Original Research Paper

Social accountability in research: a glimpse of where we are, a vision for the future

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Abstract

While much focus has been on training healthcare professionals to be more socially accountable, research itself must also evolve to reflect these values. This study seeks to explore the transformative potential of socially accountable research networks, locally and globally. We explore how social accountability (SA) is represented in research posters at four conferences, highlighting the need for abstracts to report socially accountable practices. This review selected four academic conferences held between November 2024 and September 2025 to review poster abstracts on-site or via the conference website. Our team used a custom-developed scale, verified by two SA experts, to characterize SA levels reported in conference abstracts or posters. Indicators of interest included institutional social mission, project focus, presence and role of community partnerships, level of community involvement, and health equity improvement. We reviewed 136 presentation abstracts from those four conferences. Approximately 10% of abstracts with known institutional etiology explicitly noted SA in their institutions' mission statements, and 53.3% implicitly mentioned SA values. Community partnerships were absent in 51.5% of posters. When present, community partners most commonly participated as research subjects (81.0%) and assisted with data collection (49.2%). Only 7.7% of posters demonstrated the highest level of community involvement. Evidence of actual or anticipated improvements in health equity was identified in 20.8% of posters. A review of conference abstracts demonstrated limited evidence of social accountability, reflected by a lack of alignment with institutional missions, a majority lacking community partnerships, low levels of meaningful involvement, and infrequent improvements in health equity.

Keywords: social accountability, conferences, research

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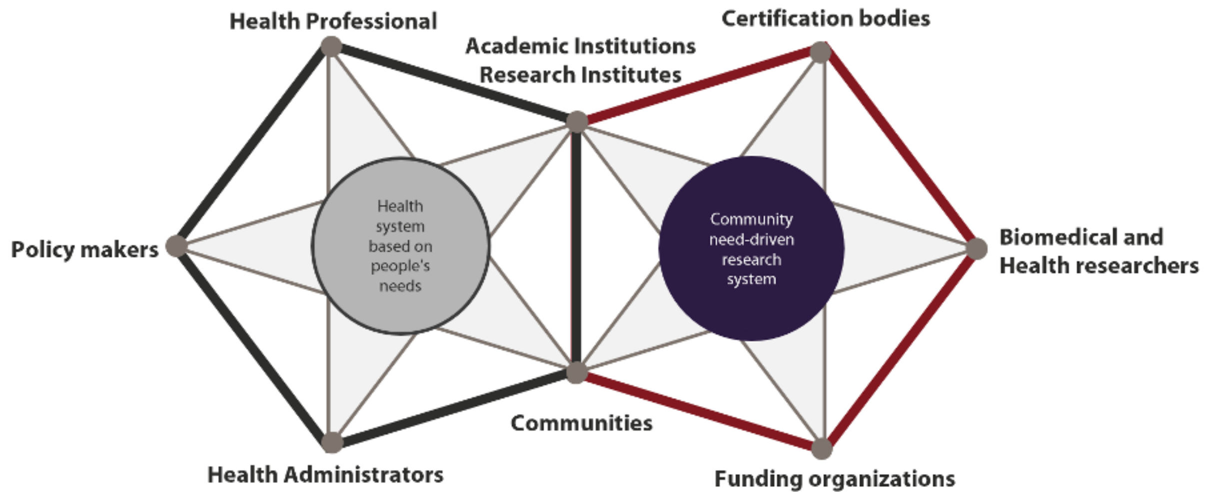
BACKGROUND

Social accountability (SA) has become a highly influential principle and movement in the education of medical and healthcare professionals. The World Health Organization's definition of SA is "*the obligation to orient education, research, and service activities towards priority health concerns of the local community, the region and/or nation one has a mandate to serve. These priorities are jointly defined by the government, health service organizations, and the public.*"[1] Numerous studies have examined SA and education, including a seminal article that ranked schools based on the contributions of their medical school graduates to their institutions' social missions.[2] Still, the potential of SA extends far beyond the process of training healthcare professionals to be more connected with the societies and communities they serve. The practice of research, including its methods, activities, and collaborations, also needs reimagining and reform to become more socially accountable. Socially accountable research extends beyond responding to priority health needs and working in communities to collaborating with community partners and demonstrating impact, thereby improving health equity. Social accountability partnerships include health administrators, communities, policymakers, healthcare providers, academia, and other sectors interested in health.[3] (See Figure 1: Double Partnership Pentagram)

