Role of social cultural factors in health partnerships: *The case of a health collaborative exchange between Malawi and Norway in trauma care and emergency medicine.*

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Abstract

Health partnerships are increasingly becoming a global phenomenon in many areas of care. One such an area is in the trauma care and emergency medicine. There are high risks of trauma and emergency care related permanent injuries, disabilities, and death mostly in Sub Saharan Africa including Malawi while the isolated cases are on the rise in the Global North countries including Norway. A call for diverse and competent health professionals is at the center of global action on trauma and emergency medicine capacity development. Partnerships in global health and development are widely recommended as a vehicle to achieve health equity if universally implemented. Drawing from this background, the Norwegian Agency for Exchange Corporation (NOREC) leads a collaborative exchange of health professionals between Haukeland Hospital (HUH) and Malawi's Kamuzu Central Hospital (KCH). This is one of many partnerships currently existing between Norway and Malawi in their quest to compliment global efforts on partnerships for health and sustainable development.

Social and cultural differences and competences within health partnerships affect partnership processes in achieving positive outcomes. As such, the study aimed at exploring the social and cultural experiences of healthcare professionals in the NOREC exchange partnership between Malawi and Norway, particularly investigating on how these experiences affected the exchange program and shaped participants cultural competences.

The Cultural Competence Model in health partnerships and the Bergen Model for Collaborative Functioning (BMCF), were used as analytical frameworks for the study. A qualitative case study design was used with semi-structured online interviews and policy documents used as methods for data collection. A total of 12 interviews were conducted.

Findings show that the participants were motivated to participate in the partnership because of their early involvement in the planning phase of the partnership, and that the partnership had clear goals. Additionally benefits for participating were also reported as motivating factors both at individual and institutional levels. It was also found that the partnership was well resourced, and this encouraged participation and helped the partnership to make significant progress towards its goals. Health professionals also reported varied social and cultural experiences, and these were encountered around issues do with communication, leadership, interactions with patients, role of families in patient care, and with co-workers in host institutions and contexts. Cultural competence

was built by experiencing the differences in the partnership environment and more specific socio-cultural interpretations and differences in the culture of work. Individual participants expressed concern over their need to feel safe and connected within the partnership setting and the conditions that come with it.

Social and cultural experiences of participants impacted on the partnership outcomes although not foreseen in the primary goal of the collaboration between Malawi and Norway. Cultural competence is both an input and an output of partnership functioning. Themes around belongingness, safety, connection and the required cultural competence in health partnerships were raised and present an opportunity to further our understanding of partnerships in development practice, health promotion and also in further development of research work in this area.

Key words and phrases*:* *Partnerships, cultural competence, health promotion, equity, social justice, trauma care, emergency medicine, synergy and antagony.*

List of Abbreviations and Acronyms

BMCF-Bergen Model for Collaborative Functioning

KCH- Kamuzu Central Hospital

HUH- Haukeland University Hospital

NOREC- Norwegian Agency for Exchange Cooperation

NSD-Norwegian Centre for Research Data (Norsk senter for forskningsdata)

SDGs- Sustainable Development Goals

USA- United States of America

UHC -Universal Health Coverage

WHO- World Health Organization

Chapter 1

Introduction and Background

1.1 Study background

This study seeks to explore the social and cultural experiences of trauma and emergency care professionals on an exchange partnership between Kamuzu Central Hospital (KCH) of Malawi and Haukeland University Hospital (HUH) in Norway. Lack of trauma care and emergency medicine is a major public health concern worldwide which result in substantial loss to individuals, families, and society (Whitaker, 2021; WHO, 2019). According to WHO (2019) the unavailability of proper trauma care and emergency medicine results in health conditions that account for more than half of deaths in low- and middle-income countries including Malawi. In sub-Saharan Africa, trauma is a leading cause of mortality in people less than 45 years (Purcell, Mulima, Reiss, Gallaher, & Charles, 2020). Due to unavailability and inaccessibility of emergency medicine and trauma care, post-traumatic stress disorder, and disabilities become a major public health burden (Kohler et al., 2017). It is estimated that 45% of deaths and 35% of disabilities related to injury (Kironji et al., 2018) can be addressed by developing comprehensive trauma and emergency care systems which unfortunately remain out of reach for many people, especially in low-and middle-countries (Agarwal-Harding et al., 2019).

Of importance to highlight is that lack of competent health personnel which presents an even larger barrier to comprehensive quality health care and mortality reduction (Gerein, Green, & Pearson, 2006; Kruk et al., 2018). In most instances health professionals are overwhelmed by the limited infrastructure and resources to provide care (Echoka et al., 2014; Wesson et al., 2015; Wilson et al., 2013). These conditions negatively influence patients' motivation to seek and access health care. Having an adequately trained health workforce with the competence to confront these complex factors becomes a priority. In this regard, North–South partnerships have been identified as one of the vehicles for this and are widely promoted to achieve effective partnerships in both clinical skills and in the general understanding of diverse social cultural health situations (Basu, Pronovost, Molello, Syed, & Wu, 2017; Corbin, 2013; Kironji et al., 2018). Partnerships therefore presents an opportunity for innovation that is essential for global action to the complex challenges presented by trauma and emergency care (Basu et al., 2017). The need to have a deeper

understanding of factors that affect people's health beyond the biomedical explanations therefore is of interest to my study (Green, 2015).

Before I go into details introducing the objectives of my study, I will first situate the study in terms of the Sustainable Development Goals (SDGs) and the partnership agenda. I will also further focus specifically on contextualizing the partnership issues discussed in this thesis relating to the Malawi and Norway partnership.

1.2 SDGs and partnerships for health

The World Health Organization (WHO), guided by the Agenda for Sustainable Development puts priority for a well-designed strategy to achieve Universal Health Coverage (UHC) and ensure access to quality essential health services including trauma and emergency medicine (WHO, 2016, 2019). Strategies and approaches have constantly been updated and suggested in the past. The Ottawa Charter on health promotion is one such previous document which provides a blueprint for health promotion, calling for coordinated international action by all countries in setting up strategies and programmes for health promotion (WHO, 1986). Building from the previous global commitments, the Sustainable Development Goals therefore calls for the strengthening of the means of implementing all the SDGs targets by revitalizing the global partnership agenda. The WHO's 72nd World Health Assembly Agenda on emergency and trauma care further reinforces the SDGs by also highlighting the need for member states to take steps forward in strengthening their emergency care systems regardless of availability of resources. In 2018, WHO launched the Global Emergency and Trauma Care Initiative to facilitate collaborative efforts with the objectives to expanding technical support to member states on trauma and emergency medicine[1]. Partnerships (SDG17) in the governance and implementation of health goals (SDG3) are found to be of importance (Morton, Pencheon, & Squires, 2017; Paulo M. Buss & Kira Fortune, 2016) and widely adopted as a mechanism for strengthening health systems and achieving the Sustainable Development Goals (Herrick, 2017; Jones & Barry, 2011b; Katisi & Daniel, 2018; Paulo M. Buss & Kira Fortune, 2016). Malawi and Norway thus, complement the current and previous efforts by institutions and governments in addressing global health inequities through partnerships.

[1] https://www.who.int/news/item/08-12-2018-global-emergency-and-trauma-care-initiative

1.3 Contextualizing Malawi-Norway partnership in emergency medicine and traumatology

Malawi is a low-income country in Southeastern Africa of approximately 19 million people, 83% of whom live in rural areas (Agarwal-Harding et al., 2019). These population demographics spill over to health systems which do not have a carrying capacity compared to the population density. Malawi thus is severely affected by emergency care trauma management burden due to poor infrastructure against a high population (Mulima, Purcell, Maine, Bjornstad, & Charles, 2021). Social and economic limitations also mean that the majority are unable to pay for medical care (Namangale & Chiumia, 2021). Malawi further faces industrial safety and transport systems challenges leading to fatalities such as road traffic accidents and occupational injuries which further put pressure on the trauma care and emergency management capacity (Ciccone et al., 2020). In 2020, the Malawian Road Traffic and Safety Services reported 10 799 road accidents, making it the country in the African region with the highest road traffic death and disability rates. The health system has an average 0.02 doctors and 0.28 nurses per 1,000 population, far below the WHO's critical level of 2.5 health workers per 1,000 needed to provide adequate care to a population (Eckerle et al., 2017). The overall health system in Malawi is overburdened, underfunded, and understaffed (Banza et al., 2018; Maine et al., 2020).

On the other hand, the current population of Norway is estimated at around 5,4 million people[2] with growing rate of aging population (Rand et al., 2019). Norway has for the past 5 years recorded stable cases of trauma while there continue to be an incremental rise of extreme cases of trauma more for men, children and the elderly (Ohm, Holvik, Madsen, Alver, & Lund, 2020). Overall, Norwegians enjoy long and healthy lives, with substantial improvement made due to effective and high-quality public funded medical care system with modern technology and clinical expertise (Sperre Saunes, Karanikolos, Sagan, & Organization, 2020). However, Norway is also facing incremental rise to trauma and emergency cases while at the same time population is increasingly becoming multicultural and growing (Mbanya, Terragni, Gele, Diaz, & Kumar, 2019) demanding health professionals with diverse backgrounds and skills to cater for all these diverse groups of society. Ongoing reforms have therefore focused on aligning provision of care to changing population health needs, including adaptive medical education (Holter & Wisborg, 2019).

[2] https://www.worldometers.info/world-population/norway-population/

1.1.1 Kamuzu Central Hospital (KCH) and Haukeland University Hospital (HUH)

Haukeland University Hospital (HUH) is the teaching hospital for the University of Bergen, and regional hospital for Western Norway, providing services to a population of approximately 1.2 million people. The hospital has a capacity of 1 400 beds, and approximately 12 000 staff members. KCH is the second largest hospital in Malawi and is the local hospital for Lilongwe as well as a tertiary referral hospital for a population of 5.5 million in the Central Region and the Southern part of the Northern Region of Malawi.

In strengthening health professionals' competences and sharing of skills between HUH and KCH, Norwegian Agency for Exchange Cooperation (NOREC) runs a professionals collaborative exchange in emergency health care and trauma, with focus on physiotherapy, radiology, and emergency care. The project is funded by the Norwegian Ministry of Development to address the global challenge of lack of qualified health personnel[3] and inequity in health and health outcomes (Greive-Price, Mistry, & Baird, 2020). The project was also designed to help achieve goals of the Norwegian development policy in implementing the SDGs. The specific goals of the project are to strengthen the competence for Norwegian health personnel through volume training and hands-on experience in trauma care for HUH health professionals, while for Malawi, the partnership aims to strengthen emergency medicine care at KCH through education and training of Malawian health personnel in the fields of radiology and physiotherapy.[4]

1.4 Problem Statement

Despite the exchange of clinical expertise and sharing of knowledge as the primary goal, the impact of social cultural settings is less emphasized in the primary goals of the partnership. Although it does not substitute clinical competence of the exchange participants, cultural competence, as alluded by Helman (2007, p. 15), "*is an important supplementary skill that should be acquired by all health professionals, in whichever context they work."* The field of health promotion acknowledges the existing gap and the need for reorienting health sector services beyond its responsibility for providing clinical and curative services (Green, 2015; WHO, 1986). The argument is that health services need to embrace an expanded mandate which is sensitive and respects cultural needs (Henderson, Horne, Hills, & Kendall, 2018; King, Shaw, Orchard, & Miller,

[3] https://www.norec.no/en/projects/health/
[4] https://www.norec.no/prosjekt/strengthening-doctors-and-nurses-in-the-face-of-trauma/

2010; WHO, 1986) and the responsibility should be shared among individuals, community groups, health professionals, health service institutions and governments. In practice, a fundamental assumption is that shared responsibility through partnerships can and should enhance efficiency and impact (WHO, 2018) and build synergy however, the understanding of contextual differences associated with culture, tradition, values, and social politics is a critical component that has been underemphasized globally both at a policy and practice level (Katisi & Daniel, 2018). The World Health Organization's 2019 report on emergency and trauma care focuses more on the clinical infrastructure and resources, however, overlooking the social cultural factors associated with the efforts to achieve Universal Health Coverage (WHO, 2019). As it is important for development programs to consider the socio-cultural contextual features of settings in the agenda of reorienting health care services (Mugisha, 2021; WHO, 1986). With this in mind and as background, this research therefore intends to achieve the following objectives:

1.5 Research Objectives

Overall Objective

- To explore the social and cultural experiences of healthcare professionals in the NOREC exchange partnership between Malawi and Norway investigating on how these experiences contributed to the partnership.

Sub objectives

- To explore motivational factors for participation in the partnership at individual health professional and institutional level for both HUH of Norway and KCH of Malawi.
- To explore how participants in the health exchange partnership experience social and cultural differences in settings between Malawi and Norway.
- To explore the socio-cultural encounters of health professionals with patients in a different social and cultural context in Malawi and Norway.
- To explore the encounters of health professionals with coworkers and management from a different social cultural context.

Chapter 2

Theoretical and Conceptual framework

2.1 Introduction

This chapter will present the theories used in this study. The Bergen Model for Collaborative Functioning (BMCF) forms the primary base for illuminating on the partners' motivation and mission to participate. In examining how socio-cultural awareness within context contributed to the partnership, I used the Campinha-Bacote's model of *cultural competence*. I intended to have a deeper exploration of how participants' encounter with socio-cultural differences in settings could have affected partnership within different sociocultural partnership context.

2.2 The Bergen Model for Collaborative Functioning

The BMCF is widely used both as a partnerships evaluation toolkit (Corbin, Mittelmark, & Lie, 2016) and an implementing guide for partnerships (Corbin, Fisher, & Bull, 2012; Haugstad, 2011). The model is premised on the realization that partnerships are an integral element in health promotion and the conditions, nature, and context of their implementation influence outcomes (Corbin, Jones, & Barry, 2018). An analysis of collaborative partnerships is important because it facilitates the understanding of health promotion partnerships by focusing on the processes of partnership and it acknowledges both negative and positive interactions (Corbin et al., 2018). The model depicts the inputs, throughputs and outputs of collaborative functioning as recurrent and interactive processes within settings (Matenga, Zulu, Corbin, & Mweemba, 2019). The key aspects of the BMCF are explained below:

Inputs

The *inputs* to a partnership include the mission, partner resources and financial resources (Matenga et al., 2019). Mission refers to the agreed-upon approach of the partnership to address a specific problem, issue or situation (Corbin, 2013). Partner resources entails the partners themselves skills, knowledge, power, commitment, connections, relationships and other attributes that human resources contribute to the partnership (Corbin, 2013; Corbin & Mittelmark, 2008). Financial resources encompass all material and monetary components within a partnership. The partnership can be motivated by the existing problem or issue at hand resultantly influencing the mission or goals of the partnership (Errecaborde et al., 2019). Likewise, Financial and material resources

available can also motivate the existence of a mission (Matenga et al., 2019). It is also a possibility that the financial resources motivate partners to join the mission.

Throughput

Throughput involves the interactive process through which inputs are distributed and utilized to achieve the mission and goals of the partnership. Encompassed within 'Throughput' includes production tasks (partnership-goals-oriented tasks and activities) and maintenance tasks (administrative tasks, plans and arrangements); and occur within the collaborative context (Corbin, 2013; Corbin & Mittelmark, 2008). Production tasks are tasks that lead directly to the outputs (Corwin, 2009) while maintenance tasks keeps the partnership going. Context is where inputs positively and negatively interact as they work on the maintenance and production of the partnership.

Input interaction within the partnership context according to Corbin, Mittelmark, and Lie (2011), is normally shaped by a combination of factors among them; *leadership* model and constitution, *communication,* structure and roles, distribution, interpretation and influence of *power*, levels of *trust* within partnership settings and the inputs themselves as they engage in work. Either the presence or lack of these collaborative processes therefore influence the negative (antagony) or positive (synergy) interactions of production and maintenance tasks (Corbin et al., 2018).

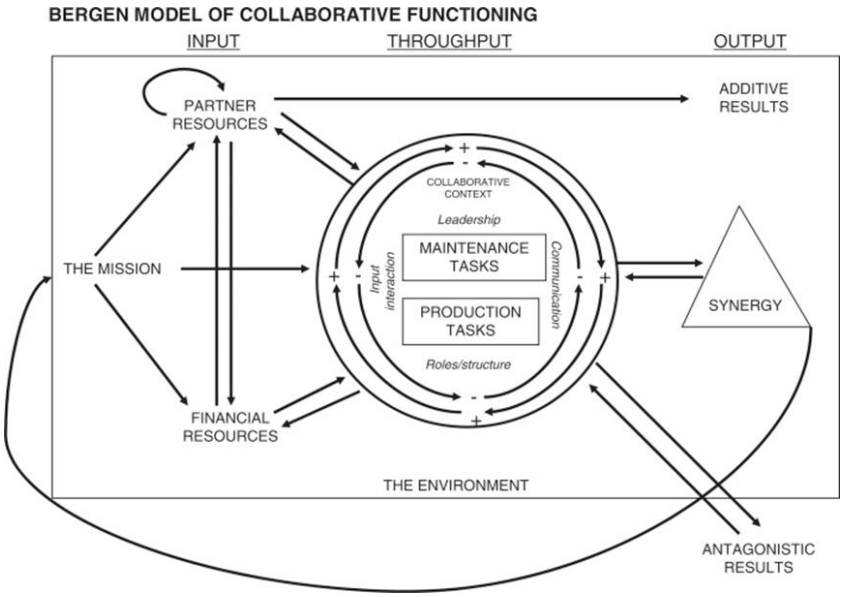
Environmental factors, as stressed within the BMCF influence the partnership context. These environmental factors encompass socio economic, cultural, and political realities of the settings within which the collaboration is situated. These factors include people's social norms, traditions culture, events, processes, actions, expectations or demands, policies and laws outside the collaboration, that have the potential to influence the partnership. Such environmental factors could conceivably facilitate and/or hinder plans (Corbin & Mittelmark, 2008; Corwin, 2009; Matenga et al., 2019).

Outputs

The outputs of partnerships entail a) addictive results entailing that the results could have been the same with or without the partnership b) Synergy: the overall positive outcome could not have been maximized without the partnership c) Antagony: partners achieve less than if they were working on their own (Corbin et al., 2018). These outputs, according to Corbin and Mittelmark (2008) feeds

back into the collaborative functioning recurring as either elements causing conflicts tensions or aspects sustaining a positive collaborative environment as illustrated in figure 1.

