IFMSA-Québec's Policy Document
Social accountability of medical schools

Adopted at the General Assembly of the Spring Congress on the June 5th 2021, in Montréal
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Policy Statement

Introduction

Social accountability of medical schools is defined by the WHO as “the obligation 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” [1]. To this end, it is crucial to collaborate with key stakeholders, such as community representatives, medical learners and governmental bodies, to understand the priorities of the population and evaluate the impact on health.

IFMSA-Québec’s Position

IFMSA-Québec vehemently defends social accountability as a central pillar of medical education. It plays a pivotal role in shaping future physicians who will be attuned to the needs of the community they serve and thus provide the most relevant, cost-effective and high-quality care possible to decrease health inequities and promote health for all. IFMSA-Québec advocates for early service-learning, improved rural and family medicine teaching, and a diverse student population to better reflect and further the priorities of the population. IFMSA-Québec also advocates for medical school graduates to be cognizant of the needs of the community they will serve and collaborate with them to ensure a socially accountable practice.

Calls to Action

This is why IFMSA-Québec, through its mandate of improving health both locally and globally, calls on the following actors:

Note: The calls to action are numbered for reference purposes, the numbering does not represent a hierarchical order.

The Municipal, provincial and federal decision-making bodies to:

1. To ensure affordable medical school tuition and accessible financial aid to remove financial barriers for applicants from diverse backgrounds;
2. To collaborate with medical schools to create scholarships for students from low socioeconomic backgrounds and/or underrepresented groups in medical schools;
3. To create funding opportunities for medical students to pursue a clinical internship in remote regions around the country.

The Faculties of Medicine to:

4. To consult with key stakeholders such as medical students, resident physicians, medical regulatory authority representatives and undergraduate and postgraduate deans to evaluate social accountability and its impacts;
5. To consult and collaborate with the community served by the medical school to co-create a socially accountable curriculum, adapted to the current needs;
6. To incorporate service-learning early in the curriculum to help students provide better whole-person care for future patients. Service-learning must educate medical students on its objectives, its benefits and its dilemmas, and prompt reflection among participants. It must be executed with the collaboration and respect of partner organizations and with the input of medical students;

7. To encourage and support student-led initiatives that promote community outreach and student awareness of community needs;
8. To prioritize collaborative medical research such as community-based participatory research and integrated knowledge translation to improve the accountability of research conducted and its subsequent translation;
9. To promote primary care through the implementation of family medicine clinical experiences and through the encouragement of students, teachers and researchers working in primary healthcare;
10. To expose students to medical practice in rural or underserved areas by providing quality and long-term clinical placements in rural or underserved communities;
11. To include admission officers who represent, as accurately as possible, the demographics of the communities surrounding the faculty of medicine;
12. To create an anti-racist and anti-discrimination environment and curriculum for medical students;
13. To promote diversity and equity in medical schools by reaching out to students in underrepresented groups and providing them with tools for their applications, by taking into account a variety of competencies in the admissions process, and by acknowledging the overlapping of social categorizations that create complex levels of discrimination (i.e. intersectionality) faced by certain applicants.

The Future Healthcare Professionals to:

14. To advocate for representation and collaborate with the faculties of medicine during curriculum design to ensure accountable education that reflects the identified priorities of populations served, and is anti-racist, anti-colonial, anti-discriminatory, and intersectional in its overall approach to learning about the health problems of people and populations.

This is why IFMSA-Quebec, through its mandate of improving health both locally and globally, is committed to:

1. Collaborating with medical faculties to advocate for socially accountable education and amplify the voices of medical students.
2. Provide medical students with opportunities to learn and advocate for the health of communities at the local and global levels through events, conferences, outreach and educational programs, and exchange programs to enhance their socially accountable medical education.
3. Ensure that our advocacy and outreach programs meet the needs of the served population and are relevant to their priorities through collaboration with community representatives.

Position Paper

Background information

In 1995, the World Health Organization defined Social Accountability of Medical Schools as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they are mandated to serve [1]. The 21st century presents medical schools and health systems with an important set of challenges: to ensure the quality of healthcare delivery, to promote health equity, to ensure the cost-effective use of resources, and to align medical education to society's needs. Academic institutions are being called upon to reduce discrepancies within healthcare delivery, redefine the roles of health professionals and demonstrate evidence of their positive impact on the people's health status.

