Review

Getting it right: Culturally safe approaches to health partnership work in low to middle income countries

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Abstract

Many health professionals become engaged in international health and education work in low to middle income countries, often as part of health partnerships. This type of work, increasingly popular in an age of global health, can present a number of challenges. Many of these involve cultural factors which are often acknowledged in the literature on overseas health work but rarely explored in depth. This paper aims to illustrate the key cultural considerations to be made by those currently engaged in or considering overseas health and education work in a low to middle income country. A comprehensive literature review methodology was used to examine data through the lens of Cultural Safety Theory and as a result provide guidance for professionals working with international colleagues. Recommendations for practice are based on the importance of gaining an understanding of the host country's history and social context and of professionals examining their own individual worldviews.

Keywords: Cultural safety; Health partnerships; International working; Low to middle income countries

1 Introduction

Global health refers to health issues of individuals or populations that can be addressed "through the sharing of knowledge, resources, and experience across cultures, societies, and international borders" (Merry, 2012). Health professionals are commonly involved in global health work in low to middle income (LMI) countries,[1] often in an educational capacity and as part of established organisational health partnerships (Crisp, 2007; All-Party Parliamentary Group [APPG] on Global Health, 2013).

Variations in resource allocation, structural organisation and professional perspectives can present challenges when working with individuals and organisations from different countries. Moreover, significant cultural differences between international partners can lead to misunderstandings and conflicting expectations (Gervedink Nijhuis et al., 2012). This paper aims to highlight culture as an important and complex facet of overseas health and education work. It will summarise key cultural considerations to be made by those currently engaged in or considering such work.

This article was developed following several years of involvement with a paediatric nurse education project in Lusaka, Zambia. A sub-Saharan country of lower middle income status, Zambia has modelled its nurse education and health systems on UK frameworks as a result of its position as a former British colony. In the past, high income (HI)[1] countries like the UK have exported ideas and training to poorer nations like Zambia on their own terms and without much consideration of the very specific needs of those countries-very much a 'top down' approach (Crisp, 2010).

The 2005 Paris Declaration on Aid Effectiveness cemented a landmark agreement between several donor and recipient countries to rethink targets and indicators for development work. In recent years the onus has been firmly on LMI countries to drive this work themselves, emphasising core principles of ownership, harmonisation, alignment, results and mutual accountability (Organisation for Economic Co-operation and Development [OECD] 2005). Individuals involved in health and education work should therefore be mindful of the same ethos in their approach to it. Crisp (2010) terms this reversal of focus 'turning the world upside down': using the strengths and successes from the developing world to help realise solutions to global health problems. Global health partnerships are thought to contribute to this by strengthening public health systems and bolstering the education, training and retention of health workers who are often in short supply (Crisp, 2007). Recent UK reports also emphasise the value of partnership work to the National Health Service itself by promoting leadership, creative problem solving and international networking (APPG on Global Health 2013, Department of Health/Department for International Development [DH/DFID] 2014, International Health Coordination Centre [IHCC] 2014).

Both overseas health and education work and the benefits gained by both sides of a partnership can be enhanced through a good understanding of inherent cultural differences. Matheson (2009, p. 1191) sees culture not as visible or characterised by external trappings like dress, food and customs, but more as "the way people view life, death and everything in between". Many papers acknowledge a cultural angle to partnership work but rarely is this explored in depth. Culture per se is not often examined as a key force within professional interaction and this presents a gap that this paper seeks to fill.

1.1 Theoretical framework

The arguments presented are viewed through the lens of Cultural Safety Theory. This was developed by Māori nurse educators in New Zealand in order to sensitise student nurses to the cultural needs of indigenous patients (Ramsden, 1992). The theory advocates striving to attain four objectives: to examine one's own cultural reality and attitudes; to cultivate open mindedness and flexibility towards different cultures; to focus on historical factors rather than placing blame on people for their current social situations; and to reach the ultimate goal of a well-educated, self-aware and therefore culturally safe workforce (Ramsden, 1992; Ramsden and Spoonley, 1994).

