From Soviet Legacy to Asian Integration: Transitioning Medical Education in Mongolia Compared to Russia and Japan

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Abstract

Mongolia's medical education system stands at a unique crossroads, shaped by its Soviet-era foundations and increasingly influenced by modern East Asian models. This comparative study explores the evolution of Mongolia's medical education in relation to the enduring legacy of Russian pedagogical frameworks and the emerging impact of Japan's integrative, patient-centered, and internationally oriented approaches. Using a qualitative approach including policy analysis and document review, the research investigates curriculum structures, clinical training models, accreditation standards, and international cooperation strategies across the three countries. The analysis reveals how Mongolia is navigating a gradual transition from rigid, centrally planned systems toward more competency-based and globally aligned frameworks. While deep-rooted institutional legacies continue to anchor Mongolia to Russian educational philosophies, increasing regional cooperation, particularly through partnerships with Japanese institutions such as Tokushima University, signals a shift toward hybridized models. The study offers critical insights into how post-socialist education systems can modernize medical training while preserving national identity and strategic autonomy.

Keywords: medical education reform, post-Soviet transition, comparative education, East Asian integration, hybridized models, Tokushima University

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Introduction

Mongolia's medical education system exists at the intersection of historical legacy and regional transformation (Rossabi, 2005). Shaped profoundly by its socialist past and decades-long alignment with the Soviet Union, Mongolia inherited a centralized and discipline-driven model of medical training (WB, 2007). This system, modeled after the Soviet Semashko approach, emphasized theoretical instruction and state-directed planning, establishing a robust infrastructure for healthcare delivery across the nation (Bashkuev, 2023; WHO, 2014). While this system laid the foundational infrastructure for producing healthcare professionals in a low-resource setting, its rigidity and limited responsiveness to global trends have prompted increasing calls for reform (Badamdorj et al., 2024). In recent years, Mongolia has intensified its engagement with East Asian neighbors, particularly Japan, stimulating a re-evaluation of pedagogical philosophies, curriculum structures, and international benchmarks. The establishment of the Mongolia–Japan Hospital of the Mongolian National University of Medical Sciences (MNUMS) in 2019, supported by the Japan International Cooperation Agency (JICA), exemplifies this collaborative effort to modernize medical education and healthcare delivery (Montastudio.M, 2019). This transitional moment presents an opportunity to examine how Mongolia navigates the dual imperatives of modernization and continuity in its approach to medical education (Bashkuev, 2023).

A comparative analysis of Mongolia, Russia, and Japan is especially pertinent for several reasons. First, Russia represents the enduring influence of Soviet-era educational frameworks that continue to anchor many institutional norms and policies in Mongolia. The Russian model, characterized by centralized control, theoretical emphasis, and limited patient-centered training, provides a reference point for understanding what Mongolia seeks to retain or move beyond (Artman, 2022; Bashkuev, 2023). In contrast, Japan offers a strikingly different approach, one marked by integration with global standards, strong quality assurance mechanisms, and an emphasis on holistic, patient-centered care (Honda et al., 2022; Kuwabara et al., 2015). As Mongolia increasingly participates in regional partnerships and international academic exchanges, Japan's model provides both inspiration and a benchmark for reform (JICA, 2014; WHO, 2014).

This study is guided by three core research questions. First, how has Mongolia's medical education evolved from its Soviet roots? This question explores the persistence and transformation of foundational structures, including curriculum design, clinical training, and faculty governance. Second, what elements of Japanese medical education are influencing Mongolia's reform efforts? This inquiry focuses on the adoption—or adaptation—of Japan's more integrative and internationally oriented practices. Third, what policy patterns and gaps emerge in Mongolia's transition? By analyzing formal documents, accreditation standards, and intergovernmental cooperation, this study identifies both progress and friction points in the reform process.

By placing Mongolia within a triadic comparative framework, this research offers critical insights into how post-socialist education systems can adapt to new regional dynamics while preserving their national identity and strategic autonomy. It also contributes to the broader discourse on educational hybridization and cross-cultural policy borrowing in the field of global health education.

