

# Indicators for Social Accountability Tool in Health Profession Education

## Self-Assessment Guide and Tool



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## Introduction

Social Accountability is a beacon to help health actors to “better respond to people and society’s priority health needs today and in the future.” Globally too many people die from preventable causes and struggle with ill health because of inadequate access to appropriate care. The lack and maldistribution of the health workforce as well as discrepancy between the needs of people and the competencies and experiences health professionals possess are hurdles to achieving Universal Access and Universal Health Coverage for all. Evidence is emerging that indicating that who gets educated, what topics they study, where and how their learning takes place influences their career choices and future practice locations. Increasing the social accountability of health workforce education institutions and their graduates is now being recognized as an effective mechanism to maximize their positive impact on health and health system strengthening. In response, global frameworks and policy guidance are embracing social accountability strategies to improve the quantity, quality and relevance of health workforce education to ensure that countries have well-trained interprofessional teams ready and willing to work with and in communities to address their health needs, wherever they live. Applying social accountability principles provides a mechanism for institutions to increase equity in education, conduct research relevant to population health needs and improve access and quality of health care delivery services, an essential goal for socially accountable institutions. Social accountability mechanisms not only foster continuous efforts to increase equity, but the relevance, cost-effectiveness and most importantly the quality of education with the ultimate goal of improving the quality of health service delivery for all.

By inspiring institutions to self-assess and become verified as a Social Accountability Institution, we will start to address health inequities and proactively incorporate the social determinants of health into health practices. The Network: Towards Unity for Health (TUFH) is dedicated to this vision and its purpose to create UNITY among key stakeholders in the health system.

Health institutions across the globe aspire to meet Social Accountability values and standards because they want to stay relevant and competitive.

- Social Accountability Verification helps stakeholders such as community (beneficiaries), consumers (students), investors (alumni), the media, and policy makers (ministries of health) support organizations that are using Social Accountability as a force for good.
- A Social Accountability Assessment evaluates how an institution’s operations and business model impacts their workers, community, environment, and consumers. A Socially Accountable Verification demonstrates that an institution is meeting the highest standards of verified performance.

- Social Accountability Verification doesn't just prove where your institute excels now—it commits you to consider stakeholder impact for the long term by building it into your company's legal structure.

Health Institutions and Systems want to self-assess and be verified because they are leading a movement toward a more socially accountable world, build relationships with like-minded institutions and individuals, attract talent, improves impact, amplifies their voice, and protects their mission.

To self-assess, we are using the Indicators of the Social Accountability Tool (ISAT) whose purpose is to help institutions and programs educating health professionals to regularly assess their progress towards greater social accountability so that their programs are optimally positioned to meet current and future health system needs and thereby increasing universal access to health and universal health coverage. ISAT can also assist schools in establishing priority areas for research and quality improvement and ensure that their strategies and activities contribute to increasing interprofessional collaboration, health equity and quality of services. In addition, it allows for comparison between institutions and across regions and countries.

This guide is to serve as a reference by institutions (e.g., health professions education institutions) when completing the ISAT Social Accountability Self-Assessment Electronic Application.

ISAT Social Accountability Self-Assessment Application consists of 4 sections that each incorporate a range of domains to be completed.

## Executive Summary: ISAT Development and Overview

Globally too many people die from preventable causes and struggle with ill health because of inadequate access to appropriate care. The lack and maldistribution of the health workforce as well as discrepancy between the needs of people and the competencies and experiences health professionals possess are hurdles to achieving Universal Access and Universal Health Coverage for all.

Evidence is emerging that indicating that who gets educated, what topics they study, where and how their learning takes place influences their career choices and future practice locations. Increasing the social accountability of health workforce education institutions and their graduates is now being recognized as an effective mechanism to maximize their positive impact on health and health system strengthening (1). Canada is leading the way by having already incorporated social accountability into their medical education accreditation standards.

### **What is Social Accountability of Health Workforce Education?**

“the obligation to direct their education, research, and service of activities towards addressing the priority health concerns of the community, region and/or nation that they have a mandate to serve. The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals and public.”

World Health Organization, 1995

In response, global frameworks and policy guidance are embracing social accountability strategies to improve the quantity, quality and relevance of health workforce education to ensure that countries have well-trained interprofessional teams ready and willing to work with and in communities to address their health needs, wherever they live. Applying social accountability principles provides a mechanism for institutions to increase equity in education, conduct research relevant to population health needs and improve access and quality of health care delivery services, an essential goal for socially accountable institutions. Social accountability mechanisms not only foster continuous efforts to increase equity, but the relevance, cost-effectiveness and most importantly the quality of education with the ultimate goal of improving the quality of health service delivery for all.

In an effort to increase the social accountability of the health workforce education in the Americas, the Pan American Health Organization (PAHO) brought together leading experts in the field of evaluating social accountability to agree on core indicators for assessing social accountability of medical schools in the Americas. Building on the existing social accountability tools the group developed the Indicators for Social Accountability Tool (ISAT). The purpose of its development is to

promote education, research and service delivery programs that is aligned with priority needs by providing health workforce education institutions with a tool to regularly assess their progress towards greater social accountability. It is a relatively straight forward diagnostic instrument that helps institutions and their stakeholders reflect on where they are, identify gaps and areas for improvement. The ISAT includes the following core components: student recruitment, selection and support; faculty recruitment and development; what, how and where students learn; research activities; governance and stakeholder engagement; school outcomes; and societal impact. Each core component is divided in four developmental phases and includes milestones, standards and indicators.

The developers of ISAT, are aware that context varies widely and that some indicators are not measurable or relevant in certain countries or institutions. It also includes a list of additional resources to help those interested in joining the global movement to transform health workforce education towards better meeting the needs of the individuals and communities their institutions serve.

## Background and Context: ISAT Development and Overview

The world suffers from staggering health inequities, that is the differences in population health that are systemic, socially produced, and preventable, therefore inherently un-just and unfair. According to the World Health Organization globally more than 400 million people rarely or never see a health worker in their lives, a reality that includes pockets of populations in high-income countries (2). In fact, the Region of the Americas remains one of the most inequitable. Such health inequities are not only unacceptable, but also costly, limiting individual opportunity and slowing economic growth. The United Nations estimates that if no action is taken the loss to the global economy due to non-communicable diseases alone could reach \$47 trillion by 2030 (3).

The shortage and geographic maldistribution of health workers and mismatch between needs and competencies remains a barrier to Universal Access and Universal Health Coverage resulting in millions of people worldwide not receiving the essential health care and services they need. According to the World Health Organization (WHO) Universal Health Coverage (UHC) "...means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." The Pan American Health Organization (PAHO) adds the concept of Universal Access defining it as "... the absence of geographical, economic, sociocultural, organizational, or gender barriers... achieved through the progressive elimination of barriers that prevent all people from having equitable use of comprehensive health services determined at the national level."