For medical schools to become more socially accountable, it is essential that each institution incorporates in their educational approach the need for improvements, which are required in several layers of the education scheme: responding to current and future health needs and challenges in society, reorienting education, research and service priorities accordingly, to strengthen governance and partnerships with other stakeholders and to use evaluation and accreditation to assess their performance and impact [2]. Social accountability is essential to medical schools because it opens a dialogue between all parties and promotes active monitoring of their accountability to students, future patients and communities. This process looks to continuously improve the services offered to the communities and to protect the rights of all interested parties by holding the institutions accountable for their actions.

Criteria for a Socially Accountable School

Socially accountable schools should be engaging, collaborative and responsive to the needs of their communities. They must be involved at the communal, regional and national levels. To be approved, changes must be made within the institution with respect to its function, curriculum, research activities, and contributions to the aforementioned community, region and nation. Medical schools can aim to obtain recognition for their work in social accountability through awards such as the ASPIRE Recognition of Excellence in Social Accountability of Schools, an initiative of the Association for Medical Education in Europe. This award evaluates medical schools' application of social accountabilities in four main domains: (1) organisation and function of the school, (2) education of doctors, (3) research activities, (4) contribution to health services for its community, region, and nation. This recognition has been most recently awarded to the University of Saskatchewan, Université de Montréal and The University of the West Indies [3]

Collaboration with Key Stakeholders

Key stakeholders play an essential role in the effectiveness of social accountability measures implemented by medical schools. These key stakeholders, with whom medical schools must collaborate to ensure social accountability, include "medical students, resident physicians, residency program directors, medical regulatory authority representatives, undergraduate medical education deans, student affairs leaders, [and] postgraduate medical education deans" [4]. Differing personal values from various parties might hinder the effective collaboration between stakeholders. Therefore, in order for social accountability to be

implemented successfully, a common definition and consensus should be agreed upon by all collaborators and the measures put in place should act upon both personal and institutional levels in order to be effective [5].

Discussion

Educational Program

Service-learning

Medical schools have a responsibility towards their communities to train socially-aware individuals who will become doctors accustomed to providing patient care that encompasses and takes into consideration the social determinants of health [6,7]. Through partnerships with community organizations, medical schools can develop service-learning opportunities for their students. Volunteering as well as the development and involvement in local projects allow medical students to gain practical experience in the needs of the population they serve. Their experiences and subsequent reflection shape tomorrow's physicians. Indeed, introducing service-learning as early as the first year of the medical program has been shown to increase the likelihood that medical students adopt a community-based perspective through their training. Service-learning also teaches students about their role as healthcare providers and how to assess a population's health. It allows them to discover existing local socioeconomic resources and to appreciate the complex relationship between health and its social determinants. Through its immediate and long-term impacts on students, schools, and the community, service-learning is a vital tool in ensuring the social accountability of medical schools [8].

Encouraging the Practice of Rural Medicine

According to 2016 Census data, the total rural population in Canada was reported to be greater than 6.5 million people, accounting for approximately 18.7% of the total Canadian population [9]. Nevertheless, it has been well-documented that rural and remote communities are served by disproportionately fewer doctors compared to their urban counterparts. In 2008, only about 8% of family medicine residency graduates completed their training in rural programs across Canadian medical schools, and in 2013, it was estimated that only 14% of Canada's family physicians were working in rural and remote communities [10,11,12].

Medical schools must foster enthusiasm for practicing medicine in rural areas through their undergraduate education curricula to ensure that an adequate proportion of the future physician workforce will meet the needs of these traditionally underserved communities. Medical schools must first educate their students about the multidimensional health inequalities that currently face rural communities and promote a sense of responsibility for population health. Medical schools must then provide multimodal exposures to rural medicine, ideally in a longitudinal manner throughout the various stages of their students' training. Significant efforts should be made to increase the inclusion of rural physicians in lecturer and preceptor roles, whereby they can act as role models to students and give valuable insights regarding rural practice [13,14,15,16]. Medical schools should also organize networking opportunities with rural physicians beyond teacher-student interactions, such as dedicated career-planning events.

The provision of high-quality clinical experiences in rural settings is paramount. There is evidence that longer rural exposures at the undergraduate medical education level is conducive to choosing a rural practice, even among students from urban backgrounds. In fact, studies have shown that “positive clinical and educational experiences in rural settings as part of undergraduate medical education” and “targeted training for rural practice at the postgraduate level” are two of the three factors most strongly associated with eventually practicing rural medicine [17,18,19]. Medical schools should therefore aim to include at least one mandatory clinical placement in a rural area within their clerkship curricula, preferably in rural family medicine, to consolidate students’ understanding and appreciation of rural health issues. Elective clinical placements in rural areas should also be offered to allow students the opportunity to further explore career possibilities within rural medicine, both in general family medicine and other specialties. Finally, medical schools must clearly communicate the postgraduate rural training opportunities that exist across their residency programs to maximize retention of interested graduating students on the rural pathway.