Cultural Safety theory originally concentrated on the bicultural dynamic between Māori and white New Zealanders but has since widened its focus to all multicultural groups (Mackay et al., 2012). It examines the social and political disadvantage experienced by people subject to colonial rule, highlighting the risk of an unaware workforce making assumptions and reinforcing stereotypes in their care of different cultural groups (Ramsden, 1992). Cultural Safety theory emphasises culture as a product of social and political reality and social inequality (Andrews et al., 2010). In this way, its principles can be extended to help promote safe attitudes within any culture, relevant to settings like Zambia which may have been colonised in the past by richer Western nations and where health partnership work is currently practised.

The use of Cultural Safety Theory as a barometer can illuminate the cultural considerations professionals need to make when engaging in overseas health education work. Few research studies are conducted in this area, the literature instead leaning towards developing cultural competence of pre-registration nursing students (Allen and Ogilvie, 2004; Law and Muir, 2006; Levi, 2009; Mkandawire-Valhmu and Doering, 2012; Parker and Macmillan, 2007; Sargent et al., 2005).

2 Design

2.1 Methodology

A comprehensive literature review was used. This lies within the qualitative, interpretive paradigm and employs a narrative and exploratory method. The literature itself provides the data from which new insights are drawn through an in depth analysis of meaning (Siu and Comerasamy, 2013). A comprehensive review aims to draw conclusions from a varied body of literature (Cronin et al., 2008), unlike a systematic review which compares like with like based on study methodology.

The iterative process required involves a cycle of identifying data sources, refining search strategies, gleaning results and synthesising new arguments and perspectives (Brown, 2009). The complex nature of culture means that multi-layered ideas needed careful extraction and therefore such interchange complemented the comprehensive style. A strict systematic review protocol demands resources unavailable to the researcher and was therefore impractical. However, efforts were made to ensure a high level of discipline and uphold systematic principles (Aveyard, 2010; Cronin et al., 2008; Siu and Comerasamy, 2013).

The approach required acknowledging the unavoidable bias as a lone researcher around the subjective notion of culture. Rigorous methods helped to present a balanced view and not merely evidence leaning towards a personal stance, important for transparency and integrity. The secondary nature of the data meant no direct contact with research participants and therefore no higher ethical approval was required.

2.2 Key search terms

nurs[1]* OR health

education OR training

cultural AND (sensitivity OR competence OR awareness OR blindness OR understanding OR diversity OR congruence OR relativism OR imperialism)

"partnership working" OR collaboration

international OR overseas

"global health partnerships"

ethic[1]* OR "best practice"

A comprehensive search was made of electronic databases including CINAHL Plus, British Nursing Index, PsycINFO, Australian Education Index, British Humanities Index, International Bibliography of the Social Sciences, SciDevNet and System for Information on Grey Literature in Europe.

Inclusion and exclusion criteria are detailed in Table 1.

Table 1

alt-text: Table 1

Included	Excluded
Papers from 2003 to 2013 (one highly relevant dated 1999)	Papers not in English
Studies of experience, process, impact or implications of working directly with professionals in low to middle income countries	Literature whose cultural content focused exclusively on patient care, pre- registration health education or overseas electives
Grey literature on global health partnership working or international nursing/health education	Papers on health systems, workforce development and other strategic themes
	Literature on school education

84 initial results were identified from these searches. After review of each abstract for relevance, a final dataset of 38 papers for inclusion was reached (29 research papers and nine pieces of grey literature).

2.3 Critical appraisal

An iterative process was attempted in order to strip each paper down to its component parts and make a balanced judgement on its methodological quality, reviewing and re-reviewing the ideas within it before analysing and interpreting them (Siu and Comerasamy, 2013). Each paper chosen for review was assessed using the CASP Qualitative Checklist (Critical Appraisal Skills Programme, 2013) and Woolliams et al.'s (2009) 'six strategic questions', both generic enough to apply to all the literature types. Research quality was variable, with descriptive, discussion or essay pieces representing over half of the journal papers. The grey literature comprised mostly UK government documents or resources from professional organisations.

2.4 Data analysis

The constant comparative analysis method was used for data analysis, specifically for thematic development in order to interrogate the data as it was collected (Aveyard, 2010). Three distinct stages of coding, categorising and theming were used to recognise patterns and interlinking relationships among the data (Thomas and Harden, 2008).

