THEnet’s Evaluation Framework for Socially Accountable Health Professional Education

Version 1.0

Monograph I
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Redefining the Role of Health Professions Education

More than a billion people globally never see a health worker in their lives. Such health inequities are not only unacceptable, but costly, limiting individual opportunity and slowing societal growth. Great disparities in health outcomes exist even in high income countries illustrating the importance of the social determinants of health, i.e. the environment in which people develop, live and work and the systems that serve them.

Inequitable and inefficient health systems are weakened by a shortage and mal-distribution of the health workforce, a major impediment for long term improvements in health outcomes in many regions. In many poor countries health professional schools end up training students for the global market, rather than to meet their own needs, at considerable cost to their own often weak health systems. While reducing inequities is complex and requires the involvement of a multitude of stakeholders, health professional schools can play a central role in improving health equity. They produce key components of the health system: the health workforce and knowledge. Yet, they are often not active participants in developing more equitable health systems. Addressing these challenges call for a radical shift in our understanding of the role of health professions education institutions.

Today’s health professional schools must form effective partnerships with the health sector, policy makers and communities to identify and help solve priority health needs. They can and should be vital contributors to health system development and agents of innovation and reform. Schools help develop the values, norms, behaviours and worldviews, held by key groups in the health system. They can shape and influence their graduates with potentially wide-ranging effects throughout the health system.

Unfortunately, current models of health workforce education are not producing the people, research and services needed to attain basic universal health coverage and the calls for reform are growing louder. The Independent Global Commission on Education of Health Professionals for the 21st Century (2010) calls for transforming institutional and educational approaches to better meet changing health system needs. Furthermore, in late 2010, The Global Consensus for Social Accountability of Medical Schools (GCSA) urged schools to improve their response to current and future health-related needs and challenges in society and reorient their activities accordingly.

However, since 2008 several health profession education institutions in underserved and rural regions of Africa, Asia, Europe, the Americas and Australia have been pioneering innovative approaches to tackle these challenges. Supported by The Atlantic Charitable Trust, eight such schools, striving towards greater social accountability, founded the Training for Health Equity Network (THEnet) in December 2008. THEnet schools define social accountability as an institutional responsibility to orient teaching, research and service activities to addressing priority health needs with a particular focus on the medically underserved.

THEnet founding schools are: Ateneo de Zamboanga University School of Medicine in the Philippines; Comprehensive Community Physician Training Program in Venezuela; Faculty of Health Sciences, Walter Sisulu University in South Africa; Flinders University School of Medicine in Australia; James Cook University Faculty of Medicine, Health and Molecular Science in Australia; Latin American Medical School in Cuba; Northern Ontario School of Medicine in Canada and University of the Philippines Manila - School of Health Sciences in Leyte.
Frameworks on social accountability have existed since the mid-1990s. However, THEnet schools determined that there were no robust, practical tools for assessing the progress of their institutions towards social accountability that effectively evaluated and compared strategies, processes and programs within and across contexts.

The focus of accreditation bodies for health professional schools (particularly for medical schools) is firmly on the process of education, with little attention paid to governance, community partnerships, distribution of resources or broader outcomes. Thus, the initial priority of THEnet was to develop a comprehensive Evaluation Framework to identify key factors that affect a school’s ability to positively influence health outcomes and health systems performance as well as to develop ways to measure them across institutions and contexts.

Finding New Ways to Measure Success of Academia

What should health professional institutions be held accountable for? THEnet schools define their success, not by how many graduates they produce or how many articles they publish, but whether their graduates have the right competencies to meet the needs of their reference populations and whether a high portion of them stay and work in regions where they are most needed. They also assess whether their research and services positively affect health policies and practice and thereby improve health in disadvantaged communities.

Using WHO’s social accountability framework11 and Boelen and Woollard’s Conceptualization, Production and Utilization Model1 as a foundation, THEnet schools worked together and with their stakeholders, to develop and test an Evaluation Framework for Socially Accountable Health Professional Education.

Measuring the impact of educational and institutional strategies on the health system and its beneficiaries is challenging, not least because “impacts” are usually the result of a myriad of factors, relationships, and events that in turn trigger ripple effects in the health system and its sub-systems. Consequently, it is difficult to attribute a specific impact to one intervention, program, or institution. However, additional empirical research is needed to identify the key factors that institutions can affect to improve health
and health system impact. In addition, our members, while insisting on rigor in the quest for evidence and measurement, kept in mind that innovation comes from thinking out of the box. As a result they agreed that the framework had to be flexible enough to provide adequate space for challenging orthodoxies, allowing for contextual differences and experimenting with new ideas.

