dean may include others with advance notice to the team.

Generally, the team meets privately with the dean. The team chair will read the

summary of the team's findings to the dean at the end of the exit conference. The team chair will emphasize to both the dean and the university chief executive that the team's summary report represents a preliminary statement of findings for consideration by the NCAMC. The team's findings are not, therefore, for widespread dissemination at this point.

Overview of Site-Visit Team Member Functions:

Duties of the Team Chair:

Overview: The team chair serves as the leader of the site-visit team's activities on site and speaks for the team during the visit.

1. During the visit, the team chair should see that the team paces its work, consolidating its observations and findings at the end of each day so that the team's findings of strengths and problem areas are refined each evening.
2. The chair should ensure that individual team members are introduced at meetings with various groups and that the purpose and focus of the accreditation visit are stated briefly.
3. The team chair will read the team's findings at the exit conference and then give the dean a written copy of the findings.
4. Review of Pre-visit Materials. The team chair should, as soon as possible, review the college's DC and SAS summary report. Any potential strengths or problem areas should be communicated to the site-visit team secretary before the site-visit begins so that they can be compiled into a preliminary set of summary findings to be discussed at the initial team caucus. The chair should also notice any areas in which additional information is needed and should communicate these areas to the team secretary.
5. The Visit Schedule. The team chair should consult with the team secretary prior to the visit about the organization of the visit and development of the visit schedule. The team chair should review the draft schedule to ensure that all relevant issues reflected in the accreditation standards are appropriately explored on site and that attention is given to potential problem areas.
6. The Site-visit Report. The team chair with secretary is responsible for writing the draft site-visit report. The team chair should carefully review the draft site-visit report to confirm that the summary findings are sufficiently documented and supported in the report narrative and appendices.

Duties of Site-Visit Team Members:

1. Logistics. The team secretary will provide information to team members about the hotel arrangements, visit schedule, and writing assignments.
2. Team members should arrive in time for the team caucus and entrance conference with the dean, and they should remain through the exit conferences with the dean and university chief executive on the last day of the survey visit.
3. Review of Pre-visit Materials. All site-visit team members should review the college's DC and SAS summary report, as soon as possible, in their areas of responsibility.
4. If there are any notable omissions or inconsistencies in the database or SAS report, the team member should inform the team secretary about them so that the team secretary can request additional information from the college.
5. As soon as possible, team members should identify potential strengths, areas in compliance with a need for monitoring, and areas of noncompliance and communicate these to the team secretary before the visit begins. These will be compiled by the team secretary and discussed at the initial team caucus.
6. Team members should not communicate directly with the college for any reason.

Main Responsibilities During and After the Site-Visit:

Team members are expected to evaluate the educational program and the resources supporting it, leading to an assessment of the level of compliance with NCAMC standards:

1. Collect and record additional data and impressions during the visit based on meetings with college personnel and review of additional documentation.
2. Contribute to development of the consensus list of college strengths, areas in compliance with a need for monitoring, and areas of noncompliance. These findings are presented by the site-visit team chair to the dean and university chief executive (or his or her designee) at the end of the site-visit.
3. Provide to the team secretary the assigned written sections of the site-visit forma

Writing the Report of a Site Visit:

The principal responsibility of the site-visit team is quality assessment. The team must prepare its own report regarding the extent to which, in its judgment, the college met the standards of good practice expressed in the general principles and the accrediting standards.

1. The Chair and the secretary have overall responsibility for the final report. The Chair's introduction in the report will cover the adequacy of the program as assessed against the standards. This section will include the recommendations for change where appropriate.
2. At the last day of site-visit (visit conclusion), the team chair must prepare a draft written report.
3. The cover sheet of the team report includes a statement that it is a draft and may contain errors; that the college may respond and offer corrections; and that the Council makes final accrediting decisions.
4. Each site-visit team member is responsible for preparing an unambiguous commentary noting any strengths and deficiencies relating to the standards for which they are responsible. And ensure that all its summary findings are fully explained and documented in the body of the report, and that all accreditation standards are accounted for.
5. Each standard will be evaluated in a section of the report and each section may include a list of recommendations. The report indicates ways, in which the college complies, substantially complies or does not comply with the standard’s requirements. Recommendations are written with enough detail to be helpful to team members on subsequent site-visits as well as the current university administration.
6. The survey report is based on information contained in the documents provided, the SAS and additional information that may be provided to the site-visit team on-site.
7. The team chair should explain that the recommendation which should be constructive to, first, the Accrediting Committee, and the final decision with the Accreditation Council.
8. The team chair must recommend to the Accreditation Council the approval, conditioned accreditation, denial, continuation, or change in the accreditation status of a college.

9. Two weeks after, the team's chair forwards its final formal recommendation and report to the council director.

Notes:

- ❑ The coordinator should refrain from any actions that could be perceived as attempts to influence the site-visit team's decision making. Similarly, site-visit team members should not accept gifts that could be perceived as attempts to influence their decision-making.
- ❑ All SAS and related materials are confidential, as is all information shared with the site-visit team while on the site visit. Each member of the site-visit team is required to preserve this confidentiality.
- ❑ Do not comment to staff or students on how the college is doing. Do not comment on the hours that the site-visit team has been working. Do not comment in relation to outcomes of the visit. Do not make value statements, e.g. this is a great program. Be positive at all times. Be on time.

Confidentiality of Information:

1. Information about the college, whether contained in the DC and college SAS, the briefing book, or obtained on site, is considered confidential and must not be disclosed to other parties.
2. A confidentiality statement is included in the NCAMC Secretariat's mailing to the survey team; this statement must be signed and returned before the site-visit.
3. Team members should hold the team findings confidential.
4. Either at the end of the site-visit or after reviewing the report, site-visit team members should dispose of materials related to the site-visit in a way that ensures its confidentiality.
5. Documents or correspondence not needed for writing the survey report can be left with the college at the conclusion of the site-visit.
6. After reviewing the draft site-visit report, team members should destroy any remaining documents, including the draft report, related to the accreditation site-visit.

Preparing the Final Report:

To ensure prompt consideration of the medical education program's accreditation status, it is essential that the draft sit-visit report be completed as quickly as possible.