This research is part of a global partnership formed under the auspices of the Dr. Gilles Arcand Centre for Health Equity, at the Northern Ontario School of

Figure 1: Double Partnership Pentagram[3]



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Medicine, to explore the transformative potential of socially accountable research networks, locally and globally.[4] The guiding precepts are Community Engagement, Research, Education, Advocacy, and System Transformation, to advance health equity. The CREATE project focuses on sharing best practices, scaling socially accountable research networks and projects, and answering the fundamental question: How can those who undertake health research, across disciplines, contexts, geographies, and cultures, become more connected and accountable to the populations they are obligated to serve?

Research on the social accountability of health conferences exists, but it primarily focuses on an external examination.[5] In line with this, a comprehensive social accountability checklist for peer-reviewed research articles has been published.[6] However, poster presentations showcase research and serve as snapshots of projects; many will not be published in peer-reviewed journals and therefore require unique methods of evaluation. Therefore, there is a need for a reporting framework for conference abstracts to capture social accountability dimensions to evaluate community involvement and impact in abstracts and posters. No study has yet systematically evaluated the extent to which social accountability appears at conferences. The current project explores how social accountability is characterized in research posters presented at four international conferences using a social accountability framework.

METHODS

This research is a review. We selected four academic conferences and reviewed poster abstracts on-site or via the conference website portal. We selected them based on the conference's scope and the researchers' convenience. See Table 1 for the conferences and their mission statements.

The final scale was evaluated by two independent, socially accountable researchers in Canada and Australia to ensure comprehension. (See Appendix 1: Conference Scale).

Indicators of Interest

Demographics

School location: We recorded the school name, or the country if no school was specified. We then examined individual schools' mission statements to determine whether they explicitly or implicitly referenced social accountability, social responsibility, social responsiveness, or equity. For mission statements, specific language using these terms was documented. We then assessed whether the school was included in the Social Mission Ranking Score, which evaluates how medical schools meet their social mission across three key dimensions of service.[2] A social mission is what a school actually does for society. While only U.S. schools were examined in this research, this aligns with the prevalence of U.S. abstracts at these conferences.

Social Accountability Parameters

Table 1: Conference Mission Statements

Sponsoring Organization	Year/Conference	Mission statement
North American Primary Care Research Group (NAPCRG)	2024 Annual conference	"NAPCRG is an interdisciplinary volunteer association committed to nurturing primary care researchers working in partnership with individuals, families, and communities."[7]
The Society of Teachers of Family Medicine (STFM)	2024 Medical education conference	"Advancing family medicine to improve health through a community of teachers and scholars."[8]
Association of American Medical Colleges (AAMC)	2025 Group on Diversity and Inclusion	"The GDI supports the efforts of AAMC-member institutions and academic medicine to foster an environment where people of all backgrounds and perspectives have an equal opportunity to thrive."[9]
The Network: Towards Unity for Health (TUFH)	2025 Annual conference	"An international, intersectoral, intergenerational organization that fosters equitable community-oriented health services, education, and research to improve health locally and globally. We convene innovative health care organizations, universities, community institutions, and thought leaders worldwide."[10]

The selected social accountability parameters were informed by existing frameworks emphasizing institutional mission alignment, community engagement, and health equity as core dimensions of socially accountable research.[3,11] Institutional mission statements were included as they reflect organizational intent and commitment to social accountability.[2,12] Community partnerships and levels of involvement were selected based on established principles of community-engaged research that emphasize collaboration and reciprocity.[13] Health equity improvement was included as a key outcome aligned with core definitions of social accountability and prior scholarship emphasizing equity impact.[14]