Figure 1 Bergen Model for Collaborative Functioning



Source: Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing, 13*(3), page *183.*

I used the BMCF to primarily discuss the partnership resources at the input stage of the partnership. The BMCF covers the inputs interaction and partnership processes such as leadership, roles, structure, and leadership however with limited explanation of how these processes are influenced by the partnership context. The Cultural Competence Model complements the BMCF because it further provides details on the social and cultural processes and encounters within this partnerships at hand and in general as elaborated below:

2.3 Cultural Competence Model

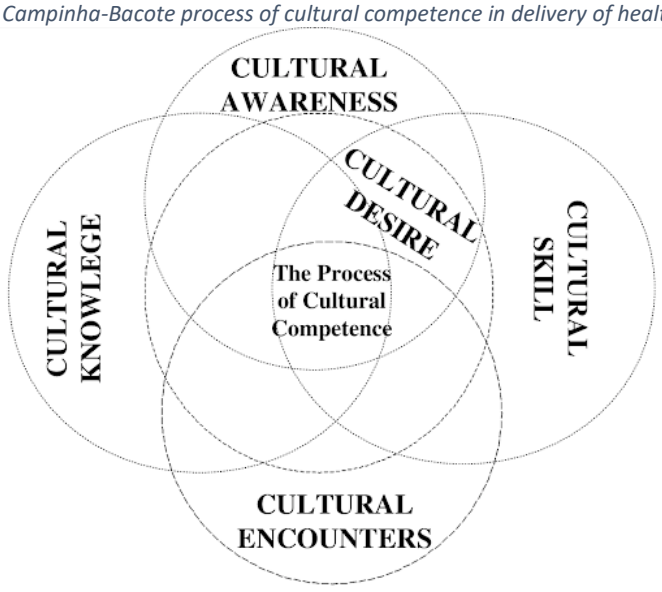
Further exploring the impact of the internal collaborative context and socio cultural and external environmental factors the research uses the Campinha-Bacote's model of cultural competence in health care delivery. According to this model by (Campinha-Bacote, 2002), cultural competence is viewed as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of individual, family, community or countries. Culture is defined as values, beliefs, customs, traditions, patterns of thinking, norms, and mores of individuals or populations (Cross, 1989; Young & Guo, 2020). Becoming familiar with

the differences and health professionals' ability to work in these sociocultural realities is what is referred to as cultural competence. The major constructs in the Campinha-Bacote's model on the process of *Cultural Competence* in the delivery of healthcare services include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002; Wall-Bassett, Hegde, Craft, & Oberlin, 2018; Young & Guo, 2020).

Cultural Awareness

Cultural awareness refers to self-awareness on one's own cultural views and the impact it can have on self and biases on the world view. Campinha-Bacote (2002) further explains that without being aware of the influence of one's own cultural or professional values, there is risk that the health care provider may engage in cultural imposition. Cultural competence begins with knowing oneself first before building upon acceptance of others (Young & Guo, 2020) and acknowledging the privilege and power inherent in one's position (Campinha-Bacote, 2019; Fitzgerald & Campinha-Bacote, 2019). In the context of this study for example, health professionals from both contexts do occupy privileged positions of varying levels in relation to their patients, hence a constant awareness and reflexivity do help.

Figure 2: Campinha-Bacote process of cultural competence in delivery of health service



Source: Campinha-Bacote (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care, Journal of Transcultural Nursing, 13(3), 181-184.

Cultural Knowledge

Cultural knowledge constitutes part of the Campinha-Bacote model and as explained by (Young & Guo, 2020), incorporates understanding another's situation and belief systems. Cultural knowledge according to (Campinha-Bacote, 2002) involves seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. In the process of seeking cultural knowledge, the healthcare professional and the healthcare organization interconnect to seek and obtain a sound educational base about culturally diverse groups (Campinha-Bacote, 2019; Fitzgerald & Campinha-Bacote, 2019). In considering cultural knowledge special focus should be on the integration of health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Young & Guo, 2020). Implicitly, it can be said that this partnership seeks to build the cultural knowledge of the health professional involved and hence this was used to explore this dimension in this study.

Cultural Skill

Cultural skill is described in the Campinha-Bacote model as the ability to collect relevant cultural data regarding the client's presented problem as well as learning and accurately performing a culturally based assessment of patience (Campinha-Bacote, 2002; Chen, Jensen, Chung, & Measom, 2020). The model recommends that health care providers select assessment tools that gather information on the patient's beliefs and values. In dealing with patients especially from a different sociocultural context, as in this study, this dimension of cultural skill becomes salient.

Cultural Encounter

Cultural encounter and cultural desire are the last two complimentary constructs in the model that encourages health care workers to directly engage in cross cultural interactions and feel motivated to learn, understand and apply cultural knowledge to the improvement of health care provision (Campinha-Bacote, 2002). Campinha-Bacote's model of cultural competence is a model for health care providers in all areas of practice, including clinical, administration, research, policy development, and education. It is, therefore, the intention of this research to explore how cultural factors affected the health collaborative exchange from the administration, policy development, education, clinical expertise and the execution of the maintenance and production tasks of the collaborative partnership.

The Cultural Competence model in health shall be used to discuss health professional experiences and social and cultural encounters both with patients and their coworkers at host institutions. The model presents an opportunity to examine in detail, how the participants were impacted by the differences in the partnership setting.

Chapter 3

Literature review

3.1 Introduction

This chapter will present the literature review of the study. I have also reviewed literature that covers partnerships at a global level and factors that influence positive partnership experiences. I then reviewed literature that covered social cultural influences in health and health partnerships. The chapter lastly identified gaps into the literature in the global partnerships with particular interest to the impact of social and cultural differences in health contexts.

3.2 Strategy for literature review

I used three electronic data bases for literature review which are Google Scholar for early stages of my literature review, Oria (University of Bergen) and Pub-Med. My inclusion criteria were to primarily use peer reviewed literature to control the quality of my research and base my ideas from intensively assessed research. I also considered literature from the last ten years (2011-2021) although I also used other articles published before that in cases where I needed to define concepts and in cases where such literature was highly relevant or limited. Some of the key words I used include, global health partnerships, north-south partnerships, cultural competence, partnerships for trauma care and emergency medicine, social cultural factors in health and global health challenges.

3.3 Global health partnerships

The world is facing many ongoing global and public health challenges such as infectious diseases, non-communicable diseases, pandemics, epidemics and natural disasters and there is an emerging consensus that inorder to successfully respond to these health challenges, a highly coordinated global response is required (Craveiro, Carvalho, & Ferrinho, 2020; Rushton & Williams, 2011; WHO, 1986, 2016, 2019). Within these global health interventions, is the recognition that current action requires both local collaboration and global partnership efforts in all areas, including in trauma care and emergency medicine (Mock, Kobusingye, Joshipura, Nguyen, & Arreola-Risa, 2005; O'Brien et al., 2018; Sheth et al., 2018; Whitaker, 2021). Existing literature acknowledges some achievable milestones where partnerships were implemented (Corbin et al., 2018). Some of the previously identified benefits of partnerships are that, they provide an opportunity to share the financial and human resource burden and close the inequality gap between and within countries

(Corbin et al., 2018; Green, 2015; Marmot et al., 2008; Plamondon, Brisbois, Dubent, & Larson, 2021). Partnerships are further seen to providing a means for sharing and giving technological and pharmaceutical support (Contu & Girei, 2014; Eckerle et al., 2017). Partnerships are also found to foster positive learning outcomes and skills development and are an opportunity for unified global responds to health emergencies like pandemics (Akin & Gözel, 2020; Contu & Girei, 2014; Eckerle et al., 2017; Katisi & Daniel, 2015; Kayambankadzanja, 2020).

However, arguments arise in the literature that reciprocal partnerships are rarely achievable (Bradley, 2017; Lough & Oppenheim, 2017). Lough and Oppenheim (2017, p. 200) argue that equal contributions within partnership are seldom achievable however, opportunities for 'fair value' can be mutually upheld. For example, these scholars argue that 'power asymmetries' (Crawford, 2003) and, the legacy of former colonial relationships and the influence they have on global health partnership initiatives results in Global North countries imposing their agenda on the global South partners (Eichbaum et al., 2021, p. 329; Ndlovu-Gatsheni, 2013). Kulasabanathan et al. (2017) argues that while the idea of reciprocity has existed as a valuable concept towards equitable relationships between the Global North and the Global South; the flow of knowledge, capacity building and service delivery has traditionally been "unidirectional" in its nature and flow. This is because in some instances neither the hosting organizations nor staff expect that the lower-resourced partner would have the capacity to reciprocate (Lough & Oppenheim, 2017). Koch (2020, p. 479) argue that failure by the Global North to acknowledge skills and competences of Global South partners as having the capacity to reciprocate has led to "epistemic injustice" in development work. According to (Fricker, Peels, & Blaauw, 2016, p. 163) epistemic injustice occurs when certain groups epistemically marginalized and thus prevented from fully participating in social processes of meaning-making. Drawing from study conducted by (Koch, 2020) in South Africa and Tanzania, differential expert credibility in the context of aid-related advisory processes emerged as a major topic with the local consultants not getting a leading role in the health partnership regardless of their experience. Similar results were found on the policy process of results based financing in Tanzania by Chimhutu, Tjomsland, Songstad, Mrisho, and Moland (2015) found donors to be dominant in agenda setting and decision making. Reciprocity and mutual accountability are found not to be genuine because there are power differentials with the donors dominating the decision making processes (Buffardi, 2017).

Literature however raises concerns over risk of such partnerships being based more on the policy preferences and priorities of the existing governments from the Global North. According to Crawford (2003), international policy priorities and general politics threatens the sovereignty of the partners involved. In a study on the United Kingdom's health systems strengthening partnership program in Pakistan, Nigeria, Afghanistan, Tanzania and Ethiopia, the influence of the UK foreign policy over the health needs of these countries is highlighted (Herrick, 2017, p. 154). Of note from what came out in the results however is that partners sovereignty in agenda setting and geopolitical use of global health partnerships as a foreign policy referred by Feldbaum and Michaud (2010, p. 1) as "health diplomacy" in global health support is inherent. In their argument, this is so because global health goals have become an efficient route to foreign penetration and a subtle external power imposition (Feldbaum & Michaud, 2010; Fowler, 2000). Kenworthy (2014) observes that these local efforts to effectively own the process of partnership and participate is undermined by powerful global agendas, leaving the community voices unheard and local realities ignored (Cheadle et al., 2008; Katisi & Daniel, 2015; Katisi, Daniel, & Mittelmark, 2016).

Studies further found partnership players against perpetuating dominance and imposition on Global South partners (Benatar, 2016; Bradley, 2017; Crawford, 2003; Katisi & Daniel, 2018; Mawdsley, 2012). There is the realization that partnerships can come with both structural and soft power to dominate (Crawford, 2003). A section of scholars report on the quantification and valuation of resources, and argue that the Global South needs to evaluate their own expertise, local resources, time and level of commitment to the partnerships (Alden & Schoeman, 2013; Katisi & Daniel, 2018). Scholars further assert that the Global South needs to reaffirm their contribution to the partnerships and shift from the acceptance of inferiority (Maldonado-Torres, 2017, p. 118; Mawdsley, 2012). Healey-Walsh, Stuart-Shor, and Muchira (2019) assert that the global south adds value into partnerships by being the cultural broker for the project, learning hub for Global North students and professionals and for facilitating access to the community (Healey-Walsh et al., 2019). The cultural and contextual competences of Global South partners as essential partnership resources are underappreciated and therefore of interest to this study.

3.4 Sustainable partnership factors

Literature lists several conditions or factors that are vital for global health partnerships to be successful. These include mutually set goals, shared learning, trust, effective leadership,

communication, adequate funding, and human as well as material resources (Corbin et al., 2018; Horwood et al., 2021; Lawrence et al., 2020; Matenga et al., 2019). Furthermore, participation by diverse, highly skilled partners was found to predict successful partnerships in local public health partnerships if they share a common vision and aligning goals ((Baker, Wilkerson, & Brennan, 2012; Corbin et al., 2018). Understanding of and approaches to the mission and or goals is identified as of significant value.

Most of the studies on collaborations however focused on factors that enable sustainable partnerships relationships (Basu et al., 2017; Errecaborde et al., 2019; Sheth et al., 2018). There is little progress done to explore partnership encounters and the contextual realities of collaborative settings and the underlying processes that shape experiences and partnership outcomes (Chimhutu, Tjomsland, & Mrisho, 2019; Katisi & Daniel, 2018) in particular sociocultural realities of partnership settings.

3.4.1 Partnership goals and agenda setting

A number of studies have found that partnerships have a greater chance of being successful when they have clearly defined goals (Basu et al., 2017; Katisi & Daniel, 2018; Van der Veken, Belaid, Delvaux, & De Brouwere, 2017) and when these goals are backed by adequate resources both in terms of human and material (Matenga et al., 2019). Corbin et al. (2011, p. 51) in their research found out that North-South partnerships proved to be more successful where effective link between resources, expertise and local knowledge was prioritized (Healey-Walsh et al., 2019; Kulasabanathan et al., 2017). Similarly, the Community that Care study from the USA exploring participation benefits and participation difficulties found that "coalition directedness", which is basically how inputs for production and maintenance are mobilized and made available in time of the partnership was important (Corbin et al., 2018; Eichbaum et al., 2021; Molosi-France & Makoni, 2020). A systematic review on North-South surgical training partnership study further concluded that there is a need to formalize partnership goals and prioritize the proper matching of educational goals with local clinical needs for partnerships to work (Greive-Price et al., 2020).

Similarly, several studies found that partnership benefits were significantly associated with 'partnership starting condition' (Craveiro et al., 2020; Matenga et al., 2019) which are the existence of resources and a clear goal that shapes the partnership's directedness (Corbin, 2017; Corbin & Mittelmark, 2008). The partnership operating environment is also highlighted as a key partnership

starting condition (Van der Veken et al., 2017). Prior relationships between and within partnerships were therefore found to be more significant in ensuring positive partnership experiences (Corbin & Mittelmark, 2008; Stott & Murphy, 2020); however, an exploration of how socio-cultural environmental factors influence these relationships and promote peer learning (Basu et al., 2017; Katisi & Daniel, 2018) is underexplored and an area of interest for this study.

Existing literature further contends that one of the reasons Global South partners find themselves in partnerships with Global North partners is because of the benefits associated with these partnerships. The resources that global north comes with in partnership goes some way in covering some inadequacies in health systems of Global South partners. Global North partners' aim has generally been associated with providing financial, material, and technical aid for the Global South (Eckerle et al., 2017; Sheth et al., 2018; Van der Veken et al., 2017). For instance, a devastating lack of access to surgical care in Tanzania (Sheth et al., 2018), an overwhelming volume of orthopedic trauma injuries in Malawi and Uganda (O'Brien et al., 2018) and limited health research capacity in Mozambique and Angola (Craveiro et al., 2020) resulted in North-South partnerships all mainly because of the existing gap in health provision, care and access. Literature further highlights that for these partnership to work there should be committed and unified approach in the cocreation of the partnership and promotion of context specific input from all partners (Basu et al., 2017). Shared partnerships development has resulted in improved ownership and promoted reciprocity (Craig & Lee, 2019; Lawrence et al., 2020; Lough & Oppenheim, 2017).

3.4.2 Leadership and partner sovereignty

Leadership and governance are identified as key partnership components within the reviewed literature (Corbin, 2013; Katisi & Daniel, 2018). Collaborative leadership that practices shared power, across partner organizations is a resources to maximize partnership success (Corbin, 2013; Kenworthy, 2014). In the quest for community partnership for public health, Cheadle et al. (2008) found out that health departments were better able to partner with community groups when they had stronger committed leaders who openly plan, effectively communicate, and mobilize the appropriate human and material resources including the use of creative funding streams (Jones & Barry, 2011a). Corbin et al. (2018) found that such partnerships managed to handle conflict and mutually understood their roles.

While partnerships are reported to bring diversity in skills, material resources and wide range of contributions to the collaboration, scholars such as Beran et al. (2016) argue that these collaborations also result in complexity in managing different interests and building trust between partners. While the underlying basis of partnerships have been to achieve results that could otherwise have not been achieved if partners acted in isolation (Horwood et al., 2021) participants felt that the partnership projects in most cases did not fully acknowledge the local contexts (Craveiro et al., 2020). The emerging argument in these studies is that where context is not prioritized, partnership outcomes are compromised. Similarly, results from Botswana showed that the biomedical approach in the implementation of the Safe Male Circumcision program hindered the success of the partnership because it conflicted with the local policies where community members and traditional leaders believed that sexual matters were culturally sensitive (Katisi et al., 2016). The project was regarded as a violation of their tradition as circumcision was more of a cultural than medical matter in Botswana resulting in partnership antagony (Katisi & Daniel, 2015, 2018; Katisi et al., 2016).

There is consensus however, that more attention should be devoted to understanding how participants experience partnership processes (Horwood et al., 2021), while promoting 'locally led' partnerships (Kokorelias, Gignac, Naglie, & Cameron, 2019) and integrating the diversity of participants' aspirations and perceptions (Marja & Suvi, 2021). Understanding the participants' overall view of their participation in the partnerships is therefore central to this study.

3.4.3 Trust and relational factors in partnerships

Building trust through personal and organizational relationships are found to be valuable ingredients for successful partnerships (Corbin & Mittelmark, 2008; Jones & Barry, 2011b; Stott & Murphy, 2020). According to Jones and Barry (2011b, p. 410) trust within partnerships comes in different levels including intrapersonal, interpersonal, societal, interorganizational and international. Scholars such as Skovdal, Magutshwa-Zitha, Campbell, Nyamukapa, and Gregson (2017) further reinforce the same conclusions by arguing that partnerships are more successful in instances where trust as an ingredient is built on a strong feeling of representation at individuals, communities or organizations relationships level. In their study on HIV response in Zimbabwe Skovdal et al. (2017) found out that individual community members had self-trust and confidence that they had more to offer to the HIV response initiatives-and failure to provide space for

individual and community participation raised trust concerns and compromised the partnership relationship.

The personal and interpersonal dimension involving how people feel and behave towards each other is identified as an important element in ensuring the success of partnerships functioning (Stott & Murphy, 2020). There is an acknowledgement by Sloan and Oliver (2013) and Stott and Murphy (2020) that most efforts to ensure effective partnerships are centered around institutions and organizations while partnerships research and practice have overlooked individual characteristics and interpersonal dynamics as key elements in building trust and safety within partnership settings. Evidence in the reviewed literature shows the link between positive partnerships outcomes in contexts were stakeholders, including patients felt safe and connected at personal level. In a study on partnerships for patient centered care, Wolf et al. (2017) found out that while collaborating together, health professionals and patients appeared to value a process of human connectedness above and beyond formalized aspects of documenting agreed goals and care planning. Similarly, in an international service learning program between Kenya and USA by Healey-Walsh et al. (2019, p. 275), participants found that trust and safety that was experienced by making connections as human beings also impacted their relationships as nurses and strengthened the partnerships at institutional level.

However, Armistead, Pettigrew, and Aves (2007) found that although trust is seen as a key element of multisector partnerships, it is an intangible phenomenon that is difficult to measure but visibly experienced more in its absence than its presence. For instance, in cases where partnerships resulted in antagony, it was found that participants' performance, satisfaction and commitment was linked to lack of trust and deteriorating relationships with the external partners. In a North-South research partnership in Zambia, Matenga et al. (2019) findings show that lack of evidence of goodwill and trust between partners resulted in antagony. The study found out that, the partnership had a "one way accountability" structure where the partners from the North did not trust Zambian partners level of transparency in managing funds leading to inequality in partnerships because of limitations in sharing responsibilities (Matenga et al., 2019; Walsh, Brugha, & Byrne, 2016). Trust is thus vital in creating synergy and it is also a responsibility of leadership to inspire trustworthiness within partnership environments (Corbin et al., 2018).

3.5 Socio-cultural factors in health

The existing body of literature reviewed on partnerships in health promotion and global health mainly focuses on assessing and evaluating on whether these partnerships are effective or not and on factors that either facilitate or impede these partnerships (Corbin et al., 2018; Eckerle et al., 2017; Katisi & Daniel, 2018; Rushton & Williams, 2011). While most reviewed literature acknowledge the need to consider context within partnership processes (Chimhutu et.al 2015), not much has was found on how social and cultural factors in health contexts and the experiences that come with that can be documented as a learning process and a contributing factor to positive partnership outcomes (Hilty et al., 2021a; Katisi et al., 2016). Culture is defined by customs, habits, and geography. As claimed by Helman (2007) cultural background has an important influence on many aspects of people's lives, including their beliefs, behavior, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, concepts of space and time, attitudes to illness, pain and other forms of misfortune (Chen et al., 2020; Young & Guo, 2020). All these cultural backgrounds may have important implications for health and health care.

