



THE NETWORK
TOWARDS UNITY FOR HEALTH

Indicators for Social Accountability Tool in Health Profession Education

Institutional Self-Assessment Guide and Tool

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**In Collaboration with the Global Consensus for Social Accountability, PAHO, TheNET,
Social Mission Alliance, and NOSM University**

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Introduction

Social Accountability is a principle and value that inspires health actors to better respond to people and society's priority health needs today and in the future. Across the globe, 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 that health professionals possess, are both barriers to achieving Universal Access and Universal Health Coverage for all. Evidence is emerging that who gets educated, what topics they study, where and how their learning takes place, each influence career choices and future practice locations. Increasing the social accountability of health workforce education institutions and their graduates is now recognized as an effective mechanism for maximizing their positive impacts on health and health systems.

In response, global frameworks and policies are embracing social accountability strategies to improve the quantity, quality, and relevance of health workforce education, all in order to ensure that countries have well-trained interprofessional teams who are ready and willing to work *with* and *in* communities to address their unique and self-identified health needs, wherever they live. The application of the principles of social accountability provides a mechanism for institutions to increase equity in education, conduct research that is accountable and relevant to population health needs, and improve access and quality of health care delivery services, each of which are essential for socially accountable institutions. Social accountability mechanisms not only foster continuous efforts to increase equity, but also 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 Socially Accountable Institution, we will 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 globe¹ aspire to meet Social Accountability values and standards because they want to stay relevant, competitive, and values-driven. To do this, we suggest pursuing both self-assessment and verification through an oversight committee, as outlined below:

¹ Social Accountability has been defined by the World Health Organization as “the obligation [of medical schools] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.” (World Health Organization, 1995).

- **Social Accountability Assessment** evaluates how an institution’s governance, operations and business model impacts their workers, community, environment, and beneficiaries. It demonstrates that an institution is actively working toward meeting the highest standards of social accountability.
- **Social Accountability Verification** also helps stakeholders such as community members, students, faculty, alumni, media, policy makers, and partner organizations to identify which institutions in their context value Social Accountability as a force for good.

Health Institutions² and Systems that self-assess have the option to be verified by an independent expert oversight committee managed by The Network: Towards Unity for Health. By becoming verified they are leading a movement toward a more socially accountable world. This involves building relationships with like-minded institutions and individuals, attracting talent, improving impact, amplifying community voices, and advancing institutional missions.

The self-assessment uses the Indicators of the Social Accountability Tool (ISAT) which is meant to help institutions and programs educating health professionals to regularly assess their progress towards greater social accountability, all so that their programs are optimally positioned to meet current and future health system needs, thereby increasing universal access to health and universal health coverage. The ISAT can also assist institutions 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.

The purpose of this guide is to serve as a reference for institutions (e.g., health professions education

What are the main defining features of Social Accountability?

“Involvement of the community in identifying community needs, setting priorities, establishing and evaluating new models of practice is seen as critical [for Social Accountability].”

The 2001 Health Canada report “Social Accountability: A Vision for Canadian Medical Schools”

Social Accountability requires responsiveness to “current and future health needs and challenges in society,” strengthening “governance and partnerships with other stakeholders” and using “evaluation and accreditation to assess performance and impact.”

The 2010 Global Consensus for the Social Accountability of Medical Schools

² Throughout this document we use the term “health education institutions” or simply “institutions” to refer to the diverse global array of medical schools, faculties of medicine, universities with programs in public health and dentistry, and in some instances hospitals and medical centers. This terminological range reflects the global breadth of institutions who are seeking to become more socially accountable.

institutions) when completing the ISAT Social Accountability Self-Assessment Application. The 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

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

Recent evidence indicates that who gets educated, what topics they study, and where and how their learning takes place, influences the career choices and future practice locations of health professionals. Increasing the social accountability of health workforce education institutions and their graduates is now 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.

In response to its widespread recognition, global frameworks and policies 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, each of which are essential goals for socially accountable institutions. Social accountability mechanisms not only foster continuous efforts to increase equity, but also seek to

What is Social Accountability in the context of Health Workforce Education?

Social Accountability is “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

How does Social Accountability relate to the broader connection between societies and their institutions?

“The creation of momentum towards a global initiative to ensure that the accreditation systems of medical schools are designed and used to better respond to priority health needs and challenges of societies today and in the future.”

Conceptual Framework Accrediting Progress
Towards Social Accountability 2024

improve 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 existing social accountability tools, the group developed the **Indicators for Social Accountability Tool (ISAT)**. Its purpose is to promote education, research, and service delivery programs that are aligned with priority health needs by providing health workforce education institutions with a tool to regularly assess their progress towards greater social accountability. It is a relatively straightforward diagnostic instrument that helps institutions and their stakeholders reflect on where they are while identifying 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
- institutional outcomes
- 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.

