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Cross-Cultural Management in Healthcare: A Case Study of Malamulo Hospital, a Seventh-Day Adventist Mission Hospital in Malawi, Africa

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CROSS-CULTURAL MANAGEMENT IN HEALTHCARE: A CASE STUDY OF MALAMULO HOSPITAL, A SEVENTH-DAY ADVENTIST MISSION HOSPITAL IN MALAWI, AFRICA

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Abstract

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This paper examines the complexity of cross-cultural management in a Seventh-day Adventist mission hospital in Malawi and the effect of national and organizational culture on employee accountability, with the goal of expanding cross-cultural management capacity among the leaders of Malamulo Hospital and Adventist Health International. The literature provides cultural dimensions to understand the national culture of Malawi as compared to the United States. However, literature on cross-cultural leadership fails to address the nuances of healthcare management in a mission context.

In this study I identify how people in the Malawian culture hold each other accountable and how the organizational culture of the hospital can be influenced to promote appropriate accountability and performance. In order to achieve this I used a case study method using focus groups, semi-structured interviews, document review, and observation at Malamulo Hospital in Malawi.

The data fell into five themes that demonstrated an organizational culture where accountability was inconsistent and the core value of the Malawian culture is interpersonal relationships, which should inform the management policies and processes. I used two of Bolman and Deal's frames—Human Resource and Symbolic—and Trebesch's ECO model as theoretical frameworks to address the findings through a two-day workshop implemented for representatives from all healthcare facilities and the health science college in Malawi. I suggest that this type of training could be extended to

other mission hospitals within Adventist Health International to expand their cross-cultural management capacity.

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Dedication

This work is dedicated to the people of Malamulo Hospital, where serving the local community and sharing the love of Christ is evident every day.

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This process could not have happened alone. First, I want to thank my husband, who has been my biggest cheerleader at every step. He has helped with editing my papers, made sure I got my work done, made me coffee to keep me going, and instilled the importance of celebration of each accomplishment. I could not have reached this milestone without his support and encouragement.

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Loma Linda University has been very supportive of my process and has provided time for me to study, financial support for my research, and guidance through the field research process. Adventist Health International has also been fully supportive of my project by facilitating the research at Malamulo and by supporting the pilot workshop. I am grateful to both organizations.

I also want to acknowledge our favorite Thai restaurant, Chanida, in Calimesa, California, which is run by a lovely couple. It has been a place for us to celebrate small or big milestones with delicious Thai food and seems an important part of this process.

Finally, I am grateful that God provided this opportunity and sustained me through it. I trust that it honors him and moves his mission forward both in Malawi and beyond.

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List of Abbreviations

AHI	Adventist Health International
AHI-AdCom	Adventist Health International – Administrative Committee
CEO	chief executive officer
CHAM	Christian Hospital Association of Malawi
CHW	community health workers
CRI	central research issue
CVS	China Values Survey
ECO	Ecology of Organizations model
FBO	faith-based organizations
GLOBE	Global Leadership and Organizational Behavior Effectiveness
HR	Human Resources
HSR	Human Subject Research
IAD	Inter-American Division
IBM	International Business Machines
IDV	Individualism vs. Collectivism
IMF	International Monetary Fund
IND	Indulgence vs. Restraint
IRB	Institutional Research Board
LLU	Loma Linda University
LLUH	Loma Linda University Health
LTO	Long-term Orientation

MAS	Masculine vs. Feminine
MH-AdCom	Malamulo Hospital – Administrative Committee
MOU	Memorandum of Understanding
PDI	Power Distance Index
SDA	Seventh-day Adventist
UAI	Uncertainty Avoidance Index
UN	United Nations
WHO	World Health Organization
WVS	World Values Survey

Introduction

An inevitable fact of life is that at some point everyone will need to access healthcare. Whether it is for a joyous event like having a baby or for an unfortunate accident or sickness, these situations are part of life, and access to healthcare is important for everyone. Yet in many countries, especially in the majority world,[1] such necessary healthcare is out of reach due to cost, distance, or a lack of trained medical professionals.

The colonial expansion after Columbus discovered the Americas in the late fifteenth century brought missionaries along with the explorers. Grundmann suggests that Columbus's discoveries marked "the beginning of the history of mission in the modern era" (2005, 21). Later, in the early nineteenth century, medical professionals from Europe and the United States first formulated the concept of medicine as a means to "establish contact with foreign cultures otherwise closed to missionary work" (Grundmann 2005, 45). Some of these ambitious doctors and nurses started dispensaries, clinics, and hospitals as a way to share the gospel with the local people and established "mission hospitals" mostly at the end of a dirt road where there was the most unmet healthcare need. Several Seventh-day Adventist hospitals and clinics were started in the late nineteenth and early twentieth centuries by determined missionaries and are still open today serving patients with a blend of local and foreign professionals.

Malawi is one country, among many in sub-Saharan Africa, that now has several faith-based hospitals and clinics that were started over the past one hundred years by

[1] There are a variety of terms that have been used for countries with the majority of their population living below poverty level in the Global South. I have chosen to use the term "majority world" in this paper as opposed to "third-world," "low-income," or "developing countries," as these terms currently seem to have a pejorative connotation.

various missionaries and church organizations. Malamulo Hospital in southern Malawi is just one such mission hospital established by Seventh-day Adventist (SDA) missionaries from the United States. The mission was started as a small school and church in 1902 (Spalding 1962, 22), and in 1908 two nurses came to the Malamulo mission to open a clinic (Robinson 1954, 159).

Today Malamulo Hospital is a 220-bed hospital (General Conference of SDAs 2016) that is part of a larger Adventist mission campus with a church, primary and secondary schools, printing press, and College of Health Sciences. The students and most of the staff for these institutions all reside on the same property as well. It is still in the same rural setting where it was started, about 45 miles (65 kms) south of Blantyre in the southern region of the country (see appendix A).

In addition to the challenges of management in general, there is an added component of running an organization in Africa. As Terence Jackson points out, "'African Management' is cross-cultural management" (2004, 16); therefore understanding the cross-cultural dynamics within a hospital is important in the management of such a facility. Currently at Malamulo there are local Malawians with medical training who work alongside the foreign specialists and leaders, which creates a dynamic intercultural setting.

The challenge of leading in this kind of cross-cultural setting, as Lingenfelter defines it, is "building a community of trust among people who come from two or more cultural traditions that provoke a clash of worldviews" (2008, 20). In addition to the complicated aspects of running a large teaching hospital in a rural, resource-poor country, the dynamics of building trust, communicating, and ensuring accountability across various cultures adds to the challenges.

Personal Connection

I became acquainted with Malamulo Hospital in 2008 when I was offered a position to work as the director of finance for the four Adventist hospitals in Malawi as a volunteer with Adventist Health International (AHI). Malamulo was facing extreme financial challenges so I was asked to focus on the financial management issues there while also serving as a resource for the other healthcare institutions as needed.

While in this role and later as interim chief executive officer (CEO), I worked with a mixture of cultures that made up the management[2] of Malamulo Hospital. At that time there were people in management positions from the United States, United Kingdom, Mexico, Malawi, Malaysia, and the Philippines, and almost all of the staff were Malawian. This multicultural setting added a unique perspective to management that caused me to wonder how culture affected the choices and decisions that we made as an administrative group.

Accountability is an important aspect in running any organization, but a hospital adds the additional responsibility of quality patient care. Both within the hospital and in the community, I saw many instances where fulfilling commitments or agreements failed according to one party's expectations. It seemed that cultural differences may have affected the outcomes and expectations, but I did not have a good understanding of the implications of culture on accountability or management at that time.

In 2011, I returned to the United States permanently and became faculty at Loma Linda University (LLU) School of Public Health. Since returning, I have been a member of the Administrative Committee of AHI (AHI-AdCom) and have remained loosely connected to Malamulo by attending AHI Malawi board meetings when possible and offering support to the leadership as needed. I am also a member of the monthly AHI

[2] I am using the term "management" in this study as opposed to "leadership" based on the definitions of each provided by Hersey, Blanchard, and Johnson (2013). See the "definitions" section.

Finance subcommittee and chair of the Human Resources and Policy subcommittee, which both report to the AHI-AdCom on related issues.

I chose to do my research at Malamulo Hospital because of the unique intersection of cross-cultural management, healthcare, and mission that occurs there naturally as well as my past experience in a leadership position there. I have maintained relationships developed while working there that have provided access and support for my research project. My question about culturally appropriate management was the basis for my research topic and study of missiology from a cross-cultural management perspective.

Purpose

The purpose of this study is to understand how culture affects accountability, organizational culture, and management capacity in the context of a SDA mission hospital in Malawi.

Goal

The goal of this study is to strengthen the capacity of cross-cultural management and strengthen organizational culture within Adventist Health International (AHI) using Malamulo Hospital as a case study.

Significance

This research is important to both AHI as an organization and the field of missiology (see the descriptions of AHI and other relevant organizations in appendix G). AHI is a volunteer-based, nonprofit organization that works in partnership with the Adventist Church structure to build capacity and manage mission hospitals. Since its beginning in 2002, AHI has primarily focused on board governance and placing US-

trained medical personnel in order to strengthen local clinical capacity, often trying to build up patient volume and revenue to prevent rural mission hospitals from closing. As the hospitals have gained more financial and operational stability, AHI has adjusted its involvement in some places according to the needs and local resources. In some settings the managers of the hospitals are not academically trained or experienced in management but rather learn "on the job" what needs to be done.

This research, which considers the organizational culture and management capacity at Malamulo Hospital, serves as a case study by which the lessons learned can be used in other AHI facilities in order to strengthen the cross-cultural management capacity and organizational culture of each hospital. Although it is beyond the scope of this paper, some of the lessons from this research have already been put into use for other mission hospitals within AHI, thereby illustrating the usefulness of the lessons learned while researching cross-cultural management at Malamulo Hospital.

The field of missiology encompasses opportunities to apply concepts of cross-cultural management to mission hospital settings. Healthcare and healing are vital parts of sharing the gospel. There is an awareness of management principles and cross-cultural issues in mission, but with this research I will bring these two separate areas together considering the cross-cultural management of healthcare in a mission setting. As Adventists, specifically, we historically have focused on contextualization and sharing the gospel globally, but there is little emphasis on the unique complexities of running a hospital among a mixture of cultures. This research may be useful in the missionary training courses that the SDA church and others conduct for the long-term missionaries or volunteers in the healthcare field.

Central Research Issue

The central research issue (CRI) is to evaluate cultural and organizational factors that have shaped employee accountability and cross-cultural management capacity within Malamulo Hospital.

Research Questions

1. What are the Malawian cultural practices for accountability?
2. What are the current accountability and management-capacity related practices at Malamulo Hospital?
3. What are the composition and relationships of the hospital staff that affect accountability and management capacity practices within Malamulo Hospital?

Application Question

What culturally sensitive model can be developed to increase employee accountability within the organizational culture and strengthen cross-cultural management capacity at Malamulo Hospital?

Limitations

The location of my field research was a limitation for this study. I live and work full time in Southern California, so conducting the field research in Malawi and then later implementing any changes proved limited, as I do not hold a leadership role at the hospital. In order to address this limitation I knew that the current administrator of the hospital and the Malamulo Hospital Administrative Committee (MH-AdCom) were supportive of my research and also interested in developing capacity within the current management team. I was also able to travel to Malawi to conduct the field research for one month in 2015. Being somewhat removed was also a benefit because I was more

objective, and although I am familiar with the people and culture, I could observe as an "outsider" to some degree.

Another limitation was the language barrier, especially when holding the community-leader focus groups. While most people employed at the hospital are fluent in English, it is a second language. The commonly spoken language in the community is Chichewa, which I do not know fluently. In order to overcome this challenge I worked with a translator for the two community focus groups. The translator is a teacher at Malamulo Secondary School, fluent in both English and Chichewa, and familiar with the community. Although he was unfamiliar with the concept of focus groups and the transcription process initially, he read the material I provided to him and learned quickly when I explained the processes. He completed all of the necessary steps to be approved as a research assistant through the Institutional Review Board (IRB) process and has maintained the approval through the renewal processes.[3] He assisted with arranging for and translating at the community focus groups, as well as typing the transcription afterwards.

Delimitations

I am conducting this study as a member of the SDA church and am focusing specifically on the SDA mission hospital context within the network of AHI. Additionally, I collected data at one SDA mission hospital in Malawi, Africa.

For the purpose of this project I am not extending this study to compare the findings between two or more hospitals, but this research could be continued in the future by applying the case method to another hospital.

[3] Since I am a full-time faculty member at Loma Linda University (LLU), Fuller suggested that I work through LLU's IRB process rather than the Fuller Human Subject Research (HSR) process. Documentation of the approval and extensions were submitted to Fuller's HSR office.

Finally, I am focusing on cross-cultural management within a healthcare context in this study and not medical mission in general or the efficacy of faith-based mission hospitals as a method for spreading the gospel.

Definitions

It is important to have a clear understanding of the terms that are being used in the context of this study so that the usage can be clearly understood. Following are some key terms and their definitions that will assist the reader to understand the rest of the paper. In addition to these definitions, appendix G describes the various organizations that I refer to in the dissertation.

Cross-cultural Leadership

I am using the definition provided by Lingenfelter that describes cross-cultural leadership as "building a community of trust among people who come from two or more cultural traditions that provoke a clash of worldviews" (2008, 20).

Leadership vs. Management

There are different opinions in the literature on the definitions and usages of the terms "leadership" and "management." Hersey, Blanchard, and Johnson define management as "the process of working with and through individuals and groups and allocating other resources . . . to accomplish organizational goals" (Hersey, Blanchard, and Johnson 2013, 3). They define leadership as occurring "whenever one person attempts to *influence the behavior of an individual or group*, regardless of the reason" (4; italics in original). For my study I am using the term "management" to describe the functions that I am analyzing; however, there may be times when I refer to "leadership,"

which is differentiated by the term "organizational goals" (Hersey, Blanchard, and Johnson 2013, 4).

Accountability

I am using the definition of accountability from Brinkerhoff: "the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors, along with the imposition of sanctions for failure to comply and/or engage in appropriate action" (2004, 372).

Motivation

I am using the definition from Blunt and Jones: "Motivation refers to a driving force or state of need deficiency which inclines a person to behave in a particular manner, or to develop a capacity for certain types of behavior" (1992, 277).

Assumptions

I am writing with the assumption that healthcare in a faith-based context is a valid aspect of mission and can be a way to share the gospel. Following the example of Jesus, who often met the physical needs of people before ministering to their spirit, healing and healthcare is still a vital part of sharing the gospel to the whole person—mind, body, and soul. In the early days of organized mission societies there was debate about the validity of doctors as missionaries (Grundmann 2005, 48), but with time and the influence of people like Albert Schweitzer, Peter Parker, and others, the importance of healthcare in missions became more accepted. In the Adventist context, the connection between the health of the body and the health of the mind and soul has long been recognized, and an emphasis on healthcare within Adventism has been a pillar of the denomination. White,

one of the founders of the Adventist Church, wrote of the importance of medical ministry in connection with sharing the gospel:

> In the work of the gospel the Lord uses different instrumentalities, and nothing is to be allowed to separate these instrumentalities. . . . Our physicians are to unite with the work of the ministry of the gospel. Through their labors, souls are to be saved, that the name of God may be magnified. . . . Medical missionary work is in no case to be divorced from the gospel ministry. The Lord has specified that the two shall be as closely connected as the arm is connected with the body. Without this union, neither part of the work is complete. The medical missionary work is the gospel in illustration. (White 1899, 6–7)

The management aspects of healthcare may not require direct interaction with patients and providing clinical healing, but from my perspective the effective leadership of healthcare institutions is imperative in order for the clinicians to be able to provide the best care possible for physical healing. Thus, management is a vital form of mission service.

Additionally I am writing with the assumption that cross-cultural management is a valid and accepted field of organizational strategy within a mission context and in general. The literature widely supports the fact that, due to globalization, organizations can be made up of people from a variety of cultural, ethnic, and socio-economic backgrounds, and this affects the culture of an organization and its management. People are grappling with the implications for every aspect of an organization, and this field of discussion is generally referred to as "cross-cultural management" or "leadership."

Overview

In the remainder of this dissertation I demonstrate the process that I used in studying cross-cultural management and organizational culture within an SDA mission hospital context, Malamulo Hospital specifically. Broadly, this paper is divided into three parts. Part 1 addresses the literature related to the Malawian and organizational cultures.

In chapter 1, I present the social and cultural literature related to Malawi by exploring Hofstede's Cultural Dimensions and how this framework can be used to understand cross-cultural management. I also review Malawian models of governance and the influence of tradition on accountability. In chapter 2, I review the literature related to organizational theory and cross-cultural management in a healthcare context specifically. I also examine Bolman and Deal's Four Frames and the ECO model from Trebesch as theories to use in analyzing the organization's culture. Chapter 3 applies the literature and theories to the Malamulo Hospital context.

Chapters 4 through 6 comprise part 2, which covers the field research at Malamulo Hospital. In chapter 4, I describe the case study method of research that I used, including focus groups, interviews, and participant observation used to collect the data. In chapter 5, I share the four themes that came from the data of Performance Evaluation, Cross-Cultural Management, Motivation, Accountability, and Organizational Structure within Malamulo Hospital. Chapter 6 analyzes the data and reviews it through the lens of the theoretical construct, and ties the analysis back to the literature to understand how this research connects with the related fields.

The final section is part 3, where I take the findings and apply them and describe the observations. Chapter 7 discusses how I have applied the findings from the research in the context of Malawian healthcare leadership through a pilot workshop and explores the lessons learned. Finally, in chapter 8, I share recommendations to Malamulo Hospital and to the broader AHI organization. I also highlight gaps in the literature that I have identified and some personal lessons I have learned through this doctoral program. In the conclusion I identify additional gaps for future research in order to add to the field of missiology and to identify how this project met my research goals.

Summary

This introduction has provided an overview of the entire dissertation and described a framework for the study that I have conducted. The stated goal, purpose, central research issue (CRI), and other parameters give a foundation to understand the rest of the dissertation. The lessons learned through this research can be used to equip leaders of mission hospitals to expand their skills in cross-cultural management. As management capacity is strengthened and attention is given to the organizational culture, it will bring the hospitals to a higher level of effectiveness as missions.

In the next two chapters I will focus on the literature related to the Malawian culture and organizational dynamics, and then in the third chapter I apply the concepts to the Malamulo Hospital context. These three chapters lay the foundation for understanding the relevant issues in cross-cultural management and organizational culture of a mission hospital in Malawi.

Part I

Toward Understanding the Interaction of Malawian Culture and Organizations

Part 1 will present the relevant literature to provide a basis for understanding Malawian and sub-Saharan cultural dimensions and traditional forms of governance, and also how they impact cross-cultural management. In addition, I will address organizational dynamics that are present in healthcare management and how the theoretical constructs of the Four Frames and the ECO model provides a way to assess and strengthen the culture of an organization. Finally, I will consider these three main theories—Hofstede's cultural dimensions, the ECO model, and the Four Frames—and apply them to the Malamulo Hospital context.

Chapter 1

Social and Cultural Literature on Malawi

"He who thinks he is leading and has no one following him is only taking a walk."

– Malawian Proverb

This chapter provides background and high-level understanding of the cultural context of Malawi as a country within the region of sub-Saharan Africa, and it introduces a framework of cultural dimensions in order to understand cultural differences. Gaining this awareness and familiarity with a framework provides tools useful in healthy intercultural relationships within a cross-cultural setting such as Malamulo Hospital in Malawi. These tools can be translated to other settings, countries, or cultures, but the focus of this study is the culture of Malawi. To begin, I will describe cross-cultural management in a mission context by sharing an experience that I had early in my work at Malamulo.

When I arrived at Malamulo I was asked to fill in for the CEO who was away for medical reasons for an unknown length of time. Within the first week or two I was asked to be part of some conversations with a family who had a dispute over land that bordered the hospital's property. Since I had just arrived I had no idea about how to deal with land, the cultural expectations, or the history of the land ownership of the mission property.

The hospital business manager explained the issues to me: the family had expanded their use of the land beyond the hospital's understanding of the borders. Although I did not have any prior understanding of how land borders and use were determined in the culture, he assured me that as the interim CEO it was important for me

to be part of the conversation along with some representatives from the other institutions on the mission land. We arrived at the home of the family and they led us around the property line where we could see how it related to the Malamulo Mission land. It seemed that there was an understanding from the mission that the mother (who was a prior employee) could farm the land, but she had passed away and the children were disputing the fact that they were infringing on mission land.

The nuances of the discussion that occurred in the shade after the walk around the property that day were not entirely clear to me as a newcomer to the country. I realized there were many unspoken complexities to the rules, contracts, and general accountability that I did not understand; but it was clear that my presence as a representative in the highest position of the hospital was important. I quickly understood that I was expected to assist with important decisions and conversations related to issues that I was unprepared for, such as land rights in a healthcare setting—and it was just the start of managing in a cross-cultural setting.

Cross-cultural Management in Mission

The literature on leadership makes little reference to cross-cultural management, although there is some discussion about leadership and management styles and what works across cultures. When authors do discuss cultural differences, it is often in the context of a multinational company that may have offices in more than one country. In the context of a mission setting there is an added spiritual component to the work that brings a different perspective to the relationships between people. In my study I will address cross-cultural nuances of managing a mission hospital, but it will not likely completely fill the gap in literature since there are myriad aspects to the topic.

Lingenfelter, writing from a mission perspective, notes the definition of leading cross-culturally as “building a community of trust among people who come from two or

more cultural traditions that provoke a clash of worldviews" (2008, 20). In his book he highlights various aspects of leadership from a biblical perspective in a cross-cultural setting, interweaving throughout the concept of building trust across cultures. Plueddemann (2009) highlights ways to develop leaders cross-culturally. He combines Hofstede's Power Distance dimension and other cultural characteristics to keep in mind when working with people from various cultures (208–9). Both Lingenfelter (2008) and Elmer in *Cross-cultural Servanthood* (2006) emphasize the importance of humility in the leader, approaching all situations from a learning perspective before making assumptions or changes. These authors base the ideas of trust, humility, and learning on a biblical worldview that would be more common in a mission context.

Cross-cultural management is often a factor in international healthcare where there may be a mixture of people from various backgrounds, especially in leadership positions. Healthcare is not always affiliated with a church or faith and is often categorized as humanitarian and development work. Many secular organizations are doing very effective and admirable work providing healthcare in the majority world.[1] Whether faith based or not, these development or healthcare-focused organizations do not necessarily focus on building cross-cultural management capacity. Jackson noted this in a recent blog where he discusses the lack of awareness of cross-cultural management among international development professionals (Jackson 2017a). He refers to Hofstede's concern that Western theories do not work abroad, but points out that more than just cultural issues are at stake; there are also political concerns related to funding sources. "Community-based organizations that grow out of the local community to meet community needs are conflicted as soon as they become financially dependent on funding from international development organisations," which require Western forms of

[1] For example: Medecins Sans Frontieres (Doctors Without Borders), Partners in Health, Gates Foundation, USAID, etc.

management (Jackson 2017a). There is a need for both secular and faith-based organizations to use relevant "indigenous knowledge" as a way to approach cross-cultural management, and in my study I intend to be aware of this need while seeking to build management capacity.

African Leadership Models

In order to understand leadership in Africa, Jackson has attempted to outline the movement of management styles across time from postcolonial, postinstrumental, to the current and future that he terms "African Renaissance": an ideal blend of management moving towards a hybrid cross-cultural management model taking the indigenous culture into account (Jackson 2004, 27–30). He outlines the five key values of the current trend in African management or Renaissance: (1) *Sharing* is somewhat related to the *ubuntu*[2] philosophy of "humanness—a pervasive spirit of caring and community, harmony and hospitality, respect and responsiveness—that individuals and groups display for one another" (Mangaliso 2001). Jackson suggests that "collective trust is a large part of this [*ubuntu*] value that should be developed in organizations before participation and empowerment initiatives can succeed" (2004, 28). (2) *Deference to Rank* is not necessarily related to Power Distance, but involves taking one's appropriate place in society and maintaining the virtue of humility and making decisions through obtaining consensus. (3) *Sanctity of Commitment* refers to mutual commitment to obligations and conformity to social expectations. (4) *Regard for Compromise and Consensus* suggests the maintenance of harmony within society, keeping an open and participative approach. (5) *Good Social and Personal Relations* relates to maintaining a good inter-ethnic harmony and a humanistic perspective (Jackson 2004, 28–29). It seems to me that his

[2] "Ubuntu" is a philosophy that originated in South Africa in the mid-nineteenth century and became more widely known after apartheid in the 1990s. https://en.wikipedia.org/wiki/Ubuntu_(philosophy).

term "African Renaissance" is moving towards a cross-cultural model to "hybridize" a model for effective management.

In general, Jackson approaches management from the African perspective, not encouraging management theory from outside Africa to be thrown out, but rather contextualized to fit the specific culture and context, affirming the traditional methods that work. "Any description of management systems within Africa should include a consideration of an 'indigenous' African management" (Jackson 2004, 29), furthering the hybridization of management across cultures. This differs somewhat from "cross-cultural" management, which is just trying to create a cohesive team out of two or more cultures without considering what may already be effective in the context. A typical approach may also be that whoever is in charge feels their methods are "right," and since the culture has a high respect for authority, that perspective may dominate without considering what is already working or how methods can be blended. The focus in cross-cultural management is more from the leaders top-down, while "African Renaissance" management is moving the focus toward what is effective in the African context, taking both indigenous tradition and Western methods into account.

The African indigenous management model is built on a milieu of influences such as colonialism and contingency-oriented leadership.[3] Jack and Westwood (2009) approach management from a postcolonial perspective and discuss the need to move away from imposing methods and theories on the "other" from outside, as described earlier. In contrast to Jackson's support of the concept of hybridization, Jack and Westwood criticize hybridizing as another method of power flowing one direction. Power flows between the core, peripheries, and semi-peripheries, so criticizing a global system

[3] Contingency-oriented leadership is based on Blunt and Jones's (1997, quoted in Jackson 2004, 102-103) perspective that popular trends in leadership theory such as transformational leadership are concerned for employees, masking the real interest in performance improvement, and if a hard approach does not work the softer, people-oriented approach may work.

such as hybridization portrays certainty of where the center and periphery reside. The authors suggest that there are multiple cores, peripheries, and semi-peripheries, and how they are identified depends on one's perspective (25–26).

Kamoche and colleagues reference Jackson and other scholarly work related to hybridization in human resource management. They affirm the interest in a "middle way" where especially multinational companies "must make adaptations to local practices and norms while seeking to implement standard global best practices" (2012, 2829). Although Jack and Westwoood seem to be in disagreement with other literature, they, along with Kamoche et al., all seem to be describing a similar sentiment involving some level of blending management approaches. The slight difference in viewpoints may be based on choice of vocabulary rather than real disagreement.

There are numerous models of cross-cultural management based on various theories and research, which I have just touched on. In order to better understand the heart of the issues, it is helpful to have a framework and language to understand cultural differences when managing across cultures. I have chosen to use Hofstede's cultural dimensions to provide that language and framework. In the next section I will explain the dimensions and why I chose Hofstede's dimensions over other cultural frameworks.

Understanding Culture

There are multiple ways to define culture, but I will cite three here. Crouch suggests, "culture is what we make of the world" (Crouch 2008, 23). Schein focuses on organizational culture, but also defines culture in general: "culture is to a group what personality or character is to an individual" (Schein 2010, 14). Nova defines culture as "a set of discourses, images, and ideas that emerge in the context of particular social struggles and political-economic processes" (2003). One of the major "social struggles" and "political-economic processes" at work in traditional culture in sub-Saharan Africa is

the effect of colonialism on local customs and traditions. When exploring the culture in Africa, the researcher (such as myself) should take colonialism into consideration since it has had such significant influence on their protectorates. The local people in those regions may have assimilated traditions that came from colonial authority. In fact, what might be considered "tradition" in former colonies in Africa could be that which was established as policy and standards during the colonial governance rather than actual precolonial culture (Ranger 1997, 602–4). Ranger goes on to suggest that what is visible now as culture is a "tradition" swayed by colonialism, missionaries, and other Western influences. The mixture of historical influences makes identifying "Malawian culture" more challenging, yet at the same time the various contextual influences must be taken into consideration with the realization that they all have an effect on motives, behavior, and expectations.

Realizing that culture is affected by various worldviews, in an effort to explain behaviors and the underlying values, several scholars have done extensive research on cultural behaviors to identify dimensions within a culture. For instance, in 1954, Levinson and Inkeles published a broad survey of literature on national culture and suggested several issues that were common worldwide among cultures (Hofstede, Hofstede, and Minkov 2010, 29–30). Hofstede and colleagues define a cultural dimension as "an aspect of a culture that can be measured relative to other cultures" (2010, 31). Using tools such as cultural dimensions provides a language and framework to approach and understand how and why certain behaviors happen and are expected.

In the 1970s Geert Hofstede was given the chance to build on Levinson and Inkeles's research by studying employees of International Business Machines (IBM) who were scattered across fifty countries yet were in similar positions within the same company. The results from Hofstede's study aligned with the findings of Levinson and Inkeles and seemed to confirm the existence of problems that are basic to all humans

while the solutions vary between countries (Hofstede, Hofstede, and Minkov 2010, 30). These problem areas were identified as "dimensions" of culture.

Another prominent study conducted by Robert J. House and his colleagues is referred to as "The Global Leadership and Organizational Behavior Effectiveness (GLOBE)" study was first published in 1991, examining culture, leadership, and organizations (House et al. 2004). The GLOBE study relies on Hofstede's research extensively and expanded the five dimensions into nine. They separated culture in the organization and culture in the society rather than just looking at the organization as Hofstede did.

In 1996, Smith, Dugan, and Trompenaars published research on seven cultural dimensions based on research in 43 countries. His research covered former Soviet countries, which were not considered in Hofstede's initial studies. Trompenaars only includes three African countries: Nigeria, Burkina Faso, and Ethiopia, which are not geographically or culturally close to Malawi. There are some differences and some similarities between Trompenaars's and Hofstede's dimensions and their research methods.

Each contemporary researcher, House, Hofstede, and Trompenaars, have critiques of the other's methods and outcomes; some of the debate is even harsh (Hofstede 1996; Hampden-Turner and Trompenaars 1997).[4] Despite criticisms and the validity of the various studies as valid options, Hofstede seems to be considered the foremost expert on cultural dimensions of management based on the frequency of references to his work in cross-cultural leadership literature. Also, Hofstede's research includes Malawi in the data

[4] In a response to Hofstede's criticism, Hampden-Turnder and Trompenaars state, "If Hofstede 'knows' that we are in the business for the money and are ready to practice intellectual dishonesty to that end, then we leave him to his immaculate perception. We have no knowledge of his motives and are content to leave such judgments to God" (Hampden-Turner and Trompenaars 1997, 1). They go on to discuss differences in their approach with Hofstede, which they sustain are legitimate and related to cultural differences in the researchers themselves.

online and includes other sub-Saharan African countries in his publications, which is helpful to be more specific to my context. For the purposes of my study, I have chosen to use Hofstede's cultural dimensions to provide a framework for understanding cross-cultural management because he includes Malawi and other sub-Saharan African countries and due to the relative ubiquity of his research as a foundation for cultural contexts. I acknowledge that other scholars have conducted studies that could be used in a similar way.

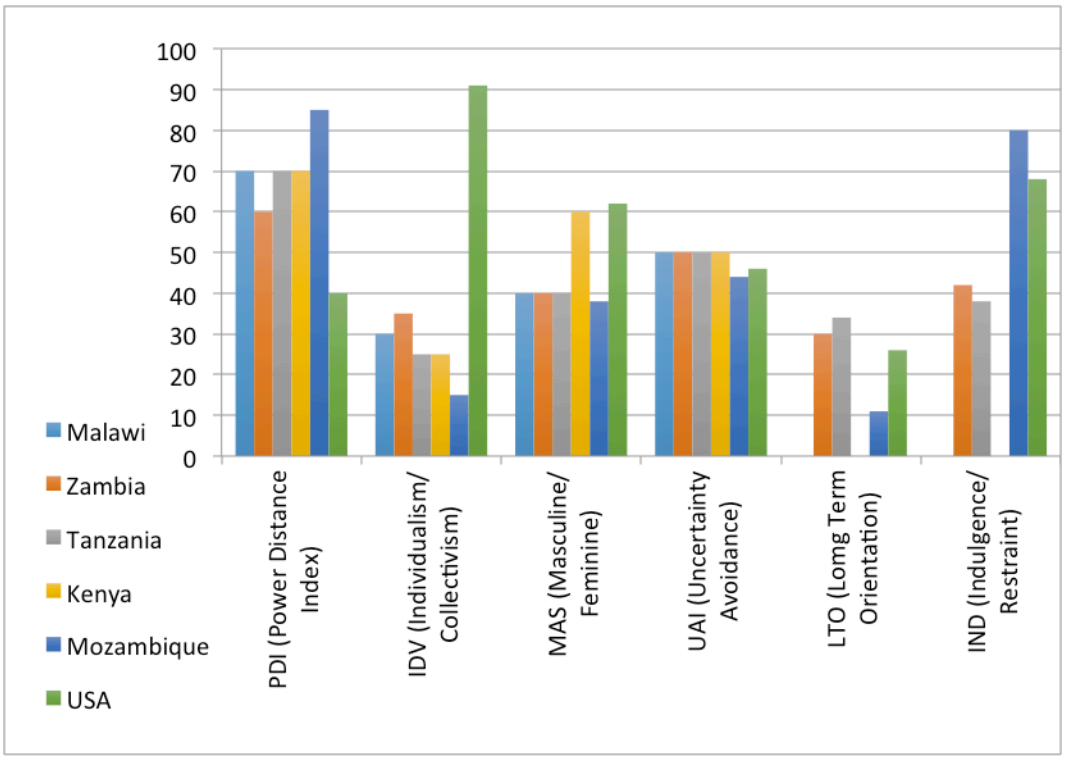

Figure 1: Hofstede's Cultural Dimensions: African Countries and the United States[5]
(Hofstede 2017)

[5] The abbreviations used in figure 1 will be described below. For LTO and IND there is no data available for Malawi and Kenya in the online tool. For the country comparison tool see https://geert-hofstede.com/countries.html. In a footnote regarding Malawi and other countries, the website states, "Scores of countries marked with an asterisk (*) are—partially or fully—*not* from Geert Hofstede but have been added through research projects of other researchers or have been derived from data representing similar countries in combination with our practitioner experience."