1. *Project type:* research, a community project, both, or other.
   Project focus: health education, advocacy, system transformation, or other.
1. *Community partnerships:* We searched for mentions of community partnerships. Upon identification, we reviewed the descriptions of the community partners' roles.
   a. Roles were categorized into four categories: conceiving the research idea, assisting with data collection, being the subject of the research or project, or other.
2. *Level of community involvement:* The researchers made the final determination of the level of community engagement. The level of engagement scale we decided upon is closely aligned with the National Academy of Medicine Community Engagement Research Index, resulting in the following scale:[15]
   a. None: Set in the community, but no role by the community
   b. Minimal: Community-engagement, but no fundamental role in the research project
   c. Moderate: The community had some involvement
   d. Maximum: Involved in every aspect, and the project/research improved health equity
1. *Health equity improvement:* We sought concrete examples or outcomes to determine whether the research has improved health equity or has the potential to do so. If a determination could not be made or was not explicit but possible, the option was "unknown."

Data Collection

Between November 2024 and September 2025, data were recorded in real time at the conferences or via the conference website on an Excel spreadsheet. If on-site at the conference, posters were randomly selected. Otherwise, randomization was achieved by systematically selecting poster presentations using a random number generator. Data was entered into RedCap, a secure database hosted by the University of New Mexico School of Medicine. [16]

Data Analysis

RedCap provided the scale entry data for further analysis. School missions were found on organization websites and screened for principles previously defined as social accountability. We grouped the individual posters by their WHO Region.[17] We used the Social Mission Article to determine their ranking by social mission.[2] A qualitative frequency analysis was then conducted in Excel to identify trends across previously defined indicators of interest.[18,19]

Ethics

IRB permission was not needed, as this was data collected in public spaces

RESULTS

We reviewed 136 presentation abstracts at four conferences. The NAPCRG 2024 comprised 45.6% of data (N = 62), STFM 2025 8.8% (N = 12), AAMC GDI 2025 5.9% (N = 8), and the TUFH 2025 39.7% (N = 54). Of the 136 presentation abstracts, 130 were for research posters, and six were categorized as community projects and other miscellaneous research types.

Demographics

School location: Most of the presentation abstracts reviewed originated from North American institutions. A subset of posters (N = 49) had unknown or unspecified institutions or locations, including cases in which only the project title was available, or the school could not be confirmed. (See Table 2).

Table 2: Poster Regions

Region	**N (%)**
African Region	5 (.04%)
Eastern Mediterranean Region	3 (.02%)
Region of the Americas	76 (56%)
Western Pacific Region	3 (.02%)
Unknown or N/A	49 (36%)
Total	**136 (100%)**

Screening of each school's mission statements and values reveals that, among 30 schools with an institution named on their poster, three explicitly mentioned social accountability (10.0%), 16 implicitly mentioned social accountability principles (53.3%), and 11 did not mention social accountability (36.7%). Finally, 20/26 (77%) of United States medical schools reviewed had a social mission ranking (see Table 3).

Two schools that explicitly mentioned social accountability in their mission statements, the University of New Mexico SOM and Western Michigan Homer Stryker School of Medicine, had 100% of their abstracts characterized as socially accountable. Five schools with a social mission ranking accounted for six socially accountable abstracts (20%).

Table 3: Social Accountability Metrics

Country	**# Schools**	**# of schools with a social mission ranking**	**Mission Statement**			**# of socially accountable abstracts**
			Implicit	Explicit	No mention	
South Africa	1	N/A	1	0	0	1
United States	26	20	13	3	10	11
Nigeria	1	N/A	1	0	0	1
Uganda	1	N/A	1	0	0	1
Mexico	1	N/A	0	0	1	1
TOTAL	**30 (100%)**	**20 (77%)***	**16 (53%)**	**3 (10%)**	**11(37%)**	**15 (50%)**

The Social Mission ranking was given only to United States schools; thus, the denominator is 26.