Yet, most efforts to address health workforce shortages have focused on increasing production, with limited attention paid to the impact of institutional and educational strategies on the location and career choices of medical graduates (4). Increasing the production of health professionals is clearly not enough as many new graduates migrate towards specialty careers in urban or high income-country settings. For example, in the last thirty years, Latin America has seen a sharp increase in the number of new medical schools. However, the quality and contribution of some of these new schools to health system strengthening is being questioned (5). Indeed, the Lancet Commission on the Education of Health Professionals for the 21st Century, suggests that the predominant "ivory tower" bio-medical urban and hospital-centric model of health professional education fails to produce graduates with the competencies and experiences to meet today's and tomorrow's needs (6).

In response, global frameworks and policy guidance including the World Health Organization's (WHO) Global Strategy on Human Resources for Health (7), the report and action plan of the High-level Commission on Health Employment and Economic Growth (ComHEEG) (8), WHO's guidelines on transforming health professional education (9), and the Pan American Health Organization's (PAHO) *Plan Of Action On Human Resources For Universal Access To Health And Universal Health Coverage 2018-2023* (10), all embrace strategies to improve the quantity, quality and relevance of health workforce education to ensure countries have interprofessional teams ready and willing to work with communities to address their health needs, wherever they live.

Fostering greater social accountability of health workforce education institutions and programs is increasingly seen as an effective mechanism to maximize their positive impact on health and health system strengthening (1). WHO defines socially accountable medical education as "the obligation to direct their education, research, and service of activities towards addressing the priority health concerns of the community, region and/or nation that they have a mandate to serve. The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals and public"(11).

While health professional schools have been implementing strategies associated with social accountability since at least the 1970s, it was not until in the mid-2000s, that an increasing number of education institutions and organizations began to actively promote and/or implement social accountability initiatives, particularly in medical education. The Network: Towards Unity For Health Conference in 2006 on "Increasing social accountability" established a Task Force on Social Accountability, which ultimately led to the development of the Global Consensus on Social Accountability in Medical Education in 2010 developed by individuals and organizations from around the globe first through a Delphi process and culminating in a meeting East London South Africa. Simultaneously, the 2010 Lancet Commission on the Education of Health Professionals for the 21st Century included section on social accountability and featured the experiences of the Training for Health Equity Network (THEnet), a partnership of health professions schools committed to social accountability (12).

A decade later, there is growing evidence of the positive impact of this approach on increasing availability, distribution, and performance of health workers in underserved regions as well as strengthening health in the regions they serve. (4,13-15). An increasing number of schools in the region of the Americas are adopting a more socially accountable community-engaged approach to



medical education and Canada has already integrated social accountability into its medical school accreditation standards. ComHEEG and the accompanying action plan calls for immediate actions including the “massive scale-up of socially accountable and transformative professional, technical and vocational education”. Both WHO GSHRH and ComHEEG are supported by WHO National Health Workforce Accounts (NHWA). The purpose of the NHWA is to facilitate the standardization of a health workforce information system to improve data quality, as well as to support tracking Human Resources for Health policy performance towards Universal Health Coverage (UHC). NHWA are relevant for national, regional and global stakeholders, and can contribute to finding answers to major policy questions related to current HRH challenges and how to optimize planning. NHWA has three education modules, including system level indicators that address the alignment of national education plans for health workers with national health plans and strategies. Module (3) on Regulation and Accreditation has two dedicated indicators for social accountability, one to assess the inclusion of social accountability in accreditation mechanisms, the other assessing the effectiveness of implementation.

### **Committee on the Accreditation of Canadian Medical Schools**

Standard 1: element 1.1.1

Social Accountability A medical school is committed to address the priority health concerns of the populations it has a responsibility to serve. The medical school's social accountability is: a) articulated in its mission statement; b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences; c) evidenced by specific outcome measures.

ComHEEG report sets out a vision whereby the health workforce should be geared towards the social determinants of health, health promotion, disease prevention, primary care and people-centered, community-based services. Yet, there are significant challenges to transforming health professional education towards this vision, one which requires greater social accountability, with focused attention on educating and training for health equity. These challenges include current educational strategies focusing on individual health rather than on population health needs; limited opportunities for learning in primary care and community settings, lack of focus on interprofessional learning, and teamwork in primary care settings; and student admission policies focusing solely on academic performance (4). A recent study on Latin American perspectives on social accountability in medical education identify several barriers in the region: the fact that most current accreditation standards do not incorporate social accountability, a lower professional value and economic incentives associated with primary care practice, the lack of indicators on social accountability as a primary responsibility of medical schools, fewer faculty role-models in primary care than subspecialty training and low quality student exposure to primary care models (5). The

recommendations of the above-mentioned study in Latin America include the development of a tool to assess social accountability of medical schools in the region, building of a regional network of medical schools focusing on the topic, and implementation of studies that incorporate the perspectives of other stakeholders including students and underserved communities themselves.

## Tool Development Process

PAHO is committed to increasing the social accountability of the health workforce education sector in the region as part of an effort to increase Universal Access to Health and Universal Health Coverage, and as a strategy to reduce health inequities. Its Strategy on Human Resources for Universal Health calls for partnering “...with the education sector to respond to the needs of health systems in transformation toward universal access to health and universal health coverage.” To support this goal, PAHO established the Consortium on Social Accountability in Health Professions Education in the Region of the Americas in 2017. To assess the social accountability of medical schools in the region, PAHO determined there was a need to develop a set of core indicators reflecting needs and contexts in the region.

To that end, in June 2017 PAHO brought leaders from key organizations and experts in the field of social accountability to Washington to agree on the core indicators for assessing social accountability of medical schools in the Region. PAHO invited leaders from AMEE’s ASPIRE Program, THEnet: Training for Health Equity Network, George Washington (GW) University’s Health Workforce Institute, Universidad del Litoral – Foro Argentino de Facultades y Escuelas de Medicinas Públicas and Comisión Nacional de Evaluación y Acreditación Universitaria, CONEAU in Argentina, Fundação Universidade Aberta do DF, FUNAB and Universidade Federal de Roraima in Brazil, University of the West Indies, Jamaica, Association of Faculties of Medicine of Canada, Interaction Institute for Social Change in Ireland, United States Agency for International Development as well as experts from PAHO.

Building on the existing social accountability tools developed by AMEE-ASPIRE, THEnet and GW the group developed an agreement on a core set of indicators known as the Indicators for Social Accountability Tool (ISAT). The existing tools had common factors although they were developed with different purposes in mind.

The ASPIRE program was established by AMEE in 2013 to encourage excellence in medical education through the development of aspirational criteria for key aspects that now include assessment of

students, student engagement, faculty development, simulation, curriculum and social accountability. The social accountability criteria encompass four domains: organization and function, education of doctors, research activities, and contribution to health services. To demonstrate social accountability, schools are expected to document plans, actions and impacts of its education, research and service, graduates and partnerships on the healthcare, health and health equity of its community, region and nation.

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Faculty at George Washington University's Institute Health Workforce in Washington, DC, developed The Social Mission Metrics Study, a national research project that is developing measurement tools for the social mission content of medical, nursing and dental education. The study<sup>1</sup> aims to transform health professions education through the development of standardized process measurement tools as key indicators of health professions schools' social mission.