Hofstede's Cultural Dimensions

Hofstede defined "dimensions of culture" as "aspect[s] of a culture that can be measured relative to other cultures" (Hofstede, Hofstede, and Minkov 2010, 31). Initially, they identified four dimensions: Power Distance (small to large), Collectivism versus Individualism, Femininity versus Masculinity, and Uncertainty Avoidance (weak to strong), (2010, 31). Later, when conducting the China Values Survey (CVS), Michal Bond worked with Hofstede to distinguish a fifth dimension termed Long-term versus Short-term orientation (Hofstede, Hofstede, and Minkov 2010, 37–38). Twenty years after the initial studies were done, Misho Minkov, working with Hofstede, identified a sixth dimension referred to as Indulgence versus Restraint (Hofstede, Hofstede, and Minkov 2010, 281). The first four dimensions are primarily related to national cultures studied initially at the offices of IBM located throughout the world, but it is understood that there are many different subcultures within each country. The last two dimensions were added as the research continued to be developed and refined.[6]

Organizations often have their own culture as well, and Hofstede differentiates this from national culture. Khatri observes that "individuals and organizations within a national culture may vary in their value orientation" (2009, 2). Hofstede clarifies that value orientations differ because members did not grow up in the culture, they had a certain amount of influence in their decision to join, and they will one day leave that culture (2010, 47). I will address organizational culture in more depth later but first I will describe each of the cultural dimensions put forth by Hofstede and his colleagues.

[6] In his research Hofstede grouped East African countries together, but only gathered data from Ethiopia, Kenya, Tanzania and Zambia (Hampden-Turner and Trompenaars 1997, 1). However, in the more recent data published online Malawi is indicated in four of the six dimensions (see figure 1).

Power Distance (PDI)

The Power Distance Index (PDI) score is defined by Hofstede as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally" (Hofstede, Hofstede, and Minkov 2010, 61). In an organization this is demonstrated by how subordinates relate to their bosses and the level of dependence present in that relationship. "In small power distance countries, there is limited dependence of subordinates on bosses and a consultative decision making style" (61). The opposite is true with large Power Distance countries where there is higher dependence of subordinates on bosses. The emotional distance between bosses and subordinates also correlates to the Power Distance level (61).

The East African group of countries ranks relatively high at 64 on the PDI, with the highest being 104 (Hofstede, Hofstede, and Minkov 2010, 58–59). More specifically Malawi is ranked at 70 according to the online tool (see figure 1).[7] This would indicate that the less-powerful members of the society are highly comfortable with the unequal distribution of power and accept the distance between people in authority and their subordinates. In a high PDI culture, such as Malawi, there would be a high level of dependence of the subordinates on their bosses. Notably, respect for hierarchy is important in the higher PDI cultures. For example, Khatri suggests that organizations with high PDI rely on the superior to make all decisions and subordinates are content without participating in decisions (2009, 3).

Jackson provides a commentary on Power Distance in relation to management practices and corroborates Hofstede's finding of the sub-Saharan African region being on the high end of the spectrum with other research. However, Jackson does not accept this as the full answer to management and suggests that saying the management style is high

[7] It should be noted that the scores for the online tool were recalibrated from the published book to fit within a 100-point scale so slight variations between the book and the online tool are expected (https://geert-hofstede.com/national-culture.html).

Power Distance is “probably inaccurate and too simplistic” (95) and more accurately a reflection of the colonial times. An explanation is that the colonial style of management was truly high Power Distance, whereas the newer “African Renaissance” style that he suggests as the way of the future is closer to the “real” culture, and would be considered medium Power Distance. “The main point is what an indigenous management style is trying to become, not what it was like before colonial times” (Jackson 2004, 96).

Although Malawi may not be the highest on the PDI, Power Distance is an important factor to take into consideration in cross-cultural management and the hospital culture. It may be more helpful to look at the score in relation to another country when considering its weight in a relationship (see figure 2). Note the large difference between the scores for the United States (40) and for Malawi (70). Expectations related to Power Distance could be an area of misunderstanding when a Malawian and someone from the United States are working together.

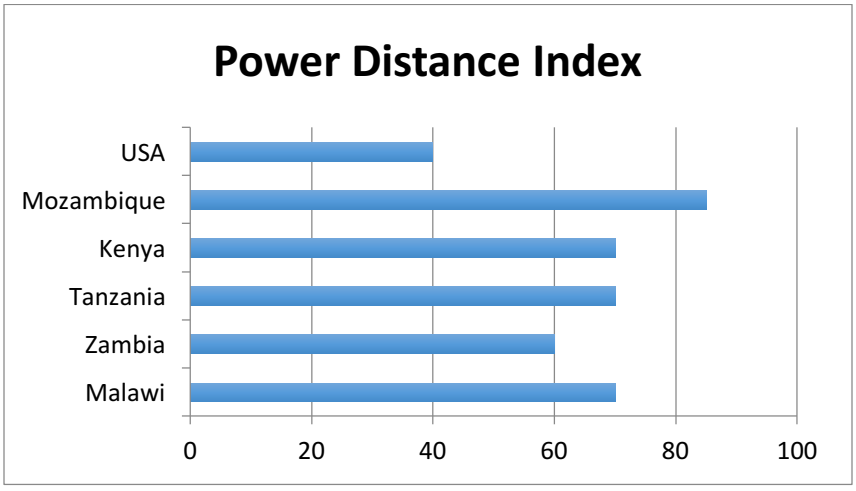

Figure 2: Power Distance Index Detail
(Hofstede 2017)

Individualism vs. Collectivism (IDV)

Individualism and Collectivism are two ends on the continuum of another dimension of society. Hofstede defines these terms:

> Individualism pertains to societies in which the ties between individuals are loose: everyone is expected to look after him- or herself and his or her immediate family. Collectivism as its opposite pertains to societies in which people from birth onward are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty. (Hofstede, Hofstede, and Minkov 2010, 92)

In order to study this dimension Hofstede and his team conducted research based on work goals around six items: personal time, freedom, challenge, training, physical conditions, and use of skills (Hofstede, Hofstede, and Minkov 2010, 92–93). The results of the survey also showed a clear correlation between the wealth of the country and the rank on the Individualism Index (IDV), where the wealthier countries ranked higher while the poorer countries ranked lower (93–94).

Looking at my research context, East Africa ranks 27 and Malawi specifically at 30, both relatively low on the IDV scale. This would indicate that the society is collectivistic and look to their role in the community to provide identity and determine the individual's responsibility to the community and vice versa. This dimension is also closely correlated to "in-groups" and "out-groups," which can be a form of support and survival based on the connections one has.

The reliance on the community collectively is evident throughout the Malawian culture as illustrated in my earlier story about the dispute of land usage at the mission, which was a community problem that was resolved through consensus by a group of key people. The Individualism dimension has the greatest variance, shown in figures 1 and 3, between Malawi (30) and the United States (91). Taking this large difference into consideration is helpful to someone coming from either culture to identify and understand the basis for different expectations. The collectivistic perspective of the sub-Saharan

Africa region was agreed upon in all of the literature that I reviewed and a major point of difference for someone coming from a Western perspective.

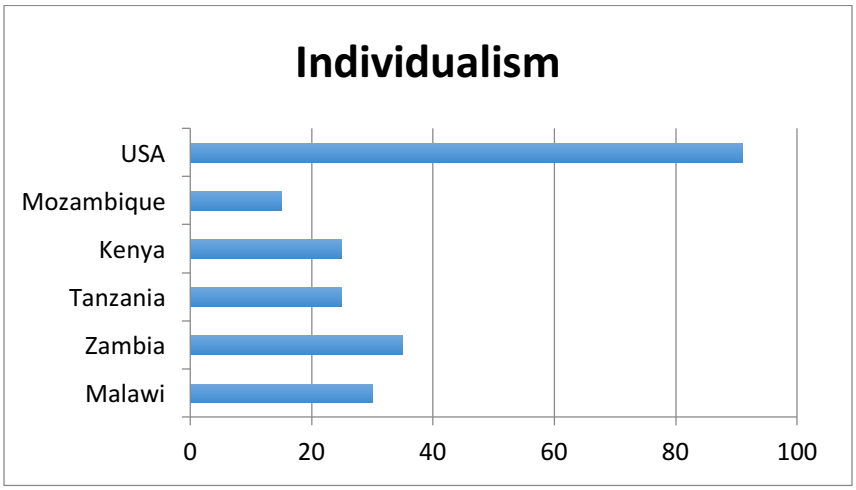

Figure 3: Individualism vs. Collectivism Detail
(Hofstede 2017)

Masculine vs. Feminine (MAS)

The masculine vs. feminine dimension was discovered because it was the only dimension where men and women consistently scored their work goals differently. Therefore the researchers identified those characteristics with gender roles. A definition of the dimension is helpful here:

> A society is called "masculine" when emotional gender roles are clearly distinct: men are supposed to be assertive, tough, and focused on material success, whereas women are supposed to be more modest, tender and concerned for the quality of life. . . . A society is called "feminine" when emotional gender roles overlap: both men and women are supposed to be modest, tender, and concerned with the quality of life. (Hofstede, Hofstede, and Minkov 2010, 140)

East African countries fall just below the middle of the index at 41, leaning slightly more toward the feminine definition (0 being feminine and 100 being masculine) (Hofstede,

Hofstede, and Minkov 2010, 143), with Malawi showing 40 in figure 4. This cultural dimension has drawn some controversy, although it has been validated by later studies. Hofstede found that this dimension is considered "politically incorrect" in higher masculine-based cultures. One reason, the researchers suggest, is that this dimension does not correlate with wealth as the others do, meaning there are just as many wealthy countries and poor countries on either end of the spectrum, which if wealth were correlated would "serve as an implicit justification that one pole must be better than the other" (Hofstede, Hofstede, and Minkov 2010, 144).

For the purposes of my study I am not focusing on this dimension. Although expectations related to gender roles add an interesting layer to cross-cultural management, it is beyond the scope of my study for purposes of time and focus. Due to my personal experience as a young, single female leader in the Malawian context, I do think this is an interesting topic for future study.

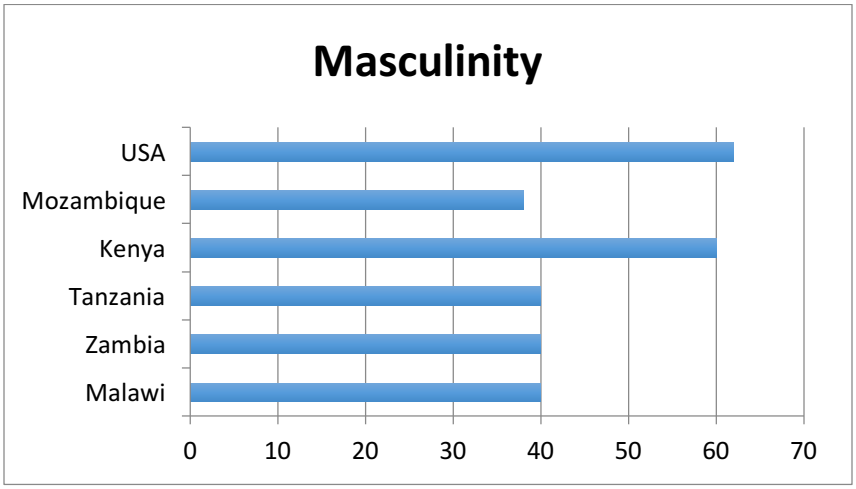

Figure 4: Masculinity vs. Femininity Detail
(Hofstede 2017)

Uncertainty Avoidance (UAI)

Uncertainty Avoidance Index (UAI) refers to the anxiety within a culture related to the unknown of the future. Uncertainty Avoidance is defined as: "the extent to which the members of a culture feel threatened by ambiguous or unknown situations" (Hofstede, Hofstede, and Minkov 2010, 191). Research shows that this could have effects on the health of citizens related to how people manage their anxiety using unhealthy indicators such as caffeine and junk food intake, and suicide rates. Anxious cultures also tend to be more expressive and emotional in forms of communication (2010, 196).

All of the African countries that were evaluated in Hofstede's research fell near the middle of this index, with the East African countries at 50, which places them as ambiguously neither comfortable nor uncomfortable with uncertainty. Jackson considered other research related to internal or external locus of control and uncertainty avoidance to describe what seems like high uncertainty avoidance in African culture. Yet, as Jackson points out, Hofstede's research does not clearly indicate this (Jackson 2004, 67). His observation is that Hofstede's sample is relatively small therefore not representative.

One reason respondents to the survey could have scored higher in this area is that uncertainty avoidance might be present when an employee's work environment is disconnected from their societal culture. "The uncertainty within the African environment may be difficult to manage through postcolonial management systems, because the system (high uncertainty avoidance) and the environment (high uncertainty) are incompatible" (Jackson 2004, 68). The added layer of understanding related to the influence of colonialism that Jackson contributes provides a deeper level of understanding to Hofstede's cultural dimensions—UAI especially. For the purposes of my research I am not focusing on UAI because, as shown in figure 5, this dimension shows very little difference between the cultures of the African countries and of the United States, based on Hofstede's research.

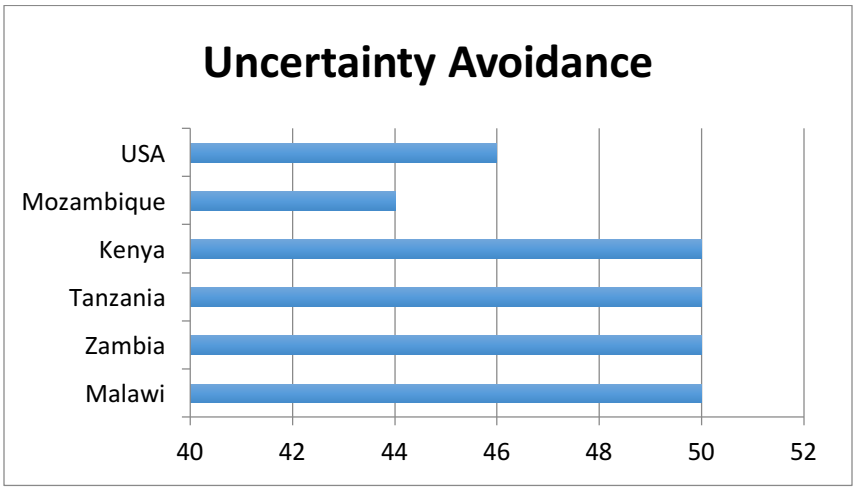

Figure 5: Uncertainty Avoidance Detail (LTO)
(Hofstede 2017)

Long-term vs. Short-term Orientation

Michal Bond conducted the Chinese Value Survey (CVS) in 1985 and found four dimensions of culture. Three were strongly correlated with Hofstede's dimensions but the fourth was not. The reason found for this dimension not being identified was because the related questions were not asked in the IBM study. Starting in 1991, Hofstede labeled this dimension found in the CVS as Long-term vs. Short-term Orientation (LTO) (Hofstede, Hofstede, and Minkov 2010, 236–39), with these definitions:

> long-term orientation stands for the fostering of virtues oriented toward future rewards—in particular, perseverance and thrift. Its opposite pole, short-term orientation, stands for the fostering of virtues related to the past and present—in particular respect for tradition, preservation of "face," and fulfilling social obligations. (Hofstede, Hofstede, and Minkov 2010, 239)

There were some doubts as to the validity of the rankings due to the few number of countries surveyed in the CVS, but in 2007, another survey was published by Monkov called the World Values Survey (WVS), and the same dimensions were measured using

different questions allowing the initial distinctions of the CVS with some modifications to be expanded to more countries.

Based on the WVS, the African countries individually surveyed were low on the index, indicating a strong correlation with Short-term Orientation (Hofstede, Hofstede, and Minkov 2010, 255–58). Maranz, who conducted research in West African countries, agrees, suggesting that for these populations, if resources are available they are meant to be used and not hoarded, which aligns with the finding of short-term orientation in Africa in general (2001, 16–17). This seems to resonate in Malawi (see figure 6) and may be applicable, although Hofstede does not report data for Malawi on this dimension. For the purposes of my research I am not focusing extensively on this dimension due to lack of data and focus of the scope of my research.

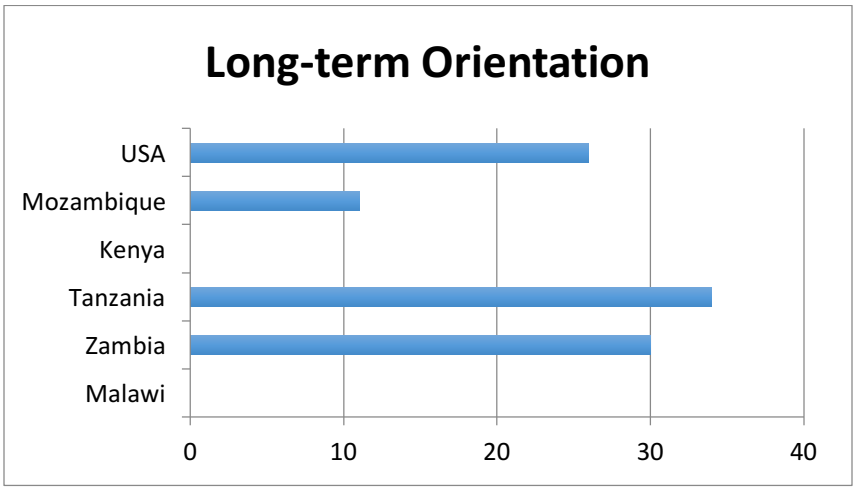

Figure 6: Long-term Orientation Detail[8]
(Hofstede 2017)

[8] Data is not available for Kenya and Malawi for this dimension.

Indulgence vs. Restraint (IND)

The WVS asked people how satisfied they are with their lives and how happy they feel, questions that address the issues of happiness or subjective well-being, which is usually related to "a cognitive evaluation of one's life and a description of one's feelings" (Hofstede, Hofstede, and Minkov 2010, 278). One finding from the WVS was the countries with the highest percentages of very happy people tended to be the poorest. In the initial analysis of the WVS, the researchers found that well-being was associated with high rankings on Individualism and low Masculinity scales. It seemed that all of the contributing factors were correlated to the relative wealth of the country. Minkov looked further at this research because it did not explain why people who ranked high on the happiness scale were not necessarily from the wealthiest countries. He identified three aspects of a new dimension: happiness, life control, and importance of leisure. These formed the core of what Minkov referred to as a cultural dimension: indulgence vs. restraint (Hofstede, Hofstede, and Minkov 2010, 278–81).

The term "indulgence" is defined as "a tendency to allow relatively free gratification of basic and natural human desires related to enjoying life and having fun" (Hofstede, Hofstede, and Minkov 2010, 281). Restraint, at the other end of the spectrum, is "a conviction that such gratification needs to be curbed and regulated by strict social norms" (Hofstede, Hofstede, and Minkov 2010, 281). Zambia was ranked at 42 and Zimbabwe at 28 on the scale, and there is no data provided for Malawi. Since there is a wide variance I am not sure that I can generalize to say where Malawian culture would fall on this scale; however, this dimension is not an area of focus for my study due to lack of data and my focus.

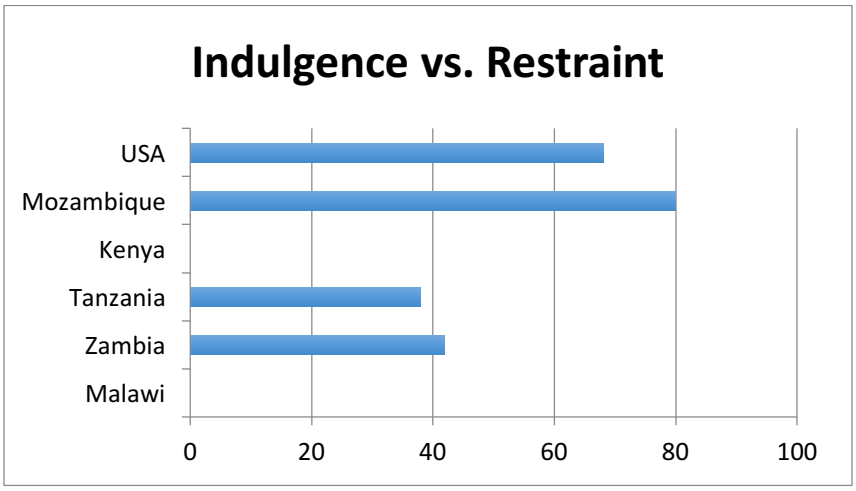

Figure 7: Indulgence vs. Restraint Detail[9]
(Hofstede 2017)

Hofstede's six cultural dimensions provide a framework and a language to use to discuss differences that could arise in a cross-cultural management situation. While there may be disagreements on his approach or methods, the framework is helpful as a tool to understand and adapt when necessary. I have chosen to focus on Power Distance and Individualism vs. Collectivism in the application portion of my study because these seem to demonstrate the most drastic differences between Malawi and US culture and therefore can provide insights for the most growth in understanding between the two cultures. The other dimensions provide valuable insight into the culture, but I did not apply them specifically in this project due to less drastic differences and less data for Malawi specifically.

Critique and Application of Hofstede's Cultural Dimensions to Malawi

Hofstede's cultural dimensions are useful as a tool to assist in understanding differences in behavior, which are based on values that a society might hold. Many people critique Hofstede and point out that his dimensions generalize the population

[9] Data is not available for Kenya and Malawi for this dimension.

unfairly or he did not select a representative sample (Jackson 2004, 67). Jackson adds further critique of Hofstede's dimensions and argues that African culture is too diverse to be simply explained in these six dimensions. He suggests that it is more helpful to focus on the content of the leadership in organizations such as coercive, remunerative, and normative control mechanisms, through which we can see the various cultural influences in management and leadership in Africa (Jackson 2004, 98–99). Bolden and Kirk's review of cultural dimensions in literature suggests that they are "motivated through a desire to provide western mangers with a better understanding of how to do business in Africa, rather than to assist African managers, organizations and communities appreciate, develop and/or enhance their own approaches" (2009, 73). Although the type of leadership displayed in an organization is vitally important, the cultural dimensions provide a broad framework that still seems helpful and can be used in a positive way for all rather than only benefiting the Westerner.

In Malawi it is evident, especially in the rural communities, that people make choices based on what is perceived as the good of the community, and they function in a decentralized traditional government model. This correlates with the low score on the Individualism (IDV) spectrum, indicating high collectivistic tendencies. Collectivism could also indicate sources for motivation and performance supporting the findings from Greenspan that family, community, and organizational reasons are all sources of motivation as well as individual factors (Greenspan et al. 2013).

The dimension of Power Distance (PDI) is helpful to consider related to the traditional forms of community organization and expectations between the leader and those being led. Researchers suggest that the colonial governance structure still influences current Malawian society, and this may contribute to the higher score on the PDI. The awareness of the importance of hierarchy and how to relate to those in authority

provides valuable knowledge for those who come from a different culture and work in Malawi.

Hofstede's other cultural dimensions of Masculine vs. Feminine, Uncertainty Avoidance, Long-term vs. Short-term, and Indulgence vs. Restraint are useful to further understand the culture, but due to the limited scope of this study I did not focus on these dimensions extensively. The last two do not provide data points for Malawi, so in-depth analysis is more difficult.

Although Hofstede is cited extensively in the literature related to leadership, organizational behavior, and cross-cultural dimensions, later researchers have questioned his interpretation of African culture. Jackson proposes that his cultural dimensions "seem inadequate in explaining cultural interaction in Africa" (2004, 2), and some generalizations were made based on a small sample of IBM employees. Hofstede focuses on global dimensions and thus lumps Eastern Africa together in his writings, which is helpful when making comparisons with the rest of the world but not helpful for studying one particular country. I did not explore in depth the research of House et al. (2004) in the GLOBE study, which built on Hofstede's initial work and described the leadership traits that seem to carry across cultures. Jackson's work (2004, 2006, 2012, 2016, 2017b) is very insightful on the specific sub-Saharan African context, and he applied Hofstede's work but also critiqued it related to the specifics of an African setting based on his own research. I have chosen to use Hofstede's dimensions, however, for the following reasons: (1) His research includes sub-Sahara African countries. (2) Based on a literature review, his work is widely accepted as a standard. And (3) it provides helpful language and a framework to open dialogue in a multicultural setting related to differences that may be experienced.

Geographical and Economic Context of Malawi

Malawi is part of sub-Saharan Africa, meaning that it is south of the Sahara (see map in appendix A). It borders on Mozambique to the east and south, Zambia to the west, and Tanzania to the north. The region was established as a British protectorate in 1891 and an official colony in 1907 named "Nyasaland." In 1964 it gained independence and was renamed the Republic of Malawi. It is a small country and often compared to the size of the US state of Pennsylvania. The population of Malawi is approximately 17 million people as of 2015 (WHO 2017). Lilongwe is the capital city, located in the central region, but Blantyre is the commercial center of the country, located in the southern region.

Malawi is among the world's most densely populated and least developed countries and consequently one of the poorest. It ranks 170 out of 188 countries on the Human Development Index[10] with the rate of 0.476 (for 2016). In 2016 the Gross National Income (GNI) was $320 per capita,[11] one of the lowest in the world, with Gross Domestic Product (GDP) at $5.44 billion (World Bank Group 2017).[12]

Since independence in 1964, the economy has not found stable footing and impact from being colonized remains. The historical significance of Malawi being colonized by the British should not be overlooked in attempting to understand the role of tradition in the culture. According to a report from the UN, large parts of Africa in precolonial times had highly decentralized political systems with local entities such as lineage groupings,

[10] The Human Development Index ranks countries based on a combination of life expectancy at birth, average education level, and gross national income per capita to determine a ranking between zero and one.

[11] GNI per capita (formerly GNP per capita) is the gross national income, converted to US dollars using the World Bank Atlas method, divided by the midyear population. GNI is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. GNI, calculated in national currency, is usually converted to U.S. dollars at official exchange rates for comparisons across economies, although an alternative rate is used when the official exchange rate is judged to diverge by an exceptionally large margin from the rate actually applied in international transactions (http://data.worldbank.org/country/malawi).

[12] For comparison, the US GNI for 2016 was $56,180 and the GDP was $18.569 trillion (https://data.worldbank.org/?locations=MW-US).

communities, and age-sets allocating resources (United Nations 2007, 3). Other parts of Africa had centralized political systems with kings. Ranger suggests that the British influence and respect for tradition prompted them to "invent" African traditions for Africans (1997, 598) where they tried to codify what they saw as "traditional" in Africa and make them into prescribed behaviors. The UN report also describes that in the decentralized systems the colonial powers "invented" chiefs and encouraged movement away from consensus-based government (United Nations 2007, 7). According to Ranger, many African scholars have "found it difficult to free themselves from the false models of colonial codified African 'tradition'" which not only provided colonizers with models of command but also "offered many Africans models of 'modern' behaviour" (1997, 598). These sources indicate that governments and external agencies may have influenced what a modern researcher perceives as "traditional government" in Africa. This may also be reflected in Hofstede's dimensions of PDI and inform Jackson's criticism of Hofstede (Jackson 2004, 25).

Ranger suggested that the British influenced "a redefined relationship between leader and led" that translated into Africans often entering in the subordinate role of a man/master relationship in various iterations (1997, 598). Ranger later observed that precolonial African "societies had certainly valued custom and continuity but custom was loosely defined and infinitely flexible. Custom helped to maintain a sense of identity but it also allowed for an adaptation so spontaneous and natural that it was often unperceived" (1997, 603).

A current researcher in Africa such as myself may have a challenge distinguishing between what is truly "African culture" and what has been assimilated by the influence of colonists, missionaries, and other Western influences with a presence on the continent over the years. Although the sources of behavior may be indistinguishable, the fact

remains that there are valued traditions in the present day that should be taken into consideration in cross-cultural management.

When the political lines of the colonial protectorates were drawn, they often crossed tribal borders within the region. The people of Malawi are made up of various ethnic groups from the Bantu group. The local groups are primarily Chewa (36%) and Lomwe (18%), Wayao (14%), Ngoni (12%), and Tumboka (9%), with a few other groups making up the rest of the population (World Atlas 2016). Malawi shares common traits with many of the neighboring countries because the ethnic groups cross the country borders. Some anthropologists suggest that colonial administrators were the first to document tribal distinctions, while others feel that these outsiders would not know enough of the local situations to identify the differences. Southall suggests that tribes were identified for "colonial administrative convenience" (1997). For these reasons cultural traits of sub-Saharan Africa tend to be similar and some generalizations can be made when looking at analysis or data from neighboring countries such as Zambia, Zimbabwe, Tanzania, and Mozambique.[13]

Traditional Models of Government

Societal structure in Africa is based on traditional forms of governance although influenced over time by various external agencies as already described briefly. Parallel to the national political structure but subservient to it, Malawi has a traditional system of government in place made up of headmen/women, chiefs, and paramount chiefs providing different levels of authority within local communities. This traditional structure can give some insight into the culture of management, leadership, and accountability.

[13] I have not been able to find large amounts of literature specifically on Malawian culture so what I have reviewed are primarily sub-Saharan African cultural descriptions and characteristics, which I have applied interchangeably. From my own experience I am able to clarify or modify observations in some cases to a more specific Malawian context, although this could be subjective to my own interpretation.

Ayisi briefly discusses traditional government models and mentions the incentives of social prestige and economic interests as motivation for the existence of this system (1979, 61–63). In contrast to Ayisi's comments regarding chiefs, Jackson emphasizes the role of chiefs as a model for how management in Africa functions with regard for compromise, consensus, and deference to rank (2004, 28–29). In traditional government, people are represented by their chiefs and are encouraged to attend public meetings such as court hearings because they are responsible to each other. Openness and participation are important values of management and traditional leadership (Jackson 2004, 29). These values and practices of society provide some insight into organizations and businesses operating in Malawi to give guidance for effective management methods.

The United Nations (UN) Economic Commission for Africa published the *Relevance of African Traditional Institutions of Governance* and discussed the role of traditional leaders at length. An important aspect of government structure is the decentralized vs. centralized model that has been used in the past. The decentralized model allows the communities to make decisions about what affects their community on a local level. It was established after the colonial era, but has been criticized related to access to financial resources (Midgley 1986, 33) and a slow decision-making process (United Nations 2007, 3).

To add to the criticisms of the decentralized method, authors of the UN report suggest that using decentralization as a basis for understanding traditional leadership is outdated, even though it is still a fact in many African countries, including Malawi. They suggest that the term "centralized vs. decentralized" is too general and "lumps various chieftaincy systems together with differing levels of accountability" (United Nations 2007, 5). The report goes on to make the point that the intricacies of traditional government are important for further research to understand "why they have remained resilient and to determine the potential contributions they can make to the building of

democratic institutions that are compatible with African realities and value systems" (United Nations 2007, 5).

Although this model may be outdated, the role of the chiefs and headmen/women varies by geographical region, but in general they function at a community level and actually contribute to the decentralization of government and policy in Africa. The traditional leaders are valuable in primarily three areas: "their advisory role to government . . . second, their developmental role . . . and third, their role in conflict resolution" (United Nations 2007, v). Jackson describes the way that a traditional leader (chief or headman) builds consensus and will only make a decision when unanimity is reached—sometimes taking days of discussion to finalize a decision. This method of governing is part of the decentralized government structure. Chiefs, as the head of a tribe, are considered to have a place of privilege and authority, but Jackson makes the point that it is "difficult to sustain an argument that this represented large inequalities between leader and follower" (2004, 105). In the community around Malamulo the Traditional Authority (the top chief in the local community) and village headmen/women are respected and hold an important role in the community structure.

In addition to leading the community on decisions and providing resources, another important role of traditional leaders is their role in the health of the community, which is important for my research related to a hospital in Malawi. Chiefs are in a position to support the efforts of the government to expand "service-delivery by participating in the administration of justice and by mobilizing human and financial resources for expanding educational and health services" (United Nations 2007, 22). For example, the traditional leaders of the catchment area surrounding Malamulo Hospital make up a constituency committee for the hospital.[14] When I worked at Malamulo the

[14] The catchment area is made up of 15 villages that have been identified as served by Malamulo Hospital. When I worked at Malamulo the population of this area was estimated to be about 80,000 people.

group of fifteen village chiefs and headmen/women gathered once per quarter or as needed with hospital leaders to discuss concerns that either party may have. This group has been supportive of innumerable health initiatives of Malamulo by providing land for remote clinics, assisting in collecting overdue bills, or explaining hospital processes or policies to the community. The Traditional Authority and village headmen/women are invaluable as representatives between the communities and hospital in the case of Malamulo Hospital.

Although there are processes of government and accountability in place from the local to national levels, corruption is still present in the country, so enforcing the policies and expecting people to abide by the laws and processes when the perception of corruption is so high can be challenging. With this being understood, there is still a level of corruption in the country at a national level. According to Transparency International[15] (2016), Malawi ranked 31 out of 100 in 2016, indicating a relatively high level of corruption countrywide.

The intricate areas of traditional government and chieftaincy have not been thoroughly studied in this project, but the way that a community functions in the Malawian society provides a helpful backdrop to understanding the context of a mission hospital within that country and culture. There are many differences of opinions on the relevance of traditional governance (United Nations 2007, 11–14), but the fact remains that communities in current-day African countries including Malawi have strong loyalties to their local traditional forms of leadership and governance, which affects the worldview.

Along with the traditional forms of government that are very influential in a rural area such as that around Malamulo, there is a formalized state government that functions

[15] A global coalition against corruption scores a "Corruption Perception Index" annually of 176 countries, 0 being the most corrupt and 100 being the least. Note that Malawi's 2016 score of 31 was a drop from 37 in 2012.

too. There are police present in each town or "boma," and there is a national judicial system modeled after the British system. The courts are independent of the executive and legislative branches of government and stratified into subordinate, high, and supreme courts where cases are tried and decided (Malawi Judiciary 2017). In addition to the courts, the government is structured as a "presidential representative republic" with a representative parliament (Wikipedia 2017). As the UN report discusses, the village chiefs play an important role in connection to the local people, but it is debated how to integrate the higher levels of chiefs into the modern governance structures. However, in Malawi chiefs make up 30 percent of the senate but largely in an advisory role (United Nations 2007, 23). Although this is a step in the right direction, the upper levels of chiefs and the government representatives still do not represent the fragmented society or cross the divide between the elite and the common villager.

Acknowledging the fact that traditional governing authorities are still present, active, and in use is vital to my understanding of the Malawian culture and how people expect to interact with those in positions of authority, especially in the rural area around Malamulo. It also indicates the importance of including traditional leaders in my data collection. These local leaders act as "gate keepers" but also can give insight into the local culture and accountability practices.

Community Culture of Malawi

Like most sub-Sahara African countries, the community structure is the primary form of society in Malawi. Fortes discusses the importance of lineage in Africa, stating, "The individual has no legal or political status except as a member of a lineage" (1997, 12). Ayisi addresses the main points of African culture and suggests that at the heart of the community in Africa is the family (1979, 14). Based on needs present in any society such as food, safety, and reproduction, structures are developed to meet those needs.

