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Review Article

Evidence of Reciprocity in Reports on International Partnerships

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The increase in global health opportunities in medical education has been accompanied by calls for ethical and reciprocal institutional partnerships. The Working Group on Ethics Guidelines in Global Health Training (WEIGHT) guidelines were developed in 2010 and are widely accepted by the global health community. We reviewed 43 articles on international partnerships from 1970 to 2010 for eight principles of reciprocity derived from the WEIGHT guidelines. The results showed that, while few articles reflected all principles, there was a trend to increasing consideration of the international partner's local needs, pre-departure cultural training, and collaborative authorship. However, learner supervision and consideration of local cost/benefit ratios decreased over the same time period. Partnerships with only one international partner or with institutional partners in Africa had lower reciprocity scores than those with two or more partners and institutional partners in Asia and South America. We recommend that a new focus on ethics in global health partnerships leads to the inclusion of the principles of reciprocity in model program descriptions in order to enable and encourage ethical, sustainable, and mutually beneficial institutional partnerships.

1. Introduction

Historically, medical missions embody medicine's core values of altruism and social responsibility [1]. Physicians responding to the inequities in access to health care across the world volunteer their services to help those in need. However, clinical service in international settings has been tainted by ethical questions. Do learners volunteer because they are seeking an adventure, that is, "voluntourism"? Are research activities in resource-limited settings taking advantage of vulnerable populations? Due to these concerns, there have been many calls for local institution ownership, sustainability, development of national research capacity [2–5], and the establishment of ethical guidelines for global health experiences [6–9]. In parallel with the development of these guidelines, the opportunity for first-hand experiences in global health has become increasingly available to health professionals at all levels of training.

Nearly all US medical schools have allowed third or fourth year medical students to study overseas [10]. In 2010, 30% of graduating American medical students participated in a global health experience compared with 6% in 1984 [11, 12]. Global health programs have been developed at all levels of medical training and across multiple disciplines. A focus on global medicine can amplify the impact of North American academic research, education, and clinical care missions and prepare academic health science systems for the challenges of a rapidly changing world [13].

In 2010, the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) group published a set of guidelines to address the multiple stakeholders involved in global health training. These guidelines are meant to address global health experiences of varying duration and levels of formality, trainees of multiple levels and disciplines, uni- and bidirectional exchanges, and the clinical, public health, research, and educational activities that take place under the umbrella of global health [14]. The WEIGHT guidelines for global health training programs represent an important effort to codify ethics and best practices for sending and host institutions, program participants, and sponsors.

Even with these published guidelines, there is a great deal of variability in published reports on global health programs. Specifically, many authors may not discuss their global health program's adherence to ethical guidelines for reciprocity in international partnerships. The failure to adequately describe this essential element of sustainable partnerships may lead to new programs being established in good faith, but without measures to ensure sustainability through an ethical and reciprocal partnership. In order to describe the extent of this problem, we undertook a review of global health program descriptions in published literature to determine the degree to which programs describe their adherence to ethical principles outlined in the WEIGHT guidelines, particularly those principles that demonstrate reciprocity in international partnerships.

2. Method

We defined "reciprocity" in this context as actions that show mutual respect and seek mutual benefit between the institutional partners. Using the WEIGHT group guidelines, we selected eight ethical principles that demonstrate reciprocity in partnerships. A systematic literature search of indexed, English-language journals using Ovid Medline (National Library of Medicine (NLM), 1966–2010), World of Science, ERIC, Google, and LISTA electronic databases was performed using major Medical Subject Headings (MeSHs) and text words:

Students, Medical (exploded)
OR
Education, Medical (exploded)
OR
Internship and Residency (exploded)
AND
International Cooperation (exploded) includes....
Developed Countries
Developing Countries
International Educational Exchange
Medical Missions, Official
AND
Partner$ OR collabora$ [searched as keywords, truncated].