The seventeen Canadian medical schools are expectedly required to approach the implementation of distributed medical education (DME) in various ways, reflecting their unique demographic and geographic considerations [20]. Nevertheless, medical schools must critically appraise the outcomes of their specific DME initiatives and verify whether they translate to increasing proportions of graduates who practice in rural and remote settings.

Students

Admissions, Equity and Diversity

Social accountability calls for the equitable demographic representation of all community members; while data are unavailable for most countries and medical schools, current evidence suggests that in Canada, the United Kingdom and the United States, students from low socioeconomic backgrounds are significantly underrepresented in medical schools despite ongoing [21]. A medical corps that is representative of the population in terms of geographics, socioeconomics, ethnicity, and gender is better equipped to respond to the various needs of its community.

Furthermore, socioeconomic backgrounds have been consistently shown to be unequally represented among medical students, since most of them have educated and non-working-class parents [22]. There is a significant discrepancy between the actual Canadian population’s distribution of wealth and medical students’ household revenues (a discrepancy that is skewed towards more privileged circumstances). Indeed, 39.7% of Canadians have a household income lower than $40,000 while only 15.4% of medical students’ parents fall into this income bracket [23]. It is also important to consider the intersectionality of the students' situation. Indeed, the disadvantages that a student may experience at any stage of the admissions process are very rarely present alone. Rather, they are numerous, depending on the student, and have simultaneous effects that must all be taken into consideration.

The lack of representation of certain ethnic and racialized groups in Canadian medical schools, namely the Black and Indigenous communities, must also be addressed. This is especially important seeing as these communities, along with refugees, face the greatest inequality with respect to access and quality of healthcare services [24]. In this regard, representation among physicians is necessary since it has been shown to increase the quality of service and reduce inequality. For instance, “given that up to 50% of Aboriginal physicians in Canada are involved in Aboriginal health, increasing the number of Aboriginal

medical students would probably lead to improved access to physician services within Aboriginal communities" [23]. Similarly, it is essential to include people representative of the medical school's demographics on the admissions committee since "it has also been speculated that increasing the minority representation on admissions committees may lead to increased physician diversity" [23]. Briefly, in order to ensure a more equitable treatment of all patients in the healthcare system, efforts must be made to align the demographics of medical students with those of the population they will serve.

Medical schools must promote diversity within their student body by encouraging underrepresented students to enter the program and by removing obstacles in the admissions process that unfairly disadvantage these students. Medical schools must reach out to students from underrepresented groups to inform them about the program, including details of their admissions processes, and provide them with the tools necessary to submit their applications. They also need to have an admissions committee that reflects the diversity that is currently lacking in the cohorts of future physicians. Medical schools and governments must collaborate to ensure affordable tuition and are encouraged to offer scholarships for applicants from lower socioeconomic statuses and/or underrepresented groups [25]. Medical schools must also develop an admissions process that takes into account a variety of qualities, such as academic, social, and personal achievements. Interviews, personal statements, curricula vitae, and validated personality tests are useful tools to complement academic grades to ensure a well-rounded and diverse student body. Moreover, medical schools must provide an opportunity for students to declare themselves in attenuating circumstances should they present with lower academic grades.

In conjecture with ensuring a comprehensive and equitable admissions process, medical schools must ensure a positive and respectful environment across the various stages of medical education. They must instill a culture of respect and reasonable accommodation towards diversity and be formally anti-racist and anti-bigotry. To this end, medical schools must develop and implement a diversity policy that condemns and sanctions discrimination and degrading behaviors based on socioeconomic status, ethnicity, religion, race, disability, or gender.

Employment of Graduates

EDI (Equity, Diversity, Inclusion) consideration should play a role in the hiring of medical school staff. "Equity" looks to eliminate systemic barriers and biases to ensure equal opportunities for all. "Diversity" refers to "differences in race, color, place of origin, religion, immigrant and newcomer status, ethnic origin, ability, sex, sexual orientation, gender identity, gender expression, and age" and lends to a diversity in perspective. "Inclusion" consists of fostering an environment where everyone's contributions are valued [26].