This, according to Ayisi, is the source of the family structure (14). The extended family is an important part of African culture and the basis of all social cooperation and responsibility. The extended family also constitutes a form of social security (Ayisi 1979, 16).

Traditionally, the tribes in Malawi are matrilineal, meaning people are connected to their lineage through the mother. In this particular tradition, the maternal uncle takes responsibility for the children of his sister. So when a man seeks to marry, the bachelor goes to the woman's maternal uncle to ask permission to marry her. When a marriage takes place, the man moves to the woman's family home or village. Phiri (1983) refers to the arrangement as the "mother right," and Fortes explains that a person is "attached to a patrilineal lineage through a female member of the lineage" (1997, 12). In the rural areas these kinds of traditions are maintained to a certain extent and people live in close connection to their relatives—usually within one day's walking distance. There may be some variance in urban settings since the traditional family system has been influenced over the decades due to colonialism, the slave trade, missionaries, and Western capitalist influences in society, causing a rise in patrilineal behavior and, consequentially, a mixture of practices.

The basic functions of society are based around the support of one's family and community as pointed out above. A phrase widely used across Africa says *Ubuntu ngumuntu ngabantu*, meaning "a person is a person through other people" (Ifejika 2006), or "I am because we are; and since we are therefore I am" (Mbiti 1989, 106). This concept was popularized in South Africa and shortened to *ubuntu* to describe the philosophy that it is only through the success and health of others that the individual can be well and thus to show the primacy of community over mere individual well-being. Maranz interprets this phrase to "mean that whatever the nature of anyone's problem, the main support and curative benefits will come from people" (2001, 122).

The term *ubuntu* is used in many recently published articles related to African management and leadership as a theory to move toward community-centered management (Walumbwa, Avolio, and Aryee 2011; James 2008; Sartorius, Merino, and Carmichael 2011; Muchiri 2011; Kamoche et al. 2012; Bolden and Kirk 2009). Jackson critiques this theory, stating that *ubuntu* in management theory is "a rather naïve approach to try to tease out from the complex historical circumstances of colonization and imperialism" (2004, 7). Later, he refers to the concept several times and seems to validate it with his comments, although he notes that it is primarily a South African concept that has not migrated up the continent significantly (62; see pp. 28, 118, 134, 250, 265–66, 268). The *ubuntu* concept seems to resonate with other management theorists who are interested in working within the existing culture and consider it a way to bring the significant role of community into accountability, leadership, and motivation principles. Although Jackson calls it "naïve," the sentiment of *ubuntu* may be a helpful concept for Western outsiders to gain an understanding of the culture and how important the community is in traditional accountability structures.

Summary

Hofstede's six cultural dimensions provide a framework for attempting to understand and interpret the culture of Malawi and the implications for various sectors such as the workplace, family, healthcare, and other areas of society. Based on my literature review, little has been written regarding the unique aspects of cross-cultural management specifically in the healthcare context of mission; this is where I am focusing my study. Specifically, from Hofstede's work I have focused on Power Distance (PDI) and Collectivism vs. Individualism (IND) and the impact that an understanding and awareness of these dimensions might have on management at Malamulo Hospital.

The structures of society and traditional governance give insight into the Malawian culture and the way authority and power function. Based on Hofstede and other researchers, community is the core of the Malawian culture. There has been influence from the West through colonialism, but the traditional governance structure continues to be valuable and relevant for my research on accountability in the culture. It is important to approach cultural differences with humility and willingness to learn without imposing changes or corrections. The literature suggests that a hybridization of leadership styles and methods would be ideal in an African context, although not the same as cross-cultural management, which acknowledges and utilizes the traditional methods where appropriate. A mission setting motivates an even stronger imperative to seek humility and be aware of culture in leadership.

In the next chapter I will examine organizational culture more closely in light of national culture while applying it to the specific setting of Malamulo Hospital and the unique challenges that the hospital leaders face there.

Chapter 2

Organizational Dynamics

The last chapter considered Hofstede's cultural dimensions applied to a Malawian context and to the traditional society of Malawi. In this chapter I will discuss the context of management within healthcare and organizational theory, which can be helpful in approaching cross-cultural management and provide a basis for a theoretical construct.

The dynamics of the organization of Malamulo is complex, with a convergence of subcultures including that of a healthcare organization, the multiple cultural backgrounds of the leaders, and a Seventh-day Adventist mission context. Approaching this complexity with one or more theoretical construct helps one understand and assess the issues that are unique to address the culture of Malamulo Hospital as an organization.

Culture, Motivation, and Management in Healthcare

Healthcare provides a unique setting for organizations to function. In addition to general management of people and processes, life and death issues must be considered. For example, if some employees do not use correct clinical methods the patient could die. The importance and urgency for meeting quality standards of care and efficient processes rises to a new level when you realize that people's lives are on the line, which creates a different organizational culture than an organization unrelated to healthcare.

In order to reach a goal with a group of people, such as quality clinical care, certain expectations for behavior or actions come into play, and relying on other people requires that they be held accountable for certain outcomes. Accountability is defined as

"the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors, along with the imposition of sanctions for failure to comply and/or to engage in appropriate action" (Brinkerhoff 2004, 372).

For my study I am most interested in performance accountability because people's actions seem to be influenced by their culture and intrinsic motivations, and thus a cross-cultural setting would seem to affect accountability greatly. Brinkerhoff names the types of accountability he discusses: financial, performance, and political, or democratic as (374). Later he applies accountability to health systems, exposing the issues that emerge and the existing gaps within a healthcare setting. Part of the purpose of performance accountability is to "support and promote improved service delivery and management through feedback and learning," which includes quality of care (375). Brinkerhoff concludes that accountability is interconnected and must also be addressed in turnaround plans as an important factor of building capacity, although it is often overlooked. It is noted that if the Ministry of Health or other players in the health system are not linked with the hospital board there may be differences in strategic initiatives, which could cause conflict and lack of progress (377).

Berlan and Shiffman suggest that "reforms that combine decentralization and community participation appear to offer the greatest promise for improving provider accountability to consumers" (2012, 273), which is a form of external accountability. Cleary, Molyneux, and Gilson advise that there be a distinction between "external" and "internal" accountability (2013, 2). Often the external accountability structures are in place due to funding and state regulations and oversight. However, the internal structures within health care systems tend to lack the same rigor.

Employee performance accountability and motivation are closely linked and can be challenging at every level. *The Global Health Workforce Alliance 2013 Annual Report*, published by the World Health Organization (WHO), reported on the Third

Global Forum on Human Resources for Health, which brought together over 1800 participants from 93 member states. The report summarizes the needs for health workers and the role of performance and motivation:

> A systems approach needs to be applied to human resources for health. This entails addressing capacity, management and working conditions as well as a solid understanding of the health labour market dynamics that affect the production, deployments, absorption into the health system, retention, performance and motivation of human resources for health. The challenge is not lack of evidence on effective policies; it is to mobilize political will and catalyse action for a contemporary agenda on human resources for health instrumental to achieving universal health coverage. (GHWA 2013, 17)

Based on the report from the WHO and the emphasis at the global level on health care workers, the role of performance and motivation is clearly a recognized issue, and they note that a unique approach is required for the health labor force. As the quote above shows, though, it is not the lack of evidence or knowledge, but "to mobilize political will and catalyse action" that is hindering the process to strengthen the capacity of health workers, including performance and motivation. The "political will" referred to by the WHO report can be thought of as initiative to address these issues at a governmental level, which will provide the catalyst for hospitals on the front lines to implement the change needed to address human resources. Often if the path to address this type of need is not opened up at the national level, people lower in the hierarchy will not have the ability to fill the gap due to other priorities or constraints.

One area mentioned specifically in the WHO report is motivation and performance, which demonstrates a need for more understanding of how to integrate these issues into practice. "Motivation refers to a driving force or state of need deficiency which inclines a person to behave in a particular manner, or to develop a capacity for certain types of behavior" (Blunt and Jones 1992, 277).

Greenspan et al. (2013) conducted research to find the source of motivation for a group of volunteer community health workers (CHWs) within four districts of Tanzania. Based on the findings, four levels of motivation emerged: individual, family, community, and organizational. An important conclusion from this study is that although there may be a strong volunteer spirit, this does not preclude the desire for financial or in-kind rewards for their work. A monetary reward reflects the commitment of the organization to the volunteer and helps them feel supported when their time is taken away from other activities such as providing for their families. The sources of motivation discovered in Greenspan's research could inform an organizational culture appropriate for the national culture that fits into a healthcare setting.

Another study was conducted in Kenya of 185 workers in eight district hospitals to discover contextual influences on worker motivation. The researchers interviewed a cross section of employees at each hospital and found three levels of motivation: personal, organizational, and national. On the organizational level, the authors (Mbindyo et al. 2009) suggest that some nonfinancial incentives could make a difference in morale and suggest offering things such as lunch to staff working in critical areas or a separate room where staff or family members could stay when their family members were admitted to the hospital. The general conclusion of this research is that motivation is complex and interlinked with various factors. When the hospital administration organizes and runs the hospital well it improves the motivation of employees (Mbindyo et al. 2009).

Although Mbindyo and Greenspan identify slightly different sources of motivation, their similarities can provide a context that can be utilized in a neighboring country such as Malawi. A difference between the studies relates to full-time employees versus volunteer CHWs, which could affect the incentive strategies. It also appears that the people studied were from the local community and not cross-cultural teams. Much of the literature reviewed in this area states the need for more research related to motivation

and incentives for health workers (Berlan and Shiffman 2012, 272, 278; Cleary, Molyneux, and Gilson 2013, 2). Despite some differences, these studies support the concept of a link between employee performance and the culture of the organization.

Another key theory related to motivation is expectancy theory, developed by Vroom in the 1960s (Northouse 2016; Hersey, Blanchard, and Johnson 2013). The assumption is that followers will be motivated for three reasons: if they think they are capable; if they believe their efforts will produce a certain outcome; and if they believe the payoff for their work is worthwhile (Northouse 2016, 116). Jackson suggests that this theory supposes "performance equals ability *times* effort," but in a collectivist society the formula is "performance equals ability *plus* effort" (italics in source; 2004, 130–31). He refers to Triandis's research and suggests that collectivist societies see performance as a group quality where one member has the ability and the others expend a lot of effort (Jackson 2004, 131). Taking this concept further, Jackson discusses the organizational culture of "in-group" vs. "out-group" and how this affects motivation. He suggests that African organizations seem to be moving toward "effective cross-cultural management . . . in order to forge multicultural groups from which may be drawn high levels of synergy" (2004, 131).

Blunt and Jones and other researchers present Maslow's hierarchy of needs as one of the primary theories of motivation. They reference several scholars who suggest that Maslow's theory cuts across cultures, yet based on their own research, disagree with this theory. They conclude that each social and cultural setting needs to be studied carefully when considering organizational or management structures and move beyond Maslow (1992, 287; Schein 2010, 144–45; Hersey, Blanchard, and Johnson 2013). In an article in the *Harvard Business Review*, Susan Fowler brings up the issue that Maslow's hierarchy does not have very much recent data to support it. Instead she suggests three areas to focus on for motivation: autonomy, relatedness, and competence (2014). Motivation and

behavior is influenced heavily by relationships, especially in a collectivistic context such as Malawi, but it is true in Western countries as well. Schein identifies four human issues that have to be resolved for organizations to function well: identity and role, power and influence, needs and goals, and acceptance and intimacy (Schein 2010, 149). At the core of these issues is how people relate and connect with each other. Few researchers have attempted to apply them to the African context, which is part of the focus of my study.

When considering accountability one must carefully look at what structures are in place and the contexts surrounding them. Jackson refers to research done by Noorderhaven, Vunderink, and Lincoln (1996 as cited in Jackson, 2004, 101), who describe perceived characteristics of "African" management as control-oriented leadership indicated by centralized decision making, unwillingness to delegate authority, and little autonomy—controlling methods that could be considered "cultural." Some observations have made that Africans lack initiative or even a sense of personal responsibility and ascribe this to a cultural factor (Onyemelukwe, 1973 as cited in Jackson, 2004, 101). Jackson clarifies these perceptions by stating,

> Rather than being a cultural characteristic of African workers to shy away from responsibility, and to not take a pride in their work, it is likely that this is part of the low commitment and involvement of employees to organizations that are seen as contrary to African culture. (Jackson 2004, 101)

A careful observation of behavior, taking the context into consideration, may reveal that what is usually termed "culture" may in fact be a behavioral response to the control-oriented management style that has its foundation in colonialism.

The literature seems to indicate that performance accountability in a healthcare setting is indeed influenced by culture. Accountability in performance is also closely tied to motivation, which also appears to be influenced by national and organizational culture. Since accountability is influenced by culture, the effectiveness of management in a cross-

cultural setting would be impacted greatly if the team member's culture was not taken into consideration. The same applies to the culture of the organization and how the relationships are cultivated to produce the desired outcomes.

Theoretical Constructs

I have examined the literature surrounding the CRI, which is "to identify the dimensions within the organization's culture that affect employee accountability and cross-cultural management capacity at Malamulo Hospital." The overarching concern that has emerged is the need for expanding cross-cultural management capacity for the people who are currently serving as institutional leaders and developing a systems approach to train and build capacity for the future of Adventist Health International (AHI). Training people regarding cultural dimensions, organizational culture, motivation, and accountability within a cultural context is necessary to have strong healthcare organizations that effectively work across cultures.

I have found two sources helpful in considering capacity building in an organizational setting. They are the framing theory from Trebesch's ECO model (2015) and Bolman and Deal (2008). The ECO model is a way to understand the interconnectedness of an organization using the illustration of interlocking loops or circles orbiting the center, showing how a "flourishing" organization flexes and adapts around the central core. Each loop represents two aspects of the organization, and changes to one side affect the aspect on the other side (see figure 8). I chose to focus on two of Bolman and Deal's Four Frames that seem to be most applicable to the context of Malamulo, which are the human resources and symbolic frames. I chose to only use two frames because I found in my research that the political and structural frames are already in use and the focus on relationships and the use of symbols seem to be closely related to the national culture and could be used to strengthen the organizational culture at the

hospital. Focusing on only two frames was also due to my time constraints to cover the material during the change pilot project.

These two constructs can be understood within the context of an organizational culture. The next section will start by explaining what organizational culture is and then consider Malamulo Hospital's organizational culture.

Organizational Culture

The culture of an organization provides the same guidance as a national culture through components such as language, the "rules" of social order, and how we get along with each other (Schein 2010, 3). The source of an organization's culture usually comes from the founder and subsequent leaders; Schein points out that culture and leadership are "two sides of the same coin" (2010, 3), and defines an organizational context thus:

> The culture of a group can now be defined as a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (2010, 18)

Another definition proposed within a meta-analysis of literature related to organizational culture and climate is

> the shared values and basic assumptions that explain why organizations do what they do and focus on what they focus on; it exists at a fundamental, perhaps preconscious, level of awareness, is grounded in history and tradition and is a source of collective identity and commitment. (Schneider et al. 2017)[1]

Yet another effort at defining organizational culture is that it is "composed of shared values and norms that inform employees about how they should perceive, think, feel, and

[1] The meta-analysis of research published in this article focused primarily on the content of the *Journal of Applied Psychology* related to this topic.

behave in relation to organizational problems" (Hartnell et al. 2016). Some recurring words in these definitions are "shared" and "values" within a defined organization.

It is helpful to have a sense of the current organizational culture of Malamulo Hospital to provide a basis for any outcomes or recommendations from my field research, but at the same time I found it difficult to describe. As Schein states, culture is an abstraction which, in order to be helpful, should be both observable and increase our understanding of events (2010, 14). I have been able to observe four key aspects of the organizational culture that seem to be part of Malamulo: First, it is a mission hospital and part of the SDA church, which creates its own subculture, including, for instance, regular morning worship services, observance of Sabbath, prayer with patients, evangelistic meetings, lifestyle education, and other practices related to a set of beliefs tied to a Protestant faith and the SDA denomination.

Second, it is a teaching hospital, so there is a special language and system that is part of the nature of a healthcare organization in addition to training the next generation of healthcare providers. Third, the organization's mission, vision, and values statements illuminate the expectations and inform the culture to some degree. Malamulo Hospital's mission statement is "to provide competent health care and training through skilled staff members prioritizing the health of patients with a special emphasis on spiritual care." The vision statement reads, "Our vision is to be the preferred provider for specialized health care and training in Malawi and beyond." The values are putting patients first, competent and skilled staff, and spiritual health. These illustrate how leadership has developed guiding sentiments that combine the healthcare with mission. Fourth and finally, as a mission hospital that is part of a worldwide church, there is an intercultural aspect where doctors, leaders, volunteers, and students are often from a variety of countries.

Taking the organization's culture into consideration gives us guidance to another level of analysis into the actual management and practices within the organization. I am

going to focus on two models that were helpful in my study to understand the hospital better and to consider how to bring change if needed: Bolman and Deal's "Framing" and Trebesch's ECO model. The next section explains these.

The Four Frames

Amid the vast sea of literature related to organizations and leadership, Bolman and Deal have developed a way to describe the way leaders think about and approach organizations, which they label "frames," defined as "a set of ideas and assumptions—that you carry in your head to help you understand and negotiate a particular 'territory'" (2008, 11). The criteria for these frames is that they are unconscious, operate very rapidly, are holistic, and result in "affective judgments" so you feel confident that you know the right thing to do (2008, 11). The authors identified four frames that serve as ways to view organizations: structural, human resource, political, and symbolic frames. Table 1 lists these and how they are characterized.

Table 1: Overview of the Four-Frame Model

(Bolman and Deal 2008, 18)

	Structural	**Human Resource**	**Political**	**Symbolic**
Metaphor for Organization	factory or machine	family	jungle	carnival, temple, theater
Central Concepts	rules, roles, goals, policies, technology, environment	needs, skills, relationships	power, conflict, competition, organizational politics	culture, meaning, metaphor, ritual, ceremony, stories, heroes
Image of Leadership	social architecture	empowerment	advocacy and political savvy	inspiration

Basic Leadership Challenge	Attune structure to task, technology, environment	Align organizational and human needs	Develop agenda and power base	Create faith, beauty, meaning

The authors suggest that these perspectives can be used to understand organizations, and although people may have an affinity for one or the other, it may be useful to employ more than one. They refer to this as "multiframe thinking," which provides an expansion of management's assumptions about how to approach challenges (Bolman and Deal 2008, 19). I will describe each frame briefly and then relate them to Malamulo.

The *Political Frame* looks at organizations as contests of individual and group interests where everyone is vying for scarce resources (Bolman and Deal 2008, 194–95). Power is a key aspect of the political frame, and negotiation between groups happens more frequently when there are few resources. The idea of a "jungle" suggests a "kill or be killed" mindset where everything is a competition and the focus is competition.

The *Structural Frame* focuses on putting people in the right roles and designing the organization appropriately to achieve the goals. Some of the assumptions of this frame are that problems can be solved by analysis, restructuring, and relying on rationality rather than personal agendas (Bolman and Deal 2008, 47). This frame has a very Western management approach based in the ideas of Max Weber, which outlined a division of labor, hierarchy of offices, rules to govern performance, technical qualifications for selecting personnel (rather than family ties), and other such principles. An organization can overuse this frame and create structures that impede progress and insist on too much control, but structure can be helpful as well.

The *Human Resource Frame* views the people within an organization as the key aspects of a company with the following assumptions:

- Organizations exist to serve human needs rather than the converse.
- People and organizations need each other.

- When the fit between individual and system is poor, one or both suffer.
- A good fit benefits both. (Bolman and Deal 2008, 122)

Using an HR Frame changes the perspective from seeing people as a necessary resource to get a job accomplished to the reason that the organization exists. A shift in perspective like this, although it seems subtle, can have a big impact on employee motivation and their perceived value to the organization. This perspective encourages an investment in people, which brings motivation in their performance. Bolman and Deal compare the HR Frame to gardening where the gardener provides what a plant needs to flourish in the same way that an organization allows and encourages people to flourish in their role (2008, 123), and if the connection between an organization and the people is not healthy then they both suffer.

The *Symbolic Frame* is based on the concept that traditions, rituals, symbols, and celebrations serve to reinforce and embed the culture in an organization. It is based on five assumptions:

- What is most important is not what happens but what it means.
- Activity and meaning are loosely coupled; events and actions have multiple interpretations.
- Facing uncertainty and ambiguity, people create symbols to resolve confusion, find direction, and anchor hope and faith.
- Events and process are often more important for what is expressed than for what is produced.
- Culture forms the superglue that bonds an organization, unites people, and helps an enterprise accomplish desired ends. (Bolman and Deal 2008, 253)

Symbols can be graphic icons, traditions that are regularly practiced, or stories and proverbs that define the purpose. Whatever they are, the interpretation provides stability and communicates a shared culture throughout an organization.

The Four Frames provide a way to see and interact with an organization; leaders may have a natural affinity for one or the other, but all are necessary for effective management of an organization. Although all four frames are in use at Malamulo, the two that I chose to focus on are the HR and symbolic frames because there seemed to be a gap in their use and they have an alignment with the national cultural values that would bring an observable and relatively easily understood application in order to strengthen the organizational culture. In my observations it seemed that these two tied most closely to strengthening cross-cultural management by focusing on relationships and the traditions of the national culture that would support the hospital culture. The political frame, on the other hand, seems to be already in use extensively due to the high Power Distance culture and the importance of hierarchy in Malawi. Following protocol and surviving with scarce resources are probably among the biggest areas of focus for the management of Malamulo. The structural frame relies on policies, plans, and strategy analysis rather than personal agendas to accomplish the goals of the organization. While this may be useful in the long term to address at Malamulo, for my initial pilot change project I did not feel this frame would make as much of an impact.

In addition to these frames, I also want to explore a model to understand, assess, and change organizations. The next section will describe the "Ecology of Organizations" (ECO) model that seemed helpful when analyzing Malamulo Hospital and its opportunities for change.

ECO Model

Part of managing any organization requires introducing change and then reacting to the effects of those decisions—often referred to as a "cause and effect loop" in systems theory. Trebesch suggests that this is not a linear process but often a circular or a spiral one that continues taking into consideration the effect of the past, present, and future on

current decisions (Trebesch 2015, 16). In order to understand the full circle more clearly Trebesch developed the Ecology of Organizations (ECO) model, which is illustrated as a series of interlocking and connecting loops that make up an organization (2015, 16–24). The model is built on the concept that organizations should flourish, which connotes an organic, living organism rather than a static or mechanical company (Trebesch 2015, 17). The four loops of the model are vision and mission, faith assumptions and values, organizational dynamics and experiences, and individuals and leaders. Trebesch suggests that flourishing organizations flex, innovate, and adapt around these core areas in relation to change and the context (25–26). The loops indicate that an action or decision that affects one end will have an effect on the opposite end of that loop and thus illustrate visually how organizations interact dynamically. See figure 8.

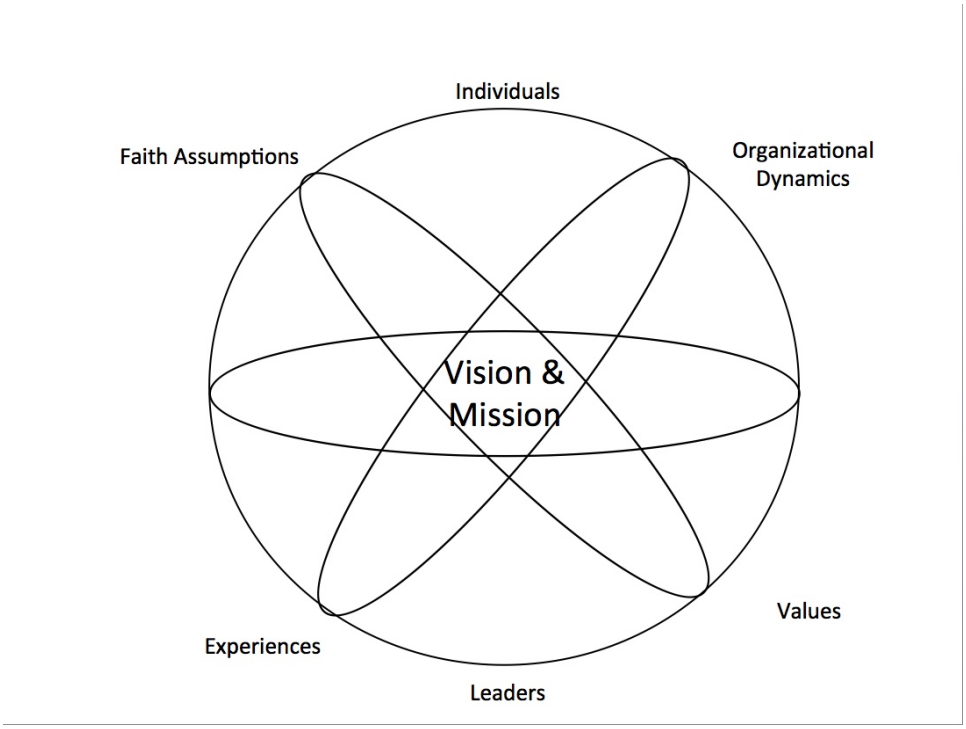

Figure 8: ECO Model
(Trebesch 2015)

The model is firmly based in the biblical narrative of creation and how people were created for connections and were made to flourish (Genesis 1:26–28). The focus is the value of people and the importance of healthy relationships in a flourishing organization, from another biblical model, the Trinity (Trebesch 2015, 40–43). This perspective is also applied to managing change, building capacity, and affecting the organizational culture. Trebesch pulls from Schein's work on organizational culture (2010), Goleman's work on emotional intelligence (2002), and other resources to create a practical model that can be applied in various situations, taking into account a cross-cultural setting.

The ECO model is useful for organizational development and provides a framework to address various areas represented by the circular model. The interlocking circles indicate that growing is a "continual practice of reflection, research, evaluation and change in order to efficiently and effectively accomplish the mission and vision and ensure that each member flourishes" (Trebesch 2015, 80). The model is really a tool that leaders can use in a process to imagine the future that they desire and then work backwards to the present considering the various aspects of the organization. The unique emphasis that it provides is a biblical foundation to focus on a flourishing organization and the people involved.

Although the focus of the ECO model is flourishing people and organizations, a lot of important structure is included as well. Trebesch references Mintzberg's work on organizational structure and extends the purpose from just "achieving tasks" to also accomplishing the vision and enable flourishing (Trebesch 2015, 116). Structure is an important part of an organization, and Trebesch suggests "structure by function" and "structure for synergy" as two healthy ways to organize, and then goes into greater detail on best practices for structure and organizations.

The Human Resource and Symbolic Frames along with the ECO model serve as the theoretical constructs that I have found helpful during this project, and they provide a structure to analyze the data and findings later on in this project. The HR Frame from Bolman and Deal is directly related to the ECO model in that both focus on nurturing environments and even use similar imagery of a living organism with words like "gardener" and "flourishing." Using symbols to reinforce the core values and mission of the organization also aligns with the ECO model, while the ECO model also includes aspects of structure, as do the Four Frames.

Summary

This chapter has described the setting and context of Malamulo Hospital in order to begin to understand its organizational culture. It also identified the theoretical constructs that I have chosen: two of Bolman and Deal's Four Frames, the HR and Symbolic Frames, and Trebesch's ECO model. These constructs are key to move my CRI forward and start to identify the dimensions of the organizational culture that affect employee accountability and cross-cultural management capacity. Using these tools I can assess and identify some gaps that could be addressed and can apply them to the data from the research as well as create a framework to expand capacity using the tools as resources. In the next chapter I will consider the literature from part 1 and apply it to the Malamulo context.

Chapter 3

Application to the Context of Malamulo Hospital

This chapter considers the context and setting of Malamulo Hospital within the Malamulo Mission and the broader Adventist Church within Malawi. In light of the previous chapters related to the national and organizational cultures, in this chapter I will apply the literature to the specific setting of Malamulo Hospital.

While studying the dimensions and applying them to the context of Malamulo Hospital, I found that the Power Distance and the Individualism versus Collectivism spectrum provided the most insight into the national culture as applied to managing an organization. For the purpose of this project I have primarily focused on these two out of the six cultural dimensions of Hofstede's research.

In addition to Hofstede's dimensions, the Four Frames from Bolman and Deal provided a helpful lens to use in approaching the organizational culture. Again, due to the relevance of the frames and the connection with the local cultural values and limited time, I focused on two of the frames: Human Resource (HR) and Symbolic.

The final model that I used to facilitate analyzing the issues as a whole was Trebesch's ECO model (see figure 8), which provides a visual representation to consider the organization as a whole and how the dynamics are interconnected.

Before I move to applying the literature to the context, I want to provide more explanation of the services and work that is being done at Malamulo Hospital as well as the greater mission and church context that it operates within.

The Malamulo Hospital Context

Malamulo Hospital began as a small clinic run by two nurses in 1908 (Robinson 1954, 159). It has grown over the past 109 years to be a large healthcare facility providing care for the surrounding rural village residents and patients traveling from Blantyre, Lilongwe, Mozambique, and places in between (see appendix B for organizational relationships). The hospital currently has approximately 220 beds[1] and offers services such as outpatient clinics, inpatient adult and pediatric care, general surgery, maternity, and community health education. The outpatient department includes specialized clinics such as anti-retroviral medication management for patients with HIV/AIDS, women's clinics providing pap smears and antenatal care, surgical visits, and "Under 5" clinics for pediatric outpatients. In 2015 the hospital-based clinic had 16,520[2] outpatient visits total (Crounse and Blanchard 2016).

Inpatient services include adult, maternity, pediatrics, and surgical care, treating illnesses commonly related to tuberculosis, malaria, pneumonia, and other diseases. In 2015 there were a total of 7,056 admissions and 1,589 deliveries representing about 52 percent occupancy rate over the year[3] (Crounse and Blanchard 2016). The hospital oversees and staffs rural clinics in the fifteen surrounding villages that make up the catchment area, as well as three satellite clinics where in some cases dental and laboratory services are also provided.[4] Combining all of the patient encounters facilitated by Malamulo Hospital for 2015 brings the total to 102,482 (Crounse and Blanchard

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[1] As reported in the *2016 SDA Yearbook*, which may or may not match the actual beds in use.

[2] The total number is made up of 661 "Under 5"; 10,766 General OPD; 1,439 Private OPD; 1,189 Pap smears; 2,396 Surgical OPD; 69 Gynecological OPD.

[3] The occupancy rate varies widely throughout the year due to the seasonal nature of illness related to malaria. During the rainy season, or "malaria season," occupancy can be over 100%.

[4] The rural village "clinics" are only open when staff from the hospital visit 1-2 times per month and are basically a designated empty building or shade tree that functions as a clinic when the staff are there and bring all supplies and medications with them. The villagers know to come on the specified day to be seen. The three satellite clinics are staffed full time and are buildings owned by the hospital but are serving the local community. A doctor or clinical officer may visit at regular intervals to see more complicated cases; otherwise the local staff treat and refer the patients. One large clinic in the city is staffed every day by a physician and sees urban patients.

2016). Just the number of patients and family members represented gives a sense of how large and busy the hospital is and the important role it plays in the community.

The hospital also serves as a clinical training site for students studying to be nurses, clinical officers, medical assistants, lab technicians, surgeons, and general practitioners. A unique program at Malamulo is the surgical training as a designated site for the Pan-African Academy of Christian Surgeons and the only internationally recognized training site for the American College of Graduate Medical Education. Given these designations, three surgical residents from Africa are being trained at Malamulo. In addition, all fourth-year general surgery residents from LLUH also rotate at Malamulo on a regular basis in order to have exposure to surgery in an international setting.[5]

The hospital employs approximately 200 staff who are primarily Malawian. The Administrative Committee (MH-AdCom) is made up of key leaders from various departments and meets weekly to discuss hospital business and make management decisions. This administrative group is multicultural and works together to lead the hospital. (Appendix C lists the MH-AdCom membership as of 2015.)

On the same Adventist mission campus resides Malamulo College of Health Sciences, which has degree programs in health related fields such as clinical officer,[6] nursing, lab technician, and public health. Most of the students in the college do some part of their clinical training at Malamulo Hospital. The college is a boarding school and has an enrollment between 400 and 800 students each year.[7] The management teams of the college and hospital have had varying levels of interaction over the years. As of 2015

[5] The formalized surgical residency training began after I had left working at Malamulo Hospital.

[6] Clinical officers have three years of training post-secondary school. They provide a similar level of care as a physician's assistant in the United States.

[7] The large variance in enrollment is due to the government requiring the school to take a certain number of students even though it is beyond the capacity of housing, clinical training, and other resources. The Malawian government pays for the majority of student's tuition, so the college leadership felt compelled to take in more students. In 2015 when I did my field research, they had about 800 students enrolled.

the hospital and college operated separately with different leadership and administrative committees. The leaders of both institutions collaborate to some degree because of the shared purpose of training healthcare providers and shared resources of staff houses, buildings, electricity, water, roads, and so forth.

In addition to the college and hospital, the mission campus has a SDA church, a secondary boarding school, a primary school, and a printing press that are all part of the Malamulo Adventist Mission. The majority of employees and families for all of these organizations reside on the mission property as well. Not only does everyone work together but they are also neighbors, living in close proximity to each other.

Malamulo Hospital is considered a large mission hospital by most standards with a lot of activity happening on a daily basis. The leaders of the hospital have to not only manage the people who report to them, but also work together as a management team in order for the hospital to function smoothly. In addition to the many patients and regular business of healthcare, the rural setting in one of the poorest countries in the world adds additional challenges related to basic necessities such as access to running water, electricity, and access to the Internet, none of which are reliable. There are also challenges related to financial resources and access to necessary medications, supplies, and maintaining the infrastructure at an acceptable level. Additionally, regular reporting to the board, donors, government, volunteer coordination, and logistics require a lot of time and energy. I do not want to dwell on the details of the various challenges, but I mention these to demonstrate that management of Malamulo Hospital is complicated, with many concerns that I have only listed briefly.

The Seventh-day Adventist Church in Malawi

Malamulo Mission, where the hospital is located, is part of the SDA Church in Malawi, which is organized as a "Union Conference" with 433,988 members as of 2015

(General Conference of SDAs 2015). There are three other SDA healthcare organizations that provide services across the country: Blantyre Adventist Hospital, a small urban hospital in Blantyre; Adventist Health Center, Lilongwe, an outpatient clinic and dental practice in the capital city; and Adventist Health Services, a network of 17 mostly rural clinics across the country managed as one organization headquartered in Blantyre. These entities are part of the 467 healthcare institutions (hospitals and clinics) affiliated with the global SDA church (General Conference of SDAs 2015, 5).

