2017

# Trust in Healthcare

## A MULTILAYERED TRANSACTIONAL-RELATIONAL APPROACH IN THE CONTEXT OF SUB-SAHARAN AFRICA

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THESIS PROJECT: GLST 5972

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APRIL 23, 2017

AUTHOR NOTE:

WORK FOUND IN THIS THESIS INCLUDES EXCERPTS FROM COURSE WRITINGS IN COURSES: GLST 5153, GLST 5962, GLST 6343, & GLST 6423

# Table of Contents

1. Introduction ........ 2
2. Methodology and Definitions ........ 3
3. Trust Framework of Healthcare Review of Literature ........ 5
4. An Exploration of Trust Relationships. ........ 7
   a. Trust between Healthcare Providers and Communities. ........ 7
      Medicine Supply ........ 7
      Distance versus Communication ........ 9
      Communication ........ 12
   b. Building Trust between Nongovernmental Organizations (NGO's) and the Government ........ 14
      Roles and Participation ........ 14
      Priority Alignment ........ 17
   c. Building Trust within Communities. ........ 18
      Collective Identity ........ 18
      The Effects of Trauma and Conflict ........ 23
   d. Building Trust between an NGO and a Surrounding Community ........ 27
      Participation ........ 27
      Broadcasting the Right Message ........ 31
   e. Building trust between the Government and People ........ 32
      Social Relationships ........ 33
      Organizational Coherency ........ 35
   f. Unifying Themes of Trust amongst all the Relationships ........ 37
5. Towards building greater trust. ........ 40
   a. Identity Management ........ 40
   b. Clarifying Motives ........ 44
   c. Participation ........ 46
   d. Supply Chain Management ........ 47
   e. The Trust Cycle ........ 50
6. Conclusion ........ 53
Works Cited ........ 54

# 1. Introduction

Healthcare is a vital component for the overall health of a nation. Inadequate healthcare delivery prevents economies from growing to the fullest of potential, whether it is lost educational opportunities due to illness, removal from the workforce or loss of general productivity. Many avenues of healthcare delivery have been devised over the years, especially in the realm of community-based healthcare delivery with the training and utilization of community healthcare workers. In all forms of healthcare delivery, there are several factors that assist and detract from genuine capacity building and community receptiveness to healthcare. Healthcare is fundamentally a transactional process that requires fostering positive trusting relationships for it to be effective. This thesis will explore the many factors that disrupt and build trust in the realm of healthcare delivery in the context of sub-Saharan Africa, specifically through the avenues of various kinds of relationships. The relationships that exist in healthcare in the context of sub-Saharan Africa are those between the community, healthcare providers, nongovernmental organizations (NGOs) and the government. These factors are explored in this thesis through field research and textual research. I performed qualitative research in the setting of Uganda and upon the current existing research published in African health journals. The themes that emerge that relate to trust are that of identity, motivation, participation and supply management. Each of the elements, if broken, may contribute to the disruption of trust. At the same time, each of these elements can be used to support each other to build trust. What the field experience and research suggest is a cycle of trust wherein positive examples of each element support each other in a progressive stepwise fashion. While it may be financially challenging to consider all of these elements, these elements point to a future where healthcare not only has the

potential to be effective, but also be built on a solid foundation of meaningful, sustainable trusting relationships.

## 2. Methodology and Definitions

I conducted initial field research in the country of Uganda in two distinct geographic regions: the capital of Kampala and the northern city of Gulu. Research was facilitated by the non-profit faith-based international organization, ChildVoice International. Staff at hospitals and local clinics were interviewed with the primary question of what is the best way to deliver healthcare in the country of Uganda. Those who were interviewed included doctors, administrators, nurses, and managers. Community members were also interviewed in the town of Lukodi, a village outside of the town of Gulu, Uganda. For this thesis, a broad literature review was performed on trust and healthcare in the greater context of sub-Saharan Africa to evaluate common themes. This broader context was chosen because of similarities of low and middle income countries and the prevalence of tropical disease and HIV. In each country, there are four primary actors in the realm of healthcare: the community, healthcare provider, the government and non-governmental organizations, both local and international.

One of the more relatively recent developments of healthcare serves as a hybrid between the community and healthcare provider, the community health worker. The community health worker was initially pioneered by Partners in Health in 1988 as a method to administer directly observed therapy for the treatment of tuberculosis. These health workers were recruited from the community and given the title of *accompagnateurs* who "would serve as the essential link between the patients, dispersed throughout rural villages in mountainous central Haiti, and the clinic-hospital complex in Cange" (Behforouz, Farmer and Mukherjee S430). These workers were community members chosen to serve as a healthcare provider and as a bridge between the

community and Partners in Health. This bridge served as not only to provide more accessible care but also as a cultural interpreter to ensure adequate treatment of disease. This has become a popular model for extending the reach of healthcare providers.

In addition to broadening reach of healthcare, there is an additional challenge of the overall expenditure on healthcare by the government. John Glenn notes how "social spending is far lower in the South, with some regions registering just a few per cent of GDP" (257). Because of limited resources, it is necessary for all actors to work together to ensure the overall health of a nation. For this thesis, actors will be categorized as: community members which include community health workers, local leaders and patients; healthcare providers which include doctors, nurses, and clinical officers; the government including government-run health institutions, officials and other officers; and non-governmental organizations which include both local and international organizations dedicated to community development.

The relationship among these actors requires a delicate balance of interaction and an element of faith. The fieldwork was facilitated by the Christian organization, ChildVoice International which is dedicated towards restoring the voices of children affected by war. The Joint Medical Store in Uganda is a large faith based group purchasing organization for selling supplies to faith affiliated health centers. In the region of Lukodi, the local clinic was started by a retired bishop of the Church of Uganda. Faith can restore relationships and benefit the whole health of human well-being. In a perfect world, the ideal interaction is best described by Daniel Groody as *perichoresis* as "a way of understanding God's invitation to humanity to join the dance of intimacy with the Trinity, to move outward towards others in love and to realize our fundamental interconnectedness with one another" (64). This ideal interconnectedness for the sake of the overall health of a nation requires trust to serve as the basis of all relationships. For

this very reason, the relationships that are embodied by these actors are grounded in a form of faith, best described in the literature and experience as trust.

## 3. Trust Framework of Healthcare Review of Literature

Trust is a challenging topic in the context of healthcare. It serves as the basis of any human to human relationship especially when considering the different types of transactions involved, such as transferring knowledge, dispensing goods, and delivering services. In 2006, the *Journal of Health Organisation and Management* dedicated an entire issue to the role of trust in healthcare. Michael Calnan and Rosemary Rowe, in their introductory article of the issue, highlighted many of the conceptual challenges of researching and conceptualizing trust relations in healthcare. Calnan and Rowe propose that trust "is not primarily dispositional or an individual attribute or psychological state, but is constructed from a set of inter-personal behaviours or from a shared identity" (351). The authors propose this after examining the literature based on patient perspectives of trust relationships and organizational literature highlighting trust relations in the workforce. They also highlighted that while some people may have high levels of trust in individual clinicians, there are much lower levels of trust in health care institutions. This difficulty in translating trust issues from a personal scale to the greater organizational scale illustrates a need to explore trust from beyond the perspective of a patient-physician experience but into a relationship focused on the broader institutional scale. Calnan and Rowe explore trust specifically in the context of the National Health Service in the United Kingdom and note how erosion of trust began at the level of the health services manager (353). The health services manager serves as the gatekeeper and coordinator who often adds complexity in the execution of healthcare. This is an easy avenue for the erosion of trust that is not easily restored. The

challenge of translating small transactions to the overall system thus requires a close look at the different personal and organizational relationships to see how to create trust.

Trust matters according to Calnan and Rowe because it serves as a quality indicator that not only looks at past performance but also serves as a launching point of future relationship and engagement (351). Trust is important from an organizational standpoint of fostering collaboration, providing effective health care and benefiting the collective good (Calnan and Rowe 352). On the other hand, trust also creates the potential for the abuse of power. There is potential for an imbalance of knowledge relationships and an imbalance of financial power and the potential for financial exploitation.

The context of low and middle-income countries adds an additional dimension to trust and healthcare. Lucy Gilson, a prominent researcher on this topic, highlights the importance of moral and social elements of equity, financing mechanisms and communication especially in regards to low and middle-income countries (1382). Equity matters because of limited resources of both within healthcare systems and within the community. Prioritizing healthcare as well as understanding the community's own feelings of automatic exclusion provides a challenge to the development of trust. Financing systems also are contributing factors as any payment system may be viewed as potential exploitation of the community by healthcare providers. Communication also is very important for this relationship of trust. Healthcare providers must not only provide empathy but must also represent "institutions that demonstrate the norms of truthfulness, solidarity and fairness" (Gilson 1382). These elements once again point to the need to examine trust beyond care and competence of the healthcare provider. It is therefore necessary to examine trust in the context of the organizational nature of healthcare systems. Gilson's research also raises concerns about the cross-cultural adaptability from lessons learned in each

individual country. Healthcare in the setting of sub-Saharan Africa is comprised of multiple stakeholders and no single unifying system. In the specific setting of Uganda, there are several nongovernmental organizations, private not-for-profit organizations as well as government-run clinics for the delivery of healthcare. Community health workers are also employed in the setting of what is known as the Village Health Team. The different avenues of healthcare delivery demonstrate the complex needs of trust relationships that must occur to ensure effectiveness. This thesis thus attempts illustrate these common themes to what disrupt trusts and demonstrates cross-cultural applications of trust disruption and trust building. By analyzing these elements of trust, patterns begin to arise which illustrate the very nature of this trust relationship involves more than behavior and are a matter of identity. Trust is the result of a process that involves the restoration of identity, clear understanding of motives, active participation and steady reliable sources of supplies. All of these elements must be present to ensure trust in the system of healthcare.

