

WORLD SUMMIT ON SOCIAL ACCOUNTABILITY

WORKING GROUP DRAFT PAPERS

Leadership in social accountability

Key issues

Leadership is an aptitude and an attitude that every health professional should master and that institutions and groups might promote and facilitate. It implies a commitment and an ability to conduct actions until it reaches the intended purpose and stewardship, accepting responsibility to shepherd and safeguard the values of others.

It applies to institutions (State, Ministry, academic institution, health service,...), groups or individuals

It involves two major dimensions: **vision and management**.

The **visionary** sets directions for action based on the identification of pressing needs and challenges in society. He argues and develops values and vision and plays the role as key opinion leader in the field of social accountability.

The **manager** organizes efficiently all available resources, sets strategy for development of plans of actions to reach the intended purpose and promote the cycle of evaluation of these direct actions.

Regarding social accountability, leaders are able to

Identify the present and future health needs of citizens and society as a whole.

Analyze the spectrum of health determinants in operation in a given society.

Argue and develop vision and management regarding social accountability.

Make use of main transformational leverages for an efficient, equitable and sustainable health system.

In relation social accountability of educational institutions, a leader is able to

- 1- To lead institutional or educational, research or health delivery programs to best respond to present and future health needs of citizens and society, making the best use of available resources and seeking additional ones.
- 2- To elaborate a long term strategic plan of an institution with social accountability as the main driving force, to apply management best practices of institution to this effect and to provide incentives to members of the institution for contributing to the plan.

- 3- To be a powerful advocate for social accountability to its own institution, but also to important stakeholders in the health system and to national bodies in charge of regulation and accreditation of educational institutions.
- 4- To develop a strong and sustainable partnership with other health actors at local level for coordinated action on social determinants related to priority health problems in a given territory (ie. through contractual arrangement for low income countries).

Priority actions

1° Design and develop self-evaluation tables (check lists) and guideline packages to be used at the three different (macro; meso and micro) levels: Institutions (University, Faculty, School, Ministry, Health organization); groups (political lobbies, department, unit, program) and individuals (facilitator).

These packages would address following themes: Capacity building of stakeholders, Strategic design, Communication, advocacy and stewardship, research and focus on 4 basic competences: situation analysis, decision making, action programming and development and evaluation.

2 To propose workshops and training for key persons at various levels “What makes a leader effective regarding social accountability? “. The training opportunities should consist of focal points that could counsel and help leaders and change initiators. In addition, international courses could be organized.

3. To continuously adapt self-evaluation table and guideline packages via continuous assessment of process and results, regarding various socio-cultural and educational contexts

Collaborative work

Proposal 1: To establish a think tank to develop a framework of a best practice guide to be leader in social accountability of an educational institution.

Proposal 2: To design an international course on social accountability in health, with focus on educational institution, small group or individual levels: defining objectives, length, audiences, support to learners, site.

Proposal 3: To lobby the concept of leadership in social accountability in main national and international organizations related to health and education, including at highest policy level, and propose opportunities to enhance capacity (ie. dispatching a paper with eminent co-signatories to key targets).

The Network: Towards Unity for Health world summit on social accountability April 2017

Partnerships concept paper

Optimal response to populations' needs is the essence of social accountability and it forms the foundation of the social contract between health professions education institutions and society. Partnership among stakeholders in health and other sectors, a pillar of social accountability, constitutes one focus area for The Network:TUFH conference on social accountability in addition to leadership, competencies, and accreditation. Partnership is essential for better health. When clean water and adequate sanitation are present in communities, health is dramatically improved. Diarrheal illness and concomitant malnutrition are reduced, respiratory illness is less frequent, and infant survival rates improve. When good roads exist between where women live and where they need to go for care during pregnancy, newborn outcomes improve. When irrigation systems are available that increase yield resulting in a small profit as well as better nutrition for farm families, health improves. Improvements like clean water, reliable roads, and improved nutrition can only be accomplished with partnerships like those between health workers, engineers, policy makers, designers, educators, and the community. Many sectors need to be connected in order to improve health and well-being – transportation, agriculture, energy, housing, literacy, and healthcare. This paper asks why partnerships are important for maintenance of the social contract between health professions education and society, who needs to be involved, and what steps participants at this conference can take so they can be created and sustained.