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Looking closely at the demographics of abstracts with confirmed institutional etiology, the majority of schools that explicitly or implicitly referenced SA in their mission statements or values (N = 19) had at least one analyzed abstract that partnered with the community in some capacity (63.2%). In contrast, the majority of schools that did not reference SA in their mission statements (N = 11) did not have research abstracts that engaged with the community (72.7%).

Social Accountability Parameters

The selected social accountability parameters were informed by existing frameworks emphasizing institutional mission alignment, community engagement, and health equity as core dimensions of socially accountable research.[1,3] Institutional mission statements were included as they reflect organizational intent and commitment to social responsibility.[2] Community partnerships and levels of involvement were selected based on established community-engaged research principles that emphasize collaboration and reciprocity.[3] Health equity improvement was included as a key outcome aligned with core definitions of social accountability and prior scholarship emphasizing equity impact.[1,20]

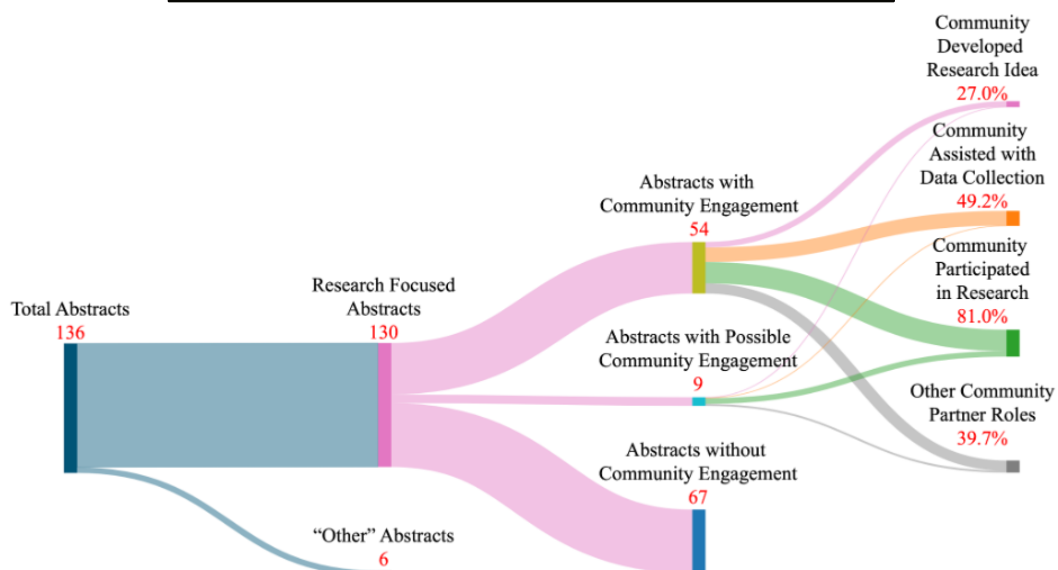
Project Type: Of the research posters reviewed (95.6%, N = 130), the projects were 71.5% research driven (N = 93), 2.3% community projects (N = 3), 22.3% both (N = 29), and 3.8% other (N = 5). Other poster types included database analysis, retrospective analysis, literature review, case study, and quasi-experimental study, all of which were included in the subsequent analysis.

Project focus: The primary focus of the research posters was "System Transformation" (70.8%, N = 92). "Advocacy" came in second (48.5%, N = 63), followed by "Health Education" (46.9%, N = 61). Posters classified as "other" (23.8%, N = 31) described focus areas including health service delivery, health professions education research, and workforce development and capacity-building initiatives. For a single research poster, the focus was not discernible and was therefore classified as "unknown" (0.8%, N = 1).