# 4. An Exploration of Trust Relationships.

## a. Trust between Healthcare Providers and Communities.

### Medicine Supply

Community well-being and health can involve multiple elements that involve physical, emotional and spiritual health. One important relationship which can serve as a backbone of the overall health of the community is that between the healthcare provider and the community. There are numerous factors that enable and limit the development of this relationship. The nature of this relationship has multiple dimensions; it is both an economic service-based relationship and an educational relationship. Fieldwork research and literature demonstrate that the most

important factor that disrupts trust between a healthcare provider and the community is the availability of medicine.

The supply of medicine is an ever-important factor in the development of trust because of the strongly held association of quality health care and quality medicine. Healthcare providers are primarily valued as dispensers of physical medicine; as such, this role forms the basis of their identity. Should the healthcare provider take on a different role and be an educator and informer, the nature of the trust relationship could be significantly different.

The Punena Health Centre, in the Bungatira region surrounding Gulu, serves as an example of this difference in trust. This health center was previously run by a non-governmental organization named ChildVoice International until 2006 when control was handed over to the government. Records prior to 2006 showed consistently high volume as well as a significant reputation in the community (Mandsager). Opinions of the health center immediately declined after transfer to governmental control. It was not because of the government and distrust of the government but rather the lack of availability of medicine. Everlyn Anyango, the clinical officer in 2016, stated that medicine is usually available throughout the month except for crucial "malaria medication which usually runs out in the middle of the month." The medicine is then acquired by appealing to various organizations in the area to supplement the shortfall. The community perception was that this clinic was not reliable because of this broken supply of medicine. Even though the shortfall of medicine is only half of the month, the overall perception of medicines available from this facility was zero (Altug).

The literature supports availability of medicine as the primary source of building trust in the relationship between healthcare providers and the community. Besigye et al. studied the issues of community involvement with two health centers in Uganda. The authors performed a

qualitative cross-sectional study using focus group discussions and interviews. The authors studied themes that promoted community involvement and themes that detracted from involvement. Positive themes included ease of mobilization, local leader initiatives and peer-review sessions. Negative themes included the lack of trust and poor communication. In regards to trust, the authors quoted some of the interview responses which largely revolved around the availability of medicines (Besigye et al. 3). The lack of supply of medicines adversely affected trust in the healthcare provider. The availability of medicine as shown in this study and in field research becomes a recurring theme in the subsequent studies presented in this thesis. While medicine may be external to what a healthcare provider ultimately represents, it becomes the primary icon of his/her identity.

### Distance versus Communication

There have been many attempts at building trust between healthcare providers and patients who live far away. It is easy to argue that trust is difficult to build because of physical distance and thus subsequent social distance. Rural medicine is challenging due to the location of traditional housing and familial relationships that keep people at a significant distance from the nearest health center. Some of the attempts at reducing distance and building relationships include the creation of the community health worker. Research about distance in regards to trust between healthcare providers and the community show that distance is not as important of a factor as one would assume.

In the context of the area studied in Uganda, the Punena Health Centre is within general walking distance to the village of Lukodi. Even closer is the Lukodi Health Centre. Further down the road, there is an additional well-utilized healthcare clinic named the Agonga Karin Hospital Center. The Agonga Karin Hospital Center had previously been a facility dedicated towards only

pediatric health but had recently upgraded its capacity to take care of all members of the community. The primary top level i.e. tertiary care hospital in the region is the Gulu Regional Referral Hospital which requires motor vehicle transportation to reach. There are several health centers all within reach for a rural village. In another region outside the capital region of Kambala is the Wentz Medical Center. Juliet Ngabaya serves as the Administrator for the Wentz Medical Center. She noted the initial lack of development in the region and how the medical center would invest in countless mission trips providing medical care, vaccinations and community education. After many years of investment and education, family members now tell all their close friends and extended family members about the excellent services. She proudly boasted "now people come from all over the region" just to receive care (Ngabaya). This fieldwork experience suggests that health centers of all levels are within physical reach and that even large distances can be readily overcome if there are certain parameters of trust. Distance in the context of field research is not the primary barrier towards trust or accessing healthcare.

In the literature, Chatt and Roberts evaluated barriers to healthcare access in rural Kanakantapa, Zambia. In Zambia, fees were eliminated for the rural setting and the purpose of the study was to highlight what still prevented people from obtaining healthcare. The researchers used a questionnaire which categorized the reasons for illness and whether they received treatment. Other data included attendance, knowledge about the clinic and reasons for not accessing healthcare. The researchers found that 2 out of the 3 villages furthest away from the clinic had low attendance rates, the third that was close by they attributed to more complex social reasons (19). In regards to knowledge of the services, only 2% did not know about the location of the clinic whereas 17% did not know about the removal of fees and 21% did not know about 24-hour service. The authors found that attendance rate increased when it was diarrhea with

respiratory symptoms, or pregnancy with diarrhea. The study highlighted the man reasons for not accessing the clinic. Fifty-five percent were related to transport and distance issues, 20% felt that there was no medicine at the clinic, 15% in regards to time, 6% preferred traditional medicine, and 1% could not afford the fees (Chatt and Roberts 19). Even though the qualitative data demonstrated that distance was a factor, the quantitative data demonstrated no correlation with distance for each symptom. In fact, people with diarrhea who accessed the clinic were associated with *greater distance* 6.05 km vs 5.64 km (Chatt and Roberts 19).

This study demonstrates an incongruity with the actual physical distance data and complaints about distance and lack of transport. Chatt and Roberts suggest that the discrepancy was due to the "way distance was measured or because of perception of distance is subjective, or related to what modes of transportation are available" (22). The subjective perception of distance versus the actual physical data suggests the issue of utilization is a more relational matter rather than a matter of resources. Having easy transport would certainly alleviate matters, but this suggest that communication and trust are more important factors in utilization, especially by the other mentioned factors for non-utilization. Once again, the availability of medicine serves as the primary drive for utilization, followed by waiting times. These factors show that proper communication of services is necessary for relationship building and trust formation. Distance is not as nearly as important as the reliable supply of medicine. In the example of Lukodi, an affordable hospital center within reach is not completely utilized because of the lack of communication of what is available. Distance is not necessarily an issue of obtaining healthcare, but serves as a barrier towards communication.

## Communication

The relationship of communication and trust building appear to be synergistic, but the actual components of communication to build trust require specific elements: reciprocity and transparency. From the literature, there are two relevant studies by Kumurenzi et al. and Ernstzen, Louw and Hillier which explore an arena where healthcare providers are more than just medicine prescribers. The ability to practice medicine in these fields requires significant communication skills. These specific communication skills require empathic approaches to a community member's understanding of disease. Furthermore, there must be an agreement upon symptoms and treatment as being genuine. Communication serves as the engine of a reciprocal trust relationship; as healthcare providers communicate trust to the community, the community returns their trust.

Ernstzen, Louw and Hillier studied the experience of those with chronic musculoskeletal pain as well as perspectives in the setting of private healthcare centers. The authors performed a qualitative study involving in-depth interviews. One theme of the interviews was trying to understand "the origin of the pain and the reason for its persistence" (Ernstzen, Louw and Hillier 3). Emotional and functional impact of pain were the other themes of the experience including "fear, worry and uncertainty" (Ernstzen, Louw and Hillier 4) and activities such as "self-care, work and limited participation in leisure activities" (Ernstzen, Louw and Hillier 4). The more salient findings were the experience with healthcare providers, especially the necessity of "guidance, care and support" (Ernstzen, Louw and Hillier 4). There were positive attributes of "approachability, good communication skills, a caring nature, genuineness, trustworthiness, and guidance" (5). Negative factors focused on lack of understanding of the pain or the perception that pain was not genuine. Communication in this situation means that the healthcare provider

must place some form of trust in the patient by believing in the patient's symptoms. The patient then in turn reciprocates trust in the healthcare provider for guidance and support.

Kumurenzi et al. studied the experiences of patients in the context of out-patient rehabilitation services in the Western Cape Province of South Africa. The patients suffering physical short term and long term disabilities were studied through qualitative methods. Patients trusted their health service providers' knowledge base and skills even though service providers themselves "were not knowledgeable enough to deal with all types of disabilities" (Kumurenzi et al. 4). Other themes included accessibility, interaction, participation, provision of information, and organization. Kumurenzi et al. illustrated the need for training and proper communication skills to build trust. These communication skills illustrate the necessity of transparency and skill in transferring knowledge especially in times of knowledge deficits. While expertise is important, these communication skills create trust despite any deficits of the healthcare provider.

Availability of medicine and communication are therefore fundamental drivers of the trust relationship especially between a healthcare provider and the community. These two factors form the basis of the fundamental identity of a healthcare provider as well as the identity of the healthcare provider-patient relationship. This identity that is created by communication can overcome issues where medicine is not necessarily the primary modality of treatment. It can even overcome knowledge deficits and other deterrents towards quality. This identity however is easily disrupted when roles are not communicated, expectations are not agreed upon, or uncertainty exists about the supply of medicine.