The relationship between the public sector and health professions education has many facets. Symbiosis is at the heart of the social contract – society bestows autonomy, status, financial reward on the health system in return for healthcare that promotes vigorous, productive citizens. Universities, in particular, help societies maximize the productivity of populations through investigations of causative, preventive, curative and rehabilitative processes. In addition, they educate a workforce that recognizes the significance of social determinants of health and effectively intervenes when illness or injury occur in individual or populations.

Essential actors to improve health include not only academic institutions and the community, but also policy makers, health managers, and health professionals. These five players are described in the seminal work by Boelen that defined the eponymous project of the WHO project Towards Unity for Health. This pentagon of stakeholders can create projects within the health sector and has potential to connect with other sectors outside of health. In either case, meaningful connection depends on unity of purpose and joint action.

Joint action is what communities of practice do together, and in doing, share knowledge and wisdom. This human interaction can be far more powerful than accessing information in the form of a book or online resource because it incorporates human experience and values. Partners in this community of practice recognize their own potential and limitations and those of their partners. They are convinced of the added value of the relationship and the complementarity among partners.

Groups of people can be connected in different ways: dense or homogeneous networks where people know each other very well and precisely synchronize their actions, or heterogeneous networks where members of the group are more removed. Heterogeneous or low density networks may not offer the same level of coordination, but they offer a different perspective and good ways to generate new ideas. They are also arguably more useful for rebounding from adversity since members of this low density network stand apart from one another's reality and can provide a fresh perspective. Communities of practice that include universities and the people who live nearby can improve societal well-being through human interaction that ensures shared knowledge and values.

Partnership and education in health professions

How is this concept of partnership manifested in health professions education? One way is for curricular content to include discussion of water, sanitation, housing, literacy, transportation, poverty, nutrition, and other key factors that profoundly influence health. Another is use of authentic problems that students tackle in intersectoral teams to address issues of social well-being. This encourages students to recognize that solutions often lie at the intersection of professional domains. Partnership can also be manifested as practice, sometimes called service learning, in which projects derived from community needs are developed, implemented, and evaluated. Service learning moves students from "knows that" to "knows how," and from "learning about" to "learning to be." Students from different fields working together with a broad sectoral range of workers can integrate facts and apply them. This is how information existing in the abstract is transformed to knowledge residing in the individual. Working together also promotes teamwork, collaboration, negotiation, and conflict resolution, topics that can be explicitly included in their education. In addition, students working on projects soon learn that complex systems involve human interaction with continuous feedback and calibration.

The public sector is intrinsic to the concept of accountability in health professions education and is an essential partner in meeting that obligation. Building partnerships between health professions institutions and communities, however, represents a special challenge. Many low-income (or underrepresented) communities have a history of being exploited by health institutions, which have viewed communities as sources of "teaching material" or research

subjects. Partnership with the public sector is represented by relationships with community organizations, government officials, health systems, and education systems. Representatives of the public may sit on governing boards of health education institutions, or in some cases may legislate curriculum, testing, or continuing education requirements. In exchange, education institutions benefit the public sector with new knowledge about health risks and benefits, disease prevalence, as well as advances in diagnosis and treatment.

Evaluation of partnerships

A related history of exploitation and use of low resource country citizens as teaching material or research subjects is a consideration when high and low resource countries engage in a relationship. These “north-south” relationships, like all partnerships, are predicated on trust.

Trust has been defined as the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor’s interests. It can be disaggregated into four components: integrity, predictability, delayed reciprocity, and exposed vulnerability. Integrity implies doing what you say you will do; predictability – knowing what others will do; delayed reciprocity – giving now with the expectation that it may be repaid in an unspecified way at an unspecified time; and exposed vulnerability – enabling others to take advantage of your vulnerabilities, but expecting that they will not. Trust is a dynamic entity – it builds slowly through iterative behavior, but diminishes quickly after a single discordant event. It is an essential ingredient in complex systems of health and well-being.