All of the healthcare institutions in Malawi are managed through a board of directors that is overseen and guided by Adventist Health International (AHI). The chair of the Board is based at LLUH and is also a member of AHIs Administrative Committee (AHI-AdCom) that meets in Loma Linda, California. The board is made up of the three main officers of the Malawi Union Conference (president, executive secretary, and treasurer), lay church members with relevant experience, and two or three representatives from AHI. There is an effort from the board to strengthen collaboration between the Malawian health institutions in order to "systematize" the SDA healthcare services in Malawi.

Beyond the local board in Malawi, AHI is the overarching organization that provides governance and some management guidance to about thirty SDA mission hospitals. AHI does not own Malamulo or any hospital, but rather works in collaboration with the local church leadership to build clinical and leadership capacity.[8]

Application of Selected Theories to Malamulo Hospital

The first two chapters explored the literature related to the societal culture of Malawi, cultural dimensions from Hofstede, Bolman and Deal's Four Frames, and Trebesch's ECO model, as well as other research related to accountability, motivation,

[8] See appendix B for an organizational relationship chart.

and organizational culture. Given the brief explanation of the Malamulo Hospital context I will now consider the theories in light of the Malawian and specifically Malamulo context. Later, I will explore in depth the findings from my field research, which will highlight the importance of nurturing relationships within the themes of performance evaluation, cross-cultural management, motivation, accountability, and organizational structure.

Hofstede's Dimensions

I have described the dimensions in detail in chapter 1 and they are illustrated in figures 1–7, which show the variances in the scores for the six dimensions among Malawi, the surrounding countries, and the United States. Although not all cross-cultural situations deal only with the United States, the comparisons illustrate where there may be large differences between Western and African cultures affecting common situations at Malamulo Hospital—where for at least the past ten years the chief executive officer has been from the United States. As I was considering the data I realized that Power Distance (PDI) and Individualism vs. Collectivism (IDV) showed large differences and may be one source of misunderstanding in working relationships (see figures 2 and 3).

When compared with the literature about the society of Malawi and the local culture, the scale suggested by Hofstede (see figure 1) seems to be an accurate representation. Traditional authority is very important, as is hierarchy, and people seem to accept and feel comfortable with the unequal distribution of power. When a leader comes into the Malawian culture it would be very important for him or her to be aware of this and to understand how it might affect one's role.[9]

[9] A personal experience to illustrate this is a presentation I gave at a board meeting after I had been in Malawi for two months where I presented a turnaround plan for the hospital's dire financial situation. The (then) president of the SDA church was a board member and challenged me at the end of the presentation, asking who I thought I was to come to Malawi and expect that this would work since they

Similarly, Malawian culture is strongly collectivist, group and event oriented, which are at the opposite end of the spectrum from the United States, which is one of the most individualistic countries that Hofstede evaluated. The importance of community, in-groups, and lineage groups would affect management of an organization especially in a rural setting where there are few employers. This is the case for Malamulo Hospital. The mission has several organizations that hire workers, but the only other large organization in that vicinity is a tea estate and some small schools.

Understanding these two cultural dimensions gives language and a framework that people from any culture could use to approach a cross-cultural setting and start to understand each other. These dimensions can also be used to consider the organizational culture, which may vary slightly from the national culture. Next I will consider Bolman and Deal's frames, which are more related to the culture of the organization.

The Four Frames

As I have already discussed, Bolman and Deal (2008) suggest four frames of organizations and they suggest that good leaders will use "multiframe thinking" in order to be able to deeply understand and appreciate an organization (2008, 18–20). I will apply the two that seemed to have the most immediate prospect of influence in the organizational culture at Malamulo Hospital: the Human Resource (HR) and Symbolic frames.

The HR Frame focuses on relationships, and based on the fact that both the literature and Hofstede's IDV dimension shows that Malawi is highly communal and relationships are very important for survival, it seems that the HR Frame could be easily applied. Although the Malawian culture is centered on community, in resource-poor areas

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have been running the hospital for decades without the kind of outcomes that I was projecting. On reflecting, my plan seemed to challenge the traditional authority roles and this man felt threatened.

people often can be neglected because of the urgency of daily needs such as financial and clinical resources, which is more reflective of the political frame. Often there can be a perception that with tight finances extra funds cannot or should not be used for investing in people, a perception that can affect the culture of the organization. Additionally, since relationships are such an important part of the culture, they could be overlooked at a place like Malamulo, where it is expected that they will just come about naturally. It seems that the intentional focus on valuing people and strengthening relationships would make a big difference at Malamulo Hospital.

With regard to the symbolic frame, another characteristic of a community-centered culture is the centrality of an oral tradition—stories, songs, drama, and symbolism—therefore it seems that the symbolic frame would be a natural fit for an organization located in that type of culture. In addition to the national culture, the subculture of an SDA mission hospital provides heroes and stories to inspire the mission of the hospital. For example the story is often told of a famous missionary doctor and pilot called Dr. Harvey who is buried in the missionary cemetery on the property. Stories of his heroism are often told of how he used the now abandoned airstrip to fly to remote villages to provide treatment or transport patients to the hospital. He died in a plane crash there at the mission with his wife and son watching, and his legacy continues through the story of his bravery and service to the people.

As with the HR Frame, the symbolic may be taken for granted with an assumption that the organizations' stories and symbols would just be known without much effort because this frame is so closely tied with the national culture. Yet even the story of Dr. Harvey demonstrates that such awareness is not automatic: the one photo of him with his plane in the hospital is small, in a dusty frame in the back corner of a meeting room. The importance of symbols to carry on the culture can be overlooked when focusing on fiscal

issues and quality of healthcare. Yet it must be intentionally utilized and strengthened as a frame in order to bolster the organizational culture.

ECO Model

The culture of an organization can also be illustrated with interconnected circles in the ECO model. When Trebesch designed the model (2015), she took into consideration cultures from the majority world that do not necessarily consider events to have a linear correlation from cause to effect. Thus, she developed the model with interconnected circles that orbit around the central vision and mission of an organization (see figure 8). The interconnected, circular design of this model is useful in a setting such as Malamulo.

One example that came out during my research was the connection of the employee's experience with the organizational dynamics. One employee told me that she often avoided attending morning worship where she might have to listen to a doctor preach who may have shouted at her for a mistake. Her experience on one side of the loop connects with the other side—the dynamics within the organization that could be affected by poor communication, lack of clear discipline, or even lack of education. With the other tools such as the cultural dimensions and frameworks, the ECO model provides a way to understand the influences and situations that impact the culture of the organization. The leaders of Malamulo Hospital can easily understand and apply the concepts within the model both to interpret and to improve the organizational culture, which in turn will produce the type of behavior and healthcare outcomes they would like to see.

Summary

These three main theories can be used together and create a dynamic framework to engage cross-cultural teams of leaders to develop and strengthen the cultures of the organizations where they work. In this research project I found the combination of these tools to be a good way to open conversation and bring awareness of how culture impacts management in a mission hospital—understanding that would hopefully lead to positive changes.

There are weaknesses with these theories; even using the three models together they cannot fully describe or address all of the issues in a unique organization. Nuances in Malamulo's local situation may not fit the models perfectly. This is to be expected, and the models are merely guides for ways to think and discuss the aspects on the ground in Malawi. Addressing the culture of an organization requires dedicated and innovative leaders as well as wisdom from the Holy Spirit to meet the challenges that arise.

In the next section I will describe my research process, and I will come back to these theories when I analyze the findings and develop recommendations to strengthen cross-cultural management skills.

Part II

Field Research at Malamulo Hospital

Part 2 will explain the qualitative research methods that I used and why they fit best into the mission hospital context of Malamulo. I will also explain the challenges and limitations that I faced in the research process and how I overcame them. I will then explain the findings that emerged from the data and apply the theoretical constructs in order to discuss the connection between what my field research revealed and the related literature. This section will build another layer of understanding to prepare for the recommendations and conclusions in the final part of the paper.

Chapter 4

Field Research Methods

In this chapter I explain the methods for research that I utilized in light of the relevant context of Malamulo Hospital. This hospital has been part of Adventist Health International (AHI) since about 2006 when it was facing major financial challenges and threats of being shut down due to debt. Since that time the hospital has paid off the significant debt and business has strengthened through efforts of management and increased clinical quality. Since 2006 there has been an increase in the number of Western-trained physicians and expanded clinical services, as well as some infrastructure upgrades. One of the major accomplishments is related to residency training. Malamulo is an official global surgery-training site for the Accreditation Council of Graduate Medical Education where surgery residents from LLUH rotate for a month at a time,[1] and it is opening a general surgery residency program through the Pan African Academy of Christian Surgeons.[2] Malamulo Hospital is now one of strongest teaching mission hospitals with a great deal of intercultural activity on campus, which provides a good setting to conduct a case study related to cross-cultural management and leadership development. This setting can provide lessons for the broader AHI organization, whether the hospitals are in Africa or elsewhere.

[1] Malamulo Hospital is the only international training site approved by the Accreditation Council of Graduate Medical Education (www.acgme.org).

[2] Pan African Academy of Christian Surgeons is committed to training African physicians in surgery specialties and has 12 training sites. They are committed to discipling the physicians in community during their residency and preparing clinical leaders to serve in Africa (www.paacs.net).

Qualitative Case Study

I chose to use the case study method to design my field research. A case study design can be used when there is a "bounded context" in the proposed research, which can be either time or space and is usually a real-life, contemporary setting (Creswell 2013, 97). Yin identifies a case study as a time when "how" or "why" questions are being asked about a contemporary situation over which the researcher has little or no control (2014, 14). The development of a case study utilizes a variety of sources for information. In this project I utilized focus groups, semi-structured interviews, document review, and participant observation. Now I will describe the methods and research process used for this project.

Pilot Test of Methods

Before traveling to Malawi I wanted to pilot test the methods to refine the questions and practice the necessary skills. Since I live in Southern California I conducted a pilot test of a focus group and two semi-structured interviews inviting people to participate who had worked and/or lived in Africa prior to coming to LLUH. The university is very multicultural with a longstanding relationship with international development and missions in Africa, so finding participants was not difficult. Several of the seven participants had experience working in Malawi as well. I used the following question for the focus group: "What is the effect of cross-cultural management on employee motivation and evaluation based on your experience in Africa?" I then developed a question plan to address this research question. Although it was not technically one of my project's research questions, the responses contributed to my topic. I was able to receive IRB approval for the focus group and all participants gave verbal consent. I provided a $10 gift card as an incentive to all participants and I found that practicing a focus group was very helpful in preparation for the field research in Malawi.

At the end I asked for feedback, and one helpful idea was to use an icebreaker to open the focus group. I put this into practice with the focus groups conducted in English at Malamulo and found it helpful.

I also conducted two interviews in the pilot test. I was able to practice the question routes, using probing questions, and avoiding leading questions. I found semi-structured interviews to be ideal. According to Bernard, semi-structured interviews are used when there is only one chance to interview someone (Bernard 2011, 157). Since my interviews were primarily a one-time event, I chose "semi-structured" through the pilot testing. Overall the pilot process was helpful both to validate the methods I had chosen as well as to provide helpful data for the project (see question routes related to research question 2 in appendix D). I also used unstructured interviews in the field research.

Who, Where, How

I conducted the field research at Malamulo Hospital in Malawi in August and September 2015. It is very important to follow the research protocols in the country where the research is being conducted, especially if outside the United States. This is a barrier that should be considered before attempting to do international research as it does require more time, money, and logistical coordination. For research approval processes I utilized the Institutional Review Board (IRB) process of Loma Linda University (LLU), where I am also a faculty member. In addition to IRB approval at LLU, I gained approval through Malawi's National Health Science's Research Committee and Malamulo Hospital's newly developed research committee.[3]

My relationship with Malamulo Hospital leadership and the research committee personnel facilitated the research approval process in Malawi, which was invaluable. I

[3] I was the first person to go through the process of approval for Malamulo's Research Committee. They were very helpful in the process; however, there were some challenges along the way, and after my field research was completed they requested feedback that reflected my experience, which I provided.

had identified key "gate keepers" (Krueger and Casey 2015, 199), and I made sure to seek their approval first. Gaining key leader's support first was also important culturally in Malawi as indicated by their high score on the Power Distance Index. If the head of the community or organization demonstrates support, it signals to the rest of the organization that the process is approved and increases the likelihood of success at gathering my data.

One of those people was Jason Blanchard,[4] the chief executive officer (CEO) of the hospital. I had been in contact with him early in my doctoral program and discussed the research topic with him before the field research started. He was very supportive at each step of the way. Another key person was Temidayo Ogunrinu,[5] who was on the hospital research committee and logistics coordinator for Malamulo Hospital. She was invaluable as a liaison with the National Health Science Research Committee, relaying messages and documents to them and coordinating the process with the Malamulo Research Committee approval. The morning after I arrived both Jason and Temidayo introduced me at the hospital morning worship and I was asked to explain my project to the staff of the hospital. Although most people knew who I was since I used to work there, I made sure that people understood my current capacity as a researcher and not an administrator or visitor from AHI. This was key in paving the way for me to have access to the entire staff and provided symbolic approval by the leadership of the hospital.

Before traveling to Malawi I had arranged the assistance of a translator, Charles Phiri, who is a teacher at the Malamulo Secondary School on the same campus. I knew him to be a reliable person who knew English very well, and he agreed to help with the project. I felt he would be an objective person but knowledgeable since he is not an employee of the hospital, but still a member of the mission community. Since he was not

[4] Mr. Blanchard is a full-time volunteer from the US working for AHI in the role of CEO since 2014. In 2016 he was appointed AHI Malawi Country Director in addition to his role at Malamulo.

[5] Ms. Ogunrinu was a Global Service Award appointee and alum of LLU's School of Public Health from the US with family roots from Nigeria. She left Malamulo in 2016 after working for approximately two years in the role of logistics coordinator.

a hospital employee there was a lower chance of any potential conflict of interest. I communicated with him via email while planning the research and he completed the Conflict of Interest Training and other necessary documents for IRB approval.

My field research at Malamulo Hospital was conducted August 26–September 16, 2015. I was able to receive full funding support for the travel, meals, and miscellaneous expenses shared equally between AHI and LLU's School of Public Health, and my time was counted as work time. Malamulo Hospital provided my accommodation at no charge.

While conducting field research my goal was to answer the first two research questions:

1. What are the Malawian cultural practices for accountability?
2. What are the current accountability and management-capacity related practices at Malamulo Hospital?

I used the question routes for each research question listed in appendix D. I conducted six focus groups and eight semi-structured interviews, not including the pilot tests. In addition to focus groups I had ten unstructured interviews as part of the observations during the four weeks in the field. I prepared verbal consent forms[6] in English and Chichewa that participants could keep if desired. Approximately fifty people participated formally with a verbal consent for the research, and informally, in casual conversation, I interviewed an estimated ten additional people who did not give formal consent. I recorded all of the focus groups and semi-structured interviews and created transcripts using codes to maintain anonymity of the participants.[7] I did not record the unstructured interviews. I provided snacks and drinks as an incentive for people in the focus groups. I also offered transportation money if it was needed. Only two ladies from the community

[6] Since I was not using video or other media, the LLU IRB staff suggested the use of verbal consent to provide the most anonymity possible. See appendix F for the consent form.

[7] See appendix E for the codes related to the data source. I will use the listed codes in chapter 4 when discussing the findings and quoting from the participants.

requested funds for their transportation. In the next sections I describe each of the methods that I used and how they were implemented.

Focus Groups

Malawi has an oral and community-based culture so I chose focus groups as an effective method for data collection because questions can be asked and answered verbally and clarified in-person in a group setting. There is also a sense of camaraderie that develops in the group that is discussing a topic together, which works well in the Malawian culture. For research question 1, Mr. Phiri assisted me in recruiting two separate focus groups from the surrounding community around Malamulo. Mr. Phiri contacted the local Traditional Authority Kwetemule to first request permission to hold focus group and then ask his assistance to find the right people for both community focus groups.[8] One group was village headmen/women and chiefs, while the other group was community leaders from surrounding villages. I conducted both focus groups in English and Mr. Phiri translated into Chichewa using the question route in appendix D. Mr. Phiri prepared typed transcripts based on the recordings of these two focus groups in Chichewa and English and emailed them to me later. I think involving the community leaders was important and I am grateful that those two focus groups worked out. The hospital plays an important role in the surrounding villages and I feel that going out to meet them in their meeting places acknowledged the importance of the community's influence as well.

The other four focus groups that I conducted were all done in English at Malamulo and Mr. Phiri did not participate in these sessions. These groups focused on research question 2 and were made up of employees and leaders of the hospital. I did not have a schedule in place before I arrived, but I was able to conduct the first focus group

[8] The Traditional Authority (the top chief in the local community) was another "gate keeper" that we approached early and included in the first community focus group. Through his participation we received support of the project in general and his approval to talk to the community leaders.

with the hospital MH-AdCom on my first day at the hospital. I think it was important to be able to hold the first focus group with the MH-AdCom so the leaders understood what I was asking and they could encourage their staff to participate later.

Mr. Chitalo, the HR manager of the hospital, was helpful in arranging the focus groups with other staff after the MH-AdCom had met. It was a busy time for the employees since they were preparing for the Centenary Celebration of the hospital; however, they were gracious and willing to meet with me. Some challenges did occur related to scheduling. For example, one day Mr. Chitalo (the HR director) had scheduled a focus group for 8:00 am with the clinical officers. I arrived in the room and waited for some time with no one arriving. Finally someone who was on vacation came and found two of her coworkers. They appeared very nervous and uncomfortable but did not say anything. I asked them if this was a bad time and they said yes, they were supposed to do rounds and they had patients waiting. I rescheduled the group to meet on another day in the afternoon and the two left to do their work. I was able to switch to a semi-structured interview with the one clinical officer who was on holiday and it worked well.

This scheduling challenge may have been due to the employees feeling pressured to agree to the focus group and not feeling comfortable telling the HR director that the morning was a bad time, while at the same time he was feeling pressure to set up groups at my request. These unspoken pressures seemed to indicate some form of "deference effect" in place where people say or act the way that they think you want them to (Bernard 2011, 178). The rescheduled focus group went well with the clinical officers, and they were eager to participate.

Generally it seemed that focus groups provided good data related to this project. I incorporated "the Fruit Game"[9] as an icebreaker based on the pilot test feedback. This

[9] In "the Fruit Game" participants choose a fruit or vegetable to represent themselves and describe why they chose that. In the focus group, they were asked to use the fruit name to refer to each other for the recording and transcript.

helped people to relax and also gave them a pseudonym to use. People seemed willing to answer questions and the group dynamic was helpful. Two people chose not to participate in a focus group after the consent was read. One person was not feeling well that day, and the other person was a new employee and not Malawian so preferred not to participate.

Semi-structured Interviews

I conducted eight semi-structured interviews that I recorded, and I used the question route in appendix D (see research question 2).[10] I typed notes and transcripts from the interviews and coded the responses. The setting and degree of formality was based on the nuances of each person or department and how well I knew that person. I used the question route as a general guideline but also asked other specific questions related to situations or stories that arose.

I sensed some occurrences of "deference effect," in which people tell you what they think you want to know in the interviews (Bernard 2011, 178), either due to not knowing the answer to a question or to wanting to save face if they answered directly. I tried to immediately clarify what I was asking for or find out whether or not the answer was possible to verify with other people later. For example, when I asked people how often employee evaluations were conducted, I found that some people did not know for sure but gave me an answer that they thought was correct. I was able to mitigate this example of deference effect by asking several different people and examining the policy.

The people that I interviewed were key people of influence that I specifically chose because of their roles. Some of them participated in focus groups as well, but I also wanted to speak with them individually. One person that I interviewed had chosen not to participate in a focus group because he was not feeling well that day. He was a key leader

[10] The two additional interviews were related to specific issues or questions and did not use the question route.

that I wanted to include and he was happy to do an interview on a different day. Another person was very quiet in the focus group and did not speak up. I wanted to know more about accountability in his specific department so I went later and interviewed him individually and gathered his perspective.

No incentives were used for the interviews. This was a variation from the interviews I conducted in the pilot test where I gave a gift card. In the US setting it was helpful to compensate people for their time but in Malawi it did not seem appropriate and gift cards are not available. I recorded the interviews on a handheld digital recorder that worked perfectly. The files were easily saved onto my computer for back up. Conducting interviews was a vital method for collecting data. The interviews covered a spectrum from semi-structured to unstructured to casual conversations; I estimate that I had about ten unstructured interviews for which I did not request consent but that contributed to my research. These informal encounters are hard to distinguish as either interviews or observation, but I approached everything during my visit as contributing to my research.

Participant Observation

Since I was focused on accountability, motivation, and management, every conversation I had while I was in Malawi seemed to apply in some way. Observing the situations and events that were happening while I was there was invaluable to my field research. As Bernard mentions, observation is "one of those strategic methods" (2011, 257), and I would say it was pivotal to this project. The process that I conducted was not always observing explicit organizational occurrences such as an employee evaluation or discipline in process, but rather paying attention to situations in the community and looking for connections to culture, accountability, motivation, and management in everyday occurrences.

For example, the morning worship times were an example of accountability and motivation in action. I was able to see and hear what was said but also observe who did or did not attend, which added to my findings. Since I worked at the hospital and had been back to visit before the research trip, I felt welcome and familiar with many of the situations and challenges going on while I was there for research. I also gathered data in casual conversations with people such as a friend of my hostess who came over for a visit who used to work at the local tea estate[11] but now was a teacher at the secondary school. In our conversation I asked her how things were different between working at the tea estate or the Adventist school, and this led to a vibrant and enlightening conversation. She explained that the main reason she had come to the school was in order to be able to observe the Sabbath; otherwise she observed many inconsistencies between the policies and actions in the school that were concerning. I found the observation at the many events and while engaging in numerous conversations that happened during my stay to be very useful.

In some ways I was an outsider to the daily management issues, so I realized there were limits to what I was given access to. People are sensitive about their privacy and so it did not seem appropriate for me to be involved in something like employee discipline or other evaluation processes. I did, however, hear stories in the interviews of situations that had happened recently both at the hospital and other organizations in the area regarding discipline and accountability. Since I was familiar with the people, processes, and expectations, I was able to quickly understand the nuances related to my research.

One example is that there had recently been a string of burglaries and vandalism on the mission, and so the community had created a group on WhatsApp to try to catch

[11] All of the surrounding land around the mission and the small town of Makwasa is owned by the Makwasa Tea Estate, which is part of a large British conglomerate that grows, processes, and exports tea. The processing plant for this particular estate is about 1 km from the entrance of the mission property, on the other side of Makwasa.

the thieves. A few nights before my arrival Jason, the CEO, had seen a message that someone had heard a thief so he went in his vehicle to find the person. Once they caught the person and the message spread on WhatsApp, people came out of their houses with panga knives,[12] sticks, rocks, and whatever they could find and started beating this man. Jason had to push him under the vehicle to keep him from getting killed and disperse the mob. Finally he was able to get the thief into the vehicle and he took him to the hospital to be treated for the gashes and abrasions received.[13] Theft and crime is an important issue related to accountability, and I was interested to hear about the use of technology to communicate and bring someone to "justice"—although the use of force is an extreme form of accountability.

When I was preparing to travel to Malawi I went with the perspective that everything that I did would be useful for my research. In almost every conversation I was able to find something that related to the topics I am studying, and I enjoyed seeing the issues at play in many different settings. Whether it was attending morning worship at the hospital, visiting a friend in the village, or having a chat over tea, each conversation and situation brought unique insights. I took many notes of these everyday observations and normal daily experiences as a way to process and analyze the information while in the field.

Document Review

The review of documents consisted primarily of electronically scanning documents that were referred to in the interviews or focus groups. I used my iPhone with the CamScanner application that turns photos into .pdf documents, which was very

[12] A type of large knife similar to a machete.

[13] Incidentally, although he had rocks in his pockets that could be used to break windows of a vehicle, they later determined that he was not the one breaking into cars but had been stealing trees from the nearby forest for firewood.

helpful since resources for photocopying was limited. It was an easy way to store files for future reference as well. The documents I reviewed were sample job descriptions and appraisal forms, sample work order forms, and the "Conditions of Service" for the hospital, which is a policy manual for employees. I also requested a few forms and reports sent via email since returning and that has worked as well. I did not review employee records to verify the stated processes or completeness.

Reliability and Validity

I chose to conduct focus groups, interviews, document review, and participant observations in this case study at Malamulo Hospital. One of the strengths of these methods is that gathering data in person allowed me to read body language and clarify any misunderstandings that I observed. In addition, because relationships and connections seem to be so important in the Malawian culture, it was important for me to be present and connect with people in person while asking for their feedback and input. I realize that these methods have some weaknesses, such as the language barrier, the limited time available to be there in person, and any personal bias or opinions of mine that might affect the analysis or questioning. To mitigate these weaknesses I made sure that my translator clearly understood the project and the questions and encouraged him to clarify my questions if I did not ask them correctly. For example, in the focus group with the chiefs, when I asked a question about celebrating something good in the village, they answered with examples of what the hospital had done for them and how they were grateful. I clarified, through the translator, to think of community events and other things beyond the hospital and they were able to answer that question.

To address my personal bias I tried my best to be aware of it before arriving and to approach everything that happened with a learning attitude. I felt that my familiarity with the people, setting, and culture was an advantage because I had that basis to start

with rather than learning all of it at once, and I already had trust and relationships with many of the participants. This also was helpful with the short time frame for in-person data collection. Since I already had familiarity with the basics of the context I could focus the majority of my time on collecting the data that I needed to accomplish my goals.

In order to maintain reliability of the data that I was collecting I used the same questioning routes for multiple focus groups and an interview guide for the semi-structured interviews (see appendix D). Yin refers to this as a "Case Study Protocol" (Yin 2014, 84–85), which creates a guide that could be followed by another researcher. To establish validity, the external validity test can be applied, which answers the question as to whether the study's findings are generalizable beyond the immediate study (Yin 2014, 48). When conducting interviews I found it challenging to stay exactly with the interview guide as other issues or ideas would lead the conversation in a different direction or the need to clarify some questions would cause distraction. Through these difficulties I did my best to listen to the stories and examples and bring the conversation back to the question routes. In the pilot test I saw a tendency in myself to ask leading questions and so in the field I made an effort to ask open-ended questions that did not lead to an answer I expected.

After I conducted the interviews and focus groups I transcribed them into electronic documents as well as the notes I took of my experiences, observations, and the process of the focus groups or interviews. In order to analyze the data I created a codebook based on the themes that I noticed surface in the data. Then I grouped quotes and observations by the themes and subthemes and used the codebook to assist with the analysis and findings from the data. I will describe the analysis of the data in chapter 6.

Summary

This chapter has outlined the methods used in the case study of Malamulo Hospital. The culture of Malawi was taken into consideration when planning the focus groups with the community leaders as well as deciding to avoid written surveys due to the language difference and lack of familiarity with completing surveys. I did not face any major difficulties in implementing the methods other than scheduling challenges and some instances of deference effect. I tried to use probing questions at times to find out the basis of the answers and identify the real issues if necessary. I did find that I had an advantage in knowing the people, the setting, and the culture; however, I did my best to approach the project objectively and put aside any presuppositions that I may have started with. From my perspective I feel that the relationships and familiarity with the setting and culture were a benefit so that I was not a complete outsider to the organization, yet I had enough distance to have fresh eyes and a different perspective. In total, I conducted six focus groups, eight semi-structured interviews, ten unstructured interviews, and gained verbal consent of about 50 people. With the general observations, however, it seemed like everyone I talked to contributed to my research. In the next chapter I will explain the findings that emerged from the data based on the methods used.

Chapter 5

Listening Carefully: Themes from the Data

In this chapter I will describe how I listened carefully to what was spoken and unspoken during the time I was at Malamulo. Before traveling to Malawi for the field research, I intentionally thought about how I planned to engage with the people there in a different way than I had when living and working there. I made every effort to observe all that was going on—not as an outsider but as an "inside-outsider." I had the benefit of some understanding of the culture and context but not the day-to-day role of a current leader.

I arrived with the plan that I wanted to make full use of the "observation" method and look for anything related to my research throughout my visit. Starting with this frame of mind helped me to listen with new ears to the conversations, meetings, and events that happened to see where culture impacted employee, personal, and community relationships.

For example, while there for research I attended the AHI-Malawi Board meeting as an invitee. I had participated in this meeting many times before, but in this instance I looked for signs of accountability and motivation at the board level. I observed efforts at accountability from the board members but limited effectiveness at follow through. In one instance, the board members had some questions on the financial reports from one facility. However, the finance subcommittee was not meeting regularly to spend more time figuring out the issues, and their questions did not seem to prevent votes of approval.

In all of my interactions I hoped to convey that I was listening to people and truly wanting to hear their stories and understand the situations that were happening. Even in casual conversations I was looking for signs of accountability in daily life. One morning I stopped by one of the homes of a physician to have tea with his wife on my way to the hospital. She has four Malawian staff that work in her home and yard so I asked her about her experience with accountability for her workers. She shared a few ways that she has found to motivate them, like using notes and lists for duties and saying thank you. I realize in some of my interviews there could have been situations of deference where people tell me what I want to hear, and without extensive time to actually observe the activities, I have to rely on the limited information that I gathered combined with my prior experience. These conversations were similar to prior interactions based on friendships that I have maintained, but I considered them through the lens of my research project.

Several themes arose from the data I collected. First, however, I want to share an important finding that laid the foundation for the rest of my discussion of these themes. My first research question was "How does the national Malawian culture hold people accountable?" Through the community focus groups I was able to confirm that there is a process for accountability in the Malawian culture, although the expectations and standards may be different than a Western standard. The chiefs explained that if someone does something wrong in the village there is a process for accountability that starts with the family and progresses to the next level of authority. Each level tries to solve the case, but if they cannot find a resolution it goes to the next higher level. The levels are family, village headman, group village headmen, Traditional Authority, and finally the local court or higher court, depending on the situation.

Although this hierarchy is in place, there does not seem to be a word or phrase in Chichewa that translates the English word *accountability*. I asked for the word in the

local language for *accountability*, and there did not seem to be a good equivalent. Nevertheless, based on the responses, it seemed that everyone had an understanding of the concept both through examples and local proverbs. I used various examples such as building a house and what would happen if the walls fell down: who would be responsible? The community members and chiefs agreed that if the walls fell down because of wind or rain then it is not the fault of the builder. If the owner had already inspected and approved the house, a new contract would have to be agreed upon to repair the damaged building (FG2 8/31/15 and FG5 9/2/15).[1] This is a different interpretation than the Western standard expecting craftsmanship to be good enough so it withstands a storm and has a warranty provided by a builder. So although there is an understanding of holding someone to a standard, it is interpreted differently than from a Western understanding.

Another evidence of accountability in the local culture was the prevalence of proverbs that illustrate how one's actions produce outcomes. One proverb I heard multiple times was *Pangano linadulitsa mutuwa Yohane*, which translates into English as "A promise led to the decapitation of John's head." My translator interpreted this proverb to mean, "when one has promised one should make sure that they fulfill their promise otherwise if they don't something bad may happen to them" (FG2 8/21/15). Another is *ukanamasukuchedwakucha*, which translates, "when you make a promise you should remember that dawn is just in sight" (FG5, 9/3/15), meaning be careful to promise what you can fulfill because you will have to do it soon. Both of these proverbs illustrate that there is a cultural expectation of consequences and being held to an agreed upon promise. In the data it seemed that keeping a promise was a very important issue, and if someone

[1] For references to focus group or interviewee responses I will use a code for the particular focus group or interview and the applicable date. "FG" refers to focus group and other initials refer to interviews. More details about these codes are given in appendix E. In some instances I refer to a pseudonym that the participant selected to identify a specific quote.

broke a promise the whole community could lose confidence in them. I often saw differences in expectations, though, among the consequences of mistakes, breaking promises, or breaking the law. For instance, while I was doing research there was a break-in and theft of money from the Malamulo secondary school. Some suspects were taken to the police for questioning and held in jail over night, but when I asked people about the situation, there was a feeling that the truth would not be discovered and the school should count it as a loss.[2] There was suspicion about who did it, but also an implication that the police could have been paid off to not investigate any further. The issue is multifaceted, and I will discuss it more later, but it seemed that people were somewhat resigned to the fact that it is hard to identify the perpetrator so the person just gets away with it.[3]

This initial finding that accountability is practiced and understood in the culture laid the foundation for the other themes that I discovered in the data and what I could eventually recommend to the hospital leadership and AHI. It is important to understand that the interpretation of accountability and how it is implemented may differ among people from various countries that have different cultural expectations for accountability. It seems that people in Malawi feel somewhat powerless and there is little infrastructure or expectations in place to provide recourse. There is a sense that people come up with an explanation and are just resigned to the fact that they cannot do anything. Nevertheless, with a confirmation that accountability to some degree is present in the culture, I will now turn to the themes that arose out of the data.

[2] There is no insurance for this type of loss.

[3] In this case and others like it, the police system seems to be part of the problem since they have no resources and often do not follow through on investigations for various reasons. Sometimes people take things into their own hands rather than reporting to the police if they catch someone in the act of a crime. If someone is charged with a crime, the likelihood of a fair legal process is not very good.

Themes from the Data

As I reviewed the data I organized key responses by the themes and subthemes that seemed to develop and created a codebook. The themes that I identified (not in any particular order of significance) were (1) Uneven Implementation of Performance Evaluations, (2) Cross-cultural Management Complexities, (3) Motivation as a Felt Need, (4) Inconsistencies in Accountability, and (5) Unclear Organizational Structure and Culture. These themes primarily relate to research question 2: "What are the current accountability and management-capacity related practices at Malamulo Hospital?" Below I will describe the data that support each theme. However, it will be clear that some themes overlap and cannot be neatly divided.

Theme 1: Uneven Implementation of Performance Evaluations

When starting this research project I thought that one outcome would be the need for an employee evaluation process that was culturally appropriate and I would be able to create a tool for the hospital staff to use. I knew that there was a process in place, but thought part of my research outcome would be a new tool to be put into use that might be more culturally appropriate. During my interviews and observations I found that there is an appraisal[4] system being used, although inconsistently. As one leader said, "The appraisal system is working, the challenge is with us as leaders because the junior employees are waiting for us to implement the system" (HR1 8:56, 8/31/15).[5] Another leader expressed frustration that some departments have never had an evaluation done and neither did this person know if they had job descriptions on file as he had not had an appraisal done in the five years he had worked there (FG1 "Guava" 8/27/15).

[4] "Appraisal" seemed to be the preferred term for the "employee evaluation" process. I will use the terms interchangeably.

[5] Edited for readability. Exact quote: "The appraisal forms—the system is working—the only challenge is with us as leaders because like juniors they are just there waiting for us to implement the system."