This document provides the first version of THEnet’s Evaluation Framework for Socially Accountable Health Professional Education. It allows schools to get a sense of where they are on the road towards greater social accountability and in their ability to increase impact on health and health services. This first version of the Framework centers on medical education. However, the Framework focuses on core common elements and was tested across health disciplines at two of THEnet schools, and we believe it can serve as a foundation to evaluate other health professional education as well. THEnet’s Evaluation Framework also serves as a starting point for its collaborative research activities. Hence, it also helps identify research and data gaps to strengthen the evidence base.

THEnet is excited to share its Framework and would like to partner with those schools interested in using it. Institutions willing to partner with THEnet will have the opportunity to contribute to refining this organic tool, that will continuously evolve in response to feedback and as root causes and causal links are examined in greater detail. Partners will in turn receive access to THEnet’s Framework Implementation Manual. They can also receive mentoring, guidance, and support documents such as focus group and survey instruments. More importantly collaborating with THEnet provides all of us with a more solid evidence base by harmonizing data collection and analysis. Together we can create better tools to support schools seeking to increase their social accountability and thereby make health equity a realistic and actionable goal.
Several health professional schools, working in marginalized urban, rural, and remote regions in high and low income countries, agreed to join forces and constitute THEnet in late 2008. The goal was to build evidence to support effective and credible change towards greater impact and accountability of academic institutions. It is a community of practice of schools of medicine and health sciences with a core commitment to achieving equity in health services and improving health outcomes.

THEnet institutions operate in highly diverse contexts. Training settings vary from poor communities in the United States, remote indigenous communities in Canada and Australia and rural regions of Africa to urban slums and marginalized communities in the Philippines including conflict-ridden Mindanao. Embedded in underserved communities and committed to principles of equity, they see communities as vital actors in the health system. The schools thus work with health system stakeholders and community members to develop innovative ways to address the spectrum of issues affecting health. Not only are students and faculty often providing health services where there were none, they are mobilizing communities to take responsibility for their own health. This ranges from reducing cardiovascular risk factors in neglected populations, to bringing municipal authorities and civil society groups together with students and faculty in projects as diverse as increasing use of latrines, and growing vegetable gardens.

Founding member schools are:
1. Ateneo de Zamboanga University School of Medicine, Philippines (ADZU)
2. Comprehensive Community Physician Training Program, Venezuela (CCPTP)
3. Flinders University School of Medicine, Australia (FLINDERS)
4. James Cook University Faculty of Medicine, Health and Molecular Sciences, Australia (JCU)
5. Latin American Medical School, Cuba
6. Northern Ontario School of Medicine, Canada (NOSM)
7. School of Health Sciences Leyte, University of the Philippines Manila, Philippines (SHS)
8. Walter Sisulu University Faculty of Health Sciences, South Africa (WSU)

Four new schools that joined THEnet in late 2011 will be testing the Framework:
1. Gezira University Faculty of Medicine, Sudan
2. Ghent University Faculty of Medicine and Health Sciences, Belgium
3. Patan Academy of Health Sciences, Nepal
4. The University of New Mexico Health Sciences Center, United States
THEnet’s Aims and Guiding Principles

THEnet’s Aims:

1. To generate new evidence and advocate for effective institutional strategies that help health professions schools meet needs of underserved communities

2. To increase the number of health professions schools using social accountability principles to meet needs of underserved populations

3. To support health professional schools engaged in reform through evidence-based policy guidance, practical tools and capacity development

4. To increase the focus on health equity and social accountability in health professions education and health system reform

THEnet’s Guiding Principles:

Despite highly different operational contexts, THEnet schools have embraced several common principles/strategies, some of which are the focus of its collaborative research.

1. Health and social needs of targeted communities guide education, research and service programs

2. Social accountability is demonstrated in action through a “whole school” approach

3. Students recruited from the communities with the greatest health care needs

4. Programs are located within or in close proximity to the communities they serve

5. Health professions education is embedded in the health system and takes place in the community and clinics instead of predominantly in university and hospital settings

6. Curriculum integrates basic and clinical sciences with population health and social sciences; and early clinical contact increases the relevance and value of theoretical learning

7. Pedagogic methods are student-centered, problem and service-based and supported by information technology

8. Community-based practitioners are recruited and trained as teachers and mentors

9. Health system actors are partners to produce locally relevant competencies

10. Faculty and programs emphasize and model commitment to public service
THEnet’s Values

The following values underpin our work, and have been defined collectively with THEnet partner schools.

**Equity:**
The state in which opportunities for health gains are available to everyone. Health is a social product and a human right, and 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 redressing inequitable distribution of resources, and **access to education**.

**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 which optimally satisfies both professional standards and community expectations.

**Relevance:**
The degree to which the most important and locally relevant problems are tackled first. This incorporates the values of responsiveness to community needs. In addition, it incorporates the principle of cultural sensitivity and competency. **Cultural competency** is not seen as a specific knowledge, attitudes and practices acquired, but a process of removing barriers to effective and open communication in the service of the patient.