Background and Theoretical Framework

Medical education systems are shaped not only by national health priorities but also by historical, political, and cultural forces. Understanding the evolution of Mongolia's medical education, and how it contrasts with the trajectories of Russia and Japan, requires situating each within its broader institutional context. This section outlines the historical development of medical education in the three countries and introduces the theoretical lens guiding this comparative analysis.

Mongolia: Soviet-Influenced Structure Post-1945

Modern medical education in Mongolia began in earnest after World War II, when the country deepened its political and institutional alignment with the Soviet Union. The establishment of the first medical school in 1942, under strong Soviet guidance, marked the beginning of a centralized, state-controlled education model, heavily influenced by the Semashko health system (Bashkuev, 2023; WHO, 2014). This system emphasized discipline-specific knowledge, theoretical rigor, and hierarchical authority in both academic and clinical training. Medical students were trained through rigid curricula with limited exposure to interdisciplinary learning or patient-centered care. While this model allowed Mongolia to develop a functional healthcare workforce in a resource-limited context, its inflexibility and limited engagement with global innovations have increasingly posed challenges in a rapidly globalizing world (Badamdorj et al., 2024).

Russia: Continuation and Reform of Centralized Medical Curricula

Russia, as the originator of Mongolia's medical education blueprint, continues to operate under a similarly centralized model, albeit with gradual reforms. The traditional Soviet curriculum remains largely intact in many institutions, prioritizing theoretical sciences in the early years and delaying clinical exposure (Markosian et al., 2020). While accreditation systems and institutional autonomy have improved since the dissolution of the USSR, core structural features such as specialization from the undergraduate level and state-controlled planning persist. However, Russia has made notable efforts in recent decades to update its system through initiatives that promote clinical simulation, international partnerships, and modular curriculum design (Kapitonova et al., 2020). These reforms, though unevenly implemented, indicate an ongoing tension between tradition and transformation.

Japan: Flexibility, Patient-Centered Training, and Internationalization

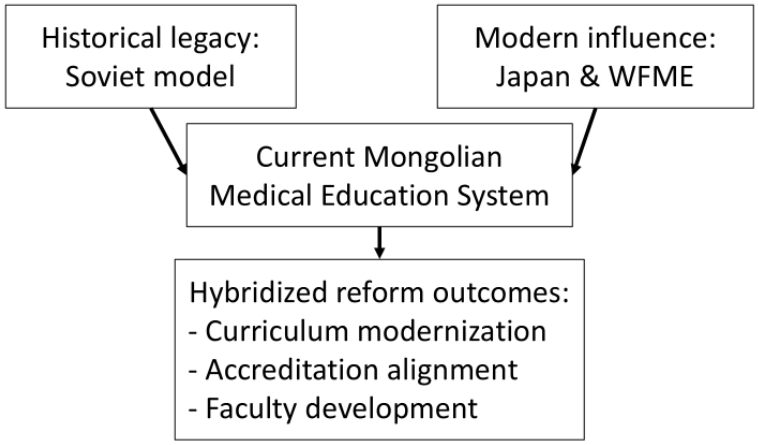
In contrast, Japan's medical education system has undergone significant modernization since the post-war U.S. occupation, evolving toward a more flexible, student-centered model. Core elements of Japan's contemporary approach include early clinical exposure, emphasis on communication and ethics, and increasing integration with global standards (Honda et al., 2022; Kuwabara et al., 2015). Japanese medical schools are also heavily involved in international collaboration, research exchange, and the implementation of accreditation systems aligned with World Federation for Medical Education (WFME) guidelines (JACME, 2021; Mori et al., 2023). The curriculum increasingly balances biomedical knowledge with soft skills, promoting a holistic understanding of patient care. Importantly, Japan's ability to incorporate global influences while maintaining cultural and institutional autonomy (CMEI, 2024) makes it a compelling model for countries like Mongolia that seek to modernize without losing national identity.