3 Results

Two main themes emerged from the data, reflected by some of the central tenets of Cultural Safety theory. Understanding context dominated many papers; in order to practise in a culturally safe way in an overseas setting, an understanding of both past and present influences on its cultural and social situation is frequently cited as crucial. A second major feature of the literature is the opportunity for individuals to enhance overseas working by reflecting on their own culture and making a thorough analysis of their own worldviews. Further findings are discussed regarding some of the ways in which practitioners can work effectively and productively with overseas colleagues. Such practical strategies are highlighted in much of the grey literature and underline the value of professionals developing their knowledge about a different culture and about themselves to the overall success of their work in another setting.

4 Understanding context

The past and the present are closely related when considering the context of professional practice. This context is something health professionals should make efforts to understand. An awareness of cultural and social norms in an overseas setting is important for cultural safety; even more so, an appreciation of a partner country's political and social history. Understanding the influence of history on the development of systems and services is especially relevant for those working in countries where current practices have evolved from imperial or colonial roots. Imperialism and colonialism, often used interchangeably, refer to forms of conquest where one country exercises power over another. The intention during the 19th century was for European countries including Britain to control parts of the world by settling a large population of permanent residents in order for those countries to benefit economically and strategically (Kohn, 2012).

During this age of Empire, Britain was the largest world power and Said (1978) describes the West's plan to control poorer countries through superior knowledge and power. Howell et al. (2011), Howell (2013), Jones (2004) and Rafferty and Solano (2007) highlight the preservation of this political ideology in their analyses of government documents and nurses' personal

correspondence written from various countries at the height of British colonial rule in the 19th and early 20th centuries. Nurses expressed colonial rhetoric as well as describing excitement and adventure in their letters home, thus establishing the dominance and international reputation of British nursing practice at the time (Solano and Rafferty, 2007).

In contrast, Jones (2004) found that nurses posted to Ceylon (Sri Lanka) made efforts to adapt both personally and professionally, appearing to respect the different culture in which they found themselves. Whilst arguing that the presence and seniority of British nurses led to their dominance over the local workforce, Jones (2004) also suggests a parallel awareness at the time about the danger of prejudice and feelings of superiority over local nurses. Ramsden (2000) sees power relations at the core of Cultural Safety Theory, and maintains that an effort to avoid power imbalances is central to working in a culturally safe way.

Many recent authors seek to distance themselves from the perceived mistakes of the past by promoting a more needs-driven approach, but others continue to expose a paternalistic and ethnocentric attitude with an implicit expectation that international standards should be both desirable and achievable in any setting (Berland, 2007; Bohanan, 2010; Palmer and Bracken, 2009). Ethnocentrism is defined by Cortis (2003) as holding an unconscious view of others by using oneself as the standard for judgement. Although unavoidable to some extent, such beliefs are thought to disempower, disrespect and effectively doom the low to middle income (LMI) partner to failure, whether at national, organisational or individual level. This is particularly discouraged in the grey literature relating to health partnership work (Crisp, 2007; Department for International Development [DFID] 2008; Humanitarian Centre, 2012; Tropical Health Education Trust [THET] 2012).

Most papers discussing historical factors in this review are British, which could suggest a particular determination or responsibility to learn from the UK's imperial past. A failure to achieve cultural understanding could imply that Britain has not moved on from outdated ideas about other countries. Although it would be foolish to judge historical practice by modern standards, this should serve as an illustration of the trajectory nursing history has taken globally. The continuing power of this history in influencing individuals' worldviews will be discussed later and also linked back to the principles of Cultural Safety theory.

Several studies place a greater emphasis on the present rather than the past. A focus on understanding the cultural norms and values of another country stresses a desire to move forward. Professionals working overseas can develop insight and understanding into their receiving culture in order to create the conditions for cultural safety and make a positive impact. Cultural sensitivity, competence and humility are all mentioned in the literature as objectives to aim for in working with people from other cultures (Cox, 2011; Enskär et al., 2011, Foster, 2009; Gervedink Nijhuis et al., 2012, Lasater et al., 2012; McAuliffe and Cohen, 2005; West-Olatunji et al., 2011) although there is little expansion on what these constructs may entail. Campinha-Bacote (1994, p1-2) defines cultural competence in her widely adopted, process driven model as the "ability to effectively work within the cultural context of an individual or community from a diverse cultural or ethnic background".