**Efficiency:**
This involves producing the greatest impact on health with available resources targeted to address priority health needs and incorporates the principle of **cost-effectiveness**.

**Partnerships:**
Partnership with all key stakeholders in developing, implementing and evaluating efforts is at the core of THEnet schools’ activities. The partnership value includes partnerships between and among all stakeholders including faculty and students; communities being served; all health and education system actors; the school and the larger academic and social accountability community. It incorporates the values of **mutual transformation**, equipping students and faculty to be agents of change and open to be changed through their partnerships. It also incorporates the value of **inter-professionalism**, or a belief that all health professionals must respect each other’s knowledge and culture and understand the role that each team member plays on the health care team. Inter-professionalism includes the key features of partnership, participation, collaboration, co-ordination and shared decision making. Where inter-professionalism is practiced, health professionals from all disciplines work together as teams with and in service of the patient and the whole community.
The operational model guiding the development of THEnet’s schools programs and its Framework, assumes that to meet the needs of the populations it serves, a health professional school must be designed based on a thorough needs assessment and understanding of the environment it operates in. This includes the social systems it seeks to impact and how various systemic and other factors may influence its operations and outcomes. The assessment is conducted in collaboration with key stakeholders including health system actors and underserved communities.

Guided by the values it espouses the school then needs to set outcome objectives and select strategies based on the information and evidence that is available. Desired competencies of health professionals and research priorities are defined based on the need assessment. It then designs and delivers programs to meet their defined outcomes. The school then evaluates its processes, strategies, outcomes and the impact the school is having on the systems, communities and individuals it serves to ensure its activities are meeting needs. This is an ongoing process and the school must continue to examine their underlying assumptions, be proactive and responsive to changing needs and demands.
Introduction to the Framework

To strengthen the evidence base on socially accountable health workforce education, as our first piece of work, we chose to develop a comprehensive Evaluation Framework (the Framework). The Framework seeks to identify key factors that affect a school’s ability to positively influence health outcomes and health systems performance and to develop ways to measure them across institutions and contexts. This first generation of the Framework was created for medical schools. However, given the basic nature of most of the questions and after having tested it across health disciplines at two schools, we believe it can serve as a foundation that is adaptive to evaluate other health professional education.

The Framework was created as an aspirational tool. It is not designed as a summative pass/fail exercise, but rather a formative exercise to help schools take a critical look at their performance and progress towards greater social accountability, and assist schools in establishing priority areas for research and improvement.

There is increased discussion globally on developing and incorporating social accountability standards in medical school accreditation and quality improvement assessments (Global Consensus for Social Accountability of Medical Schools, 201110). While THEnet is highly involved in this effort and some standards might eventually be developed from this framework, it is important to note that the Framework is not designed to be used as a ‘tick box’ for social accountability in accreditation. It is an aspirational evaluation tool for critical and honest institutional quality improvement.
To date, five of the founding THEnet schools have pilot tested the Framework (ADZU, FLINDERS, JCU, NOSM, and SHS). Each of these schools found the Framework effective, not only in evaluating the school's progress towards greater social accountability, but also in raising awareness of the issue among students, staff and stakeholders. It allowed each school to review their schools’ social accountability mission, vision and goals and identify strengths, weaknesses and gaps.

The Framework is also a comprehensive tool to identify key factors that affect a school’s ability to positively influence health outcomes and health systems performance and to develop ways to measure them across institutions and contexts. It is an organic tool that will continue to evolve as root causes and causal links are established in greater detail.

The Framework is designed to be used in its entirety, as schools may vary widely in their approach across different contexts. In addition, it is intended to be used on an institution-wide basis not at department or program levels. Moreover, for the Framework to be effective and so that its findings be acted on, institutional buy-in at highest levels is essential.

The Framework has been designed to be useful at three levels (individual schools, network and global level):

**Individual School Level:**
At individual school level the goal is to learn from others, validate and continually assess and improve schools’ performance in socially accountable medical education, research and service according to agreed standards.

**Network/Partnership Level:**
At a network/partnership level the goal is to engage in self-reflection and renewal, share collective experience and use the resulting critical mass of data for continuous improvement.

**Wider Level:**
At a wider level the goal is to facilitate, and advocate for, sustainable improvement in health services and outcomes through demonstrating the value/impact of socially accountable health professional schools. It is also to challenge other bodies and orthodoxies at local, national and international levels.

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The Framework

Using Boelen and Woollard’s Social Accountability Conceptualization–Production–Usability model (CPU model) as the foundation, the Framework seeks to assist health professional schools in assessing their social accountability by directing schools to a series of question’s under the three sections as follows:

**Section 1: How does our school work?**

This section addresses important aspects of the organization and planning of the school, frequently neglected in existing evaluation and accreditation frameworks, including an assessment of values, governance and decision-making processes and partnerships with the health sector, community groups and policy makers. It also includes documentation and understanding of the reference populations that the school serves, with particular note of underserved groups within this.