The ISAT 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 structured by differences in population health that are systemic, socially produced, unjust, and preventable. According to the World Health Organization, more than 400 million people across the globe 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 an area with some of the highest levels of health inequity. Such health inequities are not only unacceptable, but also costly in ways that limit individual opportunity and slow 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 geographical maldistribution of health workers and mismatch between needs and competencies remain as barriers 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.”⁴ The Pan American Health Organization (PAHO) adds to this 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.”⁵

Yet, most efforts to address health workforce shortages have focused on increasing production, with limited attention being paid to the impact of institutional and educational strategies on the location and career choices of medical graduates.⁶ Increasing the number of educated health professionals is clearly not enough as many new graduates turn towards specialty careers in urban or high income-country settings. For example, in the last thirty to forty 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.⁷ 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.⁸

In response, global frameworks and policy guidance including the World Health Organization's (WHO) Global Strategy on Human Resources for Health,⁹ the report and action plan of the High-level Commission on Health Employment and Economic Growth (ComHEEG),¹⁰ WHO's guidelines on transforming health professional education,¹¹ 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*,¹² 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. 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 the public."¹³

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 in East London, South Africa). Simultaneously, the 2010 Lancet Commission on the Education of Health Professionals for the 21st Century included a section on social accountability and featured the experiences of the Training for Health Equity Network (THEnet), a partnership of health professional schools committed to social accountability.¹⁴

Over a decade later, evidence continues to show the positive impact of this approach on increasing the availability, distribution, and performance of health workers in underserved regions as well as strengthening health in the regions they serve.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, and the other assessing the effectiveness of implementation.

The ComHEEG report sets out a vision whereby the health workforce should be oriented towards the social determinants of health, health promotion, disease prevention, primary care, and people-centered, community-based services. However, 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
- 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.¹⁶

A recent study on Latin American perspectives on social accountability in medical education identifies 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

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.

with primary care practice, the lack of indicators on social accountability as a primary responsibility of medical schools, and fewer faculty role-models in primary care than subspecialty training and low quality student exposure to primary care models.¹⁷ The recommendations of the above-mentioned study in Latin America include the development of a tool to assess the social accountability of medical schools in the region, the building of a regional network of medical schools focusing on the topic, and the 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.”¹⁸ 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 that 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 the 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, and 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, institutions are expected to document the plans, actions, and impacts of their education, research and service, and to enlighten their graduates and partnerships on the healthcare, health and health equity of their communities, regions, and nations.

Faculty at George Washington University's Institute for 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 study¹⁹ 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 initiative of health professional schools striving towards social accountability. Its first joint project was —building on the conceptualisation–production–usability model developed by Woollard and Boelen²⁰ and the successful strategies of its members— to develop and implement a comprehensive evaluation Framework.²¹ 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 look critically at their performance and progress towards greater social accountability and assist them in establishing priority areas for research and quality improvement.

Participants in the PAHO/WHO meeting in June 6 to 7th 2017, drew on these tools to agree on a core set of indicators of social accountability: Indicators for Social Accountability Tool (ISAT). The diagnostic tool is aimed specifically 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, 13th-17th November 2017) and the Beyond Flexner 2018 Conference (Atlanta-USA, 9th-11th April 2018). It was then reviewed at the 55th COBEM- Brazilian Congress of Medical Education (Porto Alegre-Brazil, 12th-15th October 2017). Two medical faculty from different schools did separate 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 as 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.

In 2019 PAHO partnered with The Network: Towards Unity for Health (TUFH) to operationalize the ISAT tool within medical and health science schools and faculties across the globe. TUFH set two aspirational goals to achieve the vision of the ISAT Tool: 1) by 2027, 30% of globally recognized agencies in targeted regional and countries will acknowledge Social Accountability Standards and incorporate into Accreditation Standards; and 2) 15–20% of health professional education institutions in targeted regions and countries will have completed an institutional assessment and certification process.

TUFH, to achieve these goals implemented the following strategies:

1. Promote international understanding for the need of structural adoption and implementation of Social Accountability; where health systems respond to priority health needs as informed by community input.
2. Support health institutions to become verified as Social Accountable Institutions leading to improvement and increased ability to attract undergraduates, postgraduates and faculty from all over the world.
3. Proactively engage with global entities that model health accreditation standards to incorporate Social Accountability principles and standards.
4. Inspire students to engage with visionary leadership at health institutions and pentagram partners to adopt Social Accountability principles into policies.

5. Build on the knowledge base and provide tools for health institutions to specify and measure their societal impact. Expand institutional results to include improved patient outcomes and incorporate innovative learner assessments to measure community engagement.
6. Share, publish and distribute new knowledge through TUFH Academies and TUFH publications.
7. Recognize institutions that complete the Social Accountability Institutional Assessment and accredit entities that adopt Social Accountability principles or standards.

From 2020 – 2024 TUFH piloted the tool with 10 international institutions, translated the tool and created expert oversight committees in English, French, Spanish, and Portuguese, and partnered with the Northern Ontario School of Medicine, who hosts the International Social Accountability and Accreditation Steering Committee (ISAASC), to host the Global Accountability Fellowship for School and Faculty leadership to adopt Social Accountability Standards and develop action plans.

In 2024, TUFH convened a group of global experts to review and revise ISAT to reflect the realities institutions, schools, and faculties face in 2024. The present ISAT 2.0 version is a product of that feedback.

Introduction to the 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 institutions 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 the 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 direct collaboration with stakeholders. Consequently, meaningful engagement with other stakeholders including students, service 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 various institutional levels. It can be used by leaders, faculty, and students to do a relatively rapid assessment of where the institution stands in relation to the goals of social accountability. It can be used to promote collective reflection and gather feedback to share with those who run the program or those who are responsible for strategies at institutional 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 at each stage of the process.

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

Discussing and recognizing the underlying assumptions of an institution's operational "theory of change" can be useful for identifying areas for improvement or reform. Finally, by identifying which influencing factors are known and unknown, the tool can help institutions progress and grow.²²

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?
- 3) Are there indicators that are not appropriate for the context of a particular institution, 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 an institution, program, or school where limited or no attention is being paid to social accountability and where associated strategies are not currently 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 suggests that the institution is intending to implement social accountability strategies, but it has not yet achieved the desired outcomes of these strategies.