She asserts that an individual must apply cultural skill, cultural awareness and cultural knowledge, experience cultural encounters and be bound by cultural desire in order to achieve cultural competence (Sargent et al., 2005). Time and passive adaptation to different cultural norms is not enough.

Cultural Safety shares some of these features through advocating continual learning and active effort to provoke attitude and behaviour change, but adds a socio-political dimension (Andrews et al., 2010; Ramsden, 1992). The original theory intended to aid nurses to care better for people within different ethnic and cultural contexts. It should follow that this can extend to those travelling abroad to work outside of their own culture, in either direct clinical practice or education.

Matheson (2009) states that people's own cultural norms and sense of 'rightness' are at the root of cultural imperialism, a negative concept regarded by Tomlinson (1991) as almost impossible to define but that includes notions of power, dominion and control. Matheson (2009, p. 1193) defines it in the context of overseas health practice as regarding "Western values as the pinnacle of human thought". Cultural imperialism can be regarded as one culture considering itself superior to others, judging them against its own standards.

Matheson (2009) asserts that the answer to this bias is not cultural relativism. Andrews et al. (2010)cites Haviland et al.'s (2007) observation that people within a particular culture should be evaluated according to their own values and standards and not outside ones. For example, the use of physical violence to discipline children may be seen as unacceptable within in one setting but tolerated in another as 'part of the culture', despite contravening a fundamental international children's rights agreement (United Nations, 1989). Cultural relativism exists despite its negative impact and is the opposite of ethnocentrism, or viewing things solely from one's own cultural perspective. Matheson (2009) argues that not all cultural norms in health should be accepted as valid, regardless of moral or ethical implications, simply in order to avoid the dominant Western view.

Reminding oneself that what works in the UK may not be best for an LMI setting and consciously avoiding the temptation to compare two very different settings could help to reduce ethnocentric attitudes. Acknowledgement and awareness of cultural views and their influence should be foundations of practice for health professionals working in another culture. Moreover, reaching an understanding of another culture can only be possible by individuals consciously reflecting on themselves and their own culture.

5 Understanding self

Individually, however a sense of self is constructed, Cultural Safety Theory urges individuals to examine their own reality, assumptions and attitudes in order to relate better to others (Ramsden, 1992). Cultivating this self-awareness can be a key strategy in fostering a deeper understanding of another culture. Although the literature reviewed focuses on different professional groups, professional development in nursing has embraced reflective practice in the UK for many years. This itself requires particular skills to be nurtured in order to influence learning (Oates, 2016). Formal reflection has been added to the new Nursing and Midwifery Council (NMC) requirements for revalidation in the UK (NMC, 2016); the expectation for nurses to embed such skills in their practice is now even more explicit.

Contemplating professional and personal motivations is significant in health professionals' ability to understand themselves and their reasons for working with overseas partnerships. Compassion and a desire to make a positive difference and improve lives, especially those of the underserved and poor, drive many people (Department of Health [DH] 2010; Enskär et al., 2011; Lasater et al., 2012; Mason and Anderson, 2007; Melby et al., 2008; Palmer and Bracken, 2009; Parfitt, 1999; Royal College of Nursing [RCN] 2010). Working towards the wider goal of social justice and global responsibility also features (Crisp, 2007; Suchdev et al., 2007; West-Olatunji et al., 2011), as does the development of clinical knowledge and practice, especially through education (Cox, 2011; Kerry, 2012; Mason and Anderson, 2007; Melby et al., 2008). With this comes a moral duty for nurses to support and learn from each other (Crathern and Evans, 2009; Crisp, 2007; RCN, 2010), again underlined by the NMC Code (2015) for nurses in the UK. Enskär et al. (2011) maintains that overseas experiences can create a sense of collective wisdom and deep connections between international colleagues. Melby et al. (2008) go further to say that nurse educators working in another country in fact have a higher responsibility to drive change than a single nurse practising clinically.