1. Site-visit team members should submit their sections to the team secretary.at the end of the day.
2. The draft site-visit report should be completed by four weeks after the visit. The team secretary should send a copy of the draft report (including the appendices) to the NCAMC Secretariat for review.
3. The NCAMC Executive Director will communicate with the team secretary about the draft site-visit report's organization, format, internal consistency, and thoroughness in addressing all accreditation standards and in providing sufficient documentation related to each finding.
4. Upon receiving the comments from the NCAMC Secretariat, the site-visit team secretary should make any needed revisions.
5. Finalizing the site-visit report: The final Site-visit report must be received by the NCAMC executive director no later than four weeks before the next schedule NCAMC meeting to allow adequate time for review by NCAMC members.
6. Feedback to site-visit Team Members; Following notification of the college, the NCAMC executive director will provide feedback to team members about the NCAMC response to team findings. Such feedback is one element of the team training that will assist in developing consistency across teams in the interpretation of standards.

Medical College Responsibilities:

The role of medical college participants in the accreditation process are: **Site-Visit Coordinator:** The site visit coordinator should be an experienced senior staff member who will manage the logistics of the site-visit and other administrative functions such as formatting and submitting the DC / SAS package. The site-visit coordinator will typically make hotel reservations for the survey team, coordinate ground transportation during the visit, and schedule the necessary faculty and staff identified for sessions during the site-visit.

The names and contact information of the faculty accreditation lead and site-visit

coordinator should be provided to the NCAMC Secretariat as soon as possible.

Site-Visit Preparation and Logistics:

Reviewing Site visit Team Membership. A list of Site-visit team members, with their titles and contact information, will be sent to the dean ***at least two months*** prior to the site-visit. The dean should inform the NCAMC Secretariat promptly if any team member is deemed to be inappropriate due to conflict of interest or other valid reasons.

Hotel arrangements: The dean's office should make hotel reservations for each member of the team, if available. The school should select a full-service hotel, preferably near the campus and convenient to restaurants, taxi service, etc. The hotel should be of appropriate quality.

Ground Transportation: NCAMC site-visit team will make their own travel arrangements. Instructions about transportation options from airport to hotel should be provided. In cases where the airport is a substantial distance from the medical college or where taxicabs are not readily available at the airport, it may be necessary for the dean's office to arrange ground transportation between the airport and hotel. If so, these arrangements should be coordinated with the team secretary. The dean's office should decide how to transport the team each day between their hotel and the medical college and to any instructional sites (e.g., affiliated hospitals, branch campuses) they will visit. The site-visit team secretary and site-visit coordinator should determine where and when the team will be picked up or met at the hotel, and this information should be included in the site-visit schedule.

Meals: The College should provide appropriate meals and snacks during the time the team is at the college. Providing these meals ensures the efficient use of time during the site-visit.

Site-visit Team's "Home Room" at the college: The site visit team will need a "home room" at the college equipped with a computers and printer compatible with the operating system used by the site-visit team. The home room should have a conference table large enough to accommodate visit team meetings with school personnel. A second meeting room will be needed for sessions when the survey team divides.

The staff-visit coordinator should provide a set of materials in the site-visit team "home room," including paper copies of the complete SAS subcommittee reports, and

any other documents requested by the team, such as course evaluations or syllabi.

Gifts to Team Members: The College should not provide gifts to survey team members.

CHAPTER 9

GUIDELINES OF WRITING SITE-VISIT REPORT

Introduction: The report of an accreditation Site-visit is the formal record of the site-visit team's findings related to accreditation standards. It serves as the primary source of information for accreditation decisions by NCAMC. Site-visit team members will have reviewed the SAS material before the visit. While on site, the team may also review additional information.

Each site-visit team must ensure that all its summary findings are fully explained and documented in the body of the report, and that all accreditation standards are accounted for. The site-visit report is based on information contained in the DC, additional information that may be provided to the site-visit team on-site. The medical college will be asked to carefully review the draft site-visit report to ensure that it is factually correct for the time during which the site-visit took place. No new information will be considered for addition to or modification of the report after the site-visit team concludes the visit.

Typically, each college completes a comprehensive, fair, and representative self-assessment study. There may be cases, however, in which the SAS may not accurately portray current circumstances or may express greater optimism about the existing status of the school than seems evident to the site-visit team. Site-visit team should validate the information in the SAS and the bases of conclusions drawn by the college's SAS task force. Because some of this information was collected as long as a year before the site- visit, it is important to note whether major areas of concern have been addressed and whether any new concerns recently have emerged.

Compliance Definitions:

It is the responsibility of the site-visit team to make a judgment of whether the medical education program is in compliance with each accreditation standard. Teams should use the following definitions when making this determination for each accreditation standard:

1. **In Compliance:** The required policy, process, resource, or system is in place and, if required by the standard, there is evidence to indicate that it is effective.
2. **In Compliance with a Need for Monitoring:**

   A. The medical education program has the required policy, process, resource,

or system in place, but there is insufficient evidence to indicate that it is effective. Therefore, monitoring is required to ensure that the desired outcome has been achieved.

B. The medical education program is currently in compliance with the standard, but known circumstances exist that could lead to future noncompliance [replaces the previous finding of "area in transition"].

3. **Noncompliance:** The medical education program has not met one or more of the requirements of the standard. The required policy, process, resource, or system either is not in place or is in place but has been found to be ineffective.

The Report of Accreditation Site-Visit:

Cover Page: Use the cover page, adding specific details such as school name and survey date.

Table of Contents: Make sure that all Appendix documents are listed. The report should be paged sequentially, including the Appendix.

Memorandum:

Introduction and Composition of the Site-Visit Team:

A typical example:

A site-visit of the University of NAME School of Medicine was conducted on (DAY-MONTH- YEAR), by a team representing the NCAMC. The team expresses its appreciation to Dean NAME and the administrative staff, faculty, and students for their interest and candor during the survey visit. .