Phase 4 describes a situation where proactive processes and systems are in place to measure progress toward social accountability and where institutions can demonstrate the impact of strategies and policies associated with social accountability.

It should be noted that institutions are not always able to control or influence specific policies, strategies, or activities due to various reasons, ranging from the amount of time they have had to assess Phase 4 indicators; to the lack of influence they may have on decisions around certain policies, strategies, or resource allocation; to a lack of resources for implementing desired strategies or resources to measure outcomes or assess impact. Hence, institutions are likely to be in different phases for different Core Components, and users of the ISAT may discover that the level and speed of progress can depend on a host of internal and external factors both within and beyond their control and influence. However, using the ISAT will help institutions to assess their current situation while identifying barriers and enabling factors to progress towards increasing their social accountability.

What are ISAT's Core Components?

The 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 and related institutions, not all of them can be assessed in the same way because the context, including policies and regulations, can vary from country to country. Each 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. This is a Core Component for social accountability because evidence shows that who gets admitted into medical school matters.²³ However, it should be noted that in some countries, institutions have no influence on who attends their programs because selection is done at national levels, or – in the case of Argentina – there may be no specific and universal criteria for entrance into medical school once students graduate from secondary education. In such cases, institutions striving towards greater social accountability can advocate for policy changes, reach out to underrepresented groups, and provide special academic, financial, and psychological supports to students from rural or underrepresented groups.

In many countries, institutions can use strategies to identify students with attributes and backgrounds that are predictive of their interest and desire to work in areas with high or unique needs, particularly in rural and underserved regions.²⁴ 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 (for example, such factors may include having a rural background). Institutions 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; marketing strategies; and selection based psychometric tests to assess personal attributes such as strong interpersonal skills and empathy.²⁵

Where admission or student selection committees are in place, socially accountable medical schools and related institutions include key stakeholders such as members of underserved or marginalized populations in the committees. For example, Canadian accreditation standards call 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”²⁶

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. But in poorer regions of the world, academic positions 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. Socially accountable institutions seek to attract faculty who have the competencies needed to address the health and health system needs of the region where the institution is located, and those who come from diverse socioeconomic and cultural backgrounds (ideally from the specific community it serves). Institutions also aim to recruit an appropriate balance of biomedical, population, clinical, and social sciences faculty and aim for gender parity. Rural institutions are at a disadvantage compared to urban or peri-urban institutions to recruit qualified faculty. However, community-engaged medical education – a hallmark of social accountability – is generating additional new needs but also opportunities for institutions to recruit faculty with strong interprofessional skills, who are able to work across disciplines and sectors in areas of shortage.

In addition, socially accountable institutions 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 institutions offer unique opportunities for faculty committed to social change and interested in making a tangible difference in the health and well-being of underserved rural communities. These institutions 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 and these changes have profound 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, big data, and artificial intelligence. While these changes will vary 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 institution 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 to improve their skills in education and research, some institutions establish a Faculty Development program either as part of an education department or as a separate program. Such departmental development programs support continuous professional education using information technology and other communication tools. Faculty development programs may draw on various resources from the other departments at their university such as social and political sciences, engineering, other faculties of health sciences, and community-based organizations, all in order to shape a comprehensive curriculum on the social determinants of health and community development to prepare medical students for their community placements, and to support the community engaged service-learning education program. Faculty members can be instructed in pedagogical principles of interprofessional education and active student-centered and service learning during student community placements. Such programs can 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

Curriculum development occurs through a consultative process, drawing on resources of other institutions worldwide as well as accreditation standards. In partnership with the community, community-based organizations, and local health systems, the institution identifies the health and social priority needs of the communities they serve and then integrates them into the scientific base of the curriculum. Through a combination of insights from clinical sciences and social sciences this approach can shift the predominant narrow bio-medical model towards a socio-biomedical curriculum designed to advance the teaching mission of the institution, building on the strength of the community confronted with continuously evolving needs. This curriculum may include a longitudinal theme on the social determinants of health, woven through the various courses of the curriculum. The institution's 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 programs, standardized patients, and tracking students' progression throughout their courses. 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 institution's curriculum, often blended, and focus on learners and the best available methods to ensure they attain the desired competencies. Over the past few decades, learning methods have transformed from being apprenticeship models that centered teachers and subjects where students had little input, towards a competency-based, student-centered, and more interactive approach to learning that provides students with skills in critical thinking, reflective practice, problem-solving, and the practice of life-long learning. To address the need to train productive interdisciplinary teams who can work in any setting, including in marginalized communities, an increasing number of institutions use interprofessional and team-based learning, service-learning, experiential, self-directed as well as case- and problem-based learning approaches. Advances in information technology (IT) have also increased institutions' 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 clinical learning occurring primarily in hospital settings. Already in 1961, scholars were aware that training students mainly in university hospitals is illogical and inefficient.²⁷ 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 diagnoses and management of chronic diseases takes place.²⁸ 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).

By contrast, socially accountable health workforce education seeks to provide a balanced mix of clinical experiences between primary care settings, secondary and tertiary hospitals, and opportunities to better integrate learning about the social determinants of health into the curriculum. Most socially accountable institutions provide some form of longitudinal integrated clerkships or extended times in community settings.^{29 30} This community-engaged education

approach presents remarkable opportunities 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 surveys, identify priority issues, and design and implement interventions based on agreement with all stakeholders, concluding with the student evaluating their project results and impact. Community-based rotations integrate theory and practice and offer unique opportunities for close collaboration between schools of medicine, public health, pharmacy, social sciences, and others, to work together with local community-based organizations and health centers to develop and integrate the SDH into the curriculum and develop interdisciplinary team-based approaches within community health programs tailored to priority needs.

