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CRITICAL SUCCESS FACTORS FOR MEDICAL KNOWLEDGE-TRANSFER PROJECTS FROM WESTERN TO RESOURCE-LIMITED ISLAMIC CULTURES

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Abstract

In this research project, the author tries to define critical success factors for medical knowledge transfer projects between Western and resource-poor Islamic countries.

A literature review, preliminary interviews involving two project-experienced professionals with different backgrounds and the author's own professional experience are utilized to create a questionnaire which is distributed to 107 employees of three major hospitals in Sana'a, Yemen during a live medical aid-project.

The results of this survey are discussed and further clarified using issue-focused interviews with two Arabic and two European professionals with experience in similar projects.

The identified critical success factors are used to create a checklist which can be used as a comparative tool during both the preparation and staff selection process for medical and other knowledge exchange projects.

Furthermore, the following general conclusions could be drawn:

1. The experience of participants of the above mentioned projects can be used to define critical success factors.
2. The selection of participants with outstanding communications skills and a well thought-out preparation process seem to be the main factors predicting the success of inter-cultural knowledge exchange projects.
3. The involvement in an organizational framework with experience in similar projects and professional preparation, promotion and monitoring of the project are advisable

Further research should be carried out to prove the practical use of the checklist during the interview process in a live-project and/or to further develop it for use in other inter-cultural projects.

Contents

List of Charts

List of Figures

List of Tables

List of Appendices

1 Introduction and Background

1.1 Introduction

The modern international business world is characterized by a previously unknown level of globalization due to ever-growing world-wide transport and communication networks. It is easily possible to reach any part of this planet within hours and to exchange information with anyone in a matter of seconds. The speed with which scientific knowledge is gained and converted into practical use is constantly increasing, leaving those behind who do not have the material means or the social pressure to take part in this race towards scientific progress, economic power or technological advantage. It is often forgotten that the majority of people inhabiting this planet is still trying to survive – being deprived of sufficient food, shelter and privacy; unable to obtain basic medical care. Those individuals are constantly trying to find alternative, accessible help and support.

The importance of religion, charity and tribal and communal support mechanisms are more popular than ever.

As the gaps between cultures are substantial and seem to be getting wider, hatred, extremism and finally violence have evolved and found their followers, giving rise to a problem that has a major impact on all our lives.

Recent military conflicts like the wars in the former Yugoslavia, Iraq and Afghanistan, as well as the international political differences which evolved between the international community and entire governments or certain groups in Pakistan, India and Iran not only reflect different political views but profound cultural differences and misunderstandings. These eventually have the potential to develop into local fights and violence, insurgencies, terror attacks and possibly full-grown wars.

Ignorance, intolerance, lack of specific cultural knowledge and misunderstanding of traditions, cultural rules and different law systems certainly play a major role in the formation and growth of those conflicts.

The economic and humanitarian impacts of wars are not only huge for the direct participants in these violent affrays, but specifically they damage or even annihilate the economic, social and medical systems of the countries involved. As usual, the poorer suffer most from the effects of those actions and there should be a social and humanitarian responsibility for all of us to counteract these disastrous results of violence and war.

In the course of the Iraq war, the medical system in this Islamic country virtually ceased to exist as medical facilities were destroyed and qualified personnel was unable to work

efficiently or even fled the country. Billions of dollars had to be spent by the international community to maintain or restore basic social support and medical care systems. The same is currently happening in Afghanistan and it will repeat wherever violent conflicts are fought. The necessity of diverting the flow of international financial support and human resources to current foci of crisis leads to a lack of appropriate resources which could otherwise be used to provide monetary and humanitarian aid in the poorer parts of our world.

Another problem with a huge potential to reduce or wipe out medical and social care systems is natural catastrophes which in opposition to violent disputes cannot be avoided by careful and open-minded negotiations and inter-cultural co-existence. Recent disasters like the Tsunami in the Far East, the earthquake in Haiti, droughts in Africa or floods in other parts of the world require the constant provision of humanitarian aid and material as well as financial resources from parts of the planet which are fortunate enough to be able to afford this and also have sufficient resources to provide this support.

It must not be forgotten that even without wars, terror attacks and natural disasters there is a constant need to support resource-limited societies and give them a share of recent developments in the medical, ecological and scientific fields.

Projects designed to give poorer nations the possibility of taking part in the advancements of science and technology by the transfer of knowledge and skills from the developed world to resource-limited settings can help narrow the inter-cultural gap and counteract extremism and hatred. They can also help overcome the effects of violence, war and natural catastrophes.

Who is providing this help and organizing the collection, allocation and provision of the appropriate resources?

Many countries develop and organize support programs which are funded by governmental programs, companies or private donors. Without these programs the provision of humanitarian help would be unthinkable at the current scale.

Nevertheless, in most cases the provision of such support is bound to the fulfilment of certain conditions which in some cases are there to ensure the appropriate distribution and allocation of the resources and funds provided. This is certainly a necessary precondition to make sure the help will reach the appropriate targets. Without doubt there is a certain level of corruption and bribery especially in countries which are possible targets for humanitarian help. Examples are lawsuits against ninety-three US companies for paying kickbacks to the former Hussein regime in Iraq under the UN Oil-for-Food programme (Transparency International, 2009, p.240) and the revelation of the Independent Inquiry Committee (ICC)

into the same programme which reported that 2253 companies paid similar kickbacks to Iraq in order to obtain lucrative contracts for humanitarian aid.(UN Oil for Food Programme, 2005)

On the other hand, the provision of humanitarian aid can be tied to the condition of receiving preferential business opportunities in return or shaping the political landscape of the country in question according to the expectations of the providing government. This doesn't have to be out of bad intentions and often seems only logical. It could be for instance a method of forcing the political powers in the receiving country into the application of internationally accepted political and ethical standards like free elections, freedom of the press or universal access to medical care. Likewise, the conditional provision of aid could also be a way to create political and economic dependency or result in exploitation of the natural resources (i.e. oil in the Middle East or commodities in Mongolia) and therefore the economic base of the receiver-country which carries ethical problems and could lead to later conflicts.

Therefore, the conditional provision of aid should be carried out according to commonly-accepted ethical standards. It also should be closely watched and controlled by international organizations to make sure the country in question doesn't lose its independence and/or identity.

National and international independent charity organizations provide a major part in humanitarian aid and normally should not face the problem of dependency on political and/or economic dependency. Unlike governmental or business organizations which by definition will have a political or economic agenda, these charity bodies do not need to support a political system, and they do not face the pressure to generate profit. This gives them a unique possibility of being trusted by both the giver and the receiver, provided they are carrying out their activities independently and according to internationally-accepted rules and regulations and the highest ethical standards. Kelly defines two types of ethical considerations for NGOs:

(1) ‘they should behave with integrity’

and

(2) ‘they should undertake their interventions with people as effectively as possible’(Kelly, 2010, p.207)

Organizations like ‘Médecins Sans Frontières’ (MSF), the international federation and national branches of the ‘Red Cross’ and the ‘Red Crescent’, the WHO and various branches of the UN as well as many national and international smaller organizations like ‘Merlin’ and ‘Concern’ are only a few examples of independent charity providers.

These charity bodies depend on the collection of funds for their activities from various governmental, private and institutional donors and are in constant need of qualified human resources to manage their projects and to deliver their support.

Ellis is suggesting a 'code of conduct' for organisations receiving funds from governments which could help ensure the independence of those institutions (Ellis, 2010, p.65 ff).

In 2008, MSF International spent 527 million Euros on worldwide social missions which is an increase of nearly 13% compared to the previous year (MSF, 2008, p.7). The funds were obtained by fundraising campaigns.

They need an accessible base of mainly voluntary specialists who are aware of the difficulties related to working in a resource-limited and sometimes dangerous environment. These volunteers need to be highly motivated and trained not only in their general field of expertise but also need to be able to solve highly specific problems which are unique to the location to which they are sent. They also usually do not receive any remuneration or only a small amount for their aid work.

The last and often forgotten group of providers of humanitarian aid are private individuals who show a great deal of initiative and engage in private projects be it a doctor or a nurse working in a resource-limited country without the backing of a large organization or a scientist who volunteers to teach there.

Anyone who is part of an aid project can benefit from a unique and challenging experience which she or he otherwise would not be able to obtain.

It is only logical that humanitarian support-projects need to be planned and organized in a professional way in order to generate the highest possible level of benefit for the recipients and to avoid the demotivation of the people who take part in the provision of the aid project.

Humanitarian aid projects often need to be established and organized in a relatively short period of time and the providers do not always have the luxury of an extensive and even sufficient planning period.

In reality, most of these projects begin with enthusiasm and not all of them are finished successfully.
In order to increase the success rate of those projects it is logical to approach this task in a planned and well-organized manner.

The aim of this research is to provide further understanding about critical success factors which specifically predict the outcome of medical knowledge transfer programs. It will be

specifically applied to the Islamic culture(s) in a resource-limited environment but one should be able to apply the results in a modified way to other cultures.

1.2 Background

The medical system in resource-limited Islamic countries like Yemen, Palestine or Iraq is characterized by the co-existence of a state-organized health system, a private medical sector and traditional medical services (Horaczek, 2006). The state system of medical care is a cheap but rather basic and limited system of hospitals and local medical stations which are ill-equipped, overcrowded and understaffed. The salaries of doctors, nurses and medical aid workers is extremely low and qualified staff are driven to the better equipped but substantially more expensive private medical sector where the salaries are much higher. Due to the higher fees, private medical care is inaccessible to the majority of the people. Up-to-date medical education is often only provided abroad and mainly accessible to those who have substantial financial resources to leave the country for training. Furthermore, life-long learning and continuous training is impossible or at least rather difficult for the majority of medical staff, resulting in lack of knowledge or practice of modern diagnostic and therapeutic methods. Knowledge of the advances of medical science is often provided by specialists brought into the country by charity organizations or on their own private initiative.

The profound differences between the Western and the traditional Islamic cultures can be an obstacle to the provision of help as they can result in misunderstandings and frustration on both sides. This often results in the failure or inefficiency of those projects.

For example, the comparison with Western ‘standards’ rather different approach to life and death as a God-given condition results in a different behavioural pattern of patients and families when faced with a life-threatening disease. This has to be observed when informing the patient about such a condition and when discussing treatment options and the possible gains in life expectancy and quality of life.

There is also a substantial lack or even the complete absence of a medical rehabilitation and support system which leaves the families in charge of dealing with severely disabled or terminally ill relatives. Therefore the decision for possible treatments that result in further dependency is often not made, as the author has experienced on several occasions.

The understanding of basic anatomy and the course of certain diseases is almost ubiquitous in the Western culture. In resource-deprived Islamic cultures the lack of this knowledge can lead to profound misunderstandings of the illness and possible results of treatment. Many patients cannot read or write and try to force the medic into giving reliable predictions or

guarantees for success which naturally cannot be met in many cases. Therefore repeated discussions and an often extensive time for decision-making are to be faced.

Another commonly encountered problem is the belief that the treatment in the home country of the visiting doctor or nurse would be better and guarantee a favourable outcome. This sometimes cannot be denied but it is impossible to follow that course of action due to the lack of financial resources or the inability of the patient to travel. In reverse the more practical approach should be to transfer the methods and disease-management systems which have proved to be beneficial in the Western world to the country where they need to be applied. This underpins the necessity of training and knowledge-transfer even more. A possible way out of this dilemma could be the establishment of a regular exchange and teaching program between the parties involved but in both directions. The author believes that on the long run only the continuous transfer of knowledge and skills would be capable of solving this problem.

Generally, guests with friendly intentions are very welcome in the Arabic culture which has its original roots in a long-standing tradition of tribal life in an often naturally hostile and difficult environment. It is also a fundamental part of religion to treat guests politely provided they have friendly intentions.

Nevertheless, safety of foreign guests is an issue to consider when working in an environment where weapons are traditionally a part of everyday life and tribal differences are often solved with violence.

The thoughts and facts above, which are mainly based on the personal experience of the author, underscore the importance of a well-managed planning and organization process when setting up a knowledge exchange program.

1.3 Study Rationale

1.3.1 What is the research issue?

The author has experienced several medical appointments in developing, culturally different countries (i.e. Yemen and Mongolia) which mostly, but unfortunately not always, were successful. The systematic planning and definition of possible problems during the course of a medical knowledge transfer project seems to be crucial for its later success. The expectations of both the receivers and the providers of this knowledge should be clearly understood and determined. The selection of suitable candidates to interact with each other during the course of such a project seems to have a direct impact on its efficiency and success rate.

This research project aims to filter out possible key questions which should be answered before engaging in a medical knowledge transfer project between Western and resource – limited Islamic cultures.

Its aim is to provide a practice-based tool to be used in the selection process of suitable candidates.

1.3.2 Why is it an issue and why now?

In recent years, there seems have been an increase in cultural misunderstanding especially between the Western and the Islamic cultures. Acts of violence and wars between different cultures influence our daily lives and put stress on the peaceful and tolerant co-existence of people with different cultural backgrounds.

Recent global events put the fruitful communication between members of the Western and Islamic cultures under extreme pressure.

Therefore, an active approach to the research of cultural issues could help to stop and maybe even reverse the 'intercultural divergence' that has taken place.

1.3.3 What could the research shed light on?

This research project could increase knowledge of how to improve the staff selection process in medical and related knowledge transfer programmes. The definition of key success-factors for such projects could be helpful in improving the planning process and in reducing the costs and frustration caused by possible failure or inefficiency. The creation of a simple checklist would be a simple and practical tool for anyone who is planning medical training, teaching and charity projects in resource-limited countries, whether an NGO (Non-governmental Organization), private or public charity-provider or healthcare professional.

2 Literature Review and Conceptual Framework

2.1 Schein's Three Levels of Culture

Increasing globalization and communication makes the ability to handle ethnic and cultural diversity appropriately a key qualification. A variety of new theoretical models for explanation, observation and planning of inter-cultural dynamics has developed out of practical needs (Hofstede, 1980 p.13 ff, 2006 p.12 ff). 'Cross-cultural Management' and 'Cultural Awareness' became a central part of international business.

Edgar Schein defined three levels of culture in order to shed light on the concept of culture from different points of view.

A visible superficial layer which he called ‘Artefacts’ describes the first level (Schein, 1992, p.17).
Symbols, rituals, myths, bans, requirements, as well as architecture of the firm, use of logos, required business language and dress codes reflect this layer of culture (Fischbach, 2002, p.16 ff). These superficially-visible facts are mainly recognized, analysed and interpreted by external observers (Schein, 1992, p.17 f).

The second level is made up of an invisible, supporting layer. Here attitude, philosophy and education play an important role. Schein called this layer ‘*Espoused Values’ (Schein, 1992, p.19)*. The analysis of ‘Espoused Values’ is difficult because it is necessary to differentiate between ‘written-down values’ and ‘lived values’.

The third and last layer in Schein’s model is called ‘basic underlying assumptions’. It includes beliefs and religion, social norms and values as well as visions (Schein, 1992, p.21). These unconsciously-present basic assumptions are primarily invisible to the observer and cannot be measured accurately. In fact, they often only surface when different cultures interact (Fischbach, 2002, p.18).

Schein's levels of culture provide an easy and logical classification of the factors which define a specific culture and provide a usable scheme to describe and understand a specific culture.

They also enable us to compare different cultures descriptively but lack the ability to describe and measure interactions between different cultures.

2.2 Levels of Inter-cultural Personality (Hofstede)

Hofstede's research developed a system of inter-cultural comparison which enables us to describe interactions between different cultures. This system even provides a method to semi-quantify inter-cultural relations and makes them measurable.

Hofstede’s comparative inter-cultural management study which was initially based on a large database of questionnaires of international employees of IBM marked a turning-point in the relatively young area of inter-cultural research (Weber et al., 1998, p.40). Hofstede provided a partially quantitative tool to compare national cultures by looking at four specific dimensions:

- Power Distance
- Individualism
- Masculinity
- Uncertainty Avoidance (Hofstede, 1980, p.92ff)

Later, Hofstede tried to introduce a fifth dimension: 'long-/short-term orientation'. This dimension is difficult to measure and, so far, has not been widely accepted.

Power Distance not only reflects inequality within a social setting but also the emotional distance between superiors and subordinates describing the level of acceptance and practice of the unequal distribution of power (Hofstede, 1980, p.93f, 2006, p.28ff). Inequality and hierarchical structures are a fixed part of everyday life in 'high power distance'-societies. Superiors and subordinates see each other as different people (Hofstede, 1980, p.99ff). 'Low Power Distance' cultures stand out by exerting a 'consulting' relationship between superiors and subordinates.

Individualism measures the expression of the concept (thought) of individuality in opposition to the predominance of collective thinking. In an individualistic society, inter-individual relationships are usually weak. People predominantly try and fulfil their own interests.

Members of a collective society are being raised with a strong feeling of community. Their interactive approach is defined by the formation of groups and protective behaviour within these groups (Hofstede, G. & Hofstede G. J., 2005, p. 76).