THEnet is an international collaborative of health professional schools striving towards social accountability. Its first joint project was —building on the conceptualisation—production—usability model developed by Woollard and Boelen (16) and the successful strategies of its members— to develop and implement a comprehensive evaluation Framework (17, 18). It identifies key factors affecting a school's ability to positively influence health outcomes and health systems performance and to develop ways to measure them across institutions and contexts. THEnet's Framework offers a set of comprehensive, context-sensitive quality improvement tools that prompts schools to engage with different stakeholder groups to help schools take a critical look at their performance and progress towards greater social accountability and assist them in establishing priority areas for research and improvement.

Participants in the PAHO/WHO meeting in June 6 to 7<sup>th</sup> 2017, drew on the above tools to agree on a core set of indicators of social accountability: Indicators for Social Accountability Tool (ISAT). The diagnostic tool is particularly aimed at schools in the PAHO/WHO region who, while they may be implementing strategies associated with social accountability, are new to the concept. With this tool and associated activities PAHO/WHO seeks to facilitate the transition of health education schools in the Region from a stage of social responsiveness to a new baseline of social accountability. The ISAT instrument was presented at the IV Global Forum of Human Resources for Health (Dublin-Ireland,

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<sup>1</sup> Batra, Sonal MD, MST; Orban, Julie MPH; Guterbock, Thomas M. PhD; Butler, Leigh Anne; Mullan, Fitzhugh MD Social Mission Metrics: Developing a Survey to Guide Health Professions Schools, *Academic Medicine*: December 2020 - Volume 95 - Issue 12 - p 1811-1816: doi: 10.1097/ACM.0000000000003324

13th-17th November 2017) and the Beyond Flexner 2018 Conference (Atlanta-USA, 9th-11th April 2018).

Previously the ISAT instrument was reviewed at the 55th COBEM- Brazilian Congress of Medical Education (Porto Alegre-Brazil, 12th-15th October 2017. Two medical faculty from different schools did separated translations into Portuguese, followed by a meeting to agree on a final version. The tool was reviewed and validated by representatives from 18 medical schools from the five geographical regions of Brazil during the Brazilian Meeting of the Association for Medical Education in Brazil. The representatives were organized into small groups based on their respective region and were given a Portuguese version of the ISAT. They were asked to comment on the terms used to determine clarity and common meaning and whether it was applicable and useful in their contexts. The results were compared and discussed, as well the suggestions for clarity of terms and translation. The ISAT has been applied at three Brazilian medical schools so far, in meetings for curriculum evaluation. A group of students and teachers reviewed the ISAT instrument separately and the results were then compared and discussed to identify priorities for action.

## Introduction to ISAT

### Purpose

The purpose of the Indicators of the Social Accountability Tool (ISAT) is to help institutions and programs educating health professionals in the Americas and beyond to regularly assess their progress towards greater social accountability so that their programs are optimally positioned to meet current and future health system needs and thereby increasing universal access to health and universal health coverage.

The Tool can also assist schools in establishing priority areas for research and quality improvement and ensure that their strategies and activities contribute to increasing interprofessional collaboration, health equity and quality of services. In addition, it allows for comparison between institutions and across regions and countries.

### Who should use ISAT?

The ISAT tool is designed with faculty, leaders and other key stakeholders in health workforce education in mind. A key tenet of the definition of social accountability is to identify needs in collaboration with stakeholders. Consequently, engaging other stakeholders including students,

services providers, health systems administrators and community representatives in the process of reflection on the various elements involved in educating health professionals is at the core of social accountability.

### How should the ISAT be used?

The ISAT instrument can be used in different ways and at different institutional levels. It can be used by leaders and or faculty and students to do a relatively rapid assessment of where the school stands and promote collective reflection and feedback to share with those who run the program or are responsible for strategies at university levels. However, ideally, to maximize the likelihood that findings will be acted upon, the leadership of the institutions should be committed to the process and key stakeholders should be involved.

Before exploring outcomes and impact it is also important that schools in partnership with their stakeholders are clear on what success looks like for their institutions and their ultimate beneficiaries—patients and communities. Ideally during the process of implementing ISAT stakeholders should reflect on what changes are needed in terms of individual and organizational behavior, activities and relationships to achieve the outcomes and impact the school or program is seeking. It is also an opportunity to identify what is within a school’s direct and indirect sphere of influence and what is not.

Discussing and recognizing the underlying assumptions and their own operational “theory of change” can be useful for identifying areas for improvement or reform. Finally identifying which influencing factors are known and what the current and future uncertainties might be, the tool can help schools progress and grow (19). Users may also want to respond to questions such as: 1) What are the measurement instruments and data sources that could help assess progress; 2); what are the human and material resources and estimated time involved in applying the instrument to the fullest extent; and 3) are there indicators that are not appropriate for the context of a particular schools and if so are there other indicators that might add value in determining social accountability?

### What are the ISAT Phases?

The ISAT is separated into four phases for each of the Core Components described below. Phase 1 describes a program or school where limited or no attention is being paid to social accountability and where associated strategies are not being employed. Phase 2 describes a situation where leaders and faculty are early in the process of reflecting on or starting to implement strategies or

policies associated with social accountability. Phase 3 suggest that the program or schools are implementing these strategies, but the program has not yet been able to achieve the desired outcomes of these strategies. Phase 4 describes a situation where processes and systems are in place to measure progress and where programs or schools can demonstrate the impact of strategies and policies associated with social accountability.

It should be noted that schools and programs are not always able to control or influence specific policies, strategies or activities due to various reasons including that they are new and haven't been in existence long enough to assess Phase 4 indicators, that they cannot make decisions around certain policies, strategies or resource allocation or that they may not have the resources to implement desired strategies or resources to measure outcomes or assess impact. Hence, schools and programs are likely to be in different phases for different Core Components and discover that the level and speed of progress can depend on a host of internal and external factors. However, using the ISAT should help schools and program assess the current situation, identify barrier and enabling factors to progress towards increasing their social accountability.

### What are ISAT's Core Components?

ISAT is divided into Core Components focusing on a key element to assess. While each of these Core Components is relevant to most medical schools, not all of them can be assessed in the same way as the context, including policies and regulations can vary from country to country and school to school. Each of the section below explains why the component is deemed important for social accountability, with the understanding that it may not be applicable for all.

#### Students

Most nations in the world struggle with recruiting and retaining health professionals in rural, remote, and poor regions. The reason this is a Core Component for social accountability is that evidence shows that who gets admitted into medical school matters. However, it should be noted that in some countries schools have no influence on who attends their program because selection is done at national levels or like in Argentina where there are no specific criteria for entrance into medical school once students graduate from secondary education. In such cases schools striving towards greater social accountability can advocate for policy changes, reach out to underrepresented groups and provide special academic, financial and psychological support to students from rural or underrepresented groups.

In many countries, schools can use strategies to identify students with attributes and backgrounds that are predictive of their interest and desire to work in area of needs, particularly in rural and underserved regions (20-23). Currently, in most regions of the world student selection criteria are predominantly based on students' academic performance. However, studies have shown that a combination of several factors are good predictors to increase students' motivation to practice in rural areas and underserved communities. Such factors include having a rural background, and secondary occurring in rural areas. Schools striving towards social accountability have employed several strategies to increase the socioeconomic, ethnic, and geographical diversity of students and select students they deem most likely to choose careers and practice locations in areas of need. These strategies include quota systems providing additional weighting for students from rural or underrepresented populations; community involvement; school marketing strategies; and selection based psychometric tests to assess personal attributes such as strong interpersonal skills and empathy (24).