The fact remains that although the proportion of minorities in student cohorts has gradually increased, a similar trend has not been observed in the teaching and researching staff. Moreover, staff from minority groups tend to spend more time in probationary ranks. They are also less represented in senior faculty and administrative positions, less likely to receive awards, and have been reported to experience lower career satisfaction due to higher social isolation [27].

Medical schools must also include diversity and social accountability for their teaching and researching staff. This diversity should be emphasized to allow students to benefit from a richer curriculum on account of a variety of perspectives. Both equity and inclusion need to be respected by increasing the representation

of minorities in employment to assure equal work opportunities for everyone with a welcoming and supporting environment in which everyone's input is valued.

Research

Medical research is a valuable source of information for healthcare systems to deliver safe, effective and sustainable health care to populations and individuals. It also informs the public and global health policies that are implemented to advance the health of societies at large. However, a "know-do gap" remains between the knowledge generated from research and the care or policies implemented in health systems [28,29].

Medical schools must collaborate with research funding agencies and partner organizations to direct their research endeavors towards measuring and responding to the population's needs. Medical schools must ensure that they evaluate and adapt to the changing needs of their community by developing formal processes to evaluate these needs and subsequently advocate for them in collaboration with partner organizations. The results should be made public and used in practice to provide evidence-based care [30].

Collaborative Research

Collaborative research can help bridge the know-do gap while promoting social accountability. As with all other aspects of social accountability, research conducted by medical schools should be oriented towards the needs of the population and should have a positive impact on population and/or individual health. This can be achieved by formally assessing the needs of the community, consulting the population for research design and implementation, and collaborating on knowledge translation [31,32].

The Canadian Institutes of Health Research, a major funder of health research in Canada, recognizes collaborative research methodologies as a fundamental step in bridging the know-do gap [33]. Community research partners include, but are not limited to, geographic communities, community groups with specific concerns, students, health service organizations, health workers, governments, and groups with a common identity, illness, or situation.

Community-based participatory research (CBPR) is one approach to collaborative research whereby the community (i.e. anyone affected by the research) actively collaborates with researchers in all stages of the research process. It aims to create an equitable and bidirectional relationship between both parties. Research questions and designs developed through such a collaborative effort will be more oriented towards the needs of the population. Furthermore, this approach empowers the community to advocate for their needs and contributes to more sustainable and accountable research. Lastly, CBPR research outcomes are more likely to be useful for the community and lead to improved health outcomes [34].

Integrated knowledge translation (IKT) promotes collaboration between researchers and knowledge users (i.e. those who will benefit from the research). However, while CBPR is more focused on social justice, IKT emphasizes the importance of knowledge translation and prioritizes research designs that will most likely result in applicable knowledge for users [28]. CBPR and IKT are not mutually exclusive; they are in fact often complementary.

Primary Health Care

Primary health care is an essential pillar of social accountability in medicine as it “ensures people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care - as close as feasible to people’s everyday environment” [35]. Due to the first-line nature of primary health care, it is ideally placed to understand and address the gaps in the community. Therefore, a strong primary healthcare program and graduating workforce from medical schools are indicative of their ability to respond to the needs of the served population.

Family doctors’ longitudinal relationships with their patients and the community are unique in the healthcare system. By following patients throughout their lives and by working directly in the community they serve, family doctors are uniquely placed to understand the social causes of illnesses both at a micro (i.e. in individual patients) and macro (i.e. in society at large) level. Therefore, they can better achieve a comprehensive understanding of the needs of the community and address social determinants to improve population health Through its just nature, primary health care also allows a better understanding and service of marginalized populations [36].

As recommended by the report *Future of Medical Education in Canada: A Collective Vision for MD Education* from the Association of Faculties of Medicine of Canada, which champions social accountability, medical schools must “diversify learning contexts” and “value generalism” [37]. Medical schools must offer enriching learning experiences in family medicine and other primary care settings, where the majority of Canadians receive health services. Furthermore, medical schools must ensure that students are exposed to other underrepresented specialties of medicine in order to guarantee the appropriate distribution of physicians to meet the needs of the community. Strengthening primary health care education in medical schools should also be achieved by supporting teaching staff in the discipline and by funding and encouraging research in this field [38].