Understanding different dimensions to people backgrounds requires skills and exposure as alluded to by Campinha-Bacote (2002) in the model of *cultural competence*. The model views *cultural competence* as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client, which can be an individual, family or community. This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002; Ingram, 2012; Wall-Bassett et al., 2018). Several social and cultural factors in health were found in various studies and among those includes cultural perspectives to health seeking behavior, role of family and family norms in care as well as individual identity backgrounds such as gender, race, religion, and socio-economic status. Different approaches to ensuring culturally sensitive health practice are suggested within the existing literature. For example, some scholars further describe these in the context of cultural humility (Fisher-Borne et al. 2015) and/or cultural safety (Fleming et al. 2019; Crawford et al. 2020; Kemp et al. 2020), which suggests deeper recognition and inclusion of indigenous community realities.

3.5.1 Health Seeking behavior

Health seeking behavior is identified as significantly affecting health care outcomes (Musoke, Boynton, Butler, & Musoke, 2014; Ng'ambi et al., 2020). Literature suggests that health seeking behavior is directly linked to social determinants of health. There is an acknowledgement that individual decision to seek health knowledge and make a decision on their health choices is influenced by the community and conditions in which they live (Gerald & Ogwuche, 2014; Oberoi, Chaudhary, Patnaik, & Singh, 2016). In Uganda, similarly with Malawi and the rest of Sub-Saharan Africa, traditional beliefs around the cause and cure of illness saw patients opting for non-clinical health remedies over hospital care (Nsereko et al., 2011; O'Brien et al., 2018). A study from India reported that women preferred delivering their babies at home over health facilities because care giving at health facilities was perceived not to be culturally sensitive (Widayanti, Green, Heydon, & Norris, 2020).

Additionally, many other non-health system factors were reported in Uganda to have an influence on people's health seeking behaviors. These barriers to health access include the unavailability of drugs, inaccessibility issues in terms of costs and distance and health workers' attitudes, among others (Musoke et al., 2014). An understanding of underlying contextual factors that influence health seeking behaviors and how health professionals respond to them in a partnership setting is of interest to my study.

3.5.2 Individual Identities

Individual identities were found to significantly influence not only health seekers behavior but also important in building health professionals competence to provide people centered health care. People who can be distinguished from other groups based on their specific social identity constitute a culturally diverse group (Gomez-Mejia, Balkin, Cardy, & Carson, 2007). Cultural diversity thus, includes race, religion, gender identity, geography (urban, rural, global), age, socioeconomic status, education, and language (Hilty et al., 2021a). Several scholars argue that that these different identities bring diversity amongst a population resulting in complexities that challenge patient centered care (Heckman et al., 2017; Marja & Suvi, 2021; Rassouli, Zamanzadeh, Valizadeh, Ghahramanian, & Asghari, 2020). Individual, socio-economic, and geographical barriers to health are common within the existing studies. In Norway, studies found that patients with an immigrant background face health care barriers in accessing the health system because of their background

and this ultimately result in avoidance of the healthcare system (Mbanya et al., 2019; Mbanya, Terragni, Gele, Diaz, & Kumar, 2020). Mbanya further found that the challenges were more for women with an immigrant background because husbands and family had huge influence on healthcare and disclosure of health problems (Mbanya et al., 2020)..

Also, previous research finds disparities in health outcomes due to differences in the quality of life which comes from where one is located (Marmot et al., 2008). In Malawi, a studies found that children from urban areas were more likely to be taken to health facilities for health care compared to those from rural areas (Ng'ambi et al., 2020), an argument that is reinforced by the Helliwell, Layard, Sachs, and De Neve (2020) in the World Happiness Report of 2020 where differences in the social environment separated happiness and wellbeing rankings for immigrants and those from rural areas and global south countries. In addition, language is also a cultural identity maker that influence health access (Evans, Ribbens McCarthy, Kébé, Bowlby, & Wouango, 2017; Horwood et al., 2021; Mbanya et al., 2019). In some instances, health outcomes and attitudes depended on the identity, gender and age of the health provider (Musoke et al., 2014). Physical, socioeconomic and political factors as identified by current studies, are identified to have an impact on health seeking behavior (Kroeger, 1983) An ability to understand these requires cultural competence as generally suggested by scholars(Fitzgerald & Campinha-Bacote, 2019). Cross-cultural encounters are thus found to be relevant in improving health professional workers competences which are strongly shaped by people's culture, significant life events and relationships (Xiao et al., 2020) .

3.5.3 Role of Family in Caregiving

Literature identifies the significance of family involvement in patient care and health outcomes. Community and family care offer many advantages over hospital-based care for patients receiving long-term treatment (Cohen et al., 2018; Emmamally & Brysiewicz, 2018; Kohler et al., 2017). In such instances, family support is complimentary to the understaffed and overburdened health systems mostly in the Global South (Basu et al., 2017; Kokorelias, Gignac, Naglie, & Cameron, 2019). In a study of the WHO African Partnerships for Patient Safety (APPS) involving Uganda, South Sudan and Liberia, Basu et al. (2017, p. 2) found that due to resource challenges and in response to health workforce constraints, families and guardians were actively engaged in patient care such as feeding and bathing their relatives. Similarly, Kamuzu Central Hospital (KCH) of

Lilongwe, Malawi, family members, termed Hospital Guardians provided care for their relatives (Hoffman et al., 2012).

The involvement of family is somewhat different between Global North and Global South countries (Basu et al., 2017) and studies find this as an opportunity for reverse innovation (Basu et al., 2017; Kulasabanathan et al., 2017; Syed, Dadwal, & Martin, 2013). Where people live communally, studies found that family plays a major role in health decisions (Katisi & Daniel, 2018; Kim, Kreps, & Shin, 2015; Musoke et al., 2014). In Norway, family plays peripheral roles in the health care and the decision to seek health is more individual than communal, resulting in barriers to accessing health care for example, for women from an immigrant background whose husbands and relatives are more involved in their health decisions (Mbanya et al., 2020).

The importance of building competence in understanding and acknowledging the role of family in care giving proves to be important in achieving better health outcomes. For instance, Emmamally and Brysiewicz (2018) acknowledge in regards to trauma and emergency care, that most research participants stated that they always supported and respected families' decisions in health care settings. In a study on Finnish nurses handling trauma cases by Coco, Tossavainen, Jääskeläinen, and Turunen (2013) findings further show that families often want to make decisions on how they grieve and cope with trauma, and the conclusion is that this must be acknowledged by practitioners. In a communal set up of Brazil, a study by Barreto, Arruda, Garcia-Vivar, and Marcon (2017) it is recommended that systematic work be undertaken so that the family as a social and cultural entity is valued and can collaborate in the emergency process (Lawrence et al., 2020). Marja and Suvi (2021) suggests that health care professionals exercise sensitivity in encountering patients and have a positive attitude towards individuals backgrounds including family values.

3.6 Literature Gap: Influence of Social cultural Factors in Partnerships

While this research intends to explore the role of social and cultural factors in health partnerships, limited literature exists to investigate the impact of social cultural dimensions of health promotion partnerships. The concept of social and cultural competence is highly explored in nurse education (Chen et al., 2020) and social work (Chae, Kim, Yoo, & Lee, 2019) , whilst the reviewed literature indicates limited reference to how it affects participants experiences n health partnerships (Corbin, 2013). The limited existence of literature examining how social and cultural factors as specific aspects of partnership settings, could indicate the need for further research to enhance effective

partnerships for health promotions. Previous research findings although limited suggest that flexibility in procedures, leadership and adaption to these cultural and contextual realities were important for the success of health partnerships (Corbin et al., 2018; den Hartog, Wagemakers, Vaandrager, van Dijk, & Koelen, 2014). Literature further acknowledges that health settings are socially and culturally shaped and so are health outcomes (Laverack, 2018; Mittelmark, 2014). Cultural and social elements fall under the social determinants of health (Marmot et al., 2008) and present an opportunity to further construct knowledge on effective health partnerships. While the literature recognizes acknowledge the importance of cultural competence in health care provision, it did not distinctly demonstrate the impact of sociocultural differences in health partnership which I will explore in this study.

Chapter 4

Methodology

4.1 Introduction

In this chapter, I will present my selected research approach and design, the philosophical assumptions underlying this selected approach. The chapter will also present the process and methods used for data gathering, and the chosen framework for data analysis. Strategies used to ensure quality and ethical considerations for this study will also be presented in this chapter. The perceived limitations and research design related challenges I encountered shall also be highlighted.

4.2 Research Approach and Design

Research Approach: A qualitative approach was chosen for this study. It was the most suitable approach as the research objectives focus on socio-cultural context, experiences, and values of health care professionals on an exchange program. This study is inductive and explorative in nature as it seek to construct what the research participants saw and experienced during the exchange partnership (Neuman, 2014, p. 105). In this regard, a qualitative approach was the most suitable to use. Qualitative research is characterized as an *"...emergent, inductive, interpretive, and naturalistic approach to the study of people, cases, phenomena, social situations and processes in their natural settings in order to reveal in descriptive terms the meanings that people attach to their experiences of the world"* (Yilmaz, 2013, p. 312).

Research Design: A qualitative case study was chosen for this study as the most suitable. Merriam (1998, p. xiii) defines a qualitative case study as *"an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit."* An empirical inquiry must examine a contemporary phenomenon in its real-life context (Yin, 1981) for one period or across multiple periods of time (Neuman, 2014). Identification of a specific case to be analyzed and described, bounded by clearly defined parameters is therefore primary in qualitative case study (Creswell 2018). As the *logic-in-use* to produce knowledge (Carter & Little, 2007), qualitative case study further draws from an understanding that the world consists of multiple cases, contexts and cultural meaning (Neuman 20114:167), and therefore requires in-depth focus on the case under study. A case study was best suited for me to study a partnership

setting and have an in-depth analysis of the partnership context. It is from this background that a qualitative case study was used as the strategy of inquiry, object of inquiry as well as the product of inquiry under this study.

Philosophical Standpoint: This study used social constructivism as a philosophical standpoint. In this research, I was interested in exploring the experiences of health collaborative exchange participants moving from one social setting to another. I explored the ways these experiences were shaped and challenged by the social, cultural, and contextual differences in these settings. My epistemological standpoint was therefore linked to social constructivism, a perspective that suggests that 'true meaning' of reality is rarely obvious on the surface and that one can reach it through a detailed examination of social and cultural experiences (Neuman, 2014, p. 103). According to Searle and Freeman (1995), reality is socially constructed , and in order to tap into this reality there is need to work in close collaboration with research participants, allowing them to tell their stories in detail, present their experiences and worldviews (Baxter & Jack). The goal of this research thus was to develop an understanding of social and cultural life experiences of health care professionals in Malawi and Norway and to discover how they construct meaning in such natural settings (Creswell, 2014, p. 104). Part of the research goals was to rely as much as possible on the participants views of the situation under study (Creswell, 2014, p. 8; Yin, 1981).

4.3 Data Collection

4.3.1 Study Context

Data was collected from participants from Kamuzu Central Hospital (KCH) in Malawi, Haukeland University Hospital (HUH) from Bergen, Norway and The Norwegian Agency for Exchange Cooperation (NOREC) in Førde, Norway. I chose these study contexts for the following reasons: All the three institutions were part of an existing North-South partnership. What I also considered is that Malawi is a Global South country with a typical health system of most low-income countries whilst Norway is one among health care system in the Global North. These characteristics provided me with an opportunity to explore an ideal north-south partnerships in health. These two countries were convenient because participants were easily contactable as they belong to the respective health institutions under study. NOREC was chosen because of its responsibility in facilitating the health partnership and other related partnerships between Norway and other countries. NOREC has more than one health partnership with Malawi but I selected specifically one with a Nowergian

hospital in Bergen because that is where I was based during this study. Therefore, the selection of both the study sites and participants was purposeful.

4.3.2 Selection and recruitment of participants

A purposeful selection of participants was used for both Malawian and Norwegian participants. According to Yilmaz (2013, p. 313), *"the main aim of purposeful sampling in qualitative research is to select and study a small number of people or unique cases whose study produces a wealth of detailed information and an in-depth understanding of the people, programmes, cases, and situations studied."* The inclusion criteria for this study firstly were to identify the participants who had participated in the NOREC exchange program between Malawi and Norway either as exchange participants or project leaders. In addition, these participants must have been stationed in Norway or Malawi during their participation in the project and worked for at least six continuous months in a different social setting (that is Malawi or Norway) to their home station. This inclusion criteria were aimed at gathering possible relevant data from all parties involved or affected by the health collaborative partnership. A total of nine participants and three key informants were interviewed. Four of the interviewed participants were Malawian health professionals, the other five were health professionals from Norway and the three key informants are project coordinators from NOREC, Haukeland Hospital and Kamuzu Central Hospital.

4.3.3 Recruitment Strategy

Recruitment of study informants was initially facilitated by a gatekeeper from the Department of International Collaboration at Haukeland Hospital who introduced me to participants from both Malawi and Norway. According to (Tushman & Katz, 1980, p. 1071), gatekeepers in research *are "key individuals who are both strongly connected to internal colleagues and strongly linked to external domains."* A gatekeeper was essential for my research taking the role of an "intermediary" between myself and the participants, helping me to cross boundaries to connect and facilitate access to information about the participants (Savolainen, 2020, p. 1222). The Department of International Collaboration at Haukeland Hospital manages all international collaborative initiatives that the hospital has, including details of the application process, participants, their contacts, and every other detail related to their involvement with international partners. The department introduced me to all the participants via email and I managed to recruit all 5 participants from Norway. All the interviews were done between September 1st, 2020 to November 15th, 2020.

My initial plan was to travel to Malawi for my data collection, but this was not possible due to COVID-19 pandemic. I then had to change plans to do digital interviews. I alternatively used WhatsApp and Facebook and in my initial attempts I managed to interview one participant. Participants from Malawi did not respond to the initial send invitations to participate, I then had to resort to snowballing recruitment strategy. Snowballing is a recruitment technique where early participants refer other study participants (Chambers, Bliss, & Rambur, 2020, p. 847). Whilst snowballing can lead to having many informants from the same social setting, in my case it also meant that the individuals who did end up participating did so because they found the subject interesting and wanted to take part in the research. Those participants who initially did not respond came on board after having seen their colleague participate in the interviews. I tried several strategies to secure the remaining individual interviews including through my contacts and managed to recruit three more participants from Malawi. A total of 12 participants were recruited in total, as shown in table 1 below:

Table 1 List of Participants

Name	Gender	Professional Experience
Chikondi	F	Below 10 years
Chifundo	M	Below 10 years
Tionge	M	Below 10 years
Jacob	M	Below 10 years
David	M	Below 10 years
Langa	F	Below 10 years
Hege	F	Above 10 years
Marte	F	Above 10 years
Rebekka	F	Above 10 years
Maria	F	Above 10 years
Elin	F	Above 10 years
Stian	M	Below 10 years

4.3.4 Methods of data collection

In this study, online semi structured interviews and policy documents were the data generation methods used. Initially, Focus Group Discussions were part of the data generation methods but was later disregarded due to challenges to physically travel and recruit participants in Malawi, risks of gathering people during COVID 19 and lastly the potential difficulties in coordinating participants online as technological limitations such as access to strong internet may have occurred.

4.3.5 Semi structured online Interviews

Due to the hermeneutical nature of the social cultural experiences of health professionals in different work settings, I used semi-structured online interviews using different channels among them, I used WhatsApp, zoom channels, and including direct telephone calls. Research interview is defined by Brinkmann and Kvale (2015, p. 4) as a method based on *"the conversations of daily life……an inter-view, where knowledge is constructed in the inter-action between the interviewer and the interviewee."* This method was chosen due to its extremely conversational and linguistic form, which was an opportunity to explore the feelings and experiences of health care professionals through self-expression(Turner III, 2010). Further to this, the method was also chosen because it provided a safe space for participants to invoke emotion and express themselves on sensitive topics. Interview guides were prepared, and participants contacted through email or text for the scheduled interviews.

Participants were given the opportunity to choose which channel they prefer to be interviewed through. Of the twelve interviews, one was face to face interview, two were telephone interviews, three were WhatsApp call interviews and six were conducted through Zoom. The interviews were between 45 minutes to 1 hour, all interviews were recorded after getting consent from the informants. An interview guide was used, the interview guide captured the following themes, partnerships resources goals and inputs, social and cultural experiences in different settings, reflections on social and cultural experiences in collaborative context (see appendix 1). A separate interview guide was used for the key informants, their interview guide captured these following main issues: reflections on project goals and inputs, administrative support, the concept of power and reciprocity in partnerships and overall project results, (see appendix 1). I decided to interview the key informants at a later stage in the research because I wanted to get an overview of the overall partnership after having gathered data from the participants. This gave me an opportunity to ask

questions of interest that were informed by the early interviews. As Skovdal and Cornish (2015, p. 56) point out, key informant interviews provide quick access to important facts, from carefully selected individuals who have access to those facts and can be used to inform a rapid appraisal of a situation.

4.3.6 Policy Documents and Secondary Data

I used policy documents and secondary data to supplement the interviews. The range of documents that I used includes policy documents, organizational reports, websites, and academic literature relevant to the topic. As argued by Williamson, Makkar, and Redman (2019)the use of policy documents and secondary data is a triangulation technique that informs the researcher with relevant contextual information for interviewing participants, and to provide an additional or confirmatory source of information (Downie, 2013); cited by (Natow, 2020, p. 166). Policy documents such as the government instructions on the Norwegian Agency for Exchange Cooperation, the project reports, news media, academic literature, and internet-based data from partners under study were analyzed before and during the research and thus also contributing to the construction of the problem statement, literature review, findings and the discussion. Policy documents and secondary data was therefore used to have wider understanding of the case under study (Punch & Oancea, 2014).

4.3.7 Data Management

The research data was stored and managed by following basic principles of research and ethical considerations. The recorded interviews were transcribed, anonymized, and stored in a protected computer and was only accessible for the purposes of the research by myself and my academic supervisor when required. In addition, I was the only person able to access the secured desktop as it was connected to my University of Bergen One Drive account and protected password.

4.4 Data Analysis

I used the thematic analysis approach to data analysis (Braun & Clarke, 2006). With this method, I intended to identify common patterns, recurring themes from participants responses (Braun & Clarke, 2006). In pursuit of this goal, I used Braun and Clarke (2006) analytic tool for qualitative data that provides a broad six step approach to data analysis. I did most of these steps using the NVivo, a software for data analysis and management. The steps are outlined below:

a) **Data familiarization:** The preliminary stage of data analysis started with transcribing the interviews from audio to text before generating concrete themes, as well as re-reading and recording all the recurring themes
b) **Generating initial codes:** I generated the initial codes with the aid of NVivo 12, a data management program.
c) **Searching for themes:** In this step, the codes were further categorized into broader emerging themes.
d) **Reviewing themes:** In this phase, I reviewed each theme to see to rearrange and best fit the themes into possible appropriate group (appendix 2a and 2b)
e) **Defining and naming themes:** in this step I examined the names of each theme, making sure they made sense for the arguments I wanted to emphasize in the findings
f) **Producing the report:** the final step was related to writing the emergent themes into empirical chapters of the study.

4.5 Quality Assurance

4.5.1 Trustworthiness of Research

To ensure trustworthiness of the research, I used four critical measures in qualitative research namely credibility, dependability, transferability, and confirmability.