Where admission or student selection committees are in place, socially accountable schools include key stakeholders such as members of underserved or marginalized populations in the committees. For example the relevant Canadian accreditation standard calls for;" A medical school in accordance with its social accountability mission has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior academic and educational leadership, and other relevant members of its academic community. These activities include the appropriate use of effective policies and practices, programs or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of policy and practices, program or partnership outcomes" (12).

### Faculty Recruitment

Recruiting and retaining a cadre of dedicated and well trained academic and clinical teachers is challenging in many countries, particularly in rural underserved areas. In some high-income countries such as the United States, medical school institutional value systems tend to prioritize research over teaching. Moreover, in poorer regions of the world academic position are often not well paid and faculty often earn additional income by other means which reduces the time they dedicate to teaching and mentoring students. (REF) Socially accountable schools seek to attract faculty who have the competencies needed to address the health and health system needs of the region where the school is located, come from diverse socioeconomic and cultural backgrounds and

if possible, from the community it serves. Schools also aim to recruit an appropriate balance of biomedical, population and clinical and social sciences faculty and aim for gender parity. Rural schools are at a disadvantage compared to urban or peri-urban schools to recruit qualified faculty. However, community engaged medical education, a hallmark of social accountability, is generating additional new needs but also opportunities for schools to recruit faculty with strong interprofessional skills, able to work across disciplines and sectors in area of shortage. In addition, socially accountable schools also recruit, train and support practitioners and other health care providers practicing in the community as adjunct faculty/educators in clinical and social sciences, thus expanding its pool of community preceptors. Rural schools offer unique opportunities for faculty committed to social changes and interested in making a tangible difference in the health and well-being of underserved rural communities. These schools are also providing the opportunity to contribute to the evolving transformation of medical education needed to produce a fit for purpose health workforce.

### Faculty Development

The world of medicine and health is rapidly changing with implications for medical education and practice. These changes include demographics, epidemiological transition, environmental challenges, emphasis on clinical quality and patient safety, financial challenges, and rapid advances in information technology and big data. While this varies within and between countries, faculty often receive limited training related to educational principles and teaching methodologies, student assessments and on content related to local priority needs in the communities the school serves including, public health, communication, and topics relevant to the social determinants of health. To increase the number and quality of the teaching faculty and improve their skills in education and research some schools establish a Faculty Development program either as part of an education department or as a separate program. Such department develop programs that support continuous professional education using information technology and other communication tools. The faculty development program can draw on the various resources from the other schools at their university such as social and political sciences, engineering, other schools of health sciences and community-based organizations to shape a comprehensive curriculum on social determinants health and community development to prepare medical students for their community placements and to support the community engaged service-learning education program. Faculty members will be instructed in pedagogical principles of interprofessional education and active student-centered and service learning during student community placements. The program will provide teaching and



pedagogical resources to community practitioners recruited as adjunct faculty to improve their attributes/skills to be effective mentors, teachers and preceptors.

### Curriculum: Content

The curriculum development occurs through a consultative process, drawing on resources of other schools worldwide and accreditation standards. In partnership with the community, community-based organizations and local health system the school identifies health and social priority needs of the communities they serve and integrates them in the scientific base of the curriculum content woven in to the basic, population and clinical sciences and social sciences to include comprehensively all these aspects of medicine. This shift a predominant narrow bio-medical model towards a socio-biomedical curriculum designed to advance the teaching mission of the school, building on the strength of the community confronted with continuous evolving needs. The curriculum includes a longitudinal theme on the social determinants of health woven through the various courses of the curriculum. The school education department acts as an educational resource hub for faculty and students and provides support and tools for curriculum development, teaching methodology, assessment of educational programs student and faculty assessment (formative and summative), simulation program and standardized patients and track students' progression throughout their cursus. The curriculum develops interdisciplinary courses by enlisting faculty from other schools who may receive dual appointments.

### Curriculum: Learning Methods

To increase social accountability, addressing the needs of students is key. The learning methods in socially accountable programs are aligned with the school curriculum, often blended, and focus on learners and the best available methods to ensure they attain the desired competencies. Over the past decades learning methods changed from being an apprenticeship model that was teacher and subject centered where students had little input towards a competency-based, student-centered and more interactive learning that provides students with competencies such as critical thinking, reflective practice, problem-solving and the skills to foster life-long learning. To address the need to train productive interdisciplinary teams able to work in any settings including in marginalized communities, an increasing number of schools use interprofessional and team-based learning, service-learning, experiential, self-driven as well as case and problem-based learning approaches. Advances in information technology (IT) have also increased schools' ability to have students stay in rural or remote settings for extended periods while continuing to learn with their fellow students located elsewhere as well as receiving remote-mentoring. IT also provides opportunities to learn

skills and knowledge through virtual reality applications, gaming and other technology supported approaches.

### Curriculum: Types and Location of Educational Experiences

The conventional education model—still predominant across the world—is mostly delivered in classrooms with the clinical learning occurring primarily in hospital settings. Already in 1961 it was pointed out that training students mainly in university hospitals is illogical and inefficient (25). Patients who are admitted to the hospital are frequently pre-diagnosed before being admitted and their length of stay is getting shorter and shorter. Moreover, few medical schools provide their students with substantial exposure to outpatient or general practitioner facilities, where most diagnosis and management of chronic diseases takes place (26). The implications are that students have limited understanding and exposure to the different stages of disease progression and of the conditions that generated them including social determinants of health (SDH). Socially accountable health workforce education seeks to provide a balanced mix of clinical experiences between primary care setting, secondary and tertiary hospitals and opportunities for students to better integrate learning about the social determinants of health into the curriculum. Most socially accountable schools provide some form of longitudinal integrated clerkships or extended times in community settings (27,28). This community engaged education approach presents remarkable opportunity to learn to work in interprofessional teams and for joint strategy and mutual learning between academia, local health authorities, communities and community-based NGOs. With their mentors, community members and other local partners students often conduct community survey, identify priority issues and design and implement interventions based on agreement with all stakeholders and lastly the student evaluate the project results and impact. Community based rotations integrate theory and practice and offer unique opportunities for close collaboration between the schools of medicine, public health, pharmacy, social sciences and other to work together with local community-based organizations and health centers to develop and integrate the SDH into the curriculum and develop a interdisciplinary team-based approaches within community health programs tailored to priority needs.

### Community-based Research

Social accountability calls for schools to align their research towards the priority needs of the communities they serve and to collaborate with communities in the design and implementation of research projects. The reciprocal partnership between the school, the communities it serves, and the health care system delivery provides unique opportunities for establishing a collaborative

research agenda, conduct research on health equity and community health, and around how the school could better address health system and health priorities of their populations. It also provides opportunities for the school to do research on how the educational process and education outcomes aligns with the needs of the health system and the priority needs of the communities. Socially accountable schools are currently generating evidence on the way the education and training program can influence the shortage and maldistribution of health practitioners, particularly in rural underserved regions. Community-based training brings the students in close contact with underserved communities where they build social and personal ties, live in the same conditions and experience the socio-cultural and professional environment where they are expected to practice. This provides faculty members and students a large arrays of research topics on causes and factors responsible for generating health inequities in the communities and to develop joint strategies and remedial interventions. Social accountability also calls for faculty and students to be attuned to ethical consideration related to community engaged research and assess the impact research findings are having on policies, practice and health in the communities the school serves.