Community-based Research

Social accountability calls for institutions to align their research towards the priority needs of the communities they serve, and to collaborate with communities in the design and implementation of their research projects. Reciprocal partnerships between the institution, the communities it serves, and the health care system, provide unique opportunities for establishing collaborative research agendas, conducting research on health equity and community health, and improving how institutions can better address the health system and health priorities of their populations. It also provides opportunities for institutions to do research on how their educational process and education outcomes align with the needs of the health system and the priority needs of the communities. Socially accountable institutions are currently generating evidence for how education and training programs 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.³¹ This provides faculty members and students with an array of research topics on causes and factors responsible for generating health inequities in communities, and assists them in developing joint strategies and remedial interventions. Social accountability also calls for faculty and students to be attuned to ethical considerations related to community-engaged research, and attentive to the impact research findings are having on policies, practice, and health in the communities the institution serves.

Governance

According to the AMEE Guide on *Producing a socially accountable medical school* as well as other key documents on social accountability, incorporating social accountability principles into institutional governance or program governance is an essential step. This includes the integration of social accountability principles and strategies into decision making, planning, evaluation, resource mobilization and allocation, as well as day to day management.³² While many institutions incorporate principles of social accountability — such as 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 institution 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 institutions 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 institutions, engaging with communities with a service approach is hardwired into every aspect of their work, so community members are members of boards of directors or other governance and advisory bodies. An institution's governing body makes key decisions regarding strategies, policies, and programs, including how to allocate resources. However, it should be recognized that the institution'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 stakeholders in health professional education 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."³³ 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".³⁴ According to the report of the High-Level Commission on Health Employment and

Economic Growth, curricula should be developed in partnership with communities served by the institution and with other stakeholders.³⁵ These include students, service providers, community-based organizations, governments and members of underserved populations.

Institutional 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.

Because socially accountable institutions, programs, and schools set out to produce graduates who 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 the absence 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, many current tracking efforts are done by institutions themselves,³⁶ 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. Institutions 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 from entry into health professional education until several years after graduation.

Societal Impact

To ensure that institutions are addressing evolving needs in the society, regions, and communities they serve, they need to regularly 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 the level of health in the communities they serve. Assessing the effect of education strategies on health systems and population health is clearly challenging because 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. Institutions striving towards greater accountability and impact are beginning to assess impact – for example, emerging evidence is presented in the World Health Organization's 2017 publication *Health Employment and Economic Growth: An Evidence Base* and other publications referenced in the endnotes.³⁷

Other considerations

There is a growing interest in broadening the scope of social accountability to include the concept of environmental accountability.³⁸ 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 undergraduate medical education.

ISAT SOCIAL ACCOUNTABILITY SELF-ASSESSMENT TOOL

IMPLEMENTATION GUIDE

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

The 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's oversight committees 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 its selection and then upload any relevant documents that support the selection.

Upon completion of the baseline for each of the domains, the institution will be asked to articulate a plan of action in order to advance to the next phase 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. As institutional leaders input information into this section, they are encouraged to be strategic about the selection and identification of both internal and external stakeholders and partners to ensure continuity if institutional leadership changes over time.

No.	Identity and Demographic	Explanation
1.1	Name of Institution	The name of the institution whose leaders are leading and engaging in the ISAT self-assessment process.
1.2	Institutional Leadership	The names of the institution's leaders (e.g., Rector, Vice-Chancellor, Dean, Director, CEO, etc.)
1.3	Lead Contact	The name of the institutional lead and key contact who is leading the ISAT assessment and implementation at the institution. This person will be the primary resource person for TUFH when contacting the institution in relation to the ISAT process.
1.4	Corresponding Email	Communications, notifications, and correspondences will be directed to this email address.
1.5	Date	Date of the ISAT tool completion by institution (will be automatically recorded by the electronic application).
1.6	Faculty Delegates	Please list 5 faculty delegates included in the application process who are aligned with Social Accountability principles, including their email addresses. The delegates should represent a diverse range of seniority, departments and divisions, gender and sexual orientation, and racialized and classed identities. Institutional leaders are encouraged to consider a cross-section of faculty beyond medical faculty within the university. A diverse and representative group of leaders can ensure institutional buy-in. Depending on national and regional contexts, terms like “school” and “faculties” may be defined differently. Regardless, institutional leaders should define their stakeholders and their criteria for selecting them (see 1.8 below).
1.7	Student Delegates	Please provide the names and email addresses of 5-7 student delegates, included in the application process who are

		sympathetic with Social Accountability principles, and who will be included in the application process. The delegates should represent various levels of seniority (year/batch of study), study program, gender and sexual orientation, racialization and socioeconomic class, etc.
1.8	Stakeholders and Constituent Partnerships	<p>Please provide a list of prospective and confirmed stakeholders and constituents who reflect the societies and communities to which the institution is accountable, as it undertakes the ISAT process. Please emphasize concrete representatives and groups such as health administrators, government officials, legislators, and community delegates, in ways that align with the Partnership Pentagon Plus (environment, infrastructure, economy, society, people, and the health system).³ Emphasis should be placed on concrete partners who would benefit from an institution becoming socially accountable. Institutional leaders should also consider the contextual development of each group’s involvement over time, for example by narrowing or broadening number of dedicated sub-groups</p> <p>Examples: Medical Doctors (public and private), Local Government Officials, Local and International NGOs, Hospital CEOs, Students, Medical Education Experts, Department Heads, Health Care Providers, Frontline Workers, Paramedicine Groups, Community Representatives, Primary Patient Populations and their representatives, vulnerable populations, groups that geographically span rural and urban areas, Local Executives, Community Health Care Workers, and Program Alumni.</p>

³ Markham, R., Graham, S., Hunt, M., Betkus, G., Woollard, B., Snadden, D., ... Williams, K. (2022). Social Accountability in Practice: Breathing and Weaving Together to Build Relationships and Transform Rural Health Services. *Social Innovations Journal*, 14(4). Retrieved from <https://socialinnovationsjournal.com/index.php/sij/article/view/2151>

SECTION 2. DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY

This section consists of 11 core components 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 to support your choices. You may upload supporting evidence (i.e., documents, webpage, images, published works, etc.) to justify and further elaborate on your choice.