The need for trust is particularly important in disparate relationships across sectors where a common culture may not exist. When health professionals and engineers, or engineers and community leaders get together two cultures are present - they often speak a different language, have different assumptions, and employ different behavioral norms. In addition to cultural awareness, both parties must demonstrate integrity, predictability, delayed reciprocity, and exposed vulnerability for trust to develop. Building trust with communities also may involve ceding power to a community body to exercise oversight of teaching and research activities. Both parties are often in a vulnerable situation; both need to believe that the other will care for their interests.

Finally, we need to reflect on whether relationships are working, and if they are not working, we need to fix them. Intentional, regularized analysis of interactions and outcomes provide opportunity for mid-course corrections needed to maintain relationships. Evaluation of the relationship may involve collecting community health and social data, surveying community members and students, or interviewing partnership leaders. It may also involve an examination of the career choices of graduates and the impact of community-based research projects.

Priority actions

What steps can participants at this conference take so partnerships can be created and sustained? Here are some suggestions:

1. Identify an important health need in your area of influence and develop a concrete partnership among stakeholders to prioritize actions to respond to that need.
2. Create heterogeneous social networks; the discussion boards on The Network:TUFH website provide a platform for following up on the social connections made at the conference. The strongest networks for resilience and new ideas are those that are the most diverse; find colleagues most unlike you and urge them to participate in these discussions.
3. Do something together and create a community of practice. A multi-sectoral project relevant to health in a community is a good starting point and many examples will be on display in the posters and presentations at the meeting. Initiate the discussion in Tunisia and continue it online.
4. Build trust among team members and with the community by considering the elements of integrity, predictability, delayed reciprocity, and exposed vulnerability. Remember that trust often involves cross-cultural communication when teams are diverse.
5. Recall that education institutions are built on a social contract with the public to improve health and well-being. This is the essence of social accountability.

Solutions to challenges of social well-being and health require interaction between workers from different sectors. To reduce diarrheal illness, communities need clean water and sanitation in addition to the right medicines to treat it when it does occur. To reduce the incidence of diabetes, communities need access to quality foods – a function of urban planning, fiscal policy, agricultural planning, economic strategy, energy planning, communication and transportation. The greatest leverage for improving health will come from partnerships between these sectors.

Alone, we walk fast; together we walk far. -African proverb.

ACCREDITATION DRAFT- Feb 13, 2017

Key Issues

Accreditation is probably the most important single intervention to ensure excellence and sustainability in quality management of educational institutions in the health sector. International organizations such as the World Medical Association^a and the International Association of Medical Regulatory Agencies^b have affirmed the importance of accreditation in promoting medical education quality. Today, while many countries have accreditation systems^c, a minority possess a functioning accreditation system that truly promotes medical education quality and a majority of existing systems have not been designed nor adapted by using a social accountability lens (ref)

In some countries there is an effort to widen the focus on indicators (1) to measure the potential excellence of an educational institution and program by including outcome and impact indicators as measures of excellence. There is also a need to widen the standards from only addressing the education function of medical schools (1) to consider the service and research functions as well.. The need for change in accreditation standards is due to the change in medical practice and health care systems to meet the changing health needs of society (1-6).

The trend to expand and broaden accreditation is likely to become worldwide when international, national and institutional authorities recognize that accreditation and social accountability are indispensable mechanisms to respond to challenges in health systems increasingly confronted with the escalating costs of health care, pressure for universal coverage, high expectations of consumers, health disparities, results driven institutional management, and quest for transparency and public information.

Our accreditation systems need to measure what counts- outcomes for the learner, outcomes for the patient and patient care, and outcomes for the health system. There also needs to be an expanded focus on the impact of our training, our research and our health services on the community. We need to ensure equitable access to health care, ensure sustainability in the face of tight resources, promote advocacy amongst our health care workers and ensure that health professionals address the priority health needs of any and all populations. We need to ensure that all health partners provide job opportunities and adequate working environments for the graduating physicians. These important outcomes will depend on increased collaboration between educational institutions and other sectors which should promote models of health care that are equitable, efficient and sustainable.