### b. Building Trust between Nongovernmental Organizations (NGO's) and the Government

#### Roles and Participation

The relationship between the government and NGO's is a tenuous one. NGO's exist often because of a deficiency perceived by the outside world due to disaster, conflict, or deficits of the capacity within the government. The government views the NGO as a foreign entity but is enticed by its resources. NGOs also view the government with a general sense of distrust but engage in good faith for the sake of executing their own agendas. There is also an inherent risk for any organization to lack the accountability and transparency necessary to guarantee freedom from corruption. While this may be rigorously evaluated both internally and externally by an NGO, the same may not necessarily apply to the government. Setting aside questions of transparency and accountability, the primary task that inhibits trust building within this relationship is managing expectations. These expectations involve understanding the usage and management of resources as well as understanding tasks, allowing for full participation and accountability.

Tony de Groote of BTC Uganda serves as the technical advisor for an institutional capacity building project, working closely with the Ministry of Health in Uganda. While he was grateful for the opportunity to be a part of the Ministry of Health and to work closely with government officials, de Groote noted some difficulty in the partnership, mainly in the specific roles each played in a project. De Groote would submit a highly technical project proposal and the feedback given by the government was mostly "grammatical rather than technical." In de Groote's experience, there was a greater desire for greater participation by both parties, but at some point in the exchange, there was a misunderstanding of expectations out of each other.

Others have researched and found similar themes of disparities between stated roles and different levels of participation which often included tokenism. Tokenism in the realm of psychology exists because of a group being underrepresented and becoming “tokens.” As “tokens,” they must fulfill stereotypical roles and can “isolate themselves because of poor treatment, or expectations of poor treatment, by majority-group members” (Jackson 456). In the context of healthcare, tokenism “implies a set of role relationships between stakeholders in which there is an unequal power distribution” (Bess et al. 145). This unequal power distribution as well as managing expectations and roles create what amounts to nominal participation.

Nominal participation hampers the ability of collaboration, especially in the context of intersectoral collaboration, such as that between an NGO and the government. It becomes a recurring theme throughout the literature. Brooke-Sumner, Lund and Peterson looked at the challenges of inter-sectoral collaboration in the setting of psychosocial rehabilitation in South Africa. The study was a subcomponent of a larger research consortium focused on improving mental health interventions in low resource settings. The sectors that took part in the primary studies were the National Department of Health (DOH), National Department of Social Development (DOSD) and an NGO named the South African Federation for Mental Health. In this qualitative study, the authors found several themes in the collaboration between the government and NGO’s. The first theme was that there were general perceptions of “no collaboration,” “almost zero” and some indirect collaboration through a DOH mental health coordinator (Brooke-Sumner, Lund and Peterson 4). The second theme explored the three major challenges: “lack of structured relationships and effective communication,” “lack of clarity as to the roles of the different sectors”, and “lack of support and trust in other sectors to fulfill their roles” (Brooke-Sumner, Lund and Peterson 4-5). Brooke-Sumner, Lund and Peterson established

the third theme through three primary solutions to the challenges: "roles of sectors and staff to be clarified" (6), "improving the communication and working relationship" (8) and "appropriate resource allocation" (9). In reference to this particular thesis, the primary solutions completely avoided directly addressing trust issues. The authors' primary assertion was that if people were given the proper roles, it would create the necessary environment for communication and resource allocation. This would then fulfill the necessary relationship criteria for collaboration and build trust over time.

Bawole and Hossain also explored the relationship between the local government and NGOs in Ghana, specifically in the Northern and Upper East Regions. Key informant interviews took place with NGO directors and local government officials. Bawole and Hossain found a general superficial cordiality and tokenistic collaboration. Bawole and Hossain noted elements of the relationship which included resentment as well as projecting unrealistic expectations (2075). Many relationships were also begun with extensive caution or as a matter of convenience. This data is important as it illustrates many of the underlying issues that inhibit the formation of trust: not providing meaningful participation and having unhealthy expectations.

I A Yagub explored the collaboration between government and NGO's in the setting of North Darfur State in Sudan. I A Yagub used both qualitative and quantitative techniques to examine the existing collaboration and all of its challenges. There were two specific challenges that I A Yagub found: obtaining "access to the conflict-affected areas; and challenges relating to experience and capacity" (568). Furthermore, success of joint projects was dependent on building trust (I A Yagub 567), especially when local communities could participate in making decisions. Communication also provided another necessary means of ensuring a positive

relationship. The data from this paper reinforces the notion that genuine participation is a vital component of trust building.

The data supporting the importance of expectation management and trust building is substantial. It is impossible for NGO's and local government to deliver healthcare when there is minimal participation and collaboration. This is further complicated by NGO's reliance on resources from donors to whom they are accountable. Government entities expect NGO's to be limitless resource supplies in providing healthcare. This breeds an unhealthy culture of dependency which undermines trust formation, let alone for ensuring the healthcare of a community in the hands of either. The most immediate solution is when NGO's can align their priorities with that of the government. But this often counterproductive to the overall objectives of the NGOs, especially in cases where government corruption is present.

### Priority Alignment

Priority alignment provides an avenue of moving away from tokenistic collaboration in to well defined roles and expectations. Dyke et al. studied international non-governmental organizations and how they implement equity principles in HIV/AIDS work. They chose Kenya for their case study and recruited four organizations for their research. They conducted participant observation and interviews. They specifically asked about equity, client involvement and understanding and what could organizations do to improve access to healthcare. Equity was an important value across the board. The authors found that international non-governmental organizations (INGOs) focused its programs on "vulnerable groups where the INGO was viewed as having a positive and long-standing reputation" (Dyke et al. 8). INGOs implemented equity through empowerment rather than service. The authors found that one of the key forms of success with INGOs was that their community empowerment approach aligned with the Kenyan

government's priorities. INGO dependence on their donors proved to be more challenging as there was quite a bit of donor influence that did not necessarily line up with that of the government. Dyke et al. in their discussion of their results discuss this "asymmetrical interdependence" as the "INGO did not have equal power to the Kenyan government or to the donors in implementing its equity principles" (14). The data shows that donors can play a negative influence in fostering a relationship with the government and that even with a positive relationship, the most vulnerable people may not achieve the same degree of equitable access to healthcare.

Aligning values between the government and nongovernmental organizations is not only a step towards building trust in the relationship but also has the potential to remove tokenism and facilitate genuine participation. This form of participation is a form of reciprocity, much in the same way there is reciprocity of the healthcare provider-patient relationship. Just as how a healthcare provider and patient engage in a reciprocal relationship through communication, NGOs and the government must engage in a reciprocal relationship of participation to build trust.

## c. Building Trust within Communities.

### Collective Identity

Trust at the community level is a much more difficult subject to explore. There is preferred trust of an outsider compared to that of an insider. The Surgery, a private clinic based in Kampala, Uganda, serves as an example for this preference. According to Gunna Wales, the office manager, patients overwhelmingly preferred to see Dr. Stocksley, the founding British trained doctor. This was followed by a preference for other foreign physicians and finally Ugandan physicians. Patients often needed to be persuaded that the "Ugandan doctors are just as good as the others" (Wales). This experience reflects an inherent lack of trust within the

population. While this finding may also be confounded due to a higher number of foreigners who utilize The Surgery, the preference appears to cross all national lines. The preference for the foreign physician over the local physician after research appears to be rooted in the idea of shared national identity when it comes to healthcare.

During field research, this shared national identity of healthcare emerges after interviewing many actors. In a survey of health care managers and providers in Uganda, one of the most pressing health related events was the sole radiation therapy machine in Uganda at Mulago Hospital being in disrepair. Radiation therapy, while important in the management of cancer, is only a single component of care that is combined with many additional treatments and often is only adjunct towards a total management plan. At the time of research, the short-term solution was to send people to Kenya to receive urgent radiation treatment (BBC News). This single event nonetheless captured the minds of many who were interviewed and illustrated how fragile a national healthcare identity is. This type of event triggered a general despair over the health of the nation as well as its health system. The role of maintaining a collective identity through various icons of health care then become important in building and maintaining trust.

Trust issues not only occurs at the national level, but also within communities. There are numerous barriers that prevent trust including personal history as well as a reflection of existing familial and social power structures. These issues also occur within the community on a personal level, namely in the setting of trauma and lead to mental roadblocks that prevent the formation of relationships.

Communities can be intrinsically divided if there is a history of conflict or if there is a disruption of resources. At the same time, communities share many cultural, historical, geographic and familial bonds that should facilitate multiple trusting relationships. A

community health worker, being a member of the community should have no issues in obtaining the trust of the community. Unfortunately, there are instances where the community health worker run into hurdles of trust. Singh, Cummin and Negin studied the acceptability and trust of community health workers in rural Uganda. Community health workers are typically residents but they do not experience widespread acceptance and trust due to "history, past performance or other issues" (Singh Cummin and Negin 2). This history refers to the previous roles community health workers had previously participated in the community. Some of the issues of trust included understanding how power is shared and a subsequent fear of medications. Items, which contributed to the building of trust, were using more typical channels of learning such as friendship and having respected supervision. When trying to build trust at the level of the community, there were issues of power and more culturally specific ways that the norms of society are constructed. When looking at a broader cultural perspective, Hofstede, Hofstede and Minkov describe this cultural phenomenon as uncertainty avoidance, defined as "the extent to which the members of a culture feel threatened by ambiguous or unknown situations" (191). Items such as fear of medications and fear of these new education methods create a certain anxiety and rejection by the community. Hofstede, Hofstede and Minkov's data designate that West African and East African nations score 54 and 52 out of a score of a 100, which is relatively middling to low compared to other nations. This data seems to be quite at odds with the actual experience of uncertainty avoidance. One possibility may be due to the general lack of sensitivity by those engaged in healthcare compared to those who are engaged in other fields. Another possibility is that Hofstede, Hofstede and Minkov's data may be overgeneralized and does not account for differences in rural and urban populations. Nonetheless, cultural consideration needs to be considered to develop that trusting environment within the community.