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

	remote, racialized and oppressed groups).		<p>The institution offers active support for students from underserved or underrepresented backgrounds.</p> <p>Indicators</p> <ol style="list-style-type: none"> 1. Selection criteria aim to attract students who represent the socio-economic, geographic, ethnic, linguistic, and cultural diversity of the regions the institution serves. 2. Advocacy to support access to health professions education for underserved groups. 3. Admissions Committees have geographic and demographic diversity in their make-up. 4. The institution actively encourages return to service to the communities that its faculty and graduates come from. 5. Admissions committees are made up of diverse socioeconomic backgrounds with equitable distribution of decision-making power. 	<ol style="list-style-type: none"> 2. Explicit and targeted admission pathways and educational support for learners from underserved populations who may require additional support to succeed. 3. Admission Committees have diversity in memberships and community involvement at all levels. 4. Equivalency in ratios of attrition, progress, and completion statistics of learners from underserved populations compared to all learners. 5. The institution provides scholarships and bursaries that directly support students whose social and economic class status prevents their full participation in educational opportunities. 6. The institution has an action plan for advocating for university and/or national policy reform to influence student recruitment toward social accountability. <p>Indicators of Student Support</p> <ol style="list-style-type: none"> 1. The institution has a program dedicated to award scholarships for students from underserved communities. 2. The institution has comprehensive support, counselling, and remedial programs including mental health supports for all students.
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			<p>6. The institution is exploring partnerships with other local institutions in underserved areas.</p> <p>Note: In some cases, national or institutional policies severely limit the ability of faculty and administrators to make changes in student selection. In these cases, institutions should clearly note advocacy efforts within the institution or country to shift their policies on student selection.</p>	<p>3. The institution provides additional support to students from rural and remote areas, and for students who are first generation attendees of college/university programs (for example, an enrichment term of 3-6 months or a preparatory year, as deemed appropriate by a medical school).</p> <p>4. The institution provides remote work and digital options for students who are unable to join classrooms in person.</p> <p>5. The institution ensures that all students and faculty are knowledgeable about social accountability within the contexts of recruitment, selection, and support.</p> <p>6. The institution provides financial support for student-led community engagement projects.</p>
<p>Open Comments Section</p>				

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY

Core Components	Phase 1	Phase 2	Phase 3	Phase 4
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2. FACULTY

<p>2.1 Faculty Recruitment</p>	<p>The institution recruits faculty based on “conventional” academic and clinical credentialing and most clinical teachers are based in hospital settings.</p>	<p>Milestones</p> <p>The institution 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>Milestones</p> <p>The institution 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 (for example, from beyond the sciences, and from the Social Sciences and Medical Humanities).</p> <p>Indicators</p> <p>1. The institution has a mix of primary care, clinical</p>	<p>Standards</p> <p>The institution 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. Ideally, most of the faculty who the institution employs and promotes, should possess competencies in social accountability.</p> <p>The institution 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>Indicators</p> <p>1. Faculty composition reflects the diversity of the communities the institution serves.</p> <p>2. Training, use, compensation, and recognition of community practitioners and members of the health care team in underserved communities and across the region as faculty.</p>
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			<p>specialists, subspecialists, basic sciences, and social sciences aligned with needs.</p> <p>2. Faculty selection and promotion processes aim to attract faculty from a diverse mix of professional, cultural, social, and community backgrounds.</p> <p>3. Faculty recruitment from local contexts contributes to institutional identity.</p> <p>Note: The definition of “faculty” will vary depending on national and institutional contexts. Faculty definitions for the ISAT process encourages the inclusion of all educators.</p>	<p>3. Proportion of community members and practitioners who are faculty members and adjunct faculty who are engaged with the institution in training health professionals.</p> <p>4. Proportion of faculty involved in social accountability activities to develop the health system and workforce, and health care to meet community needs.</p> <p>5. Proportion of faculty members who engage in teaching and research activities related to community health needs and service learning.</p> <p>6. The institution values education and community engagement service in their assessment for career advancement.</p> <p>7. Proportion of faculty – whether community-oriented, clinical, or of basic sciences – who have become educated about Social Accountability and incorporated it into their teaching and discipline (i.e. a cardiologist who becomes involved with primary prevention heart programs, or a gastroenterologist who participates in the ECHO Program).</p> <p>8. Proportion of faculty who come from local areas and/or bring local perspectives.</p> <p>9. Faculty are recruited from beyond the sciences, including from the Medical Humanities, bioethics and biopolitics, and Social Sciences.</p>
<p>Open Comments Section</p>				