Credibility

Credibility entails the linkage of my findings to reality. According to Shenton (2004, p. 1), In addressing credibility, researchers attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented. To ensure that the research appeared reasonable and appropriate and that the data was a true presentation of the case and topic under study, I used triangulation. Triangulation data generation methods entail exploring multiple sources of data and in this study it was done at two levels, that is, at the data methods using interviews, and reviewing policy documents identified during the research. I also applied triangulation both at methods level and at participant level, 'Elite interviews', according to Natow (2020, p. 160) provide valuable information from perspectives of power and privilege. Therefore, use of triangulation in this study using elite interviews was crucial for the credibility of the study. Furthermore to enhance the credibility of my research I used "thick description", an in-depth illustration that explicates culturally situated meanings (Geertz, 1973); and abundant concrete detail (Bochner, 2000; Geertz,

1973; Tracy, 2010). According to Tracy (2010, p. 841), researchers should evidence their due diligence, exercising appropriate time, effort, care, and thoroughness. I presented the research results in detail, directly quoting the participants. I further detailed the context of the study, describing the background of the problem, and linking it with the theory, results, and the discussions chapters. I also undertook "collaborative coding"- generating and comparing codes together with other researchers in a workshop setting to increase the credibility of the analysis.

Dependability:

Dependability entails the ability to trace, explain and confirm the research process. According to Shenton (2004, p. 71), in order to address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. To achieve dependability, this research reported in detail the purpose of the research, research design and its implementation, describing what was planned and executed on the research site/sample, participants recruitment and how data was collected. Detailed information on how conducting research in the COVID 19 pandemic era led to changes from face-to-face interviews to online interviews was provided. Audio recording and storage were used to increase dependability.

Transferability:

According to Shenton (2004, p. 63), to allow transferability, researchers provide sufficient detail of the context of the fieldwork for a reader to be able to decide whether the prevailing environment is similar to another situation with which he or she is familiar and whether the findings can justifiably be applied to the other setting. To achieve this, the study paid attention to the contextual realities of Malawi, Norway and the partnership setting. To demarcate that my research findings can be used in other context, I discussed them in relation with the existing literature and further give information on the number of participants, organizations involved, timeframe, restrictions and in details, the participants who contributed to the research.

Confirmability

Confirmability involves the use of instruments that are not dependent on human skill and perception. I followed strategies that ensured that I take steps to demonstrate that findings emerge from the data and not my own predispositions (Shenton, 2004). To reduce bias and predetermined

assumptions I followed the research design and reflexive to my own biases. I captured in detail my research steps. I jotted down all the steps and described the procedures I followed during the research. I also shared my thesis chapters and presented my results chapter in a class setting, getting feedback from my supervisor and fellow classmates.

4.6 Role of the Researcher

In pursuit of quality research, I practiced reflexibility as the researcher. The credibility of the researcher is especially important in qualitative research as it is the person who is the major instrument throughout the research process (Shenton, 2004, p. 68). This is important to be cognizant of premeditated conceptions and potential biases and factors that might have affected the research process and research outcome. This was achieved by maintaining a clear and honest relationship with my participants. My role in this research was both an insider and outsider. I was an insider from the background that I have been a participant in a NOREC collaborative partnership on education and academic freedom. I was also an insider in the sense that I come from Zimbabwe and am an African, an identity that more participants from Malawi found relatable. However, when it comes to the research area on health professionals, I was an outsider because I did not have experience with the participants' area of expertise, work context and individual experiences. I had never been to Malawi or done research with Malawians prior to this study and had limited knowledge of their health sector, making the research more explorative.

Even though I was aware of my role as a researcher, my position was also affected by the nature and context of my positionality. For instance, what motivated me to explore health partnerships effectiveness in health promotion was my previous involvement as an exchange participant before and having met one of the health professionals in Norway. I had previously worked as a programs manager for a civic organization in Africa receiving support from institutions from the Global North. This exposure also influenced my decision to explore health partnerships, how differences in settings affected outcomes and how the settings were health promoting. Firstly, because I was doing my research from Norway and having been a former NOREC participant, I observed that some participants presumed that I was doing the research on behalf of NOREC and as such were not open to share more of their experiences to me while others thought that it was an opportunity for them to share the actual reality of their experiences hoping that the research would influence

NOREC's future decisions. I however, emphasized that I was just a student and not researching on behalf of NOREC.

Secondly, some participants found social and cultural discussions sensitive and therefore I was conscious that the interview dynamics might be influenced by the fact that I am African and a former NOREC exchange participant. Before every interview, I briefed the participants and highlighted the fact that the research was an independent inquiry for the purposes of completing academic requirements. For instance, during an interview, one participant told me that they googled me and searched for me on social media after sending them my request for an interview. Noticing how important social medial and digital presence is today, I minimized my social media activity and made sure I did not post content that would link to my research or compromise the confidence of the research participants throughout the study. Additionally, for all interviews I followed the ethical guidelines including sharing information and consent forms. I further did self-evaluation by following guidelines for quality research as outlined by my research design.

4.7 Ethical Considerations

For the purposes of this research, ethical considerations were prioritized through informed consent, confidentiality, anonymity, and formal institutional research clearance. What this implies is that relevant gatekeepers and research participants must be protected and aware of research sensitivity. To ensure honesty and research accountability, all the participants approached for the research were given an opportunity to refuse or accept to participate in the project. Informed consent form was used and clear outline and communication to participants of their rights to participate or withdraw, as noted by Shenton (2004) helped to ensure that the data collection sessions involved only those who are genuinely willing to take part and prepared to offer data freely. Confidentiality, anonymity and data protection, which arises from the respect to privacy functioned as a 'pre-cautionary principle' of this research (Hammersley and Traianou, 2012: 121) cited (Punch & Oancea, 2014, p. 47) participants right to seek clarity or explanations were explained in advance to all the targeted participants so as to guard against misconduct and impropriety that might reflect on their organizations or institutions (Israel and Hay, 2006) cited by (Creswell 2014:92). An Ethical dilemma that I faced in the middle of data collection and analysis was on anonymity and protection of the research participants. For instance, the research participants were traceable within their organizations because the record of former participants in the health exchange partnerships were

known internally. To minimize the ethical dilemma, I reached out to the research participants to clarify this of which they agreed to participate but pseudonyms were used to protect participants from being individually identified. Institutional ethical clearance was obtained from the Norwegian Center for Research Data (NSD) prior to the research, see appendix 4 and the project was also then subsequently registered in RETTE.

4.8 Limitations

Challenges that affected the implementation of the research process and adjustments thereof were noted and recorded. The initial imitations stemmed from the times and context under which the research was conducted. It is essential to note that due to the COVID-19 pandemic restrictions the sample size was reduced, and methods of data collection altered. For instance, I did not manage to recruit participants for focus group discussions as originally planned in order to capture the experiences of health care professionals who were not on exchange program but worked with exchange participants from another country during the project tenure. Secondly, the research aimed at targeting participants from 2017 to 2020, however I could not be able to recruit 2020 participants because their collaboration was cancelled in the middle due to the pandemic. Though I did not manage to recruit participants for the focus group discussions and the 2020 exchange participants from Malawi and Norway, a total of 12 participants were sufficient to conduct the research. The shift from face to face (field visits) to online interviews brought challenges related to technical capacity to familiarize with the digital platforms and capacity of participants to have stable internet network and resources to buy the services.

This shift led to delays and rescheduling of interviews, and I lost one participant due to the connectivity and internet challenges. While I Initially opted for zoom audio and video interviews because of its recording features and security, not all participants were able to access it, prompting me to also consider WhatsApp calls, a platform that was convenient for the participants but unable to record the interviews from the same application. With the help of technologically competent fellow colleagues, I was able to use Audacity, a voice recording software. During the first few interviews I could have collected less information from my informants because I was not used to interviews and probing. In the first three interviews I thought that I was not getting enough data from the participants due to how I asked questions. In addition, I initially found it challenging to maintain an equilibrium between my research questions and research participants' to share their

experiences with less interruption. My supervisor however, advised me to keep the research explorative and reduce the number of interview questions. I then used a more semi structured and conversational approach for last ten interviews, and I was more satisfied with their quality.

Chapter 5

Findings

Motivations for participation at individual and organizational level

5.1 Introduction

This chapter will present the findings in relation to the partnership motivation and committed resources in the start of the partnership between Malawi and Norway. Results further show reasons for participation from both individual level and at the institutional level between HUH, KCH and NOREC. Most of the inspiration came from their inclusion in agenda setting, capacity building, financial, material, and professional benefits and the need to implement development policies at institutional level as shall be presented below.

5.2 Motivation for participation at an individual level

Participation in the agenda setting and early phases of the project

Most participants from both Malawi and Norway had previously been involved in the project development phase of the KCH-HUH partnership project. Participants felt more connected and part of the project because of their inclusion as resource persons. Subsequently they reported feeling safe and motivated to participate in achieving the project goals:

I had been in Malawi for 3 weeks before my participation, so I sort of knew my colleagues at KCH and the situation there before making the decision to participate. After my first visit, I expected to continue the work that we started when I got to Malawi especially towards the burn unit. My motivation was to see physiotherapists at KCH and HUH work together to try to figure out some key areas to focus on during my exchange tenure in Malawi. Achieving the NOREC goal was important and efforts to integrate those goals from both our end and the Malawian side was my expectation. I felt that Haukeland had a system around everything to achieve that goal and that I had come into something that was well in place with housing, transportation, security, schools, and the hospital in Malawi knew that I was coming and were expecting me. (Hege)

Just like Hege, most of the health professionals who got involved in the development of the project were motivated by the level of organization and good coordination. Tionge and Chikondi

participated because they felt that the project was authentic and well organized and had confidence in the management's capacity to handle the partnerships. Chikondi shared:

When I visited HUH as a resource person, I could see that everything was in place. The Department for International Collaboration manages many other projects, in South Africa, in Zanzibar and our project head a clear structure and system around its implementation… (Chikondi)

The participants reported having clear understanding of the aim of the project and hoped they had something more to contribute by joining the project as participants. When some of the health professionals eventually participated as exchange participants, their motivation? and attitude towards the project influenced other health professionals' willingness to take part in the project.

Multicultural exposure and familiarity with previous partnerships

While some participants had been directly involved in the NOREC project formulation, for others previous exposure to different settings and familiarity with previous rounds of partnerships between KCH and HUH also contributed much to their participation. For instance, health professionals such as Maria had participated in the exchange program at KCH before while those like Rebekka had completed their studies and internship abroad.

Like Rebekka, Hege found the partnership interesting because she remembered the history of when HUH-KCH started the partnership and she had hosted some of the previous participants and became familiar with the project:

I was familiar with the project. It started with a doctor (name given) *going to Malawi in 2001 and 2002, the doctor thought of finding resources to build a trauma center at KCH and then the physiotherapy department was involved in 2015. When we have a Malawian therapist coming to Norway, he worked with me at the burns unit for three weeks and in 2018 and 2019 she stayed with me for 3 weeks as well.* (Hege)

Marte was also suggested by her boss to lead the project due to her previous exposure to multicultural contexts:

My first time was in 2004 when I went to Malawi and started working in Haukeland in 2007 in the position I am working right now. My boss said that we had to have someone who oversees international collaboration in the department. He knew that I had worked in Tanzania before and

I already had an interest and background knowledge of international collaboration, so he chose me. (Marte)

Participants prior exposure to multicultural settings and professional experience motivated them to make the decision to participate.

Expectations and benefits as reasons for participation

Results further show that the health professional workers involved in the project made the decision informed by their expectations and benefits that came with participating. For instance, Chifundo decided to participate in the program because he was among the first professionally trained physiotherapists to graduate from a Malawian local university, and he expected to improve his professional capacity from Norway where he thought had more advanced physiotherapy department, skilled professionals, and advanced technology.

I expected to meet professionals who are highly trained and qualified and I wanted to fit in the environment, into the new system. And looking at how young our profession is in the country, we were the first to be trained in Malawi and were going to a country which has been having the program for several years, I was worried if I would fit in…. But well, the reason why I had to participate is that I needed to learn from a well-equipped and advanced physiotherapy department in Norway. (Chifundo)

For some participants, the possibility to travel together with family also encouraged their decision to participate in the project as reckoned by Rebekka,

I travelled with my family, my husband and three children. If you are at work and you have a hard day at work you come home to your family, you forget about it, your focus changes, your thoughts change because the immediate people that you care about are in front of you and you don't think that much about work or experiences and you can sort of push that away and you try to keep away and try to keep work and social family life separate. For me that helps, I think if I were there alone, I would keep those thoughts and experiences with me and in another way thinking about them more it would be maybe more difficult to keep that professional distance. The support around you is important and I think that was something that would have impacted both the decision to go and in terms of what I did in preparation both mentality and things that we had in place before going. (Rebekka)

However, for others the inability to travel with family presented copying challenges which speaks to the significance of family in both the decision to participate and the participation experience:

Leaving the family behind was hard. The time I left, my first born was just a year old. Imagine leaving a one-year-old behind and a wife, its mentally challenging. But it was a great opportunity and I had to do it for them. (Chifundo)

Norwegian participants found it easy to bring their families to Malawi while it was challenging the other way.

While Chikondi may have been motivated to participate, she was worried of her safety and if she would be able to connect with the new coworkers for her to integrate into the new system. Tionge, like Chikondi, also expected to gain experience in the use of advanced technology and equipment in trauma management:

What I thought I would gain was the skill on how to use the sophisticated machines which we do not have. For example, we do not have the Magnetic Resonate Imaging (MRI), I had not known much about trauma management. That was my goal, we were going there to learn how trauma is managed because by nature in Malawi, we have more accidents than Norway and they have their own way of approaching trauma which is different from our way. (Tionge)

In addition, David shared:

I went there to learn about CT scanning, computed tomography scanning which is one of the advanced imaging modalities that we have in radiology, and by then we had just installed ours at Kamuzu Central Hospital. (David)

While Norwegian health professionals understood and appreciated that they would learn in Malawi, after their initial visit to Malawi majority of them were motivated to offer their skills and knowledge to Malawi's Trauma and Emergency Department. As earlier mentioned, professionals such as Hege had more than 25 years of work experience while the rest of Norwegian participants had at least 10 years of experience in trauma and emergency medicine.

Although the intention to learn from a well-equipped and experienced emergency medicine at HUH was recurring, participants such as Tionge and Chifundo emphasized that they were also motivated

in marketing Malawi as a country and demonstrating their competence despite coming from a context where they operated under limited resources.

Desire to experience new environment

Generally, travelling from one context to the other was motivating for participants. Most of the participants from Malawi were very fascinated by moving to a different socio-cultural setting that Norway presented while for Norwegian participants this was also an opportunity to bring their families and friends to experience Malawi, a context different to Norway in many respects.

When I heard that Norway is a very rich country, I knew this would be a great opportunity. The fact of being in another country, especially in Europe, is desired by most of Malawians or Africans in general (Laughs), *to be abroad one day, you know that feeling. That excitement and expectation was there.* (Tionge)

While this may partly indicate participants interest to move to a different setting, financially stable economic conditions in Norway seemed lucrative for Malawian participants. In the Malawian society and specifically the context of Malawian health professionals, moving to and working in Europe is perceived as a status symbol, reputable and participants hoped that it would expose them to a wide range of economic opportunities. On the other hand, participation brought an opportunity to travel and explore different environment for Norwegian participants who hoped to bring more of their friends and families.

However, contrary to Chifundo, Hege did not have any problems moving to Malawi because her children were independent adults. Participants who were young and married found it difficult to leave their families, older participants with less dependents found it easy to make the decision to participate. However, though a few participants from Malawi were concerned about leaving family behind, majority of them felt motivated to participate because of family responsibility they have back in Malawi and hoped to benefit from the participation financially.

Challenges in recruiting new participants

Results show that while it was less difficult to recruit health workers to go to Norway from Malawi, the project faced challenges in recruiting Norwegians to Malawi. For instance, the coordinator from Malawi participated because physiotherapy was new in Malawi whilst the Norwegian coordinator

became a participant because they were fewer health care professionals from Norway prepared to travel to Malawi at that time.

Marte said:

I was not supposed to be one of the participants but after we had our project approved by the Norwegian Agency for Exchange Cooperation we asked in the department if anyone wanted to go, but no one wanted to go (laughs)… *Then I said maybe I can go myself and I became the first person to go on this project, but I was supposed to be the project manager. So, it was because this was new to people in the department, and I think many people know about Malawi but the things that they knew may not have been positive. Malawi is a low-income country and I think it is something that we do not know much about. Some people confused it with Mali in the South Coast. Lots of Norwegians are not familiar with Malawi, they were not at least ten years ago. So, we had no applications, so I had to go.* (Marte)

Participants such as Rebekka participated twice in the project while others stayed longer and extended periods in Malawi compared to those who came from Malawi to Norway.

5.3 Motivation for participation from an institutional level

I also managed to speak to project coordinators, exploring why they decided to participate in the exchange program at an institutional level. Below are the results.

Institutional Capacity Building

Results show that for Kamuzu Central hospital, their major aim was to develop the capacity of their trauma and emergency medicine department while Haukeland Hospital wanted to provide their skills and Knowledge over years of operation in Norway at the same time learn from the diversity of medical cases in Malawi. Cited in the project narrative, the aim of the partnership was to:

Strengthen traumatology and emergency medicine care at Kamuzu Central Hospital (KCH) and the new planned trauma centre LION at the hospital through education and enhanced competence of Malawian health personnel in the fields of Radiology and Physiotherapy. (NOREC Partnership Narrative Report of 2019)

For example, David mentioned that one of the reasons why he was sent to Norway was because KCH had just purchased an advanced scanner which needed trained professionals:

I was deployed there (Norway) *to learn about computed tomography scanning, it is one of the advanced imaging modalities that we have in radiology and by then we had just installed ours at KCH.* (David)

Prior to their deployment, non-had practical skill and expertise to use advanced computed tomography scanning.

Elin acknowledged the capacity development goal of the project. She said:

Our goal was to help in physiotherapy treatment for patients. For Malawi I see the benefits of the exchange program in that they are now valuing physiotherapy more and are now seeing the need for the department. I see and appreciate that KCH value the collaboration because they are having more positions for physiotherapy department. (Elin)

Building the capacity of physiotherapy and trauma care department at KCH was at the core of the collaborative partnership project. Haukeland University Hospital also exposed their health professionals to get used to work in a resource constrained environment and get exposed to conditions that were rare in Norway but are becoming more common due to the high rise in number of refugees and immigrants.

Strengthening international cooperation

While KCH and HUH aimed at exchanging knowledge and building each other's capacities in trauma and emergency medicine, NOREC's involvement was aimed at fulfilling their mandate as a Norwegian government agency responsible for international cooperation and developmental projects. NOREC's aim was therefore to feed into the Norwegian governments' international development policy:

In Norwegian we have a formal legal document, signed by the King which describes what NOREC is for under the foreign ministry. That document gives NOREC as a government agency, administrative mandate to implement international collaborations. The document clearly states that NOREC should be a center of competence for exchange as a method of international cooperation and Norwegian government commitment to the SDGs. We are called to promote these SDGs, particularly and precisely, the promotion of human rights, women rights and equality, climate, environment issues and anti-corruption. (Stian)

5.4 Supportive Resources

To ascertain how participants managed to face the challenges and deal with their fears and different perceptions about participating in the project, I was able to ask questions around what form of support they got to prepare for their integration into a different social setting. For some participants adapting into the new environment was a major concern while issues such as accommodation, travelling without family, meeting new people, and working in a totally new environment were highlighted. Several participants however felt that they had already made the decision to participate therefore were prepared enough to deal with insecure settings and ready to participate in the exchange collaboration:

I was well prepared for it, and I also had quite a few years of work experience before I left. I was used to making decisions and being in insecure settings, in the work for radiologists you must live with those insecurities, and I was used to that, so it was not a big issue for me, writing reports, discussing, and feeling a little bit confident in the report for example. (Hege).