In my experience in Malawi I have found that when I ask a question people often will say something positive about the subject and then explain the problems with it, and this was true regarding the employee appraisal process. It was important to listen beyond the first comment and use probing questions if needed. For example, most employees who had participated in the appraisal process generally seemed pleased with the process but some listed the problems as well. A nurse midwife explained that they had an appraisal done as a new employee and it was a good experience, but she later realized that coworkers were evaluating her secretly instead of the manager, and she felt that was unfair (NMT 9/13/15). They noted that the process helped them identify the strengths and weaknesses and grow professionally. One employee described the purpose of the evaluations as "quality improvement in terms of how we deliver services both to the hospital management and to the patient . . . it corners you; it molds you in many aspects—it's like a revival process" (CO1, 9/3/15). The positive and negative comments should be considered together while realizing the negative aspects indicate need for improvement.

There were inconsistencies in the employee's understanding of how often the appraisals are conducted. Some reported monthly, others quarterly, and others twice per year. According to the official *Conditions of Service*,[6] it should be done twice a year. The policy states, "The policy of Malamulo Hospital is to use the appraisal system as a feedback to individual employees for their further professional development." The steps are as follows:

1. In pursuit of the policy outlined above, Malamulo Hospital will implement open appraisal systems as a basis for performance related pay and employee career development.

2. Performance appraisals will be conducted at least two times per year.

[6] *Conditions of Service* is the equivalent of an employee handbook that serves as a policy manual as well.

3. Every employee shall be subjected to a formal performance review in an open and frank face to face discussion with those they report to (Heads of Departments) or other superiors at least once every calendar year.

4. The appraisal shall focus on the employee's strengths and weaknesses, achievements and failures, opportunities and what should be done to achieve maximum results and improve performance. (Malamulo Hospital 2013, 14)

Additionally, a separate policy outlines the three-month probationary period for new employees. That policy states that "the HOD [head of department] will also give constant feedback to the employee and management on the progress or otherwise on the performance of the probationer employee" (Malamulo Hospital 2013, 8). According to my observation and interviews it seems that the "constant feedback" referred to above is a monthly performance review for new hires, which happens for three months but may also be extended to six months if more time is needed (NMT, 9/13/15).[7] It seemed that the monthly reviews for new hires were common for the nursing department but did not extend to other departments consistently.

The first policy seems inconsistent and indicates twice a year and annually (see #2 and 3 above), and the second policy refers to monthly for new hires which can be extended beyond three months. Understandably, employees would be confused about the frequency of the evaluation process throughout the hospital.

The evaluation process uses a form that requires the reviewer to rate the employee with a score of 1–5 on each item required by their job. The evaluative statements are based on their job description. The score is totaled at the end of the form. They also must list any physical requirements of the job. The evaluator makes written comments and there is a place to list performance goals, but I did not see evidence of the goals being evaluated in subsequent appraisals to ensure achievement. Both the employee and the evaluator sign the form and it is kept in the employee files.

[7] This was also confirmed in an email from the HR manager, 11/26/15.

The pilot test focus group had some discussion of the concept of the "feed forward" technique of performance evaluation in which the goals for performance are established and then people work toward that goal (FG0 7/31/15). I was interested to see if this concept would come up in the hospital setting, so I asked many people if they could change the appraisal system, how would they do it differently. Most people responded with changes in who conducts the appraisal more than the process itself. I asked some people about the idea of setting goals and working toward the future, and all who responded to that question thought it sounded like a "nice approach" (CO2, 9/10/15), however this could have been said out of deference to my suggestion.

During daily work in the hospital discipline at times occurs on a somewhat casual basis. This is a type of evaluation, although not usually formalized in a process unless the action is egregious enough to warrant written warnings and/or dismissal. The way that disciplinary feedback is handled came up frequently in the interviews and focus groups. Casual discipline in the workplace may be a key point in cross-cultural management that needs to be carefully handled. Employees mentioned things like the importance of addressing a concern of performance to the whole group of employees when the issue is first recognized. This prevents one person from being singled out for doing something wrong in public (FG3 "Avocado" 9/2/15). Confidentiality of issues is also a concern when it pertains to one person. They would rather hear about the problem from the person in charge and not from a colleague or someone else (CO1, 9/3/15) through gossip. So a balance is needed as well as a cultural sensitivity in communication methods.

There is a policy in the *Conditions of Service* outlining the disciplinary procedure, which consists of a verbal warning recorded by the Head of Department, then a written warning filed in the employee's personnel file. If the behavior continues, a second written warning can be issued and the final step is termination (Malamulo Hospital 2013, 29). According to the administration, these methods are used; I did not review all

documentation personally however. One staff member related a story of a coworker who had been terminated without the stated process having been followed (NMT 9/13/15), so it is unclear whether the process was not followed or if the person who I talked to was just unaware of the steps. This was also just one instance, and I did not have time to evaluate more disciplinary cases. Accountability is not only evaluation or discipline, but the concepts of accountability and of evaluation and discipline are related.

Accountability related to quality patient care was not the primary focus of my research, but still may be influenced by culture and should be considered. The clinical areas have started a practice of holding a Morbidity and Mortality conference two or three times per month. This is a chance to review outcomes and, as the medical director pointed out, is a kind of evaluation although it is more systemically and clinically focused (FG1, 8/27/15). In addition, the clinical leaders were working on a quality improvement system. The committee had not been established yet when I was there but was in process.

Theme 2: Cross-cultural Management Complexities

Management is a broad concept, and many aspects of management are affected by the differences between cultures and the expectations that come with those differences. The second theme from the data explores various aspects of the management such as communication, teamwork, and fairness.

Communication is an area that can be easily overlooked but is so important in intercultural situations. Often in a resource-scarce organization such as a mission hospital, the urgent issues that take priority are resolved as they arise, and regular communication with staff or coworkers may be forgotten. I sensed a level of fear related to communicating regarding disciplinary issues, both from the leadership knowing how to approach people effectively, and also from the employees being afraid when confronted. Some managers mentioned that when they confront an employee the person becomes

depressed and “extremely downtrodden” (FG1, “Guava” 8/27/15). Employees said they felt “scolded” and “depressed the whole day” when they were talked to about their behavior or disciplined for some reason (CO1 9/10/15). The constant urgency of issues could contribute to how communication is handled. In addition, when leaders are always stressed and running from one problem to the other, less thought may be given to nonverbal cues that are deeply cultural.

One staff member noted that many employees avoid morning worship because of “the frustrations they get at the workplace . . . they say ‘if I go to morning worship, the way this person talked to me [yesterday], now today he’s in front of me preaching to me’ because of that I’ve seen that most of the times we shun away from the morning worships” (CO1 9/3/15). I observed that many of the clinical staff did not attend morning worship. Based on the comment above, the lack of attendance may be a result of poor interpersonal relationships or a prevalent sense of shame. Communication overlaps with the theme of accountability and organizational culture, which will be discussed below. It seemed the leaders were aware of these kinds of challenges because the administrative committee focus group mentioned conflict resolution and suggested that this might be an area to develop capacity in the future. As discussed earlier in relation to the ECO model, this is also an example of employee experience related to the organizational dynamics and how that loop is connected.

Teamwork and collaboration between departments is another aspect of management, which is likewise affected by cultural expectations. Based on the interviews and my observation, there are some interpersonal issues between the heads of the departments preventing them from saying anything about an employee of another department. For example, the head of one department knew that an employee in another area was stealing medications yet he did not feel comfortable bringing this to the attention of the head of the other department. He explained, “heads of departments are

afraid to say the truth about the employees" (ACC 9/15/15) to another supervisor who may be afraid of being scolded, or because that the manager may feel criticized for not doing a good job.

Other concerns such as regular supervision and fairness in discipline may also be affected by cultural expectations, which ties to perception and communication as well. A manager may feel that they are being fair in their behavior and communication, but it is perceived differently by the employee due to cultural interpretations. Because the natural culture is one of high Power Distance, the employee may not feel comfortable speaking up and sharing a concern with a supervisor.

The employees' perceptions influence the organizational culture, whether or not a perception matches the intended message, and it seems that clarifying the roles could bring unity of the heads of departments as well as emphasize the kind of accountability and teamwork that is expected within Malamulo. Administration is aware of some issues, and one leader stated the need for teamwork and communication: "we shouldn't be afraid; we shouldn't feel as if I've been told that I'm not doing my work—but if I'm told it means this one would want my department to improve" (FG1 "Apple," 8/27/15). Since there is an awareness of the concerns and of the lack of teamwork, this area seems to be a noticeable gap that could be addressed through training and capacity building in management skills.

Theme 3: Motivation as a Felt Need

As I asked questions regarding evaluation, the answers and feedback moved towards motivation and what affected employee performance. I followed this line of questions especially in the semi-structured interviews. In my interviews and observations I found several motivational initiatives that had been tried, which I summarized along with the reported outcomes in table 2.

Table 2: Motivation Methods and Outcomes at Malamulo Hospital

Technique	Reported Outcomes
Social gatherings, chocolate/candy at meetings, and public acknowledgement at the department level; used in the laboratory.	Positive reaction to these methods, but it is limited to one department.
Recognizing a "best worker" at morning worship; this title was given to a clinical officer and awarded with a new stethoscope.	There was mixed response—one person said it helped the other clinical officers to work harder. Another person said they were jealous of him and stole his stethoscope (unsubstantiated). This method has not been repeated.
Giving praise individually after good performance—usually between colleagues. This was casual and ad hoc in nature.	Staff mentioned that this was appreciated and they suggested it happen more often.
Education: while there are limited funds to send employees to gain further education, this has been tied to employee performance after 2 years of employment.	Seven staff members were away for additional education at that time. This is a strong motivational method, usually with a contract to work for the hospital upon return (ACC 9/15/15).

There was a general sense that motivation is not carried out effectively at the hospital, especially giving praise for hard work and job performance. Approximately six people that I spoke with referred to the negative relational aspects of motivation, mentioning, for example, a "soured relationship with the supervisor can contribute to motivation" (HR1 8/31/15). Another employee said, "if we fail to create a good relationship with our juniors we cannot handle conflict" (FG1 "Mindimu" 8/27/15).

We also discussed methods of motivation, and although there was some mention of financial remuneration, the majority of people seemed to value words of appreciation and being noticed for their hard work. It seemed that the administrative team felt the need to give financial rewards but are not able to due to finances, and therefore have limited

motivational methods organization wide. Employees provided suggestions for motivation such as these:

- Social activities (employees give money monthly into a fund for social events) including Christmas gifts and potlucks or outings (CO1 9/3/15)
- Staff recognition publicly in morning worship with certificates (CO2 9/10/15; FG1 8/27/15; WRK 9/9/15; FG3 9/2/15)
- Tools to do their job (Email to author 9/30/15, FG3 9/2/15)
- In-service training and education, including for administration (FG1 8/27/15; email to author 9/30/15; WRK 9/9/15)
- Developing criteria for "best worker," exchanging a medal or trophy for meeting the criteria (ensure criteria applies to all departments) (FG3 9/2/15; FG4 9/2/15)

Some employees referred to intrinsic motivation related to helping patients and the satisfaction that comes from knowing they did a good job, such as a successful cesarean section in an emergency or giving the kind of care they would wish to receive (CO1 9/3/15). Another person mentioned that working at Malamulo Hospital is the "work of God . . . this is a mission and I love to see it growing" (NMT 9/13/15).

I asked whether giving awards or recognition individually or to a group is more effective. Since Malawi is a more collectivistic culture rather than individualistic, I wondered whether individual awards would work or if they should be group based. Repeatedly in the data, people indicated that public praise was good; however, leadership would need to be sure that the same person or department was not always getting the awards or praise. Several people suggested morning worship or having a "best employee" list on a bulletin board. This was also confirmed in the focus group with the community leaders; they would encourage rewarding a teacher in the community in public with gifts for two reasons: one, so that others are encouraged to work hard, and two, if gifts are given in secret it might be seen as a bribe (FG5 9/3/15).

Theme 4: Inconsistencies in Accountability

I asked participants to define how they understand accountability, and common words used were "responsibility," "responsible for whatever you are doing," "answerable," "reliable," "efficient," and "responsible for the consequence for your job." Many examples were given that demonstrated people being held accountable for their actions, which showed a general understanding of the concept by the participants. Some even referred to the same proverbs mentioned earlier such as the beheading of John the Baptist. This understanding was also confirmed by getting a sense of how people hold each other accountable in the community via the hierarchy of authorities discussed earlier.

Another aspect of accountability in the community is the legal system in Malawi. While I was conducting research there was a major theft of approximately $11,000[8] from the Malamulo Secondary School on the same campus as the hospital. It happened the night after fees were due for the new school year, and the people I talked to felt it was an inside job. The business manager and the cashier of the Secondary School were taken to the police and bailed out the next day by the principal. There is a sentiment that police are corrupt and would not be able to find the money or would potentially get a cut of the cash for covering it up. According to one person, if they suspect corruption in the police it would be reported to the Traditional Authority for investigation. I spoke with several people about this situation, trying to understand the various aspects of holding people accountable to laws, and I saw how complicated it can be based on relationships, rumors, distrust of police, and unclear policies.[9] Although this did not happen at the hospital, it was within the immediate mission community and illustrates some of the challenges that

[8] Approximately 5,500,000 Malawian Kwacha, with an exchange rate of 500MK:1 USD at the time.

[9] The general feeling was that the money would never be found and it was a major loss to the school.

they face. The hospital operates with the same distrust of police and complicated interpersonal relationships within a close-knit community.

The hospital has several systems to promote accountability, yet they are not all working as expected. One example was in the Workshop Department, where each job that is requested was to be written on a job card. I reviewed the job card form and observed that the workshop employee is to list the materials used and when the job is done, the person making the request signs their approval that it meets their satisfaction. The materials request would be tied to the inventory logbooks. This reflects a similar system suggested in the community when someone has a house built and they inspect the work before the builder is paid. I saw some examples of completed cards in the Workshop office.

Later, I observed a worker do maintenance on the house where I was staying and I asked my missionary hostess, who had requested the repairs, about the job card process, and whether she signed off. She had never seen a job card and did not know of the process. I am unsure if the process is consistently followed or whether the parts and supply inventory is carefully tracked. I asked the workshop director about it and he was concerned. I did not verify if the process is followed for other types of employee residences. Although there is a process in place, it does not seem to be followed consistently.

The hospital *Conditions of Service* outlines the disciplinary procedure that should be followed if there is a "breach of acceptable standards" (Malamulo Hospital 2013, 29), which goes from a verbal warning up to termination. I am not sure how or when this policy and process is implemented or whether failing to maintain the job card process warrants discipline or just additional training. The workshop manager reported that very little guidance was provided to him related to employee or process management, so he may not have known how or when to hold people accountable or understand the

importance of record keeping. He did not indicate that anyone outside of the Workshop Department monitored the job card process. Another employee in the workshop was a new plumber who had recently been hired. I asked the supervisor if he was doing a good job. He said "yeah sure—sure but I already gave him a warning letter . . . so he's doing better now" (WRK 9/9/15). He did not specify what the letter was about, but this does indicate some level of accountability was present, though it was not clear whether any other consequences were given for poor behavior.

In the hospital laboratory, the manager has tried an innovative strategy by requiring employees to sign in and out on a time card. She started in 2010 and reported perhaps 20% compliance initially, and at the time of the research, about 80% of employees consistently signed in and out (email to author 11/16/15). She compares the times worked with the posted schedule and calculates overtime as well as holiday use (if they are absent) based on the times they work. One of the lab employees referenced this system and felt that it provided a lot of motivation to be accountable (FG 9/2/15). The incentive of having overtime pay is part of the motivation as well. This time card system has not been implemented in any other department or hospital-wide and there does not seem to be a plan to do this.[10]

Consistency in applying accountability is a concern. It is interesting to note that the manager of the workshop was an older Malawian and the manager of the laboratory was Filipina, so the difference in management styles could be related to culture as well as education level or other factors. I saw some innovative ideas for accountability being tested in the lab, while the workshop was not consistently applying the accountability

[10] When I worked at Malamulo we started an effort to install electronic time cards but it did not get off the ground. I do not think timecards are implemented across the hospital for several reasons: (1) It is a manual process and the lab director pointed out it takes her *a lot* of time to process. (2) Everyone is paid on a salary basis so there is little motivation to track specific hours and have it tied to pay. (3) The other leaders are not as motivated as the lab director to implement this process.

tools it had. I did not compare the two departments in depth, but did notice differences in innovation and initiative related to accountability measures.

Relationships between staff and department heads seemed to affect the amount and consistency of discipline. A situation was explained to me in which an employee noticed a coworker who was used to the style of management and seemed to do whatever they wanted without getting disciplined. Leaders were aware of the employee's actions and the person was still given more responsibility. It was suggested that because the employee and supervisor were friends that may be why the employee does not get disciplined (NMT Interview, 9/13/15). Even if this is not the case, the perception of favoritism is a problem. On the other hand, the workshop manager explained how important it is to have a relationship with your employee before you give them direction or help them with a problem. He explained,

> You have to be friendly when there is a job before, don't just tell him "go and do this, this, and this" no, but you don't even tell them how to do that job but you have to sit with him [and] ask him—though you know it—you have to ask "how can we do it?" Then you discuss and helping each other share some ideas yeah then after that you do the job then it goes well. (WRK 9/9/15)

Another interesting aspect is the fact that Malamulo is a mission hospital. Some staff suggested that because it is church run there is more forgiveness so people are moved to different roles or departments rather than terminated because the hospital wants to provide more grace instead of taking a "tough action" (FG1 8/27/15). Recommendations from the staff suggest that there definitely should be discipline and people should be held accountable. The inconsistencies in how people are treated are noted and this was a concern. Not only should people be disciplined, but they should also be recognized for good performance. Some feel that the positive reinforcement is overlooked while the discipline is the only thing noticed consistently.

Theme 5: Unclear Organizational Structure and Culture

Malamulo Hospital is part of the worldwide network of SDA mission hospitals and clinics as well as part of the national healthcare system in Malawi (see appendix B and G for more explanation of the organizations and their external influences). There are multiple external influences that the hospital must consider when making strategic decisions and managing accountability. Cleary, Molyneux, and Gilson suggest a conceptual framework in their research, showing the external influences of a health system (2013).[11] Taking these external influences and overseeing bodies into consideration is part of the challenge of leading an organization such as Malamulo Hospital. While there may not always be obvious direct correlation in management decisions, the external accountability structure affects the internal management to some degree.

As described earlier related to external motivation, the Malawi Nurses and Midwives Council requires that nurses submit their most recent performance appraisal each year in order to have his or her nursing license renewed. In my research I found that the nursing department is one of the most faithful in completing the performance appraisals because of the external requirement from the government. The HR manager also confirmed that they adopt the job descriptions for nurses that are provided by the Nurses Council (HR1 8/31/15). My follow-up question was whether the evaluations are done fairly and objectively or are they done in order to meet this requirement? The matron agreed that this was an area of concern where more training was needed to ensure evaluations are objective (FG1 8/27/15).

Part of the organizational structure consists of job descriptions for each position in the hospital. In order for employees to be evaluated they must be aware of these job descriptions before the evaluation is conducted and ideally before being hired. When

[11] Appendix B is an adaptation of Cleary et al.'s figure applied to Malamulo's external reporting structures.

reviewing the documents at the hospital I noted that most staff positions had a description on file, though I did not verify every position in detail. Nurses and other clinical positions have standardized descriptions, which are adopted from the Ministry of Health of the Malawian government. Based on reports and interviews, some departments and positions do not have job descriptions on file. The *Conditions of Service* document is distributed along with the job description to provide employees the policies of the hospital and a code of conduct. Employees are asked to sign a form that they have read the *Conditions of Service*, and this signed form is kept in their employee file. This constitutes the hospital orientation. There is department-based training as well related to the job expectations, but not an organization-wide orientation.

I observed some inconsistencies with this system of job descriptions and policies. Some department heads mentioned that they either did not have job descriptions for themselves or their staff or that the ones in place are irrelevant (FG1 8/27/15). Other staff mentioned that they did not receive the *Conditions of Service* until they had been working for one year (CO1 Interview, 9/10/15). There was also some discussion about orientation for new employees, and the heads of departments explained there are department-specific orientations and there is a general hospital orientation, which is standard for everyone (FG1 8/27/15). I did not see any evidence of a general orientation other than the *Conditions of Service* document.

The documents that I reviewed showed that the evaluation forms tie to the job description requirements, which is important. Although it was beyond my scope of research to confirm that the job descriptions themselves are appropriate for the actual work required, it was confirmed that the HR manager understood to evaluate employee performance based on the job descriptions in place. More work should be done to ensure all positions have descriptions and that they accurately reflect the required duties and tie

to the evaluations forms. It may also be helpful to incorporate the values of the organization into the performance appraisals.

The mission, vision, and values are the foundation and framework of the organization. Integrating these guiding statements into the life of an organization creates a cohesive work environment with symbols that employees can connect to. Bolman and Deal emphasize that "values characterize what an organization stands for, qualities worthy of esteem or commitment . . . values are intangible and define a unique distinguishing character" (2008, 255).

According to the signs posted around the hospital, the mission statement is "to provide competent health care and training through skilled staff members prioritizing the health of patients with a special emphasis on spiritual care." The vision of the hospital is "to be the preferred provider for specialized health care and training in Malawi and beyond." The values are putting patients first, competent and skilled staff, spiritual health. These statements are also written at the top of each evaluation form. I did not see, however, that the employee was evaluated in relation to their support or implementation of the values, mission, or vision. According to one member of Malamulo's administration, employees are expected to know the culture of the hospital, mission, and values during the orientation when they are acquainted with the *Conditions of Service* (FG1 8/27/15). But I observed that the guiding statements of the mission, vision, and values are not included in the *Conditions of Service* document.

In my observation and interviews I did not notice the mission, vision, and values of the hospital being referenced other than on bulletin boards and at the top of the employee evaluation form. The personal motivation and commitment to the general mission of a SDA hospital was evident in interviews, but it is not tied to the official statements of the hospital. Also, motivation and evaluation do not seem to be connected with the values—either written or intrinsic. Bolman and Deal comment that "the values

that count are those an organization lives, regardless of what it articulates in mission statements or formal documents" (2008, 255). Integrating the mission, vision, and values in every aspect of the organization may strengthen the normative power such that commitment to the organizational values is internalized (Jackson 2004, 45).

Overall, issues related to the organization were demonstrated throughout the discussion of the research questions and came out of the collected data. I also heard general comments related to the organizational culture from both Malawians and expatriates. I tried to step back and analyze what in the culture was enabling or encouraging the various behaviors and situations that I observed. Organizational culture was not my initial focus for my research, but when I started exploring accountability and motivation and trying to understand how and why things happened, I realized that the deeper issues behind the outward displays of employee evaluation or discipline lay in the culture of the organization itself. The core issue of the culture is a lack of intentional focus on the people and the relationships within the hospital. This was the foundation and a likely place to look for how to make a difference and implement a pilot change project.

Summary

In this chapter I have described the research data by grouping it into five themes. The findings answer the first two research questions. Question 1 asked, "How does the national Malawian culture hold people accountable?" The focus groups and observations that I conducted gave various examples of the process for holding people accountable as well as how they celebrate and reward people in the community for good behavior. The main purpose for this question was to confirm that there is an expectation and understanding within the national culture of accountability. Knowing the answer to this question provides a basis for understanding how accountability and motivation are handled in a hospital situation in the Malawian culture and community.

The five themes that were presented serve to answer the second research question: "What are the current accountability and management-capacity related practices at Malamulo Hospital?"

I was able to confirm that there is an evaluation process in place that ideally happens twice a year for full-time employed staff. It happens more frequently during the probation period when a staff person is first hired. I also identified several motivational efforts carried out and their outcomes. Part of the data showed that the evaluation process is not consistently implemented for a variety of reasons.

A finding that I did not expect was the important role of the organizational culture as a foundation to the accountability and motivation factors. Based on my observations and findings, it seemed that the underlying culture of the organization was where my change project should focus in order to impact the accountability and motivation of the employees. Surrounding and intertwined with all of this information is the effect that the culture has on implementation, communication, and leadership of the hospital. Since the management group is made up of people from a variety of countries and backgrounds, the expectations of leaders from their own cultural perspective may have an impact on the organizational culture. In fact, one of the Malawian leaders seemed to be aware of the issues and commented on them in a focus group:

> I think most of the organizational cultures they are quite good, but we as individuals we are the ones who normally try to change that kind of culture. We come with our own cultures so that maybe whatever you want it to be as an individual we want to apply it as well at your own office. . . . but if you look at the organizational culture, because I believe that maybe the organizational culture is built on the values of the hospital and the objectives of the institution, so if we follow that culture everything will be smooth. (FG1 8/27/15)

I understand this to mean that he observed that we often come in with our own cultural perspective and try to apply it in the workplace, but if we can let the values and the established culture of the organization guide the leadership then everything will go well.

Key then is to intentionally focus on creating the type of organizational culture infused in every aspect of the hospital so that it is consistent, standardized, and recognizable to anyone who joins the organization. This leads me to the next chapter where I will further analyze the themes in relation to the literature, demonstrating how the field research interacts with the published literature relevant to my study.

Chapter 6

Analysis and Discussion

In this chapter I want to connect the findings from the field research to the related literature discussed in prior chapters. Through this analysis and discussion I identify where the research adds to the body of literature related to cross-cultural management and show how the theoretical constructs can be applied to the findings. Finally, by the end of this process I hope to identify places of growth and opportunities for change at Malamulo Hospital.

To conduct this analysis I will revisit the collected data and consider them in light of the themes from the literature in order to analyze the implications that could be drawn. I have grouped the themes together as seems appropriate when tying it back to the literature.

Performance Evaluation and Accountability

Performance evaluation is a form of accountability so I will discuss these two themes together. Through the mechanism and process of reviewing an employee's work performance and setting goals for the future, the person is held accountable. Accountability is defined as "the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors, along with the imposition of sanctions for failure to comply and/or to engage in appropriate action" (Brinkerhoff 2004, 372).

As discussed earlier, the literature refers to various forms of accountability such as financial, performance, or political/democratic (Brinkerhoff 2004). The focus of performance accountability is results while financial accountability looks primarily for procedural compliance, and the political focuses on governmental accountability (Brinkerhoff 2004, 374). These types are comparable to Cleary, Molyneux, and Gilson's, who differentiate between "external" and "internal" accountability, and suggest that external methods have received higher priority and they indicate a need to strike a balance between the "accountability upwards within a health system" and "allowing the local level innovation that improves quality of care" (Cleary, Molyneux, and Gilson 2013, 2).

My research confirmed that there is a process in place for evaluation of employee performance at Malamulo Hospital, which is a form of internal accountability. Through interviews, focus groups, document review, and observation, it seemed that people understood the concept of accountability and even appreciated the growth process that comes with having someone evaluate your performance. The gap that I found was the consistency with which the evaluation process was applied and who was evaluated. Primarily the policy and process is for the staff, but generally not in place for MH-AdCom members or physicians. One physician noted he had never seen a job description or been evaluated during his time there of over five years. As Brinkerhoff points out, "sanctions without enforcement significantly diminish accountability" (2004, 373). These inconsistencies in internal accountability are noticed and could have cultural implications if those who are not evaluated are primarily not from Malawi. It could be perceived as preferential treatment because of nationality, although technically it may not be intended that way.

As the research noted, external accountability seems to be more effective. An example of external accountability described by the hospital's nurse matron is that the

Malawian National Nurses and Midwives Council require annual performance evaluations in order to renew the license of each nurse. The fact that the nursing department was the most consistent in implementing the evaluation policy appears to demonstrate that external accountability expectation enforces stronger adherence than internal policies, as Cleary suggested. Often the external accountability structures are in place due to funding and state regulations and oversight, which could be aligned with Brinkerhoff's political or democratic accountability (Brinkerhoff 2004). Brinkerhoff suggests, "weak capacity to exercise oversight of facility and practitioner performance [in healthcare] hampers efforts at accountability for the purpose of performance improvement" (Brinkerhoff 2004, 375). In my observation the external policy required by the Malawian Nurses and Midwives Council is being followed while the internal policy of regular performance evaluations is inconsistently applied. This confirms the observations by both Cleary and Brinkerhoff that external accountability is a stronger motivator.

My research found that there is some level of accountability in the Malawian culture in the community in which good behavior is rewarded and the extended family or community structure helps provide resolution for conflicts that occur. Even though the concept of accountability seems to be understood, the community lacks effective infrastructure to bring someone to justice, as in the example of the theft of money from the Malamulo Secondary School. Perhaps this reflects Malawi's low score of 31 on the Corruption Perception Index[1] (Transparency International 2016). According to this scale, national corruption, defined as "the abuse of entrusted power for private gain," is quite rampant and so could relate to a lack of consequences in holding someone accountable.

I am not suggesting that Malamulo Hospital is participating in corruption from the leadership but rather pointing out the challenge of operating an organization in the midst

[1] Annual ranking of countries from 0 (highly corrupt) to 100 (very clean).

of a culture where the concept of accountability seems to be understood but not consistently enforced. Especially within the day-to-day activities and work performance, there seems to be less urgency and consistency in holding people to the expected behavior, and this could be reflecting the high score on perception of national corruption. At the hospital, egregious cases—such as a theft in which the employee is found stealing—will lead to termination of employment, as this seems to be expected and supported by the community. For example, the business manager of Malamulo Hospital shared a recent example where a trusted cashier had recently been fired for stealing over a long period of time (ACC 9/15/15). However, if a theft occurs and the person is not caught, as in the example of the Secondary School, there is no infrastructure or legal resources for investigating the case and enforcing sanctions. Less serious issues such as tardiness or absence do not seem to carry the same level of accountability or consequences and leaders have a harder time enforcing these. In addition, managers showed a hesitancy to hold accountable people in other departments, which indicates that the culture of the organization was distrustful and competitive among leaders.

In my interviews and focus groups I asked participants if they had any suggestions for the current system of employee evaluation. People did not suggest any changes to the current method, although they agreed it should be in place and discipline was necessary. I can draw three conclusions from this: (1) most people had not experienced anything different from which they could offer suggestions, (2) the current process was working effectively and there was no need to change, or (3) they did not want to suggest anything different for fear of disagreeing with the administration who had put the process in place. Proving any of these conclusions is difficult, but they are possible reasons that concrete changes were not suggested.

The area of accountability is closely tied to the relationships between people, including trust, communication, and the perception that the organization exists to serve

the needs of people, as described in the HR Frame from Bolman and Deal (2008) It seems that any changes to the current discipline process would need to come from leadership in order to be consistent and enforced due to the high Power Distance cultural dimension. Utilizing the framework from the human resource perspective could be key in this area. Now I will turn to motivation, which is also closely related to the HR Frame, and consider how culture plays a part.

Motivation

One definition of motivation is "a driving force or state of need deficiency which inclines a person to behave in a particular manner, or to develop a capacity for certain types of behavior" (Blunt and Jones 1992, 277). As described earlier, two studies attempted to identify sources of motivation for health workers in sub-Saharan Africa. Jesse Greenspan et al. (2013, 100) identified four levels of motivation: individual, family, community, and organizational. The second study was conducted in Kenya (Mbindyo et al. 2009), and the researchers found three levels of motivation: personal, organizational, and national. There is some overlap between these two studies specifically related to organizational factors of motivation. I will address the organizational culture and structural areas in the next section.

In my data collection, a few staff reported intrinsic motivation—the satisfaction they receive from making an urgent decision which resulted in saving lives through performing a cesarean section or taking care of a patient as they would want to be treated (CO1 9/3/15). Another staff member commented "I wouldn't say I'm motivated by anything around but I always feel good when I'm doing the work of God, that's my motivation most times" (NMT 9/13/15). Others mentioned how relationships with their coworkers or superiors both positively and negatively affected their performance and motivation. Cleary, Molyneux, and Gilson confirm that the "professional identity" of a

health worker with a desire to help those in need and a calling "around the 'mission' of care could be a powerful motivator" (2013, 7).

In contrast to internal motivation, the literature points out organizational or community influences that provide motivation. One aspect of the organization is the management style, which is closely tied to the culture of origin and the expectations of the local culture. Cleary, Molyneux, and Gilson refer to hierarchical management styles, which can be transmitted throughout the organization. The authors note, "while hierarchical management styles were sometimes associated with low health worker motivation, a team based organisational culture and trust in management was found to be beneficial for motivation" (2013, 7). Malawi would be considered a culture where hierarchical management is accepted, as confirmed by their relatively high PDI score of 70 (out of 100). It could be concluded that low motivation that I observed in the data could be related to the hierarchical management style, which is commonly found in the Malawian culture. The uniqueness is that the CEO and some other leaders are from the United States so they may have adopted a hierarchical (high Power Distance) approach subconsciously because of the surrounding cultural influences and expectations.

Before I move further into organizational culture and structure, I want to note that the findings from the literature as well as the data I collected did not indicate that financial rewards were the biggest motivator for workers. In fact, multiple forms of motivation were cited by the people I interviewed as well as by the two studies above. Jackson makes the important point that reward systems should tie to the values of the managers or employees. "A lack of congruence between management systems and value systems may often imply inappropriate management system . . . and a lack of motivation" (2004, 117). Cleary and colleagues address values from a different perspective and suggest an important linkage between values, attitudes, and resources—all of these aspects need to be considered in accountability mechanisms (Cleary, Molyneux, and

Gilson 2013, 8–9). One of the important values of the Malawian culture is relationships, based on the fact that Malawi rates low on the Individualism scale (30 out of 100), indicating high Collectivism, according to Hofstede (2010) (see figure 1). The data I collected showed the importance of relationships interwoven throughout, which further confirms the centrality of interpersonal connections and relationships. Understanding the connection between the cultural value of relationships and realizing that motivation should be based on values leads me to see the importance of relationships as key to employee motivation at Malamulo.

In table 2 I listed several examples of employee motivation initiatives that had been tried as well as additional suggestions from the employees, and several are relationship based, including social activities and public recognition of "best worker." In my data collection I found the topic of relationships developed as a subtheme with at least eleven different people bringing it up (approximately 20%) in both negative and positive examples. It thus seemed to be an area that management could focus on. Cleary et al. cite a study in Ghana that suggested that good working relationships, a shared understanding and commitment to the mission, and a hands-on supportive management style "were seen to be protective of motivational levels despite other demotivating factors" (Cleary, Molyneux, and Gilson 2013, 7). By focusing on relationship, Malamulo may also offset other demotivating factors that they cannot control. Again I come back to the HR Frame from Bolman and Deal, which seems to fit the felt need of a relationship-focused organizational culture. As I show from several angles, relationships are the core of the fabric of the culture.