After the paragraph introduction, complete the section in the survey report template that lists the members of the survey team, with their names, titles, and institutions, as well as their roles on the survey team as chair, secretary, member, or observer:

Chair:

NAME, (Medicine) Dean, School of Medicine

University of

Secretary:

NAME, PhD (Anatomy) Associate Dean for Curriculum

University of

Member: (Specialty/Discipline)

Member: (Specialty/Discipline)

Summary of Site-Visit Team Findings:

Summarize the survey team's findings under each section of the standards; the team's findings should be organized as:

Areas of "Compliance" (FF, Fulfills)

Areas of "In Compliance with a Need for Monitoring" (PF, partial fills)

Areas of "Noncompliance"(NF, not fills)

Note that there may not be findings under each of these headings for each section. Each heading should be included and "none" should be listed if there are no findings for that section.

For each section, the preferred format includes providing the number and text of the standard, followed by a paragraph labeled "Finding" that summarizes the specific evidence for the team's recommendation that the area is area of compliance, an area in compliance with a need for monitoring, or an area of noncompliance. Include enough information and data in the finding to allow the reader to understand the basis for the team's recommendation about compliance.

Areas of Compliance:

An area of strength is generally considered to represent either (1) an aspect of the medical college that has been shown to be critical for the successful achievement of one or more of the college's missions or goals or (2) a truly distinctive activity or characteristic relevant to a specific accreditation standard that would be worthy of emulation. Strengths should contribute to positive institutional outcomes and should not simply reflect the school's compliance with accreditation standards.

Standards Reviewing:

Each standard is mentioned with its number with scoring and any comments.

The Data Collection (DC) and College SAS:

Comment on the quality of the DC, including its organization, completeness, and internal consistency. Note if there was information missing in the DC (that is, if questions were not completely or appropriately answered) or if there were any difficulties for the team in securing needed information before or during the visit.

Indicate whether quantitative data were updated for the current year.

Comment on the SAS in terms of the degree of participation by medical school faculty, administrators, students, and others; the comprehensiveness and depth of analyses; and the organization and quality of the conclusions and recommendations. Note the degree to which the Site-visit team's major conclusions are consistent with those of the program's SAS.

History and Setting of the College:

Briefly summarize the history of the college. Describe the medical college in terms of its size, age, public or private status, and its organizational relationships with the university, health sciences center, geographically separate/distributed campus (es), and principal teaching hospital(s). Describe the geographic relationships of the main campus to major clinical teaching sites and, where appropriate, remote campuses; include relevant maps of the locations of affiliated teaching sites and any geographically distributed campuses in the Appendix.

Note On organization of the Body of the Report:

The body of the report should include the team's narrative description and comments, referring as needed to documents collated sequentially in the Appendix at the end of the report**. List each Appendix item at the beginning of the relevant section of the report.**

In the narrative of the report, be careful to differentiate information taken from sources provided by the medical school from the findings and conclusions of the survey team.

Guidelines of Writing:

Each team member should edit his or her section(s) carefully before submitting it to the team secretary. The survey team secretary should edit the total report for clarity and consistency, as well as for spelling and formatting.

1. Use one-inch margins throughout.
2. Use the font of the template supplied by the Secretariat (11-point, Times New Roman).
3. Carefully check the quality of all images, tables, and scanned copies. Scanners may produce distortions, low contrast, or crooked pages. Be sure that originals are of high resolution for quality reproduction. Do not include color.

4. After the entire report has been completed and assembled, put page numbers in the bottom center of each page, including appendices. Number the pages of the report consecutively. Do not number each section separately.
5. Place the Table of Contents (including that for the appendix) immediately after the title page. These pages should be numbered in lowercase Roman numerals in the bottom center of the page (as in the Site-visit report template).
6. Please use common style conventions:

The word "dean" is not capitalized except when it begins a sentence or stands as "Dean Robert Jones." The same is true for vice president, provost, president, and chair. The words "medical school," "college," and "university" are not capitalized unless they begin sentences or are used as the school's full name (such as Jones Medical School). The word "faculty" is not capitalized unless it begins a sentence or is the Canadian equivalent of school, e.g., "The president intends to allocate more funds to the Jones Faculty of Medicine for laboratory construction."

Discipline names (e.g., "Physiology," "Biochemistry," "Medicine,") are capitalized when they refer to departments. Note that "department" is not capitalized unless it is used with reference to a specific discipline, as in "Department of Medicine."

Capitalize the names of formal school committees and subcommittees (e.g., Committee on Educational Policy), but do not capitalize the committee if the formal name is not used and the committee is referred to just by function (e.g., curriculum committee).

7. The covering memorandum from the team secretary follows the appendices and should be numbered as page 1.
8. Before submitting the draft report to the NCAMC Secretariat, carefully proofread the draft report to correct spelling, typographical, grammatical, and punctuation errors.
9. The team secretary should follow the instructions for the review of the draft report, as described in this document.
10. The team secretary should sign the cover memo before submitting the final copy.

CHAPTER 10

NCAMC MEETINGS AND DECISIONS

A. Organization, Timing, and Conduct of Meetings:

Regular Meetings: The NCAMC members meet in person in regular sessions monthly, unless the members agree to a different schedule (according to the NCAMC internal regulations).

Special Meetings: The Chair, after discussion with the Executive Director, may invite the council for a special meeting to deal with any issue(s) that cannot wait until the next scheduled regular meeting.

B. Accreditation Actions:

Types of Accreditation Actions; Overview:

In preparation for issuing an accreditation decision, A team from NCAMC will review and discuss the official materials (the request, SAS, and other information related to that college) and issue a decision (by voting) regarding the site-visit to that college and the progress of the accreditation status.

The validity of the accreditation will be for six years, during which the college may request one or more follow-up activities from the NCAMC. After this period, the whole process should be repeated. The NCAMC will review and discuss then approve the decision of the site-visit team, within a month started from the end of the time allowed for objection by that college.

The decision will be either:

1. **Accreditation**: When the college completes the accreditation requirements with a score of more than 40% for each domain with total score 312-395(80-100%).
2. **Conditional accreditation:** When the college score less than 40% for two or less domain and total score 195-311(50-79%). The college must fulfill the requirement within two years to be accredited.
3. **Denied accreditation**: The College will not be accredited if in more than two domain score is less than 40% and the total score is 0-194 (0-49%). The College can reapply for accreditation one year later.