### Governance

According to the AMEE Guide on *Producing a socially accountable medical school* as well as other key document on social accountability, incorporating social accountability principles into governance of an institution or program is an essential step. This includes social accountability principles and strategies being integrated into decision making, planning, evaluation, resource mobilization and allocation as well as day to day management (18, 29-31). While many schools incorporate principles of social accountability — such as including altruism or service to people and communities — into their vision, mission and value statements, they are not socially accountable unless these aspirations are reflected in the content of the program and how the school is governed. This includes the existence and use of metrics and benchmarks to assess how well the school or program is meeting the needs of the communities, region and society it serves. Social accountability also calls for schools to include internal stakeholders such as students, staff and faculty as well as external stakeholders such as marginalized communities, service providers and local authorities in decision making. For socially accountable schools engaging with communities, it serves is hardwired into every aspect of their work, so community members are members of boards of directors or other governance and advisory bodies. A school's governing body makes key decisions regarding strategies, policies and programs, including on how to allocate resources. However, it should be recognized that the school's autonomy in making these decisions can be considerably restricted by policies from the university, provincial and/or central government.

## Stakeholder Partnership and Engagement

Engaging and partnering with the stakeholders in health professional education and health is at the core of the definition of social accountability of medical schools: "... the priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public"(2). The Innovation Collaborative on Learning through Community Engagement, a participant-driven group formed by members of the National Academies of Sciences, Engineering, and Medicine's Global Forum on Innovation in Health Professional Education in the United States defines health professional education as community-engaged "...when community-academic partnerships are sustained, and they focus on the collaborative design, delivery, and evaluation of programs in order to improve the health of the people and communities the programs serve. Programs and partnerships in community-engaged education are characterized by mutual benefit and reciprocal learning, and they result in graduates who are passionate about and uniquely qualified to improve health equity" (30). According to the report of the High-Level Commission on Health Employment and Economic Growth suggest that curricula should be developed in partnership with communities served by the school and with other stakeholders. (4). These include students, service providers, community-based organizations, governments and members of underserved populations.

## School Outcomes

"The accountability of academic institutions usually ends at graduation or the publication of a paper. Outcomes—such as the placement, practices, and retention of medical graduates in areas of greatest need and the policy or practice impact of a research project—are seldom tracked." Since socially accountable programs and schools set out to produce graduates that choose careers and practice locations that are aligned with health system needs, including the needs of marginalized populations, it is essential that they track their graduates. Countries such as Australia who struggle with dearth of medical professionals in rural and remote regions and who have invested significantly in increasing recruitment and retention in those areas have set up national databases to track graduates. However, much of current tracking efforts are done by schools themselves or third parties such as program funders. Graduate tracking can also improve the education and training programs by learning what influenced graduates' career and practice location choices. Schools use various means to remain in contact with graduates, conduct research to identify important factors that affect their choices and set up systems and processes to track students' intentions and graduates from entry into health professional education until several years after graduates

## Societal Impact

To ensure that programs and schools are addressing evolving needs in the society, regions and communities they serve, schools need to regularly seek to evaluate the outcome of their efforts as well as the impact they are having on graduates and their practice. Ultimately, they should measure their impact on policies, practice and performance of the health system and health in the communities they serve. Assessing the effect of education strategies on health systems and population health is clearly challenging as it is influenced by a multitude of complex, interlinked, dynamic factors and conditions many of which are not within the control of the education institution. Consequently, researchers need to apply multiple methodologies to build evidence for attribution, contribution, and accountability. (19) Schools striving towards greater accountability and impact are beginning to assess impact. Emerging evidence is presented in the World Health Organization's 2017 publication *Health Employment and Economic Growth: An Evidence Base* and other publications referenced (4,13,32).

## Other considerations

There is a growing interest in broadening the scope of social accountability to include the concept of environmental accountability (33). The 2018 AMEE ASPIRE Social Accountability Criteria now include the obligation of medical schools to ensure they actively develop and promote environmentally sustainable solutions to address the health concerns of the community, region, and the nation they serve. While most of the social accountability literature focusses on medical student (MD) education, the impact of graduate medical education (vocational training) plays a vital role in the production, deployment and impact of the medical workforce. The role of medical schools in providing graduate medical education varies structurally around the world and is beyond the scope of the ISAT Tool which has been designed to focus on the role of the medical school.

# ISAT SOCIAL ACCOUNTABILITY SELF-ASSESSMENT TOOL

## IMPLEMENTATION GUIDE

This guide is developed to be used by institutions (e.g., health professions education institutions) to complete the ISAT Social Accountability Self-Assessment Tool. Please refer to the explanation and criteria in this guideline when filing and completing each item in the assessment tool to ensure accurate self-assessment of your institution's social accountability features.

ISAT Social Accountability Self-Assessment Tool consists of 4 sections outlined below. Each section incorporates a range of domains to be completed. Institutions are expected to complete **all items in sections 1-3 and the narrative of section 4**. The point system of **Section 4** will be completed by TUFH and the Institution during an interview process.

Section 1 (Identity, Contact and Demographic Details)

Section 2 (Developmental Phases Towards Social Accountability)

Section 3 (Stakeholder Engagement).

Section 4 (Improvement Phases Towards Social Accountability)

Upon the selection of the appropriate phase within each domain, the institution will be required to include a narrative description that supports your selection and upload any relative documents that support the selection.

Upon completion of the baseline for each domain, the institution will be asked to articulate a plan of action to move to the next phase that includes the involvement of key stakeholders (internal stakeholders, health professionals, community representatives, health care organizations, and government) in the development and implementation of the institutional plan of action.

The purpose of this Self-Assessment Tool is to serve as a baseline for an institution. Once a baseline is established the institution can develop a plan of action to move from Phase I to Phase IV over a period of time.

## SECTION 1. IDENTITY, CONTACT AND DEMOGRAPHIC DETAILS

This section is intended to collect data on the institution's identity, leadership, contact details, and demographic data relevant to the ISAT tool.

No.	Identity and Demographic	Explanation
1.1	Name of Institution	The name of the institution in which it is intended to be referred in the ISAT Report.
1.2	School Leadership	The name of the institution's leadership (e.g., rector, vice-chancellor, dean, director, CEO, etc.)
1.3	Lead Contact	The name of person-in-charge in leading the ISAT assessment and implementation in the institution. This person will be the primary resource person for TUFH when contacting the institution related to ISAT.
1.4	Corresponding Email	Communications, notifications and correspondences will be directed to this email address.
1.5	Date	Date of ISAT tool completion by institution (will be automatically recorded by electronic application)
1.6	Faculty Delegates	List of 5 faculty delegates included in the application process that aligns the process with Social Accountability principles, including their email, included in the application process. The delegates should be samples of various seniority, department/division, gender, etc.
1.7	Student Delegates	List 5 student delegates, included in the application process that aligns the process with Social Accountability principles including their email, included in the application process. The delegates should be samples of various seniority (year/batch of study), study program, gender, etc.