Community partnerships: Most research abstracts lacked community partnerships (51.5%, N = 67), while partnerships were definitively identified in 41.5% of posters (N = 54) and possibly ("Maybe") identified in 6.9% (N = 9). Of the posters where community partnerships potentially existed (N = 63, 48.5% of all research abstracts), descriptions of the partners' roles included: 27.0% research idea (N = 17), 49.2% assisted with data collection (N = 31), and 81.0% participated in research (N = 51). "Other" partner roles comprised 39.7% of posters (N = 25) and most commonly reflected community participation as study populations or service recipients (e.g., involvement as research subjects), qualitative engagement (e.g., focus groups), and service delivery and program implementation roles (e.g., mobile care units, humanitarian aid initiatives). (See Figure 2).

Level of community involvement: Among the 130 posters, community involvement varied widely. Most projects were in the category of none, defined as being set in the community without direct community

Figure 2: Stratification of Research Community Engagement



involvement (N = 65, 50%). Minimal involvement, characterized by community engagement without a fundamental role in the project, was observed in 28 posters (21.5%). Moderate involvement, indicating some degree of community participation, was identified in 22 posters (16.9%). Only 10 posters (7.7%) demonstrated maximum involvement, with community participation across all project stages and evidence of improved health equity.

Health equity improvement: Concrete examples or outcomes indicating health equity improvement were identified in 27 research posters (20.8%), suggesting that the research did, or was expected to improve health equity. In contrast, 53 posters (40.8%) did not demonstrate evidence of improved health equity. In 16 posters (12.3%), health equity impact could not be determined and was classified as unknown, reflecting posters in which improvement was possible but not clearly stated. Additionally, 34 posters (26.2%) lacked sufficient information to assess health equity outcomes and were categorized as N/A.

DISCUSSION

Social accountability in education and research is intertwined, as both require a deep appreciation of the communities they serve and a focus on improving health. There have been numerous papers published on social accountability in education, but limited research on how health professional schools, particularly those that strive towards SA in education, translate classroom learning into practice, conduct research, and ultimately communicate their findings to wider audiences, such as those who attend academic conferences. This project explored how social accountability is characterized in posters presented at four conferences via a custom-developed scale. Among abstracts with a clearly identified institutional affiliation, only 10% explicitly referenced social accountability (SA) in their institution's mission, while 53.3% reflected SA-related values implicitly. Community partnerships were not reported in 51.5% of posters. When partnerships were described, community members were most often engaged as research participants (81.0%) and contributors to data collection (49.2%). Just 7.7% of posters demonstrated the highest level of community engagement. Evidence of actual or anticipated impacts on health equity was identified in 20.8% of posters.

Overall, the posters reviewed represented a diverse range of institutions and geographic regions, reflecting both North American and global participation. We selected mission statements as a parameter because a school's mission statement is one dimension of social accountability and serves as a starting point for understanding intent, reflecting its values. It is not the statement itself that is important, but rather the motivating energy it provides. Although 80% of American medical programs reviewed had a social mission ranking, SA indicators such as community partnerships, community involvement, and health equity outcomes were rarely identified in poster content. In our review of 136 research posters, few (10%) explicitly referenced SA, and roughly half (53.3%) implicitly mentioned principles of SA, while 36.7% made no mention of SA constructs. Our findings align with prior evidence demonstrating substantial variability among medical schools in their contribution to social mission-oriented outcomes.[1]

We next examined community engagement as it is an integral part of socially accountable research. While community-engaged research is known by many names[21] and is an established research methodology, socially accountable research can be applied to any research framework, emphasizing three core pillars: collaboration, benefit reciprocity, and health improvement. In 2017, members of the Global Forum's Innovation Collaborative on Learning through Community Engagement of the National Academies of Sciences, Engineering, and Medicine proposed a definition of community engagement for education, which is also applicable to research endeavors, with its emphasis on collaboration, benefit reciprocity, and health improvement:

> *"Health professional education is community-engaged when community–academic partnerships are sustained, and they focus on the collaborative design, delivery, and evaluation of programs in order to improve the health of the people and communities the programs serve. Programs and partnerships in community-engaged education are characterized by mutual benefit and reciprocal learning…."*[22]

Our data show that when community partnerships were potentially present (48.5%), partners' roles primarily included being the subject of the research or project (81%), assisting with data collection (49.2%), and conceiving the research idea (27%). The level of community involvement for most projects (50%) was classified as none, followed by minimal (21.5%) and moderate (16.9%), with only 10 posters (7.7%) showing maximal involvement. Concrete examples or outcomes

indicating improvements in health equity were found in only 20.8% of posters.