**Section 2: What do we do?**

This section focuses on the schools’ programs including composition of students and teachers, curriculum, learning methodologies, research, service and resource allocation. This corresponds more closely to usual accreditation processes.

**Section 3: What difference do we make?**

This section includes an assessment of graduate outcomes (location, discipline, and practice), engagement and effect on health services and health system outcomes and influence with other schools. Again, this section is largely overlooked in most accreditation measures, and is frequently considered outside the scope of health professional education institutions.
### Section 1: How does our school work?

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<th>Aspirations</th>
<th>Indicators</th>
<th>Suggested Sources of Evidence</th>
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<tbody>
<tr>
<td>1.1. What do we believe in? (Values*)</td>
<td>We uphold and demonstrate shared values of social accountability as defined by THEnet.</td>
<td>Social accountability values are explicit and known and understood by students and staff. Staff/faculty and students and key stakeholders/community partners are able to give examples of how values are operationalised.</td>
<td><strong>Measurement Tools:</strong> THEnet Interviews/surveys/focus groups with students and staff/faculty, health care providers and community. <strong>Data Sources:</strong> School/University Mission or Vision statement and strategic plan. Annual Report, course materials, student manuals.</td>
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<tr>
<td>1.2. Who do we serve, what are their needs and what are the needs of our health system? (Reference population and health system)</td>
<td>We recognize and define the populations we serve with particular reference to underserved populations We define the reference populations’ needs in collaboration with these communities and other key health system stakeholders and hold ourselves accountable for addressing these needs We collaboratively plan to address the priority health and workforce needs of our reference populations and health systems We are active contributors to the health system of which we are a part and play a role in advocacy and reform. Our particular emphasis is on increasing the provision of and access to comprehensive Primary Health Care (PHC), and addressing the social determinants of health</td>
<td>Clear rationale for identification of populations Underserved populations are well defined and emphasised Priority health and workforce needs identified and regularly reviewed Awareness and understanding of reference population by students, staff/faculty and key stakeholders School, faculty/staff and students are involved in influencing and developing key policies and practices to improve health services and policies, with a particular emphasis on PHC</td>
<td><strong>Measurement Tools:</strong> Needs assessment that identifies key population, underserved populations, priority health and workforce needs Interviews/surveys/focus groups with students and staff/faculty, health care providers and community <strong>Data Sources:</strong> Documents and/or data describing reference populations as well as health services, health system, health workforce priority needs and plans to address them National/regional health workforce plan Evidence of faculty/staff and students involvement in advocacy Accreditation documents Documents demonstrating community partnerships</td>
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*The terms in parentheses are from the CPU Model¹*
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| 1.3. How do we work with others? (Partnerships) | We operate in partnership with all relevant stakeholders, with a primary focus on the priority health needs and social needs of our target populations. Our partnerships reflect our genuine commitment to meaningful collaboration with communities, health services and health care providers. | Level of involvement of key stakeholders in planning, developing and supporting teaching, service and research programs and student and faculty/staff recruitment. Community is engaged and makes and receives meaningful in-kind and financial contributions, reciprocally between schools and communities. | **Measurement Tools:** Interviews/surveys/focus groups with students and staff/faculty, health care providers and community.  
**Data Sources:**  
- Documented collaborative programs of teaching, service and research.  
- Audit of community participation and partnership outcomes.  
- Meeting minutes and content.  
- Memoranda of Understandings with health departments and communities.  
- Financial/infrastructure audit of community co-contribution. |
| 1.4. How do we make decisions? (Governance) | Our strategic decision-making involves meaningful participation from all stakeholders. | Governance structure and process ensures meaningful participation of key stakeholders in corporate, fiscal and academic governance. Constitution or mission statement reflective of stakeholder involvement in decision making. Examples of changed policies/processes in response to stakeholder feedback. | **Measurement Tools:** Interviews/surveys/focus groups with students and staff/faculty, health care providers and community.  
**Data Sources:**  
- Examples of changed policies/programs/services in response to community feedback.  
- School organisational chart.  
- Memoranda of Understanding.  
- School mission statement/charter.  
- Minutes/meeting notes from key committees.  
- Evidence of how decisions are made and who is making them.  
- Stakeholder feedback and consultation.  
- Reference groups/community committees (including student groups).  

[Website: www.thenetcommunity.org]
## Section 2: What do we do?