Dhillon and Kelly looked at their experience of Ebola and the absence of community trust. Dhillon and Kelly cite the "decades of misrule and political tumult" (788) leading to a mistrust of formal power systems. This distrust also extended to the experience of funerals which resulted in communities distrusting the need to change cultural traditions for the sake of their health. This study showed that the perspective of health care worker/response team and community requires a radical mechanism to foster the trust necessary to enact change. Specifically, there is a deeper community sense of the need for "shocks" to cause a change towards the direction of trust as well as the necessity for culturally aware "skilled interlocuters" (Dhillon and Kelly 788). In this situation, the "shocks" were the epidemic of Ebola and how rapid debilitating disease and disaster could occur. When looking at this study in a broader healthcare context, "shocks" could also be represented by other healthcare events that follow a similar profile of epidemic and panic. The communication and cross-cultural bridges amongst communities may build the foundation of trust, but the weight of disaster and reality form a necessary catalyst. This catalyst dislodges distrust within the community and allows the formation of trust relationships.

Culturally specific applications, communication and "shocks" appear to help form the necessary mechanism for trust formation but these items are still reliant on existing social networks. Zamudio-Haas et al. studied a specific programmatic strategy of methadone-assisted therapy clinics in treating those who inject drugs in Dar es Salaam, Tanzania. The program specifically required enrollment through community-based organizations in order for patients to receive treatment at a government run clinic. The researchers specifically oversampled women because they were underrepresented in those that seek therapy. Researchers used in-depth interviews, ethnographic observations of service delivery and outreach location, as well as

additional secondary sources of data. Trust/mistrust was an important theme as there was a "generation of mistrust against people who inject drugs (PWID) and mistrust of PWID towards outsiders and medical institutions" (Zamudio-Haas et al. 8). These forms of mistrust had their own mechanism where "mistrust combined with stigma to generate vehement discrimination against PWID in community and health care settings; which in turn created mistrust in PWID against outsiders and social institutions" (Zamudio-Haas et al. 9). To overcome this mistrust, community based organizations employed peer outreach and nighttime outreach. Furthermore, to reduce mistrust in the health care setting, outreach workers would use the course of "multiple outreach conversations or via connection from someone close to the woman" (Zamudio-Haas et al. 12). In addition, there was motivation for receiving treatment because "rebuilding relationships and regaining trust from family proved a central motivation to enter treatment for patients interviewed" (Zamudio-Haas et al. 13). This suggests that not only do trusted network relationships provide the necessary basis for forming trust, but a desire for rebuilding familial and communal trust relationships can facilitate health-seeking behavior. Trust relies on existing familial and communal trust relationships that need to be already in place.

Understanding social networks becomes ever more important when it comes to building trust within the community. These form the building blocks of not only trust but for the actual efficacy of healthcare initiatives. Turinawe et al. studied the Ugandan version of the community health worker, the Village Health Teams. The authors found that the communication of the Village Health Team strategy fostered an expectation which not only "brought high hopes but also some strife and competition among those who wanted to become the 'village doctors'" (Turinawe et al. 4). The researchers found that during the selection process, council leaders either chose themselves or their own preference rather than that of the community. This process

created suspicion and distrust, especially with the thought that these team members could be profiting from the selection process. Literacy requirements also forced the sidelining of many community members. Furthermore, the village health team members worked as inspectors rather than helpers and would choose to go to another village to protect their own reputation. The qualitative data of this study is important because it shows that even leaders who select members from within a community to be agents of healthcare cannot earn trust because of the lack of procedural justice and inappropriate roles. Clear communication of expectation of roles is important for the development of trust. Creating attitudes of help rather than authority is another important component of community based healthcare. Authority has a deleterious effect on trust because it creates suspicion and removes from the community in engaging in a participatory role to support each other. Help, on the other hand, creates clarity of motivation and invokes values of justice and equality.

## The Effects of Trauma and Conflict

There must be an understanding of existing accepted social and power structures within the community. That balance of power must be respected at all cost to facilitate trust. While it is possible to use shocks and the weight of reality to drastically engage trust, it is not feasible to only rely on medical disasters and outbreaks to facilitate healthcare usage. The question of power arises in the setting of post-conflict regions where there have been disrupted relationships, disrupted geographic locations, and disrupted social circles. The element that is necessary especially in situations after conflict appear to be reconciliation, especially when there are desires for community members for the sake of their own health to rebuild these familial and communal social networks. Miroslav Volf discusses the challenges of reconciliation in the context of a social covenant in which there is a "readjustment of complementary identities, the

repairing of the covenant even by those who have not broken it, and the refusal to let the covenant ever be undone" (156). While it is possible for relationship restoration through a gradual process of reconciliation as delineated by Volf, there is an additional contradictory process in the reconciliation process: significant personal emotional scars which are the result of physical and emotional trauma. These provide additional hurdles in the development of trust relationships and health seeking behaviors.

In a community forum held in Lukodi, Uganda, village members raised several issues when it came to health. The financial costs of healthcare as well as the distance were readily identified as the main barriers. The experience of the village was that the nearby clinic was far too expensive. The more distant clinic, the Punena Health Center, had no medications. The primary source of medicine, Gulu Regional Referral Hospital, was far too distant and costly to go to. When combining the cost of transportation and the cost of healthcare, the actual financial cost taken together as a sum are approximately 10,000 Ugandan Schillings, or the equivalent of $2.80 USD. The collective physical distance of these healthcare facilities as stated earlier is not that significant compared to the actual perceived distance. The real distance was that of a social distance based on trust and understanding motivations of each facility. This distance was caused by an additional factor of mental and emotional trauma as each member described themselves as "scarred" (Lukodi Village). Community members in this region had been subjected to over 30 years of conflict, displacement and resettlement. Winnnie Opwonya, a counselor working for ChildVoice International, was one of the few counselors in the region. Opwonya's main long term desire was to create a "trauma center" to allow people to come together, create a supporting environment as well as report any potential abuse to each other. Opwonya recognized that too

many development efforts are undermined because people have not been able to experience healing within this realm. It is therefore important to understand trauma in the context of trust.

While it is not necessary to conclude that every community member in this region suffers from clinically significant post-traumatic stress disorder (PTSD), it is still important to consider what additional areas trauma plays a role in the lives of a community member. While previously mentioned shocks and dire realities can facilitate trust formation, as in the case of Ebola, a long-term trust relationship cannot be sustained in such a fashion as the deleterious emotional effects of shocks begin to take its toll. Shocks and conflict create long-term mental barriers that prevent people from forging trust. Much in the same way as the experience of Lukodi village, thirty years of conflict can leave behind scars that create barriers in forming relationships, especially through additional mechanisms such as paranoia.

Freeman et al. studied the effects of paranoia and PTSD at King's College Hospital, London. They studied the presence of paranoia and PTSD at 4 weeks, 3 months and 6 months after physical assault and found that paranoia and PTSD were distinct experiences in their factor analysis (2682). Their results showed how the mechanism of paranoia perpetuates after the inciting incidence of physical trauma. They found numerous cognitive factors that helped the symptoms of mistrust such as: the proximity/location of the assault, severity of injury, ongoing physical problems, negative thoughts about others, self-blame, worry, negative beliefs about others, inter-personal sensitivity, and anomalous experiences (Freeman et al. 2681). Many of these same cognitive factors that perpetuated paranoia accounted for the persistence of PTSD even though these two entities had very distinct experiences.

While this study on PTSD and paranoia was performed in a non-African context, it provides insight into a greater understanding of cognitive factors from a cross-cultural

perspective. This study paves the way for understanding persistent mistrust and suspicious-thinking behavior in any post-conflict region as these cognitive factors that perpetuate them are not addressed. In the example provided, community members have returned to their region of previous trauma and have insufficient mental health support in the region. Recognizing the mental impacts of trauma must go beyond only classifying them in terms of these entities to addressing a greater overall cognitive trap that communities must endure. Not only do these issues need to be addressed expediently, but they must be addressed on an intergenerational level. Numerous studies have been done in places like Cambodia where trauma is passed along to generations. In the context of Uganda, Elisa Blankers, in her dissertation on how refugee trauma affects parenting and child development, states that parent's symptoms of PTSD can "brush off on the children because the chronic basic emotions of fear, sadness, and anger surround and pervade the child" (241). These same emotions are the same cognitive factors that perpetuate paranoia in Freeman et al.'s study. It is therefore possible to consider that Freeman et al.'s study on trauma has genuine cross-cultural and cross-generational relevance.

Paranoia is an entity that exists on a collective level. Gonsalves and Staley reflect on the history of the AIDS Epidemic in the United States and how it applies to Ebola. They note a similar "toxic mix of scientific ignorance and paranoia on display in the reaction to the return of health care workers from the front lines of the fight against Ebola in West Africa" (2348). While this paranoia and panic are seen specifically in the western context, it is nonetheless useful to consider the great impact paranoia has on public health. In the American response to Ebola, there was massive hysteria and disruption of health care utilization as people were afraid to engage in locations where disease was known. Stigma and fear were rampant. This further reinforces the

necessity to manage the sources of paranoia and misinformation for the sake of public health as well as for the sake of all healthcare partnerships, especially in the context of trust.