The search yielded 3,980 citations. Of these, 390 citations were identified based on titles and abstracts as appearing relevant. Additional articles were gathered through individual journal searches and by evaluating selected references cited in articles. Only articles describing institutional programs with short-term (less than 1 year in duration) international exchanges were selected. Opinion pieces, non-English language reports, and anecdotal reports were excluded. Forty-three articles were found to contain descriptions of international partnerships and were selected for review. Full text versions of selected articles were examined independently by two authors (R. A. Umoren and J. E. James) for evidence of adherence to eight principles of reciprocity included in the ethical guidelines for international partnerships proposed by the WEIGHT group. The input of a third author (DL) was sought where there was disagreement. The articles were assessed for the following eight principles of reciprocity derived from the WEIGHT group guidelines:

(1) existence of a memorandum of understanding between institutions,

(2) consideration for local needs and priorities in program activities,

(3) learner activities and supervision correspond to level of training,

(4) costs and benefits to host considered or assessed,

(5) predeparture training for learners on sociocultural, political and historical aspects of host community and research ethics (if applicable),

(6) met host and sending country requirements on licensing standards, visa policies, privacy and security of patient information, and so forth,

(7) obtained local ethics committee approval for research activities (if applicable), and

(8) inclusion or acknowledgement of host input in authorship of publications.

3. Results

The articles selected described institutional programs in undergraduate and graduate medical education. There were 34 Resource-rich or North partners from North America [10, 14–43], 2 from Europe [44–46], 3 from Asia [17, 47, 48], 1 from Australia [49], and 2 from the Middle East [34]. Resource-limited or South partners included 14 from South America [15, 18–20, 23, 28, 30, 32, 36, 41–45, 50, 51], 4 from Europe [35, 36, 48, 52], 12 from Asia [10, 17, 20, 22, 23, 31, 34, 36, 44, 45, 50, 51, 53, 54], 21 from Africa [10, 14, 15, 19, 20, 22–27, 29, 31, 34, 36–40, 44, 46, 51, 55], and 2 from the Middle East [24, 44]. Some North institutions described partnerships that included up to 8 South partners. Nearly all disciplines were represented. The majority of learners in global health programs are involved in clinical service activities with approximately one-half of learners conducting some form of research or educational activity while at the global health site. About one-quarter of the programs included training for learners in the host institutions either directly or indirectly. These training programs generally had a research focus with host faculty development programs in research methods (see Table 1).

Each article was examined closely for statements that indicated that the program design and operation met the selected principles for reciprocity in international partnerships. The results are shown in Table 2.

Most of the program descriptions were published in the last 5 years reflecting the growing interest in global health programs and partnerships. We identified decreasing trends across time in reports on learner supervision and local cost/benefit ratio consideration. There was a peak in descriptions of predeparture cultural training in the early 2000s with a decrease in the later part of the decade. On the other hand, programs were more likely to identify local needs and more

Table 1: Targeted learners and type of activities in host country.

Targeted learners	
Sending institution medical students	18 (42%)
Sending institution residents	23 (53%)
Host institution medical students	3 (7%)
Host institution residents/fellows	8 (19%)
Learner activities in host country	
Clinical service	33 (77%)
Research	21 (49%)
Education	20 (47%)

Table 2: Principles of Reciprocity in Published Descriptions of Global Health Programs.

Principles of reciprocity assessed in 43 published reports on global health programs	Number of reports (%)
(1) Memorandum of understanding (MOU)	5 (1.2)
(2) Met host and sending country requirements on licensing standards, visa policies, and privacy and security of patient information	2 (4.7)
(3) Learner activities and supervision correspond to level of training	27 (63.8)
(4) Predeparture training for learners on sociocultural, political, and historical aspects of host community and research ethics (if applicable)	13 (27.9)
(5) Consideration for local needs and priorities in program activities	22 (51.1)
(6) Costs and benefits to the host considered or assessed	11 (25.6)
(7) Obtained local ethics review committee approval (if trainee conducting research) ($N = 13$)	2 (15.4)
(8) Collaborative authorship (inclusion or acknowledgement of host faculty input in authorship of publications)	9 (20.9)