Theoretical Framework: Comparative Educational Transition

This study is grounded in the theory of policy borrowing and educational transfer (Phillips & Ochs, 2004), which explores how nations adopt, adapt, or resist educational models from other countries. In Mongolia's case, this framework helps analyze how elements of both Russian legacy and Japanese innovation are selectively integrated. The study also draws on path dependency theory, which emphasizes how historical institutional choices constrain current reforms (Pierson, 2000). In parallel, post-socialist institutional change theory emphasizes how former socialist systems undergo hybridized, non-linear transformations where imported reforms are filtered through entrenched bureaucratic norms, political legacies, and informal institutional practices (McDermott, 2002). Together, these frameworks explain how Mongolia remains anchored to its Soviet-influenced structures while also being propelled by regional trends toward East Asian modernization. The result is a hybridized model of medical education reform, simultaneously traditional and transformative, shaped by both internal legacy and external inspiration. The following conceptual framework (Figure 1) synthesizes the theoretical foundations guiding this study. It illustrates how Mongolia's medical education system is positioned at the intersection of Soviet legacies and East Asian influences, and how both external and internal forces shape its ongoing hybridization process.

Figure 1

Conceptual Framework of Mongolian Medical Education



Methodology

This study adopts a qualitative comparative approach, appropriate for analyzing the complex, historically embedded, and policy-driven nature of medical education systems across Mongolia, Russia, and Japan. The methodology is grounded in interpretive inquiry, aiming to uncover patterns, meanings, and institutional logics within the evolution of medical education reform in post-socialist and East Asian contexts.

Policy Analysis

The primary methodological tool employed is policy analysis, focused on official national and institutional-level education policies. This included a review of national medical education strategies and university accreditation standards to understand each country's overarching vision for training physicians. Special attention was paid to how these policies reflect differing

priorities such as theoretical rigor in Russia, integrative pedagogy in Japan, and transitional hybridity in Mongolia.

Official policy documents were collected from the respective Ministries of Health and Education in each country. For Mongolia, documents were sourced from the Ministry of Education and Science and the Ministry of Health, including national strategies for human resources in health. For Russia, official standards from the Ministry of Health of the Russian Federation and the Federal Service for Supervision in Education and Science (Rosobrnadzor) were examined. For Japan, policies from the Ministry of Education, Culture, Sports, Science and Technology (MEXT), as well as guidelines from the Japan Accreditation Council for Medical Education (JACME), were reviewed. These materials were analyzed thematically, with particular focus on curricular goals, accreditation logic, and reform timelines.

Document Review

To complement the policy analysis, a document review was conducted using primary and secondary sources. This included curricular frameworks and syllabi from selected medical universities in each country, specifically the Mongolian National University of Medical Sciences (MNUMS), Sechenov University in Russia, and Kyoto University in Japan. These curricula were analyzed to compare content structure, clinical exposure, emphasis on soft skills, and alignment with international standards.

In addition, guidelines issued by international organizations such as the World Health Organization (WHO), WFME, and United Nations Educational, Scientific and Cultural Organization (UNESCO) were reviewed to establish normative benchmarks in global medical education. These served as reference points to assess how closely the national systems align with globally accepted competencies, quality assurance mechanisms, and internationalization strategies.

Finally, national licensing board requirements and reform reports were analyzed to understand the mechanisms for physician certification and how reforms have responded to international pressures or domestic needs. Examples include Japan’s national medical licensing exam reforms, Mongolia’s ongoing attempts to align with ASEAN medical mobility standards, and Russia’s federal mandates for continuous professional development (CPD) and simulation-based training.

By triangulating policy texts, institutional documents, and global guidelines, this methodology enables a nuanced understanding of how each country conceptualizes, structures, and implements medical education. The analytical approach is interpretive and comparative, identifying both convergence and divergence among the three cases.

Comparative Analysis

This section presents a structured comparison of the medical education systems in Mongolia, Russia, and Japan across four key dimensions: curriculum structure, clinical training pedagogy, accreditation and regulation, and internationalization. The aim is to identify commonalities, contrasts, and emerging hybrid models that illustrate Mongolia’s ongoing transition.