Cross-cultural Management

The quality of relationships and trust in management relates directly to cross-cultural management, another area also closely tied to motivation. Malamulo Hospital has

a unique challenge in the majority of the staff being Malawian while the management team is from a variety of backgrounds (see appendix C). Not only do the managers need to develop relationships with the Malawian staff, but they also need to have healthy relationships with each other. Some of the data I collected from staff and leaders indicated that teamwork, trust, and collaboration horizontally between managers and vertically between staff and management might have been damaged over time. One staff member that I interviewed desired to have direct supervision and to have their manager involved and actively checking the work. The person reported that this would be a real motivator for them (NMT 9/13/15).

Relationships are a recurring theme across the findings and necessary to survive in a place like Malawi. In developing countries, "interdependence in a trusting relationship serves a critical role to reduce uncertainties . . . harmony within the group is preserved at all costs" (Aycan 2006, 407). The interdependence creates networks through relatives, friends, and other connections that create in-groups that provide support and a network for living. The in-groups and out-groups may be something that someone from another culture may not be aware of, and misunderstandings could occur if preference is given or if relationships are not considered in management decisions. The difference in cultural understandings of the role of relationships could be a key factor in developing an organizational culture of motivated employees.

Based on the fact that Malawi has a community-oriented culture, it makes sense that relationships would be very important in and will affect management. For example, the relationship that an employee has with the supervisor influences their motivation to perform well. Mbindyo et al. state that "good working relationships between cadres also enhance worker motivation" (2009). This is a difficult scenario in the Malamulo mission community because people live, work, worship, and learn with the same people on one campus, and maintaining boundaries is important. One staff member pointed out that

"people should be friends but familiarity is not necessary. . . . people should recognize relationship at home and relationship at the workplace which is a very different thing altogether" (NMT 9/13/15). This person added that they did not feel leadership had addressed boundaries or discussed them with the staff. The administrative focus group included a discussion of the "extent of friendships or boundaries," but they agreed "to have friends is something very much important in an institution" (FG1 "Mandimu" 8/27/15). I did not observe intentional comments from administration about boundaries to the staff, although both AHI-AdCom and staff acknowledged the issue.

Several places in the data I collected discussed communication methods related to motivation. Communication is closely related to relationships, and people connected feelings and emotions to these interactions in my observation. At least eight people mentioned relationships in the context of discipline or conflicts, and these references were primarily from staff, using negative words such as "scold," "frustrations," "fear," and "depression." As mentioned earlier, Lingenfelter emphasizes "building trust in a community of two or more cultures" (2008, 20) as a key aspect of cross-cultural leadership. Trust is based on relationships and communication plays a major part in developing those relationships. These observations tie in as well with Hofstede's dimensions, especially related to Power Distance and Collectivism, both areas in which Malawi ranks high.

Pluedemann (2009, 77–84) connects communication and context in cross-cultural leadership settings and also refers to Edward Hall's High- vs. Low-Context communication. "Low-context" communication means that people pay more attention to what is specifically said rather than interpreting through the context, creating a small pool of meaning. In contrast "high-context" means that everything has significance: atmosphere, sounds, smells, and body language contribute to the communication process, creating a large pool of meaning. Meyer explains this from a historical and cultural

perspective and indicates that countries with a strong oral tradition tend to be high context (2014, 58)—countries such as Asia and Africa with a long shared history, historically based on an oral culture and tradition. In contrast, the United States is at the extreme end of the low-context communication spectrum. "Low-context communication can seem cold and uncaring to people in high-context cultures, and high-context communication can seem baffling or even dishonest to idea-oriented people" (Plueddemann 2009, 79). As Meyer suggests, in multicultural collaborations where you may have a mixture of high-/low-communication cultures, the basic rule is "multicultural teams need low-context processes" (2014, 55). This means that at Malamulo communication should be clear with few assumptions about understandings or messages.

There is no denying that Western management principles and communication styles have spread throughout the world, including in Africa and places such as Malamulo Hospital. Jackson calls this "crossvergence" of management practices between Western management and indigenous values, belief, and knowledge systems as a result of globalization (Jackson 2004, 44). Globally, communication styles have been influenced by technology and Western influence. Even the presence of job descriptions, organizational charts, and policies within Malamulo demonstrate the influence of Western forms of management that have been adopted.

The effect of globalization on the younger generations in the workforce now is also a factor in the organizational culture. With the rise of technology and access to social media, people are no longer as isolated as they once were. Jack and Westwood suggest we should "give up the notion of culture being tightly sealed around the boundaries of the nation-state" (2009, 153). This new fluidity of culture is affecting accountability in management when the younger and educated employees are calling for change in new ways because they see different methods and processes. In the interviews I conducted, one young employee in particular was concerned with discipline and wanted to see it in

place (NMT 9/13/15). In the pilot focus group, one lady discussed the influence of technology and social media on accountability in Nigeria as an example where there has been a rise in the public holding the government accountable for their actions (FG0 7/31/15). In an effort to improve safety on the Malamulo Mission campus, a WhatsApp group was set up for security issues so that anyone who had a concern could send a message to the whole group including the security guards. The influence of technology is part of globalization and providing the average person more access to information and ideas.

Research has confirmed this: "Employees in developing countries, especially the young and well-educated generation, seek more participation in the decision-making process, especially with issues that concern them" (Aycan 2006, 414). The implications of globalization on motivation and organizational culture may be a move toward an "African Renaissance," as Jackson terms the combination of indigenous methods of Africa combined with the Western methods that could work in African organizations (Jackson 2004, 27–30; see the earlier discussion in chapter 1).

Although things may be slowly changing with the rise of technology and global awareness, the data that I collected showed that communication was a concern from both staff and management at the hospital. Given the different cultures represented within Malamulo Hospital as an organization, taking low- vs. high-context into consideration to intentionally address improved communication methods would be beneficial. Leadership may do well to involve the younger generation of employees; considering their input may also bring added loyalty and motivation to the workforce.

To summarize the analysis of the data along with the literature, I found that the values of a culture and organization are key to motivation and management and likely the core of the issues that Malamulo is facing. Figure 9 shows how the key values that have been discussed above build on each other like concentric circles, where relationships

form the core that all others build upon. When relationships are the focus, efforts to communicate effectively can follow. Communication builds trust, which in turn provides the motivation that is needed for a healthy organization. If these steps are approached with a concern for the culture and how different cultures perceive the efforts that are being made, it will lead to more effective cross-cultural management and motivated employees. Just as the outer layer of an onion does not hold its shape without the inner layers, the same with motivation, which will not be effective unless the core areas are attended to first. These concepts are difficult to extract separately because they seem to all be interconnected. Moreover, there are more values than just relationships and community, but through the illustration in figure 9 a pattern for strengthening the organization starts to come into focus. Holding this model in mind, I am going to discuss organizational culture and the implications from the data.

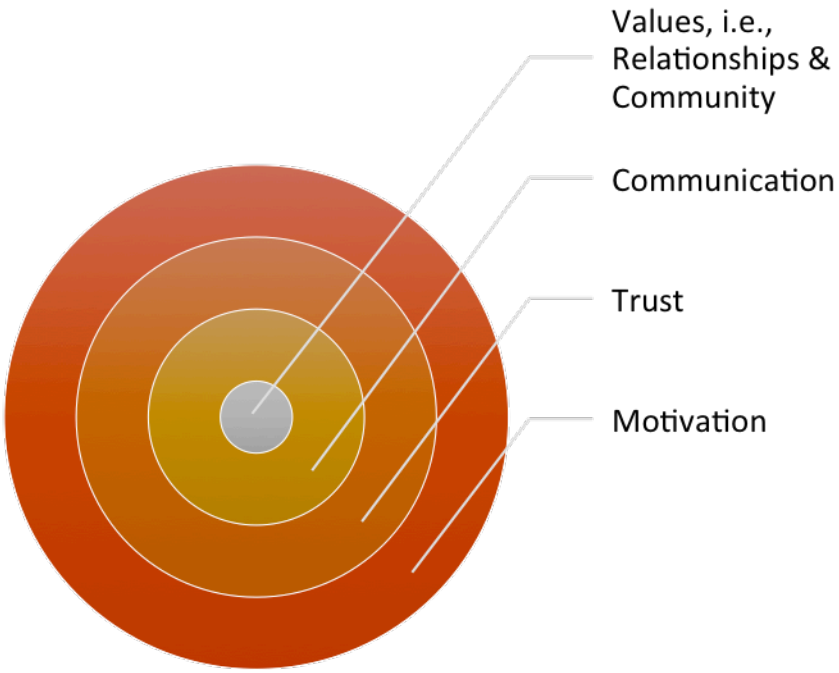

Figure 9: Values-Centered Cross-cultural Management

Organizational Culture

Though I have already touched briefly on organizational culture and its impact on motivation, now I will address it in more depth. The national culture and values of the leaders will influence the culture of the organization because leaders transmit and establish the culture of the organization through their actions, what is measured, how they react, and how they allocate resources (Schein 2010, 236). Thus, the culture of the organization is also influenced by the national cultures of the people in management positions. Since organizational culture is so tied to the leader(s) and their culture(s) I want to analyze it further.

In my interviews and observations, the culture of the organization started to surface as the overarching concern that affected everything else, such as accountability, motivation, management, and communication. Bolman and Deal's (2008) Four Frames and Trebesch's (2015) ECO model are helpful to analyze the various aspects of the culture of Malamulo Hospital and serve as theoretical constructs in my study. Using two of the frames—Human Resources and Symbolic—some gaps are identified in the culture within the hospital. In the case of the Human Resources Frame, which focuses on people and relationships, the following areas are concerns:

- Inconsistencies in applying the performance evaluation process across departments
- The high number of negative comments in the data describing interpersonal relationships between staff and management
- Lack of trust and communication among leaders
- Lack of a hospital-wide orientation process

The Symbolic Frame focuses on the use of traditions, rituals, celebrations, and symbols to reinforce the culture of the organization. Although Malawi is traditionally an oral culture where tradition is very important there are gaps in the hospital's culture related to the use of symbols. Examples include the following:

- A lack of rewards or symbolic gestures used to motivate employees has been noted.
- Mission, Vision, Values statements, though posted within the building and on documents such as performance reviews, are not reflected in, for example, employee reviews.
- Stories of important historical figures such as Dr. Jack Harvey[2] are not frequently told or featured in a prominent place.
- Few instances of intentionally celebrating and honoring behavior that leadership wants to encourage are evident.

Like the frames, the ECO model is also useful to analyze the findings at Malamulo Hospital (see figure 7). Each of the circles in the model is interconnected, with different aspects on opposite sides of the circles. For example, when I was interviewing employees, their experiences, both positive and negative, were indicative of the organizational dynamics of the hospital. Likewise, the faith assumptions of the hospital inform the values, but as pointed out above, the symbolic importance of seeing those values in place is missing. The basis of the ECO model is flourishing relationships that create healthy organizations, modeled after the Trinity. "Because we're created in God's image—the Triune God, three persons united in one—we flourish when we connect, when we experience deep relationships" (Trebesch 2015, 43). As observed earlier (see figure 9), relationships form the core of the culture and establish the foundation of effective cross-cultural management and motivation.

The ECO model (figure 7) can be compared to the interconnected structure suggested by Cleary et al. in figure 10 in which values, attitudes, and resources are interlocking like gears to influence the accountability process. Attitudes, values, and

[2] Dr. Jack Harvey, called the "flying doctor," was a pilot and physician based at Malamulo Hospital in the 1960s who flew to villages without a physician and treated the people there. In December 1973 he died in a plane crash and is buried at the Malamulo missionary cemetery. There is a small photo of him and his airplane on the back wall of a meeting room at the hospital without any explanation (http://documents.adventistarchives.org/Periodicals/RH/RH19750710-V152-28.pdf).

resources are key components of the organizational culture that directly affect the accountability process.

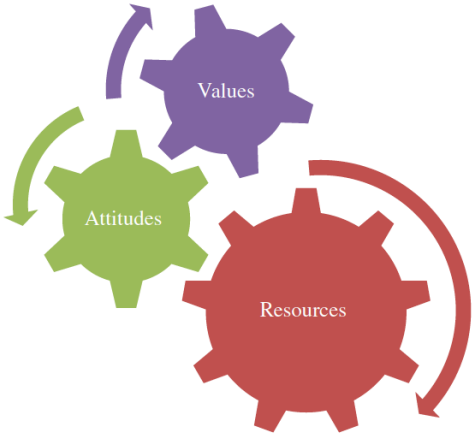

Figure 10: Factors Influencing the Functioning of Accountability Mechanisms
(Cleary, Molyneux, and Gilson 2013, 9)

I suggest that the focus should be on the culture of the hospital in order to make a lasting difference in the accountability and motivational practices for the employees. In summarizing this analysis, I will now turn to the potential areas where, based on my research, attention could bring a positive change.

Soft Spots for Change

The process of analyzing the data in light of the literature and the theoretical constructs have led me to focus on three areas in which to provide training for the hospital managers in order to bring change to the organizational culture of the hospital: (1) relationship strengthening and the impact on management, including strengths and weaknesses, (2) exploring how symbolic practices can support the goals of the hospital, and (3) communication and self-awareness of cultural differences. These three areas

overlap to some degree, as they all fall under the heading of "organizational culture." Addressing the overarching culture of the organization seems to be the best "soft spot for change" that would address the initial areas of concern that I had, such as the employee evaluation process or motivational methods. Unless the overall culture is addressed, the policies would either not be followed or not have the desired impact.

To summarize the identified areas for training, I am first concerned about the relationships at Malamulo. Since the Malawian culture is community based, the state of relationships coming up so frequently in my data, as well as in my own experiences and observations, documents a recognized gap and felt need related to human resources and flourishing relationships. Addressing it could strengthen the whole organization. Cultural differences contribute to the challenges of transparent, honest relationships and to their divergent meanings for each person, so understanding the implications of culture should be given careful attention. The technical skills of discipline, performance evaluation, and management do not seem to be the issue, but rather the quality of relationships, which make up a large part of the organizational culture, as illustrated in figure 11.

Next, the Symbolic Frame (Bolman and Deal) provides a rich connection to the Malawian culture that is not being utilized to communicate, strengthen, and build the organizational culture of the hospital. When the relationships and focus on the people in the hospital is addressed, stories, proverbs, pictures, and other symbols that make sense in the Malawian culture continue to strengthen the hospital culture.

Finally, and relating to the first two, the third area of focus is communication and self-awareness around cultural differences. Connected to the value and importance of the people of the organization, communication becomes a key tool, which must be done with cultural awareness. An important part of the process requires the management and staff to be aware of their own culture and that of others around them and how those differences affect each one's expectations.

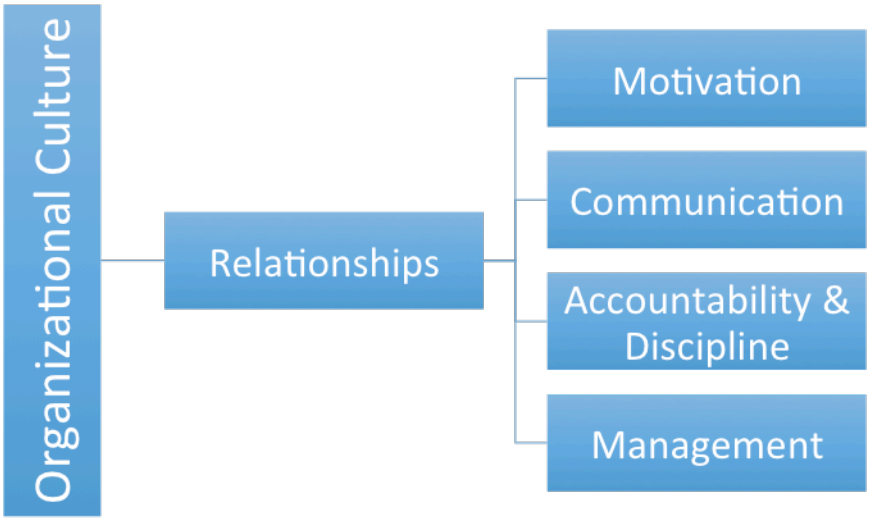

Figure 11: Centrality of Relationships to Organizational Culture

In order to pilot these concepts to strengthen Malamulo Hospital, I organized and led a two-day management-training workshop in October of 2016. The next chapter will describe that process and the lessons that I gained from the experience, as well as additional opportunities that have opened since then.

Part III

Application

The analysis of the data has clearly shown that relationships lie at the center of the Malawian culture and must be the core focus for any change project within Malamulo Hospital. This final section will show the practical purpose of the research findings within the context of Malamulo Hospital and how cross-cultural management competencies can be strengthened and implemented in other mission hospital contexts. In chapter 7, I will address the application question by describing a workshop model that I piloted in order to employ the research in the Malamulo context. I will also describe lessons learned through that pilot process. In chapter 8, I will provide recommendations for the hospital, AHI, the field of missiology, and the related literature. I will also share how this research process has impacted me personally. In the conclusion, I summarize how I have answered my initial research questions and fulfilled my goals for this research project. I will also share some ideas for future research that would build off of this work.

Chapter 7

Pilot Implementation and Outcomes

"If you want to go fast, go alone. If you want to go far, go together."
– African Proverb

In the implementation of my research findings I have attempted to answer the application question: "What culturally sensitive model can be developed to increase employee accountability within the organizational culture and strengthen cross-cultural management capacity at Malamulo Hospital?" In order to answer this question, I led a two-day pilot workshop for eleven leaders from the Malawian SDA healthcare institutions and the health sciences college. It was held in Loma Linda, California, and expanded beyond just the management of Malamulo Hospital. I focused on the three "soft spots" noted in chapter 6 and learned valuable lessons through the experience. This chapter will describe the planning and design of the pilot workshop, the delivery of the material, and the lessons learned through the entire process.

Choice of Pilot Method

I chose to pilot a workshop model to address the findings from my research and start to make a difference at Malamulo Hospital. In the analysis of the research findings, the management structure, and the organizational culture, I observed that strengthening relationships was a key area of focus, which would affect the culture of the organization. As noted in figure 11, organizational culture is filtered into processes through relationships. In order to affect the management practices I would need to consider the

relationships in order to convey and strengthen the desired organizational culture. A workshop setting could provide a place to discuss topics and facilitate connections between the participants. Schein states that organizational culture comes from three sources "1) the beliefs, values, and assumptions of founders of organizations; 2) the learning experiences of group members as their organization evolves; and 3) new beliefs, values, and assumptions brought in by new members and new leaders" (2010, 219). In the workshop I focused on the second source: learning experiences of group members. The culture of the organization must be intentionally considered and addressed by the leaders who develop their own relationships as a team in order to strengthen the organization. Since Malamulo Hospital is an old organization with many changes in leadership over the years, the current leaders may find that they need to be intentional about creating new learning experiences if any changes are to come about.

Additionally, Lingenfelter and Plueddemann suggest that cultural implications are often not considered in approaches to cross-cultural leadership from a mission perspective. They show how power plays an important role in culture within these settings, especially within the subcultures of religious groups (Plueddemann 2009, 96–97, 103–6; Lingenfelter 2008, 92–94). Power and culture affect everything, which contributes to building relationships through dialogue, and so acknowledging the issues of power and culture are key to cross-cultural leadership where a "community of trust" (Lingenfelter 2008, 21) can be developed. I felt that holding a workshop could be a small step toward building trust across the community.

The leaders of Malamulo Hospital agreed that a two-day workshop to address the organizational culture would be helpful and appropriate. This setting would facilitate further relationship building as well as provide a chance to focus on concepts that might strengthen the organizational culture and address the issues that arose in my research.

The themes from the data on organizational structure and culture, cross-cultural management and accountability led me to consider the theoretical constructs of Bolman and Deal's Four Frames and the ECO model, as well as some aspects of Hofstede's cultural dimensions as the core content for the workshop. These theories and concepts, applied to the Malamulo Hospital context, provided a basis for dialogue and conversation.

Context of the Workshop

The leaders of Malamulo Hospital were my primary focus for the workshop; however, the timing was such that LLUH planned to sponsor the leaders of all of the Malawian healthcare organizations and the Malamulo College of Health Sciences to attend a large Global Healthcare Conference on the campus of LLUH in October of 2016. I had the option of holding the workshop immediately after the conference, or traveling to Malawi and organizing a training workshop for Malamulo Hospital management only. If I held the workshop directly after the larger conference I would be able to include the other Malawian leaders. The downside was that there were only two or three representatives from each institution rather than a large group just from Malamulo Hospital.

A benefit to expanding the workshop was that it would build relationships across the healthcare network in Malawi, as well as share the training with more people within the same healthcare and cultural context. Another important factor that supported the expanded participation is that the AHI Malawi board of directors had been encouraging the institutions to work together as a "health system" across the country. This would mean standardized policies, sharing medical expertise as needed, and eventually sharing financial resources to manage a system. Holding a joint leadership workshop was a small step toward encouraging the leaders to work together creating a "health system." After

considering all of the implications and dialoguing with the CEO of Malamulo Hospital, we agreed that a two-day workshop immediately after the larger conference in Loma Linda, California, including the representatives from across Malawi, would be a good arrangement.

In addition, at the board meeting in November of 2016 soon after the workshop, the CEO of Malamulo Hospital was given the added title of country director for AHI, which was another step toward a system structure to manage the Adventist healthcare network in Malawi.[1] Although the "systems approach" was not part of my initial change project, I felt that the findings from the field research would be applicable to the broader audience and could indeed start to create relationships on which to build a healthcare system.

The group who participated was made up of eleven people plus myself: seven Malawians, one Brazilian, and three Americans. It was a mixture of CEOs, human resource (HR) managers, business managers, physicians, clinical officers, and nurses from the five Malawian organizations. Two American surgeons who work in Malawi attended the larger conference, but they did not stay for the additional two days due to overlap with a different conference. The mixture of professions was helpful to have various perspectives related to the content. The HR managers were particularly important because their work focuses on the employees and they play an important role in accountability and relationships within the organizations.

The other Malawian SDA health facilities are Blantyre Adventist Hospital, a small urban facility; Adventist Health Services, a network of seventeen clinics managed by one office in Blantyre; Adventist Health Center – Lilongwe, a dental and medical clinic in the capital city; and Malamulo College of Health Sciences, a training college on

[1] Part of creating a "system" is to have a unified board of directors, which was already in place. However, the unified policies and other standardizations have not taken place. The individual SDA health entities in Malawi have not historically worked closely and there has been some competition at times.

the same campus as Malamulo Hospital training health professionals. All of these make up the Adventist healthcare network in Malawi, and they come under the oversight of the Malawi Union Conference of Seventh-day Adventists and the AHI Malawi board of directors.[2]

The expansion to the other three facilities and college in Malawi was approved by the IRB[3] and travel arrangements were made for the participants to stay an additional two days. I was able to hold the workshop in a classroom on the LLUH campus and the additional cost of lodging, food, and supplies was covered by a grant from the LLU School of Public Health.

Workshop Overview

Following an overview of the design of the workshop, I will outline the three main learning outcomes and how they were implemented. I will show how the content of the workshop tied to my research findings and how the workshop content proved to be relevant for the participants.

While planning the workshop I followed Vella's seven-step process of "who, why, when, where, what, what for, and how" in order to have an effective learning session (2008, 32). The "who" that would attend has been discussed above and was somewhat determined by the larger conference invitees, which also answered the "when" question posed by Vella. The logistical arrangements and funding identified the participants as those attending the LLUH conference in California and by extension my workshop. If I were to have held the workshop in Malawi I would have invited additional leaders from each organization to more fully represent the administrative teams. For the

[2] Malamulo College of Health Sciences is not technically part of AHI but rather reports directly to a separate board of directors and the Malawi Union Conference of SDAs. In the past the hospital and college were managed jointly with one AdCom until the late 90s when they were separated due to financial reasons. Since they are on the same campus and share resources there is some interest in collaboration.

[3] See the modified consent form in appendix F.

purposes of a pilot, the eleven participants was a good selection to represent each institution.

Based on my research of the literature and the data I collected, I felt strongly that a discussion of national culture should be part of the workshop in order to develop self-awareness—in addition to discussion of the organizational culture that impacted accountability. I incorporated a discussion of two of Hofstede's cultural dimensions as a way to consider some primary aspects of cultural differences (see discussion in chapter 1 and figure 1).

I structured the two days around three learning outcomes that I developed from my data and that tied to the HR and Symbolic Frames (Bolman and Deal 2008), Hofstede's Cultural Dimensions (2010), and the ECO model (Trebesch 2015)—the application described in chapter 3. After I identified the learning outcomes related to the theories, I identified learning tasks that could be done during the workshop to learn or illustrate that theory in order for the participants to learn the intended outcome. See appendix H for a table that summarizes the learning outcomes, theories, and tasks and also answers Vella's "what and why," questions.

To answer Vella's "how" question I will briefly describe the workshop format. I prepared a simple workbook for each day of the sessions based on the power point slides that I created so participants could take notes and complete the prompts that correlated with the discussion. I prepared slides that described the lessons and integrated case studies. On the second day when we discussed symbols, I provided large post-it paper and asked them to work in groups to draw a symbol that represented something from their hospital. This exercise was well received and illustrated the usefulness of symbols. I was able to provide a copy of Trebesch's book for each participant to serve as a resource for exploring the ECO model.

I encouraged them to ask questions and challenge each other respectfully. Holding the session at LLUH brought them completely out of their comfort zones. Schein refers to this type of setting as a "cultural island" where participants are motivated to learn, and physically removed from their work setting; facilitators define goals and rules to help participants feel safe; and the content involves talking about concrete experiences and feelings (2010, 390–91). I intentionally asked that they sit together by entity, and in most of the situations and questions I asked them to use examples from their own organization. In this way I hoped to help them develop a deeper connection with their coworker to strengthen the relationships and actually start *doing* what we were learning.

Before we started the agenda I had prepared, I asked them if they had any lingering questions from the previous Global Healthcare Conference[4] that we could address. They asked to clarify how to implement policies that do not align with governmental policies (such as terminating someone for drinking alcohol and the labor office made them pay a fine) and how to handle physicians who do not follow policies. Other Malawian-specific management questions related to the workshop were raised:

1. How do we retain good staff? What motivational methods can be used?
2. How do we attract young professionals (physicians and management professionals)?
3. How can we deal with the problem of employing relatives (policy) and recruitment options when there is a limited pool of people?

Listening to the questions they raised confirmed that the content I had planned based on my research and analysis was appropriate to their concerns. By asking them for their input I also showed respect for their experience and perspective. I was able to modify the content and address these questions on the second day of the workshop. Vella suggests that "modeling a true attitude of inquiry and learning is perhaps the most useful

[4] The focus of the Global Healthcare Conference was human resource management.

thing a teacher of adults can do" (2002, 67). Through affirming them and their competency I built trust and allowed their energy as learners to come through (2002, 33). In the evaluation survey, 9 out of 10 said that the goals of the workshop were "met," and I attribute that to my being interested and attentive to their initial questions and concerns.[5]

In order to address the concepts and outcomes that I had prepared, I described the basics of the theories and then asked application questions and presented case studies where the participants could apply these concepts. I used three main cases, two of which were shared with me during my interviews at Malamulo. These were anonymous situations or issues, but in the discussion participants agreed that they happen commonly. I used some of the "stop and think" boxes in Trebesch's book, which were helpful for dialogue questions. The participants added their own scenarios as well—both as questions and illustrations—providing a rich discussion during both days.

The importance of the workshop was emphasized by the visit of two key leaders from LLUH. Dr. Richard Hart, president of AHI and LLUH, came the first day and to morning worship; and the second day Dr. Helen Hopp Marshak, dean of the School of Public Health,[6] stopped by to greet the group and say a few words. It was culturally significant to have these leaders visit and demonstrate their support visibly to the group.

Logistical details such as room, food, and location worked well. The classroom was well equipped with technology and sufficient space. I was able to serve tea, water, and snacks in the room for the participants. The lunches were provided on the first floor in the dining area of the building and catered by LLUH Dining Services.

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[5] The remaining one said "somewhat met." Note that no one marked "goals exceeded." Also note that only 10 participants completed the survey since one person only attended the first day.

[6] The School of Public Health is where I am employed, and they also paid for half of the expenses for the research.

Analysis of Learning Outcomes

In order to describe the results of the learning outcomes, I have listed each outcome below and the theory, activities, and discussion that addressed this outcome during the workshop. These sections are an expansion of appendix H. After the discussion of the learning outcomes, I will describe five lessons that I have learned through the pilot workshop project.

Outcome 1

Gain understanding of cultural dimensions in order to strengthen relationships between people at the hospitals and between organizations to encourage open communication

One of the main themes and purposes of this workshop was building relationships between the leaders within their own organizations. As a side benefit, spending time with their sister healthcare entities in Malawi could develop relationships beyond their own institution. According to my analysis of the research findings, the relationships people held seemed to be the foundation for the organizational culture and informed the experience of employees and leaders. Topics like fairness, communication, and motivation were interwoven and related to the strength of the relationships between the leaders and the staff.

The field data indicated that focusing on developing relationships and organizational culture is very important in this initial change effort. I used the concept of "flourishing people" in the ECO model as a basis for the workshop by suggesting that people were created by God to be connected and have healthy relationships (Trebesch 2015, 33–39). When I explained the term "flourishing" to the group I asked what the local language of Chichewa equivalent would be. They agreed that *tahnze* would fit. It means the opposite of malnourished and would refer to a child who is thriving.

As we explored the ECO model and saw how everything was interconnected through loops, the participants affirmed their understanding (see figure 8 "ECO Model"). For example, I asked them to identify a "quick fix" decision that had been made at their organizations and which loops it affected (combination of the "stop and think" boxes; Trebesch 2015, 10, 26). Each pair shared an example and their examples showed clearly how the ECO model could fit into an organization and help to assess and strengthen the organizational culture. I was surprised how well this model fit into the discussion of their organizations and was excited by the interconnections the group discovered.

Flourishing organizations require flourishing relationships, which come from healthy people. As Trebesch states, "Flourishing people produce flourishing organizations" (2015, 35). When exploring healthy relationships, the topic of trust came up. I listed six ways to build trust in your team: lead by example, communicate openly, know each other personally, do not place blame, discourage cliques, and discuss trust issues (MindTools 2016). In the dialogue that followed, we explored various aspects of trust within an organization with specific questions from the participants. The discussion and enquiries addressed some questions related to hierarchy and cultural expectations. The participants were candid and honest and demonstrated to me that the group felt safe in this setting.

Building on trust, Trebesch highlights emotional intelligence as an important aspect of the way people connect with each other (2015, 39–40). To apply this concept I presented a case example in which two employees do not get along and one reports to their supervisor that the other person was "shouting" at them. How could they use Emotional Intelligence to help them solve this issue, keeping the relationships in mind? The topic of communication came up, and we explored the concepts of transparency and high- vs. low-context communication. Generally, more collectivistic countries tend to be high-context, which assumes a pool of shared meaning (Meyer 2014). It is important for

both Malawians and non-Malawians to ensure that what they mean to say is actually communicated. Moreover, one's awareness of context, culture, oneself, and the nature of the relationships affect that communication process.

After some discussion I added to the case that the person who was "shouting" was someone in authority and asked if they would therefore handle it differently. This added to the dialogue the concept of "untouchables"[7] and those whom no one will discipline (i.e., because of Power Distance). The whole group analyzed these scenarios, and although they did not find perfect solutions, the exercise of dialoguing about these issues seemed helpful, and most of the participants were actively engaged in the conversation. I encouraged the participants to talk together and decide as a group how to handle these types of concerns. If the dialogue continues it will slowly strengthen the culture. The case study and the personal experience opened the way for the discussion of culture and specifically Power Distance in various relationships.

Self-awareness overlaps with understanding cultural dimensions and personal values, on which I spent some time through Hofstede's dimensions, the Gallup *StrengthsFinder* (Rath 2007), and their cross-cultural experience during the trip to the United States for the conference. Since many of the participants were visiting the United States for the first time, they were experiencing culture shock firsthand. The concept of cross-cultural relationships was immediate and added to the understanding of why culture makes a difference. We used their personal experiences and observations in the United States to explore what people might experience going to Malawi for the first time and how the culture of the hospital and Malawi can be shared in order to ensure consistent behavior and expectations.

[7] The term "untouchables" was brought up by a participant indicating those in positions of power that could not be disciplined or reprimanded because of their position or role.

I introduced Hofstede's cultural dimensions and especially focused on Power Distance and Individualism vs. Collectivism (Hofstede 2017). We used the comparison tool online that graphs three countries side-by-side, which led to analyzing the cultural make-up of the leadership teams at the hospitals and how Power Distance may affect their communication and relationships (Hofstede, Hofstede, and Minkov 2010). The cultural dimensions gave some clarification of why there may be differences in the AdComs related to negotiation, authority, and other expectations. Several participants exclaimed, "Oh!! That's why . . ." and described a conflict or scenario that they now understood to be culturally related.

The participants had received Rath's *StrengthsFinder 2.0* (2007) during the Global Healthcare Conference. I took the opportunity to discuss their results with the group and talk about how to use something like this in leadership to build relationships with colleagues. On the second day, everyone reported their top five strengths. They were interested and excited about the potential of using the assessment with their leaders. We discussed the idea of focusing on people's strengths rather than weaknesses as a way to motivate them, and although it was a new concept, there was interest in putting it into action.[8] In the exit survey, four out of the ten participants listed focusing on strengths as something they hope to implement when they go home.

It seemed to me that the open dialogue about the implications of culture was a new experience for most of the participants. Jackson observed that there is "low articulation" of African indigenous management techniques. He clearly states that "managers need to consciously manage the dynamics of multiculturalism in order to develop strengths and synergies from these" (Jackson 2006, 455). I concur with this

[8] One of the participants, a director of HR, wrote to me about a week after getting home asking for a way for 20 of the hospital leaders to take the *StrengthsFinder* assessment. I have researched the method and the cost; however, they have not found a way to cover the expense of $300, and as of the time of writing they have not done the assessment.

observation as I found little acknowledgement of cultural implications in management when I worked in Malawi or did the field research. In the workshop the discussion confirmed that most participants had not considered the cultural implications for management. This area needs to be intentionally taught to develop cultural awareness among both Malawians and others.

Outcome 2

Identify meaningful symbolic practices that can be implemented to support the goals of the organization

In order to address this outcome, I introduced Bolman and Deal's (2008) Four Frames, giving special emphasis to the Human Resource (HR) and the Symbolic Frames. The frames are suggested "mental models" for approaching organizations. The authors say there is no one "best" frame, but rather, the best managers will be able to utilize "multiframe thinking" to align the right frame with the right scenario. The Four Frames are HR, Political, Structural, and Symbolic (Bolman and Deal 2008, 18–19) (see table 1).