The dimension of *Masculinity* tries to integrate socially and historically-rooted gender role models into the model of cultural personality. The following points are being regarded as masculine and feminine (Table 1):

Masculine	**Feminine**
• Income: possibility of achieving high income • Appreciation: receive appropriate recognition for excellent work. • Promotion: possibility of promotion to a higher position • Challenge: be challenged at work - carry out satisfactory work	• Superior: good professional relationship to direct superior • Co-operation: high level of satisfactory co-operation with co-workers • Environment: live in an individually-pleasant and family-friendly environment • Job safety: feeling it is possible to be able to stay in a job as long as one wanted to

Table 1: Typical 'Masculine' and 'Feminine' criteria (Hofstede, 2006, p.164)

The fourth layer of inter-cultural personality is called '*Uncertainty Avoidance'*. It measures the level of uncertainty and ambiguity avoidance in a society which is achieved by formal rules. In 'Low Uncertainty Avoidance' societies insecurity is seen as part of life. This inevitably leads to riskier behaviour. Members of 'High-Uncertainty-Avoidance'-cultures are generally bound to choose a low risk strategy with a lower probability of success (Hofstede, 1983, p.82).

The 'Hofstede model' is very useful as it is based on a vast amount of real data. It allows the user to directly compare different cultures and define the areas of possible conflict. Some criticism can be exercised by the approach of fitting members into certain behavioural patterns which does not reflect individuals as such. Another deficit of the model is that due to international travel and the availability of information, 'pure' members of certain cultures are rarely to be found.

2.3 High context vs. Low context-culture (Hall)

Another popular and widely-used model is Hall's model of high and low context cultures. This theoretical concept was first published in 1976 (Hall) and further developed in the following years. Hall postulated that meaning and context are 'inextricably bound up with each other' (Hall, 1982, p.18).

His model relates the importance of code and context in different cultures. In a rather simplistic approach, the code is defined as basic (concrete) information which is transmitted. The model denies the assumption that information can only be described by what is 'said'. It is emphasized that the value of communication is supported and increased by the environment of information transfer. This environment is formed not only by the choice of specific words or the 'expectation to read between the lines' but also by non-verbal aspects like body language and social or hierarchical components.

Western cultures (i.e. Europe, USA) can be described as typical low context cultures. The major focus is the transfer of concrete, provable and conclusive information. The means of this transfer of information or knowledge is secondary. References, standardized procedures and proven facts are most important, whereas the social background of the message-bearer, his or her position in the organization or the time and location of the exchange of information are unimportant.

This is completely different in high context cultures like Arabic or Asian societies. Here it is completely unacceptable to discuss important problems ad-hoc without providing an appropriate environment and introduction.

Simplified, it can be stated that in low context cultures what is said is more important than how it is said and vice versa.

Communication in low context cultures is specific, concrete and analytical (Hall, 1982, p.18) avoiding direct confrontation (Ting-Toomey, 1985, p.71ff).

In a high context culture communication is unspecific, less concrete und rather intuitive.

Strikingly, in her excellent paper analysing Arab-American communication patterns R.S. Zaharna points out that in communication in high context cultures ‘much of the ‘burden of meaning’ appears to fall on the listener’ (Zaharna, 1995, p.241-255).

The use of adjectives like ‘high’ and ‘low’ often gives rise to value judgements. Therefore it might be useful to replace these words by more problem focused words like context-centred for high context cultures and information-centred for low context cultures.

2.4 Other Classification concepts

In addition to the above mentioned popular concepts of Schein, Hofstede and Hall there are several other approaches to classify and compare different cultural environments.

In particular, the analysis of language-based communication differences and certain culturally-different models of communication, value orientation and thought-structure can provide important insights for a successful analysis of medical knowledge transfer projects.

2.4.1. Communication

Levine distinguishes direct from indirect communication (Levine, 1985, p.29). In the Western culture communication is characterized as being rather clear, straightforward and unambiguous. In Arabic cultures though, communicative patterns are more indirect and ambiguous.

Other concepts differentiate between literally-centred and orally-centred communicative patterns (Ong, 1980, p.197-204) (Denny, 1991, p.66ff).

Literally-centred exchange of information is rather reference-based and problem-focused whereas the orally-centred communication is very stylized, vivid and plastic.

2.4.2. Value orientation

Steward and Bennett (1991, p.28ff) describe different cultures according to their perception of values. Accordingly, they define result-oriented versus status-oriented cultures.

Result-oriented cultures which are often found in the Western world (i.e. Europe, North America) place major emphasis on primarily answering the question: ‘What are you doing?’. In status-focused cultures the question: ‘Who are you?’ (Social status, provenance and social background) has a clear priority.

2.4.3. Thought model (Dodd, 1982, p.162)

In the Western world we find a linear thought model which favours a relatively strict segmentation of time patterns and verbal dominance of communication.

In Dodd's model this linear model is in opposition to the non-linear thought model in which communication doesn't put too much emphasis on time but rather focuses on a non-verbal level.

Transformation from the non-linear to the linear thought model is possible by the translation of oral and auditory communication into a visual one using written characters and symbols by the application of linear though patterns (Dodd, 1982, p.162).

2.5 Importance of Language

It is indisputable that the spoken word plays a key role in human communication. This is especially true for the Arabic language.

In a recent publication, Ben Abdeljelil provides a striking description of Arabic language and communication:

'The imagery and figurative representation in the language were characteristic in order to express conditions of life, relationships, and even feelings and ideas. Also characteristic of this discourse were the expressive, descriptive and preaching functions and genres that were more dominant than the analytic function and structure.' (Ben Abdeljelil, 2009, p.11)

This can be seen as a continuation of Levine's approach to distinguish between linear and non-linear communication.

The analysis of language as one of the main instruments of human communication enables us to identify specific cultural, social and religious properties of a specific society.

The special conditions and historic developments of culture reflect specifically in the development and utilisation of its language.

As an example we could look at a basic item like the date fruit, which has been cultivated in the Arabian Peninsula for hundreds of years. Whereas English speaking people simply refer to 'dates', Arabic people use a variety of words (kimri, chalal, rutab, tamr and barhi, dayri, maktoom and so forth) (Wehr, 1985) for this fruit which has been one of the most important nutrients for centuries.

The pre- and post-Quranic Arabic language is well known for its richness in poetic and figurative expressions. The use of a vast amount of phrases during the processes of greeting and parting which are often accompanied by figurative gestures is one example that strikes the non-Arabic speaking visitor immediately. Another example is the excessive use of metaphorical expressions when wishing 'Good Morning' which is usually relatively straight-forward in European language but requires a elaborate sequence of set phrases in Arabic with reference to 'Light', 'Goodness', flowers and so on. Ben Abdeljelil (2009) refers to this importance of the figurative use of language several times in the above-mentioned publication.

For Arabic people their language is sacred as it is the language of their religious scriptures. Therefore a basic understanding of the way Arabic people use their language is without a doubt invaluable for anyone who engages in professional and private communication with

them. (With this in mind the author has undertaken an Arabic language course running concurrently with his work on this project.)

2.6 Religious Issues

Religion is a central part in the Arabic culture. A profound knowledge of the Quran is mandatory for each Muslim and the attendance of Madrasas (which is the Arabic word for school but specifically refers to Quran-schools) at a young age is required in traditional Islamic cultures.

The close linkage between religion and daily life in Islamic cultures reflects in the excessive referral to 'God' in all thinkable situations. The requirement to pray five times a day is firmly integrated into the daily schedules in all areas of private and public life.

Therefore the knowledge of the basic beliefs and rituals of Muslims is helpful in understanding their behaviour and doing successful business (Rice, 1999, p.345).

Although there has been 'some divergence between Islamic philosophy and practice in economic life' (Ibrahim, 1997, p.45), Islamic ethics which is based on the Quranic teachings still seems to be dominating daily business life.

For any guest in an Islamic country, the observance of some simple rules like the preferable use of the right hand is not only an expression of politeness but also shows cultural acceptance and tolerance. An example of a collection of some basic rules in the Islamic world can be found in the 'Iraq, Culture Smart Card, Guide for Cultural Awareness' (MCIA, 2006).

2.7 Gender Issues

The relation between Muslim men and Muslim women has been a controversial issue for a long time. Our Western concept of the equality between man and woman is in heavy contrast to the usually-observed superiority of men over women.

Although there are some publications which argue that women in Islamic cultures 'have the right to make their own choices in the areas of education, business and property' (Syed, 2008), the reality (especially in very traditional Islamic cultures) seems to be somewhat different.

Forced marriage, 'underage' marriage veiling and prohibition to drive cars are only some of the obvious practices in some Islamic countries. Sechzer (2004) describes the roots and the development of women's status in Islam and concludes that in most if not all Muslim countries women's rights have been restricted and remain so until the present time.

The observance of the basic right of emancipation for female participants of knowledge-exchange programs should be indisputable.

2.8 Safety Issues

With regard to tribal differences and terrorist activities there are growing concerns about the safety of foreign visitors to Islamic countries (Foreign & Commonwealth Office, 2010). The abduction of foreigners has been a common problem in the Middle East in recent years and more than 200 foreign nationals were kidnapped in the last 15 years in the Yemen only. The majority of them were released unharmed but a few have lost their lives (BBC News, 18.5.2010).

2.9 Concepts of Health, Disease and Death in Islam

As medical knowledge transfer programmes are carried out in a highly specific environment it is crucial to develop an understanding of the perception of health, illness and death in different cultures. Currer, Braun and Lassey provide a cursory overview about different concepts.

Lassey (1997) puts cultural differences into a specific context by analysing the health-care systems in different countries and cultural environments. Currer (1986) and Braun (2000) analyse the perception of health and illness as well as the specific issue of end-of-life decision-making in different cultures.

In general, Muslims believe in the dependence of a happy life and after-life when adhering to the faith and applying the precepts of the Shari'a law system (Atighetchi, 2007a, p.31). This is not so different from other religions. People who look after a person who is ill are highly respected. This reflects Islamic teachings and qualified medicine to be amongst the highest-valued branches of science in Islam (second only to religious science) (Atighetchi, 2007a, p.31).

Therefore any participant in medical knowledge exchange programs can expect to be treated with high respect and politeness.

The perception of death in Islamic culture is strongly based on the belief that ‘all suffering and death therefore exist only by the will of the Creator according to explanations given by Quran 57.22’ (Atighetchi, 2007b). The acceptance of death is therefore somewhat influenced and sometimes eased by the strong faith that it is unavoidable by any means if god has decided to end someone's life.

Another aspect of dealing with Islamic patients is that they are usually accompanied by members of their families. The above-mentioned cultural specifics of the Islamic community with a strong tendency towards a collective style of living can easily explain this behavioural pattern, but they can be disorienting and feel alien to a Westerner with no experience in these matters.

2.10 Organisational versus National Culture

Individuals live not only in or originate from their national environments but they are usually also bound to the rules and regulations of the organisation which they are a part of.

Therefore it seems necessary to the author to express some thoughts on organisational culture and how it interacts with national cultural behaviour.

Any professional has her or his personal (national) cultural background. If this person is acting as a private person this cultural background predominates. However, if this person is part of an organization the rules and regulations of this organization which he or she represents interact with the 'indigenous' behavioural patterns of this person.

By looking into the results of a survey which was conducted at a large multi-national company (IBM) and which led to the definition of his concept of 'levels of inter-cultural personality', Hofstede conducted important early research into the effects of cultural identity on organisational culture. Power distance and Individualism seem to be most influential on organisational culture (Hofstede, 1980, p92ff).

In order to optimize the outcome of an international knowledge exchange program, the different interactions between the providing organisation, the receiving organisation, the individual participant and the individual receiver have to been predicted, which seems to be a rather complex undertaking.

An explanatory article published by ITAP (2010) describing organisational and national cultures and their relations states:

> 'A person can learn to adapt to processes and priorities, and a person can be persuaded to follow the exemplar behaviors of leaders in an organization. But if these priorities and leadership traits go against the deeply held national cultural values of employees, corporate values (processes and practices) will be undermined'

and further:

> 'Corporate culture never trumps national culture'.

This view is shared by the author who would conclude:

The representation of organisational culture by temporary staff in an unfamiliar and culturally different environment is bound to be extremely difficult and mainly depending on the character, training and experience of the selected participant.

If the above-mentioned statements were true, any organisation planning to undertake an international knowledge exchange project would be well-advised to apply a planned and well thought-out staff selection process.

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This short review of the substantial amount of literature addressing this topic shows that there are several concepts describing cultural issues and their interaction. The concepts are mainly derived from observation and it is difficult to follow an evidence-based research concept. There is not a uniquely valid model. We are dealing with people who act and react according to their personal experience, background and education. It is crucial not to place a person or a group of people into a 'box'. One should rather observe people in their environment and try to find a mutual level of understanding. Then successful communication should be achievable.

3 Research Questions and Objectives

Research Questions:

1. Can a critical assessment of the experience of participants in previous medical knowledge transfer projects from Western to resource–limited Islamic cultures determine possible reasons for project success or failure and be helpful in the selection of key success factors for those projects?
2. Is a systematic and highly selective approach crucial for the success-rate of medical knowledge and skill transfer from the Western to the Islamic culture?
3. Which are major key areas / competencies predicting the success-rate of such projects?

Research objectives:

1. A checklist for the assessment and comparison of potential candidates regarding inter-cultural competency, professional background and personal expectations helps to focus on key competencies to improve the success-rate of Western-to-Islamic knowledge transfer projects in Medicine.
2. It can be used as a simple tool for the selection of suitable candidates for intercultural knowledge transfer.

4 Research Design and Methodology

4.1 General research concepts and theoretical framework

In order to successfully carry out a research project it is beneficial to spend some time thinking about and clarifying the research topic.

As part of the pre-research process it is important to illuminate what the actual problem is which will be addressed. One or more research question(s) should be asked. Following this process of clarification a thorough literature research needs to be carried out in order to elucidate whether the question has already been addressed or even been answered by other authors. This literature research needs to be carried out during the pre-research stage and needs to completed and revised when the actual research topic is formulated. It is especially important in order to collect the required background information which is necessary to intelligently and critically discuss the problem.

So it seems rather likely that the initial research question or hypothesis will change in the process of preparation until it finally reflects the matter of interest and can add further knowledge about the chosen topic.

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For example, this research project started with an initial stage of real-life experience of the author who works as a consultant neurosurgeon in Europe. Over several years, he completed more than fifteen journeys to the Yemen and Mongolia to share his professional experience and to treat neurosurgical patients. He visited different hospitals and met several like-minded medical colleagues, mainly from Western European countries, who provided their expertise either on a private initiative or within a charity organisation.

The project success-rate and experience of these individuals seemed to vary considerably.

Most of the colleagues stopped their involvement after the first or second visit with a high level of frustration. This raised the question of why there were such different individual experiences and different levels of frustration. The author decided to investigate this topic systematically.

The initial approach of interviewing the participants whether successful or unsuccessful seemed easy but soon proved inappropriate as it only used a unilateral approach. The applied strategy did not consider the scientifically relatively well-examined intercultural interactions. Therefore the strategy was changed and a bilateral approach was chosen. A literature research was applied to define key areas of interest for the topic and preliminary interviews with professionals in the field of intercultural knowledge exchange were carried out to further crystallize relevant questions to be addressed.

Then the challenging project of surveying a relatively large number of Yemeni employees in three Yemeni hospitals was carried out. The results were processed and provided the basis of four more interviews. The results of the surveys and the interviews provide the basis for comprehensive discussion which culminates in the elaboration of a checklist. This checklist is planned to be a tool to improve the outcome of medical aid projects.

***

There are several concepts useful in trying to describe a typical research process. One concept is visualized as a ‘research onion’ (Saunders et al., 2007, p.102).

Research philosophy, approach, strategy/methodology, timeframe and method of data acquisition are the main sub-categories by which a research project can be defined and characterized.

The most important point is that those sub-categories which represent the layers of the ‘research onion’ shown below should be defined in a structured manner from the outer layer (‘research philosophy’) to the inner one.