Curriculum Structure and Content

At the heart of the comparative divergence lies the curriculum structure. Mongolia's medical education system, largely modeled after Soviet traditions, continues to reflect a discipline-focused, content-heavy approach. Subjects such as anatomy, physiology, and pathology are taught in isolation during the early years of training, often without contextual integration or clinical relevance. This mirrors Russia's continued adherence to a theoretical, lecture-driven model, where early exposure to the biomedical sciences is emphasized, and specialization begins at the undergraduate level (Semenova et al., 2024).

By contrast, Japan has increasingly adopted a competency-based curriculum, emphasizing outcomes such as clinical reasoning, communication, and interprofessional collaboration. Curricular reforms initiated in the 2000s, including the Model Core Curriculum and alignment with global standards, have helped shift the focus toward integrated learning and patient-centered care (Honda et al., 2022; Kuwabara et al., 2015). Mongolia has recently shown interest in these developments, piloting modular courses and beginning to revise syllabi at institutions like MNUMS. However, reform efforts remain uneven and are constrained by legacy systems and faculty training gaps.

Clinical Training and Pedagogy

In clinical training, the timing and pedagogy of patient exposure differ markedly across the three systems. In Russia and Mongolia, clinical immersion traditionally begins in the later years of medical school. Students often face limited opportunities for hands-on training early in their education, relying heavily on didactic lectures and observation. While simulation-based methods are gaining attention, especially in Russia's larger medical universities, the implementation remains inconsistent and underfunded (Sociales & Strandstrem, 2023).

Japan, on the other hand, has adopted a "early and continuous clinical exposure" model. From the third year onwards, students participate in bedside learning, clinical clerkships, and structured rotations. Moreover, Japanese pedagogy increasingly integrates active learning methods, such as problem-based learning (PBL), skills labs, and team-based clinical decision-making (Onishi, 2018). These innovations contribute to a more holistic training experience and are gradually being observed by Mongolian educators through exchange programs and faculty development workshops.

Accreditation and Regulation

Accreditation mechanisms further reveal the contrasting logics of system governance. Russia maintains a strong tradition of centralized accreditation, overseen by federal agencies such as Rosobrnadzor and the Ministry of Health. This system ensures uniformity but often lacks responsiveness to international standards, particularly those set by the WFME.

In contrast, Japan has implemented a robust national accreditation system through JACME (Japan Accreditation Council for Medical Education), which was officially recognized by WFME in 2017. JACME's accreditation criteria incorporate global best practices, including student assessment transparency, faculty qualifications, and quality improvement protocols (JACME, 2021).

Mongolia is currently in a transitional phase, seeking alignment with WFME standards in preparation for full international recognition. The country's Ministry of Education and Science, in partnership with the Ministry of Health and MNUMS, has initiated reforms in licensing and institutional accreditation. However, resource limitations and institutional inertia have slowed progress, with many universities still operating under outdated evaluation criteria (Badamdorj et al., 2024).

Internationalization and Regional Integration

Perhaps the most dynamic aspect of Mongolia's medical education reform is its increasing regional integration, particularly with Japan. In recent years, partnerships with Japanese universities—including Kyoto University and Osaka University—have enabled faculty exchanges, collaborative research, and student mobility. A key milestone was the establishment of the Mongolia–Japan Teaching Hospital in 2019, supported by JICA, which serves as both a clinical training site and a symbol of bilateral cooperation (JICA, 2022; Montastudio.M, 2019).

In terms of student mobility, Japan has positioned itself as a leader in hosting international medical trainees, although linguistic and licensing barriers remain. Russia, while traditionally a major destination for Mongolian medical students, has seen declining attractiveness due to bureaucratic and quality concerns. Meanwhile, Mongolia has begun sending students and faculty to East and Southeast Asia for training and joint degrees, reflecting a gradual pivot toward Asia-oriented educational diplomacy.

National policies regarding foreign graduate integration further illustrate system priorities. Japan has slowly opened its system to international graduates through structured pathways, while Russia continues to offer broad but rigid recognition protocols. Mongolia, still in the process of revising its licensing laws, faces challenges in evaluating foreign degrees and ensuring consistent standards.