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<td>2.1. How do we manage our resources? <em>(Field operations)</em></td>
<td>We allocate resources to operationalise our plans for community engagement and delivery of the program in communities where there is the greatest need for the provision of high quality health services. We encourage reciprocal contributions among the school, community and other stakeholders.</td>
<td>Resources for community engagement and program operationalization are distributed according to priority needs (See Key Component 1.3). Sufficient resources are available to operationalise the School’s strategic plan. Community makes and receives meaningful in-kind and financial contributions. Stakeholder satisfaction with resource allocation. Documentation of partnership agreements for engagement with local communities. Equivalence in student assessment results across sites. “Champions” are identified and supported in community and stakeholder groups. Funding to support engagement and services in priority areas is sought from a range of sources.</td>
<td>Measurement Tools: Credible, relevant needs assessment. Community and student interviews assessing satisfaction. Case studies of communities/teaching sites. Interviews/surveys/focus group discussions with ‘champions’ that are supportive of the school as well as those not familiar or supportive of the school. Mapping of external partnerships including external Memoranda of Understanding. Assessment results across sites (matched with resource allocation). Data Sources: Workforce plans and budgets. Evidence of grant funding to support underserved populations. Strategic plan and other planning documents. Student handbooks/manuals and policies/cultural manuals outlining roles and responsibilities. Documented community engagement policies.</td>
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### Section 2: What do we do? continued

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| 2.2. What, where and how do we teach? (Education program) | We have an education program that reflects the priority health system, workforce and needs of the communities we serve, as defined by community partnerships. This is evident within curriculum, pedagogy, assessment and teaching sites. Learning objectives are developed based on professional roles and responsibilities that are reflective of current and projected health and workforce needs. | **Curriculum content**
Curriculum reflects identified priority health and social needs of the community

Stakeholders involved in curriculum design and placements

Curriculum design, delivery, assessment and evaluation reflect the desired graduate attributes, the principles of generalism and integration of basic and clinical sciences with population health and social sciences

Inter-professional education opportunities available to all students

Assessment is designed to assess the acquisition of the knowledge, skills and behaviours required by socially accountable practitioners in responding to health needs of underserved populations

**Teaching methodology**
Rationale for teaching methodology clearly outlined in terms of social accountability

Teaching methodology is relevant and appropriate to learner’s needs and context

**Community placements**
Field placements developed to provide adequate exposure to priority health needs whilst learning in context

Continuity of community and clinical experience throughout the curriculum

Clear rationale for teaching site selection

Length of time student spends in supported, educationally sound placements congruent with learning needs | **Measurement Tools:**
Interviews with curriculum committee members

Community profiles showing demographics and health indicators reflecting site selection

Qualitative data supporting innovative, quality inter-professional experiences (e.g. focus groups with students and faculty/staff)

In Interviews/surveys/focus groups with students and staff/faculty, health care providers and community

**Data Sources:**
Curriculum documents – planning documents, curriculum maps (including community placement plan), workshops, publications
Student placement policies and database

Student handbooks

Student community placement reports

Curriculum database in which learning objectives align with priority health needs |

[www.thenetcommunity.org](http://www.thenetcommunity.org)
### Section 2: What do we do? continued

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<tr>
<td><strong>2.3. Who do we teach? (Learners)</strong></td>
<td>We enrol and support students who reflect the socio-demographic characteristics of our reference population, especially underserved populations</td>
<td>Percentage of student intake from reference population</td>
<td><strong>Measurement Tools:</strong> Interviews/surveys/focus groups discussions with students from underserved groups</td>
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<td>Proportional intake of underserved groups</td>
<td><strong>Data Sources:</strong> Student database</td>
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<td>Explicit and targeted support and pathways for underserved populations</td>
<td>Selection policy and processes</td>
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<td>Student progress and completion rates are equivalent across student groups</td>
<td>Rural classification</td>
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<td>Advocacy to support medical education for underserved groups</td>
<td>Student support policies: including secondary school recruitment policies</td>
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<td>We enrol and support students who reflect the socio-demographic characteristics of our reference population, especially underserved populations</td>
<td>Faculty/staff and promotions reflect a diverse mix of professional, cultural and community backgrounds</td>
<td>Wider university polices on student support and selection</td>
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<td>Proportional representation and retention of underserved groups on faculty and non-academic staff</td>
<td>Student attrition, progress and completion statistics</td>
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<td>Health service providers and community can engage in the design and implementation of the program</td>
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<td>Staff and faculty undertake cross cultural training</td>
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<td>Presence of community preceptors in the underserved community</td>
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<td>Role of community is formalized through adjunct appointments</td>
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<td><strong>2.4. Who does the teaching? (Educators)</strong></td>
<td>We recruit and support educators and other staff who: Reflect the demographics of our reference population</td>
<td>Faculty/staff and promotions reflect a diverse mix of professional, cultural and community backgrounds</td>
<td><strong>Measurement Tools:</strong> Log of community preceptors, including geographical distribution</td>
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<td>Reflect the balance of clinical, biomedical and social sciences</td>
<td>Proportional representation and retention of underserved groups on faculty and non-academic staff</td>
<td>Validated tools assessing social accountability values of staff</td>
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<td>Demonstrate commitment to SA principles</td>
<td>Health service providers and community can engage in the design and implementation of the program</td>
<td>Audit of percentage of school staff/faculty who have undertaken cultural awareness training</td>
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<td>We engage and support community and community health service providers as educators in a manner which strengthens local health services</td>
<td>Staff and faculty undertake cross cultural training</td>
<td>Interviews/surveys/focus groups with students and staff/faculty, health care providers and community</td>
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<td></td>
<td></td>
<td>Interviews/surveys or focus groups with students and staff/faculty, health care providers and community</td>
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</tbody>
</table>