## SECTION 2. DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY

This section consists of 11 items in 6 domains. All items need to be completed. Using the most appropriate/realistic developmental milestones provided in the criteria below, please indicate where your institution falls between Phase 1 and Phase 4. Please provide narrative-qualitative explanations for each category to support your choice. You may upload supporting evidence (i.e., documents, webpage, images, published works, etc) to justify and further elaborate your choice.

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
<b>1. STUDENTS</b>				
<b>1.1 Student recruitment, selection and support</b>	<p>Student selection criteria focuses mostly on academic performance or the school has no authority to change selection criteria. No emphasis on supporting students from underserved or underrepresented backgrounds.</p>	<p><b>Milestones</b></p> <p>The school is reviewing student selection criteria to better address diversity, equity and local health workforce needs; these criteria are not yet being implemented.</p>	<p><b>Milestones</b></p> <p>The school has integrated selection criteria to improve diversity and equity and address workforce needs. The school also defines the type of selection criteria related to diversity to be incorporated in its selection process.</p> <p>The school actively recruits students from underserved or underrepresented backgrounds.</p>	<p><b>Standard</b></p> <p>The student body reflects the socio-demographic and other characteristics of the communities and regions the school serves including underserved populations and those deemed most likely to be willing to serve those populations and regions.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. The proportion of learners from the populations and regions the school serves</li> <li>2. Successful outreach/orientation pathway programs for schools in underserved communities that include</li> </ol>



			<p>The school offers means of support for students from underserved or underrepresented backgrounds.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Selection criteria aim to attract students who represent the socio-economic, geographic, ethnic, linguistic and cultural diversity of the region the school serves.</li> <li>2. Advocacy to support access to health professional education for underserved groups.</li> <li>3. Admission Committees have geographic and demographic diversity in their make-up.</li> </ol>	<p>learners from those communities and track participant's outcomes.</p> <ol style="list-style-type: none"> <li>2. Explicit and targeted admission pathways and educational support for learners from underserved populations who may require additional support to succeed.</li> <li>3. Admission Committees have diversity in memberships and community involvement at all levels.</li> <li>4. Equivalency in ratios of attrition, progress and completion statistics of learners from underserved populations compared to all learners.</li> <li>5. School has a comprehensive support/counselling/remedial program</li> <li>6. School has a program dedicated to award scholarships for students from underserved communities</li> </ol>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
<b>2. FACULTY</b>				

<p><b>2.1 Faculty Recruitment</b></p>	<p>The school recruits faculty based on “conventional” academic and clinical credentialing and most clinical teachers are based in hospital settings.</p>	<p><b>Milestones</b></p> <p>The school has a strategy to recruit faculty with competencies needed to address health systems and community needs, in addition to delivering the core curriculum.</p>	<p><b>Milestones</b></p> <p>The school prioritizes recruitment of faculty who possess competencies agreed upon as needed to address the health system and community needs and reflects the diversity of the communities it serves, in addition to delivering the core curriculum.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. The school has a mix of primary care, clinical specialists, subspecialists, basic sciences and social sciences aligned with needs.</li> <li>2. Faculty selection and promotion processes aim to attract faculty from a diverse mix of professional, cultural, social and community backgrounds.</li> </ol>	<p><b>Standard/s</b></p> <p>The school employs and promotes faculty who possess competencies needed to address health systems and community needs and those reflecting the diversity of the communities it serves and incorporates the principles of social accountability in their teaching.</p> <p>The school employs, trains, and supports community members and community-based practitioners as standardized patients and educators in a manner which strengthens local health services.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Proportion of faculty who reflect gender parity and the diversity of the communities the school serves.</li> <li>2. Training, use and recognition of community practitioners and members of the health care team in underserved communities and across the region as faculty.</li> <li>3. Proportion of community members and practitioners who are faculty members and adjunct faculty who are engaged with the school in training health professionals.</li> <li>4. Proportion of faculty involved in social accountability activities to develop health, health system, health workforce, and health care to meet community needs.</li> <li>5. Proportion of faculty members who engage in teaching and research activities related to community health needs.</li> </ol>
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				6. Schools value education and community engagement service in career advancement.
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
<b>2. FACULTY</b>				
<b>2.2 Faculty Development</b>  (Note: Faculty members = all members of health care team.)	The school has no faculty development program and if there is one, it is limited to conventional pedagogical approaches and curricular topics.	<b>Milestones</b> The school has a faculty development program that values student-centered and active learning strategies but overall promotes conventional approaches.	<b>Milestones</b> 1.The school has a faculty development program that includes a focus on topics related to community needs (e.g. social determinants of health, community mobilization, etc.) as well as principles of student centered and active learning,	<b>Standard</b> The school assesses faculty performance and community engagement; and provides faculty development programs aligned with the goals of socially accountable health professional education including active, student-centered and community-based learning.  <b>Indicators</b>

			<p>assessment of students, workplace-based learning and community-based learning.</p> <p><b>Indicators</b></p> <p>1. Faculty assessment and development programs are designed to update and strengthen teaching and competencies relevant to priority health needs identified.</p> <p>2. Educators undertake training and development of cross-cultural skills/cultural humility.</p>	<p>1. Proportion of faculty who completed clinical skills training relevant to priority health care needs identified.</p> <p>2. Proportion of faculty who completed professional development in effective community engagement.</p> <p>3. Proportion of faculty who are engaged in social accountability aligned education, research and services?</p> <p>4. Proportion of faculty members from the local health workforce (including practitioners and community members) who have completed courses on teaching methodologies including inter-professional education and community service.</p> <p>5. Faculty, especially those from underserved groups, receive personalized development and career enhancement.</p> <p>6. School has a program to reward the quality of teaching and community engagement.</p>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>
<b>3. EDUCATIONAL PROGRAM</b>				

<p><b>3.1 Curriculum: Content</b></p>	<p>Curriculum is specialty driven and focuses on disease management and individual health.</p>	<p><b>Milestones</b></p> <p>The traditional curriculum incorporates elements of public health and topics related to community needs.</p>	<p><b>Milestones</b></p> <p>Curricular content reflects identified priority health, cultural and social needs of populations in the geographic area the school serves. The curriculum is competency-based and includes content related to interprofessional team work.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Required competencies are defined based on the health needs of the populations and regions the school serves.</li> <li>2. Proportion of the curriculum allocated to learning about priority community health needs not traditionally part of a medical curriculum.</li> </ol>	<p><b>Standard</b></p> <ol style="list-style-type: none"> <li>1. The curriculum design, content, delivery, assessment and evaluation reflect the expected competencies of graduates related to health equity and social accountability.</li> <li>2. Professional orientation is identified through needs assessment of the geographical area and in underserved communities the school serves in collaboration with stakeholders. It integrates the principles of primary health care, basic and clinical science with population health and social determinants of health.</li> </ol> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. School identifies graduate competencies that are based on the priority health, cultural and social needs of the geographical area the school serves and the health system and services in collaboration with community stakeholders.</li> <li>2. There is a strong alignment throughout the whole duration of the program between curricular content and the findings of needs assessment and the desired graduate competencies.</li> <li>3. Student assessment focuses on competencies that best prepare students to meet the health needs of communities, with an emphasis on primary health care and professionalism.</li> </ol>
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				4. Curriculum is reviewed regularly by all stakeholders to ensure its quality and that it meets the needs of the community.
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
<b>3.2 Curriculum: Learning Methods</b>	Learning methods are predominantly teacher-centered with few initiatives on active learning (i.e.	<b>Milestones</b> Learning methods are student-centered and include active learning, but mostly	<b>Milestones</b> Learning methods integrate student-centered and active learning with community-based service learning. <b>Indicators</b> 1. Learning methods include problem solving to address priority needs in the communities the school serves.	<b>Milestones</b> The School offers an integrated student-centered learning curriculum, with educational programs located in communities integrated with health work teams and with a clear view of social determinants of health as well as inter-professional learning. <b>Indicators</b>