The pursuit of novelty and adventure described by colonial-era nurses (Howell et al., 2011; Howell, 2013; Rafferty and Solano, 2007) continues to be a valid part of the attraction to overseas work. There must be some reward for the individual; it would be unrealistic to expect social good to be the primary motivation for most people. There could be a fine line between seeing an overseas opportunity as an exciting personal and career development and a chance to explore exotic new territory principally for one's own gain.

The personal benefits of overseas working are wide ranging and form another way of framing values and beliefs. Such ideas tend to extend beyond the self. Enskär et al. (2011) interviewed lecturers from Sweden and several African partner countries involved with an international exchange visit. Participants reported personal growth and increased self-awareness as a result of challenges to their own values and beliefs, which then promoted new ways of thinking and working. Parfitt (1999) explored the professional and personal values of nurses who had worked for at least two years in a low to middle income (LMI) country as the building blocks of their work. She found that nurses either modified their personal values, principally those relating to gender, race and power, to create an 'enabling environment', or promoted dependence through a lack of insight into their own worldviews.

Professionals do not practice free of accountability in LMI countries and this must be recognised (Crisp, 2007; DH, 2010). A lack of regulation and governance in some settings can give rise to inappropriate interventions; professionals should therefore examine the appropriateness of both their actions and their motivations. Perhaps the degree of self-awareness makes the difference, supporting Cultural Safety Theory, and such insight may come with maturity. A true understanding of professional accountability develops with experience, but much of the literature argues that anyone working overseas has a responsibility to examine their own cultural attitudes. The ability to do this may depend heavily on each individual's insight and emotional intelligence.

Many individual experiences are reported from an intensely personal point of view (Berland, 2007; Bohanan, 2010; Deedei Khalil, 2006) but a failure to consider one's own position perhaps lends an ethnocentric tone. Xu (2012) claims this is inconsistent with respect and represents the chief barrier to international collaboration. Said's (1978) work on the 'Other' bolsters the idea that we reflect on ourselves in relation to those around us. In overseas professional working, those visiting a foreign country are representing their country and culture in the minds of their hosts so it would follow that they have a responsibility to think about what that means. However, it is debatable whether this examination is developed as a result of the experiences, recommended as a measure to prevent problems, or both.

This paper is no exception to the fact that most of the literature is written by authors from HI countries. Very few papers name a co-author from an LMI country or even offer an articulation of their perspective. This finding is corroborated by Foster (2009) and McAuliffe and Cohen (2005) and means that any sense of self also comes from one direction only. What drives LMI partners in their partnership work therefore remains largely unexplored, although Chevan et al. (2012) point out this imbalance in contribution should not jeopardise the spirit of partnership. THET (2012) has made an effort to address this in an evaluation of the International Health Funding Links Scheme, a UK government established initiative. Although written by Western consultants, it allows a rare insight by focusing exclusively on the perspective of partners in Uganda, Malawi and Zambia.

6 Challenges and suggested strategies

Various cultural challenges for those working in international health partnerships become evident in the literature. Chevan et al. (2012), Crathern and Evans (2009), Gervedink Nijhuis et al. (2012), Sochan (2012) and Suchdev et al. (2007) all describe such challenges encountered during overseas experiences. For example, Gervedink Nijhuis et al. (2012) list communication breakdown, misunderstandings, conflicts and differing perspectives as examples of difficulties rooted in cultural dissimilarity. Clearly, these findings are about more than language; any breakdown in communication can be problematic, regardless of linguistic differences.

What constitutes 'good' communication and how to achieve it is mostly unexplored, perhaps because communication is so specific to each country, culture and even each individual. Furthermore, there is arguably a danger that cultural safety may be aimed in only one direction; challenges such as those described above could be equally distressing for HI partner professionals and threaten their own cultural safety. This possibility is not considered; perhaps it

needs addressing if principles of parity and mutual interests are to be upheld.