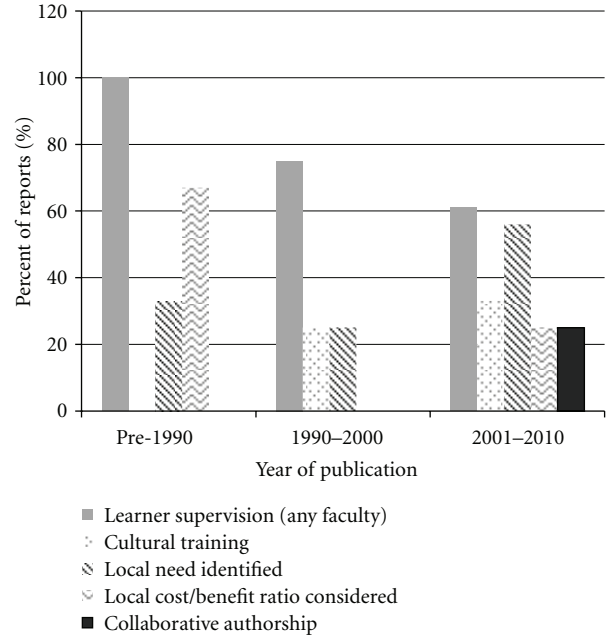

Figure 1: Principles of reciprocity in published reports on global health partnerships from 1970 to 2010.

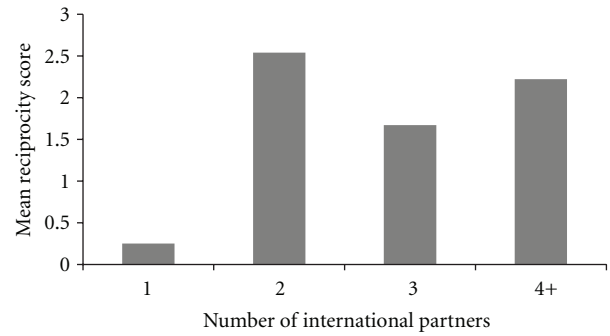

Figure 2: Average reciprocity score in relation to number of international partners.

likely to have collaborative authorship in the more recently published reports (see Figure 1).

We assigned one point to each principle of reciprocity and calculated the average reciprocity score for each program. Scores were lowest for institutions with a single partner (see Figure 2) and higher in programs with more than one international partner.

Scores differed with the location of the host institution. Resource-rich programs with host institutions in South America were more likely to have a higher average reciprocity score of 2.65 (out of a possible 8 points), compared with programs with institutional partners in Africa or Asia (see Figure 3).

4. Discussion

A first sign of commitment to the partnership is an agreement on collective goals often incorporated into a memorandum of understanding. Poorly defined program goals and the absence of a memorandum of understanding can lead to short-term partnerships that do not address or meet the needs of the host partner. Although many reports included program objectives from the perspective of the sending institution, there were few references to a memorandum of understanding between institutional partners.

Few reports identified or stated that their partnerships met host country requirements for licensing and clinical practice although licensing and visa issues are often the reason for excluding international physicians from medical exchange visits to the sending institution. This exclusion occurs despite the fact that many South partners have a need for programs that focus on faculty development and continuing education. Faculty exchanges, with an emphasis on educational programs for early career faculty from both institutions, should be encouraged as part of a reciprocal partnership.

Trainees have the potential to do more harm than good in unfamiliar settings when they exceed their actual capabilities. Overall, 64% of programs reported learner supervision.

Figure 3: Average reciprocity score differs by location of south partner of the north institution.

However, during the period from 1970 to 2011, there was a gradual decrease in stated learner supervision by either local or sending institution faculty. This trend was more pronounced in programs describing multiple partner sites. This is likely due to the difficulty in establishing a schedule for on-site faculty at multiple sites, and the overwhelming increase in learners outstripping faculty resources to monitor and mentor trainees. Although local faculty supervision may well be appropriate for the varied level of learners, levels of autonomy for practice differ among international sites and medical training institutions' accrediting bodies. Sending institution learners should receive a higher level of supervision for clinical activities in an international location where disease processes and patterns may be unfamiliar. This is particularly true with the decreased time devoted to tropical medicine in the North American curriculum over recent decades. Moreover, host institution faculty may be unable to give specific feedback because they are not familiar with the desired educational goals of the sending institution's programs [55].