The formation of trust within the community relies on relational restoration as well as the restoration and maintenance of a greater corporate identity through rebuilding of social networks. Personal restoration cannot be ignored as it provides a powerful hindrance towards the building of trust. Counseling, culturally specific applications and proper communication help dispel the propensity of trauma induced behaviors, suspicious thinking and widespread hysteria. These cognitive factors, if left unaddressed, make it impossible for the necessary relational restoration that facilitate trust.

### d. Building Trust between an NGO and a Surrounding Community

Nongovernmental organizations place themselves in a community, often not within their own original context. The natural assumption is that NGOs and communities work together in a cohesive fashion easily building trust as they desire to serve each other. Running against that collaboration are concerns for the development of a social dependency welfare state. The actual trust foundation between an NGO and surrounding community demonstrates a tenuous nature of this relationship despite the necessity for both to coexist. What the experience and literature demonstrate, equity and participation carries much more weight when it comes to the nature of this relationship.

#### Participation

During the community forum held at Lukodi, there was a strong desire for more input into the community by ChildVoice. Many other organizations had already come and gone but there was a hope that the organization would provide more vocational training. Many community members reminisced when the organization ran the local health clinic and expressed a deep

suspicion of the new privately owned clinic nearby citing exorbitant fees. Many of the women in the area had received some support and training, but an oft-repeated question came up during the forum was "What can ChildVoice do for the men?" (Lukodi Village). This conundrum between the NGO and community illustrate a typical perception that communities only want more from an organization rather than true individual betterment, but the underlying message is a deep desire for the community to have greater participation in their own wellbeing rather than sitting on the sidelines.

Participation once again becomes relevant in the realm of trust, much as in the same way between the collaboration between NGO's and the government. The literature also supports Gilson's claims of the need for expressing values of equity and procedural justice. The REACT intervention study was a study performed in Kenya, Tanzania, and Zambia on the "Response to Accountable priority setting for Trust in health systems." Zulu et al studied local perceptions and practices of fair priority setting, including healthcare stakeholders of government, NGO and health facilities in the specific context of Zambia. Priority setting is a matter of executing healthcare in a system of finite and limited resources and creating fair allocation systems. The REACT system is based on an "accountability for reasonability" (AFR) framework, that is, "agreement on a process that produces decisions which are perceived as being and legitimate and fair by stakeholders" (Zulu et al. 2). While this methodology only indirectly addresses the relationship between NGOs and the community, the hybrid team of all three provides greater insight to this particular relationship. Zulu et al. found that "inclusiveness is one of the criteria for legitimacy of decisions" (5). In their baseline study, the researchers sought to instill values of equality and fairness into local values and employed a participatory approach. During the evaluation phase of the study, they decided to broaden the decision-making process by enabling

more stakeholders who were not part of the top part of health management as well as several diverse organizations to help "achieve a greater overview over the diverse perspectives and priorities existing within the district" (7). Publicity for the project was limited due to the "limited economic resources, low literacy levels, and lack of interest by many local people in expressing their views during formal or informal opportunities for participating" (Zulu et al. 8). Overall, the authors suggest that "broad participation in priority setting has the potential of increasing legitimacy of the priority setting and the likelihood of acceptance of priorities by the community" (Zulu et al. 10). The authors noted the challenge of engaging the community level and not the district due to limitations such as: "transport, accommodation and food costs for community members attending PS meetings, but was also caused by people's lack of interest and of awareness of the possibilities of participation, illiteracy as well as established top-down practices" (Zulu et al. 10). Overall, this data reinforces the notion that participatory approaches towards healthcare require significant community investment in developing trust as well as the ability and means to enact meaningful change. This notion evokes the capabilities approach advocated by Amartya Sen and other colleagues where the "poor themselves must be the actors if their capability is to be increased" (Myers 30). Diverse organizational collaboration is therefore important in fostering a greater sense of diversity and inclusiveness. These steps towards participation require significant investment by both parties but are necessary to foster trust.

Participatory approaches are challenging even with the most well-intentioned and well supplied program. It requires significant investment of the community and cultural contextualization. Wilunda et al. studied a maternal health care project in South West Shoa Zone Ethiopia that was performed by Doctors with Africa CUAMM aimed at improving "access to

maternal and child health services through tackling demand supply side barriers to service access" (2). The project involved providing technical and material support, rehabilitation of health centers, providing supplemental supplies, training, staff supervision, improved referral systems, reduction of fees and community sensitization activities. Some of the results of the survey demonstrated significant increases in "perception about the quality of maternal health services and with higher maternal health attitude score" and "the proportion of women taking specific actions to prepare for the birth of the baby" (Wilunda et al. 4). This study found that there was a steeper increase in antenatal care coverage in the later months of the project. The authors believe it was because attention was first given towards infrastructure rather than on developing healthcare. Another finding is that postnatal care did not improve after the project. This finding was unusual and the authors cited that health extension workers needed to be fully utilized to assist in greater postnatal care. This seems to suggest that even the most well-intentioned multi-faceted, well-funded project does not necessarily provide a sustaining relationship. The slow ramp up shows that structural support cannot supplant the utility of community based participation found in health extension workers.

To develop a genuine trusting relationship between a community and a NGO, both NGO and community members must create a framework of genuine participation. When it comes to the framework of trust in the context of organizations, participation allows community members to not only understand the motivations and purposes of an NGO's presence but allows for opportunities to create procedural and distributive justice. The participation process needs to include the necessary health education but also the creation of tools for understanding and upholding equity and justice.

## Broadcasting the Right Message

Particapatory approaches while valuable also need to be supplemented with communication. Much as in the same way communication between a healthcare provider and patient requires mutual understanding, NGO's must engage in the appropriate communication to create the necessary trust relationship with the community. Muhwezi, Muhangi and Mugumya studied the differences between families of orphans and non-orphans in the context of NGO support and non-supported regions. The findings of the study demonstrated no differences between orphan care and non-orphans, suggesting that "even when the African extended family system is slowly but surely getting perforated, it is still managing to take care of orphans" (Muhwezi, Muhangi and Mugumya 114). In the context of NGO supported regions, families were more likely to seek out care. Muhwezi, Muhangi and Mugumya theorize that it was an "uptake of educational messages concerning equity, compassion and support in looking after children and care of orphans" (115) that was instrumental in providing impetus for greater health seeking behavior. In regards to a providing a framework of trust, it seems that health education is paramount for fostering positive health seeking behaviors and the necessary mechanism of internalization of messages. This health education must not only entail basic health but must also address issues of equity and thus justice.

Campbell et al. studied a rural community of Entabeni of South Africa in a program meant to bolster AIDS competence. This qualitative study discussed what increased AIDS competence at the community level. Health volunteers received training and then ran training courses for community members. A confounding variable that inhibited the growth of knowledge was a conflicting framework of "witchcraft" (Campbell et al. 167) and the men in the program being resistant to change. Overall Campbell et al. found that the project was successful in

"building volunteers' confidence, community confidence in the volunteers, and increasing people's knowledge about HIV/AIDS" (174). Other issues that they found were the lack of a coherent project image, dealing with stigma, and poor communication. Another issue was the actual internal management of the volunteer team, which reduced project ownership and impaired the ability for "broader empowerment" (Campbell et al. 175). Witchcraft was a confounding variable, which illustrates another variable of mistrust. More importantly though, communication and identity are fundamental themes for the goals of trust and collaboration between an NGO and surrounding community.

The relationship between an NGO and the community requires communication of values, broad health knowledge and allowing the community to participate in the whole process. More culturally specific strategies must be employed much like in the case of witchcraft. Communicating values of equity and justice not only provides clarification of the motives of an NGO but also creates a more positive image identity for the community. These provide the necessary elements for greater participation for the formation of trust within the relationship.

### e. Building trust between the Government and People

When it comes to the relationship between the government and the people, there is a different dynamic compared to an NGO and the community. The government must raise most of its capital from within the community they serve and has a direct responsibility towards the community. While there are many forms of accountability between the government and its people, there are multiple layers of bureaucracy and many variations in how people can participate in the government, whether it is through elections or through other platforms. This relationship echoes many of the same pitfalls of the other partnerships described so far as there

are issues of supply chain management, overlapping roles, procedural justice and the potential for harm by exclusion.

### Social Relationships

Social relationships are important within the community as previously mentioned and become a recurring theme in the context of the government and community partnership. These social relationships are important in not only because they form the foundation of any new relationship, but uphold the identity and integrity of a community, especially when it pertains to cultural practices and symbols. Harriet Birungi studied injections with needles and the evolution of trust and risk in Ugandan Healthcare, especially in the relationships of the availability of injection equipment, social relations and institutions. These injections were primarily focused on drugs that needed to be administered by needle. Birungi tracks the fall of Ugandan healthcare and loss of faith in institutions. Some of the primary issues that prevented trust included not knowing who had sterilized the equipment and perceiving nurses as being too careless because of low salaries (Birungi 1458). The evolution of distrust in the government and government institutions was coupled with wide availability of personal injection equipment. Public distrust was coupled with procedures that contradicted local practices. There was also a lack of clear organization as the government-administered injections were “considered unhygienic or unsafe because the pattern of arrangement adopted seems to be confused and contradicts the local idea of hygiene” (Birungi 1459). The social distance between the government and community members cultivated a culture of fear and distrust whereas it was much easier to put trust in existing familial and social relationships. People distrusted the government because they perceived “providers in the government setting are driven by the motive that these things are not theirs, hence no special care is given to anything, including patients” (1458). Social relationships

triumphed over institutional resources, especially when resources are readily available as "social relations do not only guarantee protection and support to the patient, but also serve as a means of gaining access to a symbolic token of healing" (Birungi 1460). In Birungi's study, the avenue of trust is through understanding existing social relationships and understanding cultural practices. The needle becomes a public symbol or icon of health. The government not only must uphold and manage the perception of these symbols of healthcare, but also become a champion and exemplary role model for the community.