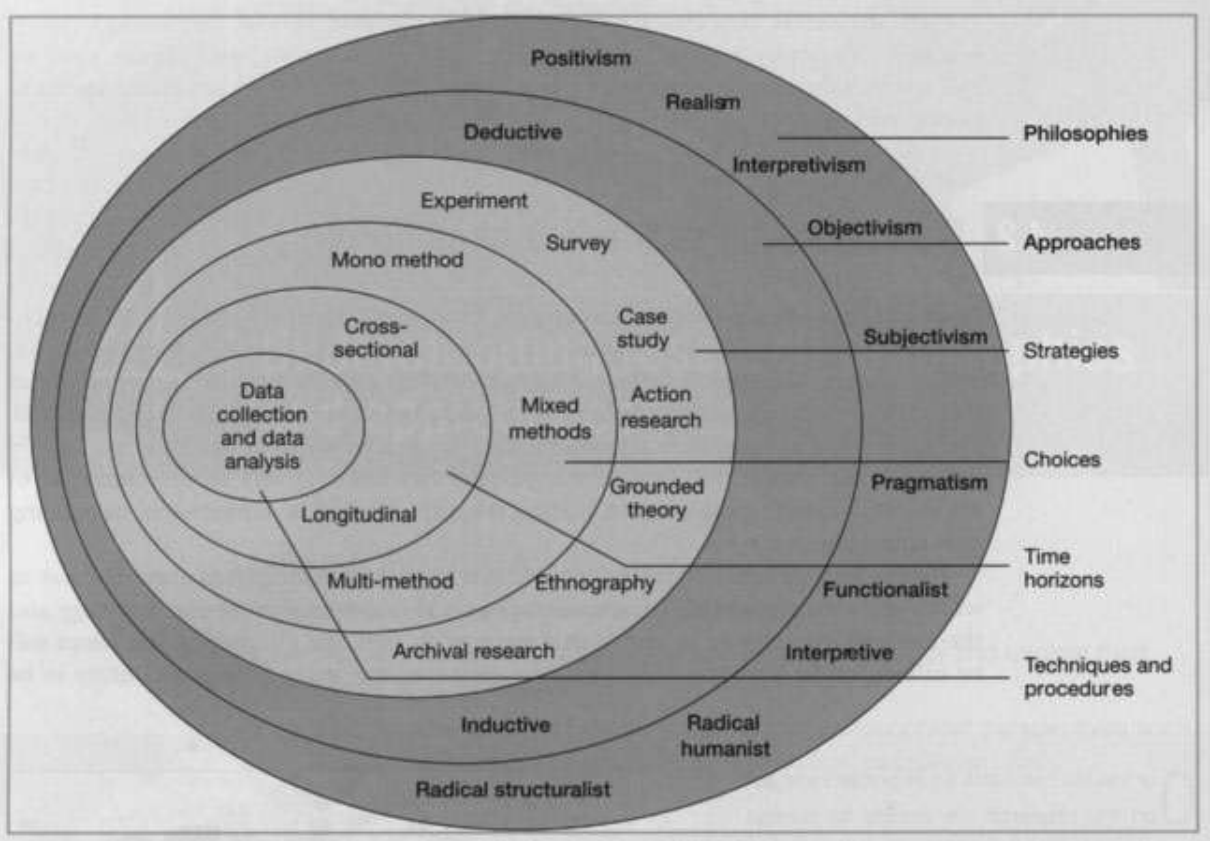

Figure 1: ‘Research Onion’, Source: M. Saunders, P. Lewis, A. Thornhill 2006

Only if the wider image (the ‘bigger picture’ behind the project or the research problem) is understood, the general way of approaching the project can be defined. Only then the research strategy and, successively, the methods can be selected. With a strategy and the appropriate methods in mind, a realistic time frame can be established. Finally, the required and feasible method of data-collection can be chosen.

4.2 Design of the proposed research project and theoretical background

I would like to discuss major concepts shown in the above Figure 1 and apply them to this research project.

According to Saunders et al. (2007, p.102ff) there are three ways to look at research philosophy which are epistemology, ontology and axiology.
'Epistemology concerns what constitutes acceptable knowledge in a field of study' (Saunders et al., 2007, p.102)

Different positions can be taken as a researcher (Saunders et al., 2007, p.103ff):

- **Positivistic view** (credible data produced by observation, research is based on facts; considered value-free and collected by an independent researcher)
- **Realistic view** (what our senses show us as reality is the truth; objects exist independently of the mind)
  - direct realism: sensual experience is an accurate image of reality
  - critical realism: sensual experience is only a representation of the reality, senses 'deceive' the observer
- **Interpretive view** 'differences between humans in role as social actors'

The interactions of participants in medical knowledge transfer projects from Western to Islamic cultures should be examined in this research project using an interpretive epistemology because of the following facts:

- The actors in such projects have a completely different, although often similar and therefore comparable personal and professional history
- The project is looking at interactions between people and not between objects.
- It is unavoidable to interpret social and professional interactions of the subjects of research in accordance with our own experience and views.

Being a practising medical scientist myself, I however cannot and do not want to avoid including a realistic element in approaching the problem. This is reflected in the aim of this research, which is to find a set of general rules that predict outcome. In my opinion this can only be achieved by including factual observations and discussing them in a critical realistic way.

Using an ontological approach to the problem of research philosophy it is difficult and impractical to take either a subjective or objective approach to the problem of intercultural knowledge transfer. I would suggest adopting a pragmatic view which mainly concentrates on the research question. An axiological determination of this research project should not be

undertaken because of the profound differences of the cultures involved and the different value concepts. During the study it is necessary to discuss the problem of 'value judgement' and the perception of value by people with different cultural backgrounds.

A different overview of different research paradigms is given in Table 5 (see Appendix A). Using this model a mixed methodology will be used with more weight on the qualitative / phenomenological side.

It was decided to utilize an inductive approach to solve the problem because data should be collected 'in the field' in order to develop a theory or in this case a theory-based tool, the envisioned checklist.

If a deductive approach (Saunders et al., 2007, Table 4.1, p.120) were to be applied, a hypothesis would need to be examined and finally approved or discarded. This seems impractical for this problem. (Appendix B)

The strategy to be used in this project is based on grounded theory, survey, ethnography, and case study. The author acts here as practitioner-researcher as he is involved in a 'living' project which is used as a vehicle for the research.

The data collection and analysis processes are suggested to be carried out using the following methods (in respective order):

1. Preliminary interview of two professionals directly involved in medical knowledge transfer projects. Preferably this should be a practising medic and the CEO of an organization providing medical aid in order to cover both sides – the provider and the receiver of aid.
   A Yemeni neurosurgeon who is routinely involved in medical knowledge exchange projects and who has several years of experience in the public as well as the private medical sectors in Sana'a, Yemen, agreed to take part in this step of the research. The UK-based CEO of an internationally active charity organization has also agreed to participate in the project.
2. As a result of the preliminary interview(s) key reasons for success and failure of such projects will be defined and key competencies for participants will be listed.
3. A questionnaire to define possible key questions to be answered to solve the research questions will be produced and translated into Arabic.
4. The questionnaire will be distributed to people directly involved (doctors, nurses, administrators, other involved persons) taking part in a real project in Yemen.
5. Semi-structured interviews will be carried out with four persons representing the key areas to be defined in step 2.

6. Following an analysis and discussion of the questionnaires and the interviews, a checklist for assessment of potential candidates is produced.

This list shows that the data-collection methods selected for this project are mainly interviews and questionnaires involving qualitative and semi-quantitative data.

4.3 Statistics

In order to compare the answers of the questionnaire, it was planned to use either a simple 'Yes – No - Don't know' design or wherever possible a five-point Likert scale. The Likert scaling system enables us to compare answers to one-dimensional questions which in this case always start with: 'How important is …'. The possible answers were 'Very important', 'Important', 'So/so' (=neutral/undecided), 'Unimportant' and 'Very unimportant'. By applying an odd-numbered scale the possibility of an undecided answer was given. The questions selected for Likert scales were extracted from the preliminary interviews if there seemed to be a broader variation in answers or opinion, or if the necessity to discuss the topic in question arose.

For comparative and rating purposes, the final results of the Likert scale questions were reduced to the sum of positive, undecided and negative answers and a percentage was calculated. Only if it was not possible to rate the individual items by the application of this method, the weighting of the answers towards 'Very important' or 'Very Unimportant' was reviewed.

The problem with the Likert scale is that is represents an ordinal scaling system. This means in this case that the difference in agreement or disagreement (virtually the 'distance') between the different scale points is not measurable which renders the calculation of mean median and similar transformations impractical and erroneous. In order to reflect those mathematical restrictions, the application of descriptive statistics will be limited to a bar chart comparison of the number / percentage of specific answers to the different topics. After combining the positive ('Very Important' + 'Important') and negative ('Very Unimportant' + 'Unimportant') answers the application of the Chi-Square-test to calculate significance is nevertheless possible.

4.4 Research ethics

When planning a research project high ethical standards need to be fulfilled. In this project this involves confidentiality about the content of the interviews to be carried out.

Due to the ability of the participants to reject participation in the survey or the interviews there is no need to involve an ethics commission or produce a document for formal consent. The

participants in the interviews are not dependent on the author and vice versa. The transcripts of the interviews are anonymous and the original transcript and/or electronic recording of the interview is retained by the author only in order to be able to prove the authenticity and validity of the research.

The author is bound by the Hippocratic Oath and by legal regulations not to reveal any private and confidential information. Any information regarding specific patients remains private and individual religious and cultural values are constantly being observed and followed. This includes not recording or publishing private information that could lead to the identification of participants of the survey.

It would be potentially problematic to include patients and their relatives in the survey as they seek medical treatment and/or advice and are therefore dependent on the author. Therefore these individuals are to be excluded from the survey.

5 Resources

The resources used during the process of research are generally available in the university library of Anglia Ruskin University, Cambridge and Berlin School of Economics, online or via personal communication with participants of the study. There is no formal level of confidentiality or secrecy to be expected. The access to certain information concerning methods and results related to projects in a competitive environment (i.e. internal financial hospital information and intra-organizational strategic and personal / corporate financial data) might be restricted and possibly not obtainable. If necessary, this needs to be addressed in the discussions part of the thesis.

6 Access to Study Population and Resources

Access to the study population is easily available to the author because of scheduled international projects involving the subjects to be addressed and questioned. The author is a practising neurosurgeon taking part in international knowledge transfer projects and has therefore unlimited access to the study population. As the author is personally participating in a current medical exchange project in Sana'a, Yemen, the return rate of the questionnaires to be handed out is expected to be exceptionally high.

The required data resources are accessible via the accreditation of the author as a business student in Berlin and Cambridge.

7 Timescale

In order to plan, carry out and successfully complete a research project it is very useful to develop a comprehensive timetable.

This timescale should be challenging, which means it should be demanding in order to produce maximum output in an efficient way. At the same time it should be realistic because unrealistic planning will inevitably lead to missed deadlines and possibly project failure.

In project management the 'Gantt Chart' (named after Henry Gantt, 1861-1919, based on a tool called harmonogram by Karol Adamieckie in 1896) is a simple, popular and widely used tool for time planning and monitoring of the progress of projects. One of the advantages of Gantt charts is the possibility of implementing it in software and web-based applications making collaboration easier.

This tool is commonly used in large projects involving many participants.

In this research project a simple timetable will be used because it is easy to manage and to follow as all tasks and deadlines are only to be met by the author. There is no need for collaboration between multiple participants which is why a Gantt chart is not needed.

The suggested general timetable for this research project is shown in Table 7 (Appendix C).

A more detailed chart showing a week-based timeline and the specific tasks to be carried out is shown in Table 8 (Appendix D). This table is more usable than Table 7 because it takes the specific professional workload of the author into consideration and therefore is more realistic.

It is important to include 'buffer zones' as potential time problems due to professional involvement make accurate time-planning somewhat more demanding and difficult.

8 Results and Analysis of Data

8.1 Preparation of the Preliminary Interviews

In the first step, following extensive literature research, key areas were defined which could be important for any research on the topic of scientific knowledge transfer from Western to resource-limited Islamic countries.

These key areas were recorded and used as a backup during the interview in order to obtain as much information as possible. It was decided to put a slightly different emphasis on specific questions according to the different needs and expectations of providers and receivers of knowledge exchange projects.

Table 2 shows typical key areas for providers and receivers:

Providers	Receivers
• Important/crucial properties of a provider of medico-professional knowledge • Common reasons for project failure • Common complaints of participants • Positive experience of participants • How does your organization prepare projects? • Is there a follow-up / feedback system and how is it run?	• Professional qualifications • Communication skills of the guest / with the guest • Language skills / Requirement and properties of a translator • Role of previous experience of the guest in similar projects • Role of emotional stress and approach to disease, treatment and death in Islamic environment • Monetary issues in Healthcare in Islamic countries • Role of Age, Gender and Religion of the guest • Duration and repetition of stay

Table 2: Typical key areas for providers and receivers

8.2 Preliminary Interviews

During the preliminary interviews careful attention was exercised not to ask suggestive questions and to let the interviewee provide as much information as possible.

The first preliminary interview was carried out at the UK headquarters of an international medical charity organization in London. The CEO of the organization agreed to take part in the study and share some of her extensive experience in the field of provision of international medical charity to countries and people in acute health emergency situations.

A transcript of the interview is provided in Appendix E.

The answers to the specific questions resulted in the following sorted list of key problems relating to the organisation of medical charity projects and the personal skills of the participants (Table 3):

Personal Skills of Participants	**Organisation of the project**

- Experience in similar projects
- High level of team competence, adaptability
- Outstanding interpersonal communication skills
- Language skills are less important than communication skills
- Professional skills are less important than communication skills
- Positive Experience of Participants:
  o High level of respect from locals & at home
  o Satisfaction of helping and doing something great
  o Fruitful communication
  o Seeing something interesting and new
	- Common complaints:
	  o Managerial deficiencies
	  o Lack of money/resources
	  o Preparation time too short
	  o Pace of action on-location too slow
	  o Participants have to fit into team (co-workers, locals)
	- Preparation:
	  o Interviews by experienced interviewers: ‘gut feeling’
	  o References not so important (don't predict reactions under specific stressful situations) = experience in similar projects more important
	  o No formal training program, language course, workshops or inductions
	- Follow-up: reports (daily/later weekly), statistics, evaluations

Table 3: Key problems relating to the organisation of medical charity projects and the personal skills of the participants (Preliminary Interview I)

In addition, the following likely reasons for failure were pointed out:

- Managerial / organisational deficiencies
- Lack of team competency
- Poor relationship with and misunderstanding of local people

Several key points were repeatedly mentioned (communication skills, team competency, management deficits) and therefore combined.

Deficits in monitoring projects, motivational deficits and leadership problems were combined as managerial deficiencies.

The second preliminary interview was carried out at the University of Science and Technology Hospital in Sana'a, Yemen, with a fully-registered Yemeni doctor (neurosurgical registrar) who is employed by both a public and a private large hospital in Sana'a. He is looking back at three years' experience in regular participation in short-term medical knowledge exchange programmes (i.e. Visiting Professor Program) involving different doctors. He agreed to take part in the study and share his experiences on the receptive side of medical knowledge transfer. He was selected for the preliminary interview because he has taken an active part in facilitating the visits of several foreign doctors by acting as an interpreter.

A transcript of the interview is provided in Appendix F.

The answers to the specific questions resulted in the following sorted list of key problems relating to the organisation of medical charity projects and the personal skills of the participants (Table 4):

Personal Skills of Participants	Organisation of the project

- Professional experience important
- Older age often related to more experience/better service (not extremely important)
- Specific skills/techniques which are currently not available should be taught
- Outstanding communication skills
- Language skills are not important
- Experience in same or similar countries advisable to know what to expect
- 'Reputation is everything' = repeated visits preferable
- Patience, honesty and cultural understanding
  o Repeated discussions with patients & relatives = collective society.
  o Different approach to disease and death = requires careful communication
- High level of respect from locals due to often good reputation of Western doctors
- Religion: generally no problem, but no public display of religion/arguments about it
	- Permanent local translator is required
	- Translator should be a medic (people often uneducated, perception of disease, locally specific communication, needs to be able to get hidden messages/meaning)
	- Payment for treatment is usual and free treatment could be equated with bad quality
	- Hospital will charge patient anyway and there is a risk that services of guests are used to generate profit
	- Discounts, different fees for treatment according to social status and financial negotiations are common and normal
	- Time for decision is often very long and repeated visits of the patient have to be expected
	- Gender is important in some specialities and situations:
	  o Surgery = male guest more accepted, female guest not acceptable
	  o Gynaecology = female guest required, male guest not acceptable
	- Duration of stay: from 5 days to about 3 weeks
	- Security issue is present but only in areas of conflict, apply common sense
	- High level of competition between local professionals is present and guest could be seen as threat

Table 4: Key problems relating to the organisation of medical charity projects and the personal skills of the participants (Preliminary Interview II)

8.3 Literature-based Definition of Key Success Factors and Key Competencies

The literature research provided specific potential key success factors in relation to potential participants which might require attention when planning and organising intercultural knowledge exchange projects.

These can also be divided into general factors, skill and experience-based factors and organisational factors (Table 9).

General Factors	Skill Based Factors	Organisational Factors
Age	General Professional Experience	Intercultural communication
Gender	Specific Professional Experience	Security
Religion	Language Experience	Translator necessary
Dress code	Work Field	Translator: local person
Social Status/Provenance	Experience in Similar Projects	Organisation or Private ?
Educational Background	Knowledge of Islamic Rules	Organisational Culture

Table 9: Possible Key Success Factors and Key Competencies (literature-based)

8.4 Production and Testing of the Questionnaire for the Survey

A preliminary English version of a questionnaire was produced combining the literature-based with the proposed key success factors which were extracted from the preliminary interviews. The selection process of the questions was carried out in the following way:

1. Question included if it appeared in both lists as important.
2. Question included if there were different opinions between the literature research and one or both preliminary interviews or between interviewees.
3. Question included if an extremely high relevance was detected either in the literature or during any of the preliminary interviews.
4. Question was included if the author experienced extremely high relevance for the success of a project due to specific conditions in Yemen. (e.g. advertising)

5. Question was excluded if it seemed not to be relevant or understandable for all participants of a general questionnaire for use in highly diverse professional group.

In order to enable reliable and comprehensive processing and to generate usable results, a number of general questions had to be included. The answers to these general questions served as descriptors of the study population with regard to age, gender, work field and professional experience.

The questions were divided into two categories delivering information about expected skills and training of foreign guests and organisational issues of the visit.