Partnership With Tokushima University

A notable dimension of Mongolia's internationalization in medical education is its long-standing and multifaceted collaboration with Tokushima University in Japan. This partnership was first formalized through an interdepartmental academic exchange agreement in 2005, later extended to an intercollegiate agreement in 2007, laying the groundwork for comprehensive academic, clinical, and research collaboration between the two institutions (TU, 2018). The relationship has evolved into a flagship model of bilateral cooperation, with wide-ranging impacts on Mongolia's medical education reform and healthcare infrastructure.

One of the most tangible outcomes of this collaboration is Tokushima University's role in supporting the establishment and capacity-building of the Mongolia–Japan Teaching Hospital (MJTH), the first university-affiliated teaching hospital in Mongolia. Opened in 2019 with technical and financial support from JICA, MJTH is a cornerstone of Mongolia's efforts to integrate modern, patient-centered care into clinical training (JICA, 2022). Tokushima University provided expert consultation in hospital planning, departmental design, and operational protocols, ensuring that MJTH could reflect Japanese standards while adapting to the Mongolian context (JICA, 2022).

Beyond infrastructure development, the collaboration has significantly contributed to human resource development. Tokushima University has conducted specialized training programs for

Mongolian physicians, nurses, and administrative personnel in key areas such as emergency medicine, infection control, nursing care, hospital administration, and medical education pedagogy (JICA, 2022; TU Hospital, 2017). These programs, implemented through both on-site training and technical cooperation missions, introduced Japanese models of interdisciplinary teamwork, ethical patient communication, and efficient hospital workflow—features still underdeveloped in Mongolia's Soviet-legacy system.

Importantly, the collaboration also encompasses student and faculty exchange, including clinical observation, joint seminars, and mutual visits. Although temporarily suspended due to the COVID-19 pandemic, these exchanges resumed in an online format in 2024, with continued plans for in-person engagement in the near future (TU, 2024). The educational interaction has also involved joint research projects, particularly in areas such as medical simulation, community health, and geriatric care, fields in which Japan's expertise provides valuable guidance for Mongolia's reform efforts.

This partnership exemplifies the policy borrowing and educational transfer process in action: Mongolia selectively adopts Japanese best practices—not as wholesale imports but as models to be contextually adapted through trusted partnerships. It also illustrates the post-socialist institutional change paradigm, where reform is less about immediate transformation and more about sustained, incremental capacity building grounded in regional trust and shared educational values. As such, the Tokushima–Mongolia collaboration stands as a critical case of how regional academic diplomacy can drive both systemic modernization and localized adaptation in medical education.

Discussion

The comparative analysis of medical education systems in Mongolia, Russia, and Japan reveals both structural contrasts and converging trends, particularly in the evolving trajectory of Mongolian medical education. This section synthesizes the findings through the lens of hybridization, policy reform gaps, cultural-system alignment, and broader implications for national health outcomes.

Hybridization in Mongolian Medical Education

Mongolia's medical education is undergoing a hybridization process, shaped by the legacy of Soviet-era structures and the growing influence of East Asian, particularly Japanese, models. While the foundational architecture—such as discipline-based curricula and delayed clinical immersion—remains aligned with the Russian model, Mongolia has incrementally incorporated components of competency-based education, early patient exposure, and soft-skill development. The involvement of Japanese institutions, especially through partnerships with Tokushima University and the Mongolia–Japan Teaching Hospital, has facilitated the selective transfer of pedagogical innovations like problem-based learning, skills labs, and quality assurance mechanisms. This hybrid model, though still in transition, reflects a pragmatic approach to reform—balancing modernization with institutional memory and resource constraints.