Since time had already been given to the HR Frame through focus on relationships, building trust, emotional intelligence, and communication, we summarized ideas of how to invest in people, applying these concepts. Their suggestions did not really demonstrate investment in relationships or flourishing people, and we analyzed this gap. I asked how they view people in their organization, and several agreed that they consider employees as a "means to an end," which contrasts with a flourishing organization where people are valued as unique persons for who they are, relating back to the ECO model.

Interestingly, Jackson cites a study that contrasts Western and non-Western management of people, suggesting that in the West people are a resource (human resources) and in African settings people are valued for themselves (*ubuntu* from the Xhosa proverb, "people are people through other people") (Jackson, 2006, 455). If we

accept Jackson's observations, it implies that the Western management perspective had been adopted in these Malawian organizations where employees were a "means to an end." Thus, teaching the "flourishing" concept was bringing them back to a more indigenous approach to viewing people. These concepts seemed to challenge the participants' thinking, and the group had difficulty coming up with applicable ideas in order to really value the employees. I do not know the reason for this; it could be a topic for additional study or more in-depth research with this group.

Moving from the HR Frame to the Symbolic, I had observed in my research that symbols are meaningful in the Malawian culture—stories, songs, images, and tradition—and used frequently throughout the country, including health education and community accountability. It seemed to be a new concept to connect symbols with the organizational culture and, further, to consider how a new employee might learn of the meaningful message or how motivation could be gained through symbols. Using symbols to strengthen the organization and motivate employees connected well with the ECO model of a flourishing organization.

The view out the classroom window provided perfect illustrations of the Symbolic Frame. We observed several examples on the LLUH campus of symbols that illustrate stories or values that are important to LLUH, such as a sculpture of a globe and the Good Samaritan. Symbols give meaning and purpose and communicate the organization's culture and can be used as a management frame especially related to motivation and reinforcing organizational culture (Bolman and Deal 2008, 254).

In order to apply a symbolic frame, the participants were asked to work in pairs and draw on poster-paper something from their organization that is an important symbol and then describe it to the group. After each group was done we considered how the staff hear about these and how they are talked about. Some of the symbols that they referenced were not easily visible, no longer maintained, or not in place yet. A discussion proceeded

about the gaps in communicating the purpose and culture of their organizations through these symbols that are important to them. The participants suggested the symbols could be used in orientation or placed in more prominent places in the building.

Outcome 3

Define an action plan to take back to the hospital in order to implement the concepts

In order to address the issue of consistency in implementation that I observed and to ensure that concepts from the workshop made an impact in the organizations, I asked the participants what they would implement from the workshop and the responses from the final day were reported in the survey. We briefly reviewed the concepts of writing goals using the SMARTER[9] acronym (Trebesch 2015, 70), and on the survey they listed concepts they planned to implement. I did not have them develop a structured action plan because of fatigue and lack of time. See appendix E for the list of concepts they intended to apply at home as reported on the surveys.

Incorporating Our Faith into Our Management

I felt that the spiritual aspect of management was important to address; I did not add another resource or separate lesson pertaining to it, but rather tried to incorporate biblical principles throughout both days. The concept of "flourishing" is based firmly in the creation model from Genesis as well as the Trinity, who function in relationships (Trebesch 2015, 11–12, 36). Both days we started the mornings with a brief worship time. On the first day, Dr. Richard Hart shared some thoughts related to the dangers of success and used the Bible stories of Samson and Elijah as illustrations. He also

[9] SMARTER is an acronym for Specific, Measurable, Achievable, Relevant, Time Oriented, Evaluated, Reviewed (Trebesch 2015, 70).

encouraged the group to think as a system and not be focused on their own organization at the expense of the others. The second day I read the teaching of Jesus of the vine and branches (John 15:1–17) using the *lectio divina*[10] method of reflection. The exercise seemed meaningful, and almost everyone shared something that they noticed in the verses. I ended with asking them to pray for each other in groups by hospital and encouraged them to connect with one another in this way. I hoped to demonstrate integration from a spiritual perspective in management by example throughout the workshop. Based on the survey, eight out of ten felt that they had a better understanding of the role of their personal faith in leadership.

Lessons Learned from the Pilot Workshop

When I reflect, I feel that the workshop experience went well for all involved. I received very positive feedback from those who completed the survey.[11] All of the respondents said the workshop was either "very useful" or "useful" according to the survey. One person made the comment that the workshop was "fruitful and timely," and another said, "It was important to have this workshop. It has acted as an eye opener. Given us a stepping process [sic] where to start from."

Holding the workshop in Loma Linda, California, seemed to be a good choice since most of the participants were able to focus away from work and also experience a new culture, helping to form a "cultural island" (Schein 2010). The downside of the location is that it may have been helpful to have more members of the MH-AdCom present. The timing of being directly after the Global Healthcare Conference was both positive and negative: positive because we could address questions or issues that arose

[10] *Lectio Divina* is a method from the early monastic traditions for reading Scripture and praying. A passage of scripture is read slowly out loud (alone or with a group), taking note of words or phrases that stand out. The passage is read again and used to prompt prayer or reflection (http://www.ignatianspirituality.com/ignatian-prayer/the-what-how-why-of-prayer/praying-with-scripture).

[11] There was one participant who only attended day one and therefore did not complete the survey.

from the larger conference discussions and travel was covered; negative because I think fatigue was showing after being in meetings for 4–5 days in a row and because of the limitation on who could attend my workshop. Logistically everything worked well in general, but could be have been better with help. I was able to plan and organize the logistical issues ahead of time and felt prepared.

Although I am happy with the results as a pilot project, there are areas I could improve when leading this type of training in the future. I have identified five key lessons from the pilot.

First, regarding the content of the workshop, I now realize that I should have written the learning outcome statements differently. I do not feel that they perfectly matched the content that I ended up presenting. Partly this was due to the timing for submission to IRB for approval before I had solidified the workshop content. I was uncertain about how much content was appropriate for the time frame and how best to address the topics that I wanted to cover. Based on my experience with the pilot, I would be better prepared to plan the learning outcomes and content in the future.

The second aspect that could be improved is timing for the training and ensuring people are able to learn and grasp the material. Since this workshop was after another set of meetings, the participants seemed overwhelmed with material. Planning for a follow-up session after a certain amount of time would enable me to verify success at implementation and address any challenges that occurred in the process.

Third, as mentioned earlier, some key people who should have participated to add more weight and effective implementation within the organization were not present. For example, the CEO of Malamulo and the principal of the College were there, but the heads of the other three institutions were not present. The location and timing limited who could attend, but having more members of management present would have been ideal. In the future, this kind of workshop should be held with all key personnel at a location

removed enough to provide some neutral ground and at a time when all can be completely engaged.

The fourth lesson that I learned relates to the evaluation survey given at the end. The wording of the questions could have been more carefully written to provide more useful feedback and the ability to follow up. The fact was that both the outcomes and the survey were created before the content was prepared—which proved challenging.

The fifth and last point relates to logistical details such as having a scribe or assistant to take notes, help with the meal arrangements, room set-up, and general coordination. I managed to handle these on my own, but I realize that it could have run more smoothly with help, and having notes from the discussions during the session would be valuable for research and learning purposes.

On the positive side regarding the lessons learned, I felt that the theories, lessons, and cases resonated well for the participants. I used cases and examples from my research at Malamulo, and these seemed applicable to the other Malawian organizations as well. Referring to the concept of a system worked well as a backdrop to nearly every topic through the lenses of relationships, leadership, and culture as well as the implementation of the concepts we discussed. My impression of keeping "system thinking" in the background seemed to be appropriate.

The order of the design is important and should be carefully planned; I found it helpful to follow Vella's seven design steps for adult education and to pay close attention to the "who, why, when, where, what, what for, and how" questions. In the future I would follow this more closely while planning the whole workshop (Vella 2008, 31–49). I have noted that the sequence is important in order to have all parts integrated.

Everyone in the group was engaged, participated, and seemed free to discuss the specific Malawian concerns and questions. When addressing context-specific management, a smaller group seemed helpful, and I plan to recommend this model to

LLUH for future conferences. It was good that I was familiar with the culture and some of the behaviors and structures related to the country as well. The fact that I had worked with most of the participants before also established a trust and camaraderie between us that was beneficial.

In the months since the workshop I have tried to get a sense of its effectiveness: whether the concepts or progress has made a difference at the hospitals. Anecdotal feedback from a physician at Blantyre Adventist Hospital and the CEO at Malamulo indicates that the concepts did not seem to make a long-lasting impact on the organizational culture of either institution. This could be improved, as mentioned above, by holding a series of trainings or personally being located close enough to have follow-up sessions or meetings with the management. It seems that the more specific I can be in working with an organization on the challenges that they are facing and encouraging them to figure out solutions step-by-step, the more that positive changes will happen. It must, however, be based on relationships and be more than a one-time event, especially working in the Malawian culture.

Finally, I feel that this workshop started to address areas of relationships and organizational culture, and it confirmed the importance of relationships that underlie all issues impacting motivation and accountability at Malamulo according to my research findings. Many other concepts were uncovered, such as Power Distance and culture, conflict resolution, implementing policies fairly, developing a systematic approach to healthcare, and other issues that can continue to be addressed. Follow up to a workshop like this could cover these types of topics.

Summary

This chapter has described the pilot workshop project implemented to address the findings from my research regarding the importance of relationships and organizational

culture and how culture affects these areas. The two-day workshop was expanded to include leaders from other SDA healthcare organizations in Malawi, which lead to some conversations about a "health system" in Malawi. I was able to focus on the cultural dimensions, the ECO model (Trebesch 2015), and to introduce two of the four frames described by Bolman and Deal (2008) as the core content for the two days. The participants' feedback from the workshop was positive, although I have had limited follow-up since the workshop.

I have articulated several lessons that I learned through the pilot project and suggested ways that the workshop model could be improved in the future. I felt that the pilot implementation went well and I will be able to use the lessons learned in future workshops or seminars of this nature.

In the next chapter I draw out the recommendations for Malamulo Hospital, AHI, the field of missiology, and future literature or research based on the findings from my study. I will also demonstrate how some of the lessons learned are already being applied in new training opportunities. Finally, I will share how my research has impacted me personally.

Chapter 8

Recommendations and Application

You cannot pick up a pebble with one finger. –Malawian Proverb[1]

An important part of this program of study is the opportunity to apply the lessons practically in the field or relevant context. My desire is that the research I have done will make a real and lasting impact on the local communities of Malawi as well as the field of missiology through healthcare. In this chapter I want to share some recommendations for Malamulo Hospital leadership from the research and my experience based on the themes identified in chapter 5. I will also share recommendations for the administrative committee of AHI, the field of missiology, and the leadership literature in general. In conclusion, I will share some lessons learned personally through the academic doctorate program.

Immediately following my field research I wrote a summary of my preliminary observations to the hospital leaders at their request. In that brief report I suggested that the administrative team focus on "Three C's: Communication, Consistency, and Culture," and I shared some anonymous feedback from the interviews and focus groups that indicated concerns in each area. As I have analyzed the data, conducted the workshop, and reviewed the literature again, I believe that focusing on relationships is the basis of the "three C's" that I initially suggested and therefore the right direction for Malamulo. The challenge is how to effectively do this in the context of a rural mission hospital in

[1] http://www.inspirationalstories.com/proverbs/t/malawian/

southern Malawi. The following section revisits the themes and lists recommendations related to each broad area. These recommendations are primarily for Malamulo Hospital leadership, although they could be generally applied to hospitals in any cultural context as long as the cultural fit is taken into consideration. In addition to my suggestions, it is imperative that the management works as a team to develop their own ideas through internal analysis and feedback to identify what would be ideal for their specific situation and mixture of people currently working at the hospital. Following these recommendations I will address AHI, the field of missiology, and gaps in the literature.

Recommendations Related to Accountability

Two themes discussed in chapter 5 relate to accountability: "Uneven Implementation of Performance Evaluations" and "Inconsistencies in Accountability" (themes 1 and 4). I am grouping recommendations together for both themes because of the overlap in the solutions that could address both areas simultaneously.

As noted in the findings, an evaluation tool is being used, however, it is inconsistently applied. For example, in addition to the annual (or bi-annual) employee appraisal process, there is another process primarily for new nursing hires, who have an assessment done monthly for the first three months. Potential action steps to address consistency and accountability include the following:

- Review the policy for performance appraisals and identify whether the wording and timing are clear. I suggest that point 2 in the policy stating that evaluations are to be performed twice a year should be revised to once per year. The policy should also include the review process for new employees.
- Clarify the review process for new employees and extend it to all new hires (not just nursing).
- Expand the performance appraisal process to include all management and physicians (Malawian or expatriate) and long-term volunteers with their appropriate evaluation feedback forms.

- Intentionally focus on consistent implementation of the revised policies, which will require training of all supervisors and managers and timely follow-up to meet stated deadlines.

- Evaluate the policies and processes related to discipline and revise them if necessary to bring the focus to the relationships and people who are part of the hospital. Training should be done for all managers and supervisors on how to handle disciplinary situations consistently and fairly.

- Intentionally seek continual improvement related to quality patient care, including clear expectations and feedback to staff.[2]

Beyond the assessment of the hospital and the processes within the organization, steps should be taken to strengthen dialogue and relationships on the mission campus. This would include the spouses and families of employees as well as people who work in other institutions on the campus. Since people live in close proximity, both the Malawians and the ex-pats need to be given the tools necessary to build flourishing relationships. Potential action steps to include the whole campus are listed below:

- Encourage small group Bible studies throughout the campus and across institutions, partnering with the Malamulo church leaders and elders.

- Celebrate various holidays or cultural celebrations as a campus to include people who may not be familiar with them (such as Malawi Independence, Christmas, Thanksgiving, or other days).

- Plan community-wide social events such as football competitions, birthday celebrations, or outings to Lake Malawi, Mt. Mulanje, or other nearby scenic attractions.

Recommendations Related to Cross-cultural Management Complexities

Cross-cultural management really covers a wide range of areas and includes the other themes as well. In order to strengthen relationships within the hospital, the MH-AdCom should start by completing the assessment rubrics in Trebesch's *Made to*

[2] Quality in patient care is beyond the scope of this paper and my expertise, but I noted in the findings that the clinical leaders were starting processes to review cases and improve quality, which I would encourage to continue.

Flourish (2015, 183–91). Completing the rubrics as a group and discussing the findings would provide helpful overall insight on the perceptions held by the group as well as open up dialogue and build relationships. Depending on the outcomes of the overall analysis, below are some steps to address the complexities of management cross-culturally:

- Strengthen manager's self-awareness by using a tool such as *StrengthsFinder* (Rath 2007) or *Total Strengths Deployment Inventory*[3] to learn more about him or herself and how one interacts with the larger group. Increased self-awareness would provide valuable tools for communication, conflict resolution, and motivation.

- Ask staff to identify ways to improve communication and transparency with the administrative committee and then work to implement the suggested improvements.

- Provide forums designed to open conversations about culture and expectations with management; this could open the door for discussions at all levels to gain understanding.

- Celebrate culture in ways that are meaningful to the people who are there. One idea is to plan an annual cultural festival where everyone has a chance to share food, traditions, or other cultural practices with the community.

Recommendations Related to Motivation and Organizational Culture

Changing the culture of an organization does not happen with one event or a one-time effort, and it is strongly influenced by the leaders. In my observation the challenges facing Malamulo Hospital are "adaptive challenges," which "are difficult because their solutions require people to change their ways" (Heifetz, Grashow, and Linsky 2009, 69). Since the problems are based on how people interact, it will require that the people connected to the problem change with those in authority moving people to act without trying to solve the problem for them (Heifetz, Grashow, and Linsky 2009, 74). The

[3] These tools are just ideas; there could be other options that would develop awareness of their strengths and how people can work best together.

process will have to be ongoing, with measurable goals and a feedback loop in order to see strong relationships and healthy cross-cultural partnerships. Below are recommended actions that should be taken:

- Identify, with current and former staff, important stories and traditions that should be shared frequently and honored on campus, and work with a task force on specific ways to share and honor them with current and future employees.
- Design and implement a standard hospital-wide orientation that all employees must complete before beginning their duties or department-specific training.
- Incorporate the hospital's values into the employee performance appraisal form and give the opportunity to evaluate how each person puts the values into practice.
- Identify key goals that the hospital would like to achieve and then experiment with ways to motivate everyone to achieve them.
- Audit the methods, frequency, and type of communication that is happening currently and consider—from the perspective of the national and organizational culture—whether it meets the needs of the employees and management. Implement one proposal at a time that will move the organization in the direction that is more people and relationship focused.
- Expand the integration of faith into the hospital and community through things like small group Bible studies or Sabbath vespers, prayer groups or partners, or other interactive activity that strengthens the focus of sharing the gospel through healthcare.

These initiatives may require some external assistance through resources from AHI, the board of directors, or the sister institutional leaders. It may be helpful to have someone with some objectivity to facilitate these kinds of initiatives, and AHI could partner with the board or Malamulo directly to provide facilitation. Through assessment and self-awareness the leaders may realize that changes to personnel or additional training need to be implemented to ensure consistency and measureable progress. As the changes are put into place, it is vital that the management team develop a long-term plan for monitoring the successes and challenges that arise. They could use an annual focus

group session, survey, or open forums to get feedback on the initiatives that have been started and where to improve.

The central issue is the importance of relationships, and this focus should be kept in mind when modifying policies, implementing new processes, or considering feedback. Bringing change to an organization is a challenging and often slow process that requires listening, creating a "guiding coalition," patience, taking small steps, and celebrating along the way (Kotter 2012).[4]

Recommendations for Adventist Health International

This case study of Malamulo Hospital is bounded by their specific context and location as a single organization, but as a case study, the themes can be applied to other mission hospitals (Creswell 2013, 98–99). Each of the hospitals that are part of AHI is at a different point of operational maturity, and some may not be ready to address the cross-cultural or organizational culture yet. In some cases the hospitals are working from one crisis to the next trying to stay open; in other cases they are just getting started and still trying to find a niche for their services. However, many hospitals are established and fairly stable and may be ready to take some time to assess their organizational culture and develop capacity in the leaders for effective cross-cultural relationships.

Given my findings, the cultural influence on management should be understood as central in any effort to develop management capacity within the AHI network. Although AHI provides some cross-cultural training for volunteers, it is not consistent, and I believe extra emphasis should be given to those in key leadership positions (such as CEOs, physicians, and country directors) to ensure that they have the resources they need to navigate the challenges related to cross-cultural management, especially in the unique

[4] More in-depth resources about the change process are available, such as Kotter's "A Sense of Urgency" (Kotter 2008) or Bridges's "Managing Transitions" (Bridges 2009).

setting of healthcare. I have also seen that even if long-term missionaries have some cross-cultural training, there is also need for AHI to consider the local leaders and managers within the hospitals who receive people from other cultures. This aspect should not be neglected. Therefore it would be ideal for AHI to conduct on-site assessment and capacity training that integrates the expatriates with the local staff or managers.

Recently, AHI has also received a request specifically related to Malamulo that confirms my focus on the importance of relationships. A request came to the board for a leadership evaluation processes including ways to do performance evaluations with the expatriate physicians and leaders at Malamulo. I have participated in discussions related to this issue due to my experience and research at Malamulo. The concerns have implications for cross-cultural management, as well as underscoring the value of relationship building. There could also be unspoken racial and cultural tensions that are prompting these requests since it is perceived that the foreigners are not accountable. These requests are in the process of being addressed by the AHI Malawi board, which will take place in November 2017, and I have recommended some self-awareness processes for everyone in management (not just particular people) and maintaining an emphasis on the relationships.

Even though it may be difficult to identify all of the reasons prompting this type of request, it is clear to me that AHI's strategy needs careful and intentional effort in addressing these organizational culture issues and in focusing on how people and relationships are valued and central to the institutions, including consistency in implementing policies and other related issues.

A step towards this goal is for AHI leadership, through partnerships with the board of directors for each country, to outline the expectations of behavior and reporting structure to the leaders of the hospitals. When roles and expectations are clear, holding people to those expectations will follow more easily. AHI can establish basic protocols

for how administrative committees and department heads relate to the board and to the employees. Nevertheless, some situations may require specific direction that addresses unique situations at the hospital being considered, while keeping relationships as the central focus of the policies and processes.

On the hospital level, the assessment tools in Trebesch's book could be used to assess the needs of the organization and then be followed by a workshop based on the assessment findings. This method would ensure that any training would be appropriate to the needs of the hospital and provide a systematic strategy for building management capacity and provide education related to the expected performance for people in managerial positions.

As part of the AHI-AdCom, I have been able to apply the lessons from my research in another region of the world where AHI is active. Around the same time that I was conducting the workshop for Malawian leaders, an administrator from the Inter-American Division[5] of the SDA church requested that AHI and LLU develop a non-academic, workforce development healthcare leadership certificate for the hospitals in their division. I was asked to lead the effort in developing the proposal and the Healthcare Leadership Certificate program during 2017 being held in Mexico for approximately 40 hospital leaders. When developing this expanded program I based the design and some content on the short workshop that I conducted for the Malawian leaders. The certificate is longer and more in depth, with more content, but is a similar model of relationship building, self-awareness, and professional development with some discussion of cross-cultural management challenges within a faith-based healthcare context. I have applied some lessons from the pilot such as having multiple sessions with feedback and implementation time. In this way the pilot project that I did for Malawi has already influenced the efforts of AHI to expand leadership capacity in other regions of the world.

[5] This division of the SDA church covers Mexico, Central America, and the Caribbean islands.

I believe that AHI and the Adventist Church needs to invest seriously into the leaders of the hospitals in each unique context in order to sustain and grow the healthcare services that in turn provide a platform for sharing the gospel with the community. The importance of relationships should not be forgotten in the urgency to meet financial and healthcare quality obligations. As AHI moves through the regions and institutions, unique issues will arise that must be handled individually with each organization in order to ensure that the people feel heard and that their unique issues are addressed.

My recommendation for AHI-AdCom is to have a full-time employee whose focus is leadership development and support who could serve as a consultant to hospital leadership as well as hospital boards. This person would systematically work with the hospitals as they are ready to address management capacity and organizational culture. My recommended action steps for AHI and this new position are as follows:

- Prepare and implement a brief orientation or training for AHI volunteers or church employees working at an AHI hospital that focuses on the role of healthcare leadership including a section on cross-cultural management and developing the organizational culture that you desire.[6]

- Provide education to the AHI-AdCom members related to cross-cultural management, building relationships in the field, and leading projects or boards, and respond to requests as they arise.

- Set up a plan to systematically work with the leaders of each AHI organization to support them at the stage they are at and encourage open communication and healthy organizational culture. Some ideas include:

    - Utilize self-awareness assessments such as *StrengthsFinder* (Rath 2007) or *Total Strengths Deployment Inventory*[7] or "Myers-Briggs Personality Tool"[8] to build self-awareness and teamwork.

[6] The people who are employed by the SDA church as full-time missionaries are required to attend a three-week training course called "Missions Institute" that gives very helpful guidance on transitioning, building cross-cultural relationships, and general missiology. It does not focus on one particular area such as hospitals or healthcare.

[7] www.totalsdi.com

[8] www.mysersbriggs.org

    - Facilitate an assessment process using Trebesch's assessment rubrics of the six components of an organization (2015, 183–91).
    - Provide follow-up and feedback based on the outcomes and feedback after assessment.
- Develop and implement a board education plan to assist board chairs with the knowledge necessary to run a hospital board and to educate the board members related to cross-cultural management and relationship building.

With these recommendations and a strategic focus on cross-cultural management capacity, I think the hospitals within AHI will attain a new level of effective, faith-based healthcare for the communities they serve. Healthcare has an important role in missions worldwide, and my research has uncovered some applications to the field of missiology as well.

Applications for the Field of Missiology

As Christians we can point to the example of Jesus who "went throughout Galilee, teaching in their synagogues, proclaiming the good news of the kingdom, and healing every disease and sickness among the people" (Matthew 4:23 NIV). Caring about people's health and addressing their physical bodies is undeniably intertwined with the gospel. When scientific knowledge was increasing dramatically in the early nineteenth century and specialization of knowledge continued to evolve, physicians wanted to travel as missionaries to use their medical skills in foreign lands. Grundmann outlines the long and sometimes painful process of changing the philosophy of the mission boards in the early nineteenth century regarding what it meant to be a "missionary" and whether a physician fit their definition (2005). Today, healthcare is an important aspect of mission services provided by denominations and mission agencies, and it is no longer disputed as a valid form of mission. The Adventist denomination operates the largest Protestant

network of healthcare institutions.[9] With this level of presence, I believe the Adventist Church has an important role and voice to contribute to the field of missiology related to healthcare as a means of spreading the gospel.

My research brings at least two important issues to light related to missiology. First, according to my research, the impact of culture on the unique challenges of managing a mission hospital has not been addressed through the lens of missiology to a great extent. There is need for the field of missiology to consider seriously the role of healthcare in mission and provide more focus and guidance to the nuances of dealing with cultural beliefs, cross-cultural partnerships, mission leadership in healthcare, and education for future healthcare professionals who are motivated for mission and service in their own or foreign contexts.

Hospitals in resource-poor countries often do not have the luxury of recruiting and paying top-performing administrators, and sometimes management skills are not emphasized as a priority when the urgency of staying open, paying salaries, and purchasing medications is the biggest concern.[10] This focus sometimes means people with little or no management training such as physicians, chaplains, nurses, or others willing to do the task at hand are put in leadership positions. Adding an intentional focus on cross-cultural management skills in a healthcare context would add to the field of missiology by combining the spiritual and cross-cultural aspects of management with the necessary technical skills.

The second issue that my research brings to missiology is the role of healthcare as mission and future possibilities within the Adventist Church. As an organization, the

[9] Adventist Health System is the largest Protestant health system in the United States (see https://www.beckershospitalreview.com/lists-and-statistics/13-largest-non-profit-hospital-systems-by-number-of-hospitals.html). Outside the US the hospitals are overseen by the local church organization, AHI, or another form of a health system. All together there are 467 hospitals and clinics worldwide affiliated with the SDA church (General Conference of SDAs 2015, 5).

[10] I am not implying that the administration at Malamulo is not talented or capable, but rather that the urgency of few financial resources pushed the "soft" skills to a lower priority.

SDA church is responsible for the 467 hospitals and clinics providing healthcare around the world (General Conference of SDAs 2015, 5), and we need to be intentional about training, supporting, and facilitating best management practices in a cross-cultural healthcare setting. By their very nature, many of the hospitals outside the United States will have a mixture of people from various cultures. Though I realize that some cross-cultural training is available for those who move between church divisions,[11] in order to strengthen management capacity, training still needs to be provided for those in management who do not move between divisions but face similar challenges.

Based on my research, a key aspect of cross-cultural management in the African context relates to its being built upon relationships and to the need to care for people in a highly collectivistic culture. A similar need is expected to be present in other collectivistic cultures as well. If healthcare is truly part of a "mission," it cannot be divorced from the spiritual aspect of attending to the soul and sharing the gospel, as well as truly caring for the people who make up the organization. All who find themselves in a management position need to be trained and supported as they provide leadership and build relationships across or among various cultures.

I have discussed briefly the unique challenges that a hospital faces as opposed to a school, church, or other business affiliated with the church structure. There is room for additional research on the cultural impact of management in healthcare settings around the world broadly, but specifically, the intersection of faith, culture, healthcare, and management in healthcare could be strengthened from the wealth of experience within the Adventist context. As a large faith-based health system, the Adventist Church could lead the way for other faith-based health systems that are challenged by the same issues

[11] The SDA headquarters provides a 3-week training course for any official church employee who leaves their home division (13 divisions in the world) and work in another division. This is also available to long-term volunteers, and AHI has sent some through the training, including myself, but not all volunteers. However, this training is not provided if a local person serves as a hospital administrator.

of integrating faith, healthcare, and mission with effective cross-cultural management skills from a unique perspective of extensive healthcare mission experience.

Recommendations for the Literature

In the review of the literature related to my research I found a wide selection of resources related to serving the poor and health (Myers 2011, 2015; Plantak 2002), doing short-term missions well (Livermore 2013; Corbett and Fikkert 2012), and cross-cultural leadership in missions (Plueddemann 2009; Lingenfelter 2008; Trebesch 2015). I found these resources helpful on different aspects and saw overlap to some degree.

What is lacking, according to my review, are resources that combine these issues and specifically address cross-cultural management in a mission healthcare setting. I found leadership literature that addressed nonprofit organizations, churches, or schools, and some journal articles approached the organizational culture of hospitals through the lens of a grant funded or nongovernmental organizations (Cleary, Molyneux, and Gilson 2013; Kamoche et al. 2012; Capacity Development Group 2010), but I did not see resources specifically for those leading in a faith-based hospital focused on mission.

Another gap relates to the unique pressure and stress that comes to those working across cultural boundaries in a humanitarian capacity, such as in a hospital, from a perspective of missions. The perceptions of what "service" or "sacrifice" means, especially in the context of Christian mission, and how behavior is interpreted is a rich area for study that has not been fully tapped. Attention to this intersection of mission, cross-cultural management, and healthcare is a unique and vital approach that I found missing in the literature.

Personal Lessons

Several aspects of the missiology doctorate program at Fuller have affected me in profound ways. Returning to Malamulo for the research was a visit down memory lane, but with a new perspective. I spent three challenging years working as a leader there and living among the community. The years I worked in Malawi impacted me deeply and were very intense due to the heavy responsibilities and few resources I had to draw from. When conducting my research, I had the chance to reflect on my personal experiences while at Malamulo and what had changed or stayed the same since I had left, four years before.

One of my observations while revisiting my experiences was that through my research I have come to view the role of missionaries differently, and I would have been more intentional in developing personal relationships with the local people and not kept myself as isolated as I did among the other expatriates. I struggle even now with this concept because there was such a sense of finding what worked for survival—for the hospital, for my personal emotional and physical health—that I often did not have the energy to handle my relationships differently.

If it were possible to go back and do things over again, in my work I would have implemented the things I have learned related to the importance of relationships in the hospital, the centrality of symbolism to create and strengthen the culture, and intentionally looking for the valuable aspects of indigenous culture that would have helped in managing the hospital. I also would have invested more time in training and building capacity in the management team to be able to work cross-culturally.

Another lesson that I learned through my field research was intentionality in listening carefully through my new lenses as a student of culture. I was able to observe and understand nuances in what was happening and have a deeper understanding of not only the Malawian culture but also general skills of working with people across cultures.

An example of the development of my skills in this area is my being able to work with my colleagues this year to implement the leadership workshop in Mexico. I have encountered many differences between the Latino and Malawian cultures, but have been able to smoothly address issues that may have been frustrating or misunderstood in the past.

Finally, during my research visit to Malamulo, I was able to explore some painful experiences and disappointments that I had while working there. A range of emotions and feelings surfaced through conversations and time spent with people I had worked with. I found that the chance to be honest about my feelings, including the positive and negative times, to be very profound and healing. For example, while I worked at Malamulo, we faced many challenges and I struggled to do my best with what few resources and limited knowledge I had. When I was there for research, some of the stress and pressures that arose previously resurfaced and brought an emotional reaction of inadequacy and failure to meet the expectations of others. In particular, I had a conversation with one of the missionary families about their first year there, which overlapped with my last year. Their adjustment was very difficult, and feelings of my inadequacy as a leader came to the surface through their frustrations of adjusting during their first few months. Although it was difficult to encounter the emotions, I believe it was beneficial to process those feelings with the family and clarify any misunderstandings that may have lingered for both of us over the intervening years.

Beyond my time doing field research in Malawi, I grew personally through this program as well. One specific area was related to leadership and organizational culture. In 2015, my second year in the program, the LLU School of Public Health where I am faculty was completely reorganized. This was a very stressful time for me personally as I was also leading an accreditation self-study for the graduate program–level

accreditation.[12] When I was studying the leadership and organizational culture literature in year three, it was immediately applicable to my work situation and gave me some tools and skills to survive during that time. Looking back with the knowledge gained through my study, I could see some of what went wrong during the reorganization and the challenges we faced that prevented achieving program accreditation. The course material was helpful to process the changes in my work setting and helped strengthen my own leadership skills. I was able to implement some of the principles such as getting "on the balcony" (Heifetz and Linsky 2002) to observe what was happening, who was affected, and what the implications were. I was also able to see the adaptive challenges that the school is facing (Heifetz, Grashow, and Linsky 2009). Although this workplace experience was separate from my field research, it was perfectly timed for my personal development, support, and growth as a mid-level leader in my organization.

Summary

My research has illuminated a specific topic that could be a focus of further missiological study: cross-cultural management applied to healthcare settings in mission. I have provided some specific ideas and recommendations for Malamulo Hospital and AHI that are based on the themes from the research findings. National culture has a profound impact on leadership in any capacity, but attention to the intersection of healthcare, management, mission, and culture offers more insight that could be explored specifically through more research and publication. There are also opportunities within the Adventist context where training could be expanded and more intentional capacity in healthcare management developed. I have suggested a model that could be implemented in AHI to partner with hospitals and governing boards to expand this capacity.

[12] I am program director for the MBA in Healthcare Administration, and we were seeking accreditation by the Commission on Accreditation for Healthcare Management Education (CAHME), which after a year-long self-study and site visit ended up being unsuccessful.

Personally, I have learned many lessons and through my research have had the opportunity to grow and develop as a leader as well as become more equipped to work cross-culturally. Now I will move to the conclusion of this study and suggestions for future research that could grow out of this project.

Conclusion and Future Steps

As I come to the conclusion of this project, I find that it is actually not the end but a way-marker along a journey. I imagine it like a signpost where I can outline the lessons learned and how I have reached this point, but just beyond the sign there are several paths that open in different directions that will continue to build on the lessons and experiences that I have outlined so far.

In this conclusion section I will revisit my initial goal, purpose, central research issue, and research questions in light of my research and application to understand the findings. I will also discuss ideas that could be considered for future research that could build off of this project.

Purpose

The purpose of this study was to understand how culture affects accountability, organizational culture, and management capacity in the context of a SDA mission hospital in Malawi as a case study for the broader organization of AHI.

I was able to accomplish this goal by observation, semi-structured interviews, document review, and focus groups where I had the chance to get a better understanding of the national and the organizational cultures. The greatest influence on accountability and management seems to come from the culture of the organization and the focus (or lack of) on relationships, which is determined primarily by the leaders and people with influence. Rather than developing a specific tool to increase employee accountability (as I was expecting early on), I focused on the organizational culture for the change pilot

project, as organizational culture seemed to be the overarching component that flowed down into accountability and motivational practices.

Goal

The goal of this study was to strengthen the capacity of cross-cultural management and organizational culture within Adventist Health International (AHI) using Malamulo Hospital as a case study.