THEnet’s Evaluation Framework for Socially Accountable Health Professional Education
## Section 2: What do we do? continued

<table>
<thead>
<tr>
<th>Key Component</th>
<th>Aspirations</th>
<th>Indicators</th>
<th>Suggested Sources of Evidence</th>
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</thead>
</table>
| 2.5. How does our research program relate to our mission and values? (Research) | We have a research agenda that reflects priority health and health system needs of our reference population developed and undertaken in partnership with key stakeholders with a focus on participatory methodologies | Projects are community-oriented involving community/population members and other key stakeholders at all stages | **Measurement Tools:**
Audit of student engagement in community action projects
Audit of publications, presentations and joint authorship with community partners

**Data Sources:**
Memoranda of Understanding
Community action research/participatory action research projects
Number of relevant grant applications
Number of internal school and faculty grants supporting social accountability projects.
Number of higher research degree and Honours students undertaking projects addressing priority health needs
Records of ethics applications
Record of community requests for partnerships and projects and actual projects and partnerships
Research priority agenda |

**Measurement Tools:**
Audit of student engagement in community action projects
Audit of publications, presentations and joint authorship with community partners

**Data Sources:**
Memoranda of Understanding
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Number of relevant grant applications
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[www.thenetcommunity.org](http://www.thenetcommunity.org)
### Section 2: What do we do? continued

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</thead>
</table>
| 2.6. What contribution do we make to delivery of health care? (Service) | Educators and students are involved in service delivery related to changing priority health needs of reference populations and reflective of future working environments  
Educators and students are involved in community development | Service provider participation in education/training activities in the community  
Students provide services as part of their training that benefits local communities in terms of access, utilization and quality of care  
Percentage of student and staff time directly involved in service delivery  
Number/proportion of co-appointments  
Examples of school responsiveness to community feedback on service delivery  
Community able to describe changes as a consequence of school involvement  
Service learning is valued within the program and by stakeholders  
Student projects partnered with the community | **Measurement Tools:**  
Community/reference population interviews/focus group discussions on faculty/staff contribution to communities  
Audit of student placement diaries  
**Data Sources:**  
Staff human resource policy for health professional work  
List of adjunct staff  
Curriculum framework  
Record of student service activity  
Training and placement records for faculty and students  
Faculty placement database  
Mission statement  
Records of student projects  
Record of community representation  
Examples of changed policies in response to community feedback, and examples of new programs/services/initiatives/projects |
Section 3: What difference do we make?

<table>
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<th>Aspirations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.1. Where are our graduates and what are they doing? (Human resources)</td>
<td>We produce graduates technically, socially and culturally suited to address the health and social needs of reference populations and health system. This will be reflected in geographical location, career choice, and professional behaviour. Our graduates particularly engage in comprehensive primary health care, (addressing the social determinants of health) and broader advocacy and reform. We are involved in the continuum of medical education and support alumni beyond graduation to promote access, quality and efficiency of health care.</td>
<td>Graduate knowledge, attitudes and skills are appropriate to their practice and settings. Number/proportion of graduates participating in continuing professional development appropriate to practice and setting. Number/proportion of graduates working and remaining in communities of need. Performance of graduates in certification exams. Distribution of graduate specialization proportional to need. Balance of graduates working in public versus private system, urban versus rural areas, primary versus secondary versus tertiary care settings. Evidence that gaps in health services are being addressed by local graduates. Graduate support programs. Graduate linkage to school after graduation. Processes in place facilitating quality care (e.g. rural locum support). Number/proportion of alumni available to mentor students and new graduates. Graduates and students recognized by community and government as key advocates.</td>
<td>Measurement Tools: Validated tools for measuring social accountability/social responsibility&lt;sup&gt;13&lt;/sup&gt; Survey of heads of departments on junior doctor performance. Interviews with community. Interviews/survey with key staff and graduates. Longitudinal graduate outcome survey and other knowledge, attitude and behaviour surveys. Data Sources: Internal graduate tracking processes. Measurement of integration of graduates including community integration. Department of Health score cards or evaluations. Alumni tracking processes. School publications. Continuing Professional Development policies and processes and MoUs with postgraduate training providers. List of advocacy activities and meetings to measure reciprocity.</td>
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</table>