Wasunna et al. studied the effects of a community based behavior change communication campaign focused on the concept of *haraka upesi* (prompt action) for all children with fevers in rural Kenya. The authors were looking at three steps in the fever management chain: initial treatment, accessing a public health facility, and adherence to therapy. Community health workers were never used before or post intervention. The authors found an overall increase in fever treatment and accessing the anti-malarial medication, but noted decline of usage of government health facilities. The authors cited the lack of guaranteed supply of medicine. The authors also noted that people were using their own hoarded stock of medicine. The authors noted that single sector interventions are incomplete and cross-sector intervention is necessary. This study once again confirms the issue of medicine supply as a fundamental disrupter of trust and reduced desire to access healthcare. Community members would rather source their own medicine out of reliability even though dosing could be incorrect. It also shows that community based communication programs have limited ability in creating greater trust but attention must primarily be focused on medicine supply. In this article, once again medicine is a primary driving factor in the formation of the trust relationships followed by existing social relationships.

## Organizational Coherency

Building upon social relationships, the government must all create a system of organizational coherency to develop trust. These serve as a parallel between social relationships of the community and the organizational management of the government. Agu, Correia and Behbani evaluate a 2003 proposal which was meant to strengthen international health cooperation through regional economic communities. The 2003 Session of the AU conference of African Ministers of Health adopted a proposal which included an establishment of Health and Social Affairs Desks among other recommendations. Some of the achievements noted by this article include multiple health communities that address specialized issues as well as capacity building within the region's economic community. What is most pertinent in this article are the specific challenges in the implementation of integration. These communities have "inadequate human and fiscal resources to pursue even their priority activities relating to political and economic integration" (110). Meetings are not attended and health desks, as initially proposed, have not been established. The authors suggest that the lack of participation is the "overall lack of political will and low priority given to social (and health) issues" (110). Another issue is how the multiplicity of international players and overlapping memberships are perceived as wasting both efforts and resources. These two factors seem to be inhibiting coordination and collaboration. This plays into a greater narrative of why governments who superficially agree to collaborate do not have the necessary allocated resources, political will or well-coordinated process to ensure execution. In the overall framework of trust, it is not only the lack of desire to build relationships but a redundancy of the multiple positions that disrupt the social network of healthcare capacity building. While this study is focused on how the government is collaborating

with other governments, it illustrates the barriers government has in implementing and executing its own programs as well as garnering the necessary trust of its people.

This organizational competence also needs to embrace procedural justice and equity. Marta Schaaf et al. describe the appropriate deployment of health workers as a necessary way to ensure there is sufficient faith in the government system. The authors note that "dissatisfaction with their postings and inadequate support for them to discharge their roles effectively" (Schaaf et al. 1) leads to poor quality of health services which subsequently erode community trust. Schaaf et al. cite this area as under-researched and not fitting any typical public health framework. There is also a lack of transparency in the decision-making process. The authors hypothesize an unwillingness to expose "corrupt and collusive networks" as well as an "informal trade" that is filled with nepotism and other less optimal decision making processes (Scaaf et al. 2). Understanding this procedural injustice provides further insight into the failures of government-administered health care as perceived by the community. Not only must the government delineate its own roles and reduce the overlap and confusion, it must also provide the necessary transparency in the whole process to gain the trust of the community. Networks of trade and decision-making that are kept from the public create a deep sense of mistrust even if community members are directly engaged in the whole process.

The final organizational elements that the government needs to address are confidentiality and investment in infrastructure. Geary et al. studied a government-administered youth directed health-services program in rural South Africa. The authors noticed that there were human resource issues of shortages of staff, breaches of confidentiality, poor facility infrastructure and lack of the appropriate space. Limited training, staffing and insufficient medical supplies are already assumed factors that create distrust with government-administered

health, but this study highlights why confidentiality and infrastructure cause additional problems. Poor infrastructure breeds mistrust because it seeds suspicion in the allocation of resources, especially if there are very drastic unmet needs. Confidentiality deters people from accessing services either through the potential of abuse, greater stigma or social isolation. Confidentiality issues in the trust relationship demonstrate the many different possibilities for perceived harm in the relationship. There is already an understanding for the need to be sensitive to physical and financial exploitation, but confidentiality requires additional factors to ensure protection and safety. Stigma from chronic disease or other socioeconomic variables comes at great social cost to an individual. This is more salient for the individual in the greater collective setting, let alone within the context of a relationship with the government. These factors are ultimately motivational factors that creates challenges in optimizing collaboration and organization within the government and capitalizing on the necessary social relationship elements to create trust.

### f. Unifying Themes of Trust amongst all the Relationships

A clear understanding of motives can drive trust relationships in healthcare. During an interview with Dr. Joseph Turyabahika of Kampala Medical Chambers Hospital, I brought up the possibility of opening a clinic in the northern region of Uganda. The very first question Turyabahika asked me was “why?” Turyabahika was incredibly guarded at the initial onset of conversation only to become more relaxed when my motives were made clear. Motivation needs to be clearly communicated by every stakeholder, especially in the realm of healthcare.

When patients perceive healthcare providers as not being able to supply medicine, they begin to question their utility and the reason for their presence within the community. Even in non-medicine dispensing roles, motivation is the key factor in building a trust relationship. The healthcare provider and patient must come to accept each other’s beliefs and attitudes about their

health and not mistake each other's roles. In the context of the community, trust becomes founded on existing familial and social structures because motivation is a collective self-interest rather than fractious competing of self-interests. This becomes important if there are community health worker selection processes as well as initiatives in providing education through community channels.

While it easy to pinpoint internal corruption as the primary source behind Government and NGO's distrust of each other, there must be recognition that motivation serves as the primary engine of corruption. NGO's must answer to the demands and goals of donors and the government employees must weigh their access to capital and power versus their own internal accountability and long-term goals. When values and goals are in alignment, motivation becomes understood across the organization, fostering trust, greater collaboration and participation. When there is tokenism, motivation is no longer unified and suspicion comes to the forefront.

The second important unifying theme is that of identity. Identity management is paramount in building trust. This identity may exist as a national identity which, if celebrated, supports a trusting relationship. Identity, if marred, erodes faith in the system and overall trust. Identity is important when it comes to ideas of stigma and confidentiality. Stigma and betrayed confidentiality lead to suspicion which lead to behaviors that perpetuate suspicious mindsets. Such behaviors then begin to erode identity of both parties of any relationship. Identity manifests itself in both familial relationships as well at the individual level. The personal cognitive factors that maintain mistrust impair the overall identity of the individual but also the greater collective identity. Participation facilitates this formation of a combined collective identity. This new collective identity would either be classified as a positive image or a negative image. If there is greater participation, there is a greater chance for a positive collective identity despite the actual

reality of health. This accounts for the initial challenges of understanding the differences between trust at the level of the patient and provider with the overall healthcare system as first noted in the case of the British National Health System. To translate trust issues from the individual level to the organizational level, there must be an avenue of creating a positive collective identity through participation.

In an era of technology, identity has become even more important to manage than before as people must manage not only their physical identity but also their digital identity. Piotr Cofta writes about the relationship between confidence, trust and identity and modern challenges: namely increased removal, proliferation of identifies and reduced control over trust, automatic authentication and disposable relationships (177). These are ideas that capture when people have in addition to a physical identity but to also having a digital identity. This digital identity is most readily seen by the proliferation of cell phones and point to a future of even greater identity challenges with the ability to form and dispose of identities and even the ability to create multiple digital identities. While many of these elements may not be directly experienced by the poorest of community members, the trends of extending technology and utilizing of technology in healthcare and communication are experiencing greater prevalence and need to also be considered.

Finally, there is inherent value in building trust in the setting of healthcare. Programs that have high amounts of trust also inherently have greater participation and utilization of services as well as general satisfaction. This trust relationship also ensures future cooperation and collaboration to adapt to changing needs. In the realm of communication, communication is geared towards explaining motivation, creating participation and fostering a positive identity.

## 5. Towards building greater trust.

Building trust within healthcare is possible when considering these unifying themes within the different relationships between that of the healthcare provider, community, NGO and government. It is difficult to exactly pinpoint where to begin the whole process of building trust in healthcare, but it is possible to focus on what comprises identity and motivation. Simon Sinek discusses that "trust begins to emerge when we have a sense that another person or organization is driven by things other than their own self-gain" (Ch. 6). The idea of focusing in on a positive identity, real or perceived, with clear communication of motivation is also supported in the literature. Tibandebage and Mackintosh explored the failures and abuse of trust in the setting of healthcare in Tanzania and traced three roots of trust: "community scrutiny, signals of trustworthiness and individual knowledge and networks" (1393). Because of their analysis of the transactional relationship of healthcare, they advocate three strategies: "supporting transactional behavior that unites calculative with other sources of trust via reputation-building; constraining individual profit-seeking through professional and managerial scrutiny and institutional design; and reinforcing value-based sources of trust through public appreciation and information" (1393). These categories reinforce the need to manage the recurring themes of each relationship of identity, motivation and delineation of roles.