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
2. FACULTY				
2.2 Faculty Development	The institution has no faculty development program or if there is one, it is limited to conventional pedagogical approaches and curricular topics.	Milestones The institution has a faculty development program that values student-centered and active learning strategies but overall promotes conventional approaches.	Milestones 1.The institution 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, assessment of students, workplace-based learning, and community-based learning. Indicators 1.Faculty assessments and development programs are	Standard The institution 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. Indicators 1. Proportion of faculty who completed clinical skills training relevant to identified priority health care needs. 2. Proportion of faculty who completed professional development in effective community engagement. 3. Proportion of faculty who are engaged in social accountability aligned education, research, and service. 4. Proportion of faculty members from the local health workforce (including practitioners and community members) who have completed courses on teaching methodologies

			<p>designed to update and strengthen teaching and competencies relevant to priority health needs.</p> <p>2. Educators undertake training and development of cross-cultural skills, cultural humility, and cultural competency.</p>	<p>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. The institution has a program to reward the quality of teaching and community engagement.</p> <p>7. Faculty are appraised of best practices and strategies to respond to society's health needs, and are recognized and rewarded for doing so.</p> <p>8. The institution includes Social Accountability Standards as part of recruitment, hiring (contracts), orientation, and promotion.</p> <p>9. The institution provides a program to bring awareness of and promote Social Accountability.</p>
<p>Open Comments Section</p>				

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
3. EDUCATIONAL PROGRAM				
3.1 Curriculum: Content	Curriculum is specialty driven and focuses on disease management and individual health.	Milestones The traditional curriculum incorporates elements of public health and topics related to community needs.	Milestones Curricular content reflects identified priority health, cultural, and social needs of the populations in the geographic area the institution serves. The curriculum is competency-based and includes content related to interprofessional team work. Indicators 1. Required competencies are defined based on the specific health needs of the populations and regions the institution serves. 2. Proportion of the curriculum allocated to learning about priority community health needs not traditionally part of a medical curriculum.	Standard 1. The curriculum design, content, delivery, assessment, and evaluation each reflect the expected competencies of graduates related to health equity and social accountability. 2. Professional orientation is identified through needs assessment of the geographical area of the underserved communities the institution serves in collaboration with stakeholders. It integrates the principles of primary health care, basic and clinical science with population health and the social determinants of health. Indicators 1. The institution identifies graduate competencies that are based on the priority health, cultural, and social needs of: the geographical area the institution serves, as well as the health system, and services in collaboration with community stakeholders.

				<p>2. There is a strong alignment throughout the whole duration of the program between curricular content and the findings of needs assessment and desired graduate competencies.</p> <p>3. Student assessment focuses on competencies that best prepare students to meet the health needs of communities, with an emphasis on primary health care.</p> <p>4. Curriculum is reviewed regularly by all stakeholders to ensure its quality and that it meets the needs of the community.</p>
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Open Comments Section

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
3.2 Curriculum: Learning Methods	Learning methods are predominantly teacher-centered with few initiatives on active learning, i.e. Teaching Based Learning, interactive lectures.	Milestones Learning methods are student-centered and include active learning, but mostly implemented in classroom settings.	Milestones Learning methods integrate student-centered and active learning with community-based service learning. Indicators 1. Learning methods include problem solving to address priority needs in the communities the institution serves. 2. The institution offers inter-professional learning opportunities in both academic and primary care contexts and students actively engage in primary care health teams. Note: We recognize that in some contexts teacher-centered approaches may be the only viable option because of policy and other limitations.	Milestones The institution 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. The institution offers a longitudinal experience pertaining to social accountability applied to different disciplines. Indicators 1. Teaching methodologies are relevant and appropriate to learner’s needs and contexts. 2. Learner satisfaction with learning methodology is reviewed on a regular basis. 3. The institution strategically defines what proportion of the curriculum is spent in inter-professional team learning environment. 4. Continuous assessment that includes evaluating and monitoring the acquisition of competencies associated with social accountability.

<p>3.3 Curriculum: Types and locations of educational experiences (Community-based education)</p>	<p>Learning takes place mostly in classrooms and hospital settings with little or no time spent in community and primary care settings.</p>	<p>Milestones Curriculum includes required short placement in primary care and community sites while most clinical learning takes place in hospital settings.</p>	<p>Milestones There is an appropriate balance in clinical training between classroom, community, primary, ambulatory, and hospital settings.</p> <p>Indicators</p> <ol style="list-style-type: none"> 1. The curriculum ensures that students achieve an appropriate mix of mandatory community, primary care, and hospital experiences. 2. Proportion of student’s time spent in community and primary care placement. 3. The curriculum provides a diversity of experiences in settings in which students learn and addresses social determinants of health. 4. Quality assurance processes including supervision and clear process for site selection. <p>Note: Institutions should distinguish between Undergraduate vs. Postgraduate Curriculum and provide details on both.</p>	<p>Standards Students are placed in community, primary care, and hospital settings, including underserved communities, with the opportunity for an extensive, immersive, experiences during the final years when most clinical learning takes place.</p> <p>Indicators</p> <ol style="list-style-type: none"> 1. Proportion of student’s time is spent in primary care, community and underserved settings each year. 2. The institution trains and assesses performance of all clinical preceptors. 3. Proportion of learners who choose careers in primary care, community and underserved settings. 4. Stakeholders directly involved in the creation and evaluation of community placements for learners. 5. Provides adequate learner exposure to priority health needs and community strengths while learning in context. 6. The institution and its stakeholders evaluate longitudinal experience in the community. 7. Community involvement is sustained throughout each year of medical education. 8. Student assessment results, in community settings, are equally valued no matter at which clinical sites the students received their training.
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				<p>9. The institution is able to articulate why they have chosen their balance of time in the hospital vs. in the community.</p> <p>10. Social Accountability is incorporated into specialization curricula content, tools, and across different types of experiences and locations.</p> <p>11. Student assessments include social accountability standards and awareness of those standards.</p> <p>12. The institution integrates the voices of community members into faculty development programs and strategy.</p>
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Open Comments Section