Priority Actions

There is mounting evidence that our accreditation should address outcomes (a measurable change) and impacts (the long term or more widespread effect of an outcome), while recognizing and accepting the importance of some process indicators. Priority actions include:

- identifying the partners that need to have input into the design of the accreditation system and its standards,
- designing an accreditation system that puts social accountability as the primordial interest,
- creating specific admissions criteria that reflect the socially accountable mission of the institution and community,
- developing curricular content that reflects the socially accountable mission ,
- demonstrating that the outcome measures and eventual impact of the medical education institution, including education , research and health service lead to more social accountability.

There are examples of these priority actions already underway, including:

- Canada 's initiatives, driven by the Future of Medical Education in Canada (FMEC) MD and PG reports, to introduce standards into their accreditation systems that expect medical schools and post graduate programs to be able to define their social accountability mission and measure it in terms of admissions, curricular content, types and locations of educational experiences.
- The CPU model(Conception-Production-Usability) from which a spectrum of standards can be designed to explore the capacity of educational institutions to identify peoples, priority health needs and health system challenges to meet the needs; to adapt its education, research and service missions to respond to those needs and challenges; and conduct followup actions and appropriate initiatives to ensure needs are fulfilled.
- THE Net's Evaluation Framework for Socially Accountable Health Professional Education (ref) designed an evaluation framework after the CPU model suggesting that social accountability be measured through the lens of: quality, equity, relevance, efficiency and partnership. A given health education program needs to assess the environment it serves and the needs of that environment and design an educational system in response to those needs, while measuring the outcomes and impact of the program.
- The Revolutions Framework, published in Academic Medicine (ref) that encourages us to pay particular attention to marginalized populations, use inter professional education models, and engage with the public and civil society.
- THE ACGME, in its paper in Academic Medicine (ref) stated that "programs will maintain accreditation based on compliance with key process elements and actual resident performance, rather than based solely on demonstration of compliance with process related standards".
- The World Health Organization headquarters and regional offices recommend countries adopt national human resources and health educational strategies that give prime importance to social accountability in establishing norms and processes for accreditation.

Collaborative work

Considering the scope of a socially accountable health professional system and contributing factors in our health professional education, our research agenda and the service we deliver, we should revamp our accreditation systems so that the accreditors are not solely fellow colleagues in the same profession.

We need to be much bolder so that all the key players – academic institutions, health professionals, communities, health managers and policy makers have input into their design and implementation and participate in the assessment of their quality (ref).

In order to see real progress across the globe on creating accreditation systems that drive us towards the socially accountable health care worker, we need all of the existing accrediting systems (eg, WFME, LCME, CACMS, GMC , CARICOM etc . etc) to come together to forge a more common vision focussing on clear and measurable criteria for social accountability that include measuring outcomes and impact.

Proposal #1 To create a think tank with stakeholder representatives to suggest mechanisms for relevant and efficient involvement of key actors in the accreditation process

Proposal #2

To set up a consultation process with existing - or soon to exist - accreditation bodies to improve the incorporation of social accountability principles into standards and processed for the accreditation of educational institutions.

Ref:

1. Abdalla, M.E., Social accountability of medical schools: do accreditation standards help promote the concept?, Journal of Case Studies in Accreditation and Assessment, 2014. Available at <http://www.aabri.com/manuscripts/121417.pdf>
 2. vanZanten, M., et al., Overview of accreditation of undergraduate medical education programmes worldwide. Medical Education, 2008. 42(9), p. 930-937
 3. Karle, H., European Specifications for global standards in medical education. Education, 2007. 41(10): p. 924-925
 4. Schwarz, A.W., Minimum essential requirements and standards in medical education. Medical Teacher, 2000. 22(6): p. 555-559
 5. Lilley, P.M. and R.M. Harden, Standards and Medical Education, Medical Teacher, 2003. 25(4): p. 349-351.
 6. Karle, H., Global Standards and Accreditation in Medical Education: A view from WFME. Academic Medicine, 2006. 81 (12 supplement): p. S43-S48
- a. WMA Resolution on WFME Global Standards for Quality Improvement of Medical Education, reaffirmed April, 2014.