Strategies to overcome cultural challenges have a generally simple focus. There is a considerable body of UK expertise which can give practical assistance and advice to professionals working with overseas partners regarding some of the challenges they may face (Crisp, 2007; DH, 2003; DH, 2010; DFID, 2008; RCN, 2010; THET, 2012). Executed according to international good practice standards, these reports repeat many consistent messages and give practical and concrete advice, providing a platform for the complex cultural and historical learning discussed earlier.

Specifically, several authors explore planning, preparation and negotiation as key strategies for success (Bohanan, 2010; Cox, 2011; Enskär et al., 2011; Crisp, 2007; DFID, 2008; Gervedink Nijhuis et al., 2012; McAuliffe and Cohen, 2005; Melby et al., 2008; RCN, 2010; THET, 2012; Xu, 2012). Learning about the host country, engaging in the culture, information gathering, and clarifying expectations are all important parts of the planning process. Cultural attitude towards planning appears to be important; THET (2012, p. 25) describe the "limited planning culture" in some low to middle income (LMI) countries or organisations as a threat to the smooth running of partnership work.

Part of the learning also involves appraising differing social and professional hierarchies, especially those between different disciplines. This may not always be anticipated as a source of conflict, but an easing of professional tensions can result from a better understanding of roles (Pullon, 2008). Once again this is dependent on an appreciation of history and context. The notion of good teamwork can be interpreted differently according to culture, but is also addressed widely in the literature (DH, 2003; Girot and Enders, 2004; RCN, 2010; THET, 2012). Cultural safety in this sense would be promoted by the acknowledgement of power relations and social context within a team (Ramsden, 2000).

Few papers address specific strategies for developing cultural proficiency, but embedding balance and equality through a respectful, mutual approach forms the essence of partnership arrangements and is heavily promoted in the literature. The very label 'partnership' emphasises the desire to achieve such parity and move away from historically paternalistic approaches. Many sources reiterate that local ownership of issues, realistic planning and goal setting, fostering mutual learning, flexibility, openness, trust and respect are examples of successful strategies for working in partnership (Crisp, 2007; DH, 2003; DH, 2010; DFID, 2008; Gervedink Nijhuis et al., 2012; Gore, 2008; Humanitarian Centre, 2012; Mason and Anderson, 2007; Melby et al., 2008; RCN, 2010; THET, 2012; Xu, 2012).

On a personal level, awareness of personal attitudes and assumptions is fundamental to learning about a different culture according to Ramsden (1992). Professionals engaged in or considering overseas work should examine their own surrounding culture with all that entails, which can inform their wider reflective practice. This includes mindfulness of important concepts such as cultural relativism. Opportunities exist in social media and guidance on working overseas from organisations such as the RCN to advise professionals on these subtle but important learning points.

Cultural safety advocates attitude change in terms of cultivating flexibility and an open mind and this takes active effort. Crisp (2010) suggests that cultural sensitivity is nothing without action; ultimately, professionals should be judged more on their behaviour than simply on their views.

7 Conclusion

Working in overseas health and education projects involves a complex range of factors, not least the ability to adjust to and embrace cultural differences. To achieve cultural safety in international working, a thorough understanding of the historical and contemporary context of the setting is recommended across the literature. The evidence broadly suggests that failure to achieve this may compromise cultural safety.

Attempts to promote balance and parity for partner institutions and professionals can be considered broadly supportive of the principles of cultural safety. There is a clear and growing message that richer and poorer countries are 'in it together', with local needs a firm priority.

The absence of good quality research co-authored by health professionals from LMI countries is striking. More would help engender a feeling that global health initiatives are truly moving forward. It would also offer a different view by strengthening the voice of those less typically heard in the debate; and highlight the cultural safety of all parties, not only those previously disadvantaged, as an interest worth protecting.

Finding cultural common ground as well as appreciating differences within partnerships would help to reinforce conditions for success. Presenting this united front, health professionals can continue to strive for the universal goal of improved global health.

Conflict of interest statement

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Footnotes

[1] In order to avoid confusion and in line with current convention, 'developing' countries are designated as 'Low to Middle Income' (LMI) countries. Developed, 'Westernised' nations are referred to as 'High Income' (HI) countries.

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