### a. Identity Management

The research suggests that managing identity becomes of paramount importance for all stakeholders in the realm of healthcare. Identity is important in both the individual sense and the larger organizational/collective sense. Identity can be based on reality but can also exist in the idealized/perceived realm such as "reputation." The notion of identity management thus means to preserve and uphold things that maintain and build this identity whether it is by self-

perception or the perception by others. This individual and collective identity is important for the formation of trust as in the context of low and middle-income countries, this identity is either fragile or less than perfect. Bryant Myers, building heavily on the idea on Jayakumar Christian's work, discusses the marring of identity of both poor and non-poor. Myers proposes that the non-poor contribute to poverty by playing "god in the lives of other people" (14). A healthcare provider automatically assumes a position of authority and greater resources and thus an identity of "playing god in the lives of other people" would seem to be a natural outcome. The literature and experience reflect a much different reality. Healthcare providers personally suffer from an identity of helplessness and powerlessness. This powerlessness and helplessness comes about from disruptions of their own supply chain as well as the overall health of a community. This powerlessness becomes even more poignant when it comes to engaging in all the necessary relationships to achieve their ends. The identity of playing "god" is an identity that is assumed by others rather than their own identity, especially when it comes to the ability to supply physical medicine. Healthcare providers not only need to assure others of their reputation but must also redefine their roles in providing care as advocates and educators rather than just medicine providers. If their identity is strictly tied to being a supplier of medicine, their reputation and identity suffers during any moment of interrupted medicine supply. This identity is also further complicated in terms of organizational management of staff, where staff needs must be met. In Birungi's study, institutions could not be trusted because nurses were deemed to be careless because of being so poorly paid. While it is impossible to guarantee that all staff are provided for financially, it is possible to improve the identity and perception of the staff by continually engaging in participation.

Organizations must manage their identities and no longer carry the perception that they are limitless supplies of benevolence. These misperceptions cause people to distrust their motivations and purpose for their presence. NGOs may begin a very transparent process of communicating to the community their resources and how they wish to use such resources. While it is easy to ask for the Government to improve its own identity through greater transparency, the multiple layers of bureaucracy and the potential for political conflict is best left up to the discretion of leaders, even if the leaders have no interest in representing the needs of the people. One simple task in terms of identity management is through tangible initiatives that go beyond free immunizations and should include a measured attempt at reporting where medicine is being administered and disease prevalence in each region. This will at least begin to allow the community and organizations to appreciate the understanding and insight to the process of government-run healthcare. While financial accountability and transparency can be challenging, there should at least be transparency in understanding the overall and area-specific state of health of each region.

The community must also consider identity management. Overcoming stigma as a community together is incredibly important, especially if it is a disease such as HIV. Akenna Uma, the center coordinator for ChildVoice International, expressed that community members "need to be morally educated so that they respect those who have the disease so they don't have stigma. People fear a stigma, so they hide." This hiding removes utilization of healthcare services not only on the individual level but also on a collective one. In the Myers/Jayakumar framework of identity, the community could suffer from "marred identity," especially when considering the plight of social, economic, financial resource and physical health deprivation. In the context of healthcare, it is easy to assume that the community is the recipient of healthcare

and not a vital contributor towards health. This is further complicated if people are the victims of trauma and conflict which provides even more barriers towards achieving a complete identity. The poor must pay more for healthcare and this inequitable access to healthcare is further exacerbated by deficiencies in medical supply chains. Stephen Fabricant et al. illustrate the higher cost of healthcare of the poor through the example of Sierra Leone. Fabricant et al., in a survey, found that increased costs were because of: greater medical needs, higher total average payments because of provider choice, high cost treatment episodes, greater efforts to obtain money for treatment, higher risk in obtaining money to pay for treatment, and being influenced by the season (184-91). When combing all the data of the survey, Fabricant et al. conclude that the poor have a difficult decision "between an inferior treatment and an effective but expensive one, with little in between" (191). This burden of healthcare as being inaccessible is perpetuated in this identity that there is little available to engage. The collective identity of posttraumatic scars and deep suspicion foster a mentality of "*we are sick that we need to spend money but otherwise have few options for our health.*" This amounts to an identity that is stuck in distrust and hopelessness. Communities need to engage and rely on existing relationships to forge a greater health identity. Community health workers are a positive step in creating opportunities for communities to shed the identity of unavailable choice and foster holistic development, but they cannot be the byproduct of procedural injustice. Their selection process can be less than perfect and their efficacy will still be limited by the amount of resources they have. Communities need to rally around their existing familial relationships and cultural identity for trust to happen. This identity needs to especially be upheld by all the stakeholders involved in healthcare: healthcare providers, organizations and the government.

Integrating the community's identity and the national identity of health is something that the government needs to embrace. In the case of Birungi's study with injections, there are multiple symbols that enhance or detract from that identity. Birungi suggests that "to restore people's trust in institutional things, they should be personally involved" (1461). This personal involvement will become even more crucial as people are given more access to information about healthcare. Symbols of healthcare need to be managed as they are crucially linked with the overall perception and trust in the system. While it is unfortunate that a cancer radiotherapy machine is in disrepair in Uganda, it demonstrates how fragile symbols of healthcare are. The government must be able to recognize these symbols and restore them immediately as they allow people to maintain confidence in the system and their own doctors. This forges a collective identity that inspires confidence and provides the necessary elements for participation.

### b. Clarifying Motives

Motivation needs to be communicated very clearly. Absence of medicine or oppressive finance schemes obscures a community's understanding of a healthcare provider's motivation. Motivation, identity and reputation are intricately linked but motivation requires a specific set of skills to address. In Birungi's study on injections, motivation was crucial because of the deep suspicion arising from the large distance between the government and the people. Participation is clearly the ideal path towards clarifying motivation. It is impossible to have representatives of every segment of the community participate as a healthcare institution can only hire so many people or engage only a small portion of the community at a time. The participation process also has to be equitable and clearly delineated. Turinawe et al's study on the selection process of community health workers demonstrates that even if there is participation, there can still be deep suspicion if the process is not transparent or readily understood. Participation does not supplant

motivation as a factor of trust. If the purpose and motivation for the process of engaging the community is clear, it is possible to build trust without exhausting all resources for the sake of participation. In the case of the Wentz Medical Center, after significant consistent outreach, the community is willing to serve as a proxy for the medical center as advocates to their own family members because of that trust relationship, even in situations of great distance.

Motivation is closely tied to the financial transaction of healthcare. User fees are a perpetual challenge towards creating sustainable affordable healthcare. Chris James et al. performed a literature review discussing whether user fees could be removed and recognized the significant cost barrier user fees impose on the poor. Their conclusions suggest that removing fees improves access as in the case of Uganda, but requires "budget reforms," preventing replacement with "informal fees" and the need for significant contextualization (James et al. 150). It is not physically possible to offer zero fee healthcare on a perpetual basis as it causes additional stresses on the system due to overutilization and reduced availability of services. This in turn cripples the formation of trust. Exorbitant high user fees also create suspicion of the intent of an institution or healthcare provider, raising suspicion for exploitation, but at the same time, they have the potential benefit for added quality. Thus if people are given the necessary value for the user fees that are collected, then trust is built. If fees are removed, there is the potential to incur other costs to patients also at the risk of loss of trust.

One trend towards balancing the delicate needs of reimbursement and cost is performance based financing (PBF). In the United States, there is growing acceptance of what are known as Accountable Care Organizations (ACOs). The sole purpose of the ACO is to contain costs by providing a fixed reimbursement for diseases as well as tracking outcomes. In a literature review of PBF, Dimitri Renmans et al. evaluate financing schemes in low- and lower middle-income

countries. Renmans et al. found that PBF is well received by healthcare providers for the sake of "motivation, quality and volume of services," (1301). Verification officers are necessary for the execution of performance based financing, but they suffered from trust issues involving "collusion and conflicts of interest" (Remnans et al. 1303). In their overall review of PBF, Remnans et al. found that effects were "mostly evaluated as mixed" (1305) and too often the levels of trust were especially fragile "complicated by a sense of unfairness and perception of nepotism or favouritism" (1306). The genuine value of performance based financing is that it theoretically should clarify motives for any player in the healthcare system as it is too easy for healthcare providers to abuse insurance systems or community members by ordering excessive number of tests for the sake of their own financial gain. Remnans et al's literature review illustrates that PBF alone is insufficient by itself without upholding clarity in motivation in the process of healthcare delivery and financing scheme. All PBF schemes will suffer if people think that treatments or withheld treatments are a means to save money and garner more personal income. In fact, it is even more detrimental considering that patients could perceive the lack of tests and testing as breaking promises to the community.

### c. Participation

Participation is a broad term but is understood as parties who can make value based decisions for themselves. Tokenism is formed when people are given nominal roles to make decisions about themselves. Each individual purpose is not clearly defined and the relationship is deemed useless. Participation from a cross cultural perspective must always be considered in the setting of the different relationships, especially in the setting of an international NGO. Even with the government and communities, there are cross-cultural implications as well, especially in considering local practices of hygiene and health.

Participation is not as easy of a task as it is assumed. There are pressures of the need of tangible results, "rather than addressing deep-rooted inequalities which cannot be easily measured" (Willis 118). Participation requires significant investment in education and training. As with many of the community health based projects, training was vital to creating the necessary skills and sufficient empowerment. This requires continual investment and not just a simple one-off project but long-term education. Participation does not always mean direct involvement of healthcare. As with the case of the Wentz Medical Center, participation could involve empowering community members to be advocate agents throughout existing nodal networks. Community health workers are still only a small component of participation and the entire community must be engaged to allow participation.

Participation may also be considered through the aligning of values between two different entities. As with the relationship between NGO's and government, value alignment builds trust because it clarifies motivation and allows actual participation rather than the easier path of tokenism. Therefore, if the community, healthcare providers, NGO's and the government could all align their values, there is a space for genuine participation. This requires significant organizational skill and extensive communication. The organizational skills necessary are carefully defining roles, a worthwhile endeavor in creating active and sustainable participation.