4. The NCAMC follow the accredited colleges annually through the submitted SSR.

C. The Objection:

1. The College has the right to appeal the decision NCAMC within fourteen days from the date of issuance of the final report by that team.

2. The Council will review, discuss and decide (accept or reject) this objection within one month from the submission of the objection by the college.

D. Follow up activities: The NCAMC may require follow-up activities if they determine that the school is not in full compliance with all accreditation standards, or if areas in compliance requiring monitoring are identified.

E. Reporting of NCAMC Accreditation decision:

To Institutions; Within 30 days of the final NCAMC decision with a copy of the final site-visit team report, should be sent to the dean of the medical school. The Letter of Accreditation includes the NCAMC decision, its findings regarding the program's strengths (for full surveys only), areas of noncompliance with accreditation standards, and areas in compliance with a need for monitoring, and any required follow-up. The Letter of Accreditation and final team report are held confidential by the NCAMC.

To External Groups and the Public; Final decisions of accreditation will be conveyed to the public, by posting of the accreditation action on the NCAMC web site.

The current accreditation status of all accredited schools is posted publicly on the NCAMC web site.

APPENDIX I

TEMPLATE OF SITE-VISIT SCHEDULE FOR ACCREDITATION

Accreditation Site Visit to (college Name) by the visit Team Representing NCAMC (Visit Date)

NAME Chair Professional practice (Surgery, Biochemistry, etc.) Professional title (dean, assistant-dean, etc.)

Medical School, University

City, Province

NAME Secretary Professional practice (Surgery, Biochemistry, etc.) Professional title (dean, assistant-dean, etc.)

Medical School, University

City, Province

NAME Member Professional practice (Surgery, Biochemistry, etc.) Professional title (dean, assistant-dean, etc.)

Medical School, University

City, Province

NAME Member Professional practice (Surgery, Biochemistry, etc.) Professional title (dean, assistant-dean, etc.)

Medical School, University

City, Province

Pre-visit day:

4:00 pm….. Team caucus

The team secretary, in collaboration with the faculty accreditation lead, can adjust the topics and time allotted for individual sessions, as well as dividing the team, in order to accommodate the distinctive characteristics of the college being visited.

1st. day:

8:00 am Entrance conference

9:00 am Dean's perspective: Accomplishments, goals, challenges

Discussion items include:

- ❑ Strengths and weaknesses of the school; if appropriate; major current issues.
- ❑ School's goals and directions; principal findings of institutional self-study.
- ❑ Organizational relationships of school with university and teaching hospital(s);

organization of dean's staff; interaction of dean with school's governance organization, councils, committees, and academic departments.

- ❑ Financial status and projections.
- ❑ Research programs and funding.
- ❑ Status of facilities for education, research, and patient care.
- ❑ Faculty development: appointment tracks, promotion, tenure.

11:00 am Educational program design, implementation, management, and evaluation.

Discussion of the following topics:

- ❑ Educational objectives, outcome measures, and how they are integrated throughout the curriculum.
- ❑ General design of the curriculum; coverage of disciplines and subject areas required by accreditation standards.

2:00-3:00 pm Lunch break.

6:00-7:00 pm Drafting report

2nd. Day:

7:45 am. The team is collected at hotel (time tentative based on distance to college)

8:30 am. (cont.) Educational program design, implementation, management, and evaluation

Discussion of the following topics:

•Instructional methods and student assessment strategies for the achievement of the school's objectives

•System for implementation and management of the curriculum; adequacy of resources and authority for the educational program and its management

•Methods for evaluating the effectiveness of the educational program and evidence of success in achieving objectives; comparability of educational experiences at all sites.

11:30am. Break

11:45am. Library and information services

Role of the library and information services in the educational program; adequacy of resources and services for the achievement of college goals

11:15am. Tour of educational and support facilities

Inspection of lecture halls, small group classrooms, labs, and study areas used for education of medical students. Visit to library and computer learning facilities. If time allows, survey team may also review clinical skills labs, student lounge and relaxation

areas, or student services offices. The team may be divided or tour as a group.

1:15pm. Discussion of student life; personal, academic, career, and financial counseling, financial aid; health services; infection control education and counseling; the learning environment and student mistreatment policies; student perspective of the curriculum, teaching, and assessment/grading; students' role and perceived value of student input in institutional planning, implementation, and evaluation.

2:00-300 pm Lunch break

6:00-7:00 pm Drafting report

3rd DAY:

7:45 am. Survey team is collected at hotel

8:30 am. Required courses

Discussion of notable achievements and ongoing challenges in individual courses and; contributions of individual courses and clerkships in achieving institutional educational objectives; adequacy of resources for education, including availability of faculty to participate in teaching; preparation of residents and graduate students for their roles in medical student teaching/assessment.

10:30 am. (Split team)

Group A: Academic counseling and learning environment

Effectiveness of academic counseling; policies and procedures for student advancement and graduation and for disciplinary actions; review of standards of conduct and policies for addressing student mistreatment.

Group B: Career counseling, Electives.

12:15pm. (Split team)

Group A: Admissions; financial aid & debt management counseling and services

Discussion of admissions process, selection criteria, quality of applicant pool; policies and goals; financial aid services.

Group B: Personal counseling; health services

Review of student health services and health and disability insurance; personal counseling and mental health services; immunizations and policies regarding exposure to infectious diseases and environmental hazards

1:00 pm. Break

1:30pm. Special programs; MSc/PhD and other joint degree programs; research for

medical students or educational innovations.

The team secretary should divide the team to cover the required clerkships in the time available.

This session may be used to cover special educational opportunities (e.g., community service programs, rural health education programs, etc.) or educational topics or strategies of which the school is particularly proud.

2:30 pm. Finances

Adequacy of finances for the achievement of the school's missions; recent financial trends and projections for various revenue.

3:00-4:00 pm Lunch break

6:00-7:00 pm Drafting report

4th DAY:

8:15 am. Resources for clinical education.

Meeting with the leadership of major clinical education facilities, focused on the adequacy of resources for medical student education (e.g., physical facilities, patient numbers and variety, regulatory or compliance constraints, etc.). The survey team may split to allow for individual meetings or the team may meet with all affiliates as a group.