**www.thenetcommunity.org**

<sup>13</sup> www.thenetcommunity.org
### Section 3: What difference do we make? continued

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<tbody>
<tr>
<td>3.2. What difference have we made to our reference population and reference health systems? (Partnerships and effects on health outcomes)</td>
<td>We have a positive impact on priority health and social needs of our reference population. In partnership with stakeholders we contribute to the transformation of health systems to be more relevant to the health needs of our reference populations. We are recognized agents of positive change by our reference population/partners and stakeholders.</td>
<td>Perceived strength of partnerships with socially accountable entities Model of partnerships reflect socially accountable values Numbers of community meetings held and joint activities and level of participation Perceived impact of medical school by community and health service Volunteer work of graduates Community satisfaction with care Measures of access to care Health, economic and social outcome indicators Access to health education opportunities and facilities Retention of health professionals in the community Outcomes and impact of students and faculty projects</td>
<td>Measurement Tools: Qualitative tools such as Most Significant Change, a participatory monitoring and evaluation of community engagement [14] Longitudinal study of population health outcomes Longitudinal studies assessing the efficiency (incorporating cost-effectiveness) of socially accountable health professional education Economic and social impact study (case studies). For example see Exploring the Socio-Economic Impact of the Northern Ontario School of Medicine. Available at: <a href="http://www.nosm.ca/reports/">http://www.nosm.ca/reports/</a> Data Sources: Memoranda of Understanding or other arrangements with key stakeholders School annual report Interviews or focus groups with communities, health service providers Social, economic and infrastructure data for populations</td>
</tr>
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</table>
### Key Component

3.3. How have we shared our ideas and influenced others?
*Dissemination/Promotion and sustainability/transformational change*

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>We are engaged in a continuous process of critical reflection and analysis with others and disseminate these learnings in many ways</td>
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<tr>
<td>We influence policy makers, education providers and other stakeholders to transform the health system</td>
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<table>
<thead>
<tr>
<th>Indicators</th>
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</thead>
<tbody>
<tr>
<td>Number of relevant publications</td>
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<td>Number of relevant conference presentations</td>
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<tr>
<td>Examples of changes to health service delivery/policy as a result of school’s activity</td>
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<tr>
<td>Level of community support of the school</td>
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<tr>
<td>Quality improvement frameworks (e.g. accreditation)</td>
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<tr>
<td>Contribution to professional groups</td>
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<tr>
<td>Partnerships with relevant stakeholders including other universities</td>
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<tr>
<td>Faculty/staff and student exchanges</td>
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<tr>
<td>Joint conferences and professional organizations</td>
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<table>
<thead>
<tr>
<th>Suggested Sources of Evidence</th>
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</thead>
<tbody>
<tr>
<td><strong>Measurement Tools:</strong> Social network analysis</td>
</tr>
<tr>
<td><strong>Data Sources:</strong> Relevant school publication/conference presentations and meeting records</td>
</tr>
<tr>
<td>Community meetings or newsletters</td>
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<tr>
<td>Workshops</td>
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<tr>
<td>Accreditation visits/external examiners reports</td>
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<tr>
<td>Exchanges students/staff/academic or community visitors</td>
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<tr>
<td>Policy records and quality improvement frameworks</td>
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<td>Proof of research utilization</td>
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<tr>
<td>Annual and financial reports</td>
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<tr>
<td>Qualitative methodologies such as Most Significant Change, a participatory monitoring and evaluation of community engagement</td>
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<tr>
<td>Interviews with communities and service providers</td>
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<tr>
<td>Number of benefactors supporting the school</td>
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<tr>
<td>Web search of other medical schools annual and financial reports</td>
</tr>
<tr>
<td>Office holders involvement in non-profit groups and professional groups</td>
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<tr>
<td>Enquiries from other health professionals about social accountability</td>
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### Key Component: What impact have we made with other schools? (Peer support and replication)

We actively engage with and support other institutions across national boundaries to achieve common social accountability goals.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Suggested Sources of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of schools partnering with THEnet referred/facilitated by the school</td>
<td><strong>Measurement Tools:</strong> Tracking system of collaborative efforts</td>
</tr>
<tr>
<td>Number of schools joined in socially accountable projects or recognizing social accountability as a core value</td>
<td><strong>Data Sources:</strong> THEnet website</td>
</tr>
<tr>
<td>Schools assisted to adopt socially accountable health professional education</td>
<td>Website activities/hits</td>
</tr>
<tr>
<td>Relevant joint research projects – number and topic</td>
<td>Number of requests for collaboration</td>
</tr>
<tr>
<td>Number of publications and conference presentations</td>
<td>Meeting notes</td>
</tr>
<tr>
<td>Number and site of peer education/mentoring visits</td>
<td>Joint publications/conference papers</td>
</tr>
<tr>
<td>Mentoring ties across schools</td>
<td>Documentation of mentoring relationships</td>
</tr>
<tr>
<td>Site visits to other schools</td>
<td>Records of joint projects and project outcomes</td>
</tr>
</tbody>
</table>