Policy Gaps and Opportunities for Reform

Despite this progress, several policy gaps persist that hinder the pace and depth of reform. Mongolia lacks a cohesive national strategy that clearly articulates the competencies expected

of medical graduates in line with global standards such as those set by the WFME. Accreditation processes remain uneven, and licensing reforms have not yet fully addressed issues of international recognition and workforce mobility. Moreover, simulation-based education and faculty development programs remain underfunded or absent at many institutions. However, these gaps also represent opportunities for reform—particularly in aligning Mongolia's national medical education strategy with ASEAN frameworks, expanding regional partnerships, and investing in digital and blended learning tools to overcome geographic disparities.

Cultural Compatibility vs. System Efficiency

One of the critical tensions in Mongolia's reform journey is the trade-off between cultural compatibility and system efficiency. Soviet-influenced models are deeply embedded in faculty training, institutional hierarchy, and societal expectations. Reform efforts that overlook these cultural dimensions risk resistance or superficial adoption (Amgalan et al., 2020). For example, Japan's emphasis on holistic care and teamwork may conflict with the traditionally hierarchical, discipline-bound structure inherited from the Soviet system. Therefore, successful reform depends not only on importing technically superior models but also on adapting them to the Mongolian sociocultural context. This highlights the importance of "deep contextualization" in policy borrowing (Phillips & Ochs, 2004), where foreign innovations must be localized to take root effectively.

Implications for Health Outcomes and Workforce Quality

The quality of medical education is directly linked to national health outcomes and the performance of the healthcare workforce. In Mongolia, where rural health disparities and workforce shortages persist, the need for competent, adaptable, and patient-centered medical professionals is especially urgent. The hybrid model emerging in Mongolian medical education holds promise in improving clinical competencies, communication skills, and ethical decision-making among future practitioners. However, without sustained policy coherence, investment in teaching infrastructure, and alignment with workforce needs, these gains may remain fragmented. A forward-looking reform strategy that addresses both educational quality and workforce deployment—especially in underserved regions—will be key to maximizing the impact of medical education on Mongolia's broader health system.

Conclusion

This manuscript has examined the evolution of Mongolia's medical education system through a comparative lens, juxtaposing it with the enduring Soviet-influenced model in Russia and the increasingly internationalized, patient-centered system in Japan. The findings reveal that Mongolia stands at a critical juncture, engaging in a complex process of hybridization—retaining core features of its historical structure while selectively integrating reforms inspired by East Asian pedagogical innovation.

Comparative analysis underscores several key takeaways. First, curriculum design in Mongolia still reflects a discipline-focused, content-heavy structure akin to the Russian model, but efforts are underway to introduce modularity, soft skills training, and integrated learning, following the Japanese example. Second, in clinical pedagogy, Mongolia continues to rely on late-stage patient immersion, though partnerships with Japanese institutions like Tokushima University are introducing earlier and more structured clinical experiences. Third, while accreditation and

quality assurance remain fragmented in Mongolia, initiatives to align with WFME standards mark a step toward global benchmarking. Finally, in terms of internationalization, Mongolia has shown clear momentum, expanding academic and institutional collaborations—particularly with Japan—as part of a broader strategy to modernize without sacrificing cultural identity or system autonomy.

To move forward effectively, Mongolian policymakers must develop a cohesive national roadmap for medical education that articulates graduate competencies aligned with WFME and ASEAN frameworks, while remaining grounded in local healthcare needs. Strengthening accreditation and licensing infrastructure through standardized evaluation, independent review, and continuous quality improvement will also be essential. Investment in faculty development and simulation-based training, particularly for rural and under-resourced medical schools, can help bridge quality gaps in clinical pedagogy. Additionally, international partnerships should be strategically leveraged to support reform, curriculum design, and hospital governance, while maintaining institutional autonomy. Finally, all reforms must be embedded within Mongolia's sociocultural context. This means promoting gradual change, supporting reform-minded faculty leaders, and ensuring that innovation is introduced in ways that are culturally resonant and institutionally feasible.

Ultimately, Mongolia's path forward lies not in wholesale transplantation of foreign models, but in the deliberate and context-sensitive integration of global best practices. By navigating this path strategically, Mongolia has the potential to build a resilient, equitable, and forward-looking medical education system capable of producing physicians who meet both national demands and international expectations for quality and professionalism.

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