Training programs must prepare learners with the knowledge and framework to approach these experiences in a principled and professional way through formal preparation for both clinical and ethical challenges of working in resource-poor settings [3, 56]. Although the number of programs reporting predeparture cultural training increased over the period under study, only 27% of programs reported predeparture cultural training. This is consistent with previous reports that fewer than 30% of learners participate in programs to prepare them for their international experience [57]. Learners that understand local customs, beliefs, and practices prior to working in such settings will be more likely to contribute and learn than those whose attitude is that their clinical skills and knowledge are already superior to those of local care providers.

On a positive note, identification of local needs and priorities is on the rise. For example, more North partners are ensuring that their proposed projects involve research or program development that is relevant to the health issues of underserved populations, fulfill a need that is agreed on by the host organization such as faculty development [15], or are based on local community needs assessments [30, 32]. This is consistent with the current focus on host community and institutional needs. Although there is a clear need for assessment of the local cost/benefit ratio of the partnership's activities, this has not been a focus of recent program evaluations.

Although the higher reciprocity scores of programs with more than one partner institution likely reflects an institutional commitment to international activities that is broad based, it is interesting to note that programs with partners in South America and Asia tend to have a higher scores on reciprocity than those in Africa. As the number of North-South institutional collaborations with African institutional partners is growing exponentially, this should provoke further examination of the approaches to partnerships on the African continent.

Our study had some limitations. We only assessed the published descriptions of programs and acknowledge that material on the program websites and specific requests from program directors might have provided more detailed descriptions of program activities. However, the purpose of this study was to determine how programs are presented in published literature because this is the first source of information to the public and to other programs interested in setting up similar partnerships. Therefore, evaluating published program descriptions on key principles of reciprocity remained the focus of the review. Secondly, the WEIGHT group guidelines were proposed for short-term exchange programs locally and internationally. They were not intended to address issues surrounding long-term (>1 year) global health service or by experts providing technical assistance [58].

The WEIGHT guidelines were, by the WEIGHT's own account, created with limited evidence to inform the development process, and a significant obstacle to generating such supporting evidence is the difficulty in measuring the performance of training programs [58]. However, they have gained wide acceptance from the global health community and are consistent with guidelines from other groups such as the American Academy of Pediatrics (AAP) Consensus guidelines for International Child Health (ICH) Electives and The Federation of Pediatric Organizations (FOPO) Global Health Working Group. The AAP consensus guidelines for ICH electives mandate cross-cultural awareness training and faculty preceptorship in the host country, and FOPO has called for residency programs to respect the rights, autonomy, and confidentiality of patients and families in clinical care, research, and operational programs [59].

We therefore propose that programs be encouraged to describe their partnerships using key ethical elements of reciprocity and that a set of standards be applied to articles on global health programs that are being considered for publication.

(1) Stated program goals of both partners or existence of a memorandum of understanding between partner institutions.

(2) Statement of local needs and priorities that guide program activities.

(3) Assurance that trainee activities correspond to level of training and indication of supervision.

(4) Consideration of costs and benefits to the host.

(5) Training in appropriate language skills relevant to the host's locale as well as sociocultural, political, and historical aspects of host community.

(6) Adherence to host country licensing standards, visa policies, research ethics review, training on privacy and security of patient information.

(7) Ethics committee approval for research and appropriate training in international research ethics.

(8) Adherence to international standards for authorship of publications with input for host faculty and if possible collaborative authorship.

As proposed by the WEIGHT group, it is anticipated that these principles will fulfill the requirement that partnerships must be ethical. Further evaluation of the degree to which these principles predict the productivity and durability of partnerships is needed.

5. Conclusion

Authors are constrained to describe the most important components of their programs within the limited space allotted to published reports. This has forced emphasis on program curricula and evaluation over the elements that lead to ethical and sustainable partnerships. Although some recently published articles show evidence of reciprocity with a trend to increasing identification of local needs and collaborative authorship, many do not. Of additional concern are the lower reciprocity scores of partnerships formed between North and South institutions in Africa compared to Asia and S. America. Young partnerships must be established not only with good intentions, but also on ethical principles. We recommend that the eight key principles of reciprocity described in this paper be used as a minimum set of standards for published program descriptions to encourage institutions entering new global health partnerships to take a more ethical and sustainable approach to partnering.

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