Participants' mental preparedness may have been at the core for their preparedness while various reasons that motivated them to participate might also have aided.

Pre-training and Post training Support

Preparatory training was identified as one of the most important part of the exchange program cycle. Both participants and coordinators regarded this as the first step in the exchange collaboration and a platform where participants shared experiences and interacted with colleagues from different settings. Majority of the participants felt that the training was very relevant to prepare them to adapt when both travelling to and coming back from the exchange program. Several participants thought this training was an important platform to unlearn different stereotypes and perceptions between nations and people.

Tionge remarked:

Norec provided a predeparture training to help us prepare for possible cultural shock that we might have to experience. There was a psychologist who introduced us to the topic around stereotypes. It was very important because people have some stereotypes when they see you coming from Africa so I had to get prepared of what I would possibly receive and what I would expect to encounter. For example, it was through the predeparture training that I became aware that there

were people who did not even know where a country like Malawi was. I was expecting people like professors to at least have a glimpse of where Malawi was, but this just showed me that not everybody can know about you and your identity. It was a very necessary mental preparation for me. (Tionge)

However, while most of the participants found the pre-training useful, Jacob contested that the information was "too general" and less addressed the realities of his own profession describing the facilitators as "less conversant" with trauma and emergency medicine while more attention and examples were drawn from other fields.

There are many social campaign programs that are given more attention, things like 'drums in the prisons', 'bringing change in the community' but less attention was given to those of us who work behind buildings. People will not easily see what we do so sometimes they forget us during trainings, they only take those that can carry the banner for NOREC but those that carry the banner at the backstage are hardly noticed. When health care is improved it is not always that person that was doing civic education, or social change but all of us. (Jacob)

The training provided by NOREC reportedly created a foundation for cultural interaction and participants familiarity with the project. Profession and contest specific information and training was also considered important for participants. In the next chapter, I will now present the participants encounters and experiences with patients during the exchange partnership.

Chapter 6

Encounters and experiences with patients from a different socio-cultural context

6.1 Introduction

This chapter will present participants experiences with patients under a different social and cultural work setting. I will also present how they handled their relationships with patients in their role as care givers. The themes that came out in the findings include health seeking behavior, communication, patients' level of education and the influence of leadership, gender, race and age in the relationships.

6.2 Health professionals encounter with patients

Health professional's relationship and early encounter with patients

Most of the health professionals from both Norway and Malawi reported a generally accommodative relationship with patients during care giving in their host countries as reported by Hege,

I was welcomed and accepted by patients. It was very nice when you come in the morning, and all the relatives and patients are very happy to see you, they all greet you, it is a good spirit in the ward even though they had these big burns and in lots of pain, but all had very nice communication that also a good experience. (Hege)

Cultural connotations of the relationship between the patient and the health professionals were, however, a recurring theme throughout the study. Most of the Malawian health professionals found Norwegian patients to be more expressive and according to Chikondi, the relationship was flat and patients *"were more like clients."* Norwegian patients were therefore perceived more open and exhibiting freedom to make decisions or at least get involved in the decision-making process, a movement away from the traditional patient-caregiver paternalistic relationship. This empowered the patient more according to Tionge,

"There is what we call paternalism in health care, when health care professionals have more control over patients. You can see this difference in control on patients among health care professionals in Norway and Malawi. The more we are moving is that direction of less control the more patients have more opportunity to make decisions themselves." (Tionge)

In the case of Malawi, hierarchy and respecting authority or expert power is a sociocultural element that shapes and forms the bases of relationships. Consequently, Norwegian health professionals found Malawian patients as mostly reserved, quiet, and humble as noted by Rebekka:

The patients were mostly quiet even if they had bad injuries. The guardians were also very quiet, not complaining and there was very little questions asked at least to me.…maybe they were humble in meeting the health professionals in the hospital. I think what was different from Norwegian relatives and patience is that maybe they are more forward, more aware of their rights as patients. (Rebekka)

Malawian patients' humility in traumatic situations is also recurring in the findings. Most Norwegian participants experienced minimal display of emotion by Malawian patients and their relatives in a hospital setting. Norwegian health professionals thus reported different experiences on how patients and their families communicated and expressed emotion, grief, or pain when facing traumatic health conditions and this made it difficult for them to know how to act appropriately in supporting the relatives. As one health professional from Norway to Malawi noted:

Things that stick with me most was to come across very sick children. I had these images of seeing the patients and seeing the scanned images and the severity of the disease; then noticing how little farce around it was disturbing. It was very surprising for me that we had seriously ill patients and were children, but I could see lack of display of emotion. I understand that it was devastating as well for Malawian relatives but in Norway it would be shown in a different way by the relatives, so maybe we grieve and handle crisis situations differently. That was one of the things I brought back with me that they are different ways of grieving. (Hege)

Malawian patients were also described as less shy in revealing their bodies in front of health professionals during body examinations. Maria had similar experiences with patients and felt that she needed to be oriented about such patient behavior to avoid cultural shock and getting uncomfortable around patients.

In Norway, it is very common that every patient needs privacy, you need to shield the patient, give them space and if you are scanning the abdomen you need to cover everything except the abdomen. In Malawi when people came for some examination, they just took off their clothes and they were

not shy at all. That was different and it would be very nice to get some information on how it is to live in villages and what is normal there. (Maria)

Where the humbleness and quietness of Malawian patients was generally interpreted as lack of exposure and understanding of their rights as patients while Norwegian patients were described as '*more forward'* and knowing their rights, a socio-cultural interpretation of how hierarchy, authority and power influenced how patients' relationship with and behavior around authority was also acknowledged by health professionals.

Health Seeking behaviors in a different sociocultural context.

Participants reported more advanced and severe health cases in Malawi compared to Norway. Patients' attitudes towards disease and their health seeking behaviors led to Norwegian participants treating more patients with advanced medical conditions at KCH. Severe emergency care cases were encountered more in Malawi as compared to isolated cases in Norway. It was reported that patients visited the hospital when they were too sick or when the diseases were at an advanced stage. In contexts like Malawi people only seek care at hospitals after everything else has failed. In other words, health facilities were the last options after traditional medicine, religious inquiries, herbs, and related home remedies. In addition, these severe cases were prevalent among patients from rural and peripheral areas outside of Lilongwe who may also have been more cultural and following traditional medicine more compared to those from urban Malawi while also facing accessibility challenges to travel long distances to the KCH for medication. Contrary to that, in Norway, the health care is mostly free and treated as the priority system of reference while exposing patients to minimal financial commitment in case of disease. One health professional shared:

I had a very huge experience that many of patients come to the hospital at a very advanced stage of the disease. One explanation was that it was an obstacle if they lived in very rural areas that are long distance from hospitals or community health centers. Another obstacle was the economic ability to travel, and the economic loss incurred by leaving their homes. There was also the mentioning of local doctors that uses traditional medicine that was the first choice of treatment of disease or suspected disease. Also, maybe it was difficult for them, first they had to have a guardian with them and that would be two people leaving the home and maybe if there was a difficult on the provider of the family leaving the home as well. I know that in Norway you must seek medical help from your doctor if you reach those stages of a disease. (Rebekka).

Unlike the Norwegian health system that provide free health care, highly funded and equipped with advanced medical infrastructure and information technology, Malawian patients were deterred to seek medical care because of high medical fees and low-income opportunities opting to fend for their families if they could until the condition becomes more severe. Economic status of Malawi, high population density and institutional capacity at Kamuzu central hospital to cater for as many patients delayed care and all led to the prevalence of advanced medical cases compared to Norway's smaller population with a rich economy.

These two hospitals are different, of course they are all referral hospitals but when you look at the population of Norway, it is about 5 million people, and those people are very rich. However, when you look at KCH, it is a referral hospital but there is no complete district hospital in Lilongwe…. KCH still handles even primary, secondary, and even tertiary cases. Most of the cases that are supposed to be handled by lesser hospital, but they are still handled by KCH. We see almost every patient unlike HUH which is practically a referral hospital. Even if a staff member is injured there at HUH they will start with that smaller hospital and then only when it's necessary that is when they go to HUH because that is like a referral hospital, only serious cases of those who have been injured and if it's only through booking unless it is like a real emergency. That is why I saw that there they were more organized but here in Malawi almost everything goes, there is no organization at all, there is no control. (David)

Though the severe medical cases were experienced more in Malawi, reports suggested that a few cases of severely delayed medical conditions were also recorded in Norway. Some patients with severe cases had immigrant background and were still familiarizing with the health system in Norway. Other patients did not have relatives or guardians, they lived alone, and had minimal social contact which is typical of Norway according to some participants from Malawi. Some of the mentioned reasons were that the readily available working system made some patient more reluctant to seek medical care, others were generally afraid to know the consequences of their health conditions. Hege claimed:

When providing care to Norwegians you really must emphasize the need to follow instructions and you must follow them up closely when they are not doing the exercises. They have so much information at their disposal and individual choices to make. It is easy for Norwegian patients because they have more following up, they can come to outpatients' clinics often. (Hege)

Health professionals encounter with extreme cases gave them more insight on the socio-cultural and environmental conditions. While it was mentioned by Maria that the NOREC project had no provision for them to go into outskirt areas, she requested and was granted permission to visit the district hospitals in Malawi to assess the equipment and have a general understanding of the environment beyond the hospital setting.

Communication with patients in a different cultural context

Language and communication reportedly brought different cultural tension between patients and health care professionals. For most of the health professionals, language influenced significantly how they communicated, interacted with and understood patients' conditions. Though some of Malawian participants thought that they would be rejected by patients, they found it easier to communicate with Norwegian patients in English and described them as generally welcoming.

Chifundo shared,

I experienced very smooth interactions especially when the supervisor allocated me English speaking patients. I did not expect such a smooth experience because I thought patients would not allow me to see them upon discovering that I was a Malawian who just came on an exchange program and going to be their physiotherapist. On the contrary they were so excited that they were going to be examined by someone new. So, on that part I found it exciting, it would have been very hard if it were the other way around. (Chifundo)

On the contrary, language was generally a significant barrier in situations where health professionals needed to act independently and understand the patient's condition and or give a medical instruction to the patient,

Interacting with patients from outside of Lilongwe was quite hard. While I could not speak Chichewa, not all Malawian patients could communicate in English and that made it difficult for me to know if they were in pain or whether they had understood my instructions. (Maria)

For Langa as well, language was a serious barrier and she felt rejected because sometimes patients preferred Norwegian nurses to her because they felt more comfortable to express themselves in their local language.

6.2.4 Age, Race, and Sex Identities in care giving

Results show that age, race, and sex identities of both the patients and the health care workers contributed more to the relationships and care giving in the hospital setting. Some of the Malawian health professionals reported skepticism from elderly patients in Norway:

With elderly patients the experience was a bit different. Some of them were skeptical of outsiders, these are people who have grown up in Norway, they have spent the rest of their lives in Norway, they know little English, I encountered one or two cases where patients felt more at ease when I am working closer to a Norwegian professional compared to when I was alone. (Jacob).

In addition, some participants faced challenges in connecting with patients due to age differences and level of previous exposure to multicultural contexts. One official administering the project highlighted,

What we noticed is that some health professionals on exchange struggled to connect due to age differences. In some cases, at HUH we had patients and colleagues with wide age difference, some in their 50s or 60s while others were younger colleagues exposed to English music and American shows and generally travel a lot. The experience working with these patients colleagues was likely different for Malawian participants possibly because of age and level of exposure... (Elin)

This skepticism was also shared by Langa,

A patient asked a Norwegian nurse to do the procedure instead of me and I could not understand deep Norwegian, but my supervisor told me that she will perform the procedure instead and that the patient was anxious. (Langa)

While participants experienced skepticism particularly from elderly patients, it may have due to various reasons among those that Norway is beginning to develop multiculturally with elderly patients learning to be more comfortable around multicultural hospital setting.

could have been different to that encountered with younger patients.

In most instances Malawian patients and their relatives trusted more the exchange participants coming from Norway compared to their locally trained and practicing care givers. Participants such as Maria found this experience challenging because they had to communicate with the patients or their relatives and redirect them to the health professional qualified to attend to them.

I had a few challenges with that, at the hospital here in Malawi, when everyone sees a health professional from abroad with the medical coat, they think you are a doctor. Some patients came to me and asked if I could do their examinations. I said No, I cannot do that, when I told them that my colleagues are much better than me at this; they did not believe me. (Maria)

Tionge thought that the Malawian patients could have trusted external health professionals more because of preexisting stereotypes and general mistrust of local expertise, products, and services.

There is perception that white people are more knowledgeable than us in Malawi, most of the patients in Malawi are happy when they have been attended to by a white person. The only problem is language barrier for the patients and the Norwegians especially for less educated people who cannot speak English. (Tionge)

While health professionals acknowledged the existence of social cultural differences in experiences with age and race, Chikondi expressed contentment with her encounter with patients and stated that she *'felt welcomed and valued'* by patients at HUH regardless of age and her gender as a woman:

When I am treating patients back home, some of them even refuse treatment by just looking at my appearance as a young female health care worker. They opt for older people to treat them which is different from Norway. Patients did not really look at how old I was or how young I was looking; they just came to get the help. This was more assuring and very encouraging to come across patients who were elderly and were very willing to get help from me, it was very encouraging and very assuring. (Chikondi).

In Malawi, age and gender carry cultural meaning related to authority and power with younger people expected to give respect and authority to the elderly, therefore the relationship between patients and health professionals may have been influenced by that.

6.2.5 Level of education and literacy of the patients

Several participants felt that the level of education hugely affected the extent to which patients were able to understand and respond to health care.

"…what shaped most of my relationships at HUH was patients' level of education, social and economic status. Patients' level of understanding of medical concepts in Norway was different so was my approach in giving instructions compared to how I would do it in Malawi. My patients in

Norway quickly grasped what I would explain to them and they were very much invested in the procedures. Almost all of them had basic level of education and mostly working." (Chikondi)

Health professionals such as Chifundo thought that differences in levels in education and comprehension resulted in delays with more time taken to explain and ensure patience understand and give the correct recommendations.

In Malawi you spend more time with a patient because it is difficult for you to put across what you want the patient to know, while in Norway, it did not take longer time to see a patient, I did not have to spend one hour with one patient, 15-20 minutes was enough. (Chifundo)

Chifundo's experience also revealed the differences in socio-cultural and health system context. Health care giving in Malawi is less structured because health professionals would in most cases move from one department or section to the other due to limited resources and high demand. Due to the communal and sensitive nature of relationships in Malawi, health care preceded social relationships where the health worker would have more conversation beyond the treatment thereby taking more time. While in Norway, it is more instrumental and structured, following ethos of the new public management and results-based system that prioritize efficiency, limiting patient health care professional relationship within the medical boundaries.

Some health professionals from Norway contested that the ability to successfully meet patients' needs might not have sorely depended on their level of education but the care giver's ability to communicate and ensure that they understood the instructions. Participants reported that though in Malawi, patients who came from villages and outside the city had limited opportunities of education therefore lower levels of literacy, they were more cooperative and followed all the health recommendations once they understood what to do.

Very many of the patients came from small villages outside the Lilongwe. Very few of them have been to school and understanding of the body and what we were telling them made me maybe ensure that they have understood what I have said even more than Norwegian patients. What impressed me above all was that when I instructed patients in Malawi, they followed up what you said more than what I experienced with patients in Norway. (Hege)

While education and literacy of patients affected how health care professionals communicated, diagnosed, and gave instructions to patience, the delays in attending to patients might also have

been influenced by both the social cultural and health systems differences in settings between HUH and KCH.

Chapter 7

Health professionals' encounters with co-workers and management

7.1 Introduction

This chapter presents findings drawn from participants experiences with coworkers at their host health institutions in both Norway and Malawi. Participants interaction with management, and other health care professionals at their host institutions proved significant in building good working relations. Below are the detailed findings.

7.2 Experiences with professionals from a different context

Understanding the system around teamwork and interdisciplinary relations in collaborative context

Integrating into the new workspace for most participants meant that they needed to learn the new routines and understand the organizational culture at their new workstation by interacting and coordinating with coworkers:

Whilst working with other health professionals in Malawi I realized that I could not go there and tell them what to do, I needed to know the system and it takes time to know how your new teammates operate. I think, you think you understand the system after a couple of weeks or months then realize later that there are things happening that you are not aware of, important things that keeps the system going. But I was not part of the system because it was going on in Chichewa and happening without me being involved. So, I learned earlier that I know just a little about the system, and it was difficult to give advice about the system that I do not know. Because of that I really needed to cooperate with my coworkers there to get to know the system and to have them helping me to understand it and until then, I was able to meaningfully contribute. (Hege)

Participants from Malawi on the other side were more willing to participate in teams and listen to any advice from Norwegian health professionals especially when they felt that their way of managing trauma was being respected and when they felt valued as professionals coming from the Global South. Jacob found understanding others working context and respect to be at the core for team collaboration,

People are curious to understand how others do their work, through that Norwegian health professionals also helped me to understand how things are done in their context. For example, those coming from HUH were trying to adapt to our way of doing things. They understood that they cannot change everything, they needed to understand that we have our way of doing things under limited resources. For them to be able to help us on our work, they should know where to start from, they should better understand how we think and I think that is what they have learnt, they have tried to understand that, and I am satisfied with the progress. (Jacob)

Most of the exchange participants tapped into the local professionals' contextual knowledge to learn about new diseases and health cases, in performing hospital routines aligned to their duties. Participants such as Maria felt that knowledge sharing was more effective when training and education involved effective communication and executing tasks together with colleagues.

When I worked in CT and X ray departments learning was more effective by working together. I told my colleagues in Malawi that I was not there to only give them information, but we needed work together, share and discuss things. Learning within teams is not a situation where only one person is working, and the other is giving instructions. We shared knowledge by effectively communicating and asking questions like…. why did you do this, what do you think about doing it this way," (Maria)

When Malawian health professionals at KCH noticeably demonstrated commitment to work, exchange professionals from Norway became more willing to assist them when they needed professional help or advice. Despite high volumes of emergency cases at KCH pediatric ward, health professionals from HUH such as Rebekka felt *"relevant"* when Malawian doctors referred to her physiotherapy reports and interpreted the findings relatable to her context in Norway; because to her *"it would not help as a radiologist when nobody reads your report,"* (Rebekka). Other participants also found motivation from working with dedicated coworkers,

The clinical doctors on the ground in Malawi were very dedicated in their work which also motivated me to be dedicated on their behalf and on the behalf of patients. There were very many hardworking Malawian health professionals who were at work early and logging off late and would contact me maybe late after work because they have patients and when I could, I would help from my home. (Marte)

Both Norwegian health professionals and Malawian health professionals acknowledged that understanding each other's background facilitated their integration, the ability to work together, provide and seek help from coworkers.

Building mutual trust

While understanding and respecting the partnership context was essential for team collaboration, participants from both KCH and HUH reported the significance of mutual trust and how efforts in building trust with coworkers helped them integrate. The majority felt that they were trusted and welcomed when they showed more learning interest and commitment to the work and working with others.

David shared his positive sentiments with regards to trust during his tenure in Norway:

One thing I admired at Haukeland is that they valued teamwork and they trusted people. They believe in people and even though they were supposed to supervise us sometimes they even left us alone to do our job. (David)

Tionge added,

Professionally I had to ask a lot of questions on how they work and take the initiative by asking for permission to work on patients. When my colleagues in Norway observed my efforts in trying to be conversant with the work, correctly pronouncing words in Norwegian language while instructing patients they were very happy. They started giving me more and more opportunities to attend to patients. (Tionge)

Hege further elaborated that for her, trust was something she invested in and worked for before the host professionals could be less skeptical and willing to work with her.