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 3</i>	<i>Phase 4</i>
4. RESEARCH				

<p>4.1 Community-Based, Community-Engaged, and Socially Accountable Research</p> <p>Note: For an ongoing project focused on Socially Accountable Research, see: https://www.arcandcentre.ca/research/create</p>	<p>Limited or no research focusing on priority issues in the communities that the institution serves.</p>	<p>Milestones</p> <p>A number of individual faculty members, at their own initiative, conduct research that is relevant to particular health equity, community health, and workforce needs.</p>	<p>Milestones</p> <p>The institution has specific community-based research programs supported mainly by faculty members with irregular participation of students, health workers, and community members</p> <p>Indicator</p> <p>Proportion of research projects that have a translational component that is relevant and accessible to the communities they serve.</p>	<p>Milestones</p> <p>The institution has an integrated research programs based on the social determinants of health, with substantial participation of students, faculty, health workers and community members. The institution has integrated research programs across all educational departments that focuses on health equity, gender parity, and community health needs.</p> <p>Indicators</p> <ol style="list-style-type: none"> 1. Research projects and results arise from identified community needs and are regularly presented to the community, with demonstrable impact on regional community health. 2. Proportion of research is community-based and involve socially accountable research projects involving community members and other stakeholders. 3. Proportion of research is community-engaged and involve socially accountable research projects engaging community members and other stakeholders. 4. Demonstrable impact of research on health services, policy, and practice. 5. Faculty and students who do community-based, community-engaged, and/or socially accountable research are recognized and rewarded.
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				<p>6. Curricula includes resources on how to do community-based, community-engaged, and/or socially accountable research.</p> <p>7. The institution identifies motivated and committed community leaders interested in contributing to the development of curricula and research in ways that allow them to influence decisions.</p> <p>8. The school assesses the sustainable impact on people’s health in the specific region it is mandated to serve, in close partnership with key stakeholders in that region.</p>
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Open Comments Section

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
5. GOVERNANCE				
5.1 Governance (Social Accountability Mandate)	<p>No social accountability mandate appears in the institution's vision, mission and values.</p> <p>Decision-making is done through councils and committees solely composed of faculty members.</p>	<p>Milestones</p> <p>Contemplation of a socially accountable mandate in the institution's vision, mission, and values is underway.</p> <p>Institution's councils and committees are composed of faculty and students.</p>	<p>Milestones</p> <p>1. Social accountability mandates are present in the school's strategic plan, mission, vision, and values.</p> <p>2. Decision-making is done through partnership tables and councils and committees representing both internal and external stakeholders including communities.</p> <p>Indicators</p> <p>1. The governance structure includes a statement and/or policy</p>	<p>Standards</p> <p>A social accountability mandate is part of the institution's vision, mission, and values. It is fully defined, with metrics and benchmarks, and is presently being implemented.</p> <p>Indicators</p> <p>1. The governance structure includes both a statement and/or policy and action plan regarding Social Accountability on the institution's commitment to respond to people and society's needs.</p> <p>2. Important institutional decisions reflect the input of key stakeholders, including educators, leaders, learners, and communities.</p> <p>3. Evidence that education, research, and service are designed, implemented and evaluated by external stakeholders.</p>

			regarding Social Accountability on the institution's commitment to respond to people and society's needs.	
5.2 Stakeholder and Partner engagement	Decisions are made by university and/or faculty authorities with no regard to social accountability or involvement of stakeholders, including community partners.	Milestones Decisions are made by the university and/or faculty authorities with limited regard to social accountability or formal involvement of stakeholders.	Milestones Decisions are made through consultation and formal involvement of stakeholders in some but not all committees and processes. Indicators 1. Decisions are made with inputs from targeted stakeholders. 2. The institution has policy and processes in place to seek out and consult with stakeholders in decision making.	Standards The institution actively partners with students, faculty, health sector stakeholders, policy makers, and communities to design, manage, and evaluate both education and research activities that address the priority health and social needs of the communities the institution serves. The institution takes an explicitly multi-sectoral approach that reaches beyond the health sector. Indicators 1. Decisions that affect the social accountability mandate of the institution consistently reflect the input of key stakeholders including educators, leaders, learners, service providers, patients, governments, and communities 2. Evidence that external stakeholders from the community are actively involved in the design, implementation and evaluation of education, research, and service.

			<p>3. The institution has a clear method for identifying and connecting with stakeholders.</p>	<p>4. Proportion of projects and partnerships involving local communities and health service providers that the institution has a mandate to serve.</p> <p>5. Institutional leadership includes personnel who have demonstrated knowledge of the theory and practice of social accountability, ideally in influential and visible roles beyond departmental chairs and deans.</p> <p>6. The institution provides leadership training in Social Accountability.</p> <p>7. Institutions document the move from identifying stakeholders, to developing partnerships and welcoming partners into the decision-making and program evaluation of the institution.</p>
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Open Comments Section

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
SCHOOL OUTCOMES, GRADUATES, AND SOCIETAL IMPACT				
6. 1 School/ Graduate Outcomes	The school does not track its graduates.	Milestones The school is developing systems and processes to track the location and practice of its graduates.	Milestones The school tracks its graduates and is beginning to measure its influence on graduates' location and practice. Indicators <ul style="list-style-type: none"> ● Graduate career choice and practice location. ● Research on educational factors that influence location and career choices. 	Standards An appropriate number of the school's graduates practice according to where they are needed within the geographical regions the school serves. Indicators <ol style="list-style-type: none"> 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. Tracking shows a consistent upward trend, and/or the school demonstrates efforts toward improving its statistics. 2. The school uses feedback from its graduates to adjust its programs as part of continual quality improvement. 3. The practice-choices of graduates reflect the needs of the regions that the school serves for primary care and specialties. 4. Location of graduates closely mirrors geographical distribution of health needs in the communities and regions the school and its graduates serve. 5. The school works closely with post-graduate/vocational residency training programs to develop a continuum of learning. 6. Proportion of graduates practicing in high need areas and professional orientations such as primary care. 7. Graduates become social catalysts who make a public impact beyond clinical settings.

