



EDITORIAL

The Need for Trust in Global Health and Global Radiology Initiatives

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Introduction

“To shape our future, we must understand our past.” – V. Amos, United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, 2012

DESPITE much international effort over decades to right the wrongs of colonialism, this history still affects humanitarian initiatives, resulting in poorer health for many people, and disappointment for both hosts and donors.

The Origins of Colonial Medicine and Its Legacy for Humanitarian Help

To better understand impediments to sustainable humanitarian programs, we need to look at the history of the international medical donor system. From the mid-nineteenth century until the end of formal colonial rule, the colonial field served as a laboratory for the techniques of later humanitarian action, especially colonial medicine and health services (1). Medical treatment was extended to indigenous populations in a broader effort to convert these populations to the religion of the home country. The proselytizing aspect of missionary activity was included in medical work “in the conviction that the benefits of medical science would by themselves promote conversion” (1). Religion still plays an important role in medical missions and humanitarian endeavors today. Judith Lasker, in her book *Hoping to Help* (2), observes that in 2016, “every major Christian denomination has a missionary branch operating in many parts of the world, with

medical care often a central part of the work.” This is true of other major religions as well. Lasker warns that when religious practices are incorporated they can be prioritized over the medical program.

In the colonial era, missionary medicine for indigenous populations was also motivated by the need to protect workforces from disease. The link between colonial health and colonial labor is well demonstrated in South Africa with the Chamber of Mines founding a medical institute in 1913 to study diseases affecting mine laborers. The search for a cure for yellow fever with the creation of the Panama Canal is another example of the camouflaged incentive to help local people while furthering imperial control. In hindsight, we see that many advances in vaccination, prevention, and treatment in developing countries were made because Western nations had military or commercial interests in areas of prevalent debilitating diseases.

Neo-colonialist thinking in healthcare, defined as the framing of health issues by national security or economic concerns, is hardly different from what our predecessors did. In an increasingly globalized world, a key principle of the international conception of global health is to protect citizens of industrialized countries against external threats to health, particularly infectious diseases carried across national borders. The recent examples of Zika and Ebola demonstrate such neo-colonialist thinking and action. Public health issues labeled as “international” become of interest to high income countries when their own safety is at risk. To quote Liu from

Médecins Sans Frontières (MSF) in 2015, “When Ebola became a security threat, and no longer a humanitarian crisis affecting a handful of poor countries in West Africa, finally the world began to wake up” (3).

When a single totalitarian Western standard for healthcare success ignores the view of the local population, it is also no better than repeating colonial medical history. Consider, for instance, the attempt to impose North American norms on breast cancer screening (e.g. a free mammogram every 1-2 years for women over 40 years old) to culturally, genetically and socio-politically different populations of African, Asian or Middle-Eastern women. When a few Western manufacturing companies are positioned to benefit from such guidelines, why is this not a form of neo-colonialism?

Individuals with formal education and financial interests may also have ulterior motives in bringing Western practices to the poor and uneducated. To quote Lasker again, “earlier forms of colonialism involved extraction of raw materials, often by force [to]...increase the wealth and comfort of the colonial masters. Today’s volunteers might use their experiences in poor countries to build careers, social capital, and personal satisfaction. It is possible to see some similarities between these two types of “extractions” of benefits from poor countries” (2). When we consider these parallels, it should not surprise us to meet resistance to recommended guidelines coming from the donor countries.

Global Imaging Missions and Organizations

To counteract the legacy of neo-colonialism, we point to areas where global imaging organizations need to implement changes to improve the success of their missions. One is the failure to attach regulations to the core principles that most imaging NGOs (non-governmental organizations) profess to value. A second is failure to require behaviors that generate trust. Although most imaging NGOs include cultural competence, sustainability, multi-disciplinarity and universal access among their core values, we find few regulations attached to these principles. Therefore, efforts put in place by other actors of the medical system (funding, contracting, provision, governance and administration) are dependent on the individual values and experiences of participating volunteers. Since few volunteers have been sensitized to cultural issues or to the importance of the host/donor relationship, and because there is no determination of their cultural competence, missions are of variable quality and success. In effect, we need to address the neo-colonialism trap directly.

Increasing Trust

“The moment there is suspicion about a person’s motives, everything he does becomes tainted.” – Mahatma Ghandi

If colonial memories and neo-colonial behaviors are root causes of the baffling resistance by intended beneficiaries to global health interventions, how can the perception that

healthcare recipients have of global health initiatives be improved?

Answering this question is crucial because even when medical programs are genuinely humanitarian in nature, local opposition can often have serious negative consequences for the results of the missions. Dr. Liu of MSF boils it all down to trust, which she says is the single most important guarantor of the success of an operation. Trust-building is a vital leadership tool in global healthcare. According to experts, in a situation of a high level of trust, the speed of transactions is high and cost is low (4). Sadly, the opposite is more often the case in global health efforts: trust is low, and missions are slow to complete and very costly.

A good place to learn how to increase trust is to examine “positive deviants,” success stories that show how the twin specters of neo-colonialism and low trust can be surmounted. The MSF model for best practice centers in Foya, Liberia during the Ebola crisis is one such positive deviant from which we can gain inspiration (5).

Even though the Foya Center followed standard intervention methods of isolation, medical care, outreach work, surveillance and safe burials, these good practices alone were not enough. Close involvement of people from local communities was vital. “The understanding of the people and communities affected by the Ebola outbreak was key to containing the virus and for people to accept MSF’s medical activities in the area” (5). It was the efforts and behaviors that MSF in Foya developed to increase trust that helped solve the Ebola crisis within 42 days in this village. High trust: high speed, low cost.