….the people in the system are so used to people coming and going for shorter and longer periods, so they sort of have skepticism to work with a new person coming into the system which meant that I needed to gain their trust to show that I was there not just as an observer but to be part of the system and that takes time. (Hege)

Most of Norwegian participants felt that although it was easier for them to be trusted and integrated into the system because of the knowledge and professional experience needed in Malawi's trauma

care department, they faced challenges on how to balance between respecting other people's system and sharing their knowledge.

Because I was coming from a different country with knowledge and skills that KCH needed for the CT scanner, they easily welcomed me. Having something to offer made it easier to integrate but it was difficult sometimes having the background that I have of many years of management experience, I have worked with images for 30 years and I had an idea of what was required and how it should be done but then to adapt that respectfully into someone else environment sometimes can be a challenge but I think we were able to have a balance where I was trying to be respectful. (Marte)

Underlying trust concerns and presumptive cultural perceptions were recurring factors in the collaboration between teams.

Confronting the differences in work ethics

Experiences of existing differences in professional and work ethic between Malawian and Norwegian participants initially created cultural clashes but later transformed into an opportunity for participants to learn and understand the context beyond the hospital setting. Participants from both KCH and HUH struggled to cope with differences in work culture in relation to time management, structure of meetings, reporting for work and generally job execution. Norwegian participants were frustrated by the slow and casual approach to work in Malawi while Malawians experienced a more structured, time guided health system and team oriented working culture. For instance, participants such as Rebekka reported facing challenges in adjusting to the working culture *"In Norway, we have working hours and we keep them"*. Tionge and Chifundo on the other side felt that there were too many schedules, deadlines, reporting and team meetings *"discussing almost same things week in week out"* but also acknowledged the efficiency that came with that; while Chikondi felt that she was not informed of the reporting arrangements prior to the exchange and only got to know of what she was expected of during exchange program. One participant from Malawi shared,

To tell you the truth, colleagues at HUH are good time managers. When it is time to work, they do not do anything apart from work and they are very punctual. When we go for lunch at one O'clock in Malawi, some even come back at 3pm (laughs)…. *You cannot separate our colleagues in Norway*

from meetings as well, I struggled to handle too many meetings (laughs)….. *I remember the first participants from Norway really struggled too to cope in Malawi because we literally had no space for meetings to hear from them and see how best we could work together. What I learnt is that anything good comes from planning and better planning yields better results, better planning means good meetings, so I think that too has been something that has made me a changed person even though I did not really enjoy the frequency of the meetings.* (Tionge)

Hege reinforced Tionge's submissions as she shared:

The cultural difference is that in Norway, we want to have everything very efficient but when I worked at KCH, I had to learn that the tempo is different in Malawi than in Norway. I want much to happen faster, but I learnt that I should just adjust and be patient. (Hege)

The importance of prioritizing job descriptions, duties and roles was echoed by Elin citing those participants began appreciating the *"importance of having a system around everything and staying loyal to the system." Most of* Malawian participants reported experiencing more patient oriented care at HUH,

In Malawi, we are more relaxed and freer to interact with anybody at any time., we can even go out together and do something else but for Norwegian participants everything was about work. I think It is not good for patients to come and wait. In Malawi when you go to a hospital, and a friend of a doctor comes you are made to wait for minutes or even hours until they finish dealing with the friend. I think we need to improve on that. When I went to Norway, it is non-negotiable and known that the patient comes first. (Jacob)

While time management and adhering to the roles and regulations were mentioned by participants from both Malawi and Norway, showing up late and in extreme cases persistent absenteeism stood out as sources of tension between Norwegian health professionals and coworkers in Malawi. While not showing up at work without official communication was not common in Norway, participants from Norway were "*frustrated"* while others "*hardly understood*" why Malawian health care professionals come to work late, having longer lunch times, with some constantly absent, missing out on meetings or logging off early. After experiencing this working culture, most participants wanted to be aware of the reasons behind these experienced differences:

My colleagues helped me to understand their daily lives by talking to them on how they do not even have water in the house in the morning to shower. In Norway we have hot water to take a shower, you have a washing machine, you have the bus that comes in time, and you know when it leaves. What I learnt from my colleague is that their daily living is very much different from my Norwegian way of life and that influenced their work as well and ability to arrive on time, how to get in time to work, daily life after work, takes time to wash clothes, do shopping, its longer distances or a lot more complicated to get around…that explained why they come late, why they go early and how they work both at the hospital and in private health facilities to get enough income. That made it more understandable…when get up at 4 am in the morning and you get home by 5 pm, you are tired and that explains a lot. All this made me realize that things are done differently and the responsibility of how one works was accounted differently because at Haukeland, you would have quickly lost your job. (Hege)

Rebekka reinforced Hege's submission, mentioning how Malawian health professionals found a way of covering up for each other,

They shared tasks among themselves because many of the people in the department and other departments too had several jobs to be able to provide themselves. I think that if you did not show up at work one day in Malawi it would not be taken as gravely as it would be in Norway. (Rebekka)

Other participants from Norway had to to communicate their concerns which later challenged coworkers to show up at work. Because HUH hosted health professionals from other countries with well-functioning health systems, some Norwegian participants reported getting inspiration from how these health professionals facing similar challenges at KCH handled the same concerns.

*I did not change my way of working; I did the same things as I would do in Norway. I would have questions about it especially when I had an appointment with a person, and they do not show up. Frustrating as it could have been, I tried to remain respectful and less judgmental to my coworkers at KCH because there were not all things I knew about every person's life and things they were going through. They could have a solid reason for not showing up, I tried to do my work as I would have done at home. (*Marte)

Rebekka shared,

Other physicians were there, there were lots of health professionals from Germany, USA and all over who had sort of comparable health systems with that of Norway, they continued with their work as usual and that was comforting. (Rebekka)

Maria added,

I had to share my concerns with them. Very quickly they understood that they had to come to work because I could call them if not.

Differences in work and professional ethics were a source of tension in the partnership. Malawi, issues of low work motivation was exacerbated by poor working conditions, low salaries and poor monitoring and reporting mechanisms to regulate the performance and adherence to job requirements. The structured and routine centered work relations from Norway work culture created challenges for Malawians coming from a communal and more casual context were work and personal relationships are fluid. Cultural clashes stemmed from these differences in approach to work and what was considered acceptable work behavior between the context of KCH and HUH.

Communication and knowledge sharing experiences

Communication emerged as one of the integral parts of the collaborative partnership. Communication was referenced in at least three ways; in terms of language of instruction, social relationships, and cultural interpretation in communication. Most of participants reported effective communication when using English language. However, language emerged as the major barrier for effective communication for Malawian participants in Norway while the same was experienced by Norwegian participants. For example, while most Norwegian participants felt *"lucky because in Lilongwe many people spoke English,"* majority of Malawian participants could not cope with Norwegian language. Health professionals such as Tionge *"felt like an intruder,"* during meetings and it resulted in some participants absconding these meetings. Similarly other Norwegian participants '*felt isolated'* during brief social breaks and when delivering care.

Jacob shared:

We usually had morning meetings; it was a meeting discussed in Norwegian. I attended almost every meeting, but I did not have a clue of what was being discussed. Unless there was something specific that I was supposed to do then they will explain or when I see people excited or happy and I would ask someone what was happening.

Tionge and Langa added that some Nowergian nurses were uncomfortable to work with them every time their supervisors were not at work because they felt more comfortable speaking in Norwegian. Norwegian participants also felt that the language barrier secluded them to fully participate in employee discussions and social interactions that were conveyed in Chichewa:

They talk in Chichewa and I did not know the language. It is not a problem with me but I really wanted to know the language and it would be so much nice to know the language so you could be part of all the discussions and the communication. That is when I felt mostly isolated. (Hege).

Rebekka on the other hand felt that social interactions took much of the time that was supposed to be dedicated to care giving.

…being polite, socially discussing and greeting everyone in the team was one of the big differences and for someone like me coming from Norway, that means that the things take more longer time and of cause in an acute setting if you have something that needs to be dealt with quickly you must skip those steps. (Rebekka)

However, Chikondi had somewhat different perspective on language and communication concerns, citing that coworker at Haukeland hospital and the project leaders were aware of the barriers in communication and made efforts because of their vast experience in working with international participants. While other participants felt that their hosts deliberately spoke in Norwegian to frustrate and exclude them, results also showed that because Norwegian was the language of instruction in Norway, some technical and medical terms were more effectively communicated using Norwegian as the official language.

Coming from a place where we speak our native language as well, I would not expect someone who has grown up the whole life in their country speaking their language to just suddenly switch to speaking in English, I mean it was not fair from where I was coming from. That is why I was very understanding while also they were very understanding on their part, trying to explain and interpret Norwegian for me. Also, because it was not the first time collaborating and taking a person to Norway, most of my colleagues were very aware that maybe they had to at least speak some English when I am around. Also, my colleagues were teaching me a little bit of Norwegian, so I learnt most of my Norwegian from my coworkers. It was not very difficult because they were well cognizant that there was someone at this place who did not understand Norwegian, so they

were very welcoming, and they were very considerate by speaking in English when I was around.... for some conversations that they were having in Norwegian they would always explain to me that it was going to be difficult for them to explain it in English, so they were going to speak in Norwegian. It was not hard for me. (Chikondi)

Some participants showed cultural desire and willingness to learn with regards to language and communication. One participant from Norway liked the social interactions at work because it also meant she would connect and learn more about Malawi, get used to Chichewa and the general culture.

It was a nice and good experience being with my colleagues in the morning, we had a small room were all colleagues met in the morning. The discussion and the communication we had in that room was really a nice way of starting the day and building a team. (Maria).

Others found the language barrier as an opportunity to work with a local health practitioner.

.... for me I also used it as an excuse to work together with the local radiographer (laughs)*... I think in our profession it is more effective to understand the context around patient's condition by working together with the local radiographer for this collaboration to work,* (Rebekka)

David had to learn Norwegian online and later joined the lessons,

…. *they send us to do a language course, at the same time I was practicing Norwegian. As soon as I picked some Norwegian it was smooth, later I even found out that most of them can speak English smoothly, they were just shy, they were used to speaking in Norwegian, so it was not a problem at all.* (David)

Contrary to David, Tionge felt isolated, and ended up not attending the meetings.

I think every Friday there was a presentation when we will be learning a lot of things. At first, I would go there but I later stopped going to the presentations because honestly, they were happening in their language, and they could not care that you were there. And you know how it feels to be asking everyone next to you of the proceedings, it means the person will even miss the information that they are getting there. (Tionge)

While some Malawian participants might have thought that the communication tensions were deliberate, it emerged that age differences between health professionals might have influenced their

conduct. What came out was that older health professionals at HUH could have been uncomfortable speaking in English because of getting used to Norwegian language, and generally there was inadequate knowledge of the exchange collaboration across departments and participants might have withheld themselves for fear of being culturally inappropriate. One project coordinator is quoted below:

Malawian participants had problems connecting with their colleagues at Haukeland because some people are uncomfortable speaking English, or they did not really know enough about the people coming. I do not think Norwegian health workers have any issues with having Malawian participants, but they have not been more information about what they are doing there. It has been an issue, but I think we are getting used to having people from other cultures. When they are comfortable speaking English, they also become comfortable asking questions and more interested in learning something new. I also think when people come from Malawi, it is important that their Norwegian counterparts are well informed about their roles in the department, and I think it is improving. (Elin)

Communication and language presented social and cultural dynamics to the interaction between health professionals. While Norwegian health professionals faced minimal challenges with communication and language in Malawi, communication and language as social cultural tools in relationship building

7.3 Management-caregiver relationship: Experiences and Impact

7.3.1 Experiences

Results show that the relationships between the management and the health professionals impacted individual participants experiences during the exchange collaboration. Most participants reported having received support from the management before and during the exchange program. Key notable findings pointed to significance of hierarchy between partners and within the hospital setting, impacting the relationships between professionals from different professions and their perceived power and influence from both the Malawian and Norwegian perspective.

Hege shared:

We have a flat structure in Norway, I think as a Norwegian, when you go to Malawi, you are going to step on so many toes, especially when you go to some government office in Malawi. I think I

behaved differently in Malawi because I tried to speak more politely, not that I am not polite in Norway, but we are sort of on the same level but in Malawi, you feel that you are really seating on a lower level and that is the same with the doctors as well. (Hege)

One of the project managers further explained how professional related to power and position.

An element that I have seen both from Norwegian participants and Malawian participants was about the way they work in teams. I think there was a reflection by a Malawian participant that she had at least not used to the level of respect that she observed between different professions at the hospital. I assumed that maybe from her experience back in Malawi there is more rivalry between professions. For example, if you are a doctor, you approach a nurse in a certain way and if you are a nurse, you approach a radiologist in a certain way. There are more specific ways of communicating depending on your profession and your formal position. (Stian)

Similarity with what has been explained earlier in chapter 6, positions and qualifications carries social and cultural significance in Malawi, creating visible social strata.

Participants however reported a gap between management and the health care workers both at the departmental level and at the national level. Some cited that because the management were balancing between running the departments administratively and supervising the participants, there was limited contact.

I think at the level I was in the hospital those with authority are far away from the people working there. They are employed by the ministry of health and there are no representatives from the ministry of health in the department, so they have sort of distance between those in authority and those employed. In Norway you have a much closer attendance of those who have the authority and that might also be a contributing factor in terms of what you do, how you perform your tasks that there might be some repercussion or consequences…its maybe more transparent what you do and what you do not do in your job. (Marte)

Unlike Jacob who felt trusted by being left to work on his own as earlier reported, Tionge felt the lack of direct supervision isolated him from everyday process at the hospital in Norway.

In the department where I was working, there was no person who could direct me, like whom I could report to. You know if you have anything else you report to someone within the department.

But the one who was supervising me was in nuclear medicine, another department which was even outside the hospital. (Tionge)

Hege devised strategies to meet up with the supervisor by using platforms such as WhatsApp,

With the head of Department, he was a quite busy man, I tried to set up meetings with him sort of to reveal cases with him, there was obviously many things that was unknown to me with the disease panorama in Malawi, the infectious diseases and other cancer types that I was not familiar with. I found out that the best way for me to interact with him regularly was to set up a meeting, so we communicated regularly on WhatsApp and made appointments so that we could seat down together and that was an important training for me. (Hege)

7.3.2 Program impact and suggestions for future programs

Results show that in terms of institutional development and capacity building, the project significantly enhanced the existing relationships between the HUH and KCH. The collaboration between HUH and KCH has been going on since 2007, with technical and material support invested in equipping the hospital in Malawi. All the participants mentioned that the project led to the refurbishment of the emergency department in Malawi, improvement of the information system and patients records. At a personal level, all Norwegian participants felt mentally strengthened to deal with stressful situations and advanced cases while most of Malawian participants indicated that international exposure made them confident professionally at the same time open minded to new cultures.

Before I went to Norway, I was very much reserved, I was in my own small box but now I feel I am free, I have seen something new. Look like am saying I say the program is new in the country (Malawi) *you are not so sure that you are doing the right thing but with that exposure you are so certain now, I feel so certain I am doing the right thing and I feel confident now than before, I feel I can fit in any society now. I feel I am more advanced in my approach to issues as I was before. I now know so many people, we talk all the time, I am more connected now. I feel this whole exchange provided me with credible experience, which is very rich, I will not regret.* (Jacob)

Uniquely, Maria became more attached to her host country and came out with changed perspectives and understanding of the gap that existed between Malawi and Norway and as such, she had to remain in Malawi for her to contribute more to the health system.

I learnt to appreciate things that we have at HUH. It's very easy to just come on to your work mode and complain about everything that does not work, we should feel lucky that we have the systems…even though you have to wait for a few minutes, but it actually works. I felt like the work at Haukeland wasn't that important as the work at KCH and I remained behind. (Maria)

Participants and the management also felt that the collaboration needed to invest more on the previous participants especially in the development of future collaboration. Most of the previous participants from Malawi felt that they have more to offer in the future collaborations and felt that their participation and the developing project drafts would help in balancing between the management and with recommendations from those who were on the exchange.

The next project there should be more consultations with the participants who have visited these areas before they draft future programs that involves exchange of participants. These things are done in offices you know, where people think they want to do ABCD but we the participants are the ones that see the reality and the implementation of those ones is dependent on what I have experienced. So, I think the more you have the participants on the negotiating table, it cannot be everyone but maybe one or two. What you cannot maybe you can note is how things are done at HUH? there are important but are too general. (Chifundo)

One participant suggested that the partnership should consider recruiting beyond young people allow participation of older health professionals as the department at HUH only have more of senior professionals.

My experience is that with the NOREC goals they have a certain age limit, and, in our department, people are getting older and it's hard to find people to go for the exchange. I think it would be possible for older people to go even though there is issue that they might be seen more as advisors. (Hege)

Because of how stressful moving from one work setting to the other, Marte suggested deploying two participants from the same profession at the same time so that they support each other in dealing with stressful situations. Mental health concerns for participants dealing with trauma cases were therefore a recurring theme:

There is a lot of road accidents in Malawi, we have people coming to the hospital who are seriously injured and then not be able to treat them properly is sometimes very difficult for participants. If

you are working in a school or with culture or something you will experience challenges, but it will not be that in-your-face horrific accident where ten people just come at the hospital in a lorry and are dropped off and you must take care of them as best as you can with little resources. So, what we have been trying to advocate with NOREC for a long time is that we would really like two people from the same profession to go together. And then if you are alone away from your family, you are the only one in your profession, you do not have many people to discuss with maybe, we see that that is very difficult for some people. I think that also applies to programs in midwifery for example, when midwives are here they always work with gynecologist doctor but here they are left by themselves to deal with very difficult situations and personal impact that has on them as individuals is sometimes very harsh. (Marte)

Health professional experiences with coworkers affected their feelings about the partnership and helped them better understand the differences and possible ways of improving the relationships. The following chapter will discuss the findings and identify key areas for deeper reflections relating to the theories and the literature.

Chapter 8

Discussion

8.1 Introduction

With this study, my aim was to situate socio-cultural differences within a health partnership setting between Kamuzu Central Hospital from Malawi and Haukeland University Hospital in Norway. This partnership is funded by NOREC. The study paid particular attention to how experiences of health professionals who participated in this exchange program affected and contributed to the exchange at both the individual and institutional level. To achieve this, I wanted to understand their motivation for participating in the exchange program. Additionally, I also wanted to explore and understand the participants' experiences in a different social cultural setting, that is in the context of this study, relating to their encounters with patients, and newfound colleagues at their host institutions in Malawi and Norway.

This discussion is framed in three parts which are: a) a discussion in relation to participants motivation for participation. This part uses the BMCF to illuminate these motives which are related to partnership inputs and partnership tasks and responsibilities b) a discussion to explore the participants experience with patients and coworkers and this part uses the Cultural Competence Model to interpret and explain further these experiences in a multicultural context. Along with these theoretical frameworks, relevant studies from the field will also be used to relate to the findings of this study.

8.2 Discussion of findings in relation to partnership inputs and participants motivation for participation

The first research question of this study was to explore what inspired the collaboration and subsequent participation from a health professional perspective and the institutional perspective. This section will discussion the main findings related to this research question. These findings are presented in chapter 5 of this thesis.