**Measurement Tools:** Tracking system of collaborative efforts

**Data Sources:**
- THEnet website
- Website activities/hits
- Number of requests for collaboration
- Meeting notes
- Joint publications/conference papers
- Documentation of mentoring relationships
- Records of joint projects and project outcomes
Guide to Evaluation Framework Terminology

**Aspirations:** A vision statement; the end objective for schools aspiring to social accountability.

**Champions:** These are defined as community personnel (often but not always health professionals) who will act as key linkage personnel in supporting a partnership or community engagement processes. They may be referred to by different names in different contexts, including community liaison personnel, linkage officers and so on.

**Community Development:** This is defined as formal and informal activities that students and staff undertaken in partnership with communities that enhance community health and social wellbeing.

**Community Engagement:** THEnet schools believe that ‘real’ community engagement involves a greater depth of involvement, or engagement, in decision-making processes and all stages of planning, implementation and evaluation. So, the terms ‘engagement’ and ‘participation’ may cover a multitude of ways in which the community and/or stakeholder groups are actually involved in schools. It is useful to be aware that there are different levels of community or stakeholder engagement. It is important to note that these levels are not mutually exclusive, but rather represent a continuum in the ways that stakeholders and community members may be engaged in program planning and evaluation.

**Community Partnerships:** We define partnerships as conscious high quality engagement with communities and/or individuals where the intent is shared decision making.

**Comprehensive Primary Health Care:** This is defined according to the WHO as “… socially appropriate, universally accessible, scientifically sound, first level care provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams support by integrated referral systems in a way that gives priority to those most in need and addresses health inequalities; maximizes community and individual self-reliance, participation and control and; involves collaboration and partnership with other sectors to promote public health.”

**Existing Data Sources:** This includes data and documents already being collected at schools. It may include existing surveys, evaluations or research projects. For example a graduate survey or a qualitative research project with community leaders.

**Faculty and Non-academic Staff Definitions:** We recognize that different terms are used to refer to academic and non-academic university staff in different parts of the world. For the purposes of this framework we will refer to academic staff as faculty, and other staff as non-academic staff.
Focus Groups/Surveys/Interviews: THEnet schools found that some information was not documented and was best captured through interviews or focus group discussions. THEnet Implementation Guide outlines suggested focus group/interview questions.

Health and Social Needs: We use the World Health’s Organization’s definition of health: "...a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." 18.

Health System: We use the World Health’s Organization’s definition of a health system: "A health system consists of all organisations, people and actions whose primary intent is to promote, restore and maintain health. Its goals are improving health and health equity in ways that are responsive, financially fair and make the best, or most efficient, use of available resources." 19.

Indicators: These are measures, both quantitative and qualitative, of the progress of a school towards social accountability.

Key Component contains the key elements of the framework written plain English.

Measurement Tools: These include tools that have been developed by THEnet for use by schools, and existing validated tools that are appropriate to the aspiration.

Participatory Action Research has several definitions including “Participatory research is defined as systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change.” 20. It refers to research that is based on shared ownership of the research project, a community-based analysis of social problems, and an orientation towards community action. It often includes a commitment to bring together broad social analysis, and action to improve things.

Partner Schools/Individuals has been used interchangeably to describe tertiary education schools and individuals members who are partners of the Training for Health Equity Network.

Professional Behaviour: In addition to traditionally accepted definitions of clinical professionalism, for THEnet schools desirable professional behaviour is embodied in competent and confident transformational scholars dedicated and equipped to be agents of change in health systems and societies. We therefore expect our graduates to have a thorough understanding of the biological, psychological and social determinants of health, and a strong commitment to providing high quality health services and addressing inequities in health care delivery.

Resources: We refer to human, financial or in-kind resources.

Reference Communities/Populations are defined as the population that the school serves and the communities within this. This needs to be defined for each participating school with particular reference to the underserved populations in terms of health services.

Service-Learning "...is a structured learning experience that combines community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens”. 21.

Social Accountability: THEnet schools collectively agreed to adapt the World Health Organization’s 21 definition of social accountability, amended to bring a focus on the underserved in line with their core mission (in brackets): "Social accountability is the obligation to orient education, research, and service activities towards priority health concerns of the local communities, the region and/or national (schools) one has a mandate to serve. These priorities are jointly defined by government, health service organizations, and the public, [and especially, the underserved]."
References


2. The Save the Children Fund. No Child Out of Reach - Time to End the Health Worker Crisis. Save The Children UK; 2011.


References continued