Where applicable a five-point Likert scale was applied. The rest of the questions offered three possibilities: ‘Yes’ – ‘No’ – ‘Don't know/care’.

At the end of the questionnaire the participating employees were invited to provide personal characteristics which they would like or dislike in visiting guests and there was also room for suggestions to improve visitor's programs and relevant remarks.

The completion of the questionnaire required on average not more than about 5 minutes.

The anonymous questionnaire was initially produced in English applying the above mentioned rules and then translated into Arabic. In a third step, the survey was then re-translated by a different person back into English to minimize possible errors due to translational variations. Furthermore, the questionnaire was presented to two native Arabic speakers who explained their understanding of the survey to the author.

Some slight changes had to be applied to make sure the questions were understandable and unequivocal.

A possible source for bias was encountered during the execution of the survey:

There is a certain number of Indian and Pakistani staff who wanted to take part in the survey but obviously come from a totally different cultural background.

Due to their linguistic communication in English they received an English version of the survey which could be used for comparative purposes but was not used for the core study.

The English version of the questionnaire can be found in Appendix G and the final Arabic version in Appendix H.

8.5 Results of the Survey

8.5.1 General description of the study population

8.5.1.1 Gender and age distribution of the study population

For a period of three days, the questionnaires had been handed out to all accessible employees of the largest privately run hospital in Sana'a (University of Science and Technology Hospital, N=64) and to the surgical employees on duty of two other hospitals in Sana'a (Yemen German Hospital, N=33 and Saudi German Hospital, N=10). A total of 120 questionnaires were handed out. The return rate was 89.2 % (N=107).

The gender and age distribution of the study population is shown in Charts 1 and 2.

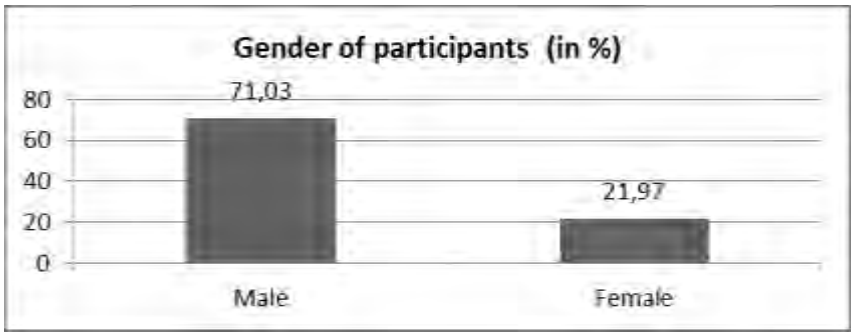

Chart 1: Gender distribution of participants

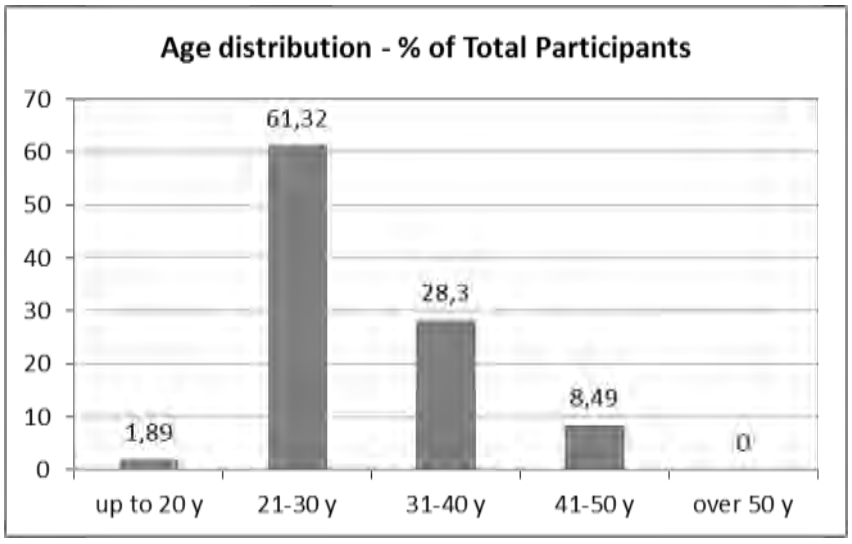

Chart 2: Age distribution of study group (N=107)

8.5.1.2 Field of work and work experience of the questioned employees

The distribution of the work field and the work experience of the questioned employees are depicted in Charts 3 and 4:

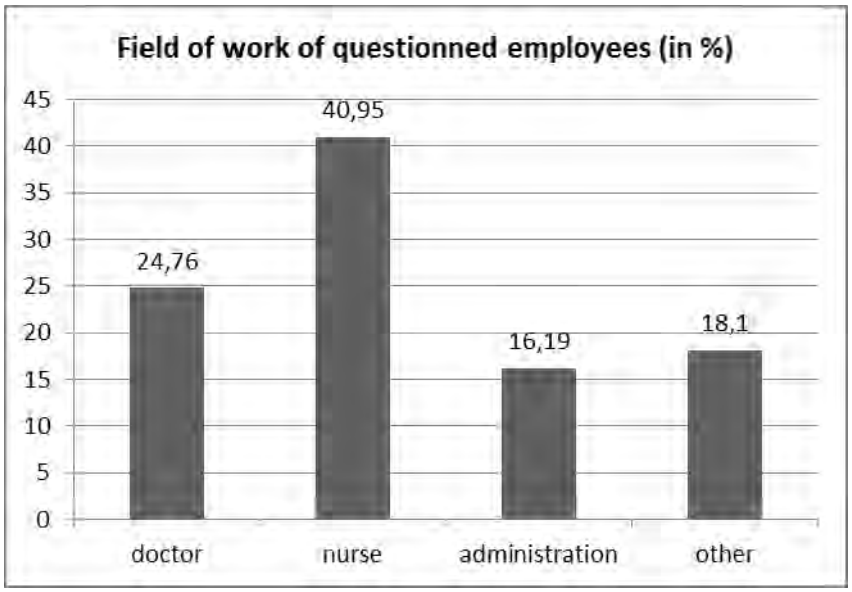

Chart 3: Work field of the study group (N=107)

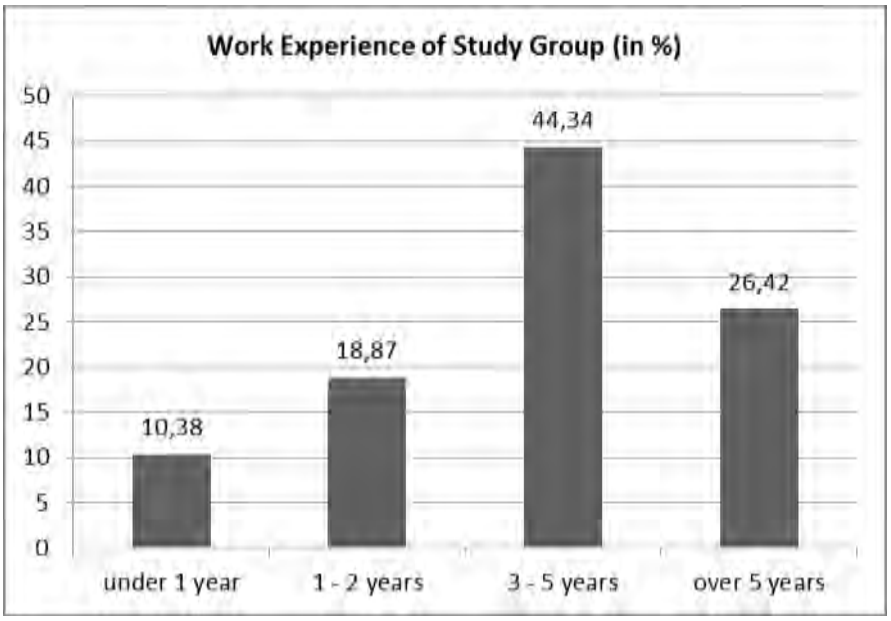

Chart 4: Years of Work Experience of the study population (in %)

8.5.2 Skills and Training of the visitor

8.5.2.1 Professional experience and specific professional skills (hard skills)

The importance of overall professional experience of the potential visitor was to be rated on a 5-point Likert scale. Furthermore, questions whether the guest should offer training in basic or highly specific/new skills which are not available in the target region were to be answered on a Yes/No basis.

The results are shown in Charts 5, 6 and 7:

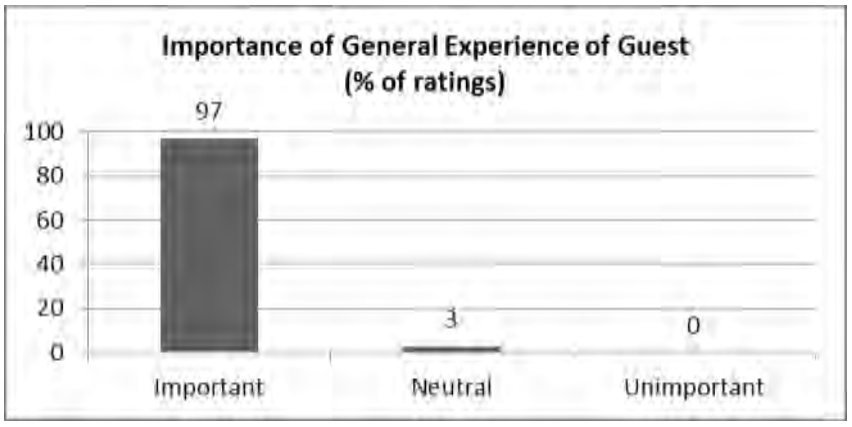

Chart 5: Importance of overall professional experience of guest (using 5-point Likert scale)

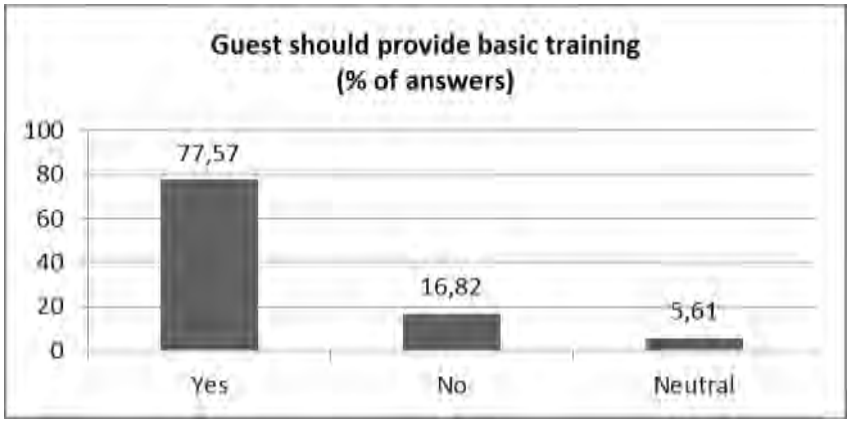

Chart 6: Desired Ability of Guest to provide Basic Training

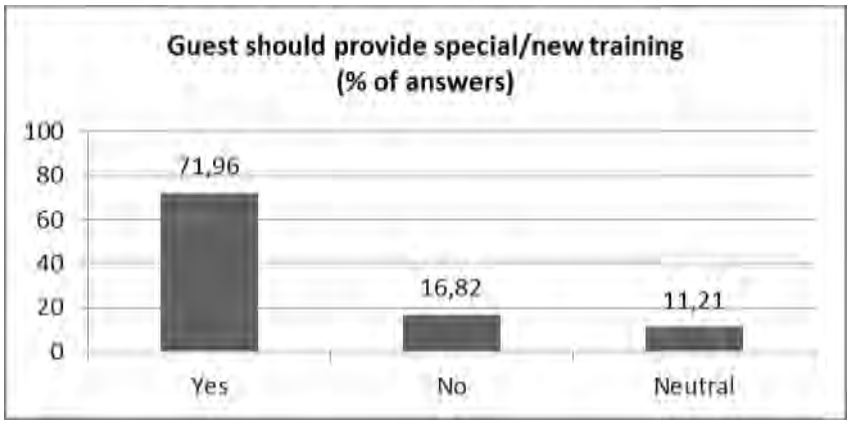

Chart 7: Desired Ability of Guest to provide Specific Training

These results show the significant importance of a substantial professional experience of the potential guest. The transfer of basic as well as highly specific professional knowledge is equally desired by the targets of the knowledge transfer.

8.5.2.2 Communication skills (soft skills) and language skills (hard skills)

Communication skills seem to play an important role in the preparation, delivery and assessment of inter-cultural aid and knowledge-transfer projects. A scale or decision-based rating of the importance of general communication and inter-personal skills seemed rather impractical as it proved difficult to define specific personal properties which would reflect each participant's views. Therefore desired personal characteristics of potential guest were requested in the free text section of the questionnaire, the results of which are shown under item 8.5.2.5.

The command of the local language (Arabic) might be helpful and was therefore addressed in the questionnaire as a five-scale item. The results are shown in Chart 8.

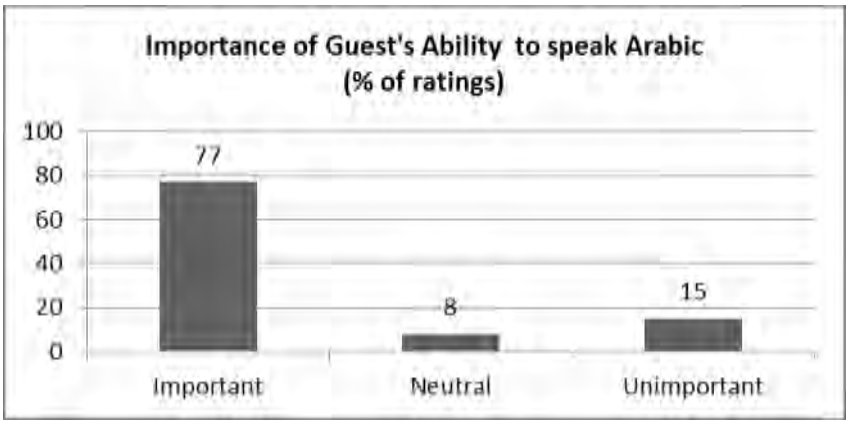

Chart 8: Importance of Guest's command of Arabic language (using 5-point Likert scale)

Here, a clear preference of the receivers of the aid for guest with an ability to speak Arabic seems to be present.

8.5.2.3 Knowledge of Islam and Previous Work Experience in a Similar Environment (soft skills / hard skills)

The study population's rating of the importance of a basic knowledge of the local religion is shown in Chart 9.

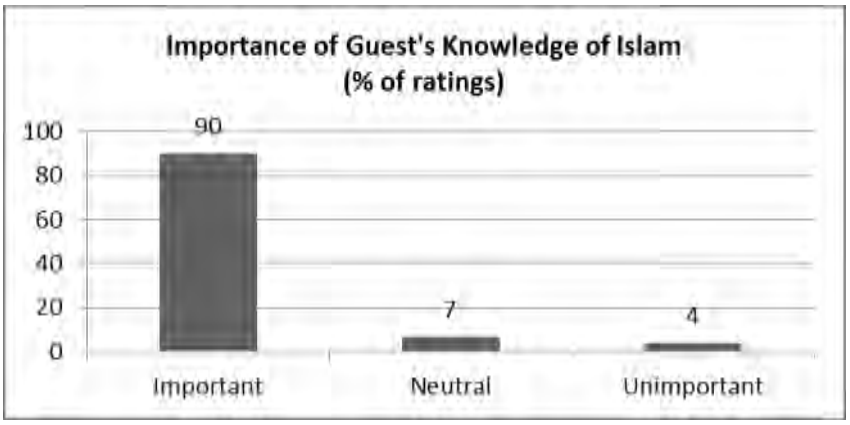

Chart 9: Importance of Guest's basic knowledge of Islam
(using 5-point Likert scale)

A person who has previous work experience in similar environments and therefore is more likely know how to behave appropriately in a specific cultural environment could be preferred by the host population. Therefore the topic of preference of a guest with previous work experience in an Arabic country was included in the questionnaire (Chart 10):

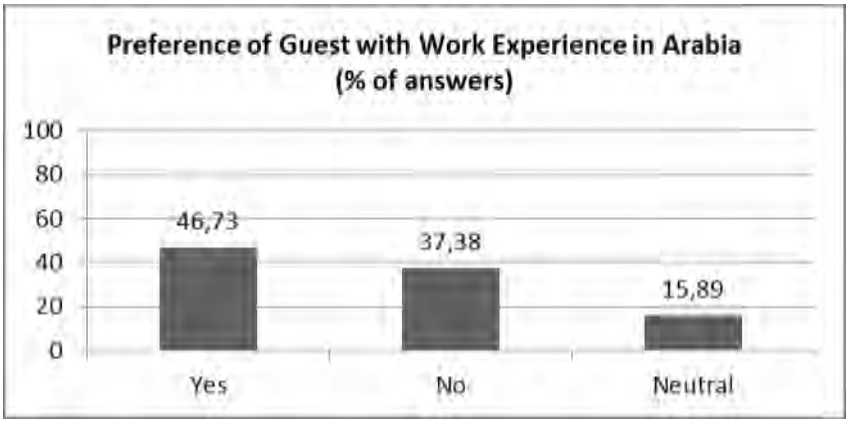

Chart 10: Preference of Guest who worked in Arabia before

The receivers of the help programme do not seem to prefer guests who worked in Arabia before.