It should be possible to develop equivalent behaviors and practices for global imaging missions to increase trust. These changes in behaviors touch directly the two weak spots identified during our analysis (Table 1): regulations and culture. They include, but not exclusively, having a clear message; speaking to communities in their native language; re-designing management centers to create transparency; showing loyalty and investing in long-term programs; delivering results and practicing accountability; and listening to local people, addressing their concerns and involving them in their care.

NGOs that adopt such trust-increasing approaches must instill them in all their volunteers before they enter the field. This involves vetting volunteers for their track record as well as their medical credentials, focusing on good intent and integrity as well as knowledge, and leadership. Another trust-inducing measure would valorize quality control mechanisms among the regulations governing each mission. Adopting and communicating these behaviors in preparation for a mission would increase credibility and, therefore, trust in the mission among its beneficiaries, increasing likelihood of success.

Conclusion

We have looked at global healthcare through an unusual lens, by studying the effects of local colonial legacy. “The white

Table 1. Trust-increasing behavior examples in humanitarian healthcare programs.

Behavior (as per Covey)	MSF Foya Approach	Imaging NGOs
<i>Talk straight</i>	<ul style="list-style-type: none"> • Clear message • Comprehensive health promotion and communication activities 	<ul style="list-style-type: none"> • Clear message • Comprehensive screening promotion • Technology explanation (x-rays, US, biopsy, etc.)
<i>Demonstrate respect</i>	<ul style="list-style-type: none"> • Speaking to communities in native languages • Respect of burial ceremonies within safe limits • Psychosocial help provided to families and patients 	<ul style="list-style-type: none"> • Speaking to communities in native languages • Respect individual dignity • Respect cultural beliefs • Send culturally prepared volunteers • Send competent volunteers
<i>Create transparency</i>	<ul style="list-style-type: none"> • Re-design management center • Address rumors of what is happening inside • See-through fences 	<ul style="list-style-type: none"> • Re-design management center • Address rumors of what is happening inside • Allow family members if requested
<i>Right wrongs</i>	<ul style="list-style-type: none"> • MSF learned from the mistakes performed in the past and established a new model 	<ul style="list-style-type: none"> • Consider long-term program instead of short-term missions • Evaluate process and outcomes of the imaging • Encourage retroaction and host evaluation
<i>Show loyalty</i>	<ul style="list-style-type: none"> • After success, MSF started resuscitating Healthcare system in the country 	<ul style="list-style-type: none"> • Long-term program • Emphasis on mutuality and continuity
<i>Deliver results</i>	<ul style="list-style-type: none"> • 42 days after implementation, no Ebola cases in Foya 	<ul style="list-style-type: none"> • Develop short-, middle-, long-term performance indicators for host location • Provide continuous support via tele-consultation and webinars
<i>Get better</i>	<ul style="list-style-type: none"> • MSF acted on feedback received by population and local workers 	<ul style="list-style-type: none"> • Obtain feedback for radiologists and imaging team
<i>Confront reality</i>	<ul style="list-style-type: none"> • Took the Ebola issues head on, e.g., explained reasons why not all burial customs could be respected and kept control 	<ul style="list-style-type: none"> • Target one specific issue at a time • Obtain local data • Go beyond simple delivery of technology • Explore the benefits of prevention and screening
<i>Clarify expectations</i>	<ul style="list-style-type: none"> • Team of psychosocial counselors provided to ensure that patients and families were supported and well informed 	<ul style="list-style-type: none"> • Terms of mission length and technological support to be presented • Ensure post-visit support (by radiologist, physician, etc.) • Interdisciplinary experts provided to support all members of the prevention/screening team, including the family and patients themselves
<i>Practice accountability</i>	<ul style="list-style-type: none"> • Monitoring of new cases and results of new model of care 	<ul style="list-style-type: none"> • Monitor data on specific clinical issues but also on technological issues, such as number of cases, maintenance, efficiency, quality control, etc.
<i>Listen first</i>	<ul style="list-style-type: none"> • Foya model is an example of listening to the concerns of local people 	<ul style="list-style-type: none"> • Listen to the local host's physical and organizational set-up and challenges • Build local capacity and expertise
<i>Keep commitments</i>	<ul style="list-style-type: none"> • After success, MSF started resuscitating Healthcare system in the country 	<ul style="list-style-type: none"> • Promote long-term missions and program rather than short-term • Have volunteers stay longer and return on site
<i>Extend trust</i>	<ul style="list-style-type: none"> • Involvement of the local people • Employment of a music group to record and perform an Ebola awareness song • Families trusted, encouraged and facilitated to safely visit patients 	<ul style="list-style-type: none"> • Train the trainers programs with local Universities • Participate and encourage local research and publication • Develop local leadership

man's burden" complex is unfortunately still visible in the world of humanitarian global health.

Resistance to global health interventions is easier to understand with reference to the perceptions, culture and behaviors of both the donors and recipients. In addition, structural analysis of a health care organization, whether governmental or non-governmental, and identification of areas of weakness within the organizations with respect to trust-building can ensure that intervention will be better targeted, and more likely to successfully achieve the intended goals. By paying attention to developing credibility and competence, and by showing behaviors as suggested above, health workers' actions will have a better reputation, while their presence within the targeted community can lead to more rapid, less costly acceptance.

In conclusion, the best way to improve implementation and sustainability of humanitarian missions, including those of global imaging, is to employ the currency of the new economy: trust.

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