Familiarity with project goals and involvement in agenda setting

Of particular interest in the findings was the process of the partnership project development and participants familiarity with the goals and inclusion in the agenda setting of the collaborative

partnership. The findings show that the majority of the participants who participated in the project from both Malawi and Norway had previously been involved in the project as resource persons or assisted in providing support to previous participants. Prior to the project inception, partners met and deliberated on the goals and specific areas for the partnership. They created consultative interactions in which at least participants from the first round of the exchange managed to familiarize with the project and their future hosts. The participants that followed the first round of exchange were also inspired to participate by previous participants. This finding is reinforced by findings from a research in Tanzania where community inclusion in agenda setting and project implementation significantly increased the project recruitment of new members (Corbin, 2013; Corbin et al., 2016). On the other hand, however, setting priorities without involving local stakeholders was found to contribute to tensions in maintaining a balanced partnership in Mozambique and Angola (Craveiro et al., 2020). Additionally, a study from Botswana found that antagony in the partnership largely emanated from unrealistic goals and a lack of appreciation to contextual needs, knowledge, values and norms (Katisi et al., 2016). This finding and other studies mentioned demonstrate that the engagement of local stakeholders, including potential participants of the project is important in building a sense of ownership which is a critical component for any partnership to succeed (Noormahomed et al., 2017).

Partnership Benefits

Participation in the agenda setting phase gave the participants a general understanding of the goals and objectives of the project. This enabled these potential participants not only to know and understand the needs of the project in terms of human and material needs, but also gave them an idea of how they could potentially contribute and benefit from this partnership project. For instance, majority of Malawian participants were motivated by their career objectives to acquire a new set of skills and exposure to advanced medical infrastructure while a significant number of Norwegian health professionals felt that they had professional skills, experience, and exposure to contribute to the project goals and assist in the development of the trauma and emergency department at KCH in Malawi. Both motivations come from the background that health service delivery is among the weakest parts of health systems in low-income countries like Malawi with both infrastructure and resources compromising quality and access (Johansson et al., 2020; Kayambankadzanja, 2020; Kruk et al., 2018). For most of the Malawian health professionals therefore, the partnership

presented an opportunity to work in a well-resourced health system in Norway as previously found in most North-South partnerships (Craveiro et al., 2020; O'Brien et al., 2018; Sheth et al., 2018).

In addition, participating would build professional reputation for participants. In a study on the International Union for Health Promotion and Education Corbin et al. (2012, p. 52) argued that an important factor of the union's success as a collaboration has been to develop mechanisms to meet its members needs for growth. They found that the members were motivated by building resumes, and professional reputation through working on health promotion projects or holding leadership positions at regional and global levels (Corbin et al., 2012). Furthermore, participants in Malawi saw the exchange as an opportunity for better renumeration. Better renumeration was also a motivating factor in for participants interest to move to Norway. Skilled personnel, funding and adequate infrastructure described as "inputs" (Matenga et al., 2019; Siegel, 2010) are fundamentally important starting conditions motivating partnerships and determining positive outcomes in partnerships efforts (Craveiro et al., 2020; Matenga et al., 2019).

An interesting finding is that strong motivation for participation, which might have been the basis of the partnership between HUH-KCH came from a shared interest at institutional and national policy level. Fundings suggest that both HUH and KCH intended to build the capacity of their health professionals and the institutions in trauma care and emergency medicine. NOREC on the other hand wanted to implement the Norwegian development policy which is premised on partnerships for SDGs. Within the partnership arrangement, KCH and HUH were expected to provide both human resources to administer the project and skilled health professionals (radiographers, Physiotherapist, radiologists) to participate in the partnership as the exchange participants. Health promotion literature in particular Green (2015) argue that governments through its departments like NOREC should be at the center of creating an enabling environment for health promotion action.

The partnership design by NOREC demonstrated an attempt at creating an enabling environment with a reciprocal foundation ensuring that all the partners involved deployed health professionals to work in a different socio-cultural contextual setting. NOREC was further motivated in facilitating the distribution of knowledge and expertise to Malawi in a model that also encouraged all partners to contribute to the partnership. For instance, NOREC expected all partners to declare their motivation for participating in the partnership and level of commitment in the project

development and implantation. One example of a similar partnership is between the Johns Hopkins Medicine/Armstrong Institute for Patient Safety (AI) and partnering hospitals in Liberia, Uganda and South Sudan (Basu et al., 2017). Basu et al. (2017) found that partnerships formulated on the pretext of mutually respectful relationships and a clearly developed structure and processes for shared learning motivates partners at institutional level.

8.3 Discussion relating to participants' encounters and experiences with patients, coworkers and management

I used the term "cultural competence" in this study to refer to a set of behaviors, knowledge, skills and attitudes that enable an individual, organizations and collaborative partners to communicate and co-operate effectively with individuals and communities in cross-cultural situations (Campinha-Bacote, 1999; Henderson et al., 2018; Marja & Suvi, 2021; Sharifi, Adib-Hajbaghery, & Najafi, 2019). In collaborative contexts, acquiring cultural comptence requires patients, openness and tolerance (Marja & Suvi, 2021), and this hugely affected participants experiences in a number of collaborative processes including communication, leadership, trust and overall patient care.

8.3.1 Cultural Awareness

Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional back ground. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different culturally(Campinha-Bacote, 2002, 2019).

Findings show partcipants cultural awareness in respecting their host partners operating conditions and context in health care. Participants cultural awareness of differences in context helped to build trust and respect, reduced tentions and promoted synegy. Some of the Norwegian health professionals reported being more motivated to provide medical advice to Malawian health professionals in instances where they actively showed commitment to shared learning. Most of Norwegian health professionals were aware that their experience in the field of emmergency medicine would possibly undermine local knowledge of Malawian health professionals if they did not adopt a partcipatory learning and training approach that could accommodate the local health professionals. Findings also show that Malawian health professionals were more willing to accept the education and training from Norwegian health professionals when they felt their local approaches to trauma care and emmergency medicine were being respected. Both Norwegian and

Malawian health professionals were more motivated when their contributions and competences as health professionals coming from different contexts were being acknowledged. Participants, concerns over their own biases is also reaised in previous studies. Studies confirm that, if not carefully and intentionally designed, cross cultural learning experiences and partnerships have the potential to reinforce bias, stereotypes, paternalistic actions, and a superior-inferior dichotomy (Lough & Tom, 2018; Mtawa & Wilson-Strydom, 2018; Ventres & Wilson, 2015). Participants were therefore mostly aware of the influence of their professional values and experiences, the risk of engaging in cultural imposition and power domination (Campinha-Bacote, 2002; Chapman, 2018; Healey-Walsh et al., 2019). For example, when providing training Maria told her Malawian colleauges that she was not there only to give information but to work together, discuss and give suggessions as a collective. Hege also claimed that whilst working with other health professionals in Malawi she realized that she could not go there and tell them what to do, but also learn from them and their way of operation. Participants' sensitivity to the differences resulted in more opportunities of collaboration and cocreation within the health setting.

Howerever, partcipants' age, race, gender and national identies, emerge as a source of bias regarding training and education, and initial interaction with patients. For instance, while participants were aware of the risk of imposing their own views on their partners, Marte cited the dilema in balancing between sharing professional knowledge at KCH and the need to respect and acknowledge local efforts under the resource constrained context. Furthermore, participants were both anxious and catious in their interaction with patients and coworkers at their host institutions citing skeptism around being accepted and fear of being rejection. While the skepticism demostrated bias, it also showed that participants were aware of the differences. Similar findings are found in the Kenya Service-Learning Program by (Healey-Walsh et al., 2019, p. 273) where participants preconceived biases emanated from percieved differences, supported by the superior-inferior binary with Western knoweldge and values as superior aspirational norms. In this research, participants became cautious to actively engage, expressed doubt and had trust concerns. Though promotion of shared learning is criticized as being pseudo empowerment (Kulasabanathan et al., 2017), the promotion of shared learning and reciprocity (Basu et al., 2017) is inherently visible in partcipants attempts to avoid cultural biases within the partnership.

The ability of both Norwegian and Malawian health professionals to respect each other's sovereignty depended on their cultural awareness (Campinha-Bacote, 2002) relating to the possible imbalances which could have resulted from these racial, cultural, gender and socioeconomic differences within the relationship. These differences need to be explored and understood if equitable partnerships are to be achieved (Healey-Walsh et al., 2019; Katisi & Daniel, 2018; Latta, Kruger, Payne, Weaver, & VanSickle, 2018).

8.3.2 Cultural knowledge and skills

Cultural knowledge entails the process of seeking and obtaining an educational foundation in culturally diverse group setting (Campinha-Bacote, 2002; Lin, Lee, & Huang, 2017) while cultural skill addresses the need to evaluate cases promptly and to recommend appropriate adjustments to care after aquiring the knowledge (Campinha-Bacote, 2002; Hilty et al., 2021b; Lin et al., 2017). Understanding of the others' situation and belief systems and developing knowledge and skills to integrate into a culturally different health setting is regarded important in health partnerships (Young & Guo, 2020).

The study illustrates the importance and impact of cultural knowledge when building a foundation for team collaboration. Health professionals in their local contexts, were key in bridging and building cultural knowledge and skill in health care at both KCH and HUH. For example, most of the exchange participants tapped into the local professionals contextual knowledge to familiarize themselves with unfamiliar diseases and context specific health cases, as well as in performing hospital routines aligned to their duties. The more partcipants managed to communicate effectively and ask each other questions the more they managed to understand patients behaviors and the sociocultural context around them. To illustrate this further, most participants also mentioned that they struggled in cases where they did not have a local health professional to consult or rely on. An example here can be when Rebbecca did not find any local doctor to help with the interpretation of a radiology report (Chapter 7). This example serves to show that local knowledge helped participants to situate cases in context. The application of cultural knowledge to clinical care (Lin et al., 2017) depended on the local doctor's culturally sensitive interpretation of the hospital routines. In a study by Healey-Walsh et al. (2019, p. 275), partcipants reported being able to observe the cultural knowledge, and skill that their working partners possessed. This explains why

in this study a few partcipants felt neglected or frustrated when they did not have someone to work closely with, as shown by Rebekka's case. The need to work with or have a local resource person from the host organization proved to be important in this study.

In addition, both KCH and HUH participants reported the significance of mutual trust and how efforts in building trust with coworkers helped them build the needed set of information and knowledge to integrate. Mutual trust was mostly built by participants' commitment to their work, working with others, and consulting the locals whenever necessary. Willingness to take up tasks was considered as important and necessary in build contextual knowledge and for participants who showed this willingness, it also made local professionals comfortable to work with them. The need for participants to be culturally aware proved significant in facilitating the development of sound cultural attitude to build trust and perform culturally sensitive tasks (Campinha-Bacote, 2002; Lin et al., 2017). It is argued that that partnership value and collaborative advantage can therefore mostly be secured through the development of a culture of mutual reliance and trust (Coleman, 2008, p. 28). Similarly, in a partnership study between Kenyan and American students, participants reported that working together closely and connecting as humans helped them acknowledge similarities as opposed to emphasizing differences (Healey-Walsh et al., 2019).

8.3.4 Cultural Encounter and Desire

Cultural encounter is the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse background (Campinha-Bacote, 2002; Sharifi et al., 2019). Cultural desire involves the motivation to engage in the process of becoming culturally competent (Campinha-Bacote, 2002; Cole & Gunther, 2019).

Most of the health professionals from Malawi found it easier to interact with patients from Norway because the patients took a participatory role in their own treatment by researching for themselves and by asking for more medically sound questions as reckoned by Chikondi and Tionge in chapter 6 . Secondly, there was general consensus that the patient and health worker relation was more flat and less partenalistic in Norway compared to Malawi. Some participants as a result were "disturbed" by the silence and submissive nature of patients and their families in Malawi while others interpreted it as humility and felt motivated their humbleness. These different experiences

were mostly interpreted as either lack or presence of exposure, knowledge and education among patients by most of the health professionals from HUH and KCH. These findings can be interpreted within the Cultural Comptence model in the sense that partcipants interpretation of these experiences were influenced by their level of cultural competence, that includes level of awareness of ones own priviledges, existing biases and assumptions about others (Campinha-Bacote, 2019). Fitzgerald and Campinha-Bacote (2019) further recomment the need for self-examination and critical reflection of one's own biases towards other cultures and the in-depth exploration of one's cultural (organizational and individual) background.

Challenges to interpret patients and familys' body language, attitudes to care and health seeking behavior could also have been influenced by the partcipants cultural knowledge especially with regards to the language of communication. Malawian patients mostly from ouside lilongwe spoke Chichewa while Malawian health professionals could not speak Norwegian resulting in potential loss of meaning and emotion these interactions. Participants such as Rebekka were unable to interpret the way Malawian handled crises situation and grief however this improved their cultural knowledge regarding the differences between Malawi and Norway. In a previous study that seeked to interprete language, emotions and cross-cultural translation it was found that understanding language was instrumental in interpreting patients conditions and families behaviours in health care situtaion in the context of Senegal, a similar phenominon in the results found at HUH and KCH (Evans et al., 2017).

While partcipants' interpretation of their initial encounter with patients were mostly influenced by indivudal biases, previous studies accredit similar patient-care giver relationships to social cultural differences in settings (Gerald & Ogwuche, 2014; Grossman, Campo, Feitosa, & Salas, 2021; Mittelmark, 2014). In a study in Nigeria Gerald and Ogwuche (2014) argued that individual, familial and societal norms influenced patient behavior and attitudes. Such behaviours and attitudes affects patients expectation and health professionals' cultural desire to understand and find the best way possible to help patients (Oberoi et al., 2016). Other studies also found that the patients behaviour in the face of a health professionals was also influenced by how society relates to authority (Hofstede, 2003; Tran, Scherpbier, van Dalen, Do Van, & Wright, 2020). Similar experiences were shared by Chikondi who described Norwegian patients *"more like clients"* while Tionge described the deferences in level of paternalism in care giving between Norway and

Malawi. Health professionals experiences of these contextual norms and condititions put some of the participants biases to test and presented an opportunity to gain cultural competences. These experiences demostrate how cultural competence was more of a process that constituted layers of experiences and encounters that provided an opportunity to question participants preexisting biases and interpretations(Fitzgerald & Campinha-Bacote, 2019; Healey-Walsh et al., 2019).

Cultural, socio-economic and health care delivery systems factors were identified as major causes of delays in the treatment of severe health conditions. Partcipants reported experiencing extreme health conditions and advanced cases especially in Malawi. Poor infrustructure and health systems capacity concerns are mentioned as significantly impacting health seeker behavior. In a previous study on patients access to health services at Kamuzu Central Hospital by Namangale and Chiumia (2021) findings show that due to the limited carrying capacity of the hospital and lack of other health facilities led to informal payment of health professionals by patients and their gaurdiance for better services or favors. Habibov and Cheung (2017) laments that informal payments is a common practice that results in barriers to healthcare utilization for low-income patient. Above that, socio cultural meaning of sickness, religious beliefs, family fear of economic loss and the use of alternative health remedies such as traditional medicine all influence health seekers behavior (Nsereko et al., 2011; Poortaghi et al., 2015). This finding is backed by previous empirical studies which suggests that the presence or absence of health and illness and; the subsequent process of making the decision on when to seek help and the chosen health remedy is a socio-cultural phenomenon that goes beyond the conventional health system (Kironji et al., 2018; Nsereko et al., 2011).

Therefore in this regard, both findings and existing literature amplify the concept of cultural cultural competence and having an understanding of these socio cultural and contextual dyanamics proves important in in overcoming barriers in health service partnerships.

Language was the major barrier for communication and collaboration and overcoming this barrier formed the bases of participants understanding of both patients health conditions and internal support and coordination. Some participants managed to build cultural skill by seeking contextual knowledge from local health professionals in interpreting patients health seeking behavior as mentioned earlier but also created tention between mostly Malawian partcipants in Norway. Some

participants found the language barrier as an opportunity to learn a new language and enhance their cultural competence , others found the differences in language as an opportunity to always work with a local health professional. For others, the social interactions during break times, though in a different language was seen as an opportunity to connect with their coworkers at a social level. By acknolwding the language barrier and finding ways to create value out of the challenge demostrates participants cultural desire in building their competence and contribution to the partnership.

Literature reinforces the salience of effective communication as one of the factors that influenced participants experiences during exchange programs. In a health research collaborative partnership in Congo, Horwood et al. (2021) found that english competency, particularly among non english students, negatively affected their performance. Adopting English as a medium of instruction was regarded a solution but wide-ranging support to develop English proficiency among staff and students was also essential to ensure that the challenges did not outweigh the benefits. This is also reflected in the Cultural Competence Models which calls for the gathering of cultural knowledge that helps better understand the needs of patienmts or colleagues within a muticultural settings in order to make the most effective health decisions (Fitzgerald & Campinha-Bacote, 2019). Effective communication, including a working langauge is an important aspect in becoming culturally aware, learn and develop skills towards cultural competence.

Evidence from existing studies argue that cultural competence is an essential component that needs to be infused into health professionals practice and research (Cole & Gunther, 2019, p. 117). Studies further assert that as people acquire health knowledge, their decision in finding the appropriate remedy is also influenced by provider-related attitudes and behaviors (Gerald & Ogwuche, 2014; Oberoi et al., 2016). Cultural desire as attitudinal trait (Campinha-Bacote, 2002) involves the concept of caring and as such, health professionals conduct can influence health outcomes. For instance, after partcipating in the partnership, health professionals from Norway felt that they were now mentally prepared to deal with stressful situations or rare medical cases as shared by Marte. For Malawians, the exchange program boosted their professional confidence and cultural awareness as narrated by Jacob after his echange in Norway. Similarly, results from the Universities of Washington and University of Nairobi partnership, (Monroe-Wise et al., 2014) American participants reported a significant increase in exposure to various tropical and other

diseases, an increased sense of self-reliance, particularly in a resource-limited setting, and an improved understanding of how social and cultural factors can affect health. Kenyan trainees reported both an increase in clinical skills and confidence, and an appreciation for learning a different approach to patient care and professionalism (Monroe-Wise et al., 2014).

8.4 Discussion in relation to synergy and antagony

In the section I will discuss synegy and anatgony both as part of the partnership process and the partnership outputs. Since my study is primarily focused on partnerships and the experiences of health professionals during the partnership implementation, I find this relevant to provide input on the overall partnership between HUH and KCH using the BMFC.

Synergy

Although the sociocultural differences in settings proved to be significantly integral within partnership context and in this research, influenced health professionals experiences during exchange, the interactive processes within resulted in partnership synergy. The term 'synergy,' as applied in this research and according to Corbin (2013, p. 52) describes the multiplicative interaction of people and resources to solve problems that cannot be tackled by any of the partners working alone. The partners, health professionals on exchange, their skills and experiences complemented by the socio-cultural interactions within the partnership resulted in more positive outcomes for the individuals involved, the partnership and the communities served by KCH and HUH. Health professionals from Norway felt that they were culturally aware of diverse cultures and mentally prepared to deal with stressful situations or rare medical cases. For Malawians, the exchange program boosted their professional confidence and cultural awareness. Similarly, results from the Universities of Washington and University of Nairobi partnership, Monroe-Wise et al. (2014) University of Washington trainees reported a significant increase in exposure to various tropical and other diseases, an increased sense of self-reliance, particularly in a resource-limited setting, and an improved understanding of how social and cultural factors can affect health. Kenyan trainees reported both an increase in clinical skills and confidence, and an appreciation for learning a different approach to patient care and professionalism (Monroe-Wise et al., 2014).