Conclusion

Socially accountable medical schools benefit students, faculties, and communities. Through engagement and partnerships with local organizations, medical schools can contribute to the improvement of the patient population they serve [32]. This impact can be measured by evaluating the impact of social accountability measures through indicators such as the health outcomes of the community and the employment status of medical school graduates. For instance, in the Philippines, the consistent work of a socially accountable medical school located in the rural area of Zamboanga reduced the infant mortality rate by 90% and resulted in 80% of the graduates committing to working in underserved settings [39]. The socially accountable medical student and future physician will be able to view their patient with a biopsychosocial perspective and have the required skills to improve their reality, and it is clear that this perspective has real impact on health outcomes and benefits the global wellbeing of individuals.

Bibliography

[1] Boelen C, Heck JE. Defining and measuring the social accountability of medical schools, Geneva: WHO. 1995. Retrieved from: http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf.

[2] The Network: Towards Unity for Health (TUFH). Tunis Declaration. 2017. Retrieved from: http://www.worldsummitonsocialaccountability.com/

[3] Areas of Excellence to be Recognised. ASPIRE. 2021. Available from: https://www.aspire-to-excellence.org/Areas+of+Excellence/

[4] Kassam A et al. Key Stakeholder Opinions for a National Learner Education Handover. BMC Medical Education. 2019 May;19(1):150. doi:10.1186/s12909-019-1598-7.

[5] Preston R et al. From Personal to Global: Understandings of Social Accountability from Stakeholders at Four Medical Schools. Medical Teacher. 2016 Oct;38(10):987–94. doi:10.3109/0142159X.2015.1114596.

[6] Association of American Medical Colleges. Achieving Health Equity: How Academic Medicine Is Addressing the Social Determinants of Health. 2016. Available from: https://store.aamc.org/downloadable/download/sample/sample_id/78/

[7] Pelletier SG. Service-Learning Plays Vital Role in Understanding Social Determinants of Health. 2018 Sep27. Available from: https://www.aamc.org/news-insights/service-learning-plays-vital-role-understanding-social-determinants-health

[8] Stewart T, Wubbena Z. An Overview of Infusing Service-Learning in Medical Education. International Journal of Medical Education. 2014;5:147-156. doi: 10.5116/ijme.53ae.c907.

[9] Population and Dwelling Count Highlight Tables, 2016 Census: Population counts, for Canada, provinces and territories, census divisions, population centre size groups and rural areas, 2016 Census – 100% data. Statistics Canada. 2018. Cat no 98-402-X2016001. Available from: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/pd-pl/Table.cfm?Lang=Eng&T=101&S=50&O=A. Accessed 12 Feb 2021.

[10] Bosco C, Oandasan I. Review of family medicine within rural and remote Canada: education, practice, and policy. Mississauga, ON: College of Family Physicians of Canada. 2016.

[11] Charbonneau G. Recruiting physicians to practise in rural communities. Can Fam Physician 2018;64:621.

[12] Canadian Institute for Health Information. Physicians Canada, 2013: summary report. Ottawa, ON: Canadian Institute for Health Information;.2014

[13] Pong RW, Heng D. The link between rural medical education and rural medical practice location: literature review and synthesis. Sudbury, ON: Centre for Rural and Northern Health Research, Laurentian University. 2005.

[14] Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. The Rural Road Map for Action: directions. 2017. Available from: https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf. Accessed 12 Feb 2021.

[15] Soles TL, Wilson CR, Oandasan IF. Family medicine education in rural communities as a health service intervention supporting recruitment and retention of physicians: advancing rural family medicine: the Canadian Collaborative Taskforce. Can Fam Physician. 2017;63:32–8.

[16] Stagg P, Prideaux D, Greenhill J, Sweet L. Are medical students influenced by preceptors in making career choices, and if so how? A systematic review. Rural and Remote Health. 2012 [cited 2021 Feb12];12:1832.

[17] Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization. 2010 [cited 2021 Feb12]. Available from: http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf.

[18] Strasser R, Couper I, Wynn-Jones J, et al. Education for rural practice in rural practice. Educ Prim Care. 2016;27(1):10–4. doi:10.1080/14739879.2015.1128684.

[19] Strasser R. Learning in context: education for remote rural health care. Rural and Remote Health 2016 [cited 2021 Feb12];16: 4033. Available: www.rrh.org.au/journal/article/4033.

[20] Ellaway R, Bates J. Distributed medical education in Canada. CMEJ. 2018;9(1):e1-5. doi: 10.36834/cmej.43348

[21] Curtis S, Blundell C, Platz C, Turner L. Successfully widening access to medicine, Part 1: Recruitment and admissions. Journal of the Royal Society of Medicine. 2014;107(9):342–346. doi: 10.4103/1357-6283.109785.