	Teaching Based Learning (TBL), interactive lectures).	implemented in classroom settings.	2. The school offers inter-professional learning in primary care contexts and students actively engage in primary care health teams.	<ol style="list-style-type: none"> <li>1. Teaching methodologies are relevant and appropriate to learner's needs and context.</li> <li>2. Learner satisfaction with learning methodology is reviewed on a regular basis.</li> <li>3. Proportion of the curriculum is spent in inter-professional team learning environment</li> <li>4. Continuous assessment that includes evaluating and monitoring the acquisition of competencies associated with social accountability.</li> </ol>
<b>3.3 Curriculum: Types and locations of educational experiences</b> (Community-based education)	Learning takes place mostly in classrooms and hospital settings with little or no time spent in community and primary care settings.	<b>Milestones</b> Curriculum includes required short placement in primary care and community sites while most clinical learning takes place in hospital settings.	<b>Milestones</b> There is an appropriate balance in clinical training between classroom, community, primary, ambulatory and hospital settings. <b>Indicators</b> <ol style="list-style-type: none"> <li>1. The curriculum ensures that students achieve an appropriate mix of mandatory community, primary care and hospital experiences.</li> <li>2. Proportion of student's time spent in community and primary care placement.</li> <li>3. The curriculum provides a diversity of experiences in settings in which students</li> </ol>	<b>Standard/s</b> Students are placed in community, primary care and hospital settings, including underserved communities, with the opportunity for an extensive, immersive experience during the final years when most clinical learning takes place. <b>Indicators</b> <ol style="list-style-type: none"> <li>1. Proportion of student's time is spent in primary care, community and underserved settings each year.</li> <li>2. School trains and assesses performance of all clinical preceptors.</li> <li>3. Proportion of learners who choose careers in primary care, community and underserved settings.</li> <li>4. Stakeholders involved in creation and evaluation of community placements for learners.</li> </ol>

			<p>learn and addresses social determinants of health.</p> <p>4. Quality assurance processes including supervision and clear process for site selection</p>	<p>5. Provides adequate learner exposure to priority health needs while learning in context.</p> <p>6. Schools and their stakeholders evaluate longitudinal experience in the community.</p> <p>7. Student assessment results are equivalent no matter which clinical sites the students received their training.</p>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>
<b>4. RESEARCH</b>				



<p><b>4.1 Community-Based Research</b></p>	<p>Limited or no research focusing on priority issues in the communities that the school serves.</p>	<p><b>Milestones</b></p> <p>A number of individual faculty members, at their own initiative, conduct research that is relevant to health equity, community health and workforce needs.</p>	<p><b>Milestones</b></p> <p>The school has specific community-based research program supported mainly by faculty members with irregular participation of students, health workers and community members</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Proportion of research projects that have a translational component that is relevant to the communities they serve.</li> </ol>	<p><b>Milestones</b></p> <p>The school has an integrated research program based on the social determinants of health, with participation of students, faculty, health workers and community members.</p> <p>The school has an integrated research program within all educational departments that focuses on health equity, gender parity and community health needs.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Research results regularly presented to the community, with demonstrable impact on the local health.</li> <li>2. Proportion of community-based research projects that involve community members and other stakeholders.</li> <li>3. Demonstrated impact of research on health services, policy and practice</li> </ol>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>

5. GOVERNANCE				
<p><b>5.1 Governance</b></p>	<p>No social accountability mandate in the school's vision, mission and values.</p> <p>Decision-making done through councils solely represented by faculty members.</p>	<p><b>Milestones</b></p> <p>Contemplation of a socially accountable mandate in school's vision, mission and values is underway.</p> <p>School's councils represented by faculty and students.</p>	<p><b>Milestones</b></p> <p>1. Social accountability mandates the school's strategic plan, mission, vision and values.</p> <p>2. Decision-making done through partnership and councils representing internal and external stakeholders including communities.</p>	<p><b>Standard/s</b></p> <p>A Social accountability mandate in the school's vision, mission and values that is fully defined, with metrics and benchmarks, and is being implemented.</p> <p><b>Indicators</b></p> <p>1. Important school's decisions reflect the input of key stakeholders, including educators, leaders, learners and communities.</p> <p>2. Evidence that education, research and service are designed, implemented and evaluated by external stakeholders.</p>
<p><b>5.2 Stakeholder partnership and engagement</b></p>	<p>Decisions are made by university and/or faculty authorities with no regards to social accountability or involvement of stakeholders including community partners.</p>	<p><b>Milestones</b></p> <p>Decisions are made by the university and/or faculty authorities with limited regards to social accountability or formal involvement of stakeholders.</p>	<p><b>Milestones</b></p> <p>Decisions are made through consultation with formal involvement of stakeholders in some but not all committees and processes.</p> <p><b>Indicators</b></p>	<p><b>Standard/s</b></p> <p>The school actively partners with students, faculty, health sector stakeholders, policy makers and communities to design, manage and evaluate education, and research activities that address the priority health and social needs of the communities the school serves.</p> <p><b>Indicators</b></p> <p>1. Decisions that affect the social accountability mandate of the school consistently reflect the input of key stakeholders including</p>

			<ol style="list-style-type: none"> <li>1. Decisions are made with inputs from targeted stakeholders.</li> <li>2. The school has policy and processes in place to seek out and consult with stakeholders in decision making.</li> </ol>	<p>educators, leaders, learners, service providers, patients, government and communities</p> <ol style="list-style-type: none"> <li>2. Evidence that external stakeholders from the community are actively involved in the design, implementation and evaluation of education, research and service.</li> <li>3. Proportion of projects and partnerships involving communities and health service providers.</li> </ol>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>
<b>SCHOOL OUTCOMES AND SOCIETAL IMPACT</b>				
<b>6. 1 School Outcomes</b>	The school doesn't track its graduates.	<b>Milestones</b> The school is developing systems and processes to track the location and practice of its graduates.	<b>Milestones</b> The school tracks its graduates and is beginning to measure its influence on graduates' location and practice.	<b>Standard/s</b> An appropriate number of the school's graduates practice according to where they are needed in the geographical region the school serves.
			<b>Indicators</b>	<b>Indicators</b> <ol style="list-style-type: none"> <li>1. There is a system in place to continuously track the school's graduates and the relevance of the training they received to their practice.</li> <li>2. The school uses feedback from its graduates to adjust its programs as part of continual quality improvement</li> </ol>