10: 30am. Break

11:00 am. Hospital tour

Inspection of clinical, educational, and student support facilities

1:00pm. Clinical departments

Successes and ongoing challenges in administrative functioning of departments; adequacy of resources for all missions (clinical, research, scholarship, teaching); departmental support for faculty and residents; balancing of clinical and academic demands on faculty

2:00pm. Basic science departments

Successes and ongoing challenges in administrative functioning of departments; adequacy of resources for all missions (research, scholarship, teaching); departmental support for faculty and graduate programs; balancing of research and other academic demands on faculty

2:00-3:00 Pm Lunch break

6:00-7:00 pm Drafting report

5th DAY:

8:00 am. Light breakfast with junior faculty

Discussion of faculty development and mentoring; positioning for promotion and tenure; teaching and assessment skills; perceptions of curriculum and students; understanding of institutional goals; role in faculty governance; faculty life

9:00 am. Institutional faculty issues (Tenure and promotion, faculty governance, faculty development, etc.).

Discussion of faculty appointment, promotion, and tenure policies; faculty development opportunities; effectiveness of faculty governance; faculty compensation and incentives; opportunities for collegial interaction among faculty.

10:00 am. Graduate program in basic sciences; basic science and clinical research

Discussion of funding, quality, and review of graduate training programs in basic sciences; levels of scholarly productivity and health of the research enterprise.

11:00Am. Team Caucus and Lunch (Private Session).

1:00 pm. Exit Conference with dean and university leadership.

2:00-3:00 pm Lunch break.

6:00-7:00 pm Drafting report.

APPENDIX II

Site-Visit Team Findings
Visit to college name { / /20 }

Only include standards where there are elements with findings of either "compliance or compliance need monitoring and noncompliance."

Summary of Site-Visit Team Findings:

For each finding, list the element number and full wording under the relevant standard and performance recommendation.

Standard 1:

Element(s) that is/are in compliance and incompliance with need of monitoring select the correct wording based on the number of elements with findings in the category.

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 2:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 3:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 4:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 5:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 6:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 7:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 8:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 9:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

Standard 10:

Element #. Full Wording
Finding:
Element(s) that is/are noncompliance
Element #. Full Wording
Finding:

APPENDIX III

TEMPLATE OF EXIT CONFERENCE AND STATEMENT TO THE DEAN

[Type of Visit and Name of the college] [Date of the visit]

(Beginning of oral statement)During this site-visit, team members assessed the medical education program at the **[Name of the college]** using the standards outlined in the NCAMC guidelines." The purpose of this exit statement is to report the team's findings to you.

The team secretary will draft a site-visit report, in which the findings are linked to specific accreditation standards and includes compliance recommendations. You will have an opportunity to review a draft of this report prior to its submission to the NCAMC. The details of this process are summarized in the printed copy of this statement that I will give to you following the conclusion of my verbal report.

The team expresses its sincere appreciation to [Name of the Dean] and the staff, faculty, and students of the [Name of the college] for their many courtesies and accommodations during the site-visit. [Insert the names of individuals who] merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the survey.

This report summarizes the findings and professional judgments of the site-visit team that visited the [**Name of the college**] on [**Date of the Visit**], based on the information provided by the college and its representatives before and during the accreditation survey.

The findings should be listed in order by the standard the team believes is the relevant standard. The finding will be linked to the standard in the draft report so the team needs to have had that conversation prior to the end of the visit. The reason is that the team may not link the finding to the most appropriate standard and allows the Secretariats to provide guidance during the review period.

For example:

Standard 1 (name of standard)

Finding:

Standard 2

Finding:

Standard 3

Finding:

This concludes the team's findings.

Next steps:

A draft Site-visit report will be prepared in which the team's findings will be linked to accreditation standards along with compliance recommendations identified as: 1) areas in compliance, 2) areas in compliance with a need for monitoring, or 3) areas in noncompliance. The team secretary will send the report to you. You will have ten working days to provide feedback on factual errors and concerns about the tone of the report. Editorial comments on the report are welcomed, but not required.

Factual errors or concerns regarding the tone of the report should be detailed in a letter/email to the team secretary. Errors can be noted with corrections, and comments made using Track changes. The letter/e-mail may only reference information contained in the briefing book, submitted by your program, or in documents provided to the site-visit team before or during this visit. Actions taken or information discovered after the visit will not be considered. This letter is the only opportunity you will have to provide feedback on the content of the report and will not be shared with the NCAMC.

When the report is finalized, the team secretary will notify you in writing that the report has been revised to address errors of fact and tone based on the judgment of the team.

If you have any remaining concerns about the process of this site visit or the tone of the report you may write a letter to NCAMC.

Once the NCAMC have made its determinations, you will receive a copy of the final report, along with a letter of accreditation that specifies the accreditation status of the medical education program and any required follow-up.

This concludes the Exit Session.

Please be advised there is no discussion of the findings after the exit statement has been read. The chair can clarify the subsequent steps but should not engage in conversations about what the accreditation committees are likely to do with respect to accreditation status or follow-up. There can be no discussion or debate about the team findings. The dean will have an opportunity to address errors as noted in the text above. The team can allow the dean to decide if he/she would like to have one exit session which the university president also attends.

APPENDIX IV

SITE-VIST REPORT OF

THE

NAME OF UNIVERSITY
NAME OF COLLEGE

City, State

Date of Survey

PREPARED BY SITE-VISIT TEAM

FOR THE

National Council for Accreditation of Medical Colleges, NCAMC

TABLE OF CONTENTS Page

Standard 4:

Elements

Standard 5:

Elements

Standard 6:

Elements

Standard 7:

Elements

Standard 8:

Element

Standard 9:

Elements

Standard 10:

Elements

MEMORANDUM
TO: National council for accrediting medical colleges

FROM: The Secretary of the SITE-VIST team That Visited [Name of COLLEGE] on [Dates]

RE: Report of the SITE-VISIT Team

On behalf of the NCAMC site-visit team that visited the [Name of college] on [Dates], the following report of the team's findings is provided.