[22] Mathers J, Parry J. Why Are There So Few Working-Class Applicants to Medical Schools? Learning from the Success Stories. Medical Education. 2009;43(3):219–28. doi: 10.1111/j.1365-2923.2008.03274.x.

[23] Dhalla IA et al. Characteristics of First-Year Students in Canadian Medical Schools. CMAJ. 2002 Apr;166(8):1029–35. PMID: 12002979; PMCID: PMC100877.

[24] Waldron IRG. The Impact of Inequality on Health in Canada: A Multi-Dimensional Framework. Diversity & Equality in Health and Care. 2010;7(4). Available from: https://diversityhealthcare.imedpub.com/abstract/the-impact-of-inequality-on-health-in-canada-a-multidimensional-framework-1943.html.

[25] Rourke J. Social Accountability in Medical Schools. Academic Medicine. 2013 March;88(3):430. doi: 10.1097/ACM.0b013e3182864f8c.

[26] Government of Canada, Natural Sciences and Engineering Research Council of Canada. Equity, Diversity and Inclusion. 2019 May 9. Available from: https://www.nserc-crsng.gc.ca/NSERC-CRSNG/EDI-EDI/Dimensions_Dimensions_eng.asp.

[27] Guevara JP et al. Minority Faculty Development Programs and Underrepresented Minority Faculty Representation at US Medical Schools. JAMA. 2013 Dec;310(21):2297–304. doi:10.1001/jama.2013.282116.

[28] Jull, J., Giles, A. & Graham, I.D. Community-based participatory research and integrated knowledge translation: advancing the co-creation of knowledge [Internet]. Implementation Sci. 2017 [cited 2021 Jan22];12:150. doi: 10.1186/s13012-017-0696-3

[29] van den Driessen Mareeuw, F., Vaandrager, L., Klerkx, L. et al. Beyond bridging the know-do gap: a qualitative study of systemic interaction to foster knowledge exchange in the public health sector in The Netherlands [Internet]. BMC Public Health. 2015 [cited 2021 Jan22];5:922. doi: 10.1186/s12889-015-2271-7

[30] Health Canada. Policy Social accountability: a vision for Canadian medical schools. 2001; cat no H39-602/2002. Available: www.hc-sc.gc.ca/hppb/healthcare/pdf/socialaccountability.pdf

[31] Global Consensus for Social Accountability of Medical Schools [Internet]. Universitat de Barcelona. 2015 [cited 2021 Jan22]. Available from: http://www.ub.edu/medicina_unitateducaciomedica/documentos/Global%20Consensus.pdf.

[32] Rourke, J. Social Accountability: A Framework for Medical Schools to Improve the Health of the Populations They Serve [Internet]. Academic Medicine, 2018 Aug [cited 2021 Jan22];93(8):1120-1124. doi: 10.1097/ACM.0000000000002239

[33] Government of Canada. Guide to Knowledge Translation Planning at CIHR: Integrated and End-of-Grant Approaches [Internet]. Canadian Institutes of Health Research. 2015 Mar [cited 2021 Jan22]. Available from: https://cihr-irsc.gc.ca/e/45321.html

[34] Horowitz CR, Robinson M, Seifer S. Community-Based Participatory Research From the Margin to the Mainstream [Internet]. Circulation. 2009 [cited 2021 Jan22]. Available from: https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.107.729863

[35] Primary health care [Internet]. World Health Organization. World Health Organization; 2019 [cited 2021 Jan31]. Available from: https://www.who.int/news-room/fact-sheets/detail/primary-health-care

[36] Buchman S, Woollard R, Meili R, Goel R. Practising social accountability: From theory to action. Can Fam Physician. 2016 Jan [cited 2021 Jan30];62(1):15-18.

[37] Meili R, Buchman S. Social accountability: at the heart of family medicine [Internet]. Can Fam Physician. 2013 Apr [cited 2021 Jan30];59(4):335-336.

[38] Camelot G, Monnet E. La responsabilité sociale des facultés de médecine dans l'évolution du système de santé: Quelles attentes et quelles réponses des principaux intervenants et des facultés? [Internet]. Santé Publique. 2003 [cited 2021Jan30];HS(15):201-220. doi: 10.3917/spub.hs030.0201

[39] Boelen C. Why should social accountability be a benchmark for excellence in medical education? [Internet]. Educación Médica. 2016;17(3):101-105. doi: 10.1016/j.edumed.2016.06.004.