8.5.2.4 Age and Gender Issues and Attachment to Specific Specialities

There seems to be an awareness of the age (Chart 11) of potential guests although the importance of this item is by no means seen as high as for the above mentioned issues of professional expertise.

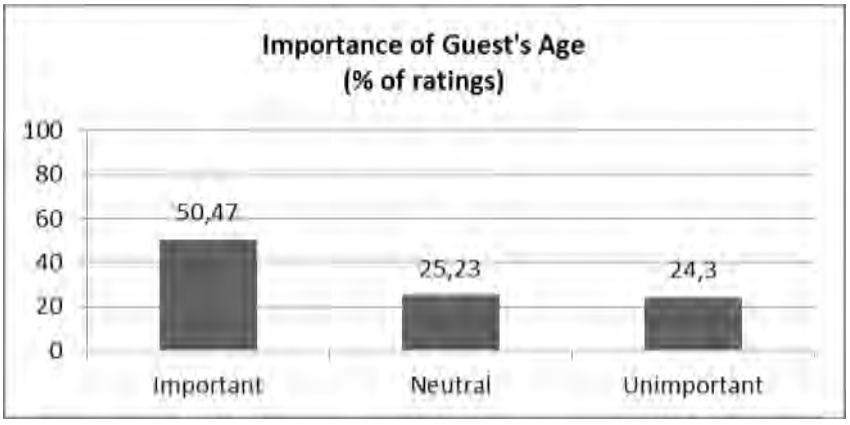

Chart 11: Importance of Guest's Age
(using 5-point Likert scale)

About half of the participants show a gender preference for the visitors with male guests being preferred (Chart 12). This might be a reflection of male dominance in the Arabic culture but could also just stand out because of the majority of male participants due to the specific gender distribution in Arabic hospitals. The gender issue should be discussed in the interviews as it could be of significance especially for specific specialities.

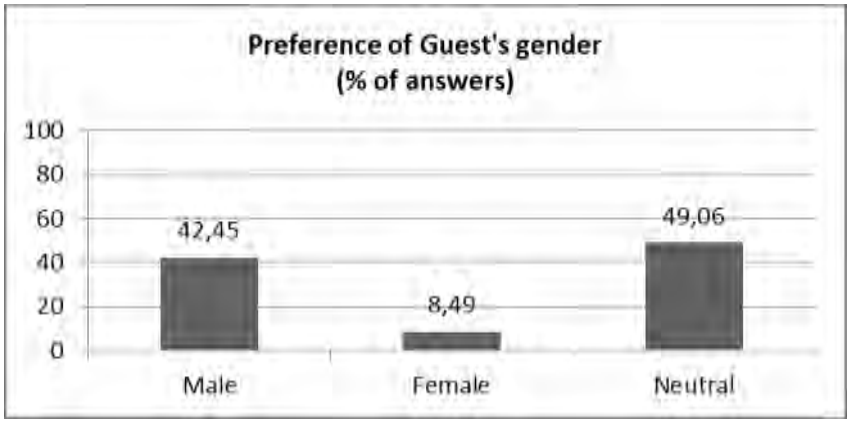

Chart 12: Preference of Guest Gender

Chart 13 shows absolute numbers of clearly preferred male or female guests in specific medico-professional environments.

This chart is to be regarded with caution because it shows only absolute numbers and is not necessarily representative for general tendencies as the participants could either mark several specialities or none at all. Nevertheless it enables us to point out specialities in which the gender issue might be more relevant.

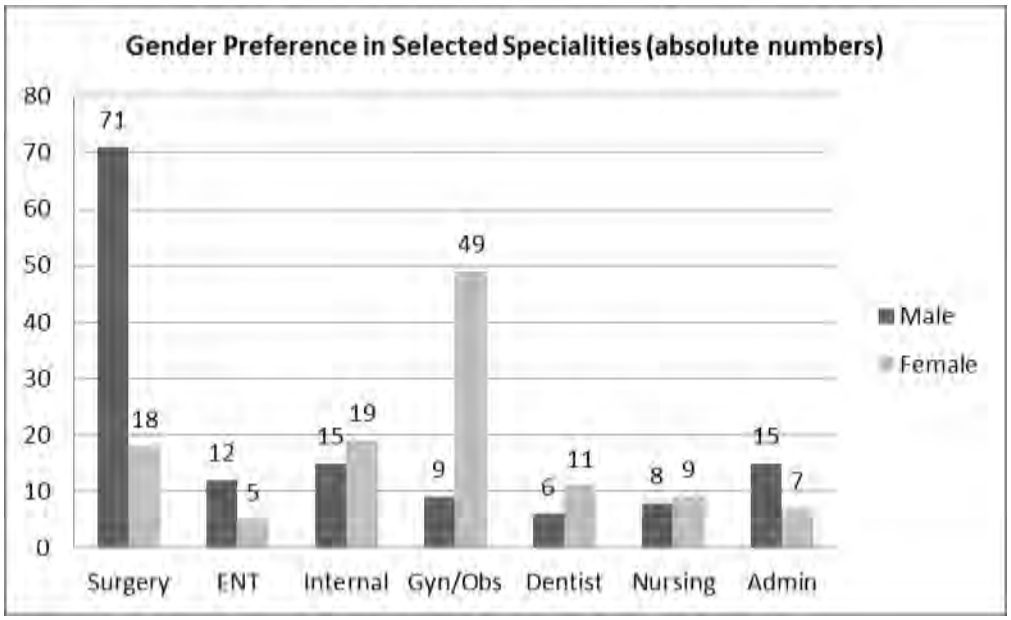

Chart 13: Preferred Gender of Guests in Selected Specialities (absolute numbers)

8.5.2.5 Preferred personal characteristics

Chart 14 depicts how the surveyed employees rated the importance of the guest's own religion.

It suggests that there is no significant preference or importance as to which religion the guest belongs to. Given the importance of religion in local everyday life this seems surprising but may also reflect the understanding, that any visitor is relatively likely not to be a Muslim in any case.

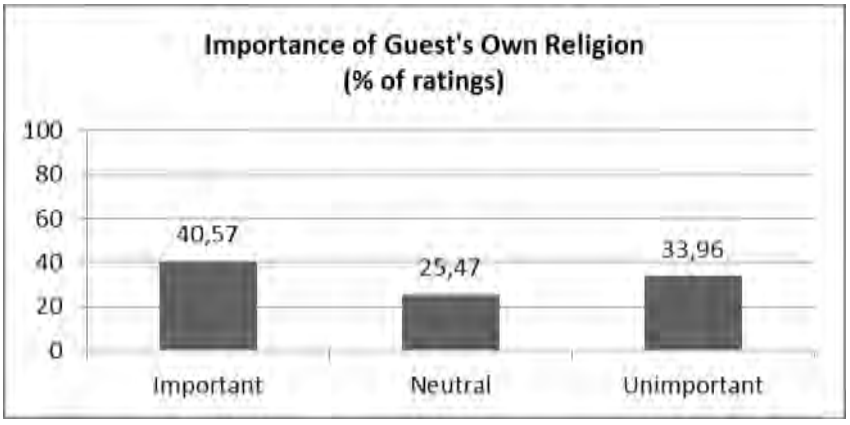

Chart 14: Importance of Guest's Own Religion (using 5-point Likert scale)

An analysis of the free text comments regarding preferred personal characteristics on Page 2 of the questionnaire (individual comments were grouped and counted) is shown in Table 10.

This is, of course, very subjective and is intended to define possible areas which are of interest for the involved individuals and therefore might need further discussion and clarification.

Group of characteristics	Characteristics and No of occurrence		Characteristics and No of occurrence	
Personality	Non-superior	35	Polite, gentle	9
	High ethics	33	Not arrogant	6
	Not Easily excitable	17	Smile	8
	Truthful/Faithful	11	Good personality	7
	Respectful	10	Open minded / tolerant	7
	Patience	10	Human	4
Professional Experience	Experience	41	Certificate	12
	Special skills	21	Famous	9
Patient skills	Patient skills	49		
Inter-cultural skills	Interest in country and people	18	Arabic skills	8
	Non-interference with local matters	5		
Work-skills	Efficiency	12	High work quality	4
	Share knowledge	7	Follow up patients	4
	Co-operative	7	Learn from locals	2
	Hard-working	7		
Age	Not too old	10	Not too young	1
Money	Not money-focused	19		

Table 10: Free text comments regarding preferred personal features of possible guests

8.5.3 Organization of the visit

8.5.3.1 Advertising, time scale of preparation

In an environment in which access to modern sources of information like internet, satellite TV and similar technologies is likely to be non-ubiquitous, appropriate and accessible advertising seems to be an important preparatory step for any aid project involving a broad base of individuals (patients).

Chart 15 shows the study population's rating of the importance of advertising efforts for knowledge exchange / aid projects.

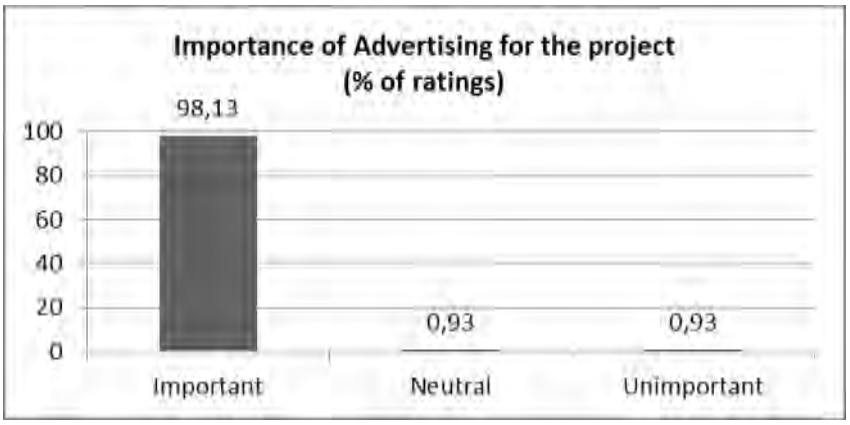

Chart 15: Importance of Advertising (using 5-point Likert scale)

When asked for the preferred preparatory time-scale for a medical knowledge exchange project, **82.52% (N=89)** of the questioned individuals provided an answer. The average suggested time for preparation of a medical knowledge exchange project was calculated to be **23 days**.

8.5.3.2 Communication with local population and colleagues, cultural heritage and history

The opinion of the questioned employees about the importance of the guests meeting local people and visiting historical and cultural sites in the host country is shown in Charts 16 & 17.

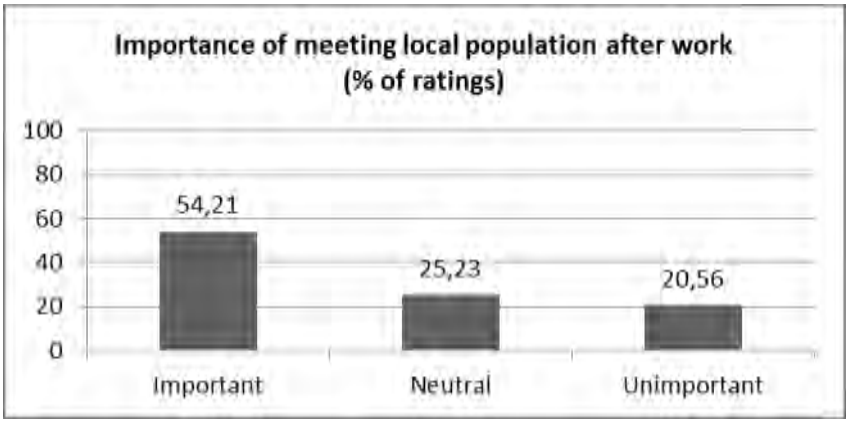

Chart 16: Importance of guests meeting the local population after work (using 5-point Likert scale)

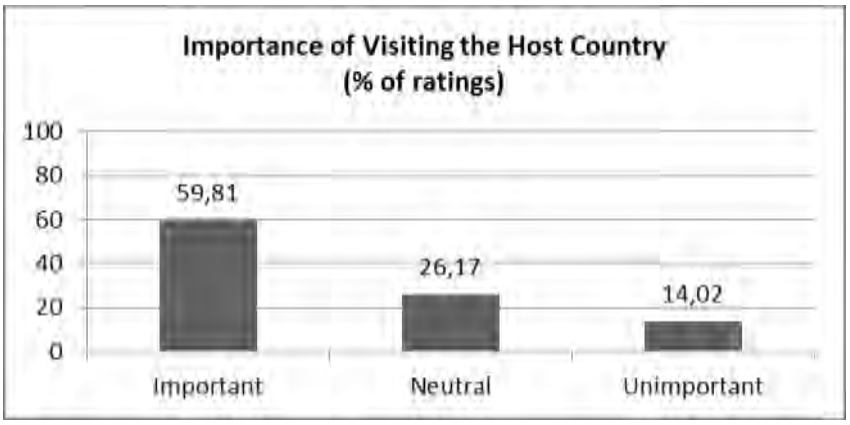

Chart 17: Importance of Guests visiting historically/culturally important sites (using 5-point Likert scale)

The interesting question whether guests could be seen as a threat to the local colleagues is clearly answered in Chart 18 defining this topic an issue of further discussion:

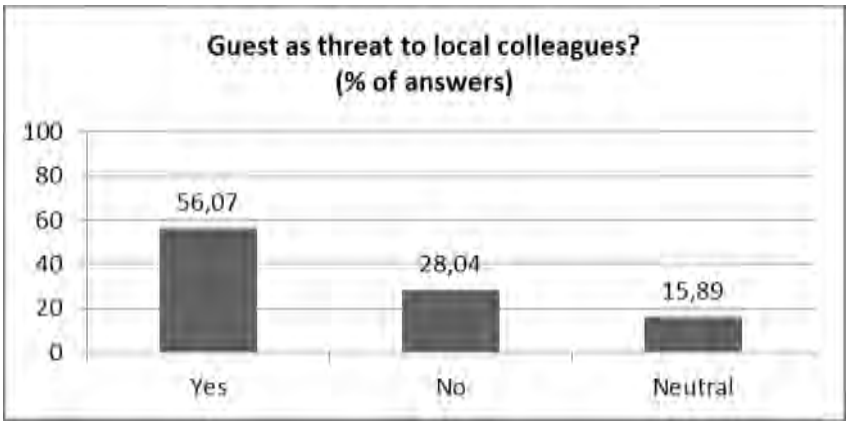

Chart 18: 'Could guest be seen as a threat to local colleagues?'

Although many participants of the survey would like to welcome an Arabic speaking guest (8.5.2.2.), this is often impossible to achieve. Therefore the provision of an interpreter seems more practical.

Charts 18 and 19 show the opinion of the surveyed employees as to whether this interpreter should be local and/or a medical professional as well.

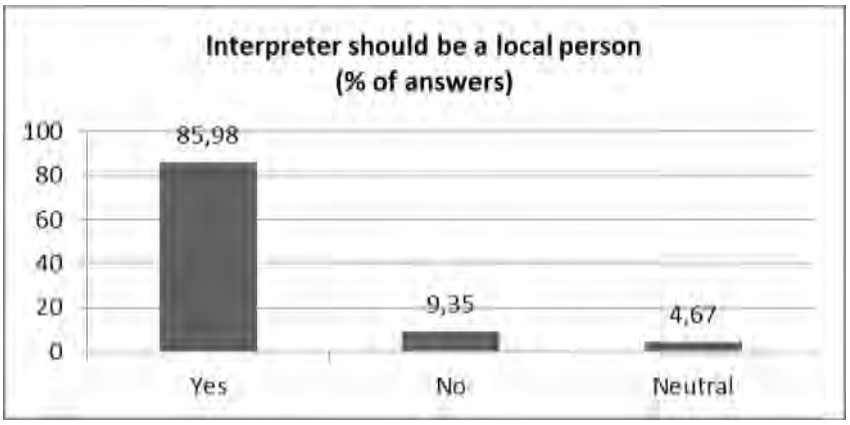

Chart 18: 'Interpreter should be a local person.'

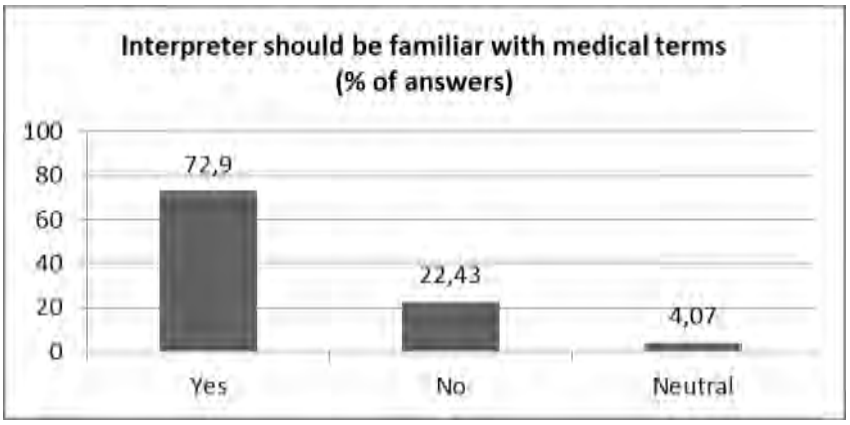

Chart 19: 'Interpreter should be a doctor.'