Respectfully,

[Name], Secretary

INTRODUCTION

A sit-visit of the [Name of college] was conducted on [Dates], by the following team representing the

National council for accrediting medical colleges

Chair:
Name (Professional Specialty)
Title
Institution
City & State

Secretary:
Name (Professional Specialty)
Title
Institution
City & State

Member:
Name (Professional Specialty)
Title
Institution
City & State

Member:
Name (Professional Specialty)
Title
Institution
City & State

LCME Faculty Fellow:
Name (Professional Specialty)
Title
Institution
City & State

[SAMPLE]
The team expresses its sincere appreciation to Dean [Name] and the staff, faculty, and students of [Medical School Name] for their many courtesies and accommodations during the survey visit. (Others' names) merit special recognition and commendation for their thoughtful visit preparations and generous support during the conduct of the survey.

ACCREDITATION HISTORY
THE DATA COLLECTION AND COLLEGE SELF- ASSESSMENT STUDY

[Briefly note the following:
- Quality of the DC
- Involvement of faculty, students, other stakeholders in the Institutional Self-Assessment Study
- Correlation between the college SAS. findings and the team findings.

HISTORY AND SETTING OF THE college

[Briefly summarize the relevant history of the school]

STANDARDS

Standard 1:
Detailed description
ELEMENTS
Standard 2:
Detailed description
ELEMENTS
Standard 3:
Detailed description
ELEMENTS
Standard 4:
Detailed description
ELEMENT
Standard 5:
Detailed description
ELEMENTS
Standard 6:
Detailed description
ELEMENTS
Standard 7:
Detailed description
ELEMENTS
Standard 8:
Detailed description
ELEMENTS
Standard 9:
Detailed description
ELEMENTS
Standard 10:
Detailed description
ELEMENTS

Appendix V
Examples of questionnaire

These are Example of questionnaire the college may use for self-assessment study. These can be modified according to the college size, number of staff, and stakeholders (Dean, faculty, students, health and education authorities, health association and community representative**).**

1. Vision, Mission and Objectives Statement:

Please; respond to the following questions as part of your contribution to improve your college performance.

Please choose one; faculty member ( ), graduate ( ), student ( ), administrator ( ),

Target	Questions	Presentation
Curric commtt faculty	Are mission and objectives used for planning and monitoring?	yes ( )no( )
Stakeholders	Do you participate in setting of vision, mission, and objectives?	yes ( ) no ( )
stakeholders	Have mission and objectives been made known to you?	yes ( ) no( )
Faculty students	Are you aware about change in program, polices, and procedures?	Strongly agree ( ), Agree( ) disagree( ), strongly disagree ( )
stakeholders	Are mission and objectives used to select curriculum content, for learning experience	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
stakeholders	Are the mission and objectives used in evaluation of effectiveness of curriculum?	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
stakeholders	Are linkage of the learning and curriculum objective are well defined?	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )

2. The Medical Curriculum:

Target	Components	presentation
Students graduates	Does curriculum provide you with learning opportunities in all disciplines to practice safely?	Strongly satisfied( ), moderately satisfied( ), unsatisfied ( ), unsatisfied at all( )

graduates	Does the curriculum prepare you for critical thinking and lifelong learning?	Yes( ), No( )
Stakeholders	Satisfaction with Curriculum objectives content	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Stakeholders	Does the curriculum contain all items?	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Faculty Students graduates	Do students acquire knowledge, skills, attitude in health promotion and other disciplines	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Faculty, students, graduates	Relevance of content of basic science to objectives	Strongly satisfied( ), moderately satisfied( ),unsatisfied( ), unsatisfied at all( )
Faculty, students, graduates	Are Humanitarian values are taught in clinical science?	Strongly satisfied( ), modrately satisfied( ), unsatisfied( ), unsatisfied at all( )
Faculty, students, graduates	Are the level of knowledge and understanding .skills and attitudes expected of the students at each phase of the curriculum known to Faculty, students, graduates?	Yes( ),No( )
Faculty, students , graduates	Presence of new teaching methods fosters students-center teaching, analytic thinking and life-long learning?	Yes( ),No( )
Students	Do they have adequate knowledge about new technologies?	Yes( ),No( )
Students graduates	Determine how early exposure of student to clinical setting?	Fact / opinion
Faculty and student	Presence of training in different setting as rural hospitals, community clinics...etc.	Yes( ),No( )
Faculty and student	Training in PHCC, community clinics, on common transient conditions	Yes( ),No( )
Students	Does have a project	Yes( ),No( )
Students graduates	Do you have training on issue medical ethics	Yes( ),No( )

3. Students Assessment:

Target	Components	presentation
students	Are assessment method made known to students	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Faculty students	Presence of continuous assessment (formative exam)	Yes( ), No( )

Faculty, students graduates	To examine the percentage of clinical in clinical disciplines	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Students graduates	Presence of training on communication skills and attitude toward patient and team	Yes( ),No( )
Students graduates	Presence of training on communication skills and attitude toward health care team	Yes( ), No( )

4. Program Evaluation:

Target	**Components**	**presentation**
Faculty, students	Have the students and d faculty role in evaluation and feedback	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Document	feedback mechanism is important element in program evaluation	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Curriculum committee faculty	Does the college has a mechanism to respond to community	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )

5. Students:

Target	**Components**	**presentation**
Students	Presence of advisory board	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
students	Availability of immunization program	Yes( ), No( )
Faculty, students	Presence of elective activities	Yes( ), No( )

6. Staff:

Target	**Components**	**presentation Yes( ), No( )**
Faculty ,students	Presence of recruitment and promotion university regulations	Yes( ), No( )
Faculty	Presence of appointments between basic and clinical science	Yes( ), No( )
Faculty	Presence of part time appointments	Yes( ), No( )
Faculty	Presence of appointments between college and hospital	Yes( ), No( ),not

Faculty	Staff have access to development program	Yes( ), No( )
Faculty	Presence of evidence based Teaching facilities	Yes( ), No( )

7. Educational Resources:

Target	Components	presentation
Faculty curriculum committee	is the physical resources responds to curriculum changes	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Hospital administrators	Are affiliated health institutions are accredited	Yes( ), No( )
Faculty, students	All specialties are present at affiliated hospitals	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Faculty , students	Presence of ambulatory care services	%opinion Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Faculty , students	Availability of educational facilities in hospitals	Yes( ), No( )
Students, graduates	Availability of welfare facilities	Yes( ), No( )
Students, graduates	Spaces for sport and elective activities	Yes( ), No( )