DEVELOPMENTAL PHASES TOWARDS SOCIAL ACCOUNTABILITY				
Core Components	Phase 1	Phase 2	Phase 3	Phase 4
INSTITUTIONAL OUTCOMES AND SOCIETAL IMPACT				
6.2 Societal Impact	The institution does not measure the impact it has on the regions it serves.	<p>Milestones</p> <p>The institution is developing systematic measurement of its societal impact.</p> <p>Note: Institutions are encouraged to name minimum and maximum outcomes, and establish gradual development plans open to different levels of institutional maturity.</p>	<p>Milestones</p> <p>The institution implements research to systematically measure its societal impact</p> <p>Indicator</p> <p>1. Faculty, outlines community research opportunities to assess the impact of implementing social accountability strategies in geographic regions.</p>	<p>Standards</p> <p>The institution’s education, research, graduates, health service, and partnerships have a positive impact on the health care, the health and equity of the communities and regions that the institution and its graduates serve.</p> <p>Indicators</p> <ol style="list-style-type: none"> 1. Systematic measurement of the institution’s impact on well-defined and specific territories, populations, communities, and regions. 2. Graduates contribute to improving the quality and equity of healthcare access in the specific communities they serve. 3. Institution’s educational programs are integral to regional health care systems. 4. The institution’s partnerships with health care organizations and communities include projects that improve the health of underserved populations. 5. Institutional and its graduates are actively engaged in improving health systems, advocacy for underserved populations, and increased health equity. 6. Research findings inform policy and practice to improve health and health care in the regions that the institution serves.

			2. Faculty, in partnership with community partners, implements research to assess the impact of implementing social accountability strategies on the geographical regions it serves.	7. The institution is able to clarify target populations and corresponding target impacts related to societal impact (specific health care impact measures), and has a corresponding strategic development plan. 8. The institution adheres to accreditation standards and procedures inspired by Social Accountability.
Open Comments Section				

Concluding Guidelines

In general, the ISAT process should be considered an ongoing and iterative project in quality improvement and peer review, rather than an accreditation process, ranking, or zero-sum pass/fail outcome. As such, language pertaining to the ISAT should be not of simple success or failure, but rather what we strive to achieve locally and globally together. The aims of Social Accountability are best pursued by moving toward greater specificity in all of the areas outlined above. Because Social Accountability is a universal vision, it must be contextualized and adapted differently to particular spaces and places. The ISAT process ought to encourage institutions and their leaders to think carefully and act decisively to maximize their societal impact on the specific regions, populations,

and communities they are tasked to serve by peoples and their governments. The ISAT process provides resources and self-assessment tools for this journey by establishing a high standard and incentive to work toward greater Social Accountability. Many aspects of the tool outlined above will doubtless be beyond the control of those administrators and leaders who are leading the ISAT process in their contexts, and this means that awareness of and movement toward these goals is more important than final achievement of them. This also means that progress toward Social Accountability will depend upon the clear and deliberate definition and pursuit of the values that underpin accreditation and evaluation efforts. Reflection on the values that inform our vision of Social Accountability is at the core of this process.

SECTION 3. STAKEHOLDER ENGAGEMENT

This section consists of 5 items. All items need to be completed. This section aims to understand to what extent institutions engage with stakeholders in planning for advancements, policy, and decisions. Using the most appropriate and 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 core components in 6 domains. All components need to be considered. 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 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 toward excellence in social accountability as it relates to a particular element of medical education.
- **Indicator:** Is a measure, quantitative or qualitative, of the progress of an institution 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 health 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 the 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” (Jacoby, B. (1996). Service-learning in today’s higher education. In B. Jacoby (Ed.), *Service-Learning in Higher Education: Concepts and Practices*. San-Francisco, CA: Jossey-Bass.)
- **Stakeholder:** A stakeholder in health workforce education is anyone who has an interest in the success of an institution, 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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³⁴ Talib Z, Palsdottir B, Briggs M, Clithero A, Miniclier Cobb N, Marjadi B, et al. Defining community-engaged health professional education: a step toward building the evidence. *NAM Perspectives* 2017. Available from <https://nam.edu/wp-content/uploads/2017/01/Defining-Community-Engaged-Health-Professional-Education-A-Step-Toward-Building-the-Evidence.pdf>

³⁵ See note 4, above.

³⁶ See, for example, Hogenbirk JC, Strasser RP, French MG (2022) Ten years of graduates: A cross-sectional study of the practice location of doctors trained at a socially accountable medical school. PLOS ONE 17(9): e0274499. <https://doi.org/10.1371/journal.pone.0274499>

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³⁸ Pearson D, Walpole S, Barna S. Challenges to professionalism: Social accountability and global environmental change. *Med Teach*. 2015;37:9,825–830