There is a strong preference for local interpreters who are doctors.

Interestingly, the employees rated it slightly more important that the interpreter should be a local resident than that this person is a doctor at the same time.

8.5.3.3 Remuneration Issues

The views of the study population regarding the remuneration of potential visitors and possible differences to local salary rates are shown in the following Charts 20 and 21:

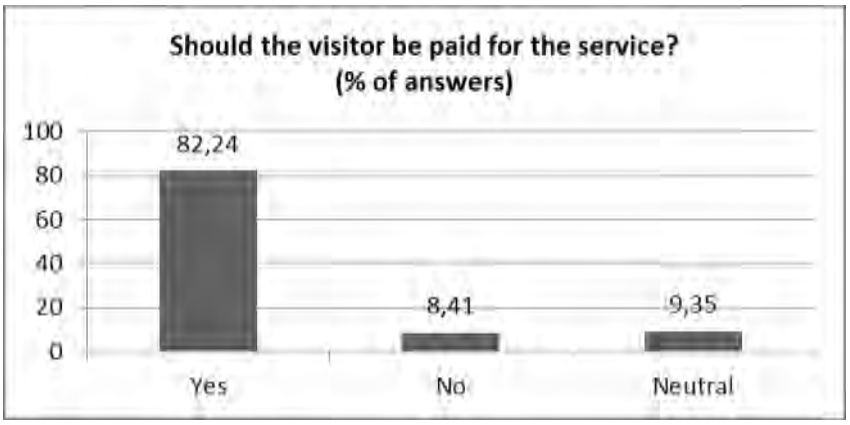

Chart 20: 'Should the guest's service be paid for?'

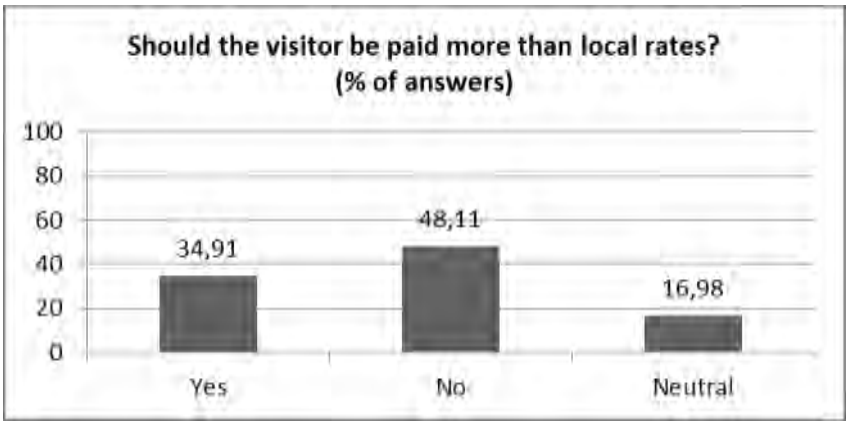

Chart 21: 'Should the guest's service be paid more than locals?'

Interestingly, the majority of the questioned people voted for a paid service of the visitors. This issue might lead to controversial discussions in the context of the provision of charity and developmental aid. Therefore it will be included in the interview section and specifically addressed in the discussion.

8.5.3.4 Safety Issues

As mentioned above, safety is a growing concern and might be an important obstacle towards the provision of aid programmes especially after serious attacks on foreign guests in Yemen.

The result of the survey regarding safety issues is shown in Chart 22:

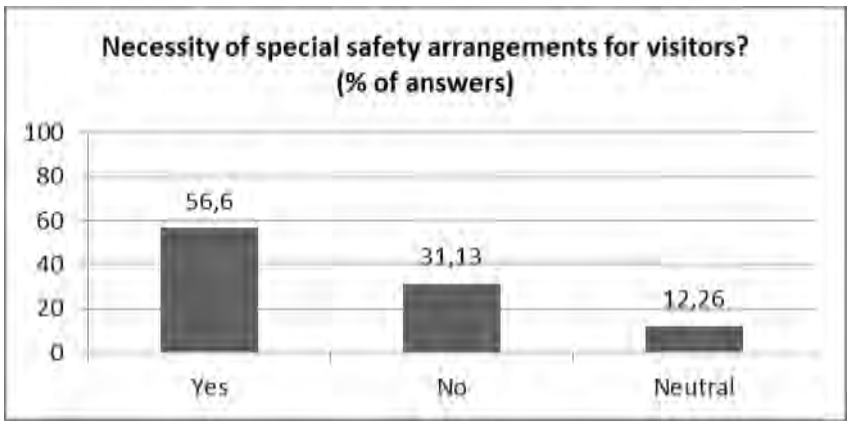

Chart 22:
Necessity of specific safety and security arrangements to protect guests

It seems that the security threats towards foreign guests are somewhat underestimated by the local population. Only half the questioned employees think that special measures should be taken. It would be interesting to see a similar result surveying potential participants or their relatives or co-workers. This issue should therefore be elaborated on in the interview and discussion sections.

8.5.3.5 Organizational structure of the provider, single or repeated visits

The answer to the question if the visitor should rather be part of an organization or act as a private person is given in Chart 23:

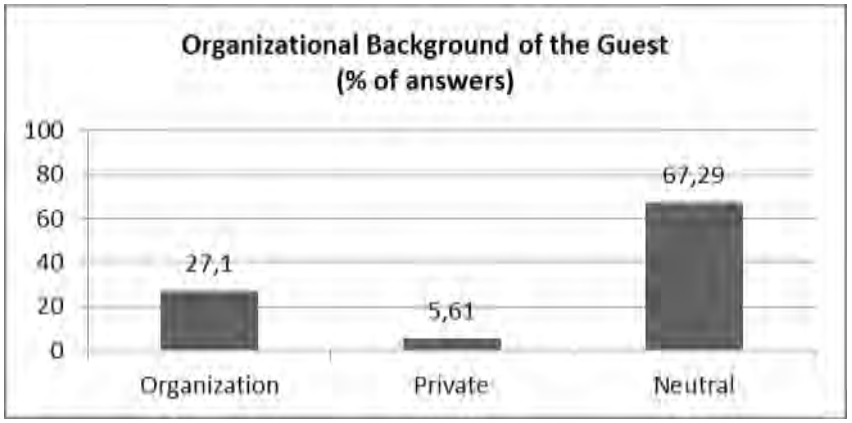

Chart 23: Organizational background of the visitor

This shows that the majority of participants are undecided or neutral but if there is a preference it is clearly towards an organizational background.

Interestingly, if the participants are asked whether they would prefer to work with the same person repeatedly, there is no major difference between the percentage of participants who would like to work with the same person repeatedly and those who'd rather like to see different persons. (Chart 24)
The reason for this might be that it could be more interesting to work with different people with a similar cultural background to maximize the benefit by taking different approaches.

Chart 24: Position towards regular visits of the same person

This issue should definitely be discussed in the interviews because from the author's own experience the visits seem to become significantly more efficient, at least during the first few repetitions, before the benefit seems to decrease for both sides.

More insight into this complex phenomenon might be gathered by relating the answers to the different professional backgrounds of the participants. (I.e. repeated visits of the same person could be favoured by doctors in order to establish friendships and professional co-operation between visits and ease the preparation of further projects.) Chart 25 shows the distribution of the opinions about regular visits of the same person (in this case doctor) in relation of the profession of the participant:

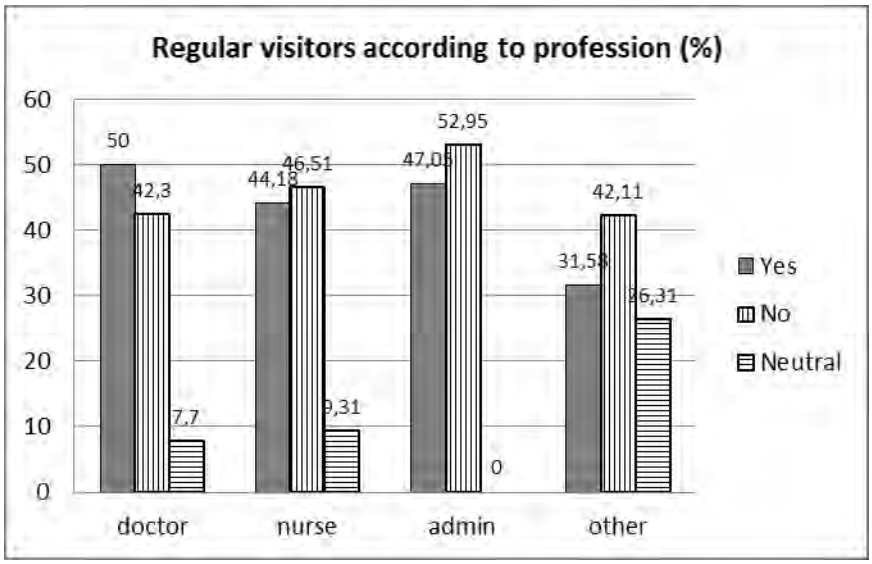

Chart 25: Position towards regular visits of the same person according to professional group

There seems to be no relevant difference in opinion even between the different professional groups.

The possibility of contacting the visitor even after returning home should prove beneficial for following up the treated patients and solving possible problems. Chart 26 shows how the participants of the survey rated the importance of this possibility:

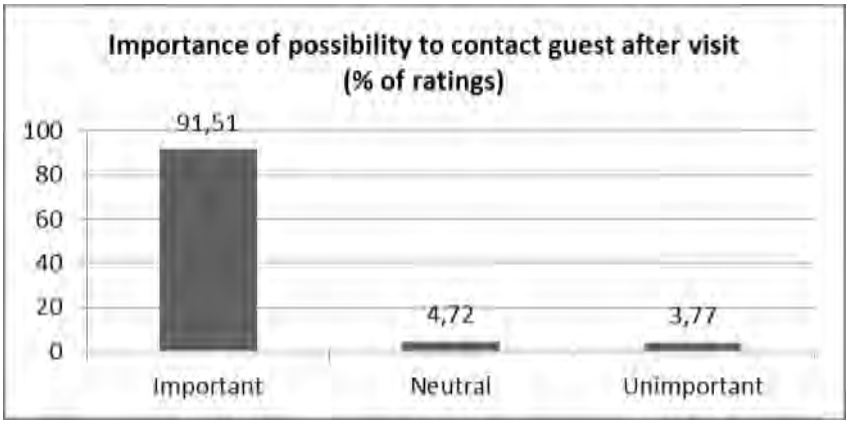

Chart 26: Importance of the possibility to contact the visitor after the project (using 5-point Likert scale)

In comparing charts 24 and 26 a potential problem arises:
It might be expected that if roughly half of the questioned employees favour different visitors each time, a similar relation should show when the question about the preparedness of the previous guest to be contacted at a later point is asked. Interestingly, this is not the case. There is potential for friction which in fact was experienced by the author himself during a few live projects. The author would even suggest that this problem, which on first sight might appear to be negligible, even has a real potential of jeopardizing a whole project. This is why this problem needs to be elaborated on at greater length later.

8.5.3.6 Suggestions

The free text suggestions which could be made at the end of the questionnaire are relatively difficult to analyse as those answers reflect highly subjective views. Nevertheless, the inclusion of this section in the survey could be helpful as it reflects problems which, in the opinion of the participant, were not (or not fully) discussed or covered by the other questions.

Table 11 shows the main suggestions arranged according to topic and frequency.

The main topics mentioned were the appropriate preparation of the visit, sufficient advertising, the inclusion of some form of teaching programme, the availability of the programme for all patients (poor and rich), repeated visits and the availability of the visitor for follow-ups. These topics will be included in the interviews and extra weighting will be applied in the selection process for the final checklist.

Topic Group	Topic (number of occurrence)	Remarks
Personal Properties	Special Knowledge & Expertise (12)	rare specialities complicated cases
	Fairness with colleagues (6)	no disadvantage for locals co-operate with local colleagues
Organization Issues	Preparation & Supplies (41)	Assignment of personnel and resources Provision of needed instruments/supplies Planning of patients (appointments)
	Follow-up System /Repetition (20)	Selection of specialities in need for guest Continuous contact with visitors Exact dates for repeated visit
	Advertising (19)	Early enough Specify expertise of visitor Efficient channels
	Teaching (17)	Lectures (to local staff) Case discussions Guest should be willing to learn from locals
	Guest-availability to poor & rich (14)	Ensure equal treatment of all patients Ability to reduce price or work for free
	Surroundings (7)	First aim to help people Comfortable
	Schedule (5)	Arrange visits to local attractions Reliable

Table 11: Free text suggestions for the organization of intercultural knowledge exchange programmes

8.6 Definition of the Key Questions for the Semi-structured Interviews

The semi-structured interviews were carried out after the questionnaires were processed and general opinion-tendencies on the surveyed topics were identified. All topics of the questionnaire were addressed and special emphasis was given to those results that seemed surprising and unexpected. Those topics were preparation of the visit with regard to staff selection (guest profile/co-workers) and time schedule, communication issues, advertising, gender and age of the visitors, remuneration issues, religion and safety. According to plan, the interview was semi-structured and the interviewee could emphasize specific topics if she or he wished to do so. There might be a difference in opinion between Arabic and European interviewees. Therefore the answers will be grouped and compared.

8.7 ***Results of the Semi-structured Interviews*** *(compare Appendices I and J)*

8.7.1 Professional Qualification of Visitors

The Arabic interviewees pointed out that both, general and specialized knowledge in the field of interest are important. 'Gaps in the number of specialists and in knowledge need to be filled'. At the same time the main purpose of the visit should be to educate the local professionals and not just the provision of service which would stop with the departure of the guest.

One of the interviewees mentioned succinctly:
'If you are coming here, don't bring the fish but teach me to go fishing myself!'

The non-medical European interviewee seemed to put slightly more emphasis on the general skills because we are acting in a resource-poor environment and stressed the point that the skill-set needs to match the concrete requirements in the specific situation. As 'refined specialism often goes with refined and high levels of technical support and equipment', the selection of which knowledge and skills are to be transferred depends on whether they are repeatable once the visitor has left.

As Lyndall Stein eloquently put it:
'You may sing a couple of wonderful arias, but no one is gonna be singing on when you have left.'
She also experienced herself that 'people in resource-poor settings often don't have enough of their peers to get the stew of excitement to learn and start new things.' This has implications in selecting the right person for the job, someone who is equipped with the right set of skills and who can encourage others to learn.

8.7.2 Language Skills

The ability to speak the local (Arabic) language is certainly a big advantage to gain trust and sympathy of the local people. Nevertheless, all the interviewees agree that it is not really imperative to be able to speak the language as even native speakers who are not 'locals' may experience difficulties understanding the local subtleties of language and behaviour. It is much more important to ensure the continuous attendance of a translator who not only needs to be familiar with local habits and language but also with the specific terminology (e.g. medical terms). It should also be a person who is trusted and respected by the local people and the co-workers.

8.7.3 Contact with People and Visits to the Host Country

The guest's use of the possibility of visiting the country and meeting local people is not only a good chance to understand habits and everyday living-conditions of the local people but is also very helpful in establishing trust and making the programme or the individual visitor known to the local people. This also provides a way of promoting the project.

This previously unexplored issue was pointed out by one of the Arabic interviewees: 'This is a key for success for the (following) visits because they (people and colleagues) will rather send patients to someone they know.' The interviewed European medical professional takes a similar standpoint.

Visiting the country also makes the visits more interesting for the guests and 'makes them understand in which context people live'. (L.Stein)

'Sitting in a room watching CNN is gonna teach you nothing.' (L.Stein)

8.7.4 Religion and personal position towards Islam

All interviewees expressed the opinion that religious issues, be it the guest's religion or the local religion, should not play any role during the visit and needs to be avoided.

It is certainly not always possible to avoid touching religious topics during a visit but 'religion should not be mixed with work'. (I.Al-Kebsi)

Interestingly, the Arabic interviewees both think and expressed during the interviews that knowledge of basic Islamic rules is 'beneficial and helps understand life, behaviour, attitude and the position of people towards therapy' (I.Al-Kebsi) and is even important in order to 'avoid conflict and misunderstanding.' (K.Al-Kharazi)

The European interviewees pointed out that religion is not important at all but basic rules should be accepted and that 'Your greatest problem in those countries is not your religion but that you are different.' (L.Stein)

8.7.5 Length, Repetition, Preparation Time and Advertising of Visits

The general opinion of the Arabic interviewees and the medical professional German interviewee is that medical knowledge-exchange visits should be about two to four weeks long. This provides enough time to prepare patients and get used to each other. Visits which last longer than four weeks might become boring for the visitor because she or he will be regarded as 'local'. It is therefore advisable to plan repeated visits of two to four weeks length. This would be good for 'building a name and to follow-up patients' (I.Al-Kebsi, K.Al-Kharazi)

Lyndall Stein suggested mixing people who have been to the country before with people who come for the first time. The enables the newcomers to benefit from the knowledge of the experienced and increases the chance of bringing in fresh ideas from the new visitors.