b. IAMRA. Accreditation of Medical Education Programs, 2016

c. Directory of Organizations and Recognize/Accredit Medical Schools. Accessed at <http://www.faimer.org>

Background note for the theme COMPETENCIES for the World Summit on SA

Fostering socially accountable health and educational systems is the key to advance universal health coverage and the WHO strategy on human resources for health. These goals can be achieved if changes take place, not only in educational institutions, but in the wider context of health care system environments. For these changes to take place in educational institutions, they must demonstrate in actions that are reflective of social accountability in the three **core areas of education, service and research**:

- In the field of **education**, educational institutions must recognize and promote development of **competences of health care professionals** *for delivering healthcare to meet the needs of the community and working in health teams to deliver health care through the available health systems and to be able to improve these systems.*
- To foster **research** that is in line with social accountability principles, **educational institutions must recognize and promote development of competences of health care professionals for research and scholarship** *related to investigating and identifying factors contributing to social inequity in the region and do operational research on existing service delivery. It is important to ensure better utilization of available services by those in need, irrespective of their capacity to pay.*
- To foster **service delivery** that is in line with social accountability principles, **educational institutions must recognize and promote development of competences of health care professionals for delivering the services** by identifying and providing learning experiences within their respective institutions that demonstrate social accountability through the service provided by the institution itself.

Keeping the above principles of social accountability in mind, participants are encouraged to participate in group discussion that would result in formulation of recommendations for future action under the following three sections:

1.Key issues

Which are the important issues to address under this theme “Competencies” to enhance social accountability principles and practice and enable educational institutions to make a greater impact on people’s health?

This would include the competencies to be acquired by the health professionals to keep people and populations healthy, the best conditions that these institutions could create to facilitate acquisition of these competencies by graduates and the health systems that would best utilize and reward these competent socially accountable health professionals and partner with the health professional education institutions.

- *Focusing on the development of competences of health professionals that are needed to keep people and populations healthy. Broadly these health care practitioners need*

to have a 'dual identity', to be competent in clinical practice as well as the social and health systems and to be competent as a leader, manager and change agent. The competences should include an understanding, defining and application of social determinants of health, health promotion as well as risk and disease prevention and rehabilitation, person centred care, concepts of professionalism, teamwork, delegation of tasks, health advocacy, cultural competence, communication skills, leadership and management skills, attention to underserved and marginalized and vulnerable populations, engaging and empowering communities, information management and technology, ability to adapt and cope with diverse communities and actively engage with them and lifelong learning and researching. There is also a need to develop competencies related to reflective practice, self care and resilience and incorporate 'health system science' as the third science of medical education besides basic and clinical sciences.

- *What institutions could do and the best conditions that could help in acquiring these competencies are including in curricula the foundational concepts of population health, social determinants of health, cultural competence and caring for underserved populations for all health professionals regardless of specialties, early and longitudinal exposure to community health sites with different level of services, offering diversity of learning opportunities including inter-professional education, training of teaching staff and other professionals in different community sites to be role models and creating transformative learning opportunities, and focusing on assessments that will help students not only pass to test, but become 'fit for purpose'. The institutions also need to develop mechanisms for partnering with the health systems and develop synergistic partnerships*
- *The competencies required in the context of the complex and changing health care systems are adaptability, systems based practice, reflective practice and practice based improvement, leadership and inter- professional teamwork. Developing a culture of quality improvement and patient safety are the key competencies that are essential for practice in all health care contexts.*
- *Maintaining of these competencies is an important socially accountable behavior and needs to be practiced. Health care systems need to be supportive for health care professionals to be able to practice the acquired competencies optimally in the relevant contexts.*

2. What are the actions to be taken in priority to make sustainable progress in the implementation of social accountability approaches in educational institutions:

1- Local level:

- Developing / enhancing the competencies of deans, faculty and staff of health care institutions about the concept and principals of social accountability and how it could contribute to health for all
- Developing strategic partnerships with the key stakeholders in health care systems for training and service thereby facilitating optimum use of health systems and system changes
- Creating opportunities for inter professional education and collaborative practice across disciplines