8. Governance and Administration of the Medical College:

Target	Components	presentation
Curriculum committee	Obvious line for control over curriculum	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Faculty and senior hospital administration	Sharing of college objectives	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
College administrator	Other sources of funding, if present?	%opinion Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Staff	Are they informed about responsibilities	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
Staff, students	Presence of a site for all policies and regulations	Yes( ), No( )
faculty	The college is committed to Iraqi regulations	Yes( ), No( )

9. Research:

Target	Components	presentation
stakeholders	Presence of research environment	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )
Faculty	Presence of balance in areas for researches	Strongly agree ( ), Agree( ) disagree( ),strongly disagree ( )
students	Availability of opportunities for research's during study	Strongly satisfied( ), moderately satisfied( ), unsatisfied( ), unsatisfied at all( )

10. Continuous Professional Development:

Target	Components	presentation
faculty	Are you participating in CME	Yes( ), No( )

APPENDIX VI

STAKEHOLDERS INTERVIEW

Instructions to the interviewer:

1. Introduce yourself
2. Explain the reason for interview
3. Agree on time limits and keep to them. Interviews should be kept to around an hour in length.
4. Ask factual questions before opinion ones
5. Use probes or exploratory issues as needed. Probes include:
6. Would you give me an example?
7. Can you elaborate on that idea?
8. Would you explain that further?
9. I'm not sure I understand what you're saying.
10. Is there anything else?
11. Do not read out the choices mentioned below some of the explanatory questions. Use them as suggestions and as a guide for recording responses.
12. Inform about conditions of confidentiality.
13. Ask permission for use of tape recorder and/or note-taking if you are to use.
14. Paraphrase: let the respondent see a summary of the findings of the interview.

General information:

- Interviewer(s):
- Date of interview:
- Name of person interviewed:
- Position:

Introduction (Including informed consent):

I want to thank you for taking the time to meet with me today. My name is _____. In an attempt for self-assessment and improvement of the educational program, this structured interview was designed for key stakeholders for evaluation of their satisfaction and level of participation in addition to assessment of various educational activities relevance to later practice. The interview should take less than an hour. I will be taping the session because I don't want to miss any of your comments. Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent, if this is your wish. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time. Are there any questions about what I have just explained? Are you willing to participate in this interview?

Signed Interviewee Signed Interviewer Date

Core questions and Exploratory Issues:

- This interview guide identifies core questions that should be covered in stakeholder interviews in each review site. While each individual stakeholder may not be able to address each core question, the combination of interviews in each site should cover the core questions. However, reviewers will need to make judgments about which of the questions to be covered should be pursued with each individual stakeholder.

- Each core question is followed by a list of exploratory issues that reviewers should pursue, as appropriate, in the interview. As with the core questions, some of the exploratory issues will be more or less applicable to individual stakeholders.

- Notes from the interview are recorded on the Stakeholder Interview Guide form to be later summarized and interpreted by the survey team.

1. **Curriculum**
Core Question: Describe the extent to which the school educational program is appropriate to produce a competent basic doctor and lifelong learner?
Probing and Exploratory Issues **itution? (More than one item may be chosen)** **□ Discipline-based □ Integrated □ Community-based** **□ Problem-based □ Systematic □ Hospital-based** **□ Student-centered □ Teacher-centered** **□ Were you ever a member of the curriculum committee of the institution?** **□ If yes, what was your contribution?** **□ Are you aware of the competencies required from the graduates of the school?** **Show the interviewed stakeholder the list of school competencies then ask:** **□ Do you think that the institution's educational program will lead to achievement of those competencies? Elaborate** **□ Do you think that those competencies are sufficient to produce competent physicians? Elaborate** **□ Do the competencies expected from the school student upon graduation match your expectations for a safe basic doctor practice?**

□ Would you like to add any other competencies to those predetermined by the school?
□ How would you judge the alumni readiness for postgraduate medical training upon graduation?
□ To what extent does the curriculum encourage the development of each of the following scientific methods?
Critical thinking
□To a great extent □To some extent □To little extent □No existence of such methods
Analytical thinking
□To a great extent □To some extent □To little extent □No existence of such methods
Evidence-based medicine
□To a great extent □To some extent □To little extent □No existence of such methods
Continuous self-learning
□To a great extent □To some extent □To little extent □No existence of such methods

Please use separate paper for feedback

3. Students

Core Question: In your opinion, are the size and nature of student intake decided in consultation with the relevant stakeholders and reviewed periodically to meet the needs of community and society.

Probing and Exploratory Issues
□ Do you know the student admission policy of the school?
□ Are you satisfied with this students' admission policy? Elaborate
□ Have you ever been consulted about the size and nature of student intake?
□ If yes, what was your opinion? And was it taken into consideration in the actions of the school or relevant decision making authorities?
□ Is the admission policy regulated periodically to meet the needs of community and society? If yes, elaborate.
□ If no, what are the obstacles in your opinion to such periodical review?

Please use separate paper for feedback

2. **Program evaluation**

Core Question: How are the principal stakeholders within the medical school involved in program evaluation?

Probing and Exploratory Issues
□ Have you been ever asked to give your feedback about the educational program of the institution?
□ Have you ever been asked to share in program evaluation of the institution?

□ If yes, how? To what extent or in which parts of the evaluations were stakeholders involved?
□ Have you ever been informed of the results of program evaluation of the institution?
□ If yes, how?
□ To what extent are stakeholders involved in the evaluation and development of the program? (Ask about numbers and positions of those involved)
□ What difficulties were encountered in the nearest e
aluation you shared in? What actions were taken to resolve them?

Please use separate paper for feedback

3. **Governance and administration**

Core Question: How are the principal stakeholders within the medical school involved in the governance and organizational structure of the school?

Probing and Exploratory Issues
□ Are you a member in any of the school committees?
□ Are you a member in the School Board?
□ Is there any sort of collaboration between you and the school? Elaborate
□ In your opinion, is the stakeholders' representation and contribution to the governance and administration of the school adequate?