### d. Supply Chain Management

The steady supply of medicines across all relationships is an important reason for distrust in healthcare. If there are consistent supplies of medicine, there will be trust. People will be willing to travel to great lengths to access healthcare. Supply chain management is an invaluable tool for medicine and could be taught to all levels of healthcare providers. The current literature on supply chain management and healthcare suggests a few established strategies. Kwon, Kim

and Martin note many areas where healthcare in the United States do not fully employ the full benefits of supply chain management compared to other comparable industries. Kwon, Kim and Martin cite that health providers have higher logistic costs compared to other industries, possibly because of overreliance on group purchasing organizations and independent delivery networks (422). By only relying on group purchasing organizations, healthcare providers only receive a small benefit of supply chain management. There are other avenues of inefficiency such as the actual procurement process, warehouse utilization, transport costs as well as other process shortcomings that also need to be evaluated. Kwon, Kim and Martin argue that healthcare organizations should invest in "supplier relationship management, logistics operational tools and process improvement" (427). In the case of Uganda, there are several group purchasing equivalents, with the two largest organizations, the National Medical Store and the Joint Medical Store. Scandals and disruption in access to these stores cripple the system not only in utilization but has lasting effects on identity and trust in the system. There must be more than just reliance on group purchasing organization; there should also be employment of other supply chain techniques, especially when it comes to reducing the cost of distribution.

Paltriccia and Tiacci advocate for the use of radiofrequency identification (RFID) to help track inventory management as it "allows the implementation of continuous review policy, which is known to reduce the uncertainty period with respect to periodic review policies" (1516). While RFID technology is not available to all it is worthwhile to consider the utility in its investment. In the case of a rural health clinic which runs out of medicine regularly by midmonth, RFID and other tracking programs could initiate an early procurement cycle for medicine rather than when supplies run out. If technology such as RFID is not financially attainable, it is possible to institute more traditional ways of inventory tracking. Constantly

monitoring supplies through any means of technology then becomes paramount to ensuring trust in the organization.

Another concept of supply chain management is the idea of strategic outsourcing. Cristina Machado Guimarães and José Crespo de Carvalho suggest ideas of incorporating lean and outsourcing ideas to healthcare supply chain management. Lean is an operations management tool from Toyota focused on reducing inefficiencies and refining processes to create added value. The idea of outsourcing is meant to focus on elements a healthcare organization is particularly skilled at while outsourcing the functions that they are not skilled at or that are deemed redundant. In the instance of two health clinics that are within the same geographical catchment, one clinic could specialize in HIV and another clinic could specialize in food, nutrition and digestive tract functions. Per Guimarães and de Carvalho "healthcare organizations with longer experience in outsourcing take more benefits from it, not only for expanding activities beyond to the core and clinical activities, but also to experience a more cooperative environment with their suppliers" (155). Outsourcing in the context of resource poor communities seems counter intuitive, but it something to be considered in areas where there are more redundancies in a tighter geographical area. Unsurprisingly, Guimarães and de Carvalho conclude how "trust plays a main role and not all organisations, for cultural reasons, are able to play it quite in the 'Toyota way'" (155).

These are only a few supply chain management techniques suggested and may be challenging to implement without considerable capital investment, but it is a worthy consideration given the cost savings and the ability to ensure stable supplies of necessary medicine. In an ideal world, there will be multiple avenues of drug suppliers and delivery systems with sufficient incentive to drive the price and improve the whole process, however

some initiative needs to be taken by all actors. Even community members practice these techniques by utilizing their own supplies of medicine and needles as shown in the literature. All the other actors must improve their process so that this scenario should be reserved as a last resort.

### e. The Trust Cycle

With the four elements of identity, motivation, participation and supply chain management, a new model of trust in a healthcare system emerges in the form of a cycle. This cycle is delineated by a perpetual chain of identity, motivation, participation, supply chain management and trust.

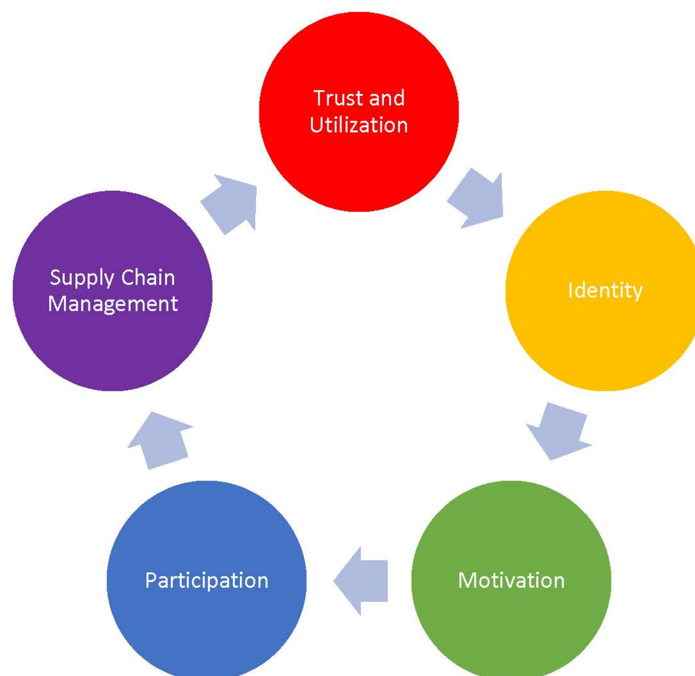


*Figure 1 The Proposed Cycle of Trust in Healthcare*

Forging a new identity is a daunting task but is one of the first and final outcomes of the cycle of trust. Building upon this identity, motivation must be made known and fully clarified. Motivation enables a community with their identity of empowerment to begin to participate and

desire greater change in their own lives. This participation needs to be coupled with appropriate supply chain management. If people want to utilize a service but there is no availability, the cycle is broken and this chain must start all over again. Once supplies are steadily ensured, a genuine trust relationship is formed with utilization. Presumably, when a nation engages more frequently with its healthcare, an even greater health identity emerges, triggering a new iteration of the cycle. Any element that disrupts a portion of the cycle prevents additional steps from forming. It is also entirely possible to engage the community to become excited and motivated about their own health, but without supplies trust is broken and results are returned to square one.

The relationship between motivation and participation in the African Great Lakes region has been studied by Mulema and Mazur. While their research was focused on agricultural work and encouraging farmers to participate in innovation platforms, participation is based on the expectation of material, economic, development, social, and purposive benefits i.e. the primary motivation. According Mulema and Mazur, "active and sustainable participation is achieved with actual realization of short-term benefits" (225). This demonstrates that motivation and participation cannot act alone. In healthcare, these benefits would comprise of the actual engagement of the healthcare provider which can only happen with adequate supplies and provision of care by healthcare providers.

One of the more challenging arguments to this cycle is the relationship of participation and supply chain management. I argue that participation ensures that the agents who are delivering, transporting goods, purchasing and knowing what goods are available are crucial in the supply chain. Participation in these matters ensures supply chain management has a strong foundation, without which, supply chain management becomes more of a guessing game rather than reliant on real time data.

This cycle also suggest that it is entirely plausible to enter the cycle at any point. Even if an agent is not trustworthy, by having ample readily available supplies, an agent can create trust through continuing along the cycle of identity, motivation and participation. It is also possible to bolster any deficiencies in the cycle by overloading earlier segments to help push the process forward, similar to the concept of inertia. In the setting of western Africa and Ebola, the "shock" of Ebola and accepted cultural practices was overcome by ample external relief aid and extensive aid in participation which helped push past the broken identity and distrust into a cycle that made motivation and participation very clear. This cycle illustrates that all health initiatives and businesses must consider these individual elements and be willing to invest into each segment.

What is absent from this cycle is understanding how to create financial sustainability within the whole cycle. This is an avenue for further research. One proposal is to consider how to have each investment within each element balanced by financial returns. Investment in a health identity should be able to yield greater user fees through increased ability to pay or a risk-pooling funding initiative. Money spent on marketing or clarifying motivation could lead to a greater referral service and reduced costs from collaboration. Investing into participation could yield a return in the form of reduced costs of labor as there would be a greater volunteer force. Greater investment into supply chain management could theoretically lower costs, reduce overhead and lead to long-term discounts. Increased trust and utilization builds value and yields a return on investment through sufficient fees. While not each element will be revenue neutral, it is entirely plausible that the collective system could be. This will be the next avenue of research as too often financial sustainability is understood by pooling risk, reducing utilization and improving health outcomes as with the case of performance based financing. In situations of reliance upon external sources of revenue, this trust cycle and potential cost savings could be communicated to

investors and donors especially in regards to why each element is invaluable and inseparable from each other.

## 6. Conclusion

Healthcare is built on relationships and trust. The goal of all healthcare capacity building initiatives should be focused on these five elements of identity, motivation, participation, supply and trust. These elements serve to reinforce each other in a cycle that can be repeated and improved with each iteration. While these terms are broad, they are composed of many different elements of individual and collective identity restoration, clarifying and creating genuine motives for all actors, aligning values and organizational participation, and multiple supply management techniques. Each element requires fundamental skills of communication and recognition of the negative effects of lack of transparency and stigma. This also stresses the importance of greater research and investment in the realm of supply chain management of medicine and medical supplies. This crucial element if ignored could cripple the whole process. The hope is that careful recognition of every one of these elements will yield sustainable and meaningful healthcare for all.

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