			<ul style="list-style-type: none"> <li>• Graduate career choice and practice location.</li> <li>• Research on educational factors that influence location and career choices.</li> </ul>	<p>3. The practice choices of graduates reflect the needs of the region that the school serves for primary care and specialties.</p> <p>4. Location of graduates closely mirrors geographical distribution of health needs in the communities and regions the school and its graduates serve.</p> <p>5. The school works closely with post-graduate/vocational residency training programs to develop a continuum of learning.</p> <p>6. Proportion of graduates practicing in high need areas and professional orientations such as primary care.</p>
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DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>
SCHOOL OUTCOMES AND SOCIETAL				

<p><b>6.2 Societal Impact</b></p>	<p>The school doesn't measure the impact it has on the region it serves.</p>	<p><b>Milestones</b></p> <p>The school is developing systematic measurement of its societal impact.</p>	<p><b>Milestones</b></p> <p>The school implements research to systematically measure its societal impact</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Faculty implements research to assess the impact of implementing social accountability strategies on the geographical region it serves.</li> </ol>	<p><b>Standard/s</b></p> <p>The school's education, research, its graduates, health service and partnerships have a positive impact on the health care, the health and health equity of the communities/regions the school and its graduates serve.</p> <p><b>Indicators</b></p> <ol style="list-style-type: none"> <li>1. Systematic measurement of the school's impact.</li> <li>2. Graduates contribute to improving the quality and equity of healthcare access in the communities they serve.</li> <li>3. The school's educational programs are an integral part of its region's health care system.</li> <li>4. The school's partnerships with health care organizations and communities include projects that improve the health of underserved populations.</li> <li>5. School and its graduates are actively engaged in improving health systems, advocacy for underserved populations and increased health equity.</li> <li>6. Research findings inform policy and practice to improve health and health care in the region the school serves.</li> </ol>
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### SECTION 3. STAKEHOLDER ENGAGEMENT

This section consists of 5 items. All items need to be completed. This section aims to understand to what extent do institutions engage stakeholders in planning for advancements, policy and decisions. Using the most appropriate/realistic developmental descriptions provided in the criteria below, please indicate where your institution falls between Phase 1 and Phase 4:

Phases	Stakeholders Involved
Phase 1	Involvement of internal stakeholders (i.e., faculty members and students) in the completion of self-assessment and action plans to advance to the next stage.
Phase 2	Involvement of internal stakeholders and health professionals and community representatives in the completion of self-assessment and action plans to advance to the next stage.
Phase 3	Involvement of internal stakeholders, health professionals, community representatives and health care organizations in the completion of self-assessment and action plans to advance to the next stage.
Phase 4	Involvement of internal stakeholders, health professionals, community representatives, health care organizations, and government in the completion of self-assessment and action plans to advance to the next stage.

#### SECTION 4. IMPROVEMENT PHASES TOWARDS SOCIAL ACCOUNTABILITY

This section consists of 11 items in 6 domains. All items need to be completed. Using the developmental milestones provided in the criteria below, please indicate your institution's plan of action to move to the next phase. Please articulate the plan to involve stakeholders including internal stakeholders, health professionals, community representatives, health care organizations, and government. You may upload a supporting evidence (i.e., documents, webpage, images, published works, etc) to justify and further elaborate upon your action plans.

Phases	Stakeholders Involved
Phase 1	The plan is concrete and realistic to move the institution to the next phase in 2-3 years and involves internal stakeholders (i.e., faculty members and students) in the completion of self-assessment and action plans to advance to the next stage.
Phase 2	The plan is concrete and realistic to move the institution to the next phase in 1-2 years and involves internal stakeholders, health professionals and community representatives in the completion of self-assessment and action plans to advance to the next stage.
Phase 3	The plan is concrete and realistic to move the institution to the next phase in 1-2 years and involves internal stakeholders, health professionals, community representatives and health care organizations in the completion of self-assessment and action plans to advance to the next stage.
Phase 4	The plan is concrete and realistic to move the institution to the next phase in 6 months to 1 year and involves internal stakeholders, health professionals, community representatives, health care organizations, and government in the completion of self-assessment and action plans to advance to the next stage.

## GLOSSARY

- **Standard:** The description of the aspiration for excellence social accountability as it relates to a particular element of medical education.
- **Indicator:** Is a measure, quantitative or qualitative, of the progress of a school towards social accountability. An indicator *measures progress towards the standard*.
- **Milestone:** It describes a significant stage in the progress of a program towards social accountability.
- **Conventional medical education:** In this document the term refers to medical education that tends to be discipline-oriented and didactic. The curriculum tends to focus on medical care, with clinical learning taking place mostly in tertiary care settings. The content is not systematically aligned with changing needs and education tends to be teacher rather than learner centered with limited opportunities for self-directed and service learning.
- **Quality:** The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. These health services must be delivered in a way that optimally satisfies both professional standards and community expectations.
- **Equity:** The state in which opportunities for health gains are available to everyone. Health is a social product and a human right. Health equity (that is, the absence of systemic inequality across population groups) and social determinants of health should be considered in all aspects of education, research and service activities. This incorporates the principles of social justice, or addressing the unequal distribution of resources, and universal access to education.
- **Relevance:** The degree to which the most important and locally relevant problems are tackled first. This incorporates the value of responsiveness to community needs. In addition, it incorporates the principles of cultural sensitivity and competency. Cultural competency is defined as the process of removing barriers to effective and open communication in the service of a patient.
- **Professionalism:** It is understood as the whole of knowledge, skills, principles and values that support an ideal practice of Medicine in the framework of the highest standards of scientific, ethical and humanitarian quality and knowledge of social needs
- **Efficiency/Cost Effectiveness:** This involves producing the greatest impact on health, with available resources targeted to address priority health needs, and incorporates the principle of cost-effectiveness.



- **Interprofessional Education:** According to WHO/PAHO Interprofessional Education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.
- **Service Learning:** Is “a form of experiential education in which [learners] engage in activities that address human and community needs together, with structured opportunities for reflection designed to achieve desired learning outcomes.”<sup>2</sup>
- **Stakeholder:** A stakeholder in health workforce education is anyone who has an interest in the success of a strategy, program or school. They can be individuals or organizations either indirectly or directly impacted by the success or failure of the effort. Stakeholders include students, government officials, community members, service providers, administrators, and faculty.
- **Faculty member:** employees of the educational institution, to include lecturers/professors, managerial staffs and administrators.

## Appendices

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## Glossary

**Standard:** The description of the aspiration for excellence social accountability as it relates to a particular element of medical education.

**Indicator:** Is a measure, quantitative or qualitative, of the progress of a school towards social accountability. An indicator *measures progress towards the standard*.

**Milestone:** It describes a significant stage in the progress of a program towards social accountability.

**Conventional medical education:** In this document the term refers to medical education that tends to be discipline-oriented and didactic. The curriculum tends to focus on medical care, with clinical learning taking place mostly in tertiary care settings. The content is not systematically aligned with changing needs and education tends to be teacher rather than learner centered with limited opportunities for self-directed and service learning.

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