Assessment of the conference data also revealed areas of interest requiring further investigation, such as the need for increased data on international SA research projects and improved stratification of socially accountable research. Having involved conferences held in the United States, the majority of our data is from North American communities, and less than 1% of the data could be positively matched to an international institution outside the American region. Furthermore, though this project's focus was on the quantity of community engagement, a more fine-grained analysis of *how* communities are engaged, in conjunction with indicators of successful intervention, could better inform future research.

Beyond geographic disparities, our findings also reveal gaps across specific social accountability parameters. Few projects reflected deeper collaboration, such as co-design, shared decision-making, or community-led dissemination. Health equity outcomes were also infrequently described, suggesting limited linkage to measurable impact. These findings highlight the need for clearer reporting standards and stronger integration of socially accountable practices across all stages of research.

Together, these findings highlight gaps between institutional social missions and the extent to which research practices reflect socially accountable values. Acknowledging the role of community members, unless they desire anonymity, and the potential for research to improve health equity should be emphasized to solidify the findings as co-created. Discussion of acknowledgment or authorship criteria should ideally occur during the research planning phase.[23] The practices of research, including its methods, activities, and collaborations, need reimaging and reform to become more socially accountable.

Limitations: The methodology relied heavily on information from abstracts and posters, which often lacked sufficient project details for rigorous data classification and stratification to prevent misinterpretation. This can be especially problematic, as the data were collected and analyzed by multiple researchers across the four conferences, with only one, or both the abstract and the poster available. Regardless of the strict definitions used to promote homogeneity in poster/abstract analysis, some degree of variation may remain. Furthermore, measurement bias may be introduced as different conferences may exhibit varying levels of community involvement depending on the values of their governing bodies. We may not be able to control for this, though we may further encourage discernment of conference differences in future research. As a future direction, we have approached the four conference organizers to embed a survey link in the abstract submission form, enabling submitters to assess their social accountability.

CONCLUSION

The data collected across multiple conferences indicate not only a lack of social accountability in modern medical research but also a lack of awareness of its importance. A future of socially accountable, community-derived research requires that each research organization monitor such research both nationally and internationally, and that discerning conference bodies encourage it. By increasing social accountability in research, both the quality and impact of research may improve through better responses to population needs. Our findings suggest that priority areas for advancing socially accountable research include increasing representation of underrepresented regions, strengthening meaningful community engagement across research phases, and improving explicit reporting of health equity outcomes.

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APPENDIX 1: CONFERENCE SCALE

1. Abstract focus
   a. Research
   b. Community Project
   c. Both
   d. Neither

2. What is the focus of your research?
   a. Health education
   b. Advocacy
   c. System transformation
   d. Other ____________________

3. Did you partner with a community?
   a. Yes
      i. If yes, what was the role of the community?
         1. Research idea
         2. Assisted with data collection
         3. Participated as the subject of the research/project
         4. Other (please describe)

      ii. Level of community involvement
         1. None: Set in the community but no real role by the community
         2. Minimal: Community-engagement but no real role in the research project
         3. Moderate: Had some involvement
         4. Maximum: Involved in every aspect, and the project/research improved health equity
   b. No
   c. Unsure

4. Will or did the research or project improve health equity?Did the research or project improve health equity?
   a. Yes
      i. If yes, provide examples or outcomes
   b. No
   c. Unknown

5. Who assessed or will assess your research?
   a. Internal faculty
   b. External persons (peer reviewers)
   c. Community members (health partners)