Please use separate paper for feedback

4. **Overall satisfaction of program quality**

Core Question: Are you satisfied with the overall quality of the educational program?

How would you describe the school graduates performance in the workplace as compared to other schools graduates?
□ Would you recommend this program to prospective students?
□ In your opinion, what are the most important points of strength about the medical school?
□ In your opinion, what are the most important points of weakness about your medical school?
□ Mention threats (if any).
□ Mention opportunities (if any).

Please use separate paper for feedback

Students' interview guide:

The interview guide used for the self-study can be used during the various targeted populations during the site visit. The following areas may be added as relevant:

Assessment of Students
Core Question: In your opinion, are the assessment methods clearly compatible with educational objectives and can promote learning? **Probing and Exploratory Issues** **□ As far as you know, are there any new assessment methods introduced recently to your assessment system?** **□ Are the number and nature of examinations assessing the various curricular elements to encourage integrated learning?** **□ As regards the methods of students' students, is there a balance between formative and summative assessment?**
Educational resources
Core Question: Does the school have sufficient resources to ensure that the curriculum can be delivered adequately? **Probing and Exploratory Issues** **□ Do you think …… is available sufficiently as an educational resource** **□ Physical facilities □ Clinical experience** **□ Clinical training facilities □ Educational expertise** **□ Information technology** **□ Does the school have a policy that fosters the relationship between research and education?** **□ Please describe the research facilities and areas of research priorities at the institution** **□ Does the school provide appropriate resources to facilitate regional and international exchange of academic staff?**

5. **Mission and Objectives**

Core Question: How has the school involved its principal stakeholders in formulating and reviewing the mission and objective statements?

Probing and Exploratory Issues

- **Do you know the mission of the medical school?**
- **Do you think …… is well represented in the mission?**
  - **a- Social responsibility. b- Research attainment. c- Community involvement. d. Readiness for postgraduate training**
- **Have you participated in either mission formulation or review?**
- **If yes, what was your share?**
- **What actions did the school take to encourage stakeholder involvement in formulating and reviewing the mission and objective statements?**

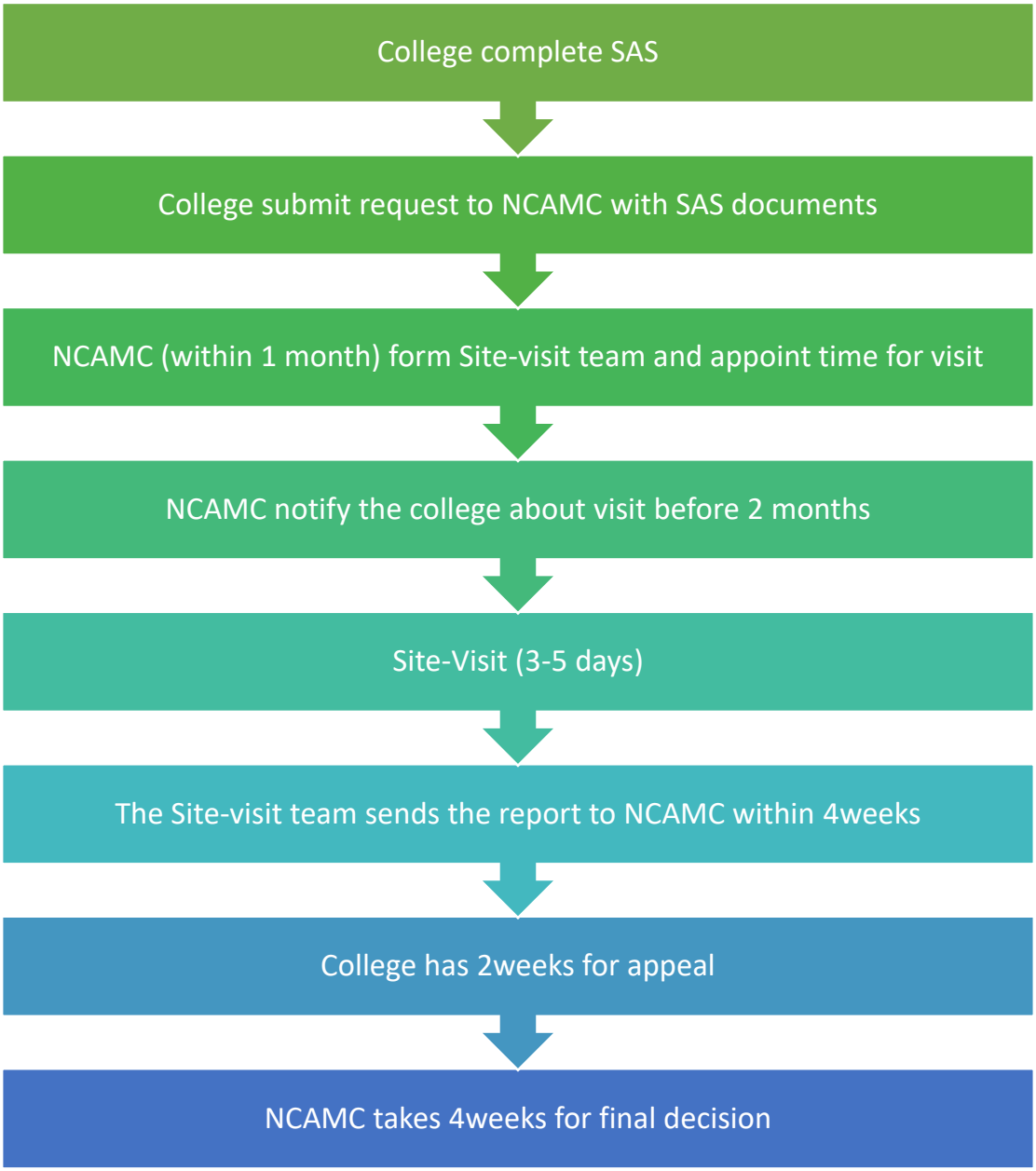
Show the school general objectives to the interviewed stakeholder then ask:

- **In your opinion, do the school general objectives reflect the mission?**

Please use separate paper for feedback

APPENDIX VII

ACCREDITATION PROCESS TIMING



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