Synegy was also realised as evidenced by partcipants cultural desire to continue contributing to their host organizations and their expression of interest to be involved in future cohorts of the

exchange partnership. Some partcipants from Norway had different perspectives to efficiency within health care delivery and learnt to be patient under environments with limited resources

An exmple of this can be summed up from Mary's reasons to remain behind in Malawi after the exchange partnership as shared that her expereinces made her feel like *'the work at Haukeland wasn't that important as the work at KCH.'* Comments by Mary summarises the growing empathy and cultural desire as a result of the exposure to a different setting. Most participants, like Marte grew in empathy and become more connected and comitted to projects in their host county which can be theoretically linked to the claims by Campinha-Bacote in the process of cultural competence. According to Campinha-Bacote (2002) cultural desire involves the conciousness and willinngness to want to be culturally competent. Campinha-Bacote (2019) further connects cultural desire to the level of understanding of social inequalities and how they affect individuals and wanting to act on them as exhibited by Marte. Synergy is therefore demostrated by participants' profound commitment to social justice actions, including volunteering to stay in their host country or committing to help in the development of the partnership..

Antagony

Negative experiences which were identified and mentioned by most of the participants emanated from the preexisting perspectives around power, sovereignty, trust, and communication. Health professionals' encounter with these processes of partnership functioning were influenced by the socio-cultural interactions that followed. Participants experienced challenges around communication, social cultural differences on health seeking behavior, team collaboration, and their identity. Through the process of cultural competence, aided but leadership, communication, and trust, the HUH-KCH partnership yielded more results as seen by the increased interest in physiotherapy department at KCH and the subsequent interest in recruiting more health professionals.

The NOREC partnership between HUH and KCH seems to be a successful partnership due to among other reasons, readily available resources, efforts in promoting inclusive participation and contribution by all the partners and most importantly the freiendship that has developed between the partners due to many years of collaboration. Findings further indicates on the need to provide more support for partcipants including knowledgable contact persons with cultural competence and familiarity of or from the host country. Addressing power differences and creating more

opportunities for human to human interaction are recommended. While all the partcipants expressed positive impact of the exchange, effective communication with participants and giving them an opportunity to be involved after partcipating in the project was recommended by most of the partcipants and inherently influencing their attitudes towards the overal program.

Chapter 9

Final Remarks

9.1 Introduction

This chapter presents some final remarks and key issues that are not directly situated within the research questions but are relevant to global development, health promotion and partnerships. These key development issues include the SDGs and approaches and principles of health promotion as reflected below.

9.2 Final remarks within the framework of health promotion

It is also very important for me to also highlight some of the concerns raised by participants and have been topical in developing effective models for global partnerships. While majority of participants experienced shared learning at different dimensions, the opportunity for shared learning was halted by the environmental regulations for instance that Malawian health professions were regulated not to work independently in Norway while the Norwegian health professionals did not face similar challenges in Malawi. Malawian participants were keen to demonstrate their capacity and desire to be treated as equally competent and capable health professionals as their Norwegian counterparts. This experience influenced perspectives and attitudes around the partnership. Health professionals such as Tionge cited that part of their motivation for participating to 'represent his country,'-demonstrating a shift from the acceptance of inferiority (Maldonado-Torres, 2017, p. 118). However, the same health professional went on to suggest that being unable to independently work undermined his professional qualifications and made him feel like a medical student again. What is positive is that health professionals from both Malawi and Norway including the project leaders demonstrated cultural competence as they acknowledged that regulations should have been communicated well in the start of the partnership.

Previous studies challenge that structures that sustain domination (Katisi & Daniel, 2018) and limiting fair opportunities for experts from the global north (Koch & Weingart, 2016) must be revisited so as to constantly improve partnership outcomes. Several scholars in the field of development observe the need for vigilance at the stage of establishing a partnership, which includes the self determination to quantify and attach value on expertise and non-financial inputs by the global South (Katisi & Daniel, 2018), chief among them the culturally competent human

resources they bring (Corbin & Mittelmark, 2008; Craveiro et al., 2020), and the diplomatic capital that comes with global health partnerships (Herrick, 2017; Mawdsley, 2012). Crawford (2003) suggests that mutual ownership and accountability in the start of the partnership would prevent more powerful partners from dominating partnership implementation.

The findings demonstrate the importance of settings in health partnership contexts (Fortune et al., 2018; Mittelmark, 2014). According to (Mittelmark, 2014), settings approach to health promotion puts priority on the relationship between people, their behavior and their environment and building knowledge around the interaction of these factors helps in building cultural competence (Renzaho, Romios, Crock, & Sønderlund, 2013; Young & Guo, 2020). In the results we find the health professionals from Norway to Malawi struggling to understand why their Malawian counterparts came to work late or left early which they later discover that Malawian doctors were working multiple jobs due to low renumeration and had to leave early to prepare for the next day due to limited social amenities like an effective transport system. The need to have a comprehensive analysis of environmental influences of health outcomes beyond individual health behaviors (Green, 2015), or exclusively biomedical or clinical approaches to health-proved important for effective collaboration and reduced tension between health professionals on exchange and locals.

9.3 SDGs and partnership on social determinants of health

The Commission on Social Determinants of Health (Schrecker, 2019), primarily initiated to confront health inequities between and within nations (Marmot et al., 2008, p. 1661), places an assessment on global governance, inequitable power relations, distribution of money, and general life situations across geographies-as largely the drivers of health equity and social injustice. At a global partnership level, both KCH and HUH acknowledged the differences in health conditions and health inequity between Malawi and Norway. The gap that exists in emergency medicine and trauma management both at resource capacity level and on experience in the field of trauma management is thus the foundation of the partnership. The trauma department in KCH was new, under resourced, understaffed with high volumes of medical cases compared to Norway. The sharp contrast as results showed, is exacerbated by the differences in economic conditions between the two countries and efforts to deal with these differences narrows the inequality gaps between countries. Action on the existing capacity gap between HUH and KCH further brings the social

justice and human rights dimension (Marmot et al., 2008; McPhail-Bell, Fredericks, & Brough, 2013).

The commitment by KCH and HUH as well as the cooperation and motivation by both Norwegian health professionals and Malawian health professionals to participate in the partnership corresponds with the global agenda for the SDGs. Goal 17 of the SDGs acknowledges the interconnectedness of the goals and invest in partnerships between and within countries to realize the goals. To achieve SDG 3 on health and well-being, the KCH-HUH partnership improved health outcomes in Malawi whilst it strengthened the cultural competence of health professionals from both countries thereby reducing inequality (WHO, 2016). There is also general consensus within existing studies that tackling global health inequalities demands international commitment and coordination (Marmot et al., 2008). The NOREC exchange program between these two countries, as shown in the findings, was formed on the principle of reciprocity, whereby both HUH and KCH had to declare what they would benefit and offer for the partnership as a precondition in the development of the project. This showed an attempt to address power challenges that comes with partnerships (Crawford, 2003; Katisi & Daniel, 2018) HUH and KCH, thus demonstrating efforts towards social justice and equality as each partner declared what they could offer and what they needed in return.

The study reinforces the education agenda highlighted in SDG 4. My research findings puts emphasis on training and education that respect context and promote shared learning and reciprocity (Basu et al., 2017; Lough & Oppenheim, 2017). Several partnerships research on health workers training and research collaborations suggest learning and teaching models that respects researchers and professionals from the global South. This research thus, pushes for the consideration of complex and context-specific dynamics around partnership needs both for the initial formation and for the eventual success of the partnerships (Schrecker, 2017).

9.4 Study Limitations

Context

Initially, the context in which the study was conducted was limiting due to the COVID-19 pandemic and the subsequent locdown meaures. Resultantly, I did not manage to travel to Malawi for the field research as origianlly planned. Most likely I could have managed to get diverse

perspectives had I managed to visit Malawi and interact face to face with the participants. Aditionally, my initial plan was to also interview health professionals, who had not participated in the programs themselves, but who had worked and interacted with exchange partcipants at the host institutions. However, I had to reduce the number of research participants bacuse of the study timeline I found interviewing only the participants and coordinators as more convinient than the initially inteted focus group discussions. Awider range of participants including focus group discussions could have given me more opportunity for a wider perspectives.

Challenges with digital data collection

I conducted my entire interviews online and had to adhere to ethical research standards, however this was more difficult in cases where internet connectivity was a concern. Secondly, it was my first time doing online research and equally a new approach including for our school. This sutuation limited my flexibility partcularly with regards to an opportunity to connect with the participants where I could read other human interactive traits like body language.

9.5 Conclusion

This study aimed at exploring the social cultural experiences of health care professionals in different context of Malawi and Norway and how these experiences contributed to the partnership. Partnership starting conditions and the available resources both at individual and institutional level were the motivating factors for participating in the partnership. The importance of building conditions that facilitates relationships between individuals and partners prior to the partnership were found to be important. The study also shows that previous exposure to multicultural work settings prior to the partnership influenced participation both at institutional and individual levels. Clearly visible partnership gains and reasons such as partners' social and economic goals, values of providing service to humanity, building professional reputation, providing economic support for family were all social and contextual factors for participating. Findings show that social and cultural experiences of participants had implications on health services though they were not the primary goal of the collaboration between Malawi and Norway.

Cultural awareness of participants proved to be an integral part in the selection of committed health professionals and the effective implementation of the partnership. Clinical competence needs to be complemented with cultural competence for more positive partnership returns. The participants

encounter with social and cultural differences in both Malawi and Norway formed the bases of individual connections and mutual trust, cross cultural collaboration. Human connectedness and the feeling of being safe are critical aspects of trust that emerged from the research and of potential research interest. Consideration of the impact of diverse cultural backgrounds on health is thus a matter of social justice and health equity and as such, need to be prioritized in health partnerships research and practice as evidenced by how participants became safer and more connected as they build their cultural knowledge.

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APPENDIX 1: Interview guides

Interview Guide for Participants

- What is your background and relationship with NOREC?
- What were your expectations before moving to Norway/Malawi?
- How was the experience moving from Norway?
- How was the Experience working in a different social cultural setting?

a) With patients
b) With coworkers
c) With the management
d) During knowledge sharing, training, and capacity building

- What was your memorable experience in these interactions?
- What was your biggest challenge working in a different social and cultural setting?
- How did you adjust to these experiences?
- What did you learn from these experiences?
- How far did the project go in achieving the intended goals?
- What do you think can be done differently to ensure effectiveness of health professionals?

Interview Guide for the Management

Project Objective

- What does the exchange program seek to achieve?
- Who and what are the resources invested in this project, please explain?
- What is your understanding of cultural competence in collaborative partnerships?
- Do you think your participants were well resourced enough to understand and adjust to the cultural differences in their host countries? Please give examples

Collaborative Context

- Can you please describe the collaborative context and things you consider before, during and after the partnerships?
- What is your experience working with different people from different cultures?
- What are some of the challenges you have faced in relation to participants ability to adjust to a new environment?
- What could have been the source of such challenges
- How have you addressed these challenges?
- What kind of support is readily available for the participants as far as their integration, social, cultural and contextual awareness?
- How are cultural difference affecting the implementation of the project… are the noticeable positive and or negative implications.
- What do you think needs to be done more to improve the partnership? (With special attention to the social and cultural context of the project implantation)

Appendix 2a: Thematic Analysis-Health professionals on exchange

Codes	Basic Themes	Organizing Themes
• Encouraged by friends to participate. • Previous exposure to different settings • Expectation to gain knowledge and exposure on how to manage trauma. • Felt the project had enough resources and a system to host participants. • Expectation of improving emergency care in Malawi. • Professional growth and exposure to advanced technologies. • Goal was to build Capacity.	Reasons for participation?	Motivational factors for participation
• Elderly patients uncomfortable to be treated by someone from outside. (Norway) • Patients respecting health professionals regardless of age. (Malawi)	Significance of Age and trust in health settings/	Experiences with Patients
• Patients in Norway know more of their rights. • Patients have more opportunities to make decisions for themselves. • Patients given information to decide for themselves. • Wide access to information influence patient involvement and quality of care • The use and power of written information when executing therapy. • Important to treat patients with respect. • Need to give patients personal space	Patient involvement and Right to access information	
• The level of education affects the gap and differences between the health care workers and the patients. • In Malawi patients will worship you • Patients in Norway are more knowledgeable of their conditions. • In Malawi, you need to explain more, and you spend more time with patients. • Widely available information makes it difficult for patients in Norway to follow instructions compared to Malawian patients	Patients level of education and literacy	
• Overwhelmed by advanced cases because of huge population. • Seek traditional medicine first before hospital. • Delays treatment because of distance • Limited economy delayed treatment. • Availability of information reduces advanced cases.	Advanced medical Cases	

• **Patients lacked emotion or sense of pain.**	**Grieving**	
• **Eye contact is important when treating patients who are very sick.** • **Patients more respectful when communicating with health professionals.** • **Patients interested in getting service from health care professional of a different culture**	**Communication**	
• **Access to and availability of patient information is important in caregiving**	**Access to and availability of patient information in care**	
• **Family plays a key role in Care giving.** • **Family provides moral support and eases mental pressure**	**Role of Family and Guardians in Care giving**	
• **Responsible Doctors present and communicating interest in the work findings.** • **Important to work in teams to learn more from each other.**	**Interdisciplinary and team collaboration**	**Experiences with Co Workers**
• **Learnt that anything good comes from planning.** • **Language was a barrier**	**Team Meetings**	
• **Building trust was a priority in a multicultural collaboration**	**Trust within collaborative context**	
• **Effective training happens when you work together.** • **Helped understand the diversity of cases and disease panorama.** • **They did not tell us how we were going to work/orientation.** • **most of the presentations made as training where being presented in Norwegian.**	**Training**	
• **Greetings and social interactions influenced how health care workers felt about work.** • **In Malawi there is more interaction between colleagues beyond work**	**Social Interaction affected how health care workers felt at work.**	
• **Meetings in Norwegian** • **Health professionals aware of the language barrier** • **Did not manage to participate in daily chatting**	**Feeling of Isolation**	
• **Language barrier**	**Experience with Language**	
• **Pretraining improved cultural awareness and social integration.**	**Pretraining and post training**	**Resources and Support System**

• **Support person needed to integrate and feel welcome.** • **Moral support from friends** • **Traveling with coworkers helped integrate**	**Support Person Needed to Integrate**	
• **Norec provided everything.** • **Housing concerns from health professionals** • **HUH and KCH have experience in handling patients**	**Administrative Support**	
• **Exchange of participants** • **Malawian Medical qualifications regulated in Norway.** • **Different treatment of exchange health care workers across departments**	**Reflecting on Power and reciprocity in the collaboration**	**Reflecting on Power and reciprocity in the collaboration**

APPENDIX 2b: Thematic Analysis-Interviews with Management and Team Leaders

• **Position matters in Malawi** • **There is a flat structure in Norway.** • **Get more connected by asking more questions.** • **Supportive Administration** • **Contact with immediate bosses sometimes challenging.** • **Those with authority are far away from health care workers.** • **Participants less involved in the project after the exchange**	**Supervision and Hierarchy**	**Management-health professionals relationship and its impact on the collaboration**
• **Need to understand the health system to integrate and contribute.** • **Respecting and understanding other's systems** • **Well equipped, specialized, and systematic care in Norway** • **Malawian health professionals under resourced** • **Access to Patient information**	**Understanding health systems for effective collaboration**	**Understanding of Health Systems in different social and cultural settings**
• **Norec provided funding.** • **Housing concerns from health professionals** • **HUH and KCH have experience in handling patients** • **Communication challenges**	**Administrative Support**	**Project Resources**
• **Emergency Department in Malawi Refurbished** • **International exposure enhancing confidence in health Professionals.** • **Learned not to worry about small things.** • **Part of Knowledge learnt not applicable to home context.** • **Staying behind in the host country to contributing more** • **Trust** • **Individuals Professional Development** • **Capacity built** • **Open mindedness**	**Impact**	**Project Impact Output and Recommendations**

APPENDIX 3: Consent Form

Informed Consent Form

Title of Research: Role of Social Cultural factors in Health Partnerships: Exploring the social cultural experiences in care giving of health professionals on an exchange program. *The case of Malawi and Norway's NOREC Health collaborative Exchange in Trauma and Emergency Care.*

Principle Investigator, Affiliation and Contact Information: Archlove Takunda Tanyanyiwa, University of Bergen: Archlove.Tanyanyiwa@student.uib.no

Additional Investigators and Affiliations: Victor Chimhutu (Supervisor)

University of Bergen: victor.chimhutu@uib.no

1. **Introduction and Purpose of the Study**

The research seeks to explore individual experiences of professional health care workers who have been part of or have worked in an exchange collaboration. Views are gathered to explore their experiences and how these can be used to facilitate better outcomes

2. **Description of the Research**

The research is a qualitative case study that seeks to explore the experiences of health care professionals who participated in the Norec collaborative exchange and executed their duties in a different social and cultural context. The purpose of this study is to investigate the impact of social cultural settings to individual and collective goals in relation exchange partnerships.

3. **What Participation Entails**

When you become part of the research, you will be asked to respond to interview questions that last between 30 minutes or 1 hour and can be requested to be part of a focus group discussion of about 5 to 8 participants with other health care workers. We estimate that 10 participants who have participated in the exchange partnership will enroll from Malawi and Norway. We are also estimating 8 participants to take part in the focus group discussions with 6 other participants drawn from the management of the institutions involved.

4. **Potential Risks and Discomforts**

The research is focusing on social and cultural issues and some might be sensitive to self-belief or those of others however, will ensure confidentiality and protection of your identity as this research is purely for academic purposes with the possibility of publication later in academic journals

5. **Potential Benefits**

Health professionals who participate in the research may have better understanding of additional information of their operational context beyond the clinical demands of their job.

6. **Confidentiality**

No individual identity shall be disclosed or shared except for the purposes of this research, ie with the supervisor and the examiners. All information taken from the study will be coded to protect each subject's name. No names or other identifying information will be used when discussing or reporting data.

7. **Authorization**

By signing this form, you authorize the use and disclosure of the following

information for this research:

8. **Compensation**

The research is academic and therefore there will be no compensation thereof for participating as one of the respondents.

9. **Voluntary Participation and Authorization**

Your decision to participate in this study is complete voluntary. If you decide to not participate in this study, it will not affect the care, services, or benefits to which you are entitled. If you decide to participate in this study, you may withdraw from your participation at any time without penalty.

10. **Cost/Reimbursements**

There is no cost for participating in this study. Any medical expenses resulting from participation in this study will not be reimbursed by the investigators.

I voluntarily agree to participate in this research program

□ Yes

□ No

I understand that I will be given a copy of this signed Consent Form.

Name of Participant:

Signature: Date:

Name of Witness):

Signature: Date:

Person Obtaining Consent:

Signature: Date:

APPENDIX 4: NSD Ethical Clearance Letter

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD's assessment

Project title

Role of Social Cultural factors in Health Partnerships: Exploring the social cultural experiences in care giving of health professionals on an exchange program. The case of Malawi and Norway's NOREC Health collaborative Exchange in Trauma and Emergency Care.

Reference number

434310

Registered

28.07.2020 by archlove takunda tanyanyiwa - archlovetaku@gmail.com

Data controller (institution responsible for the project)

University of Bergen / The Faculty of Psychology / Hemil Center

Project leader (academic employee / supervisor or PhD candidate)

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Type of project

Student project, Master's thesis

Contact information, student

Archlove Takunda Tanyanyiwa, archlovetaku@gmail.com, tel: 92565958

Project period

17.08.2020 - 31.12.2021

Status

30.08.2021 - Assessed

Assessment (2)

30.08.2021 - Assessed

NSD has assessed the change registered on 06.08.2021.

We find that the processing of personal data in this project will comply with data protection legislation, as long