Cross-Cultural Global Medical Education: A Qualitative Study of Healthcare Students and Providers in Lesotho

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Background

A paradigm shift in global health has led non-governmental organizations (NGOs) to focus on supporting the education of local providers in an effort to build a sustainable healthcare workforce in low-income countries.

Objective

To describe cross-cultural medical education abroad by exploring the effect of culture on student-teacher relationships and knowledge acquisition and transfer in Lesotho.

Methods

A qualitative study was conducted in July of 2018 in Maseru, Lesotho. The study enrolled international educators and Basotho educators and learners from a purposive sample. Participants were asked open-ended questions to describe their culture, perceptions of health, medical educational experiences, and educational interactions with other practitioners and patients. The interview guide was adapted from E. Lynch & M. Hanson’s survey on developing cross-cultural competence. Interviews were recorded and transcribed verbatim. Transcripts were analyzed using phenomenology and coded independently by two investigators until thematic saturation was reached.

Results: Three Major Themes and Subthemes

Educational Content:

Culturally-rooted beliefs regarding health and social norms affect student receptivity to and practical application of educational content.

- Prevalence of Traditional Healing
- Cultural Taboos and social norms influencing receptivity
- Cultural terminology for disease processes

R10: "...in the early years of breastfeeding if you tell them that the first milk is the best because it contains this and that, culturally it’s not considered clean so the women would express [and] discard that milk."

R2: “I was able to connect my culture because I knew the diagnosis in my culture, my language. This person is saying Nyoko and it is there in her culture, in his culture. Let’s listen what are the symptoms of this Nyoko and then we will be able to help him.”

Educational Methodology:

Student preferences for teaching methods and styles are influenced by English language proficiency and degree of comfort and engagement with Western culture.

- Language barriers in printed and verbal communication
- Narrative medicine - Lesotho student and educator preference for storytelling to illustrate important points
- Culturally rooted learner personalities

R14: "...it’s all in English and you assume that everybody understands because we teach only in English, but then ... the senior HIV counselor [comes in] within 10 minutes she swapped from English to Sesotho, and you sense that it becomes more animadverted, much more interactive”

R16a: "...when you want to instill something then you can give a live living example in their own culture. Basically bringing in their practice into what you are teaching”

Influence of Political and Social Power Dynamics:

Political and social power dynamics influence how information is disseminated and implemented in practice.

- Gender roles and importance of age/experience
- Incentives for learning and knowledge transfer
- Effect of transition from technical assistance to direct service delivery

R9: "...and they see me as junior and they do not see me as a mentor.... So the way I worked with them was to give them respect...I would be doing it together with them, not telling, but doing. So in that way they started understanding my role as a mentor.”

R4: "Knowledge is power, knowledge is money, so you don’t share your knowledge.”

Limitations

- Sample size of 24 subjects
- No inclusion of community health workers, traditional healers, or representatives from the Lesotho Ministry of Health introduces selection bias.
- Needs assessment of Basotho learners is not generalizable to cross cultural medical education in other cultures or countries
- Researcher presence and semi-structured interview design may have influenced interviewee responses.
- The use of two distinct interview methods, including individual interviews and focus groups, may affect the weight of participant responses and introduce bias.

Conclusions

Unique barriers arise when distinct cultures interact in the medical educational setting. Curricular design in global medical education could benefit from engaging students and educators in conversations about their culture by identifying ways in which educational content, methodology, and power dynamics affect transfer and utilization of information. Further adapting the semi-structured interview technique could be useful as a strategy to inform cross-cultural curricular design.

References