- Developing mechanisms for community engagement and community involvement in developing, implementing and assessing educational programs
- Developing wellness program for students / health care professionals

2- *National level:*

- Addressing social determinants of health
- Creating health care systems that are better for patients, communities and nations
- Developing policies to have equal distribution of health institutions geographically rather than concentrated in urban and metropolis cities (a problem in many countries of SEA)
- Developing accreditation systems for health care institutions that measure institutional performance against standards incorporating principals of social accountability

3- *International level:*

- Incorporation of 'health system science' as the third science of medical education besides basic and clinical science.
- Advocacy through more international events
- Involvement of international organizations in disseminating concepts of social accountability all over the world using different means.
- Fostering partnerships in Social accountability area between institutions on the international level

3- Collaborative work

Which initiatives should be taken to insure organizations- official partners of the world summit and others- contribute optimally to initiating, deepening or accelerating progress in making educational institutions more socially accountable ?

- Developing guidelines on how best to operationalize inter professional education, training and its assessment
- Building the relationships developed during the summit towards actions with WHO / other participating organizations as partners
- Formulating a working group to develop a road map for implementing the recommendations of the summit in collaboration with the participating organizations. This could be spearheaded by Network as convener, using methods to facilitate total engagement, obtaining widest viewpoints (diverging), and then prioritizing into specific actions.

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Actions proposed at the world summit on social accountability

This is a tentative synthesis of the different actions proposed so far by the 4 different thematic working groups. Their selection is based on following criteria :

- 1- **Priorities** to advance the cause of social accountability in the health sector with a focus on human resources and educational institutions.
- 2- **Global relevance** as applicable to any country or institution at different paces of development.
- 3- **Attractiveness** to a majority of health partners (see partnership pentagone) either in their own interest or/and for collaborative purposes.
- 4- **System approach** as they enhance capacity at national policy level, institutional level, individual level,
- 5- **Practicality** as they can potentially initiate without much delay a concrete programme of collaboration.

LIST of ACTIONS

Action 1 Global advocacy : to lobby the concept of social accountability in main national and international organizations related to health and education, including at highest policy level, and propose opportunities to enhance capacity (ie. position paper by eminent co-signatories, publication in peer reviewed journal).

Action 2 Leadership training in social accountability : to offer educational opportunities to heads of institutions or departments to master principles, methods, programs and evaluation instruments pertinent to social accountability in the health sector (ie. design of national / international course, defining objectives, length, audiences, support to learners, site.)

Action 3 Guideline packages : to design and compile good practice material to implement the social accountability approach, at institutional level (university, faculty, school, ministry, health organization); group level (department, unit, program) and individual level (facilitator).They would address following themes: strategic design, capacity building of stakeholders, communication, advocacy and stewardship, research, evaluation.

Action 4 Inter-professional education and practice : to design and promote strategies to enhance optimal collaboration among professionals from the health and health related sectors to ensure universal coverage, considering opportunities for evolving roles of professionals, delegations of tasks, participation of citizens and civil society as a whole.

Action 5 Partnership in practice : to identify an important health need in a defined territory and develop concrete partnership among stakeholders to prioritize actions to respond to that need, including social determinants of health (ie. establishing a long term contract between a territory and an educational institution with respective obligations commonly agreed upon).

Action 6 Socially accountable accreditation : to develop accreditation systems for health care institutions that measure institutional performance against standards incorporating principles of social accountability, ensuring that all key players – academic institutions, health professionals, communities, health managers and policy makers have input into their design and implementation and participate in the assessment of their quality.

Action 7 Global harmonization of standards : In order to see real progress across the globe on creating accreditation systems that drive us towards the socially accountable health care worker, to mobilize all existing accrediting systems (eg, WFME, LCME, CIDMEF, CACMS, GMC , CARICOM, ...) to forge a more common vision focussing on clear and measurable criteria for social accountability that include measuring outcomes and impact.

Action 8 Global communication platform : the creation of a network that will assist in coordinating the different actions, inform on progress, animate a community of practice, be a depository of top of the art documents and experiences in social accountability, reach out to key stakeholders, establish collaborative links with other like-minded networks.