**EDITORIAL**

# Social Accountability: From Hospital to Society

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As a supervisor for residential internship program in 2003, I came across a domestic violence case referred from a health post to Dhankuta District Hospital at midnight. The patient was hit with a Nepalese dagger (khukuri). The cut injury was sharp and deep from a corner of mouth to lower part of neck. Though the case looked complicated, it could be managed, due to availability of specialists from B. P. Koirala Institute of Health Sciences (BPKIHS) posted at the hospital. If he had to be referred, chances of his survival would have been minimal as the nearest tertiary care facility was 50 kilometres away in a difficult geographical terrain. Reflecting on this scenario, the social accountability of BPKIHS, through its concept of teaching districts has made a significant impact on the population living in rural areas.

Social accountability (SA) is a global responsibility. World Bank defines it as "an approach towards building accountability that relies on civic engagement, i.e., ordinary citizens and/or civil society organizations participate directly or indirectly in exacting accountability" [1]. In terms of Health Professions Education, social accountability was defined and developed in 1995 for World Health Organization which stated that 'medical schools have 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' [2]. Social accountability has four values: quality, equity, relevance and cost-effectiveness [2, 3]. Momentum has been gained, from its conceptualization, in developed and developing world to explore and discover their best fit for their own contexts in including social accountability within the curriculum [3 - 5].

BPKIHS was established in 1993, with a vision of self-governing, self-reliant international health sciences university and a national centre for providing quality health services both, tertiary as well as primary, and developing replicable and sustainable models of integrated health systems sensitive to the needs of both individuals and the community living in urban as well as rural areas [6]. The socially accountable curricular model of BPKIHS

have been a foundation for many other curricula of Nepal and South Asia. The vision, mission and goal of any health professions education school to include social accountability, for the area they are situated in, is crucial especially in countries like Nepal. The shortage of primary care physicians in the rural areas of low- and middle-income countries is an established fact [7]. This gap is broadening as young graduates are migrating due to job opportunities becoming thinner within the country. The priority health concerns, and health workforce needed for any country, are to be identified jointly by their governments, health care organizations, health professionals and the public [8]. In modern medicine, social medicine, which includes community medicine, primary health care, family medicine, is given secondary priority for graduates [9, 10]. This trend has been adding to the gap in human resources in primary health care. Governmental agencies and health professions institutions should work collaboratively not competitively to address the social accountability mandates. The Network: Towards Unity for Health (TUFH) has been trailblazing the social accountability movement and bringing together social accountable schools and other stakeholders through its collaborative partnership and network. The self-assessment tools developed by TUFH and Training for Health Equity Network (THEnet) help institutions to guide through social accountability mandates [11, 12].

In the national context, few recommendations are made in order to bring social accountability mandates to practice for better health outcomes.

• Prioritization and utilization of human resource for health. Human resource for health is a key driver for health care delivery. More seats for social medicine specialists (community medicine, family medicine, primary care physicians) are to be made available for residency programs. Human resource generation is a huge national investment. Every effort should be made to plan the human resource needs for the country and create a good working environment for the workforce within the country.

• Distributed Health Professions Education: Distributed learning help students get experience in all their future workspaces from primary care to tertiary care facilities. Community oriented programs are to be encouraged to engage the students during their studies so that they feel responsible to the people they serve.

• Inclusion in national regulatory accreditation standards: Publicly funded institutions have these SA mandates included in the curriculum and their strategic planning. Inclusion of social accountability measures within each national council's accreditation standards will motivate privately owned institutions to invest in rural health services.

• Building community of practice (CoP): Building national, regional and global network amongst the social accountable schools. The network can share each other's experiences and learn from others' success and advocate to the government regarding its health policy. The CoP also builds confidence to follow evidence-based practices.

At the governmental level, every effort is being made to alleviate the health care situations in Nepal. However, people in the rural community are unable to utilize these facilities due to many challenges. Making Health Professions Education schools more socially accountable and responsible to the society they serve, is the way we can bring better health outcomes for our rural populations.

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