Knowledge exchange programmes should be planned without rush and the opinion of the interviewees is that several months should be allowed for preparation.

The importance of promotion of the programmes was especially pointed out by the Arabic interviewees and the European medical professional. It is important to let people and colleagues know about the programme well in advance, repeatedly using different media appropriate for the country in question in order to make sure the information reaches those in need. The promotion should be organized and carried out by local programme organizers but a certain level of supervision and communication is advisable to make sure the service can be accessed by people in need and not only by people privileged to reach the guest or even to get the information about the guest's arrival.

8.7.6 Cultural Training – Induction

There is a different opinion regarding possible cultural induction or briefing activities. All interviewees agree that some basic cultural induction is beneficial. Three interviewees would rather have the cultural briefing happen before the start of the visit whereas one European interviewee would favour on-site briefing by locals preceded by general preparation beforehand.

8.7.7 Age and Gender

The answers to the question whether younger or older visitors would be preferable clearly favour experienced people who ‘are not too young’ (J.Zierski). The reason for this selection, however, seems to be somewhat different:

The Arabic interviewees favour middle-aged guests because they have more experience and are more accepted in their culture. Both interviewees emphasize the importance of physical health and the capability of working under demanding conditions.

The European interviewees, who are both at least sixty years old, clearly favour older people due to their higher level of experience and the ‘better equipment to deal with challenging situations’ although ‘Young people should not be excluded if they have the right experience’. (L.Stein)

Very young people should be avoided because of several reasons. They naturally will have less experience and they ‘often find it more difficult to maintain an appropriate level of modesty and think they know more than they do.’

The Arabic interviewees clearly state that the gender issue plays no role except in specialities which deal with private parts of the human body, like ‘gynaecology, obstetrics and breast surgery’. (K.Al-Kharazi)

Interestingly, it was suggested that the engagement of ‘women beyond a certain age which lets them not being seen as a possible conquest makes them safer in an interesting way’. (L.Stein)

Nevertheless the specific attitude towards women in Islamic countries and possible consequences of inviting them need to be addressed during the planning process and participants, especially the female ones, need to be aware of them.

8.7.8 Organizational or Private Visitors

The general opinion of the Arabic interviewees and the German medic is that it doesn’t really matter if the visitor is part of an organization or acts as a private person as long as he or she is qualified enough to do the job. The interviewee with an organizational background (L.Stein) clearly favours organizational visits because of the infrastructure to organize the visit and to meet the safety requirements.

8.7.9 Visitor as Threat to Locals

In general it seems to be likely that the visitor could be seen as a threat to the local professionals. The Arabic interviewees and the European medical professional do not agree on this matter whereas the other European interviewee does agree.

In order to reduce the threat-level, it was suggested by two interviewees to share work and exchange knowledge in both directions and put special emphasis on co-operation. The public display of the acceptance of the local professional's expertise by a visitor who is aware of the problem is probably a good way of reducing the tension between locals and guest(s).

8.7.10 Remuneration Issues

The opinion of the interviewees regarding payment for the service visitors are providing is different. The Arabic interviewees think it is absolutely normal and even required that the visitors should be paid for their service. The European visitors agree that if an exchange of money is unavoidable but not wished by the provider of help, the funds should be 're-injected' into the system to the people most in need. The biggest challenge for this is to find and access those very poor people as well as to ensure they will benefit. At local level, public goods are often manipulated for profit. An example is the National Health Service where facilities sometimes are used for private patients and NHS patients are occasionally put behind private patients by doctors who are paid by the NHS. Lyndall Stein points out the importance of transparency and proposes to make 'richer people aware that part of their payment will make sure poor people can access the service.' This seems to be a practical and accepted way of charity in both the European and the Islamic cultures.

Clear communication regarding whether the treatment is free of charge or not and the monitoring of the preparation and execution of the project by an observer who is trusted by both sides, the provider and the receiver of help, is mandatory.

8.7.11 Safety Issues

The Arabic interviewees acknowledge a safety issue in their country but at the same time show a certain tendency to play it down. They point out that common sense and the presence of local people would solve most problems. Naturally, there might be some bias of local pride and the inability to imagine the concerns of guests who come from a generally safe and regulated environment.

Lyndall Stein, who is very experienced in working in high risk environments, takes a different view: Countries like Yemen must be seen as 'high risk environments' and a specialized, well

thought-out security plan is mandatory. This includes the involvement of experienced people to draw up this security plan as well as special training for the participants.

9 Discussion and Production of the Final Checklist

9.1 Discussion

In this research project the validity and practical value of Schein's concept of three levels of culture has become visible once again:

The first, superficial layer of culture, the 'Artifacts' initially seemed to logically explain how the people who are going to be approached during medical knowledge-exchange projects would like to be treated and how these assumed expectations would shape the design and course of such a project.

It seemed obvious from the age and gender distribution in a typical Islamic hospital that young and middle-aged visitors with knowledge of the local language and the religious traditions and habits would be preferred. It also appeared to be unquestioned that male guests would be preferred and that safety of the visitors would be a major issue.

Surprisingly, during the survey and especially in the following interviews with representatives of both cultures involved, it became visible that these assumptions were not always correct.

There was a preference of middle-aged and older guests and gender or religion did not seem to play a major role. The command of the local language was seem as a positive feature but it was not seen critical for the success of the projects.

This can be seen as a result of the influence of the invisible layers of Schein's model. It is extremely interesting that in the course of a live project in which the survey was carried out the participants seemed to be sensitized to follow a rather practical approach when answering the questions.

Due to his repeated work in the field, the author was given the unique chance of approaching a relatively large population of health employees in a geographically special (Middle East, Yemen) and culturally specific (Islamic country, resource-limited) region which is otherwise rather difficult to access. The participants in the survey showed a positive attitude towards the project and were very interested in taking part in the research project. This is reflected in the exceptionally high return-rate of the questionnaires.

The surveys were personally handed out and re-collected by the author who has repeatedly worked at and is well known in all three participating hospitals. This lack of anonymity and high level of personal involvement resulted in a positive attitude of the staff towards the author which also reflected in several employees requesting a copy of the final paper after its completion.

The application of Hofstede's concept of Intercultural Personality in order to compare the Yemeni culture with a typical Western culture like that of the U.K. or Germany shows some profound differences which make intercultural frictions likely.

In the Yemeni culture, Power Distance and Masculinity levels appear to be relatively high, reflecting the Yemeni society being relatively paternalistic, hierarchical and polarizing. The level of individualism seems to be relatively low, emphasizing relationships over tasks and making private opinion less important. The society seems to show a medium to high level of uncertainty avoidance where conflicts are felt to be rather threatening.

In the experience of the author the inter-personal relations in a typical Islamic hospital seem to follow this model relatively strictly. There is a well-structured, powerful hierarchy, indirect communication predominates and at the same time the collective takes priority over the individual. This is reflected not only in the collective prayers which are incorporated into the daily routine but also in the family- and group-based approach to patient presentation, treatment, illness, recovery and death.

Western cultures like that of the United Kingdom and Germany follow a different pattern. Power Distance and Masculinity levels are much lower making consultative and compromise-based behaviour more likely. At the same time a rather task-based approach is often followed and conflicts are more acceptable.

As mentioned above, one of the major problems in applying these cultural models is the increasing mixture of different cultural backgrounds especially in the developed Western societies as well as increasing levels of globalization which make clear characterization of cultures impossible. However, Yemeni society is still relatively untouched and therefore those models can be applied more easily.

The general view of the participants towards possible affiliations of potential visitors with Charity and other organizations initially did not seem to be of any importance. The author, for instance, favoured the flexibility and independence of private visitors.

Interestingly, there seems to be a tendency to favour an organizational background of the visitor. This may be due to the good reputation of many charity organizations. Another reason for the preference of an organizational background is the possibility of connecting the project and the participants with the values, experience and reliability of a well-established body, which oversees the preparation, provision and monitoring of the project.

The possibility of providing a conclusive safety concept and the immense importance of a well-planned preparation and follow-up process for any knowledge-exchange programme are invaluable advantages of an organizational background of such programmes.

Interestingly, the Arabic interviewees did not share the same opinion as the Western interviewees regarding safety. The failure of an aid project in an unstable global region due to a safety incident would be a catastrophic outcome and must be avoided at all costs. Therefore it seems only logical to follow the suggestions of the Western interviewees and regard it as a critical success factor.

When looking at our specific topic of medical knowledge exchange, three dimensions need to be considered:

1. How does the national cultural identity of the employee (program participant) fit into the organisational culture of the program provider?
2. How does the organisational culture of the program provider interact with the culture of the program target organisation?
3. How does the organisational culture or the program provider represented by the participant interact with the national culture of the individuals receiving the program?

These questions need to be addressed and answered during the programme-planning and staff-selection processes.

The desire of those in receipt of the aid to be able to communicate with the guest in the local language was expected from a review of the literature and the fear of potential communication barriers. Interestingly, there was only moderate demand for Arabic speaking visitors and the wish for an excellent overall ability to communicate in a sympathetic and tolerant way was much more emphasized.
Nevertheless the provision of an interpreter who preferably should have a medical (or project related) background should potentially lower this communication barrier or, in the case of a local translator, even reverse it and prove an advantage. The interviewees specifically suggested local professionals (i.e. students, nurses, doctors) to be charged with interpretation and direct mediation of communication between the locals and the visitor.

The fact that the hosts would like the guest to have a basic knowledge of Islam, but do not necessarily regard the religion of the guest as an important selection criterion is extremely interesting. From written research and personal experience it might be expected that there would be a clear preference for Muslim guests. This seems not to be the case. Lyndall Stein

was probably correct when she mentioned that the hosts expect that their guests will mostly be non-Muslims in any case.

Nevertheless, in order to ensure success, a general interest in and respect and tolerance of the Islamic religion seem to be key properties of individuals who are going to be professionally active in this region.

The issue of remuneration and distribution of fees and supplies was not expected to be of importance when planning this research-project. Nevertheless it could be identified as a key problem which needs to be addressed, solved and monitored before, during and after the help-project. Bilaterally acceptable ways of dealing with profit and returning those profits and other financial and material means back to the community and of not excluding poor people have to be found and ensured.

It is very interesting that most of those questioned find it necessary to be able to contact the guest even after completion of the project. In other words this means that the responsibility of the guest towards the receivers (patients as well as colleagues) in their opinion should not stop after the completion of the project.
From a another perspective, about half of those people would rather see a different person each time the project is repeated. It could be argued that this is a way of denying their own 'responsibility' towards the guest, i.e. staying in contact with visitors or giving them a chance to see the results of their work or building up something more substantial by repeating the visits. It seems rather short-sighted to describe a knowledge exchange, aid or charity project as uni-directional only. There is always a return of information on both sides. This means the care-provider, or whatever we want to call the person who is sharing knowledge and skills, always gets something in return. This should never be forgotten.

The rewards don't need to be material. A smile, a laugh, the knowledge that someone will live is often the only payment charity workers receive.

It should not be forgotten that anyone who decides to provide help in any way sometimes also needs support and acknowledgement Therefore during the planning process of inter-cultural help programmes it is necessary to enable the participants to access help and support in emotionally and physically difficult situations.

As a result of the survey, it appears that the participants in aid programmes are often expected to be available and provide counsel and feed-back or even follow-up after they have left or after the project is closed. On the other hand repeat visits, although they are regarded as being more efficient than the first one due to several reasons are not demanded by the same percentage of questioned people.

Any aid project should have some symbiotic characteristics; be it just to let the helper know about the fruit of her or his efforts. Any sign of ‘parasitic transformation’ in such a project should be investigated and reversed.

This is therefore certainly a worthwhile topic of discussion during the preparation of any project. By openly addressing the possible concerns of the potential guests being used to start something great but at the same time being cut off from seeing the results of their work, frustration could be avoided and the success of the project will be made more likely. Models such as the previously suggested gradual or rotating exchange of project participants might prove helpful.

It is obvious that nearly a third of participants comment on preparation issues for the projects in question stressing the importance of a proper and well though-out planning process. This supports the thesis that project planning and preparation in a well-organized and professional way is a key success factor for intercultural knowledge exchange projects.

The above mentioned problem, that ‘people in resource-poor settings often don’t have enough of their peers to get the stew of excitement to learn and start new things’ let’s us conclude that it is certainly a good idea to assess the capability of inspiring and encouraging other people in the process of picking the most competent and appropriate person for participation in those knowledge exchange programmes.

The suggestion of mixing people with experience in working in a specific country or area of a country, with people who come for the first time could be an interesting idea in making knowledge programmes more successful. The rotation principle would enable the newcomers to benefit from the knowledge of the experienced and increases the likelihood of bringing in fresh ideas from the new visitors.

A scheme as people-based as a knowledge exchange project thrives on the communicative and improvising ability of the people who carry it out. Therefore ‘scenarios’ which are to be solved by the candidate during the interview could help to assess their ability to transfer theory into action.

Finally, the question of how to determine or to measure the success of a project needs to be addressed during the planning process. It might be very helpful to define project-specific measurable criteria for the evaluation of inter-cultural aid-programmes.

9.2 Final Checklist (Page 1 and 2)

General Information (optional)	**Fit**				**NoFit**
Age : …… Years Preferred Range: …….	☐				☐
Gender : Female / Male Required: F / M / n/a	☐				☐
Profession : ……	☐				☐
Basic Skills (to be assessed during interview)	**Very Good**	**Good**	**Neutral**	**Poor**	**Very Poor**
Communication skills (general impression)	☐	☐	☐	☐	☐
Professional experience (i.e. years of practice, achievements)	☐	☐	☐	☐	☐
Teaching skills (i.e. teaching record, professional history)	☐	☐	☐	☐	☐
Team capability	☐	☐	☐	☐	☐
Scenarios (Give concrete examples !)	**Very Good**	**Good**	**Neutral**	**Poor**	**Very Good**
'How would you handle it if you were a threat to colleagues?' ……	☐	☐	☐	☐	☐
'There is a security threat? How would you react?' ……	☐	☐	☐	☐	☐
'How would you measure the success of the project?' ……	☐	☐	☐	☐	☐
Appearance (general impression during interview)	**Strong Yes**	**Yes**	**Neither Nor**	**No**	**Strong No**
Trustworthy	☐	☐	☐	☐	☐
Honest	☐	☐	☐	☐	☐
Respectful towards others	☐	☐	☐	☐	☐
Patient	☐	☐	☐	☐	☐
Please count marks in each column ! **<u>Primary Criteria</u>** **Total Count:**		**↓(A)**	**–**		**↓(B)**

<u>Primary Rating</u> is A – B ☐

Secondary Criteria (specify where possible !)	**Yes / Relevant**	**None or Irrelevant**
Special professional expertise: ……	☐	☐
Regular (repeated) availability for projects: ……	☐	☐
Language skills: ……	☐	☐
Activity in similar projects / countries : …….....	☐	☐
General knowledge of target country / region: ……	☐	☐
General knowledge / interest of/in Islam lifestyle.	☐	☐

Please count marks in <u>left</u> column only! ↓

Secondary Rating

Primary Rating (min: -14/max:+14)

(see page 1)

Secondary Rating (up to 6)

Primary and Secondary Ratings are comparative figure to help selecting suitable candidates.

The Primary Rating is much more relevant for selection.

The Secondary Rating can be used to compare candidates with similar Primary Ratings.

10 Conclusions and Recommendations

As a result of this research project the following statements can be made:

4. The utilization of the experience of participants in previous medical knowledge transfer projects from Western to resource–limited Islamic cultures can be helpful in the selection of key success factors for those projects.
5. It is difficult to determine possible reasons for project failure or success because of the great difficulty in defining those outcomes and the variety of possible projects and personalities involved. Nevertheless some general conclusions can be drawn.
6. Systematic planning and preparation of those projects and a refined staff selection-process are advisable.
7. The following areas and competencies play a key role for the success of medical knowledge exchange programmes between Western and resource-poor Islamic cultures:
    1. Inter-personal and inter-cultural communication skills of participants
    2. Professional and personal experience and training of participants
    3. Safety awareness of organizers and participants
    4. Involvement in an organizational framework with experience in similar projects
    5. Professional and experienced preparation, promotion and monitoring of the project

The selection of participants with outstanding communications skills and a refined and long-enough preparation and staff selection process seem to be the main factors predicting the success of inter-cultural knowledge exchange projects.

As a result of this research project, a checklist was produced which may be helpful in easing the process of staff selection for inter-cultural exchange programmes.

The elaborated checklist can be used as a tool to compare potential candidates for medical and other knowledge exchange programmes between Western and resource-poor Islamic cultures. It should also prove helpful in focusing on key success factors for those projects

Further research should be carried out to prove the practical use of the checklist during the interview process in a live-project and/or to further develop it for use in other inter-cultural projects.