I piloted a two-day workshop as a method to strengthen management capacity and organizational culture throughout AHI. The workshop was conducted for the leaders of all of the SDA health facilities and training college in Malawi including Malamulo Hospital, using the themes and findings from the field research to create the content for the workshop. During this workshop we addressed the following outcomes:

1. Gain understanding of cultural dimensions in order to strengthen relationships between people at the hospitals and between organizations to encourage open communication
2. Identify meaningful symbolic practices that can be implemented to support the goals of the organization
3. Define an action plan to take back to the hospital in order to implement the concepts

The workshop was successful, but only a pilot test of one method that could be used to expand capacity. I have made recommendations to the hospital related to the five themes that arose from the research and that take into consideration the experience of the workshop and some lessons learned through that process. The recommendations relate to accountability, cross-cultural management, motivation, and organizational culture.

I have also made recommendations for AHI as an organization to take the lessons learned from Malamulo Hospital in order to inform their future plans for equipping managers and leaders in mission hospital settings. I have recommended that the focus on

relationships be a strategic area for the organization. In order to implement this recommendation they need to have a dedicated person to lead the effort and coordinate assessments and training at the hospital level.

Central Research Issue

The central research issue was to evaluate cultural and organizational factors that have shaped employee accountability and cross-cultural management capacity within Malamulo Hospital.

Although the national culture of Malawi is an important factor and should be taken into consideration, the culture of the organization is directly related to employee accountability and cross-cultural management practices. I found that the necessary tools and policies for accountability were in place, but the culture of the organization did not encourage consistent application of those policies in all departments and at all levels. The organizational culture did not seem to intentionally focus on valuing people and relationships, which in turn seemed to affect the performance and motivation of employees. The research I was able to do brought to light practices that could be implemented within the hospital that would be appropriate for the local culture and strengthen motivation and accountability, and they center on the importance of relationships. For example, when I presented the concept of the Symbolic Frame (Bolman and Deal 2008), the leaders of the hospitals were able to identify powerful stories that could be repeated to increase employee motivation to contribute to the mission of the hospital and would communicate the intended culture of the hospital.

Recommendations for Future Study

This study has opened the door for further research opportunities to better understand cross-cultural management within mission hospitals. While many directions

could be pursued, the following are a few suggestions that would build on what I have done:

- Pre and Post analysis of employee motivational levels with an intervention using the ECO model or the Four Frames theoretical constructs
- Further study of the additional two frames not addressed: Political and Structural Frames
- Further analysis and study of the four cultural dimensions of Hofstede that were not focused on, even including gathering data for Malawi related to LTO and IND, which Hofstede does not currently have available
- Further evaluation of the organizational culture of mission hospitals and deeper exploration to understand the factors that affect it
- Expansion of the research methods to other SDA healthcare facilities in Malawi to replicate or verify the data
- Guidelines and training materials for management of faith-based mission or development organizations that work in cross-cultural settings
- Greater understanding and documentation of the history of Adventist medical missions

I noted earlier that there are gaps in the literature related to the intersection of culture, healthcare, management, and mission, which needs to be filled. I believe that as an Adventist I am in a unique position to address this gap with continued study related to these topics and ways we can contribute to the field of missiology.

Final Thoughts

My research at Malamulo Hospital sought to understand the national culture and how it relates to the management of the hospital in the context of a variety of cultures and an Adventist mission setting. I feel that I was successful in my efforts and discovered the enormous importance of relationships in cross-cultural management. Beyond having the correct policies or procedures in place, people have to be valued and cared for in order

for the organization to flourish. In the pilot project I was able to use the lessons learned from the research and begin to apply them to the training for leaders from all SDA health facilities and the health sciences college in Malawi. I believe that the principles of understanding the local culture and how it relates to the organizational culture and to management can be applied to any mission hospital setting. The tools such as the ECO model or the Four Frames can be helpful or expanded upon to be used within AHI or other faith-based health systems. I have already applied some of the lessons learned to a leadership-training workshop I am leading in Mexico for the fourteen SDA hospitals in that region during 2017.

Now more than ever before, I believe that healthcare is a vital and necessary part of the *missio Dei* and an important way that God is at work in the world. I am also even more passionate about the need for effective training and equipping for those in management positions—whether local or expatriate—to be prepared to face the challenges of leading a mission hospital. I hope that my experience and research can help others to avoid some of the challenges or mistakes that I faced, and that others in turn can share their experiences—which will better equip everyone working in this important field of managing healthcare in a mission setting.

In addition to the organizational application, the research process has taught me personally how to ask good questions and observe objectively without relying on my own interpretation or experience alone, thus biasing my information. I have also gained tremendous understanding about leadership and cross-cultural management and what it takes to bring organizational change with consideration of the structure and culture in its setting. I have gained personal confidence and skills that have been helpful in my work as a faculty member at Loma Linda University and as a member of AHI's administrative committee, and these will take me to unknown destinations in the future.

Appendix A

Maps

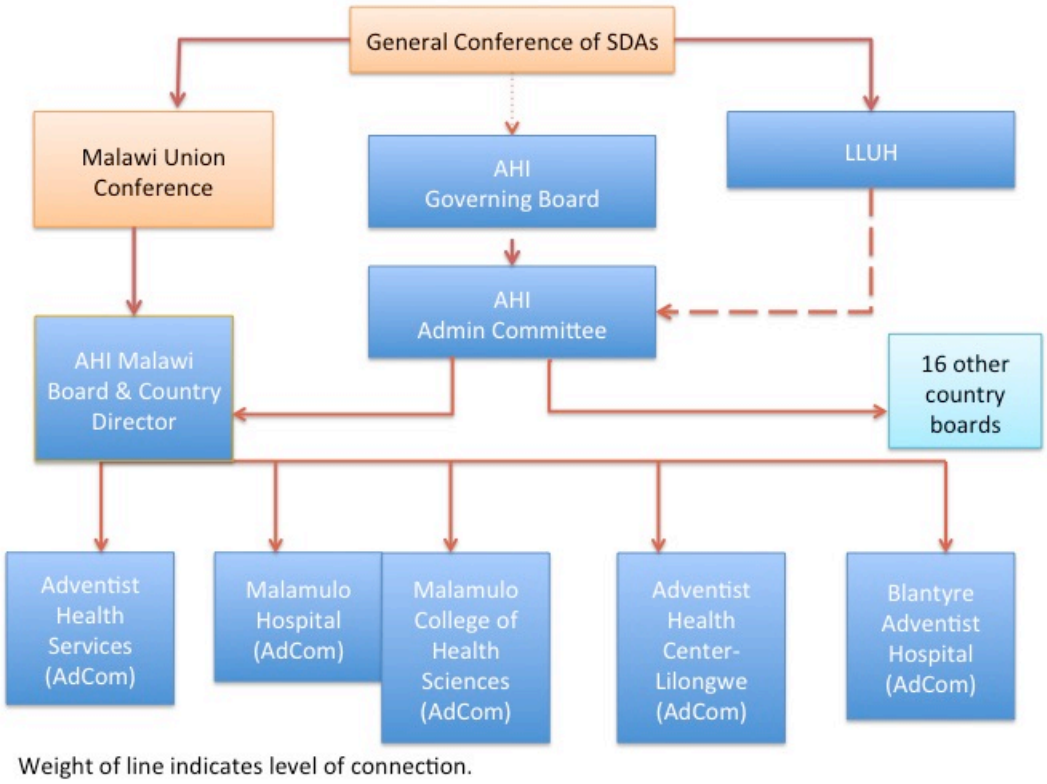
Malamulo Adventist Hospital is located in the southern region, about 60 km from Blantyre and 20 km from Thyolo. Blantyre Adventist Hospital is in the center of Blantyre, the largest city in Malawi. Adventist Health Center, Lilongwe, is in the capital city of Lilongwe.[1] There are 17 clinics scattered throughout the country managed as one system called Adventist Health Services, based in Blantyre.

[1] Africa Map: https://www.cia.gov/library/publications/the-world-factbook/docs/refmaps.html Malawi map: https://www.cia.gov/library/publications/the-world-factbook/geos/mi.html.

Appendix B

Organizational Relationships

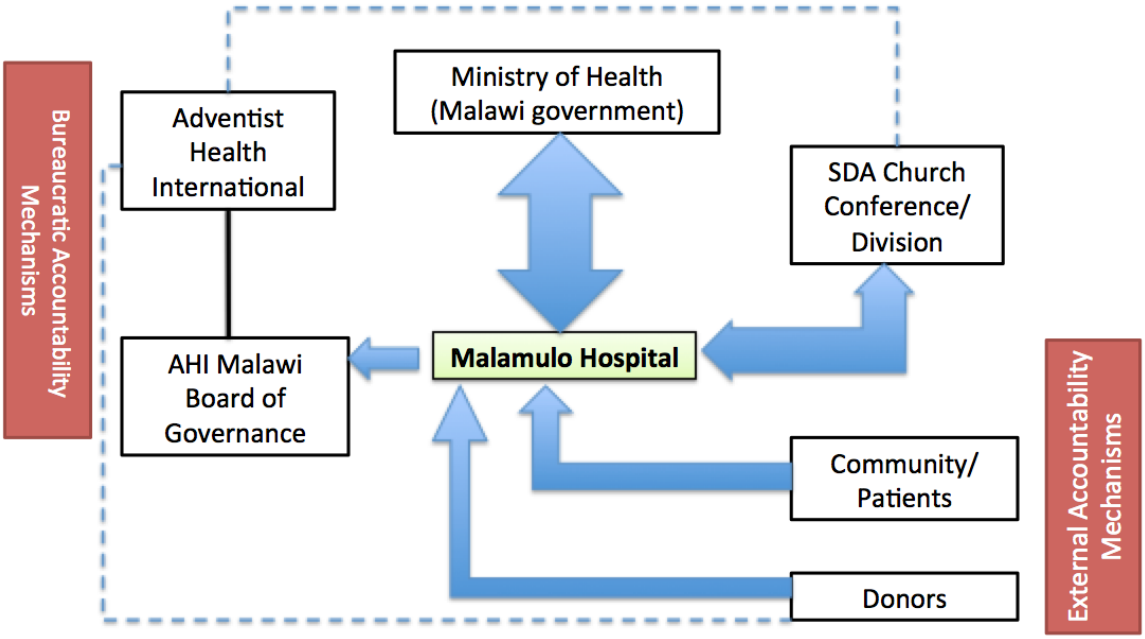
Malamulo Hospital Relationship to SDA Church Institutions



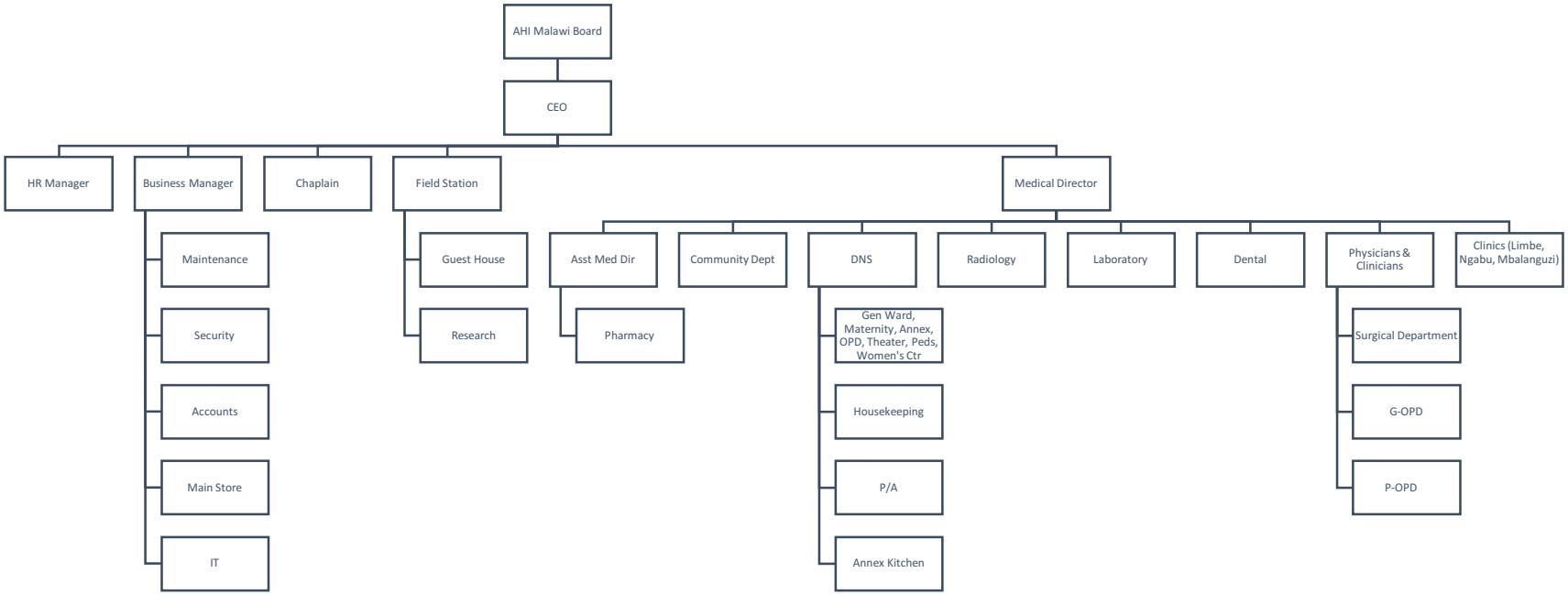
This organizational chart is an effort to visually demonstrate the structure and relationships between Malamulo Hospital, AHI, LLUH, and the General Conference of SDAs. Below is another view of the external influences, which includes the Ministry of Health in the Malawian government and external organizations or groups such as donors,

the community, etc. In both illustrations the weight and size of the arrows indicate the level of relationships.

Malamulo Hospital Relationship to External Organizations



Malamulo Hospital Organizational Chart (Nov 2017)



Appendix C

Malamulo Hospital Administrative Leadership List

As of 2015 (the time of on-site data collection)

Position	**Nationality**	**Member of AdCom? Y or N**	**Gender**	**Year Started in this Role at Malamulo**
Chief Executive Officer	American	Y	Male	Feb 2014
Chief Medical Officer	American	Y	Male	Nov 2012
Lab Director	Filipina	Y	Female	2009
Nursing Matron	Malawian	Y	Female	2009
Business Manager	Malawian	Y	Male	2009
HR Director	Malawian	Y	Male	2010
Surgeon 1 (Dir of Residency) (MD)	American	Y	Male	Oct 2010
Surgeon 2 (MD)	Ethiopian	N	Male	2014
OB-GYN (MD)	American	N	Female	2015
Internal Med (MD)	American	N	Male	2016
Family Practice (MD)	American	N	Female	2016
Community Health Director	Malawian	Y	Male	2014
Chief Clinical Officer	Malawian	N	NA	NA
Chaplain	Malawian	Y	Male	NA
Head of Maintenance	Malawian	N	Male	NA

NA = not available

Appendix D

Question Routes

RESEARCH QUESTION 1:

What are the Malawian cultural practices for accountability?

Focus groups:

Group 1 selection criteria:
– Malamulo area community/village leaders
– People in leadership positions: teachers, business owners, professionals
– Both men and women combined

Group 2 selection criteria:
– Chiefs, headmen/women of local villages

Both sections and focus groups will use the following plan and questions:

FOCUS GROUP QUESTIONS (Research question 1):

1. In the community here what kind of events do you celebrate?

2. How does the community celebrate together?

3. Can you tell me a story about how you celebrated when someone did something good?

4. How do you explain the word “accountability”? (What is the Chichewa word?)

5. Are there any stories/proverbs/dramas/songs that talk about accountability? (ask them to create a drama about accountability)

6. What does the drama/song/proverb mean?

7. Let’s imagine that someone breaks a law and is cheating or stealing. How does the community know who is stealing or cheating?

8. What do people do when someone breaks a promise?

9. Can you describe an experience where someone did not keep their promise? What happened to that person?

10. When someone is working at a job, what would be a good way to tell them they did a good job?

11. If someone is hired to build a house and they do not do a good job and the house falls down, what happens to that person?

12. Is there anything else that you want to add that we did not covered?

RESEARCH QUESTION 2:

What are the current accountability and management-capacity related practices at Malamulo Hospital?

Focus groups will be conducted with probably 2 groups for each section. Administration and staff will be interviewed separately.

Group 1:
– Nurses/clinicians of Malamulo Hospital (separate groups)
– Mixture of men and women
– No leadership included

Group 2:
– General staff of Malamulo Hospital
– Mixture of men and women
– No leadership present

Group 3:
– Hospital administrative council members

ICE BREAKER: Have participants identify their favorite fruit or vegetable and write it on a nametag. Ask them to introduce themselves as this fruit or vegetable. This will be their pseudonym

FOCUS GROUP QUESTIONS (Research question 1):

1. How do you explain the word “accountability” and what comes to mind? (What is the Chichewa word?)

2. When someone is hired at the hospital, do they know what they are supposed to do?

3. How do you know when you have done a good job in your work?

4. How do employees find out they did something wrong?

5. If there were certain expectations about performance, how would you communicate that to someone and follow up?

6. What is a good way to tell someone at work that they did something right?

7. What is a good way to tell someone that they did something wrong?

8. Do you have anything to add to our discussion?

SEMI-STRUCTURED INTERVIEW QUESTIONS:

1. How do people know what they are supposed to do in their positions?

2. Does Malamulo Hospital need to have an evaluation process for their employees?

3. What is the purpose of employee evaluations?

4. Explain a time when you experienced being evaluated or when you did an evaluation of someone else. Explain how it was or was not effective.

5. What are barriers for seeing improvement in employee behavior or skills?

6. What process would you establish if you could start over?

Appendix E

Data Collection Reference Table

Reference Codes:		# People
ACC	Interview – Accounts staff (9/15/15)	1
LAB	Interview – Lab Director	1
HR1	Interview – HR Mgr (8/31/15)	1
OBS	Observation Notes	
CO1	Interview – Clinical Officer 1 (9/3/15)	1
CO2	Interview – Clinical Officer 2 (9/10/15)	1
WRK	Interview – Workshop Manager (9/9/15)	1
PI1	Pilot Interview – KS (8/3/15)	1
PI2	Pilot Interview – DD (8/3/15)	1
EM	Med Dir email (9/30/15)	1
NMT	Interview – Nurse Midwife Technician (9/13/15)	1
FG0	Focus Group 0 – Pilot Test (7/31/15)	7
FG1	Focus Group 1 – Admin (8/28/15)	7
FG2	Focus Group 2 – Chiefs (9/3/15)	7
FG3	Focus Group 3 – Nurses (9/2/15)	6
FG4	Focus Group 4 – Staff (9/2/15)	5
FG5	Focus Group 5 – Community Leaders (9/2/15)	5
GC	Interview – GC health leader (4/4/17)	1

Appendix F

LOMA LINDA UNIVERSITY
School of Public Health

Verbal Consent Form

Informed Verbal Consent
(translated into Chichewa as well)

The purpose of the research project is to learn about the culture of Malawi related to accountability. The lessons will be applied the to the employee evaluation process at Malamulo Hospital in Malawi, Africa. You are part of a group of about 100 people. To be part of this study you are an employee, community member, or administrator of Malamulo Hospital. In addition you must be between 18-80 years of age.

You will participate in an individual interview or in a focus group and will be asked questions. Some people may participate in both an individual interview and focus group. An interpreter will be used if necessary to be sure the questions and answers are clear. The interviews will take approximately one to two hours and will be recorded for research purposes. The focus groups will be made up of 6-8 people and will be conducted in a group setting with a translator. Individual interviews will be with myself and a translator (if needed). The focus groups will take place on the Malamulo campus within a designated meeting room or within the designated meeting place in the community. The individual interviews will take place at the hospital or in an agreed location.

Although you will not benefit individually, the information you provide can give instruction to the cultural context to improve the employee evaluation and management

process for Malamulo Hospital. The risks of participating in this research is time away from your job or your family and any concerns in the community that you are helping with research. Participating in the interviews will not affect your job.

Your participation is voluntary and not required. If at any time you do not wish to answer a question or want to change your mind you have the right to stop participating in the study without penalty. You will not lose any benefits to which you are entitled. All responses are confidential and will not be identified unless you provide permission. The records of your interview will be kept on a password protected computer.

Payment will be made to reimburse transportation costs to and from the focus group location.

If you have any questions about the study please contact myself, Elisa Blethen, at eblethen@llu.edu or +001 909-558-8680. If you have questions about your rights as a participant please contact Mr. Pax Matipwiri, Director of Health Projects & Community Health Services +265-999439705, +265-884553208 or paxmatipwiri@gmail.com

Consent Statement

If you are 18 years of age or older and you have read the consent and all your questions have been answered. You understand that you may withdraw from the study at any time and that you will not lose any of the benefits that you would otherwise receive by withdrawing early. All of the answers you provide to Elisa Blethen will be kept private.

I consent to participating in "Study Of Culturally Appropriate Employee Management Practices Within Malamulo Hospital in Southern Malawi" being given by Elisa Blethen.

To indicate if you are willing to participate in this research or not please respond verbally by saying: "YES" or "NO." If you respond, NO, you may leave the interview at this time.

Modified Verbal Consent for Leadership Workshop

LOMA LINDA UNIVERSITY
School of Public Health

Informed Verbal Consent
(to be read aloud and translated as appropriate)

The purpose of the research project is to learn about the culture of Malawi related to accountability. The lessons will be applied the to the employee evaluation process at Malamulo Hospital in Malawi, Africa. You are part of a group of about 100 people. To be part of this study you are an employee, community member, or administrator of an Adventist Health International affiliated institution in Malawi.[1] In addition you must be between 18-80 years of age.

You will participate in an individual interview, in a focus group, or workshop and may be asked questions. Some people may participate in one or all of the events. An interpreter will be used if necessary to be sure the questions and answers are clear. The interviews will take approximately one to two hours and will be recorded for research purposes. The focus groups will be made up of 6-8 people and will be conducted in a group setting with a translator. Individual interviews will be with myself and a translator (if needed). The focus groups will take place on the Malamulo campus within a designated meeting room or within the designated meeting place in the community. The individual interviews will take place at the hospital or in an agreed location. The leadership workshop will take place in Loma Linda, CA.

Although you will not benefit individually, the information you provide can give instruction to the cultural context to improve the employee evaluation and management process for Malamulo Hospital. The risks of participating in this research is time away from your job or your family international travel and any concerns in the community that you are helping with research. Participating in the interviews will not affect your job.

Your participation is voluntary and not required. If at any time you do not wish to answer a question or want to change your mind you have the right to stop participating in the study without penalty. You will not lose any benefits to which you are entitled. All

[1] Highlighted areas were changed from original verbal consent and approved by IRB.

responses are confidential and will not be identified unless you provide permission. The records of your interview will be kept on a password protected computer.

Payment will be made to reimburse transportation costs to and from the focus group location.

If you have any questions about the study please contact myself, Elisa Blethen, at eblethen@llu.edu or +001 909-558-8680. If you have questions about your rights as a participant please contact Mr. Pax Matipwiri, Director of Health Projects & Community Health Services +265-999439705, +265-884553208 or paxmatipwiri@gmail.com

Consent Statement

If you are 18 years of age or older and you have read the consent and all your questions have been answered. You understand that you may withdraw from the study at any time and that you will not lose any of the benefits that you would otherwise receive by withdrawing early. All of the answers you provide to Elisa Blethen will be kept private.

I consent to participating in "Study Of Culturally Appropriate Employee Management Practices Within Malamulo Hospital in Southern Malawi" being given by Elisa Blethen.

To indicate if you are willing to participate in this research or not please respond verbally by saying: "YES" or "NO." If you respond, NO, you may leave the interview at this time.

(This will be translated into Chichewa if needed.)

Appendix G

Organizational Descriptions

Adventist Health International (AHI)

AHI is a nonprofit multinational health network managing more than 30 hospitals and approximately 75 clinics outside of the United States. It was started in 1997 and is based in Loma Linda, California (AHI 2014). It is an Adventist organization working in collaboration with the denomination but not directly under the structure of the SDA church headquarters. Currently more than $1 million is raised annually through philanthropic gifts that go to support the volunteers and consultants who work with AHI on a full- or part-time basis. The funding also covers some limited equipment and construction for hospitals and board member travel.

The structure of the AHI consists of a governing board with corporate members, which include various Adventist health and humanitarian organizations and some representatives from the SDA General Conference leadership. Below the governing board, the Administrative Committee for AHI (AHI-AdCom) is made up primarily of professional volunteers affiliated with Loma Linda University Health (LLUH) who handle the day-to-day functions of AHI, chair country boards, or serve as consultants to the field. (See appendix B for a chart of the organizational relationships including connection to Malawian institutions.)

In each country where AHI is involved a Memorandum of Understanding (MOU) is agreed upon with the local Adventist Church leadership. The hospitals and clinics that are overseen by AHI remain the property of the SDA Church, but with the MOU AHI can

function in the country. When an MOU is signed, AHI works with the church leadership to establish or modify a governing board to manage the healthcare institutions in that country.

AHI operates on the campus of LLUH, a SDA health sciences university and an 800-bed teaching hospital in Loma Linda, California. AHI and LLUH function in a mutually beneficial manner, with LLUH providing volunteer leaders and consultants for international hospitals and space to function. AHI provides connections to mission and volunteer opportunities for students and employees of LLUH to serve the global community. I am an employee of LLU's School of Public Health and a member of the AHI-AdCom.

Administrative Committee-AHI (AHI-AdCom)

The role of this committee is to manage the daily activities of the hospital network, carrying out functions such as serving on hospital boards, managing a volunteer process, serving as consultants and experts, raising and managing funds, and handling various issues that arise. The AHI-AdCom meets weekly to handle the regular management concerns that come to our attention, hear reports from facilities, and manage relationship with other organizations. The group is made up of various subcommittees such as Finance, Business Development, Facilities, and Human Resources and Policy. I am currently chairing the Human Resources and Policy subcommittee and am a member of the Finance subcommittee.

Seventh-day Adventist (SDA) Church

The SDA Church is a Protestant denomination that was officially organized in 1863 (General Conference of SDAs 1863). It has grown into a worldwide denomination with nearly 19 million members as of 2015 (Trim 2016, 5). The Church is structured into

thirteen divisions around the world that operate as regional "offices" of the General Conference. The Church owns various institutions in addition to churches, such as primary, secondary, and tertiary schools; publishing houses; clinics, hospitals, and other ministries. As of 2014, there were 175 hospitals and 385 clinics or dispensaries as part of the global SDA church (Trim 2016, 4).

The SDA church in Malawi had 467,828 members at the end of 2015 and is designated as a "Union Conference" (Trim 2016, 23). There are four healthcare institutions in Malawi: Malamulo Hospital (rural, 220 beds), Blantyre Adventist Hospital (urban, 35 beds), Adventist Health Clinic, Lilongwe (urban dental and medical clinic, 10 beds), and Adventist Health Services (network of 17 rural clinics throughout Malawi managed as one system).

Christian Health Association of Malawi

The Christian Health Association of Malawi (CHAM) is an ecumenical nongovernmental organization providing medical care and training of healthcare professionals in Malawi. Their church-owned facilities primarily are in hard-to-reach areas and serve the poor. CHAM has 20 major hospitals, 30 community hospitals, and 121 clinics, plus 12 training colleges (DanChurchAid 2017; CHAM 2016).

Malamulo Hospital extends the Malawian government healthcare system in the Thyolo District in the southern region. The closest government hospital is in the town of Thyolo, about 20 kms from Malamulo and closer to Blantyre. In the sub-Saharan region in 2014, mission hospitals accounted for 30% to 70% of all healthcare in the country, with Malawi being at 37% (CHAM 2016) (see figure 12). In Malawi these faith-based hospitals are organized under the Christian Health Association of Malawi (CHAM), which has 20 major hospitals, 30 community hospitals, and 121 clinics (DanChurchAid 2017).

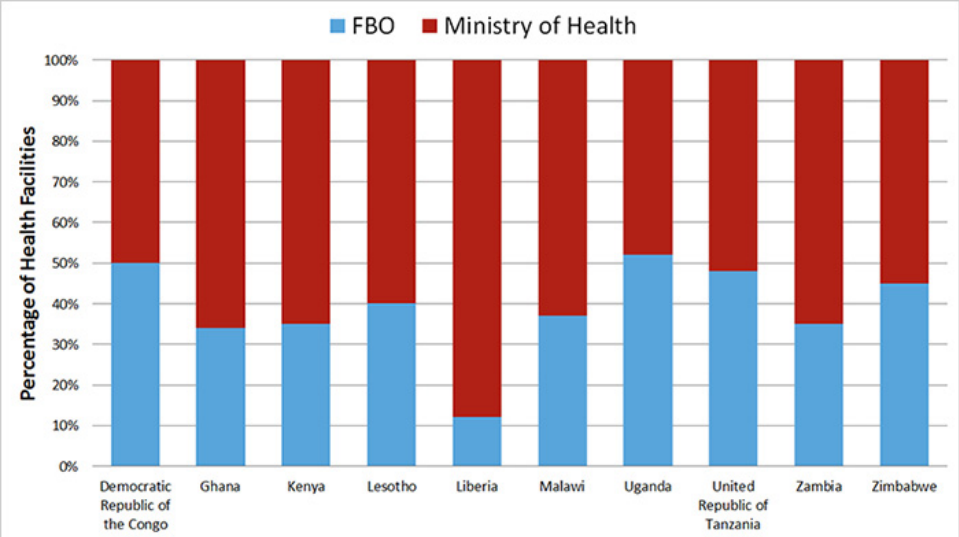


Figure 12: Contributions of Christian Health Networks in Select African Countries
(Mwarey, Hafner, and Nyamupachitu 2014)

Mission Hospital

In Malawi, a "mission hospital" is run by a faith-based organization (FBO) and is usually part of the Christian Health Association of Malawi (CHAM), which is under the guidance of the government's Ministry of Health. Being part of CHAM gives mission hospitals or clinics support for staff salaries and discounted rates for medication through the government purchasing programs. These hospitals usually cater to the rural poor, and clinical officers,[1] nurses, and sometimes physicians provide the care. CHAM hospitals set their own fee structure and collect payments for services whereas government hospitals do not charge for routine medical care. Malamulo Hospital is a member of CHAM and is considered a "mission hospital."

[1] Clinical officers have been trained for three years post secondary school. They are similar to a physician's assistant in the US. In Malawi they provide primary care and basic procedures, however, they can also specialize with additional training in areas such as pediatrics, ophthalmology, anesthesia, orthopedics, or other areas.

Private Hospital

A private hospital in Malawi may also be faith based but is not designated as a "mission hospital." For example, Blantyre Adventist Hospital is faith based as part of the SDA church but is not considered a "mission hospital" in Malawi. It is designated as a private hospital. It is in an urban setting with the majority of services provided for the middle to upper class of society. Private hospitals generally do not use clinical officers, usually have nicer facilities, and may provide access to more specialized care. Private hospitals set their own fee structures and negotiate contracts with insurance companies or private businesses that are self-insured. They are not part of CHAM and do not have access to the government medical supplies or salaries.

Appendix H

Workshop Learning Outcomes, Theories, and Learning Tasks

Learning Outcome	Related Research Finding	Theories	Learning Tasks
1. Gain understanding of cultural dimensions in order to strengthen relationships between people at the hospitals and between organizations to encourage open communication	Lack of communication and misunderstanding between leaders/staff that may be culturally based	• ECO model – discussing organizational culture and structure • Hofstede's Cultural Dimensions of Management – especially focusing on Power Distance and Individualism • Bolman and Deal – HR Frame – developing people and investing in relationships • Golman's Emotional Intelligence – focusing on self-awareness, including cultural awareness and strengths	• Identify a "quick fix" that your organization tried and discuss which loop(s) in the model were affected. • Use the online tool to graph cultural dimensions, compare Malawi with two other countries, and discuss the findings. • Discuss developing trust with leadership and employees to strengthen relationships and appropriate communication methods. • Use Emotional Intelligence to discuss a case study where two employees are disagreeing and how best to handle it. Then add that one is in a leadership position to address Power Distance issues.

2. Identify meaningful symbolic practices that can be implemented to support the goals of the organization	Lack of integration of mission/ vision/ values into the culture of the hospital related to employee motivation and accountability	• Bolman and Deal – Symbolic Frame – importance of symbols and communicating that to employees	• Participants draw a picture to illustrate a symbolic item or event that is in place at their organization and explain it to everyone.
3. Define an action plan to take back to the hospital in order to implement the concepts	Lack of consistency and follow-through on plans or initiatives	• "SMARTER" goals (Trebesch)	• On Day 1 each team identifies goals they could implement from the discussions. On Day 2 each participant lists on the survey the ideas or concepts that they could implement in their own context.

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Vitae

Elisa Blethen was raised in a Seventh-day Adventist home. She committed her life to Christ through baptism at 9 years of age. Elisa's first international service opportunity was as a senior in high school when her class traveled to the Philippines for three weeks to conduct an evangelistic series and Bible studies. The seed of international travel was planted in her heart and would bear fruit years later.

In college, Elisa only had a chance for one brief trip to the Dominican Republic while studying at Southern Adventist University. She graduated with a bachelor's degree in Accounting in 2000. Immediately following graduation she traveled to Zambia to work for a one-year volunteer appointment as the Business Manager at Riverside Farm Institute, a mission farm and adult training center about an hour west of Lusaka.

Upon returning to the United States in 2001, Elisa worked as a Financial Analyst for Adventist Health System in Orlando, FL where she pursued a Master in Business Administration (MBA) degree from the University of Central Florida and completed it in May of 2006. In addition, she was also a leader in young adult ministries of the local Adventist church and held a role in a national young adult advisory for the Seventh-day Adventist denomination. She participated in a mission trip to Peru in 2005 and led a young adult mission trip to Roatan, Honduras in 2006.

In 2006 Elisa transferred to Illinois and worked as Assistant Chief Financial Officer (CFO) for Adventist Bolingbrook Hospital and Adventist GlenOaks Hospital in the Chicago suburbs. It was during this time that she felt the pull of long-term mission again and God started to lead her towards a combination of healthcare, management, and mission.

In 2008 the opportunity to work as a volunteer hospital leader in Malawi, Africa came available and Elisa was invited to be the Director of Finance and Interim Administrator for Malamulo Hospital. She worked there for three years under the guidance of Adventist Health International (AHI). Since returning to the United States in 2011 she has maintained a role with AHI's administrative committee while working as an Assistant Professor at Loma Linda University's School of Public Health through 2017.

The opportunity to combine international healthcare service with leadership developed further in 2017 when she led a hybrid training course for forty healthcare leaders from fourteen hospitals in Mexico and Central America. Elisa coordinated the three in-person sessions in Cancun, Mexico and oversaw the curriculum during the 9-month course.

Elisa still serves as a member of the AHI administrative committee while working at Director of Finance for Adventist Health's Northern California Region based in Santa Rosa, CA where opportunities for service continue.