11 Appendices

Appendix A

Summary of the Quantitative and Qualitative Paradigms

Quantitative Research also known as the Positivist Paradigm	Qualitative Research also known as the Phenomenological Paradigm
Older tradition, derived from scientific enquiry.	Developed from research into human experience.
Data take the form of numbers.	Data take the form of "not-numbers".
Reality is assumed to be a fixed concept.	Reality is assumed to alter according to perspective.
Researcher maintains objectivity, remaining aloof and distant from the researched.	There is interaction between researcher and researched, possibly to the extent of intersubjectivity where both collaborate on the work as a whole.
Ensuring reliability means that the work may be repeated with the same findings.	Reliability may not be possible with human experience. It is less important.
Large representative samples.	Small samples, not necessarily representative.
Validity may be low.	Great importance placed on validity - the truth or trustworthiness of the research.
Findings to be generalisable to whole population studied.	Findings not generalisable, may be "transferable" in certain circumstances.
Deductive, or hypothetico-deductive stance - tests pre-set theories and hypotheses.	Inductive stance develops theory from observation.
"Artificial" research setting, controlled by the researcher.	"Natural" setting for the researched.

(derived from Easterby-Smith, Thorpe & Lowe, 1997; Hussey & Hussey, 1997)

Table 5

Comparison of quantitative and qualitative research paradigms

Source: lecture notes, J.Knowles, Cambridge 2009

Appendix B

Deduction emphasises	*Induction emphasises*
■ scientific principles ■ moving from theory to data ■ the need to explain causal relationships between variables ■ the collection of quantitative data ■ the application of controls to ensure validity of data ■ the operationalisation of concepts to ensure clarity of definition ■ a highly structured approach ■ researcher independence of what is being researched ■ the necessity to select samples of sufficient size in order to generalise conclusions	■ gaining an understanding of the meanings humans attach to events ■ a close understanding of the research context ■ the collection of qualitative data ■ a more flexible structure to permit changes of research emphasis as the research progresses ■ a realisation that the researcher is part of the research process ■ less concern with the need to generalise

Table 6: Comparison of Deductive and Inductive Approaches
Source: Saunders, Mark (2007)

Appendix C

Date (range)	Task to be completed	Remarks
Dec 2009 / Jan 2010	Literature research and Research Proposal	Research Proposal: 4.Jan2010
end Feb 2010	Final structure of topic and adjustments to objectives, strategy, methodology	
early March 2010	Preliminary Interview(s) in Sana'a / London	during planned project-visit to Sana'a, Yemen
end March	Write literature review	
early April 2010	Review preliminary interview(s), find key issues and produce questionnaire	Visit supervisor !
late April 2010	Write methods part	
early May 2010	Perform interviews, hand out questionnaires personally (collect local questionnaires in Sana'a)	during planned project-visit to Sana'a, Yemen and in Germany/U.K.
June 2010	Review results (interviews/questionnaires)	Visit supervisor !
early/mid July 2010	Produce checklist and write-up findings/results	Visit supervisor !
end July 2010	Write remaining parts of thesis	
1st August 2010	Revise thesis, print, bind	
7th August 2010	Submit thesis	

Table 7

General Time Schedule for the Research Project

Appendix D

Task		*Literature Research*	*Write & submit Research Proposal*	*Adjust and Finalize Objectives, Strategy & Methods*	*Preliminary Interview(s) in Sana'a & London*	*Write literature Review*	*Review prelim. Interviews & define key issues*	*Produce questionnaire*	*Write Methods Part*	*Perform Interviews*	*Hand out/send questionnaires*	*Collect data / questionnaires (Yemen/Europe)*	*Review Data / Results*	*Produce checklist*	*Write Results Part*	*Write remaining part of thesis*	*Revise thesis*	*Print / bind*	*Submit*	*See Supervisor*
week		...																		
	47	X																		
	48	X																		
Dec	49	X	X																	
	50	X	X																	
	51	X	X																	
	52	X	X																	
Jan	1	X	X																	
	2	X																		
	3	X																		
	4	X																		
Feb	5	X		X																
	6	X		X																
	7			X		X														
	8					X														
Mar	9				X															X
	10				X															
	11					X														
	12					X														
Apr	13						X													
	14						X	X												X
	15						X	X												
	16								X											
May	17								X		X									
	18									X	X									
	19									X		X								
	20											X								
Jun	21												X							
	22												X							X
	23												X							
	24																			
Jul	25													X						
	26													X	X					X
	27														X					
	28															X				
Aug	29																X	X		
	30																		X	

Table 8: Detailed Time Schedule for the Research Project

(adjusted to author's professional timetable, including scheduled visits to Yemen)

Appendix E

Transcript of Preliminary Interview I (29 January 2010, London)

1. **Which do you think are the key properties of a successful provider of professional (medical) knowledge?**

   - 'We preferably choose people who have proven their ability to perform in similar projects.'
   - 'We look for people who show a high level of adaptability.'
   - Experience and ability to live and work with other people in an often insecure and primitive environment.
   - Proven ability to build a team and efficiently work in a team
   - outstanding interpersonal communication skills (not necessarily language skills although this would be helpful)
   - Proven experience in comparable projects (especially for team leaders) and longer assignments
   - 'Professional skills are important but not more than communication skills, team skills and motivation.'

2. **Which are, in your opinion, the most common reasons for failure or difficulties during an aid project?**

   - Managerial deficiencies (failure to build/run a team, failure to motivate, lack of experience in similar projects, failure to recognize potential problems)
   - Failure to monitor projects efficiently (on-site and off-site) and to recognize potential problems and threads before they endanger the success of the project.
   - Poor relationship with and insufficient understanding of local people

3. **What do project participants most often complain of?**

   - Not enough presence of leadership / guidance
   - Lack of money and resources
   - Pace of action (preparation time too short, duration to bring measures to live too slow in area of project due to cultural, social, logistic differences/misunderstandings)
   - Lack of appropriate preparation for what awaits them on-site (i.e. cruelty, poverty, violence, insecurity, primitive conditions)
   - 'Participants often do not like not being able to do things themselves and having to fit into the system (of the organization/of the local society)
   - HR (terms and conditions not communicated/understood clearly enough)

4. **What do project participants often like?**

   - High level of respect from local people and at home

- Satisfaction to do something different and great
- Efficient and fruitful communication with local people and with organizers
- See something interesting and new

5. How do you at your organisation prepare new projects?

- Routinely perform interviews with new participants
- 'Gut instinct' of experienced interviewers
- Don't necessarily rely on references because they are often subjective and do not predict the performance of the person under the specific circumstances
- Remove people early if there are problems – need for regular progress reports/experienced team leaders with good interpersonal skills
- No formal training program, preparatory workshops, language course or inductions

6. How do you follow-up the projects?

- Daily / later weekly reports
- Statistics
- Evaluations

Appendix F

Transcript of Preliminary Interview II (22 February 2010, Sana'a)

1. **Professional qualifications or ability to adjust and communicate**

   - both important
   - communication skills are especially important in our society
   - needs to be able to do things that are not provided already or at a more modern level

2. **Communication skills**

   - translator necessary
   - people are often uneducated and don't know how to describe symptoms and also don't understand the disease

3. **Language skills / translator**

   - not important
   - needs translator who is familiar with the professional topic/speciality to avoid confusion/ misunder-
     standing and ease communication with guest
   - translator needs to be familiar with the local culture and preferably should be a local person who
     understands the people
   - translator needs not only to translate language but also meaning
   - should be with the projects all the time

4. **Experience in similar countries**

   - experience and knowledge of ways to communicate with people is crucial to know what is to be
     expected

5. **Emotional stress / approach to disease and treatment**

   - foreign doctors are usually trusted due to good reputation of training
   - patient usually has to be well informed repeatedly, honestly about the procedure and the risks
     especially in serious conditions/procedures
   - approach to disease is different (religion, faith)
   - for routine procedures complications should not be stressed too much because this implies insecurity
     on the side of the doctor
   - reputation is everything

6. **Money issues and access to medical care**

   - different to Western system, usually no insurance
   - payment for treatment

- patient has to pay by themselves (some insurances)
- often medical ‘tourism’ within town/country to get advice for treatment and then negotiate the lowest price
- people often have to sell cars etc. to get treatment
- often reduction of price needs to be negotiated/ understanding of usual price for treatment is necessary
- payment for service is important because otherwise hospital would charge anyway and see the visit as a way to make money
- if treatment would be free the rate of unnecessary visits would be increased and patients would assume to get better service if they have to pay a certain amount of money
- money issues and dealing with poor patients who need treatment need to clarified with administration beforehand

7. **Age, Gender (i.e. acceptance of female doctors), Religion** (should it be obvious/public)

- thinking that older doctors are more experienced
- but not too important
- in surgery male is more trusted, females not accepted
- in gynecology/obstetrics male doctors unacceptable
- religion no problem because people know anyway
- certain religions should not be made public to avoid problems

8. **Duration of stay**

- not too short (2-4 days too short), people need time to decide and to travel to hospital, follow-up
- not more than a couple of weeks (2-3 weeks)
- patients will come repeatedly if they know that doctor is here for a longer time
- decision for treatment would be delayed

9. **Competition with local doctors**

- there is a lot of competition
- local doctors are often angry and jealous that someone from abroad intrudes into their environment

10. **Security**

- there is a security issue
- often overdone and over-emphasized, common sense should be applied
- needs to be addressed beforehand
- in cities often no problem, in rural areas there is a real risk, measures taken/agreed for protection

Appendix G

Questionnaire for Survey in Sana'a – English Version - Page 1

Jorn A. Horaczek MD MSc — Cambridge / Berlin

Questionnaire

Critical Success Factors for Medical Knowledge Exchange Programs

General Questions

What is your gender? Male ☐ Female ☐

How old are you? 18-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ over 50 ☐

Which is you field of work? Doctor ☐ Nurse/Carer ☐ Administration ☐ Other ☐

How long have you worked in this field? 0-1 year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐

Your opinion about the Skills and Training of the visitor (Please mark on the scale)

	very important	important	neither/ nor	unimportant	very unimportant
How important is **professional experience** of the visitor?	☐	☐	☐	☐	☐
How important is the ability of the visitor to **speak Arabic**?	☐	☐	☐	☐	☐
How important is the **age** of the visitor?	☐	☐	☐	☐	☐
How important is the **religion** of the visitor?	☐	☐	☐	☐	☐
Is the possibility to **contact the guest** afterwards important?	☐	☐	☐	☐	☐

Should the guest be a **general specialist** in his field of work? Yes ☐ No ☐ Don't care ☐

Should the guest offer **methods** that are not available here yet? Yes ☐ No ☐ Don't care ☐

Do you prefer a visitor who worked in Arabic countries before? Yes ☐ No ☐ Don't care ☐

Do you prefer male or female visitors? Male ☐ Female ☐ Don't care ☐

I **prefer male** guests in: Surgery ☐ ENT ☐ Internal ☐ Gyne/Obs ☐ Dentist ☐ Nursing ☐ Admin ☐

I **prefer female** guests in: Surgery ☐ ENT ☐ Internal ☐ Gyne/Obs ☐ Dentist ☐ Nursing ☐ Admin ☐

Organization of the visit

	very important	important	neither/ nor	unimportant	very unimportant
How important is **advertising**? (i.e. newspapers, TV, poster)	☐	☐	☐	☐	☐
How important is knowledge of the guest about **Islam**?	☐	☐	☐	☐	☐
How important is it that the guest **meets locals** after work?	☐	☐	☐	☐	☐
How important is it that the guest **visits the country**?	☐	☐	☐	☐	☐

Do you think the visitor should be **paid** for the visit? Yes ☐ No ☐ Don't know ☐

If "Yes": Should the visitor be paid **more than local doctors**? Yes ☐ No ☐ Don't know ☐

Do you think the visitor needs special **security arrangements**? Yes ☐ No ☐ Don't know ☐

Should the guest have a **permanent LOCAL translator**? Yes ☐ No ☐ Don't know ☐

Should the **translator be a doctor** as well? Yes ☐ No ☐ Don't know ☐

How long in advance would you like to know about the visit? ..... Don't care ☐

Should the same visitor come **regularly**? Yes ☐ No ☐ Don't know ☐

Should the visitor be part of an **organization or private**? Organization ☐ Private ☐ Don't care ☐

Do you think a foreign visitor can be a **threat to local doctors**? Yes ☐ No ☐ Don't know ☐

Questionnaire for Survey in Sana'a – English Version - Page

Jorn A. Horaczek MD MSc Cambridge / Berlin

Which **personal characteristics** of guest would you like most?

Which **personal characteristics** of guest would you dislike most?

Write any **suggestions** to improve visitors' programmes and anything you think is important for this issue below: (in Arabic or in English)

The finished research publication in English will be available in October 2010.
Please provide your email address or your name and department on a separate piece of paper if you would like to get a copy.

Thank you for your participation.

Best wishes
Jorn A. Horaczek MD MSc Sana'a, May 2010

Appendix H

Questionnaire for Survey in Sana'a – Arabic Version - Page 1

جورن هورازيك MD MSC كامبردج / برلين

عوامـــل نجاح برامج الزيارات الطبية

أسئلـــة عامة

١- جنسك ☐ ذكر ☐ أنثى.
٢- عمرك ☐ ١٨-٢٠ ☐ ٢١-٣٠ ☐ ٣١-٤٠ ☐ ٤١ – ٥٠ ☐ أكبر من خمسين عاما.
٣- عملك ☐ طبيب ☐ ممرض ☐ إداري ☐ أخرى.
٤- المدة التي تعمل فيها ☐ ٠- ١ سنة ☐ ١ – ٢ سنة ☐ ٣ - ٥ سنة ☐ ٦ – ١٠ سنة.

* أرناك حول مهارات وتدريب الزائر (من فضلك ضع علامة حول إختيارك) :

	مهم جدا	مهم	لايعني شيء	غير مهم	غير مهم على الاطلاق
١- ماأهمية الخبرة المهنية للزائر.	☐	☐	☐	☐	☐
٢- ماأهمية أن يتكلم الزائر العربي.	☐	☐	☐	☐	☐
٣- ماأهمية العمر للزائر.	☐	☐	☐	☐	☐
٤- مامدى أهمية ديانة للزائر.	☐	☐	☐	☐	☐
٥- إمكانية التواصل مع الزائر بعد الزيارة.	☐	☐	☐	☐	☐

	نعم	لا	لا أعلم
٦- هل من الضروري تواجد أخصائي في نفس المجال عند معاينة المرضى.	☐	☐	☐
٨- هل يجب على الزائر توفير طرق معالجة غير المتاحة هنا.	☐	☐	☐
٩- هل تفضل ان يكون الزائر قدعمل في أحد الأقطار العربية من سابق.	☐	☐	☐

	ذكر	أنثى	لا أعلم
١٠- هل تفضل أن يكون الزائر.	☐	☐	☐

	الجراحة	أنف أذن وحنجرة	باطنية	نساء وولادة	أسنان	تمريض	إدارة
١١- أفضل زائر في.	☐	☐	☐	☐	☐	☐	☐
١٢- أفضل زائره في.	☐	☐	☐	☐	☐	☐	☐

* تنظيم الزيارات:

	مهم جدا	مهم	لايعني شيء	غير مهم	غير مهم على الاطلاق
١- ما أهمية الإعلانات للزيارة (مثال في التلفزيون في الصحف أوغيره).	☐	☐	☐	☐	☐
٢- ماأهمية معرفة الزائر بالإسلام.	☐	☐	☐	☐	☐
٣- ماأهمية أن يلتقي الزائر بالمواطنين بعد العمل.	☐	☐	☐	☐	☐
٤- ماأهمية أن يزور المناطق التاريخية في الوطن.	☐	☐	☐	☐	☐

	نعم	لا	لا أعلم
٥- هل تظن أنه من الضروري أن يأخذ الزائر أجرا على عمله.	☐	☐	☐
٦- إذا كان نعم فهل يجب إعطائه أجر أكثر من الأطباء الموجودين.	☐	☐	☐
٧- هل تظن أن الزائر بحاجة إلى الحماية الأمنية	☐	☐	☐
٨- هل يجب أن يكون هناك مترجم بإستمرار مع الزائر .	☐	☐	☐
٩- هل يجب أن يكون هناك المترجم طبيب.	☐	☐	☐

١٠- كم المدة التي قبلها تريد أن تعرف أن هناك زائر قادم ..... ☐ لايهمني

	نعم	لا	لا أعلم
١١- هل يجب أن يأتي الزائر نفسه بصورة متكررة.	☐	☐	☐
١٢- هل تظن أن الزائر الغريب قد يكون تحديداً للأطباء الموجودين في البلد.	☐	☐	☐

	منظمة حكومية	قطاع خاص	لا يهمني
١٣- هل يجب أن يكون الزائر جزاء من منظمة أو قطاع خاص.	☐	☐	☐

Questionnaire for Survey in Sana'a – Arabic Version - Page 2

س/ماهي الخصائص الشخصية للزائر التي تحبها أن تكون؟

س/ماهي الخصائص الشخصية التي لاتحب أن تكون في الزائر؟

ملاحظات عامة:
الرجاء كتابة أي إقتراحات تظن أن تساهم في نجاح الزيارات (بالعربية أو بالإنجليزية)؟

سينتهي البحث في أكتوبر ٢٠١٠م

الرجاء كتابة الإيميل الخاص في ورقة منفصلة إذا كنت ترغب في الحصول على نسخة من نتائج البحث.

شكراً لمشاركتك،،،،،

أطيب الأمنيات
جورن هورازيك

صنعاء / مايو/ ٢٠١٠م

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